Handbook for Parliamentarians on the MILLENNIUM DEVELOPMENT GOALS MDGs

Political Support & Action

Parliamentarians' Group on MDGs
PG-MDGs

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Parliamentarians' Group on Millennium Development Goals
(PG-MDGs)

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Handbook for Parliamentarians on
MDGs: Political Support &Action

Research & Authored by:

Laura Keenan

Editorial Inputs:

Vinod Bhanu
Avinash Kumar
Lysa John

Proof Reading:

John Butler

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सत्यमेव जयते

राष्ट्रपति
भारत गणतंत्र
PRESIDENT
REPUBLIC OF INDIA

MESSAGE

I am happy to learn that the Parliamentary Group on the Millennium Development Goals (PG-MDGs) is bringing out a Handbook for Parliamentarians on MDGs to raise awareness amongst policy makers about progress in key areas of human development in India.

Millennium Development Goals (MDGs) are the global commitments to save humanity from hunger, disease and poverty and to move towards equitable growth and sustainable development. These are important milestones on the path towards inclusive growth and empowerment of the marginalized sections of the global community. Our country plays a major role in making this global campaign for all round socio-economic development a success. Parliamentarians, as people's representatives, have the tremendous responsibility of making people aware about the targets and issues involved in these goals and ensure people's participation in the various programmes launched in our country which aim to realize these goals.

I extend my greetings and felicitations to the group of MPs and wish their efforts every success.

Pratibha Patil

(Pratibha Devisingh Patil)

New Delhi
September 1, 2008

सत्यमेव जयते

प्रधान मंत्री

Prime Minister

MESSAGE

I am glad to know that the Parliamentary Group on the Millennium Development Goals (PG-MDGs) is bringing out a Hand Book for Parliamentarians on MDGs.

Millennium Development Goals constitute a global commitment to realizing basic development rights of all citizens within a definite time frame. A substantial part of the backlog challenge of Millennium Development Goals lies in South Asia. These goals relate to urgent basic needs which need to be addressed by Governments and societies working together for which the role of public leadership is critical. It is, therefore, appropriate that the Parliamentary Group on Millennium Development Goals take up the effort to sensitize public leadership on these goals and keep up the pressure for their time bound delivery. I am sure this Hand Book that is being produced on this occasion would contribute to that effort.

(Manmohan Singh)

New Delhi
20 August, 2008

Foreword

On behalf of the Parliamentarians' Group on the Millennium Development Goals (PG-MDGs), I am pleased to present this handbook on the MDGs in India. This series of policy documents charts the country's progress towards realising the eight target goals areas: including, first and foremost, the elimination of poverty and suffering. The seven remaining goal areas are working towards this same ultimate objective, where poverty is not only experienced as economic deficit but also as social deprivation and discrimination, symptoms and causes of wider injustices and iniquities. Our aim is to generate understanding of the MDGs within the Indian context and identify the critical financing and policy gaps.

India's rural poor are of limited visibility to an international audience familiar with stories of a rising shining India. With 9 per cent growth rates, hefty FDI flows, rivalry with China, possibilities of inclusion alongside the current G8 nations and some of the wealthiest billionaires in the world, India is now the fourth largest and the second fastest growing economy in the world. Over the last three years, India's exports have almost doubled. But discussed far less often are the 220-230 million impoverished Indian nationals living on less than $1 a day (PPP), which amounts to nearly a quarter of the entire population (NSS data). If this figure was to be increased to $2 PPP, we would be talking about nearly 80 per cent of men, women and children in India today. Incidence of child malnutrition surpasses sub-Saharan Africa by over two thirds. Of the 5.36 lakh women worldwide who die during pregnancy or childbirth, 1.17 lakh of these are Indian and account for almost 65 per cent of all global maternal deaths.

There are some very substantial questions arising from this handbook, not least concerning the illogicality of many lateral schemes in an environment that lacks the basic investment and infrastructure to render these programmes even vaguely sustainable. In this respect, many of the MDGs are incongruous: how can we talk about reducing maternal mortality rates when essential medicines, well trained public health workers and functioning health centres are inaccessible to vast sectors of the populace? How can we really consider how to maintain the natural resources on which millions depend for their livelihoods when the government continues to refuse to avoid tying development into carbon-intensive energy patterns and set targets for more environmentally sustainable development? We can throw all the money into JSY, NACP, SSA that we desire, but these will not address the root causes of poor health, inaccessible, overpriced medicines or high dropout rates, all of which will determine whether or not India can achieve the MDGs by the 2015 deadline. Growth alone will not provide a solution to abject poverty. In order to create the holistic strategies needed to deal with India's bleak underside, there must be a reconsideration of an entire policy approach.

When considering the eight goal areas and their implications for Indian policy, we must take into account the cyclical causes of poverty and develop appropriate policy responses to break this cycle. True, it is the local community who can best assess the interrelatedness of these factors, and the PG-MDGs recognises the need for meaningful decentralisation when it comes to targeted interventions. However, the framework provided by the MDGs allows us to consider some of the overarching causes and indicators of poverty and how these are enacted within India today. Subsequently, we can assess how policies effected by our fellow politicians can best serve the needs of our constituents.

For example, Goals 4 and 5 relate to a fundamental oversight in current government strategies: the inaccessibility of healthcare, pivotal in establishing why India is faring so poorly in reducing the incidence of infant/maternal mortality. We urge the government to move away from vertical programmes such as JSY, which is only concerned with emergency obstetrics. What chance does a rural woman really have if her health has suffered from childhood, she is likely malnourished, underweight and anaemic, and has not been reached by the

public health system until the moment when she is going into labour? At this point, she is clapped on the back for making it to a public institution (providing of course she has not given birth in the ambulance on the way there), given a small sum of money with no counselling as to how best to spend this sum (i.e. investing it in the health and welfare of newborn), and likely persuaded to use this money to spend on her already sizeable and very poor family. At no point does this money contribute to the wider problems that endanger her health over a longer-term basis - health problems that are largely a consequence of the gender imbalance, inaccessible health systems, lack of preventative and potentially lifesaving interventions and limited prenatal care.

The time has come for immediate action to accompany the promises: no more token gestures, but sustainable, holistic and comprehensive strategies that integrate education, health, nutrition, livelihoods and food security. It is a universal human right to live in dignity, free from want, and alleviation of poverty is fundamental to the realisation of all other human rights. The UPA government has unravelled some key programmes with immense potential to be progressive, not least the National Rural Employment Guarantee Scheme (NREGS). Such initiatives should develop a multi-pronged, rights based approach to poverty reduction, with a focus on transparency, accountability and participation: this will mark not just a shift in *how* programmes are implemented but also the reasoning *why*. Poverty alleviation is a human right; it is not charity, but an act of empowerment and the delivery of fundamental entitlements. This rebalancing must be visible in national planning, policy and implementation. Our ability to influence poverty is inherently entangled with national capacity for good governance, which includes educating citizens as to their rights and developing ability within communities to promote and maintain truly inclusive growth.

This handbook is a relatively extensive document detailing existing policy and Planning Commission agendas, as well as policy recommendations for each Goal area. It is accompanied by a series of factsheets that outline the critical issues. The book is an introduction to the MDGs and will be followed by a series of documents on some of the key policies related to the MDGs in India, namely, NREGA, the Women's Reservation Bill and the Climate Change Action Plan.

Finally, the writers and research team at the Centre for Legislative Research and Advocacy (CLRA) have worked tirelessly to put together this document, and we must express our gratitude for their work in co-ordinating the PG-MDG programme and investing so much time in authoring this handbook. The PG-MDGs is extremely appreciative of their hard work over the past few months. On behalf of the PG-MDGs, I also value the initiative undertaken by the CLRA team in bringing us together under the PG-MDGs, and creating space for us to take on some of the most important social, economic and political challenges in India today.

To conclude, I trust that this handbook will adequately inform my fellow parliamentarians and other policy makers, and that it will assist them in carrying forward the issues related to the MDGs and human development at the appropriate policy levels.

Supriya Sule, MP
Chairperson, PG-MDGs

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Finally, thanks must go to Oxfam for supporting the “Parliamentarians' Handbook on the MDGs.”

Parliamentarians' Group on Millennium Development Goals
(PG-MDGs)

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Vice-Chairperson

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(Centre for Legislative Research and Advocacy (CLRA) is the hosting / implementing organisation of the PG-MDGs)

Introduction

Parliament and Parliamentarians have a major role in promoting and achieving the Millennium Development Goals (MDGs) in India. The aim of this handbook is to assist our Parliamentarians in monitoring India's progress towards achieving the eight international targets for poverty alleviation, and to intensify their legislative, budgetary, oversight and advocacy functions. As an advocacy and sensitisation tool, this publication also seeks to raise awareness on the MDGs and address concerns regarding scope, applicability and relevance of the eight goal areas for India today. Most importantly, we hope it will prove useful to those parliamentarians who are endeavouring to promote the MDGs and to give effect to policies and legislation that will enable India to achieve these critical targets.

Members of Parliament (MPs) are assigned significant roles and responsibilities. MPs are in a unique position, in that they are representatives of the people, policy makers, law makers, and hold the government accountable by checking and monitoring government functions. They are mandated to act in the interests of the people and to ensure that the implementing bodies work for the public good, perhaps by advocating on behalf of their constituents. However, they are also leaders who can influence and transform public opinion and behaviour. Through performing his/her parliamentary duties, a well-informed MP can effectively serve both people and country and bring about wider social change.

Ultimately, MPs are in a position to take ownership of national development processes, oversee MDG strategies, and ensure good governance and adequate investment in public services and infrastructure. Enhanced governance and institutional capacity will in turn generate direct investment and development which can lift more out of poverty. To achieve this, national leaders and policy makers must exert sustained political will and commitment as the 2015 deadline for the achievement of the MDGs draws closer.

What are the Millennium Development Goals?

In 2000, 189 Heads of State and government met as representatives of their citizens at the UN Millennium Summit and together signed the Millennium Declaration. Here, they agreed to "free our fellow men, women and children from the abject and dehumanising conditions of extreme poverty, to which more than a billion of them are currently subjected." Less developed countries pledged to strengthen policies and governance mechanisms; richer countries pledged to provide aid and resources. For the first time, governments on a national level and international institutions on a global level, e.g. the World Bank, the International Monetary Fund (IMF), regional development banks, admitted accountability for ensuring progress towards achieving these goals.

These objectives are founded on basic human rights - the rights of each person and child on the planet to health, education, shelter, and livelihood security.

There are eight goals in total:

Goal 1: Eradicate Extreme Hunger and Poverty

Goal 2: Achieve Universal Primary Education

Goal 3: Promote Gender Equality and Empower Women

Goal 4: Reduce Child Mortality

Goal 5: Improve Maternal Health


Goal 6: Combat HIV / AIDS, Malaria and other diseases


Goal 7: Ensure Environmental Sustainability


Goal 8: Develop a Global Partnership for Development

The world has made some headway in achieving many of the goals. Between 1990 and 2002, average overall incomes increased by approximately 21 per cent; the number of people in extreme poverty declined by an estimated 130 million; life expectancy rose from 63 years to nearly 65 years; an additional 8 per cent of people in the developing world received access to water and an additional 15 per cent acquired access to improved sanitation services (United Nations Millennium Project). However, there remain huge disparities both between individual goals and between, even within, countries - a situation that has been exacerbated by soaring food prices and slow global growth. The world has now passed the halfway point and is at a crucial stage in terms of determining whether or not these targets can be attained. It is now that governments in developing and developed countries alike must maximise their efforts to alleviate poverty, suffering and injustice, both at home and abroad.

The Millennium Development Goals in India

"We will have time to reach the Millennium Development Goals worldwide and in most, or even all, individual countries but only if we break with business as usual. We cannot win overnight. Success will require sustained action across the entire decade between now and the deadline. It takes time to train the teachers, nurses and engineers; to build the roads, schools and hospitals; to grow the small and large businesses able to create the jobs and income needed. So we must start now. And we must more than double global development assistance over the next few years. Nothing less will help to achieve the Goals."

Kofi Annan
Former United Nations Secretary-General

The Government of India has optimistically announced that the MDG targets will be reached ahead of the 2015 deadline. India's Tenth Five Year Plan (2002-2007) took note of the MDGs and highlighted a number of targets to be achieved during the plan period. The Eleventh Five Year Plan (2007-2012) focuses on "faster and more inclusive growth" and proposes state-specific targets for poverty reduction. It seeks to lower poverty by 10 per cent, generate 70 million new jobs, and reduce unemployment to less than 5 per cent. Public resources to key sectors have been increased through a number of centrally sponsored initiatives, such as the National Rural Health Mission (NRHM) to provide a holistic approach to healthcare delivery, the Sarya Shiksha Abhiyan (SSA) to universalise elementary education and the National Rural Employment Guarantee Scheme, which guarantees 100 days of work to every below poverty line (BPL) household. The National Common Minimum Programme (NCMP) of the current UPA Government also correlates with the MDG framework. Some of the objectives outlined in the latest plan are actually more ambitious than the MDG targets.

These initiatives make sense given that India is now classified as a "middle income country". With a steady 8-9 per cent annual growth rate and surging foreign direct investment, India is rapidly emerging as a key player in the world's economic community and repeatedly boasts of having four billionaires present amongst the ten richest individuals in the world. Indeed, there has been considerable progress in line with specific social indicators, particularly "those that respond to vertical, campaign-like approaches" (UNICEF) such as polio eradication and net enrolment in primary schools. However, where there is a need for more systemic change in attitude and infrastructure (e.g. provision of good primary care services), progress has been significantly less notable. The United Nations Development Project's (UNDP) Human Development Report (HDR) ranked India 128th out of 177 countries in 2000. There was little difference in the country's position in 2007/8, indicating that there was no marked gain in the quality of life of the average Indian citizen. There remain 400 million people who struggle to put together a single meal in a day.

India homes nearly a quarter of the world's poor and one third of the world's underweight children. In March 2006, the UN Special Rapporteur on the Right to Food announced that "food insecurity is growing" - this at a time when half the population in 5 states lives in severe poverty. Against this backdrop, 15 per cent of the population will not live beyond the age of 40. Most concerning is perhaps India's embarrassing performance in reducing maternal and infant mortality rates: for every 100,000 live births in India, it is estimated that 407 mothers die; in Uttar Pradesh the figure is as high as 73/1000.

The effectiveness of India's poverty reduction programmes will be critical in determining the state of the global poverty situation in 2015. Salil Shetty, Global Director of the UN Millennium Campaign, announced in 2008 that "India's progress on critical indicators such as Maternal and Infant Mortality, Food Security, School Enrolment and Retention and Universal Access to Water and Sanitation will determine if the world as a whole will achieve the MDGs. Today the country has all the resources required to end extreme poverty and social exclusion. The people of India must act together to ensure that the political will to put these resources to action is harnessed."

What can Parliamentarians do about the MDGs?

Effectively raise public awareness of MDGs and participate in MDG campaigns at national and local levels

Monitor and influence the local government's development policies and actions

Influence government, social/ religious/local leaders and public officials to take positive action and hold themselves accountable for progress in local development

Encourage and establish public forums for debate about issues related to MDGs. Use the constituency office and political party meetings to debate issues with communities and develop consensus on national policies

As law makers or decision makers, MPs can design, adopt and oversee the implementation of legislation and government programmes/policy

As overseers of government activities, MPs can monitor the progress and ground level commitment of the government towards the achievement of the MDGs

Ensure that adequate and cost effective funding is provided to state governments to meet the objectives of the various schemes and programmes

Verify that budgetary allocations are in line with approved government priorities for meeting the MDG commitments, and ensure that the budget reflects the importance of MDG targets in India. Lobby for the budget to include increased allocations for the realisation of MDGs if necessary, and for effective and targeted expenditure.

Individual MPs can raise issues pertaining to MDGs in Parliament through Questions and other parliamentary measures, including utilisation of concerned Parliamentary Committees

Parliament needs to integrate the MDGs within debates and scrutinise government policy positions on an ongoing basis, in order to ensure that the government is meeting its obligations to achieve the Goals

Organise debates on MDGs, their effectiveness and coherence under the mandate of the Parliamentary Committees, and the implementation of social programmes corresponding to the MDGs; organise seminars on budgetary procedures, assessment and monitoring, and the factoring in of budgetary indicators related to each of the Goals

Develop and strengthen innovative partnerships with civil society

In order to scrutinise and assess the various government programmes etc., MPs need to support and initiate steps to establish a Standing Committee on the MDGs

Ensure that Parliament scrutinises all government policies to clarify whether they are consistent with national and international development objectives

Take the initiative to establish a network of legislators for the MDGs within the country

Establish the practise of having parliamentary debates ahead of all major international meetings and signing of international treaties, including WTO ministerial meetings etc.

Use foreign visits or international conferences as occasions to raise concerns about the obligations of more developed countries to increase the quality of aid, aid volume and effectiveness

A Note on Our Sources

In the official report on the MDGs (2005), the Ministry's Secretary claimed that the absence of "sufficiently reliable data" prevented a valid assessment of India's performance against a number of key indicators. This included the proportion of people living below $1 (PPP) a day; maternal mortality ratio; unemployment of young people, and proportion of the population not obtaining the minimum required level of energy consumption. This handbook attempts to fill in these gaps, using data from international bodies such as the WHO and UN institutions as well as from GoI sources, such as the Census, National Sample Surveys (NSS) and National Family health Surveys (NFHS).

Eradicate Extreme Hunger and Poverty

Nearly a quarter of the world's poor live in India.
30 per cent of the total population live below the poverty line.
There are more than 200 million malnourished people in India.

Achieve Universal Primary Education

According to a UNESCO report (2005), India is officially home to the most illiterate people in the world.
Pupil dropout rates have increased to 50 per cent in the last 5 years.
90 per cent of India's 36 million children with disabilities are out of school.

Promote Gender Equality and Empower Women

India ranks in the bottom 10 of an international list on women's participation in the economy.
There is only 8 per cent female representation in Parliament.
There are currently 927 girls under 6 years for every 1000 boys, declining from 945 in the last decade.

Reduce Child Mortality

One out of every ten Indian children will not reach the age of 5.
Malnutrition contributes to over 50 per cent of child deaths.
India has the lowest child immunisation rate in South Asia.

Improve Maternal Health

India has the largest number of maternal deaths in the world, and yet spends only 0.9 per cent GDP on healthcare.
UN agencies report that maternal death is 41 times more likely in India than in the US, and 10 times more likely than in China.
In 2005-06, under half of all births were assisted by skilled health personnel.

Combat HIV/AIDS, Malaria and other diseases

Every year there are approximately 18 lakh new cases of TB in India.
India is one of just four countries where polio is still endemic.
25 per cent of people living with HIV in India have been refused medical treatment on the basis of their HIV-positive status.

Ensure Environmental Sustainability

By 2025, the per capita availability of water is likely to slip below the critical mark of 1,000 cubic metres.
About 4 in 5 households in India do not have toilet facilities.
India is the fourth largest greenhouse gas emitter in the world, and yet is one of the most vulnerable countries to the effects of climate change.

Develop a Global Partnership for Development

The South Asia bloc is the only region in the world lacking a single city with 24/7 water supply.
Intraregional trade makes up less than 2 per cent of GDP in South Asia, as compared to more than 20 per cent for East Asia.
Half of all people living with HIV/AIDS depend upon India for generic production of essential medicines.

Contents

Goal 1: Eradicate Extreme Poverty and Hunger

Overview

Poverty reduction must be treated as a fundamental human right that considers the causes, not only the symptoms, of poverty. Even given an overall decline in the proportion of people living below the official poverty line, inequality in India is heightening. According to the latest Social Development Report, 43.8 per cent of Scheduled Tribes and 36.2 per cent of Scheduled Castes are below the poverty line (BPL). Per capita annual income in Bihar is a mere Rs. 6400, and this - in the words of the World Bank - makes it "one of the most densely populated agglomerations of poor people anywhere in the world" (2005). A developing nation cannot leave anyone behind in the processes of change; to do so makes development a façade of numbers and meaningless statistics. A change in outlook is therefore required, which reconsiders the role of health, education, empowerment and employability as the route to achieving sustainable development, rather than mere outcomes of growth: without progress against these interlinked goal areas, poverty will remain self-perpetuating.

UN Targets and Indicators

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below $1 (PPP) per day 2. Poverty gap ratio [incidence x depth of poverty 3. Share of poorest quintile in national consumption
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under-five years of age 5. Proportion of population below minimum level of dietary energy consumption

Status

Indicator	Value according to United Nations data	2015 target	Status (based on UN projected values)
% population living below the poverty line	8.7% below $1; 77% below $2 (PPP)	18.8%	On track
% adults undernourished	Adults (15-49): 33% females, 28% males	31.1%	On track
% children undernourished	46% underweight; 38% stunted; 19% wasted	27.4%	Off track

Target 1

There are currently **260 million people** in India living below the official poverty line (BPL) of Rs 12 per day (GoI). This is just under thirty per cent of the total population and nearly a quarter of all the world's poor.[i]

In five states, **half the population** is in severe poverty (UNDP, 2008). In rural areas, this figure increases to 75 per cent.

More than a third of the scheduled caste and almost half of the scheduled tribe population live below the official poverty line (GoI).

Target 2

- There are more than **200 million malnourished people** in India (UN estimates) including around 70 per cent of India's rural populations.

  Nearly half of children under the age of 5 are underweight, and half suffer from malnutrition (NFHS-3). The country is home to **half of the world's malnourished children** – more than in Sub-Saharan Africa.

  There has been minimal change in the proportion of underweight children between NFHS-2 and -3, and numbers remain predictably higher in the more economically backward states. In Madhya Pradesh 60 per cent of children are underweight. In some states, the proportion of malnourished children has actually increased from the mid 90s to the present day. Scheduled caste (54 per cent) and scheduled tribe (56 per cent) children are more affected by malnutrition than others.

  One third of the adult married women in the country are underweight (NFHS-3).

  Lower social status of female children leads to inadequate health care and nutrition. The Ministry of Women and Child Development states that gender discrimination leads to widespread female malnutrition. For example, nearly half of girls suffer from stunted growth, compared with one fifth of boys.

  Nearly three quarters of children under three years of age and half of all adult women **are anaemic**, with severe anaemia still highly prevalent. These rates have **worsened significantly since the mid-1990s** (NFHS-2 and -3).

  In recent years, **per capita calorie consumption has decreased amongst the poorest groups** (see figure 1).

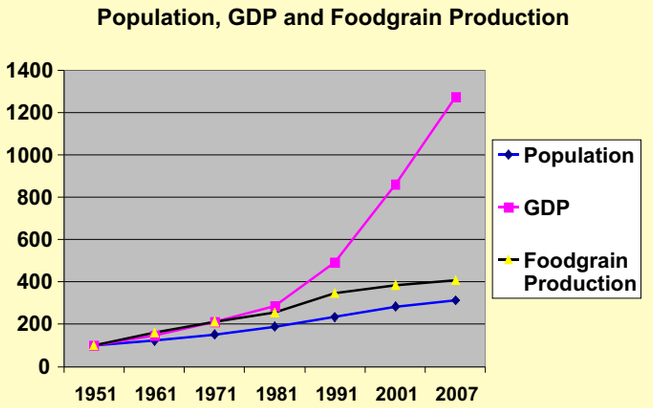

Figure 1. Source: Biraj Patnaik, Office of the Commissioners to the Supreme Court, Writ 196/ 2001

Between 1972 and 2005 per capita calorie intake in rural India has fallen, on average, by 100 calories. Still more serious is the fact that the average per capita intake of protein also declined. According to Jean Ziegler, the UN Special Rapporteur on the Right to Food, **"Food insecurity is growing"**.

Since 2002, there have been approximately **312 agrarian suicides every day**, or roughly one every 30 minutes (National Crimes Record Bureau.)

Nearly 70 per cent of India's population is rural, and farming is the primary source of livelihood. The latest Budget announced a highly disappointing **agrarian growth rate of 2.6 per cent** between 2007 and 2008: unless longer term measures are taken to remedy this poor performance and increase security for India's farmers, widespread agrarian distress will only be worsened.

Background

The government has introduced a number of schemes under the **National Common Minimum Programme** (NCMP) to tackle the problem of rural poverty and food insecurity, the most significant of which are the **National Rural Employment Guarantee Scheme** (NREGS) and the **Public Distribution Scheme** (PDS). The approach of both the **Tenth and Eleventh Five Year Plan** focuses on creating meaningful employment opportunities for 70 million people.

Agrarian Loan Waiver

The 2008-9 Budget promised to resolve the issue of agrarian debt by waiving farm loans, giving relief to an estimated four crore farmers. However, the waiver will only cover "small and marginal farmers", which is defined as those owning up to 1-2 hectares of land. Farmers cultivating crops in rainfed, arid, and semi-arid areas may own 4-5 hectares, but their income remains unstable and is largely dependent on the vagaries of the climate. Secondly, the programme only covers farmers who have taken loans from scheduled commercial banks, regional rural banks, and cooperative credit institutions. National Sample Survey Organisation (NSSO) data suggests that **42.3 per cent of outstanding debt has been sourced from moneylenders, traders, relatives, and friends.** According to the Maharastra government (one of the worst affected states), only 4.48 lakh farmers - 25 per cent - could avail loans from formal institutions in 2005-6.

Public Distribution System (PDS) and Antyodaya Anna Yojana (AAY)

The PDS aspires to make a minimum quantity of food available to every household, even in the remotest parts of the country, at a price they can afford. It has helped in eliminating famine and has quadrupled foodgrain production. However, a study from the Planning Commission (2005) has reported that PDS currently **reaches only about 57 per cent of the BPL households**, and meets only 10-30 per cent of individual food needs.

Under Antyodaya Anna Yojana (AAY), the government identifies 2.5 crore of the poorest families and provides food grains at highly subsidised prices. Additionally, for those districts not covered by NREGS, Rs 2,800 crore was allocated in 2006-07 under Sampoorna Gramin Rojgar Yojana (which provides a combination of cash and food for work). Under this scheme, 50 lakh tonnes of food grains amounting to Rs 5,000 crore are allotted to states/UTs. State governments are responsible for identifying families that fall below the poverty line. However, reports suggest that in many cases lists are not finalised and the poor are unidentified, ration shops are far from the people who need them, or subsidised prices are still out of reach for the most marginalised.

The Department of Food and Public Distribution (2005) distinguishes the responsibility of central government from that of the states, delineating that the GoI must guarantee procurement, storage, transportation, and supply of subsidised grain, determine household grain entitlement and issue prices under PDS. Implementation remains with the state governments, who must focus on fixation of eligibility; identification of beneficiaries and issuing ration cards; establishing a network of fair price shops to distribute the food grain, and monitoring the implementation of the scheme.

Currently, it seems that problems occur largely at the stage of **implementation**. The DFPD report attributes these difficulties largely to four factors: foodgrains are unlifted, which affects quality and cost of transportation; food grains are diverted to the open market; BPL households are not correctly identified, and foodgrains meant for the consumption of the poorest citizens are diverted to above poverty line (APL) households.

36 per cent of the food produced is estimated to be diverted to the Black Market (Planning Commission)**.** In some states, estimates for this "leakage" reach 80 per cent. Collectively, this means that **only 27 paise of every rupee spent on TPDS reaches the intended beneficiaries.** In addition, **47.5 per cent of cards were estimated to be bogus**, i.e. held by ineligible or non-existent households (based on data from DFPD, GoI, April 2005). In most states homeless individuals and street dwellers have difficulty obtaining the cards, as do newly married persons, migrant workers and inter-state migrant workers. The PDS Control Order proposes that "State Governments shall get the lists of BPL and Antyodaya families reviewed every year for the purpose of deletion of ineligible families and inclusion of eligible families". However, state governments have not yet revised BPL/AAY cards.

The poverty line roughly approximates to Rs. 368 for rural and Rs. 573 for urban areas in most GoI policy. However, it has not been adequately redefined since 1973-4. Thus, many critics argue that many impoverished households are not being identified under the present classification system, with more effective assessments possible through monitoring of calorie consumption. Recent studies have suggested that Rs 650/1000 is required to meet calorific requirements in rural/urban areas respectively. The 2005 inter-ministry task group argued that "cereal and calorie deficiency is a better direct measure of food security", whilst the 10th Plan working group report on PDS (2001) also found methodological difficulties with identifying BPL households. Given this **fundamental obstacle in**

baseline data, it is perhaps not surprising that PDS has been relatively ineffective in tackling malnutrition to date.

National Rural Employment Guarantee Scheme (NREGS)

The Act guarantees **100 days of employment per household at minimum wage**, and is the first piece of legislation that compels the state to provide a social safety net for impoverished rural households. Up until now the scheme has covered 330 districts across different States; it is due to cover 596 districts in 2008 ahead of schedule. The adoption of a **rights-based approach to work**, including the payment of minimum wages, should contribute to enhancing the quality of life for the rural poor. NREGS has immense potential to be progressive, not only in creating employment, but also food security, workers' rights and social security, community and resource development etc. Under the Scheme, women are now entitled to equal and minimum wages.

In Rajasthan, where public awareness of the programme is high, 77 days of employment per rural household were provided in 2007. However, a draft report by the Comptroller and Auditor General reveals that on average **only 3.2 per cent of registered households could avail of 100 days 'guaranteed' work**. The average employment under NREGS was **just 18 days**.

Administrative deficiencies have meant that adequate work has not been accurately calculated for the local workforce. Gaps may result in a lapse of several days between short-term jobs, and there are currently limited projects with the longer-term potential to sustain a village's workforce. Shortages have led not only to "touting" of work, but also pockets where minimum wage is not being provided. This problem is exacerbated when monitoring is ineffective or absent or when specific tasks are not included in the SSR.

The GoI spent Rs 18,406 crores on waged employment in 2005-6, before NREGS was launched. Under NREGS, 2006-7 expenditure was 16,117 crores, with 16,000 announced in the current budget – meaning that there has actually been a decline in investment.

Percentage of households that possess ration card (NSS 61st round)

	Any card	BPL card	APL card	AAY card
Poorest	77.3	44.2	28.2	4.9
Q2	81.6	40.5	38.4	2.7
Q3	83.3	40.0	41.6	1.8
Q4	84.9	30.5	52.7	1.7
Richest	87.5	16.8	70.1	0.6

(Source: Office of the Commissioners to the Supreme Court)

Policy Recommendations

Agriculture

Loans are not the only contributing factor to agrarian suicides. For success in agricultural development there must be immediate **convergence between ministries and schemes**. A separate commission should be established with powers to take decisions on issues related to agriculture such as cropping patterns, genetic modification technology, pricing policies and irrigation. Line departments then need to be integrated to ensure that policies are effectively implemented. Governments must consider price rises for essential commodities–education, oil, fertilisers etc - and high costs for basic services such as health and education. At a local government level, **campaigns should be initiated against illegal money lending** and penal measures implemented where necessary.

Existing agrarian reform legislation should not be strengthened to serve largescale farming enterprises and agribusiness. There is a need for **increased public investment in smallholder agriculture and research into changing conditions, crops and farming practices.** Efforts must be made to diversify cropping patterns in areas of unviable mono-cropping, and local governments should initiate research into **alternative low cost organic/natural**

farming models. The current system of rainfed agriculture will always have substantial limitations on yield, and the use of technology to combat this substantially reduces profit margins. There is now an emerging market for organic produce in the metros, where awareness of the health benefits of organic foodstuffs has been rising. Farmers must be provided with information on how to deal with pests/declining productivity of land, and advice must be available to farmers from alternative sources than agents and companies. **State governments should look at establishing e-networks, support groups or resource centres** to provide training and information and influence behaviour.

To support its cotton farmers, the government should consider **tariff barriers/import duty to discourage cheaper imports**. Dr M. S. Swaminathan, renowned international agricultural scientist and former Co-chairman of the UN Millennium Task Force on Hunger, has recommended the establishment of a Price Stabilisation fund to protect cotton farmers from the volatile international cotton market, largely owing to excessive subsidies for cotton farmers in the U.S.A (See Goal 8). He has also suggested that the Central Government adopt a differential matrix in terms of minimum support prices. Minimum support prices have often not been universally available and particularly not to small and marginal farmers, and these **have to be carefully matched to the cost of cultivation of each specific crop in every state.**

Public Distribution System

In 2007 the Ministry for Consumer Affairs, Food, and Public Distribution established a Central Vigilance Committee to make recommendations for the improvement of the PDS. The Committee report concluded that corruption pervades the entire distribution chain, and that the best available solution would be to **minimise human interaction and introduce computerised technology.** The government must also initiate and enforce a **"Zero tolerance" campaign** to target corruption through the PDS system. One possible remedial measure to address the problem of bogus cards would be to introduce an **Amnesty Scheme** for four weeks prior to a wider campaign resulting in prosecution. Door to door surveys should result in prosecution and publication of names for anyone above the poverty line who is holding a bogus card, including officers of Departments. **Section 15A currently offers unnecessary protection to public servants and this should be repealed,** making public servants more accountable for their actions. Licenses of Fair Priced Shops (FPS) accused of malpractice should be immediately revoked, and enforcement squads should be strengthened. State governments must then undertake **stringent reviews of the ration cards every year as directed under the PDS Control Order, 2001.** The Committee recommends that in the interim period before weeding out all excess BPL cards, state governments should allocate 35 kg. for excess cards allocated over and above the number of households, as per 2001 population norms.

Administrative problems need to be resolved to **protect unorganised workers and their families**, i.e. "roaming ration cards" need to be distributed to those who cannot stay in one place, and those in the unorganised sector, the homeless, migrants, widows etc who cannot produce documentation for a ration card should be a top priority: spot-checking can instantly ensure eligibility without lengthy delays.

Monitoring of PDS must run simultaneously with monitoring of malnourishment. A national early-warning system should also be developed to record starvation deaths, generate emergency responses and improve accountability within states and districts.

A helpline should be established and **public awareness of PDS increased** through regular public meetings, potentially in collaboration with reputable NGOs.

The Committee report recommends **increases in the BPL threshold from Rs. 24,200 to Rs. 49,284.**

National Rural Employment Guarantee Scheme (NREGS)

There must be a shift from Department Mode to **Mission Mode**, with strategic co-ordination between central and state government and local panchyats and clearly **defined objectives and outputs for all officials.** There must be explicit timelines established for NREGA, with **milestones and measurable objectives** that can be shared amongst stakeholders.

There are a number of measures that need to be implemented to tackle administrative failings. As the draft CAG report states: "The MoRD needs to ensure that State governments take swift and immediate action to remedy these deficiencies and improve their administrative and technical infrastructure." Wage payments must be delivered on time, placed in

advance in the respective bank/post office and then delivered every week to the accounts of the individual workers. Where a "ceiling" has been imposed on what can be paid to workers, it may be necessary to review this policy in cases where skilled workers are required for the completion of the tasks in hand.

There should be **at least one large project that will generate high employment potential over a sustained period of time**. Given the objectives of the Scheme, the work should also contribute to improving the livelihoods of local farmers with perceptible benefits. This is an opportunity to also work towards **adaptation and food security** by tackling the underlying, locally specific causes of poverty and developing the land accordingly. Each panchayat should be assisted in **preparing a comprehensive plan through the participation of the local community**, which establishes suitable works as part of a long-term plan over the coming years. The Act states that 50 per cent of works should be planned and implemented at panchayat level: as yet, in many states this has been severely neglected.

Projects should encompass **development of SC/ST lands**, which must be identified at state level. Forest protection, restoration and conservation can also come under NREGA. The Centre for Environment Concerns recommends "a three-year approach to rejuvenate fallow lands into productive use with drought resistant characteristics. This involves working on soil in the first year, water in the next and microbes and environmental services in the third. Such an approach to underlying conditions should be followed with investments for its productive use… with crops, horticulture or plantations."

Social security should be provided through **life insurance and health insurance schemes** for workers. To allow the full participation of women workers, provisions must be made in the community for **childcare as well as transport to the areas of work**. Linkages with Anganwadis should be made i.e., funds from NREGA can go to the Aganwadi centres for providing care to children of wage seekers.

It is necessary for a **labour register** to be maintained in each district, and there should be statewise **NREGA workers' unions** to monitor the scheme and enhance accountability. There should also be mechanisms in place for **grievance resolution**, with formal state level protocol on instigating and placing complaints. Accountability will be further strengthened by improving transparency in regard to wages and allocations of work, which should be made freely available by specially appointed officers.

To link NREGA with measures to increase food security and tackle hunger/malnutrition, **rice and vegetables can be distributed as a proportion of the wage packet**. As with the PDS, this must be monitored to ensure that governments are adequately storing and transporting the commodities and that they are then available at a fixed price. It would be the responsibility of the central government to guarantee fixed prices, minimum support prices and storage and transport facilities. Workers' collectives can take responsibility for effective repayments.

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i There are a number of issues with current definitions of poverty in India, and the real figures are likely to be much higher. Six years ago, the Planning Commission claimed that under 20 per cent of India's poor were below the poverty line (BPL). India's first Social Development Report, 2006 then adjusted this figure to 26 per cent (193 million in rural areas, 67 million in urban). The poverty line in India only assesses the most basic calorie intake of 2400 calories per day (equivalent to Rs 368 and Rs 573 per month in rural and urban areas respectively), without considering essential nutritional requirements or other expenditure, e.g. lodgings, education and healthcare.

ii For more on strengthening local governance institutions, see section on **The Panchayat Extension of Scheduled Areas (PESA) Act, 1996** under Goal 7: Ensuring Environmental Sustainability.

iii For more on effective and targeted interventions on nutrition, see Goal 4: Reducing Child Mortality.

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Goal 2: Achieve Universal Primary Education

Overview

The UPA government has accepted that education is critical for sustainable development. Linked to this is the emphasis on ensuring education for girl children and enhancing employability. However, purely lateral interventions will not suffice: one critical problem is that employment opportunities and economic productivity are not seen to bear any direct correlation to the length of time a child spends in the classroom. This is not merely limited foresight by the parents. Rural parents can see that education is in principle desirable for their children. However, sending a child to school for the sake of ticking a box marked inclusion in the government's logbook is not really inclusion at all: this child needs to gain measurable skills that will allow him or her to become a productive citizen, leading a life that contributes to and benefits from wider economic growth and development. A World Bank survey has highlighted the inadequacies of rural education infrastructure, such as staff absenteeism and shortages. There are also few vocational options that will develop skills for sustainable livelihood security. Government must concentrate on providing "meaningful education", which provides a series of possible exit routes and is linked to actual sustainable employment projects.

UN Targets and Indicators

Target: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.	▪ Net enrolment ratio in primary education. ▪ Proportion of pupils starting grade 1 who reach grade 5. ▪ Literacy rates of 15-24 year olds.

Status

Indicator	Value according to United Nations data	2015 target	Status (based on UN projected values)
Net enrolment ratio in primary education	76 per cent (2000 2005) 89 per cent (UNESCO)	100 per cent	On track
Literacy rate of 15-24 year olds	76 per cent (2001)	100 per cent	On track
Proportion of pupils starting grade 1 who reach grade 5	Apparent survival rate-(the number of students in grade 5 as a ratio of the number in grade 1): 67 per cent (GoI data)	100 per cent	Off track

According to a UNESCO report (2005), India is officially home to **the most illiterate people in the world.**

Between 1991 and 2001, India saw record increases in literacy of 13.17 per cent – the highest in any decade since independence. However, 35 per cent of all children in the 7-14 age group cannot read a Class 1 text, and there are immense gaps in literacy levels both by population and by state. State-wise, Kerala (91 per cent) has the highest percentage of literates, whereas in Bihar less than half of the population can read and write.

The Government estimates that there were about **95 lakh students out of school in 2005**.

17-18 per cent of all children out of school worldwide live in India. In Bihar, nearly one fifth of all children are excluded from formal education. The Social and Research Institute (SRI) has reported that the Muslim girl child is particularly likely to be out of school and enrolment rates of Muslim girls have shown a steep decline in relation to the all-Indian average (Council for Social Development Report, 2006). Contrary to popular opinion, the Sachar Committee Report (2006) has identified that most

Muslim parents are keen to educate their children in mainstream education but are often prevented from doing so because of obstacles to access within their community.

There is currently a **94 per cent enrolment rate** at primary level. However, pupil **dropout rates have increased in the last 5 years to nearly 40 per cent** (Select Educational Statistics, GoI, 2006). **Amongst Scheduled Castes and Tribes, the dropout rate between Class 1 and 10 is 73 per cent.**

During unannounced visits to a nationally representative sample of government primary schools, **a quarter of teachers were absent** and only about half were actually teaching (World Bank, 2004).

75,884 of primary schools in fifteen states/union territories were operating with just one teacher. Higher rates of absenteeism were concentrated in the poorer states: for example, 42 per cent of teachers were absent in Jharkhand.

Around one third of government primary school teachers have not completed higher secondary. Only 28 per cent of government schools had electricity in 2005; one in five schools does not have a building; 10 per cent have no blackboard; 40 per cent have no separate toilet facility for girls and half are without a library.

Across the subcontinent **90 per cent of India's 36 million children aged 4-16 years with physical and mental disabilities are out of school.**

Contemporary India is one of the few countries worldwide where the education of disabled children does not fall within the purview of the Human Resource Development (Education) Ministry; rather, it is the responsibility of the omnibus Ministry of Social Justice and Empowerment. The prime focus of the Union Ministry of Social Justice and Empowerment is rehabilitation, not education, and education is not part of its agenda.

Background

First and foremost, it is important to note that the Constitution guarantees **education for every Indian child, not just at elementary level, but to the age of 14:** "primary education" cannot be the cut-off if education is to contribute to employability and the attribution of relevant life skills.

In 1986, the Government of India established the **National Policy on Education**, which emphasises three main aspects: universal **access** and enrolment, universal **retention** of children up to 14 years of age, and substantial improvement in the **quality** of education. The more recent **National Curriculum Framework**, 2005, adds relevance, flexibility and quality for modernising the system of education, as well as ensuring professionalism amongst teachers.

The **Tenth Five Year Plan** promised to have all children in school by 2003. Combined with the **Sarva Shiksha Abhiyan** (SSA), enrolment drives launched during this period reduced the number of out-of-school children from 42 million at the beginning of the Plan period to 13 million in 2005, whilst the number of illiterates declined in absolute terms by 25 million between 1991 and 2001 (Ministry of Statistics and Programme Implementation). The **Eleventh Five Year Plan** proposes to address failings in **infrastructure** and **quality of teaching** in state schools, which, it states, should be comparable to that of the Kendriya Vidyalayas. In terms of access, the government has promised primary and upper primary schools within a walking distance of one and three km.

The Government also passed the **Constitution (86th Amendment) Act**, 2002, which makes elementary education a fundamental right for all children in the age group of **6-14 years**. In 1993, the Supreme Court argued that the State has no right to deny its constitutional obligation under article 21A to provide free and compulsory education to all children until the age of 14 years. The Court added that the fundamental right to education continues after the age of 14, but acknowledged that this would be subject to economic restrictions and the capacity of individual states/union territories.

Current Policy

Right to Education Bill

The UPA government is yet to table the Right to Education Bill, 2008 (RTE) in the Parliament, although the Prime Minister has promised it will be introduced in the Monsoon session, 2008. Instead of enacting a national Bill, the government sent a "Model Bill" to the states in 2006 and asked them to make the necessary changes in

their existing education laws: this has not been approved by Parliament or recommended by the CABE, and **transfers and displaces responsibility onto individual states**.

In contrast, the RTE Bill formally transcribes and legitimises the right of the child to **free and compulsory education of an equitable quality**. It outlines the responsibilities of the state to both children in and out of school, the responsibilities of schools, teachers and of local authorities, prescribed norms and standards for schools and monitoring and recognition procedures. It implies that informal schools and teachers will have to be qualified as per the standards defined in the National Council for Teacher Education Act, 1993. The National Commission for Elementary Education would be responsible for monitoring all aspects of elementary education to ensure equitability and consistency in quality.

Under this legislation, **private schools must guarantee to admit at least 25 per cent of children from poorer sections** without any cost to these families; screening tests at the time of admission and capitation fees are also prohibited for all children. Private schools would only be established after certification from a loosely defined 'Competent Authority', but the Bill is silent on regulation beyond this.

One problem with the Bill as it stands is that it **fails to define what is meant by 'equitable quality'**, and of course does not discuss micro-management. It talks about certain basic standards for physical infrastructure (rooms, teachers, toilets etc) but does not outline expectations for progression of key skills or development of relevant, livelihoods-related competencies. Some form of assurance must be in place to ensure that the child acquires necessary skills and that overall learning outcomes are met in each classroom. The legislation also fails to address the reasons for so many children being out of school and appropriate measures for increasing access and remedying these root causes of exclusion.

The Bill briefly discusses the right of children with "severe or profound disability, [who] cannot be provided elementary education in a neighbourhood school" to be provided education in "an appropriate alternative environment as may be prescribed". This alternative environment is not elaborated on; there are no norms for physical infrastructure or teacher competencies, and **it does not mention anything about the special educational needs of children with disabilities** who may otherwise be able to attend school (accessibility features such as wheelchair ramps, for instance, learning materials in Braille, sensitised teachers etc.). It also limits disability to the definition in Section 2 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, which does not consider disabilities as defined by the National Trust Act, 1999 (autism, cerebral palsy). Children with learning disabilities, e.g. dyslexia, are also neglected: these children may require special attention and teaching methods, and yet formal schooling would still be the ideal environment for their educational development. Currently, 36 million disabled children are excluded from school. There is no money in rural areas to spend on the establishment of special schools, and yet there is no national policy to guarantee inclusive measures to enable access to mainstream education.

Concerningly, there are also substantive **vagaries concerning financing**. Depending on different teacher salary scales, the National Institute of Educational Planning and Administration originally predicted that the minimum additional expenditure would be Rs 36,000 crore per annum, with gradual decreases over time. This would be easily encompassed within additional expenditure on school education to 3 per cent GDP, as promised under the NCMP (see below). The Education Cess has been predicted to cover a marginal proportion of the additional requirements. As of yet, central government has not committed itself to any expenditure and the total costs of implementation have not figured in the final working of the Bill.

Education is **a fundamental right** that no government can deny, but only the passing of the Bill will ensure access to schooling for every Indian child– particularly as the government considers reneging on its promises to children in India and asking individual States to provide a greater proportion of investment in SSA. State governments may be unable to meet the additional fiscal requirements demanded by the Bill, and central government will therefore be mandated to fund additional increases as a proportion of the annual budget. This needs to be a definite commitment, with the required money earmarked specifically for the purpose of enacting and realising the right to education in India.

The **Common Minimum Programme** promises to:

Raise public spending on education to at least 6 per cent GDP, with at least half spent on primary and secondary sectors

There have been substantive increases in allocations of funds since the 1990s: up 56 per cent from Rs 57.5 billion in 2003-4 to Rs 89.8 billion during 2004-5, and increased by another 36 per cent in 2005-6. However, the Union Budget for 2008-9 conceded a 20 per cent increase in allocations to education, which marked a nearly 15 per cent decline in rates of investment. At this rate, India will

fall short of the internationally accepted levels of 6 per cent GDP for public expenditure on education: in India, this currently stands at around **3 per cent**. Currently, finding **access to upper primary schools** is one of the biggest problems parents and students face: in some of the worst affected states such as West Bengal, only one in five children who enrol in primary school will find a school beyond Class IV. The annual growth rate of school buildings lags at around one per cent, much beyond population increases, and **in some states teacher pupil ratios are as high as 1:80** (CAG report).

The Centre has also proposed to establish "model schools" through public-private partnership (PPP) initiatives, the Government providing the land and infrastructure that will enable private interests groups to gain access to public education. One clause in the proposal under the 11th Plan states that schools developed through PPPs will not face any encumbrances to the private party after 30 years. Educomp Solutions Ltd, an education service provider that acquired US-based learning.com for $24.5 million, has a tie-up with 6,000 schools across the country, providing information and communication technologies (ICT) programme under the Sarva Siksha Abhiyan (SSA). The company aims to expand in the Bimaru States of Bihar, Madhya Pradesh, Uttar Pradesh, Rajasthan and Haryana to increase the number of tie-ups with schools to 12,000-15,000 by the end of the fiscal year.

Public schools suffer from **high rates of teacher absenteeism and unfilled posts, lack of resources, deficiencies in basic infrastructure**, as well as an overall decline in the number of schools being established that bears no relation to rises in population. In this context, it is perhaps not so surprising that private schools have become a preferred option on the ground – and not just for the wealthy. The latest NSSO data has revealed sharp rises in the number of children at unrecognised private schools: one study suggested that this includes nearly 36 per cent of children in Uttar Pradesh (Kazmin, 2000). However, the standards of education are not always vastly improved in the private sector. Quality depends upon the programme under which the school is run, and many private schools are not recognised because they cannot meet basic requirements.

Rather than washing their hands of the education of the nation's youth, it should be possible to fix the current system with effective decentralisation of management, which enables efficiency in communication channels; appropriate auditing and monitoring procedures, and increased investment. In many schools, what is lacking is motivation and commitment; this is something that can be initiated at the central level by passing the Education Bill, increasing funding, and developing and implementing policy related to accessibility and retention. There also needs to be a revised overall strategy in conjunction with the Bill, which considers **curriculum changes, classroom environment, teacher training and motivation, community attitudes and linkages, assessed learning outcomes and effective integration with higher and further education**, including development of livelihoods opportunities. This will mark a revised commitment to quality and universal education as a means of achieving all-inclusive socio-economic development, as well as explicitly correlating education with employment.

Introduce a cess on all central taxes to finance the commitment to universalise access to quality basic education

The Government of India has been levying an education **cess of 2 per cent on income tax, corporation tax, excise duties and service tax,** fetching around 5000 crore a year. This is accrued in a non-lapsable fund, the *Prarambhik Shiksha Kosh,* and then distributed to the SSA and the Mid-Day Meal Scheme (see below). Currently there is very little transparency on how this cess has been allocated. Critics also suggest that the government, not the tax-payers, should be shouldering the primary responsibility for providing basic education to children in the 6-14 age group. So far, the **cess has basically funded increases to the SSA and MDMS**: it does not mark additional increases to the government's original intentions.

Implement the Mid-Day Meal Scheme (MDMS)

The Scheme provides one meal at mid-day with a nutritional value of 450 calories, 12 grams protein and adequate quantities of micronutrients to all children in class 1-5 in Government / aided schools. About 12 crore children studying at the primary stage are being covered under the Programme. Assistance is now provided for meeting the cost of cooking, management and provision of mid-day meals through the summer holidays in drought affected areas, whilst the 2008-9 Budget also extended the Mid-Day Meal Scheme to upper primary schools across the country. The Ministry of Statistics and Programme Implementation reports that the programme is converged with ongoing rural and urban development programmes which integrate the local community, such as self-help groups and NGOs. However, the states with the highest number of malnourished children remain those where the mid-day meal programme is not fully implemented, and the latest NFHS data found that **nearly half of Indian children are still underweight despite the extension of the MDMS**. The links between

health, nutrition and education have never been fully developed into government strategies, especially for the poorest children: a child who is malnourished and sick will not be able to develop to his full potential under any system. Concerns have also been raised about the interests of the private sector, who have been lobbying to replace the hot nutritious foods of the MDMS with packaged, processed foods of less nutritional value. This would be extremely detrimental to the health needs and subsequently the academic performance of Indian children.

Sarva Shiksha Abhiyan (SSA)

This has been a significant flagship programme of the present UPA government, with the goal of achieving **universal primary education through community-ownership** of the school system. The Sarva Shiksha Abhiyan (Education for All) campaign promises to deliver "**useful and quality elementary education**" to all children in the 6-14 age group by 2010, and emphasises the education of girl children and children with special needs, for which there should be a "zero rejection policy". Over 10 lakh new Elementary Schools have been opened; 93,000 school buildings have been completed or are in progress; about 5 lakh additional teachers have been appointed; free text books are being distributed to girls and SC/ST boys (5 crore) in classes 1 to 8.

SSA incorporates several components for particular groups of children. For BPL families, children – particularly girl children - are often needed at home for childcare/household tasks, or alternatively to earn a supplementary income. **Early Childhood Care and Education Centres (ECCE)** are being introduced to support the families of those with younger siblings, preparing children of 3-6 years old for entry into schools and thereby freeing older girls from sibling care. Community level initiatives of this nature are a means of creating sustained engagement with young people and their families so as to enable longer term access to the school system.

The **Education Guarantee Scheme** (EGS) is establishing **alternative and private education centres across** India. One concern is that it is the less well off, usually girls and the socially marginalised, who are educated in EGS alternative schools, thereby **further perpetuating iniquities and relegating those most in need of assistance to a second tier of education.** In this regard, SSA modalities of alternative schools/EGS centres and para teachers are a major catastrophe, requiring less government expenditure and **further diluting an already flailing public education system** without outlining strategies for reintegration. The proposed RTE Bill tries to correct this, but fails to make explicit any level of financial commitment.

On a similar level, the **National Programme for Education of Girls at Elementary Level** targets areas where female literacy is below the national average and the gender gap is worse than the national average, providing "region specific strategies" (Ministry of Statistics and Programme Implementation) to enable girls to come to school. These strategies include remedial teaching through bridge courses and residential camps. As of January 2008, the **Kasturba Gandhi Balika Vidyalaya** (KGBV) Scheme has established 1724 residential schools for girls at elementary level, belonging predominantly to SC, ST, OBC and minorities in difficult areas. The government report (2007) on the KGBV found that communities generally responded well to the programme and that many states had shown commendable commitment to making it operational in a short space of time. However, there have been a number of implementation issues, including lack of availability of data on out of school children or children from marginalised communities. In many states, there has also been minimum effort to use the bridge schools to reintegrate pupils within formal schooling. Many of the rented buildings were found to be inadequate, e.g. lack of sanitation or space, particularly given issues of caste discrimination, and budget for construction was often insufficient.

This is not unique to the KGBV: infrastructural failings are severely hampering the effectiveness of SSA programmes in many states. There are, for example, delays ranging from 1 to 9 months in supplying free textbooks, and, despite claims to the contrary, education is not yet free. Families are spending as much as Rs 350 per child per year on uniforms, stationery and transport.

The government's focus must be on **increasing access and retention in public school institutions**. Following the Sachar Committee Report (2006), the Prime Minister's **15-Point Programme for Welfare of the Minorities** promised to ensure equitable delivery of education for all minority children by, amongst other measures, improving infrastructure through the Maulana Azad Education Foundation; providing greater resources for teaching Urdu in primary and upper primary schools; modernising Madarsa education and ensuring universal availability of ICDS. Whilst such measures mark a positive step forward, it must also be added that the Sachar Committee Report stressed that many Muslim parents want to send their children to mainstream schools but are prevented from doing so because of **access barriers** (distance of schools– particularly secondary schools – from Muslim communities, lack of safe routes for girl children etc.)

and **poor quality schooling in SC/ST/Muslim areas**. This money would be far better invested in improving the quality of mainstream education and infrastructure available to minorities, including transport. **Gender sensitive education policies** are also absolutely critical: girl children from minority backgrounds are still more vulnerable and face even greater challenges to the completion of 8 years full-time education, and it is essential that policy makers assess the situation on the ground when considering how to enhance accessibility.

In terms of modernisation of **Madarsas**, this has in any case largely been **a nominal effort,** with limited provisions for teaching of science, mathematics and English: even those teachers who have been appointed obtain a minimal salary and report frequent delays in payment. The Report also implies that it may be beneficial to make English the medium of teaching from primary level. Since there are less secondary schools in Muslim areas, students will likely have to attend a non-Urdu speaking school after finishing elementary education and sit examinations in either Hindi or English - not considering the lack of provisions for Urdu speakers at university and in subsequent employment. This thereby overwrites the value gained by teaching in Urdu at primary level, and, in fact, might actually make it more difficult for the child to reach his/her potential later on in life.

Given that there are so many challenges still to be overcome and that there is massive income disparity between states, **central government proposals to increase state government investment in SSA to 50 per cent from its present level of 15 per cent is a frightening prospect**. In the present climate, such a move would likely result in even more substantial declines in investment in education over the coming years.

Policy Recommendations

To provide equitable education to all children, the **Right to Education Bill** must be passed as a matter of absolute priority to guarantee the achievement of baseline norms and standards across India. Equitable quality needs to be defined to ensure that certain minimum standards are safeguarded by law, irrespective of location, finances, number and situation of the children. With this legislation, the Central Government must guarantee that **entirely *free* education** be provided, which means coverage of all costs – not merely fees. The Bill should also demarcate the progress a child is expected to achieve as he or she moves through the school system, with national benchmarks to be achieved in all classrooms. The Right to Education must be **enforceable** and the Central Government accountable if the system fails to provide education to any Indian child, as outlined in the Constitution. Article 44 (Chapter VII), which protects against "action taken in good faith", must be removed or qualified, for the potential remains for gross misuse of this provision. There can be no excuses for shelving a fundamental human right.

In the interim, the so-called Model Bill must be made **publicly available** and submitted to the CABE for approval, so that the concerns of the public and educationalists can be specifically addressed. The Government must then provide for implementation of the Bill, drawing up a timeline in consultation with the implementing authorities in the states that guarantees quality and infrastructure. A **high-level Task force** must also be established under the leadership of the Prime Minister of India to drive and monitor the implementation of the Bill. The task force must include representatives of State, local Governments, teachers, NCERT, NGO's and parents. Similar bodies may be set up at state levels.

"Para" schools and teachers must be officially reformed into **regular schools with qualified teachers** within a specified time frame, and strategies must be drawn up for reintegrating children in current EGS/alternative schools into mainstream education.

The Education Bill must be amended to **specify the rights of the disabled child**, with a more detailed analysis of what provisions will be made: i.e. sensitised teaching, Braille texts, physically accessible schools. Measures for inclusion into formal schooling of children with learning difficulties must also be made explicit. Alternatively, the "appropriate environment" for those children physically unable to access the school (which in many cases should be a last resort) must be broken down in the same terms as the environment demarcated for children in the formal school system: number of teachers, availability of resources, sanitation etc.

Providing access to children with disabilities must come under the purview of the Ministry for Education, and there should be an **explicit rights-based policy on delivering education to disabled**

children. The lack of disability-friendly transport services, buildings and sensitised teachers needs to be tackled. Inclusive schools have to address the needs of all children in every community and the central and state governments must train teachers to manage inclusive classrooms. Budgetary increases will also need to be provided to ensure that the needs of disabled children are met.

The government needs to make long-term commitments to improving infrastructure, which will require the international minimum of **6 per cent GDP investment**. The government promised in the NCMP that this should be achieved by 2009, and new benchmarks should be established against which progress can be monitored. In terms of targeted investment, it is essential to improve classroom practices and assessment/audit processes, as delineated in the Right to Education Bill. The establishment of an **independent auditory body** will enhance the accountability of state governments in providing equitable education to all children. State governments must maintain accurate monitoring mechanisms, records and up to date data including that on out of school children. **Motivated staff** are also essential for a well-functioning school system. There should be regular meetings between teachers and local officials so that grievances can be aired, and teachers should be provided with a redressal mechanism in the Bill in the case of a complaint against the management team or the local authority. There may also be a demand for professional development trainings and workshops to enhance the knowledge of teachers and update their teaching methodology, but these trainings must be constructive and run by professional, highly qualified staff. The priority must be on "**meaningful access**" (Dr. Vimala Ramachandran), which entails a holistic approach that incorporates objectives such as regular attendance, availability of resources and a suitable environment that is integrated within the community.

There is a need to develop a **standard nationalised curriculum** to be followed by all schools in key areas of learning, and schools will need to be audited to check that they are following these guidelines and keeping to required standards.

The **linkages between primary to upper primary, middle and high school and then to higher and technical/vocational education** must be fully developed and there should be a series of possible exit routes after Class VIII, including skills and livelihoods training. Formal education has to become a realistic and attractive option throughout adolescence, which, if it is to become viable for India's poor, means correlating it to **economic security and sustainable livelihood activities**. There must therefore be a range of locally determined exit points, drawn up after analysis of local employment opportunities (health, agriculture, nursing, infrastructure development, environment and resource management etc.). There are also potential linkages with NREGS. A multi-pronged approach will encourage community investment in education, whilst secondary education must be realigned as a priority: this will not only enable active citizenship and enhance employability, but also improve retention rates through the primary sector.

The Bill should incorporate provisions for regulating private schools rather than merely supporting privatisation efforts.

Since early childhood care and education (ECCE) is not being provided to all children of the country, it should be covered by the government including and include all children between 0 to 14 years.

Increased community involvement can address poverty related causes and linkages for children being out of school or dropping out of education. **Village education committees** can assess the ground reality, involve stakeholders and find sustainable solutions, and research has shown that, where there is an active committee monitoring the school, there are higher attendance rates and increased community awareness about entitlements. These bodies should be established as a matter of course to develop decentralised strategies that target the individual needs of children and families. Display boards exhibiting basic information about government schemes and incentives, progress and capacity of the school (number of students/teachers, performance against key indicators etc) is one way of generating awareness and stepping up participation, as well as increasing transparency. Creative use of local and modern technology will also create wider links into both the immediate community and wider society, and **children must also be encouraged to participate** in decision making about their school and education.

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Goal 3: Promote Gender Equality and Empower Women

Overview

Gender inequality encompasses a range of interlinked issues and problems, including poor access to healthcare and education services, inadequate nutrition, lack of access to resources and limited and undervalued employment opportunities. The Constitution guarantees equal rights for men and women, and makes equal participation, freedom of thought and non-discrimination explicit fundamental rights. And yet, the gulf between a woman's daily life and these visionary promises is phenomenal. Simply put, the growing imbalance in the sex ratio occurs because more women die before reaching adulthood, whether this takes place because of "sex selection" and deliberate infanticide, through violence, neglect of healthcare and simple nutritional needs or risky teenage pregnancies. This is not just a matter of implementing a handful of lateral polices. The real change has to be cultural and address, in Amartya Sen's words, "received values". Women must become visible in all policy decisions, because all policy decisions affect women as well as men and affect women differently to men, whether this be the "softer" or the "harder" issues, such as trade, agriculture, defence, employment etc. Political representation is essential to achieve this vision, but it will not miraculously eradicate misogyny at the grassroots level. In order to achieve this, government must look at empowering women and protecting their rights at every stage of their life cycle, from enhancing employability through formal and mainstream education; developing the capacity of women and girl children to take on leadership roles and challenge prevailing discourses; monitoring health and malnutrition; looking after maternal health throughout pregnancy, and guaranteeing social security and recognition of employment in the unorganised sector. This will entail challenging attitudes and belief on the ground, sensitising the authorities and involving both men and women in the processes of change.

UN Targets and Indicators

Target: Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels by 2015	• Ratio of girls to boys in primary, secondary and tertiary education • Ratio of literate women to men, 15-24 years old • Share of women in wage employment in the non-agriculture Sector • Proportion of seats held by women in national parliament

Status

Indicator	Value according to United Nations data	2015 target	Status (based on UN projected values)
Ratio of girls to boys in primary, secondary and tertiary education	Primary: 91% (2005) Secondary: 70% (2003) Tertiary: 66% (2003)	Primary: 100% Secondary: 100%	Off track
Ratio of literate women to men, 15-24 years	80% (2001)	100%	Off track
Women in waged employment in non-agricultural sector	18% (2004)	N/A	N/A
Proportion of seats held by women in national parliament	Lok Sabha: 45 of 542 (2007), i.e. 8% Rajya Sabha: 25 of 245 (2007), i.e. 10%	N/A	N/A

- **India ranks in the bottom 10 of an international list on women's participation in the economy.**

  On economic parameters, the World Economic Forum has reported that the only six countries performing worse are Iran, Bahrain, Oman, Pakistan, Saudi Arabia and Yemen (2007). **Labour force participation is rated as 36 per cent for women as against 84 per cent for men.** Nearly all Indian women are engaged in informal employment, and most of the work that women do, such as collecting fuel, fodder and water, growing vegetables or keeping poultry for domestic consumption goes unrecorded in the Census counts. The National Sample Survey estimates that 17 per cent of rural women are incorrectly recorded as non-workers: many are forced to work for pitiable wages and are denied social security benefits. In no state is a woman paid the same for doing the same work as a man. Justification is usually that the tasks are different, women's work "lighter" etc. This ignores the fact that much of the truly backbreaking work, particularly in agriculture, is reserved for women. Moreover, a Central Statistical Organisation study (1998-9) found that, of a sample of nearly 19,000 men and women across the country, women sleep on average 2 hours less than men and have only 5 minutes leisure-time each day, compared to 2 hours for men. And gender iniquity is not just a problem affecting the uneducated rural poor: only **3 per cent of legislators, senior officials and managers are women.**

- Women are under-represented in governance institutions. **Only 8 per cent of seats in Parliament are held by women.**

- According to the 2001 Census, the total population literacy rate was 65 per cent: this encompasses three quarters of the male population and only **just over half of the female population**.

  Enrolment in primary school has substantially increased for girls over the previous years, with 87 per cent enrolment as against 92 per cent for boys. At the lower primary level, 95 girls are enrolled for every 100 boys; this ratio reduces to 88 girls per 100 boys at upper primary (UN). One fifth of women who never attended school reported that they were required for household/family business or outside work. Education is not just an issue of employability, though this is also key: a few years of schooling for the mother has been found to reduce the infant mortality rate by almost 40 per cent (UN, 2001).

- In terms of **health and survival** indicators, India is **third from the bottom** in the WEF list - with only Azerbaijan and Armenia faring worse.

- There is a significant gender gap in terms of micronutrient absorption. **More than 80 per cent of women suffer from anaemia,** and over half reduce their food intake during pregnancy instead of increasing it (NFHS-3).

- The deficit of girl children in India has risen from 3 million in 1901 to 36 million in 2001. As per the 2001 Census there are currently just **927 girls under 6 years for every 1000 boys**, marking a decline from 945 in the last decade alone**.**

  This adverse trend in the sex ratio is often attributed to **female foeticide and infanticide**, made easier with the development of new technologies in sex-detection and subsequent sex-selective abortions. There is significant regional variation across states. Delhi has recorded a decline from 915 girls per 1000 boys in 1991 to 868 girls per 1000 boys in 2001: this means that 24,000 girls go 'missing' in Delhi every year. **In 2001 there were 798 females per 1000 males in the relatively wealthy Punjab**. This is not linked to poverty or lack of education: Chandigarh, the City Beautiful, has the dubious distinction of having the lowest sex ratio (773) in the whole of the country, despite having one of the highest literacy rates. In the states where sex selection is most rampant, there are entire villages where the men cannot find women to marry. This has resulted in the process of "buying" women from other states, and, where the family can afford to buy just one woman, she may be expected to "service" all the men in the family. The 10 'best-rated' districts are in Arunachal Pradesh, Jammu and Kashmir, Chhattisgarh, Andhra Pradesh, Orissa and Sikkim where technology (such as pre-natal diagnostic tests that have aided female foeticide) has not made such significant inroads. However, girls also go "missing" because of long-term neglect that causes morbidity and mortality: less breast-feeding, less nutrition, less home-based care or medical treatment - hence poorer health and shorter lifespans.

- There is a rise in violence against women, with rape the fastest growing crime in India. **The number of rapes per day has increased by nearly 700 per cent since 1971** (National Crime Records Bureau)**.**

  Among 35 cities with a population of more than a million, Delhi topped the list of crimes against women with 4,134 cases. One-third of the rapes and a fifth of the molestations took place in the city. Records reveal that 7,618 women were killed for dowry in 2006, an increase of 12.2 per cent from 2005. Uttar Pradesh with 1,798 cases had the highest number of such deaths, followed by Bihar with 1,188

cases. Well over **a third of women (37 per cent) have reported experiencing spousal violence** (NFHS-3): the real incidence is likely to be much higher.

- **44.5 per cent of girls under 18 were married in 2005-6** (NFHS-3)**.** This increases by over 10 per cent in rural areas.

  According to UNICEF, 82 percent of girls in Rajasthan – where the practice is particularly wide-spread – are married by 18; 15 percent of girls in rural areas across the country are married before 13, and 52 percent of girls have their first pregnancy between 15 and 19. Babies born to girls under 17 are 60 per cent more likely to die during their first year of life. UNICEF has demonstrated that girls between 15 and 19 are twice as likely to die of pregnancy-related reasons as girls between 20 and 24 (2006), whilst a World Health Organisation study (1998) has furthermore revealed that child brides are significantly more likely to be victims of domestic abuse or to contract sexually transmitted diseases – particularly when marriage is to older men - and have shorter lives than girls who get married later. In fact, the practice of child marriage impacts social development efforts across the board, with child mothers often lacking the skills, education, resources and decision making capabilities to nourish their children and meet their needs, which further perpetuates the cycle of poverty. The 1948 Universal Declaration of Human Rights explicitly states that consent "cannot be free and full" when one of the parties lacks the maturity to make an informed decision about a life partner. Child marriage is therefore a violation of international human rights.

Background

The **Tenth Five Year Plan** formalised the intention of reducing the gender gaps in literacy and waged employment by at least 50 per cent by 2007. The **Eleventh Plan** focuses on lowering the gender gap in literacy by 10 percentage points. The general approach is through provision of adequate needs-based training to women, so as to enable them to enter all sectors of the economy on an equal footing with men. Plans also highlight the need to strengthen women's political participation at all levels and their role in decision making.

One of the six basic principles mentioned in the preamble to the **National Common Minimum Programme** is to **"fully empower women politically, educationally, economically and legally".** The NCMP discusses reservation for women of half the seats in the Vidhan Sabha and the Lok Sabha, as well as guaranteeing rights of ownership. It states that one third of the money flowing into Panchayats should be earmarked for the development of women and children, promises the introduction of legislation on domestic violence and gender discrimination, and the mass expansion of schemes for microfinance across the country. It also commits the government to ensuring facilities for schooling with special provisions for female children.

Current Policy

The National Programme for Girls at Elementary Level (NPEGEL)

NPEGEL, specially tailored to ensure that girls have access to elementary education, is now part of the Sarya Shiksha Abhiyan (SSA). Under this programme, two lakh teachers have been trained in gender sensitisation, and free uniforms have been issued to two crore girls.

The National Literacy Mission (NLM)

Initiated in 1988, the Mission is centred around the premise that, "since women account for an overwhelming percentage of the total number of illiterates, the National Literacy Mission is for all practical purposes a mission of imparting functional literacy to women." 60 per cent of the beneficiaries are women. To sustain adult literacy the NLM also provides Post Literacy Campaigns and Continuing Education Programmes through volunteers. 120 million people are now literate as a result of the programme; the gap in male:female literacy has decreased from 25 per cent in 1991 to 22 per cent in 2001.

Mahila Samakyha

The Mahila Samakyha aims to address women's perceptions of themselves though mobilisation of marginalised rural women. The approach is to educate

rural women about the importance of educating girl children. Originally the programme was 100 per cent Dutch funded, but since 2003 it has been funded by the Government of India, now covering almost 16,000 villages in nine states.

Women's Reservation Bill, Draft

In the May 2004 general election, 539 candidates were elected to the 14th Lok Sabha. Only 44 of them were women.

The Bill is designed to enable **gender equity in Parliament,** increasing political participation of women to raise awareness of issues related to gender inequality and allowing parliament and policy to truly represent the people – of which 48 per cent are women. India's supposedly more retrograde neighbour, Pakistan, has already guaranteed 17 per cent reservation of seats in their Parliament. In panchayats, one third of seats have been reserved for women: with a million women being elected to the panchayats in the country every five years, this is the largest mobilisation of women in public life in the world.

First introduced in the Lok Sabha on September 12, 1996 and presented in Parliament on several occasions since then, the Bill has still not been passed owing to lack of political consensus. 181 male members of Parliament would not be able to contest elections if the Bill was legitimised, and MPs have expressed their concerns that, due to a system of rotating seats, they would be unable to adequately nurse their constituencies. The next draft then proposed to increase the number of seats by one-third in line with population rises (54 to 102 crores from 1971 to 2001, according to the census); such a move would have been legal under Article 82 of the Constitution, which allows for changes in the number of seats upon the completion of each census. One major concern is whether or not to incorporate an "OBC" quota, a quota within a quota, into the Bill. This is despite the fact that there is not currently any general OBC quota in the Parliament.

On the 7th May 2008, the Bill was finally tabled in the Rajya Sabha, meaning that it will not lapse when the current government is drawn to a close. The next stage is the discussion of the Bill within the Standing Committee during the Monsoon session.

Protection of Women against Domestic Violence Bill, 2005, and Hindu Succession Amendment Bill, 2004

The landmark **Hindu Succession (Amendment) Bill** was passed in 2004. It proposes to remove Discrimination against women in the Hindu Succession Act by giving equal rights to Hindu, Buddhist, Jain or Sikh women, including married daughters, in acquiring parental property. The father's property is to be equally shared if he dies without making a will. Social biases run deep, however: in most cases, the terms of the will automatically favour the son, and provisions need to be made to check the practice of 'persuading' daughters to give up their share in joint family property. **Muslim and tribal women are also outside the purview of this law.**

The **Domestic Violence Act** (DVA) was passed in 2005. The Act widens the scope of the term 'domestic violence' to incorporate **sexual, physical, economic and social abuse**, and acknowledges that domestic violence is a widely prevalent and universal problem of power relationships. More importantly, it marks a departure from penal provisions towards **positive assertions of civil rights' protection and injunctions**. The DVA outlines the right to protection from violence, dispossession from the matrimonial home and alternate residence. It also provides scope for claiming economic protection, including maintenance. Given that the legislation applies to the private sphere of the household, implementation remains a challenge, particularly in rural areas where an insidious patriarchy disables access to legal care. Some states such as Rajasthan rely not on Protection Officers to record incidents and respond appropriately, but on the police force, thereby limiting the effectiveness of a multilateral response. There are also concerns about the willingness of the authorities to implement the Act.

Amendments to the **Sati Prevention Act, 1987** propose to criminalise onlookers as well as the priest who performs the ritual and engages in glorifying the act. These have still not been passed by Parliament.

Pre-Conception and Pre-Natal Diagnostic Techniques Act (PC & PNDT Act), 1994

The Government has taken action to strengthen the PC & PNDT Act, as well as concentrating on raising awareness of the issue of sex-selective abortion. The principle strategy has been to **ban the use of sex-selective techniques before and after conception**, and also to **ban advertisements** in any form regarding sex determination. The **'Save the Girl Child' campaign** has been launched, and under the National Rural Health Mission Auxiliary Nursing Midwives (ANM) and Accredited Social Health Activists (ASHA) are being sensitised on the issue. Funds have been provided to all States/UTs under the Rural Child Health programme for implementation of the Act and related activities.

There are also a number of state level initiatives. In the 2001 census, Haryana's 0-6 sex ratio was a shocking 819. Data for 2006 indicates that it has risen to 854, still well below the national average but an improvement on its status five years ago. The Haryana Government decided to award Rs. 5 lakh to the village which showed the most improvement in reducing the gap.

As of yet, the government has **not set targets for reducing the gender imbalance**, and chances of prosecution are remote: after 12 years, the first conviction took place in March 2007. The Supreme Court has issued directions to all states regarding the proper implementation of the PNDT Act. However, in some states **the appropriate Committee has never met**, and many states have failed to issue the necessary Government Resolutions (GRs) to appoint Appropriate Authorities (AAs) and other authorities (UNFPA).

There is a critical conflict of interest at the heart of the Act: **those responsible for monitoring and implementation belong to the same medical community against whom action would be taken**. Effective implementation is therefore only possible through community involvement, and the situation can only change if the government and appropriate authorities come down heavily on the medical profession. The lack of proper monitoring is an issue that needs to be addressed as a matter of priority. While a National Support and Monitoring cell has been established in Delhi to assist the PCPNDT office in the implementation of the Act across the country, this body is in a state of transition. In addition, the PCPNDT office itself often fails to hold District or State AAs accountable: consequently, no action is taken when the law is not effectively implemented.

It is important to note that the imbalance in the sex ratio is not only attributable to sex selective technologies, but relates to longer term neglect of female health and wellbeing from infancy. Any effective response to this issue must consider multilateral interventions to challenge prevailing attitudes towards gender on the ground and specifically concentrate on monitoring the health of girl children through sustained community involvement. For more on how this can be achieved, see Goal 4: Reducing Infant Mortality.

The Prohibition of Child Marriage Act, 2006

The Child Marriage Restraint Act, 1929 established 18 as the legal age for marriage for women and 21 for men. However, implementation of the law was sporadic, offering very little in the way of protection to India's most marginalised and vulnerable citizens, particularly its girl children. The 2001 Census revealed that **1.5 million girls under the age of 15 were already married**, with 20 per cent of these already mothers to at least one child. In Bihar, 40 per cent of girls have been found to be married by age 15, 71 per cent by 18 (Demographic and Health Surveys, 2006). This is particularly worrying, given that the primary cause of mortality for 15-19 year old Indian girls is early pregnancy. Health risks to both mother and infant are severe and child brides frequently have limited access to health and family planning services; the UN also reports that child brides are likely to die younger than those who are married at a later age and remain disproportionately poor.

The Central Government (Legislative Department, Ministry of Law & Justice) introduced the Prevention of Child Marriage Bill, 2004 in the Rajya Sabha, which was subsequently passed in 2006. This Bill makes marriage to a child voidable and requires the husband or guardian (if the husband is also a minor) to pay maintenance to the underage wife until the point of her remarriage. The Bill aims to close a loophole in the 1929 Act which renders a child marriage illegal but not void. Provisions are made for the maintenance and custody of children born of child marriages, as well as the appointment of Child Marriage Prevention Officers within states.

One critical problem with the Act as it stands is that **the marriage is only void if the child or guardian files proceedings**, which assumes a certain amount of empowerment that is unlikely in the case of an underage spouse or a willingness that is unlikely in the case of a guardian who is benefiting from dowry or other incentives. A child marriage is intrinsically invalid only in the instance of "compulsion": traditional marriages are therefore implicitly validated. The Act does not discuss registration of child marriage or compulsory reporting by officals. In addition, the Act also fails to criminalise aiding, abetting or solemnising of child marriages or participation in the ceremony, with **no specific penalties for officials or elected representatives who witness or take part in these activities.**

Under the terms of the Act, states should be prioritising the **appointment of Enforcement Officers,** who should have the powers of a police officer to prevent child marriage, investigate complaints and initiate the process of prosecution in the case of contravention. This officer and supporting advisory board should also take responsibility for raising awareness of the issue and monitor prevalence of child marriage across the state. There also needs to be incentives to discourage the practice of child marriage within poor communities, since motivations are often largely economic - particularly in the case of the daughter's family. Girls will tend to marry

later if there are alternative livelihood options which reduce the need for early economic protection: it would be constructive, therefore, to explore possibilities of linking campaigns with promotion of skills development that leads towards specific employment.

India has not signed the UN Convention on Consent Marriage, Minimum Age of Marriage and Registration of Marriages.

Micro-Credit Initiatives

Micro-credit initiatives through self-help groups (SHGs) provide a group of participants from a shared socio-economic background, particularly women, with access to credit mechanisms for development of livelihoods activities. The Department of Women and Child Development implements schemes such as the STEP (Support to Training and Employment Programme for Women) Programme, often operational in collaboration with local NGOs. Currently, public sector banks earmark 5 per cent of their net bank credit for lending specifically to women.

Through a well-trained army of development professionals, the World Bank has successfully touted SHGs as *the* strategy for rural poverty alleviation. Savings are mobilised and disseminate large amounts of credit, and there are good rates of repayment: from the Bank's perspective, this is financially sustainable development. However, there are a number of concerns about the World Bank model. The Bank has been particularly vociferous in its desire for complete privatisation of lending agencies: this means removing all subsidies for those banks which explicitly service the poor and also encouraging market interest amongst corporate microlenders. Whilst philanthropic lenders do exist, there are also lenders who see the potential for real profit from microfinance initiatives that, on average, promise a return at 20-100 per cent interest with average repayment rates of well over 95 per cent. Under this paradigm, microfinance becomes an end in itself, and the role of the state is significantly diminished: in this regard, it seems to tally perfectly with the neo-liberal agenda that has long served the interests of the World Bank Group.

On the ground, there are **few self-help groups providing additional services or advocacy to its members**, and recent studies have highlighted that many work through a traditional **"top-down" approach** that does little to empower its members. International donors can force a solution onto a community with little concern for local conditions and potential social divisions such as caste, class etc., whilst non-participative management structures further marginalise the most vulnerable members of the group.

This is not to say that there is no place for SHGs in India. However, the state cannot permit its poorest and most marginalised to become a battleground for the market. Interventions and regulations are therefore required to enable SHGs to achieve the appropriate balance between achieving financial self-sufficiency and offering adequate subsidies to include the poorest women in its outreach, whilst state governments can also create an enabling environment to make SHGs a platform for addressing wider issues of poverty and disempowerment. The best SHGs are those that see poverty in all its dimensions and incorporate objectives of enhancing the welfare of rural women through advocacy, social protection and increasing access to essential services.

The **Micro-Finance Development and Regulation Bill, 2007** was introduced by the Union Finance Minister in the Lok Sabha on 20th March 2007, and sought to realise 'orderly growth and development of the microfinance sector'. Micro-finance organisations (MFOs) are potentially channelling the savings of some of the country's poorest people into the hands of the biggest corporate players, and yet under this Bill there were significant vagaries as to whom was included in its scope: not necessarily not-for-profit organisations or NBFCs (Non Banking Financial Companies), although history has shown that lack of experience in banking can lead this sector to default on their depositors. Indeed, these two sub-classifications make up about 90 per cent of MFIs, including some of the largest. The legislation also determined that the National Bank of Agriculture and Rural Development (NABARD) would be the primary regulatory authority as well as the key service provider, leading to allegations of a central conflict of interest at the heart of the Bill.

There is a need for legislation on this topic, and this legislation must protect the interests of the poor and most vulnerable and provide universal access to integrated financial services of banks. The loopholes must be tightened and there will need to be extensive consultation with women's groups and stakeholders, along with sustained involvement from the Ministry of Women and Child Development. It must also be clear that SHGs are not an alternative to public investment, and that the focus cannot be on efficient transactions and repayments. **Social issues, participation and empowerment are an essential and legitimate agenda of the SHGs.**

> ***Best practice:*** *Notable examples of successful programmes include the* ***Self Employed Women's Association (SEWA)*** *of Ahmedabad, which started life as a trade union for rural women. SEWA not only provides lower interest loans to rural women, but also* ***advocates on labour rights*** *on behalf of women in the unorganised sector, delivers healthcare, legal services, training programmes and provides other supportive services to enable women to gain employment and self-sufficiency.*

Policy Recommendations

Education

- **The formal school system needs to be rendered more gender sensitive,** which will entail appropriate curricula, infrastructure and sensitised teachers. In order to empower women, education must provide a route to employability through skills and livelihoods training. Links would be possible through both micro-credit schemes and the NREGS, both of which could be integrated with public education. Schools must provide basic infrastructure such as toilets for girls, with safety guaranteed both on the way to work, perhaps through provision of transport, and within the school environment itself. Where drop-outs are high, research needs to be instigated as to the reasons for this: potentially more flexible timings may need to be considered to allow girls time to undertake domestic duties. There also needs to be formal and systematic monitoring of education quality which considers the differing needs of boy and girl children. Expenditure on girls' education needs to be monitored, with special focus groups on SC, ST, Muslim, OBC and remote areas. There should be flexible budgeting norms to develop separate projects in areas within districts where there is particularly low female literacy/enrolment.

Employment

- There needs to be **social security legislation** to cover the unorganised sector, with a particular focus on women and other vulnerable groups. Special Economic Zones (SEZs) and Export Processing Zones (EPZs) need to be monitored to ensure that minimum wage and acceptable working conditions are being met. Resource allocations must also **support women's care roles,** thereby recognising the essential work women perform in this capacity.

- Research and policies need to be augmented to **protect the interests of the large numbers of women involved in the agricultural sector.** Under the 2008-9 Budget, the "Support to States' Extension Programme for Extension Reforms" scheme provides demand driven extension services through the active involvement of farmers/women farmers/subject matter specialists/NGOs/Krishi Vigyan Kendras etc. Gender concerns are being mainstreamed by mandating that 30 per cent of the resources on programmes and activities are allocated for women farmers. This needs to be implemented and prioritised.

- Single women currently find themselves excluded from many programmes due to conventional definitions of a family household: this needs to be addressed. Having the option of a separate livelihood devoid of marital dependency, i.e. **a distinct card for NREGA**, would empower women and provide them with access to resources that are often lacking for women in difficult marital situations. It would also mean that the entire family would not have to relocate in the case of the father migrating, which will have an impact on drop-out rates of elder female siblings.

Domestic Violence

- Violence against women will continue for as long as social attitudes do not change and women's rights are not recognised. Members of the police, the judiciary, and medical personnel need to realise the importance of setting up mechanisms to ensure that women are protected from violence, and that services cater for women and are correlated to ensure **holistic protection at all levels**. Without creating an enabling environment on the ground, legal protection will remain inaccessible to oppressed or marginalised women. Programmes therefore need to be linked to education and information campaigns to raise awareness about the legislation, law enforcement agencies must be sensitised, and empowerment initiatives involving both women and men should be established. Community led programmes can **educate and raise awareness about legislation and policy**, as well as women's rights: for example, a formally structured critical mass of women such as SHGs are good support systems to counter domestic violence. These programmes must also **involve men**, as well as young people, students, and people of different professional backgrounds. Separate funds should be established for monitoring the implementation of the Domestic Violence Act.

Sex Selection

- To tackle the issue of sex selection, the government must concentrate on supply (the women and families who request the termination of the girl child), demand (the doctors who provide the

Abortion) and **implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques (Regulation and Prevention of misuse) Act** (PCPNDT). State governments can collaborate with the Medical Associations and Councils to build positive relationships with local medical professionals and sensitise both doctors and local communities about the Act. No campaign on this issue can function without the support of the medical community itself. Block level meetings with village authorities and the local public can appeal to communities to abstain from the practice of female foeticide, as well as district meetings involving all municipal committee councillors, social activists and medical practitioners. Strict medical audits of scanning centres should take place by computer analysis of the data submitted by clinics and surgeries. Based on these reports, disciplinary action must take place against scanning centres who indulge in malpractice. Special attention must be paid to villages where the sex ratio is low, and senior officials must monitor and make visits to these areas to ensure administrative pressure is placed on all those involved in administration/implementation of the Act. Midwives, ANMs and nurses must be identified and contactable; sensitisation seminars may also work to offer advice and information. Information on the issue should be an integral part of training for future doctors and nurses.

- The UNFPA has reported that many Appropriate Authorities (AAs) interviewed in 2006 found it difficult to incriminate fellow doctors, and therefore concludes that the AA should be a government official. However, there is also a need for the AA to be legally orientated: many doctors have been released on minor technical gaps or because of contravention of general legal practices. There should be clear guidelines on how the AA will be supported and protected when they file cases against members of the medical community. **Clear guidelines on roles and responsibilities** must be issued to both AAs and Advisory Committees, who need to know what records to check, how often they should be checked and how to record visits. A **central point/database** where members of the Advisory Board, doctors and public can call to get information about the Act and its implementation would assist in this process. The appointment of junior level staff will further enable the AA to carry out his/her responsibilities by assisting in inspection and mobility support, assessing data and reviewing caseloads.
- The **Judiciary must also be sensitised to the PCPNDT Act**, potentially through information provision and sensitisation workshops for Judges and lawyers.
- Activities towards implementation of the PCPNDT Act can be **brought within the NRHM**, which would open up the possibility of interlocking the issue with other social factors and also drawing from larger pools of funds. However, given that the NRHM largely focuses on poorer and rural communities, it will be necessary to ensure effective targeting.

Child Marriage

- The Prohibition of Child Marriage Act must be amended **to make all child marriages void, irrespective of who files the complaint.** It must also **explicitly criminalise the process of aiding child marriages**, including onlookers and those who carry out the ceremony. States should urgently appoint **Enforcement Officers** with powers of intervention, who are capable of investigating complaints and initiating prosecutions. Child marriage must also be monitored across the state in collaboration with panchyats, which means funds must be released to **improve and develop data and monitoring systems.**
- The practice of child marriage will continue where there exists poverty and gender iniquities, which trap girls into the role of economic burden or trade capital, exchanged for goods, money or livestock. It is therefore important to **integrate child marriage prevention into other public initiatives**, such as education, employment, health and HIV prevention. **Alternative livelihood training** must be provided that is safe and inclusive, with meaningful employment (perhaps through credit schemes) guaranteed at the end of the process. This will empower girls and incentivise education. Teachers should be trained in how to deal with girls identified as at-risk and their families; life skills should encourage assertiveness and leadership whilst informing and educating women citizens as to their rights and entitlements. MPs can support **public education programmes** about the negative effects of child marriage and the rights of women and girl children, and look for ways to build the capacity of civil society groups working for community mobilisation on the issue. The UNFPA stresses the importance of involvement of men and grassroots advocacy with boys as a means of tackling discriminatory norms and practices, including the targeting of traditional and religious leaders.

Healthcare, Family Planning and Reproductive Health

- In priority areas – i.e. those where indicators such as maternal mortality rates reveal a worrying trend in terms of women's health – **preventative steps need to be initiated to improve the health and nutritional status of local women.** Local health officials should be employed to send ASHAs into the communities to **identify at risk women**; Dais can also be integrated into the mainstream public health system and trained to monitor and perform basic routine tasks, such as allocation of iron supplements, nutrition during pregnancy and pre- and ante-natal care. **Health insurance** must be provided to women in their own name, perhaps through linkages with micro-finance initiatives and government schemes.
- Information and services must address the full range of women's **sexual and reproductive health needs** in a safe, non-judgmental and non-discriminatory environment. This entails accessibility of good quality family planning services, counselling for couples and prevention of unwanted pregnancies. Safe motherhood services and infant care must be provided during and after pregnancy, and contraceptives must be available in regular and uninterrupted supplies.
- **Gender sensitive life skills training** is a means of promoting gender awareness in boys and girls from a young age. This aspect of the Adolescent Education Programme (AEP) should be emphasised. Adolescence is an age when girls and boys undergo physical and emotional changes. Due to a lack of information, many fall victim to trafficking, forced marriages, unwanted pregnancies, unsafe abortions, sexually transmitted diseases and child abuse. It is essential to recognise that adolescence and sexuality are intrinsically linked: all programmes that deal with reproductive rights (including policies concerned with STIs) must have a separate focus on the needs of India's adolescent population.

Governance

- The Government must strive to enhance awareness of legal rights, e.g. inheritance laws, the Domestic Violence Act, and provide **legal support services** wherever required.
- **Existing programmes need to be engendered,** e.g. NREGA, NRHM. Existing laws need to be continuously reviewed from a gender perspective, and gender budgeting re-evaluated and extended with allocations for capacity building of the Gender Budget Cells in the different Ministries. Minimum increases to gender allocations in the housing sector have been sustained, despite the fact that women currently own less that one per cent of the world's property (Oxfam). The Budget also needs to consider women as a heterogeneous entity, and different considerations need to be made for women of different castes, women of rural/urban backgrounds, women with disability etc. Provision of **sex disaggregated data** needs to be a priority to enable the most effective targeting within Ministries and programmes.

  The **Reservation Bill** was a promise made under the NCMP and must not now sit in limbo with the respective Standing Committee. It is essential to recognise that women have an equal part to play in social, economic and political structures, and that this Bill is integral to achieving and communicating the government's commitment to eradicating gender prejudice and creating a fairer society. It must therefore be passed as a matter of priority.

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Goal 4: Reduce Child Mortality

Overview

With one in ten children dying before the age of 5, India has an embarrassingly high infant mortality rate along with chronic infant morbidity: this is a very good indicator as to the status of public health care and infrastructure available to the general populace. It is doubly concerning that progress has stagnated over the last few years. It is likely that there is some correlation with Union expenditure on children under six years of age, which is currently only about one per cent of the total Budget. Government policy has, at least in the planning documents, rightly emphasised maternal health as critical to tackling the issue of infant mortality: much research has shown that the health, nutritional and educational status of the mother makes an immense impact on the infant's chances of survival. During the latest MoHFW survey, however, only one in four pregnant women received a single antenatal checkup. The survey also reported a decline in awareness of diarrhoea management, despite the fact that diarrhoea is one of the single major causes of infant mortality. It is therefore imperative that the mother receives appropriate care, counselling and information at the various stages of her child's life cycle. She herself must also have sufficient food and compensation for staying at home and providing adequate care for her children. Meanwhile, government must relay a sustained and revised focus on child health, development, education and nutrition within one holistic system of care, which will entail increased investment in pre-school education and nutrition.

Un Targets and Indicators

Target: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	• Under five mortality rate (probability of dying between birth and exactly five years of age expressed per 1 000 live births). • Infant mortality rate (probability of dying between birth and exactly one year of age expressed per 1 000 live births). • Proportion of 1 year old children immunised against measles

Status

Indicator	Value according to United Nations data	2015 target	Status (based on UN projected values)
Under five mortality rate (per 1000 live births)	85 (2004)	41	Off track
Infant mortality rate (per 1000 live births)	58 (2005)	27	Off track
Proportion of 1 year old children immunised against measles	58 (2005)	N/A	N/A

- 2.7 million children under 5 die every year. At **58 deaths per 1000 live births**, India's Infant Mortality Rate (IMR) is worse than many countries in Sub-Saharan Africa. **One out of ten Indian children will not reach the age of 5.**

Sri Lanka has an IMR of 11 deaths per 1000 live births. Even Bangladesh has a lower IMR at a still alarmingly high rate of 52/1000, and progress has generally been more rapid and consistent. In developed countries, the rate is approximately

5 deaths per 1000 live births (statistics for United Kingdom). **Uttar Pradesh has an IMR of 73/1000**.

- At 30 per cent of all births, India has the **highest number of neonatal deaths (within the first 28 days of birth) in the world**. India's Neonatal Mortality Rate (NMR) of 40 per 100,000 live births (2002) amounts to 60 per cent of infant mortality and over half of all deaths of children under 5 years of age.

  Of every four children that die before reaching the age of five years, one dies in the first three days since birth. The principal causes of neonatal deaths and neonatal disorders are bacterial infections (52 per cent), asphyxia (20 per cent), prematurity (15 per cent) and neonatal tetanus, pneumonia, diarrhoea, and measles. Birth injuries are an additional cause.

- **Malnutrition contributes to over 50 per cent of child deaths.**

  Over three-quarters of neonatal deaths occur among infants who have a low birth weight (less than 2.5 kg at birth), and in India, one-third of all neonates are underweight. The proportion of undernourished children, based on standard weight-for-age criteria, was virtually the same in 2005-06 as in 1998-99: in both years, nearly half of all Indian children were underweight. The incidence of anaemia among children was actually a little *higher* in 2005-06 according to the available National Family Health Survey 3 (NFHS-3) data. Even the decline of stunting in that period, from 45 per cent to 38 per cent, is far from impressive - about one percentage point per year. If the incidence of stunting continues to decline at this rate, it will take another 25 years or so to reach levels similar to those in China today. In addition, **Indian mothers are likely to be weak, undernourished and anaemic**, which commonly results in low birth weight; in turn, this contributes to child undernutrition and a reduced capacity to fight infection and disease. Whilst malnutrition affects 200 million Indians, the largest deficits in calorie consumption actually occur in pregnant and lactating women: the longer-term consequences of this lack of nutrient/energy consumption include foetal loss, low birth weight and death during infancy.

- One in four pregnant women have not had a single antenatal checkup, and **a majority of deliveries take place without the assistance of a health professional.** About one-third of expectant mothers in India are not immunised against tetanus, which helps prevent both mother and child infection at birth.

- At any one time, one fifth of all children suffer from diarrhoea and nearly a third have fever.

  Poverty and lack of awareness prevent mothers from providing adequate care for their children. For instance, breastfeeding may be limited or weaning methods flawed, with only 23 per cent of babies breastfed within one hour of birth, and just 46 per cent exclusively breastfed for the first six months. Although diarrhoea is the second largest killer of babies, **only 43 per cent of mothers know about Oral Rehydration Supplements and only 26 per cent report ever having used it** (NFHS-3)**.** Similarly, only one-third of children are fed complementary foods between the ages of six and nine months, the period when breastfeeding should be supplemented.

- Currently, **India has the lowest child immunisation rate in South Asia.**

  Child immunisation rates were much the same in 2005-06 as in 1998-99. The proportion of children who have not had a BCG vaccine in India is twice as high as in Nepal, more than five times as high as in Bangladesh, and almost 30 times higher than in Sri Lanka.

- In 2005-06, just 59 per cent of children aged 1-year old received measles vaccinations.

  The number of reported cases of measles in India has been increasing from 39,000 in 2000 to 61,000 in 2006 (World Health Organisation). Under the Global Plan for Reducing Measles Mortality (2006-10), the **WHO and UNICEF have identified India as one of 47 priority countries that make-up 95 per cent of global measles deaths.** In developing countries, risks of fatality associated with measles increase ten fold or more, with complications including diarrhoea, pneumonia and croup. The WHO reports that severe measles is particularly likely in poorly nourished young children, those with heightened vulnerability to developing a severe case of the virus including children who do not receive sufficient vitamin A, or whose immune systems have been weakened by HIV/AIDS or other diseases.

- **Scheduled tribe children have only a 26 per cent chance of being immunised**. This drops to 4 per cent for a ST child born in Bihar.

  Among 'scheduled caste' children in Bihar, only 11 per cent are fully immunised. In contrast, a Tamil Nadu child has around a 90 per cent chance of being fully immunised by the age of one (even higher among privileged Tamil families). In 7 states, the rate of immunisation has actually fallen.

Child deprivation in India and South Asia, 2004

	Bangladesh	Bhutan	India	Nepal	Pakistan	Sri Lanka
Immunisation (percentage of children under 3 who have *not* received essential vaccinations [BCG, DTP3, MCV, Pol3] taken as average)						
Child undernutrition (per cent of children with the stated condition)	14.5	10.5	**34.25**	20.5	30.75	2.75
Underweight (per cent)	**48**	19	47	**48**	38	29
Stunted (per cent)	43	40	46	**51**	37	14
Wasted (per cent)	13	3	**16**	10	13	14
Infant mortality rate (per 1000 live births)	52.5	45	55	53.9	**67.5**	11

Source: UNICEF (2006), 'State of the World's Children' and UNPD. In each row, the 'worst' figure is highlighted.

Background

The **Tenth Five Year Plan** looked to reduce India's IMR to 45 by 2007 and to 28 by 2012. The **Eleventh Plan** aspires to a reduction of the IMR to 28. Strategy concentrates on reducing malnutrition among children between 0 and 3 years of age to half of its current level, and on breaking the cycle of ill health and maternal and infant mortality by tackling the incidence of anaemia and malnutrition amongst adolescent girls. Similarly the **National Common Minimum Programme** (NCMP) promises significant expansion of nutrition programmes, particularly for the girl child. A **National Plan of Action for Children, 2005** has established time bound achievements for certain indicators such as infant mortality, access to safe drinking water etc.

Current Policy

Reproductive and Child Health Programme (RCH)

The second phase of **RCH** was launched in April 2005 with a heightened focus on child survival and safe motherhood, as well as a new emphasis on community involvement to assure early recognition of symptoms. The approach of RCH Phase II is concerned with the integrated management of Neonatal and Childhood Illnesses; home based care of newborns; education of mothers (i.e. promotion of breastfeeding and complementary feeding); control of deaths due to Acute Respiratory Infections (ARI); control of deaths due to diarrhoeal diseases; supplementation with micronutrients Vitamin A and iron, and the Universal Immunisation Programme. During the latest MoHFW survey, however, only 10.1 per cent of women were visited by a health worker during pregnancy. The survey also recorded a decline in awareness of diarrhoea management (RHS 1 and II data).

Integrated Child Development Series (ICDS)

Initiated in October, 1975 in response to the evident problems of persistent hunger and malnutrition, the ICDS is designed to provide a holistic approach for converging basic services for improved childcare, early stimulation and learning, health and nutrition, water and environmental sanitation. The target groups are young children, expectant and nursing mothers and women groups, to be reached through nearly 300,000 trained community-based Anganwadi workers and an equal number of helpers, supportive community structures/women groups. In 2001, the Supreme Court directed the state governments and union territories to implement the ICDS in full and to ensure that every ICDS disbursing centre in the country provides specified nutrition to young children, malnourished children, adolescent girls, pregnant woman and nursing mothers. The court also ordered that there should be a disbursement centre in every settlement.

Reports suggest that progress has been made: **infant mortality rates have declined from 94 per 1000 live births in 1981 to 73 in 1994 and to 58 in 2005.** Allocations to the ICDS increased from Rs. 4761 crore in 2007-08 to 6000 crore in 2008-9, with salaries increasing for anganwadi workers to Rs 1500 per month and helpers to Rs 750 per month. At the end of December 2007, 5959 ICDS projects were running, with beneficiaries including 629 lakh children and 132 lakh pregnant and lactating mothers; the number of sanctioned Anganwadi centres has also increased from 758,000 in March 2004 to over 1.05 million as of 2007 (MoHFW). Nevertheless, it is also clear that, for a scheme that has been in operation for three decades, the benefits are disappointingly limited, with 110 million children still outside of the programme's reach.

Supplementary nutrition to children and nursing/expectant mothers from low-income families has so far largely been restricted to **rice and wheat**. Supplements alone on top of cereals and grains risk causing toxic side-effects in malnourished children. For 3-6 year olds, there is nothing available but cereal-based items of little nutritional value with no provisions for nutritious hot meals. There are frequent complaints of delays in Central Government's transferrances of resources for this programme with accusations of diversion of food, while s**tate governments differ substantially in the amount and quality of supplementary nutrition** that is provided. In March 2008 debate began about making packaged foods (such as biscuits) from private manufacturing companies part of the food served within the programme. There are valid concerns about such a proposal, particularly as it has been raised **under pressure from partisan commercial groups** looking to improve their own profits; it is troubling that this suggestion is still being explored despite the fact that the Supreme Court has explicitly banned contractors in the supply of supplementary nutrition in ICDS. Fears reside that, given reduced allocations to the aganwadis as against what was originally proposed in the Eleventh Plan, these biscuits could become the only food consumed by children.

Currently, only **about one per cent of the total Union Budget is spent on children under six years of age,** meaning that it remains a low priority for the government, despite disturbingly high morbidity and mortality within this age range. There are still **not enough anganwadis or anganwadi workers**, and they lack adequate resources to meet all the nutritional requirements of the pregnant and lactating mothers, infants and small children who need their services. If the declared norm of one anganwadi per 1000 population is to be met, there should be 14 lakh anganwadis; currently, **only around 10 lakh are estimated to be operational.** Even with the 14 lakh centres, each one will be dealing with 100 children alone, not counting adolescent girls, pregnant women and lactating mothers. Poor coverage of needy groups under the scheme is also a consequence of the **location of the anganwadi centre**, which typically tends to be in the main village or in upper or dominant caste hamlets in rural areas. This restricts the access to such services by deprived communities such as SCs and Sts, who often live slightly apart from the centre. In addition, the **timing of the anganwadi centres** effectively rules out many of the poorest households, since they are open only for four hours a day. When both parents are working, which is typically the case among rural labouring households in many parts of the country, it is difficult to deliver and collect the child from the centre in time. Children in such households are therefore excluded from the services and will remain unreachable to the organised health system.

One further and as yet unintegrated problem is that the current **National Maternity Benefit Scheme (NMBS)** which targets BPL pregnant women is unavailable in most of the country, leaving poor women without maternity entitlements. As these women tend to be employed in the unorganised sector, this prevents them from contributing sufficient time or resources to the health and welfare of their children.

Integrated Management of Newborn and Childhood Illnesses (IMNCI) and Expanded Programme on Immunisation (EPI)

Under the IMNCI, baseline workers are trained in the holistic management of measles, malaria, pneumonia, diarrhoea and malnutrition. In 2006-07, 75 districts across the country had initiated the implementation of IMNCI, and it will gradually be phased into the whole of the country.

In turn, the EPI aims to reduce prevalence, mortality and disabilities by **providing free vaccination to all eligible children against six preventable diseases:** tuberculosis, diphtheria, pertussis, tetanus, polio and measles. The Programme became part of the RCHP in 1997. The Union Budget provides for routine immunisation against these diseases. However, according to the WHO, failure **to deliver at least one dose of measles vaccine to all infants** is the primary reason for continuing prevalence of childhood measles and mortality. They also **cite "reporting of actual number of children vaccinated"** as an implementation issue, whilst the Ministry of Health and Family Welfare reports that **immunisation sessions are still not being held regularly in the community.** The MoHFW has

attributed failures in immunisation programmes to staff shortages, lack of training, inadequate mobility of health workers and problem of delivery of vaccines, whilst the UN reports problems with ensuring cold chain and vaccine storage services.

Policy Recommendations

ICDS and RCH strategies must be drawn up holistically, considering social and cultural barriers to exclusion and integrating relevant Departments and Ministries. ICDS should itself be viewed only as part of a comprehensive overall strategy to deal with infant health, care and nutrition. Aganwadi centres need to be increased to meet the national target of 14 lakh, and government must also consider releasing funds for the appointment of **one additional Aganwadi worker** to promote breastfeeding, nutrition counselling etc., with the other freed to manage the centre with crèche and pre-school facilities etc. A Planning Commission report (2007) estimated that posting an additional worker in each of the country's Anganwadis would cost Rs 1,000 crores per year, with 14 lakh Anganwadis, at twice the current salaries, costing only Rs 3,360 crores per year (Gupta et al).[1]

Recent studies have shown that breastfeeding within an hour of birth can reduce the risk of neonatal mortality by almost a third. It is the role of community health workers – ASHAs, ANMs, Dais – to ensure that women are aware of this and provided with effective **counselling and support immediately after delivery. A support system should also enable weekly home visits to assist in exclusive breastfeeding.** There needs to be formal written guidelines and training for those who work in the field to ensure that women are armed with the skills and information to give their children the best chance of survival. Currently, there are no incentives for ASHAs achieving Infant and Young Child Feeding targets.

The **ICDS and NRHM should be better converged to more effectively prevent and manage malnourishment.** Nutrition counselling needs to be given to the families at the Aganwadi centres to ensure that the food is given to the child as directed. **Nutrition rehabilitation centres** should be established in health centres in areas with high malnutrition and treated as a mainstream intervention alongside immunisation, and Aganwadi workers should be trained to make referrals to the PHC where necessary. The nutritional value of food provided under ICDS also needs to be reviewed, considering alternative sources of protein such as milk, or eggs and meat in predominantly non-vegetarian communities. Pulses and grains are amongst the poorest forms of protein for infants. **Meals should provide a balance of pulses, milk, cereals, eggs and vegetables to tackle nutritional deficiencies;** the value and side-effects of supplements or fortified grains has not been researched, and "nutrient embedded chemicals" are no substitute for balanced meals.

Pre-school education needs to receive a revived focus, providing nutrition and health services along the lines of the Mid Day Meals Scheme. Sharing of cooked meals at Aganwadi centres is also a means of breaking down social prejudices, as well as ensuring sustained attendance. There are currently no provisions for providing nutritious hot meals to this age-group. With the appointment of a second Aganwadi worker, **pre-schools can be used as a base for monitoring of health and malnourishment,** with treatments provided for preventable illnesses and diseases where required (e.g. worming pills, oral rehydration supplements).

Policies concerned with children under 6 years of age must be prioritised, so as to protect both children today and the informed, healthy citizens of the future. The PC report recommends an **integrated approach that focuses equally on child health, child development/education and child nutrition, all to be provided "in the same system of care".** There must then be different strategies for different target age-groups: children of 0-6 months of age who require exclusive breastfeeding; children of 6 months to 3 years, before pre-school, and children of 3 years to 6 years, the pre-school years.

It is well documented that the health and nutritional status of the mother has a direct bearing on the infant's health and his/her chances of survival. There are obvious manifestations of the linkages which require more lateral interventions: for example**, adolescent girls and young women should be given the MMR vaccine** as a matter of course in order to prevent the incidence of rubella during pregnancy, which can result in severe defects and infant mortality. However, the wider issue of gender inequality and social injustice impacts upon the role of the woman as care-giver, and, in order to adequately support her child, she must be appropriately empowered socially

[1] For more on pre and ante-natal care and basic health infrastructure/investment, see recommendations for Goal 5: Reducing Maternal Mortality.

and financially. The mothers themselves ultimately have rights, which include the right to sufficient food and adequate nutrition and **compensation** for staying at home to look after her children. Provisions need to be made **for improving and widening access to the National Maternity Benefit Scheme.** This form of social security should not be controversial, is already partially implemented in the formal sector and is standard policy in more developed countries. For example, in the UK, a statutory maternity pay is made by employers to their employees on a weekly basis, and all UK citizens are entitled to apply for child benefit. Preventative and curative health care must also be locally and immediately available, with skills to manage common but potentially severe illnesses. **A task force must be established to review and make recommendations for maternity entitlements and current legislation**, ensuring that mothers and children are realising their rights to nutrition, rest and exclusive breastfeeding in the initial postnatal period with existing laws brought into line with these recommendations. Funds must be released so that all informal work can be covered, and the **National Maternity Benefit Scheme must be improved** to encompass any women excluded from other schemes and provisions (See Gupta et al, report prepared for the Planning Commission, 2007).

Crèches need to be available with 10 per cent of Aganwadi centres converted to Aganwadi-cum-crèches **and additional major expansion of the Rajiv Gandhi Crèche Scheme**. This will enable breastfeeding to be sustained when a mother has to bring in an income. Official breaks would also have to be scheduled into the working day.

Immunisation coverage still needs to be dramatically increased. According to the World Health Organisation, such a step-up will require **adequate training of health care workers, vaccine procurement, supply, maintenance of cold chain and co-ordination between central and state governments.** The Pan-American Health Organisation recommends a three-pronged strategy for effective intervention: one nationwide campaign which targets children between one and fourteen years; routine vaccination amongst infants, and mass campaigns every four years to target all children of one to four years, irrespective of previous vaccination status. This is known as **"Catch-up, Keep-up and Follow-up"**. The initial campaign must promote a single day of the week for free vaccinations at a centre with extended opening hours, and be widely publicised through TV and media with information about the risks of not getting children vaccinated (Chakravarti, 2005). Panchayats should also provide transport to difficult-to-reach groups on vaccination days.

A surveillance project should be initiated in every state to monitor the progress of routine immunisation and identify those sectors of the community not currently able to access immunisation services, and address reasons for such. Incidence and coverage must be jointly monitored, with timely reports presented at state and national levels – not merely part of reporting under RCH. Districts should report monthly to regional offices, and detail plans of upcoming community vaccine sessions. **High risk areas must be recognised**, as well as those with poor programme performance; there must also be provision of **disaggregated data** in terms of incidence and vaccine coverage.

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Goal 5: Improve Maternal Health

5 IMPROVE MATERNAL HEALTH

Overview

India's abysmal maternal mortality rates are one of the most discussed anachronisms amongst the nation's social scientists. Currently, there are states which number amongst the worst performing regions in the world, and India as a whole has more maternal deaths than any other nation. The simple fact of the matter is, India invests only around 1 per cent GDP in healthcare. Not only this, but the money that is invested goes on purely lateral interventions that do little to improve the health of Indian women. Whilst a mother can receive monetary rewards for making it to a government institution under JSY, she has likely received no antenatal care up to this point, and, when she arrives at her local health centre, will presumably find it understaffed, underfunded and without certain basic infrastructure. Assuming that poor women will not seek emergency treatment when required is naïve; they are however less likely to take care of their health when money is scarce and the woman's health needs take a low priority in terms of household expenditure. Interventions at the moment of birth alone will therefore fail to provide long-term improvements in infant and maternal mortality rates. What IS needed is a longer term commitment to public healthcare and nutritional services, services that are accessible to all women of childbearing age and especially target these women before the point at which they become sick mothers and yet another avoidable statistic. If each preventable maternal death is a violation of human rights, India's shocking incidence of maternal mortality is, in the words of the former UN Special Rapporteur on the Right to Health, "a human rights catastrophe".

UN Targets and Indicators

Target: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	• Maternal mortality ratio (MMR)* • Proportion of births attended by skilled health personnel * MMR is measured by the number of maternal deaths per 100,000 live births of women aged 15-49 years

Status

Indicator	Value according to United Nations data	2015 target	Status (based on UN projected values)
Maternal mortality ratio (per 1000 live births)	450 (2001-3)	109	Off track
Proportion of births attended by skilled health personnel	48 (2005-6)	100 percent	N/A

- The Sample Registration System of the Government of India estimated the MMR to be 301 per 100,000 live births in 2001-03, a decline from 398 for 1997-98. **The WHO, UNICEF, UNFPA and World Bank suggest 450 per 100,000 live births between 2001-03**. This is 4 times higher than the 2010 National Population Policy (NPP) goal.

  In absolute terms, India has the largest number of maternal deaths in the world. UN agencies report that maternal death is 41 times more likely in India than in the US, and 10 times more likely than in China. MMR varies across states from 110 in Kerala to 517 in Uttar Pradesh and Uttarakhand. Nine states - Bihar, Jharkhand, Orissa, Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Uttarakhand, and Assam – account for two-thirds of the country's maternal deaths, whilst **Rajasthan and Orissa have two of the highest MMRs in the world.**

- India currently spends just over **1 per cent GDP on healthcare**, which works out as US $6.39 per capita per annum. The Commission for Macroeconomics and Health advises that minimum spending on essential health interventions in developing countries should be between US $30-$40 per capita.

  Public financing of health in China (PPP) reaches US $21.7 per capita; government expenditure in Sri Lanka amounts to US $15.57; in Malaysia this is $78.42, which is over 10 times higher. Accordingly, Malaysia's, China's, and Sri Lanka's MMR are 41, 56, and 92/100,000 respectively, as compared with 540/100,000 in India. In all three of these Asian countries, between 97 and 100 per cent of births are now attended by skilled health personnel, whilst an Indian mother has **less than a 50:50 chance of a skilled professional being with her when she gives birth.** According to the latest WHO statistics, even **the Bangladeshi government spends 10 per cent more on health** as a proportion of total health-related expenditure and 2 per cent more as a proportion of total government expenditure: this is a country where the gross per capita income is only US $2340 (PPP, 2006). It is perhaps no surprise, then, that life expectancy is the same at birth for the average Bangladeshi as it is for their considerably wealthier neighbour.

- In 2007, the World Health Organisation ranked India's healthcare system 112th in the world: lower income Bangladesh was 88th, Sri Lanka 76th and Malaysia 49th.

- According to the Bulletin on Rural Health Statistics in India (2006), there is **a national shortage of 20,903 Sub-Centres (SCs), 4803 Primary Health Centres (PHCs) and 2653 Community Health Centres (CHCs),** as per the 2001 population norm. There is only **one bed per 6000 people.**

- In 2005-06, about **48 per cent of births were assisted by skilled health personnel** (about 75 per cent in urban areas and 39 per cent in rural areas). 31 per cent of rural deliveries were in hospitals or health centres.

- **The wealthiest groups are three times more likely to receive care than the poorest** (World Health Organisation, 2008).

- **Abortions related complications account for 8 percent of all maternal deaths**.

  The National Family Health Survey-3 estimates that the family planning needs of 13.2 per cent of married women are not met. According to the WHO, there is a total of 31.3 million people unable to access vital family planning services when required. The movement to reduce sex selection in India has made access to abortion more limited, particularly for those with less disposable income.

  Risk factors include **malnutrition, inadequate access to healthcare, lack of education, social exclusion and child marriage.**

Background

The **Tenth Five Year Plan** aimed to reduce MMR to 200 by 2007 and to 100 by 2012. The **Eleventh Plan** maintains this target of 100 per 100,000 live births. The approach recommended by the taskforce report largely targets adolescent girls and on reducing the incidence of anaemia and malnutrition.

Current Policy

> "When women die in childbirth it is usually the result of a cascade of breakdowns in their interactions with the health system: delays in seeking care, inability to act on medical advice, and failure of the health system to provide adequate or timely care."
>
> *World Health Organisation (2005)*

The National Common Minimum Programme commits to:

Raising public spending on health to at least 2-3 per cent GDP, with a focus on primary health care

The reasons for India's poor performance in reducing child and maternal mortality rates relate largely to **accessibility of healthcare (preventative and curative), inadequate nutrition, and insufficient efforts to provide immunisation**. Whilst the government to date

has largely focused its efforts on lateral programmes such as the Janani Suraksha Yojana (JSY), essential antenatal care has been severely neglected.

The World Health Organisation has reported that 20 per cent of maternal deaths occur because of illness and infection. India currently homes one fifth of the world's diseases, the regular level of malnourished children is higher than that of Sub-Saharan Africa, and there are higher rates of anaemia and maternal undernourishment. One third of the adult married women in the country are underweight and over half of all adult women are anaemic. Within this context, it is hardly surprising that complications contribute to such a large proportion of maternal deaths. Without providing continuous care from conception, interventions at the moment of birth alone will be ineffective and will certainly not provide the long-term improvements in infant and maternal mortality rates sought by the government.

The figures for public sector investment in healthcare are disconcerting. India's 80 per cent + private expenditure rates (the vast majority of which is out of pocket) and **0.9 per cent GDP investment** are now notorious in the international community. In the 2008-9 budget, the government promised what will amount to a mere 0.35 per cent GDP increase – leaving the total investment of GDP in the coming year at **just over 1 per cent**. NRHM received only an 18-20 per cent increase in 2007-08. The proposed allocation for NRHM in 2008-9 is Rs.12,050 crore: an increase of 11.4 per cent over 2007-08, and far short of the UPA's commitment to increase NRHM allocation by 30 per cent each year. Reports suggest that increases have only yet been channelled into vertical (and often pre-existing) projects, selective interventions and targeting of diseases - not towards strengthening infrastructure and widening access to regular health services. There is one further problem: whilst 260 crore rupees might be given under NRHM, state governments frequently have little idea how to use this money.

Increased investment alone is of course insufficient. Interventions and expenditure have to be effectively targeted towards infrastructural improvements and preventative treatment, not only emergency obsetrics. There are currently **shortages of nearly 25,000 Sub-Centres and Primary Health Centres (PHCs) and 2653 Community Health Centres (CHCs)**. Furthermore, almost 50 per cent of the existing health infrastructure is in rented buildings. Up to one in three doctors' posts remain vacant in rural India; of those that are filled, around two thirds may be absent at any one time. Since 1997, nine out of ten doctors trained with public money have since moved into the private sector. There will be **1 bed per 6000 people** (even neighbouring Bangladesh can double this, whilst Sri Lanka's ratio is 17 times better), PHCs will often be closed, and, according to the Indian Institute for Population Sciences, just 20 percent will have a phone and only 12 percent undergo "regular maintenance". In some states, the majority will not have electricity. Referrals are often not available.

India is in a position to promote tertiary care to an international audience, but local primary level care is severely neglected, with radically insufficient resources for preventive and promotive health interventions. This also has an impact on the availability of family planning services, where there is little incentive for private sector involvement. The taskforce report that fed into the Eleventh Five Year Plan explicitly recommends partnerships with private and non-profit organisations and NGOs, particularly where the partner supplies capital investment and delivers the services under contract with the government. The Finance Ministry has also proposed to grant a **five year tax break** to encourage private hospitals to be established anywhere in India with the exception of specified urban areas.

In terms of curative care and primary care interventions, the private sector is notoriously slow at responding to gaps in the market, and there are few models to follow. Increasing privatisation of the medical system without regulations (audits, reviews, good practice guidelines) leads to numerous abuses, whether this is in **over-specialisation of service delivery, refusal to treat poorer patients or tendency to perform more costly procedures, unnecessary operations and over-medicate.** The poor are often unable to pay and thus are a "financial liability"; in addition, there is a risk of providers denying care at state facilities and making referrals to their private practices where more money can be made.

Currently, the second most common cause of debt in rural India is healthcare provision. It is thus of real concern that the National Rural Health Mission (NRHM) places an emphasis on user fees as a potential generator of income. Time and time again, research has demonstrated that charging for essential services decreases usage and disproportionately affects the poorest sectors of society. INSAAF International brought out a report in 2002 which presented cases of patients in the Punjab being ejected from public hospitals when they lacked the resources to cover the costs; exemption cards were repeatedly not issued to those who were entitled to them, and only 1 out of 150 women in the slums of Bhatinda, a city of 270,000 people, had even heard about the cards. Reports suggested a 20-40 per cent reduction in

outpatient cases. The alternative – and it is the only alternative for those without access to any form of direct cash - is not seeking treatment or medicines, a decision which has obvious ramifications for India's disappointing performance in curbing the spread of communicable diseases.

It is most often those who live closest to subsistence level who are forced to make direct payments for essential healthcare services, and **nearly half of the households who are in debt or have been forced to sell off assets did so to finance hospital expenditure.** This is a vicious cycle, where expenditure on healthcare creates poverty, which contributes to malnourishment, decreases economic productivity and perpetuates further ill health. The system is also inefficient: with the exception of Karnataka and Punjab**, no state has managed to mobilise more than three per cent of the total cost of running a hospital. Moreover,** centres remain underfunded in the poorest areas where hospitals struggle to generate income from user fees: the growing divide between services available to rich and poor is therefore perpetuated.

National Rural Health Mission (NRHM) aims to:

Reduce total fertility rate to 2:1

A large percentage of couples report an unmet need for contraception, with only 30 per cent of those who want to delay or space childbearing able to do so. This gap contributes in turn to the high numbers of unsafe abortions, as a desire to limit family size is the main motivation cited by women who are obtaining abortion services.

The Tenth Five Year Plan committed the government to meet the unmet need for contraception and enable families to achieve their reproductive goals. The government has been focusing on districts that have shown little decline in fertility rates, where adolescent reproductive health, counselling services and access to safe abortions are now being emphasised. Centrally assigned targets rather than local needs assessment processes are currently driving the activities of state governments. This again would be an area which would benefit from increased involvement of Dais and ASHAs: the stakeholders – men included – must be consulted to determine what services are required and how these can be rendered more accessible to all members of the community.

In some parts of the country there have been good social marketing programmes of condoms and oral contraceptives, but in many areas awareness of reversible methods of contraception is severely limited.

The focus on sterilisation can make irresponsible breeding the focus, rather than treating the provision of maternity and family planning services as a right for all citizens. According to the WHO, three out of four users rely on sterilisation, which is the most common method even amongst married adolescents, and less than 7 per cent of married women use officially sponsored spacing methods (pills, IUD and condoms). Contraceptive use is particularly low in Meghalaya, Bihar and Uttar Pradesh.

Improve facilities for institutional deliveries under the Janani Suraksha Yojana (JSY)

JSY is 100 per cent centrally-sponsored, giving mothers and ASHAs cash incentives for institutional deliveries. Reports from states indicate significant increases in institutional deliveries due to demand side financing.

However, there are numerous accounts of women not receiving the money to which they are entitled. In Uttar Pradesh, the state with the highest MMR in India, a report found that only 7 women out of 68 received JSY money, and 3 or 4 of these women were asked to pay Rs 500 of their own JSY money to the providers. Furthermore, mothers who deliver at home or on the way to the hospital are not receiving any JSY compensation. The focus of JSY is on institutional delivery, so the government has claimed that the benefits must be linked to this process. The Supreme Court has since refuted this right to discriminate against women who have home deliveries. In Orissa & West Bengal, women must receive 3 ANC checkups in order to get the JSY money; in rural areas, women have domestic and financial obligations which may not enable them to sacrifice the time or money to meet such conditions.

JSY and institutional deliveries are being pushed vigorously without much improvement in quality of services, either in the public sector hospitals or the unregulated private sector. In some areas, infrastructural failings may mean that institutional deliveries are unsafe or, given accessibility issues, impossible. At present, there are no oversight mechanisms to ensure either the maintenance of acceptable standards or the equitable treatment of all female patients**. Providing monetary incentives only at the point of birth does little to address the health needs of mothers**; the money is likely to be transferred to the family coiffeurs without tackling longer term, potentially terminal health risks such as malnutrition and anaemia. Assuming that poor women will not seek emergency treatment when required is naïve; they are however less likely to seek care prior to this event when money is scarce and the family has other priorities than the mother's health. If women are not using healthcare services, localised assessments

need to take place to understand why this might be happening and address the issues that subsequently arise. Women's help groups can be a means of taking stock of the situation.

In 2006-7, 39.48 lakh women received JSY money. At Rs. 1000 per woman, this amounts to nearly 395 crore in total annual government spending, and the government has plans for expanding the scheme and reaching still more women. This money could have gone a long way to improve basic infrastructure and widening access, or at least into centrally sponsored nutritional programmes that target the 16.6 crore (165,666,650) women who are underweight, or the 39.8 crore (397, 600, 000) who are anaemic.

Enhance access to skilled service provision and emergency obstetric care for women in rural areas and slums, through the Reproductive and Child Health Programme phase 2 (RCH-2)

Under the NRHM, 320,000 Accredited Social Health Activists (ASHAs) have been recruited and over 200,000 have received orientation training. The lack of infrastructure and service providers, however, frequently means that there are no trained *Dai*s or ASHAs available. Auxiliary Nurse Midwives (ANMs) are also in short supply: in recent years, the tasks demanded of them have shifted significantly and yet there has been little retraining within the changed paradigm. The ANM is expected to fill up 18 registers in one month for the care she provides. Dismissive treatment of traditional medicines and care-givers has also cut off existing resources and therefore further pronounced infrastructural failings and shortages. Rather than integrating Dais into the larger overall support structure, current policy and negative attitudes within the system have largely marginalised this additional resource capacity from mainstream hospitals. Dais are an excellent link to the community. **With basic training, incentives and the possibility of registration,** these women are in a prime position for identifying the most vulnerable and high risk members of the community and making use of existing initiatives to ensure that they receive the benefits to which they might be entitled. Early **identification and targeted interventions** at this stage would be lifesaving for many poorer women and their newborns, since preventative care could be provided through the dais throughout pregnancy. Supplementary nutrition, iron supplements, diagnosis of opportunistic infections are all essential measures towards reducing maternal mortality.

In terms of physical infrastructure, health care facilities can be very spread out and located far away from where people live - particularly from Dalits and Marginalised groups. Having Dais who can reach these women would be more effective than making sure they are brought to health centres at the actual birth. The problem is not that poor women do not seek emergency care when necessary, but that there are a number of access barriers to preventative care. For instance, user charges for poor women deter many women from seeking care, administrative difficulties mean that they lack certification declaring them to be below the poverty line, or a lack of information prevents people from claiming their entitlements. One survey in Andhra Pradesh revealed that **only 20-25 per cent of women in villages were using services at the nutrition centres** established by the Rural Development Scheme, and most of these were wealthy women, women who lived nearby the nutrition centre, and women of the higher castes.

The approach of RCH Phase II is for states to prepare 5-year plans linked to clear outcomes and performance benchmarked service packages. However, in many states it is immensely difficult to acquire accurate data on maternal deaths due to **inaccurate and under-representative counts,** and this is largely because of targets affecting reporting procedures. Very few deaths are being reported as "maternal deaths," and instead are being reported as accidents, etc. In most PHCs there are also **no procedures for grievance redressal, compensation, legal protection of the victims, or liability at any level.** Without accreditation or oversight mechanisms, targets will be ineffective.

Major concerns are the lack of continuum of care from home to facility level, minimal assistance in planning, no clear referral procedures and insufficient antenatal and postnatal care.

Policy Recommendations

Public Investment

Crucially, the government must fulfil its promise of **2-3 per cent GDP investment** in healthcare. This must be achieved prior to any effective discussion of individual policies and programmes - all of which are contingent on increased baseline investment. How this money is invested is also critical. As the former UN Special Rapporteur on health has made clear, **the right to health must be integrated into national policies with**

indicators, benchmarks, impact assessments and budgetary analysis. It is clear that performance on maternal/infant mortality cannot be improved without certain basic, solid and targeted investments in infrastructure, i.e. **motivated and well-paid staff, established and integrated audit and regulatory systems, excellent political communication, with citizens who come to expect well-performing public services as a right.** A holistic approach to healthcare should consider nutrition, sanitation, access to water, housing, transport, education, immunisation, employment and gender, and this oversight is integral - the World Health Organisation has found that environmental conditions such as diarrhoea and malnutrition contribute to twenty four percent of mortality in developing countries. The relevant Ministries must therefore integrate their programmes to coordinate efforts and build a collective effort towards reducing morbidity and mortality. Using Dais and ASHAs to reach the community and target vulnerable women of childbearing age or, at the latest, during pregnancy itself, will redirect the approach towards improving maternal health: **when maternal health is improved, maternal mortality will fall**. This means a revised political focus that is not just on emergency obstetrics under JSY, but an expression of the government's commitment to improving the nation's health.

Within this context**, public private partnerships should be reviewed** to ensure that service delivery is being strengthened so as to achieve universal access to healthcare. Ultimately, private partnerships cannot be an alternative to adequate government investment, and it must remain the obligation of the state to ensure access to treatment for every citizen: this is not something that the market can be relied upon to provide. In the interim, there is need for certain preliminary measures before wider implementation of any partnership initiatives - particularly in the poorest districts where commercial schemes will struggle to generate profits.

Decentralisation:

At present there is no **fiscal decentralisation** and extremely limited local control over planning and implementation. Financing strategies must consider localised control over both resources and decision making on expenditure, which can help to increase accountability of local officials whilst imparting increased responsibility, ownership and incentives to local agents. In the Indian context, placing implementation in the hands of local stakeholders may well improve transparency and subsequently enhance the quality and efficiency of public services.

Currently, the financial resources available to PRIs fall far short of what is needed if they are to fulfil their responsibilities. Whilst the primary responsibility for revenue raising may rest with local bodies and state governments, there are inevitable discrepancies and variations in how much money a PRI is capable of generating depending on its location and per capita income distribution. The Tenth and Eleventh Finance Commission therefore discuss the possibility of an ad hoc grant to supplement income and incorporate incentives for decentralisation. In addition, resources could be provided for the provision of basic services such as water/sanitation to ensure that minimum standards are provided irrespective of the wealth of a given community. The World Bank has recommended the creation of **suitable incentive packages** and the strengthening of **State Financial Corporations** (SFCs) to track the performance of local governments, to provide a census on local government finances and compile an annual report on inter-governmental fiscal relations.

Stakeholders must also be involved in identifying the needs of a community, particularly when it comes to provision of family planning services. This means meaningful participation of women and men to address gaps in delivery and tackle problems related to community access.

Audit, Review, Accreditation:

Resources must be rationally allocated, and transparency and accountability safeguards installed at all levels in public and private service delivery institutions**.** Stringent measures for financial accountability will discourage corruption, particularly demands for informal payments for delivery of health services. There are already policies and laws concerning abortion, right to food, right to information, child marriage etc. In reality, there must be **a set of guidelines, parameters and standards with clearly defined roles for different agencies** in order to ensure that these are implemented; the framework provided by the Indian Public Health Standards should be extended to the private sector, and there must also be effective audit, review and accreditation procedures. Accreditation enables all stakeholders – government, private partners, patients - to reach a consensus on appropriate practices within a given climate. At present, there is no operational accreditation body for medical providers. The current Medical Council reportedly rarely takes up cases and practitioners are not held to account, and is basically, therefore, non-functioning. **Publicly available health impact assessments and democratically elected local health councils are effective methods of enhancing accountability.**

The lack or inadequacy of monitoring systems/MIS restricts quality compliance and increases the potential for corruption: there is a need for **regular district level maternal death audits** that are continually reviewed. **Liability** must be enforced in cases of denial of care, negligence or malpractice, and proactive measures must be taken to ensure services are delivered from within an equity framework; one route to achieving this is in **increasing the participation of women and community members** in demanding and monitoring services. **Panchayati Raj Institutions should also play a bigger role in the supervision and monitoring of PHCs.**

The Clinical Establishments (Registration and Regulation) Bill, 2007 has been introduced in the Lok Sabha. The nature of the regulation and strategies for implementation are not defined. The standards, it claims, will be set later by the parliament, which is a very prolonged process: there are **no timelines, strategies, or devolution of responsibilities.** The risk is that regulation might never happen. Patient rights are not considered, no provision is made for liability or accountability, and the potential for corruption remains.

There are some examples of good practice in enhancing accountability from across India, including the documentation of maternal deaths taking place in Andhra Pradesh, Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Karnataka, as well as maternal health social audits being conducted in Uttar Pradesh and Uttarakhand. There is a Forum on Women's Health Rights in Uttar Pradesh, and public hearings on maternal health with the State Women's Commission in Orissa. In Tamil Nadu, all maternal deaths are notifiable and personnel of the health system should convey news of a maternal death within 24 hours; otherwise, they face a penalty. A district review committee meets monthly and reviews maternal deaths.

Primary Care Infrastructure:

In terms of developing state level infrastructure (aside from monitoring and accreditation), there are a number of measures that need to be taken at the levels of policy and implementation. The government must concentrate on ensuring total availability of critical infrastructure, staff, equipment and supply inputs at all levels of public health facilities for delivery and emergency care, especially in remote areas. Priority should be given to poor, underserved and marginalised communities, **providing transport for logistical access to centres where necessary.** Aganwadi centres must be open at hours that suit the local community: this may often mean outside of typical working hours for parents who must work to support their families. There is a need for affirmative action for excluded and vulnerable populations such as young people, SC and ST and people living with HIV/AIDS - added to which must be the **ensured accessibility of comprehensive, integrated healthcare services, including diverse contraceptive methods and safe abortions.** Services have to be available to each member of the community and accessible - logistically and financially - to the poorest and most marginalised.

To achieve inclusive, quality service provision, the base of skilled providers for delivery and abortion (including community workers as well as doctors, nurses, midwives) will need to be enhanced. The use of AYUSH practitioners at PHCs is also a worrying trend, since many are merely replacing rather than supplementing those who have moved to the private system or abroad. One solution to the shortage of public sector doctors in rural areas might be to initiate a policy in which **every doctor/health worker has to complete some years in a rural posting**, or at least see out a set term of service within the public system to the value of their training. **The capacity and skills of Dais and ANMs must be strengthened**, and this goes beyond setting targets for institutional delivery; rather, **care should be perceived as a continuum** from pregnancy to post-childbirth and newborn care, correlated with referrals, Primary Health Care, and reproductive and family health services. There also needs to be training in technical skills and the nature of the role of the Dais post-birth. **Regular in-service training** enhances knowledge and skills and ensures familiarity with new programmes and approaches; this should also apply to providers and managers.

Dais are an essential link between community and health centres and should be recognised as such. They have the capacity to identify and address the needs of the most vulnerable members of the community and make effective interventions before complications arise. To perform these services, measures must be taken to ensure they are formally integrated within the system and their role clearly defined, with basic training to allow them to meet these expectations. Incentives must also be addressed, with the option of formal recognition and registration once certain criteria have been met. **Attitudinal development training** would also allow the Dais and all those involved in service delivery to provide equitable and rights-based care to all classes, castes and genders.

Child Marriage:

The Child Marriage Restraint Act, 1976, should be strictly enforced to reduce the number of high risk teenage pregnancies and increase the potential for educated girl citizens. **Education and awareness campaigns** should also be launched, applying not only to child marriage but also to the issues of sex selection, contraception and safe abortion[1].

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[1] For more on this issue, see Goal 3: Achieving Gender Equality

Goal 6: Combat HIV/Malaria and Other Diseases

6
COMBAT HIV/AIDS, MALARIA & OTHER DISEASES

Overview

The National AIDS Control Programme (NACP) has made substantial strides in its third phase, expanding investment, collaboration, accessibility and targeted prevention amongst high risk groups. However, one critical limiting factor in developing effective policy responses to HIV/AIDS is the lack of reliable statistical information. Aside from deficiencies in physical infrastructure, fear of the social repercussions of a positive result is preventing many people from approaching Voluntary Counselling and Testing (VCT) Centres. Tackling discrimination must therefore be an absolute priority for the government, not only to safeguard fundamental human rights amongst people living with HIV/AIDS (PLHIV), but also to enable a more extensive assessment of the scope of the epidemic and implement effective, targeted policy interventions. This will mean prioritising the passing of the HIV/AIDS Bill. As well as working closely with those identified as high risk, there is also a growing need to focus on changing trends within the HIV epidemic which reveal that two of the greatest rises in prevalence are amongst young people (15-29 years) and women, who are often picking up the infection from regular partners. Awareness about HIV is lowest among women, especially in rural and tribal areas, and this is making them increasingly vulnerable to HIV infection. In terms of treatment, cost-effective results can only be achieved if TB and HIV infected patients receive "high quality medical care" and understand the need to ascribe to a long term treatment regime: this will entail strengthening health and support infrastructure and systems of care. TB also needs to become a priority for the government since the country has of yet failed to contain the epidemic: alongside systemic changes and more effective monitoring on the ground, this may require a mass campaign along the lines of the polio eradication project to tackle misconceptions amongst patients.

UN Targets and Indicators

Target: Halt and begin to reverse the spread of HIV/AIDS by 2015 **Target:** Halt and begin to reverse the incidence of malaria and other major diseases	• HIV prevalence among 15-24 year old pregnant women • Condom use rate or the contraceptive prevalence rate • Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years • Prevalence and death rates with malaria • Proportion of population in malaria risk areas using effective prevention/treatment measures • Prevalence and death rates with tuberculosis

Status

Indicator	Value according to United Nations data	2015 target	Status (based on UN projected values)
HIV prevalence among 15-24 year old pregnant women	0.55 per cent (2006)	No target set	N/A
Prevalence rates of malaria Per capita prevalence and death rates for TB	16.7 lakh cases, i.e. about 157 cases per 100,000 population (2006)	N/A	N/A
	299/100,000 and death rate of 28/100,000	Reduction by 50 per cent relative to 1990 levels: 284/100,000 and death rate of 21/100,000	On track

According to National AIDS Control Organisation (NACO) estimates, there are **at least 25 lakh** (2.5 million) **people infected with HIV in India** (2006).

UNAIDS reported 57 lakh (5.7 million) living with HIV in India at the end of 2005. NACO have since disputed this estimate and the revised figure stands between 20 and 30 lakh (2 and 3 million): this is controversial, however, since "many of those infected are still not aware about their status" (NACO, 2008), i.e. are simply not getting tested. This is largely owing to widespread stigma and discrimination associated with a positive diagnosis. Infection rates soared throughout the 1990s and today the epidemic affects *all* sectors of Indian society, not just the groups such as sex workers and truck drivers with which it was originally associated. With less than 30 per cent of India's population, almost 70 per cent of India's HIV cases are in Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Manipur and Nagaland.

In 2006, **16.7** (1.67 million) **lakh malaria cases** were reported in India, i.e., one in about 630 persons.

In India **18 lakh** (1.8 million) **tuberculosis cases occur annually**, accounting for one-fifth of the world's new TB cases and two-thirds of the cases in the South-East Asia Region

There was a sharp increase in the number of polio cases in India in 2007 (**873 confirmed cases from 66 cases in 2005**) (WHO data). India is one of four countries along with Pakistan, Nigeria and Afghanistan where polio is still endemic.

The deadline for polio eradication in India has now been pushed back to 2010, but India would have to show no new cases for three years to be declared polio-free. Whilst the National Family Health Survey-3 (NFHS-3) suggests that states such as Chhattisgarh and Madhya Pradesh have made progress in extending coverage of polio vaccination programmes, coverage in states such as the Punjab and Maharashtra has diminished in the last seven years. UNICEF's *State of the World's Children* report (2007) records that only 58 per cent of newly borns received drops in 2006, and this is less still amongst SC/ST communities.

HIV/AIDS

Background:

"The statement that India has the AIDS problem under control is not true. There is a decline in prevalence in some of the Southern states... In the rest of the county, there are no arguments to demonstrate that AIDS is under control."

(Peter Piot, Executive Director of UNAIDS)

In India, HIV has spread mainly through **unprotected sexual activity**. Almost half of all new infections are reported among people between 15 and 29 years of age, whilst the report of the Commission on AIDS in Asia (2008) found that **men who buy sex constitute the largest infected population group**. This then exposes ostensibly

"low-risk" sectors to increased possibility of infection, namely, their wives and regular sexual partners.

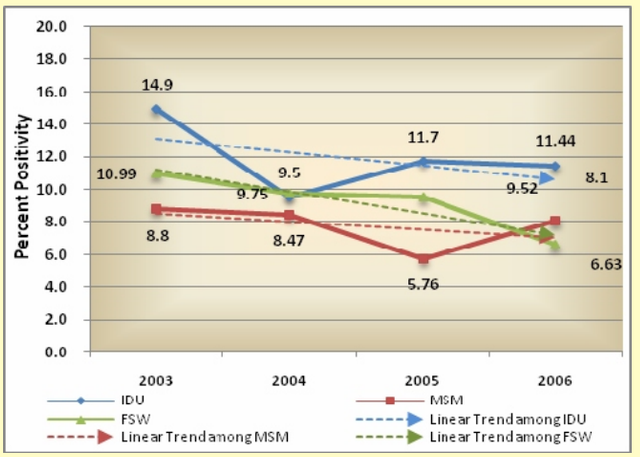
Women account for 38 per cent of new infections in India. They are more likely to be uneducated and illiterate, which makes it difficult to obtain information on HIV and negotiate safe sex practice within and outside marriage, and they are also less likely to be able to assert themselves when it comes to decisions regarding sexual behaviour. Child marriage further increases vulnerability of young girls and makes it more difficult to access preventative, testing and counselling services. In some states, minors may not be able to access VCT services without parental consent as per existing guidelines. One further risk is that HIV positive women unknowingly transmit the virus to their children. It is estimated that 55,000 to 60,000 children are born every year to mothers who are HIV positive (UNICEF). **Without effective interventions, the risk of transmission from an infected mother to her child is 15-25 per cent.** Women also make up more than 70 per cent of care givers, many of whom are themselves infected and lack access to social security.

"The voluntary counselling and testing (VCT) centres are not women-friendly. Very few have women staff. ***ART centres are not women friendly****. There is no gynaecologist and no internal coordination for women to access additional services. There is a lack of privacy and confidentiality in the VCT Centres for women."*

(Interview, Member, PLHIV Network. Source: UNFPA)

NACO has estimated a total **high risk population** of 20 lakh (2 million), which includes female sex workers (FSWs), men having sex with men (MSMs), and injecting drug users (IDUs). The government has stated that it will take a "**Harm Minimisation**" approach to IDUs by supporting NGOs running harm reduction (such as needle exchanges) and rehabilitation programmes. A more liberal engagement with FSWs in some states has facilitated **peer counselling, condom promotion, and treatment of sexually transmitted infections** and seemingly reduced incidence within this group (see Figure 1), with nearly one third of FSWs reporting attendance or participation in either a campaign or meeting on STIs/HIV/AIDS in the previous year (Behaviour Surveillance Survey, 2006). As an example, more than 200 sex workers in Tamil Nadu belong to a "union" which seeks official recognition and undertakes advocacy to promote and safeguard their rights.

Figure 1: *Trends among High Risk Groups, India 2003-06 (Source: HIV Sentinel Surveillance)*



Nevertheless, these measures have been relatively inconsistent across the country: only 38 percent of FSWs possessed comprehensive knowledge of HIV transmission and prevention in the 2006 survey, and the same number again have tested themselves for HIV infection.

A 2006 study for the National Council for Applied Economic Research found that **one quarter of people living with HIV in India have been refused medical treatment** on the basis of their HIV positive status. People in marginalised groups - female sex workers, hijras (transgender) and gay men - are often stigmatised not only because of their HIV status, but also because they belong to socially excluded groups. Discriminatory treatment by those involved in implementing HIV/AIDS related programmes can affect the quality of services towards people living with HIV, whilst police harassment and community stigmatism often force the epidemic underground and decrease the effectiveness of prevention efforts.

"Women in prostitution are those mostly affected [by legislation] as there are frequent raids in the brothel. There are instances of violence against sex workers, especially young sex workers. Street children and orphans are abused similarly by the law enforcers."

(Interview, Counsellor at Faith-Based Organisation. Source: UNFPA)

Limited access to information about HIV/AIDS has perpetuated stigma, whilst **lack of education and open discussion** has hindered prevention efforts. In a recent survey of young people in Delhi and Lucknow, around one third of the respondents were found to be lacking in awareness of safe sex. Two

common reasons for not using condoms were reluctance in obtaining them and fear of "side effects". Meanwhile, the NFHS-3 indicated that **only half of rural women are aware of AIDS** and, amongst women with no education, this figure is reduced to one in three. Only 9 per cent of the women in the poorest fifth of the population said that they were aware that condom use can prevent HIV transmission.

Poverty is one of the contributing factors to the spread of HIV/AIDS and increases the vulnerability of high risk groups, whilst HIV/AIDS also exacerbates poverty at the macro-economic level. Up to 3 per cent of a country's labour force are estimated to be lost to HIV/AIDS in hard-hit countries each year. Once infected with HIV, the virus creates a cycle of poverty by reducing the economic productivity and social opportunities of affected households. Extreme poverty often forces women and young girls into the sex trade, which increases their risk of exposure to HIV.

An International Labour Organisation (ILO) study (2002) found that **38 per cent of children with HIV infected parents had to withdraw from school to work,** with over a third lacking access to basic resources. Moreover, people living with HIV/AIDS often struggle to access insurance and social security mechanisms.

Current Policy

National AIDS Control Programme (NACP)

Phase III of the National AIDS Control Programme (NACP) was implemented in 2007-8 and will run for five years: it aims to halt and reverse the HIV epidemic in India during its timeframe. Strategies concentrate on:

- **Prevention amongst high risk groups** and the general population with targeted interventions
- Provisions of **enhanced care, support and treatment** to more people living with HIV (PLHIV)
- Improving **health infrastructure, systems and resources** in prevention, care and treatment at district, state and national level
- Strengthening **national information management systems**

The "guiding principles" behind NACO's approach are **equity;** respect for the rights of PLHIV, including creation of an enabling environment; civil society participation; universal access to prevention, care and treatment, and implementation of evidence based programmatic interventions with extensive monitoring and evaluation (UNFPA).

In 2008, NACO began to roll out government funded second-line antiretroviral treatment (ART). Second line antiretrovirals (ARVs) are essential for cases of HIV which have become resistant to the effects of the medication, thereby necessitating a change in antiretroviral regime. NACO's initial one-year goal aims to provide second-line ART for an estimated 3000 people in India who have become resistant to first-line drugs. There are also plans to improve the provision of nevirapine to pregnant mothers with HIV, a drug which virtually eliminates the risk of passing infection on to the child.

However, it is estimated that HIV prevention **programmes are only reaching 15 per cent of young people and 17 per cent of those in high risk groups** (UNICEF). Access to treatment also remains elusive. ARVs have been available in richer countries since 1996. As in many poorer countries - and despite the fact that the country is a major provider of cheap generic ARVs to the rest of the world - access to this essential medicine is severely limited in India: as of October 2007, **only about 100,000 people (approximately 20 per cent of those in need) were receiving ARV treatment** (NACO). Those that can afford it can sometimes obtain the drugs through private health facilities, but the vast majority of people cannot afford sustained out of pocket expenditure on healthcare.

The World Health Organisation has reported that **only 3.9 per cent of all pregnant women access HIV mother-child transmission services**, and, out of an estimated 189,000 HIV-positive pregnant women, less than 8 per cent receive treatment to prevent transmission to their children (NACO, 2008). There are currently just 307 government run Prevention of Mother to Child Transmission (PMTCT) facilities in 15 states that are providing comprehensive services (including confidential testing and counselling, ARVs and follow-up care to minimise risks of transmission). **Nutritional counselling** should also be available so that pregnant mothers gain awareness of the local conditions, which will determine whether the preferred and safest option on the ground is breastfeeding or formula milk. Moreover, even when treatment to prevent mother-to-

child-transmission is available, some women often do not request it because of the stigma surrounding HIV.

All of these programmes need dramatic scale-up to ensure that women and children continue to take life saving drugs and that communities can provide a supportive environment to families living with HIV/AIDS.

Interventions continue to be affected by **shortage of drugs, equipment and personnel and lack of overall transparency.** Information about drug stocks and shortages is still not publicly available and requires a lot more attention. There is **no material in local languages for HIV-positive people on availability of ART or enrolment procedures, drugs, possible side-effects and the importance of treatment adherence.** One 2007 study found that 41 per cent of respondents did not take ART because of lack of knowledge about the treatment, whilst various patients have reported starting treatment without proper counselling about side-effects, the possibility of drug resistance which could require second-line treatment and the need to take the drugs regularly for life. **Monitoring procedures** are currently woefully inadequate, and public health infrastructure needs to receive adequate investment before NACO interventions, with or without proposed private partnerships, can begin to take hold.

Chapter XVI, Section 377 of the Indian Penal Code, 1860

Section 377 is a Victorian piece of legislation introduced under British rule to criminalise homosexual activity, also commonly referred to as the 'Anti-Sodomy Law'. It legislates against "unnatural sexual offenses", including he who "voluntarily has carnal intercourse against the order of nature with any man, woman or animal", punishment for which shall be up to 10 years imprisonment. In England, homosexual behaviour between consenting adults, in private, was decriminalised in 1967. Section 377 is currently under a constitutional challenge at the Delhi High Court.

Section 377 has been used as justification for numerous assaults on men who have sex with men (MSMs) by the authorities, and in many states **law enforcement activities have effectively driven MSM communities underground**. This has made these groups very difficult to reach with NACP interventions and there is a decided lack of reliable statistical information about prevalence rates.

The evidence that is there, however, should be of particular concern for government planning agencies. 5 per cent (2.35 million) of sexually active men aged 18 and above have been reported to be having regular anal sex with other men (NFHS-3): only 10 per cent of these were found to be male sex workers. Amongst the MSM population, statistics for condom use are remarkably low: with non-commercial partners, for instance, the National AIDS Research Institute reported less than 40 per cent condom use. Official NACO estimates for incidence amongst MSMs is now 6.41 percent (2006). In certain sub-groups, however, rates of infection may be even more concerning: the Humsafar Trust found positivity of 13.8 per cent of samples collected amongst MSMs at six sex sites in 1999-2000. A prevalence above 5 per cent is seen as 'hyper-endemic'.

In the first year of NACP-3, the number of targeted interventions for MSMs was increased from 30 to 230. However, support services are difficult to get off the ground: at present, there are no **sensitisation programmes for public health workers and service providers**, and there are no STI clinics directed at oral or anal sex services. Support groups and national/community based organisations would widen access to VCT centres, but this will only be possible to any real extent once Section 377 has been repealed in line with other democratic nations across the globe.

This is no longer a time for political denial of the evidence: sex between men is happening in India, and, whilst the law criminalises homosexual activity, this group will remain unreachable to public health interventions. MSMs also includes a huge bridge group: bisexuals, who transmit the virus to the non-MSM community. As with decriminalisation of the sex-trade or controlling the drugs trade, this piece of legislation must be removed before there can be any meaningful engagement with these groups. Without strategic targeting, the risks of transmission amongst MSMs and their partners will continue to threaten NACO success rates.

HIV/AIDS Bill

Thought to be tabled in 2007, the HIV/AIDS Bill (2005) has still not been passed. It has already been accepted by the health ministry. The Bill addresses the issue of discrimination **in employment, healthcare, education and other places, besides informed consent** for testing, treatment and research. It legalises a safe working environment for healthcare workers, proposes protection of inheritance and property rights, and recognises community-based alternatives to institutionalisation for vulnerable and affected children. There is the suggestion of creating a health ombudsperson in all districts to curb the growing discrimination against HIV/AIDS patients.

Legislation needs to address the issue of **social**

security and insurance as a matter of priority. Unlike in countries such as the UK or USA, Indian insurance companies have been rejecting coverage of those testing positive for HIV/AIDS, and also refusing to settle their policies and pay the benefits to their nominees. Companies must be prevailed upon to extend coverage to people living with HIV/AIDS and their families and should not be allowed to discriminate, as is the case for other infectious diseases. Government also needs to address pension schemes and universalise procedure and standards across states. Widows are currently particularly vulnerable to poverty and marginalisation and often lack documentation to prove eligibility for the Widow Pension Scheme, whilst entitlements vary immensely between states. In some states the Scheme barely even covers travel to collect the pension. Kerala, for example, offers a meagre Rs. 110 per month.

People affected by HIV face denial and discrimination in public and private institutions, health care settings, employment and educational services on the sole grounds of their health status. Women have been forced to give birth in corridors because doctors refuse to treat them; children of HIV positive parents are routinely excluded from school (whether or not they themselves are positive); nurses refuse to associate themselves with positive patients; banks refuse to allow people living with HIV/AIDS to open accounts and the list goes on. India currently has **no law to prevent discrimination against people living with HIV/AIDS**, which is in part why there are no reliable statistics against which the real extent of the HIV epidemic in India can be appropriately assessed.

The alternative to addressing issues of stigma and testing is enforced testing - a scenario that has been discussed in several states. This would be a tragic denial of human rights and extremely detrimental to the welfare of infected persons, particularly if the stigma associated with a positive diagnosis is not tackled first. Although voluntary HIV testing is widely supported, cases have been reported of **people being tested in hospitals without their consent**. Advocacy and sensitisation on rights-based issues is therefore absolutely imperative alongside the Bill to ensure that people living with HIV/AIDS can lead a life of dignity and know that their civil rights are secure.

"Young women will never talk of condoms due to cultural barriers. The voluntary counselling and testing (VCT) programs are stand alone programs and not integrated. Girls and young women are not using the services **due to fear of stigma and discrimination."**

(Interview, Member, PLHIV Network. Source: UNFPA)

Adolescent Education Programme

The National and State Adolescence Education Plans, developed by the Department of Education, aim for:

- 100 per cent coverage of schools (33 million students every academic year)
- Inclusion of HIV prevention education in the curricula of students (Grade I-XII)
- Inclusion of HIV prevention education in the curricula of pre-service and in-service teacher training
- Inclusion in the curricula of alternate innovative education schemes and adult learning programmes
- Incorporation of measures into the education policy to prevent stigma and discrimination against learners/students and educators and ensure access to life skills education for HIV prevention
- Skills-based school programmes that shape the ideas and attitudes of a generation in gender equality, as well as encouraging compassion towards people living with HIV/AIDS and taking responsibility for choices related to sexual behaviour.

The Adolescent Education Programme (AEP) is currently proposed for introduction in CBSE affiliated schools, beginning at Grade IX and delivering **a curriculum which includes growing up, HIV/AIDS, life skills and extra curricular activities.** Already, 96,000 of the 150,000 high schools in India train teachers and peer educators to pass on life skills and preventive messages. **Gender awareness and women's rights** are highlighted within the AEP, in a course which is designed to empower young women to enter into sexual relations and child-bearing on their own terms. Critics have argued that the manual is not suitable for all districts, particularly more conservative rural areas. However, the framework does not preclude the possibility of working with community workers, NGOs, health providers, educators and young people themselves to adapt the methodology within reason, and the foreword to the AEP manual explicitly advises state education departments to modify the content to suit local conditions.

Policy Recommendations

A report commissioned by NACO and the MoHFW (2007) recommends that the government work within the NRHM framework to:

- Strengthen existing public health infrastructure;
- Effectively target high risk groups, in particular increasing access to **youth and women-friendly health services**;
- Integrate **prevention, care, support and treatment** with NRHM initiatives through RCH;
- Guarantee **supply of and access to condoms**;
- Expand access to institutional deliveries, family planning and abortion services, STD treatment, health education and nutritional support, breast feeding, alcohol, drug abuse services etc.;
- Ensure treatment of TB and opportunistic infections through **TB control programmes**;
- Implement procedures to prevent stigma and redress discrimination in healthcare settings by raising awareness, knowledge and empathy, and by enforcing disciplinary action where required;
- Train all health care providers in public health facilities at all levels on HIV prevention and avoiding stigma and discrimination;
- Increase usage of existing schemes and programmes by removing financial barriers and ensuring **social security** to those affected by HIV/AIDS;
- Ensure access to safe blood;
- Strengthen **data management and review performance** at state and district levels;
- Strengthen **district health societies** to oversee implementation
- Expedite the processing of the **HIV/AIDS Bill** and utilise existing policies and laws to protect people living with HIV/AIDS/affected families against stigma and discrimination.

Prevention

Primary prevention among young people is the greatest hope to change the course of the growing epidemic in India. There may be potential for expansion of peer education programmes along with the Adolescent Education Programme (AEP). Educators and policy makers need to take a firm stand on the matter of introducing **participative sex education in schools** in order to offer the best degree of protection for India's youth. Peer educators must be equipped to provide referrals to other services in the community. Male and female condoms should also be more accessible to young people. In addition to education through the formal school system, however, it is necessary to reach the **70 million young people who are currently out of school.** These are likely to represent the most vulnerable and high-risk groups, including street children, children in institutions and child labourers.

Work also with boys and men to enhance their understanding and change their behaviour around STD prevention, which will impact upon the likelihood of transmission to partners.

At present, women tend to be tested for HIV in antenatal clinics. **Prevention of Mother to Child Transmission Centres** must be established in district and sub-district health facilities.

Sex workers in urban areas should be educated about their rights to **female contraceptives**. In addition, blood tests and screenings should be offered, and women should be encouraged to make use of such services. Distributing pamphlets and posting signs in well-known red-light districts raises awareness among female sex workers and their clients, whilst a World Bank Study (2004) has demonstrated that effective education programmes - facilitated by co-operation with the police force and local authorities - can promote and increase condom use amongst sex workers.

Section 377 of the Indian Penal Code needs to be repealed to decriminalise homosexuality, which will enable more effective targeting of this high-risk group through NACP initiatives.

Initiate a **mass media campaign** with HIV prevention messages for the general public, particularly targeting young women and other high risk groups.

Testing

Remove any provisions that demand parental consent for testing of minors to increase access to services

Introduce and promote **a model of best practice for VCT Centres in rural areas** that emphasises the importance of a safe and supportive environment

that is women and youth friendly, of confidentiality, and provision of counselling services

Treatment and Care

As the World Bank has reported (2004), cost-effective results can only be achieved if HIV infected patients receive **"high quality medical care"** and thus are able to understand the need to adhere to the sometimes arduous treatment regime prescribed by physicians. If the three drug regime is not strictly followed, drug-resistant strains of the virus are more likely to occur and spread. There must therefore be systems in place for arranging **follow up appointments and sustaining uninterrupted supplies of ARVs.**

A "structured treatment" regime will require **training physicians in antiretroviral therapy management, the prescription of a standard triple-drug combination and support from a cross-disciplinary team, including a nutritionist and counsellor** who will also discuss prevention of transmission. There will need to be **regular contact and review procedures** with the team, as well as lab-based monitoring of the patient's response to the treatment; such contact will concurrently enable prompt diagnoses and treatment of opportunistic infection.

The government must evaluate costs and effectiveness of alternative therapy programmes, and **research which models best encourage adherence to treatment regimes.**

The community-based workers proposed under the NRHM (National Rural Health Mission), e.g. ASHAs and ANMs, are important links between the programme and communities to ensure early diagnosis, adherence to treatment regimes, and care for affected families and children. **Anganwadi workers must be sensitised and sensitise others** on the rights of children/adults who are HIV-positive or otherwise affected by HIV/AIDS and on the mechanics of inclusion in public services/community events. **Confidentiality** must be emphasised and **disciplinary procedures** instigated following any breaches of patient confidentiality. The skills of anganwadi workers must be developed, particularly in high prevalence districts so as to ensure adequate nutrition and healthcare for infected people.

A few states have policies related to care of vulnerable children affected by HIV/AIDS, but most have failed to respond to affected children or to denial of education/health care. Programmes to train teachers and doctors, to educate children, and to increase public knowledge of HIV have begun in some states, but these need vast expansion. The **Integrated Child Protection Scheme (ICPS)** plans to address the needs of orphaned children through 'care and protection', especially social protection with community-based interventions like 'sponsorships', alternative care programmes, and additional provision in childcare institutions. However, ICPS does not mention any specific services for children living with HIV. **Institutional care must remain the last option and for the shortest duration.** It is the responsibility of the Ministry for Human Resource Development to ensure that all children affected by HIV are able to realise their right to education and are supported to complete their education, and there must be explicit legislation to ensure that there is no discrimination for admission and retention (see World Bank, 2004).

Discrimination

The HIV/AIDS Bill must be tabled as a matter of urgency. Subsequently, community awareness programmes must be initiated to help tackle discrimination, which prevents many people from being tested and receiving treatment: this will involve (re)training primary care providers/people working in service delivery (i.e. teachers, ASHAs, nurses, midwives). A **District Ombudsman** would assist in implementing the Bill at a community level. Communication campaigns should also be increased to target stigma and discrimination, and provide quality control to prevent the inadvertent use of stigmatising messages.

Governance

The National AIDS Control Programme (NACP) must converge with the **Health and Family Welfare programmes (HFW),** which have an existing capacity to reach every village and community. Attitudinal changes, prevention/management and condom promotion are the cornerstones of HIV/AIDS prevention, and all three overlap with RCH interventions. Areas of cross cutting importance that need to be addressed in prevention and care strategies include: gender, private sector involvement, and reduction of stigma and discrimination among health care providers and communities (NACO and the MoHFW, 2005).

PLHIV must be more involved in national HIV programmes and policies, as well as **the National AIDS Committee**: to date, consultations have largely been with external consultants and experts.

MALARIA

Current Policy

National Vector Borne Diseases Control Programme

Seven states in the North-East are being provided with 100 per cent central government assistance to implement disease control mechanisms in remote areas. Over 5 lakh Drug Distribution Centres, Fever Treatment Depots and malaria clinics have been established, 54 lakh bed nets supplied free or highly subsidised to high risk areas in endemic states, and the Intensified Malaria Control Project (IMCP) is currently overseeing 106 districts across 10 states, with an aggregate population of 100 million.

Policy Recommendations

To eliminate the malarial parasite and effectively manage the disease, diagnosis must be performed at an early stage and a complete course of treatment strictly adhered to. Referral services must be strengthened, and communities and districts must be prepared for epidemics to enable rapid response.

To **reduce the risk of transmission,** local governments can encourage indoor residual spraying in selected high risk areas as well as the habitual use of insecticide treated bed nets. There is also potential for developing minor environmental engineering for reduction of breeding grounds.

Rural, tribal, SC and vulnerable populations must have **adequate coverage and access to malaria control services** proportionate with the burden of disease. The UN cites lack of Drug Distribution Centers and Fever Treatment Depots in remote areas as one of the key challenges.

Governments must consider how **rapid urbanisation, colonisation of forest fringes, movement migration and various developmental activities** can increase the risk of spreading and develop preventative strategies accordingly.

TUBERCULOSIS

Background

TB is preventable and curable, yet kills the largest number of people worldwide. Often patients abandon therapy when they "feel better" or become asymptomatic. Failure to complete the course leads to the development of new strains of drug-resistant TB. The links with HIV make this a particular cause for concern for the medical profession: HIV patients, owing to their immune suppressed status, easily catch TB infections. TB promotes progression of AIDS and AIDS promotes progression of TB; TB is the leading cause of death in people with AIDS.

From 2000 to 2004, 20 per cent of global TB cases have been resistant to standard treatments, with 2 per cent resistant to second-line drugs.

Case Study: Drug resistant TB strains in Mumbai

In Hinduja National Hospital, Mumbai, 1,274 out of 3,904 lab tests for Mycobacterium TB were positive for TB, 32 per cent of these were multi-drug resistant TB (MDR-TB) and 8 per cent were extensively drug resistant TB (XDR-TB). The death rate of those patients carrying XDR-TB was 42 per cent. Dr Sushil Jain said that "serious efforts are needed to tackle this deadly disease, which may become a global emergency. XDR-TB has long existed in India but has been under-recognised and under-treated". Dr. Jain went on to say: "Most labs in India are not equipped to perform drug susceptibility tests so exact prevalence is difficult to ascertain, and treatment in the absence of reliable sensitivity report is difficult."

American Thoracic Society, ***Extremely Drug Resistant TB, A Growing Problem in India*** *(May 2007)*

Current Policy

Revised National Tuberculosis Control Programme (RNTCP)

Under the technical leadership of the Central Tuberculosis Division (CTD) within the Ministry of Health and Family Welfare (MOHFW), the Revised National Tuberculosis Control Programme (RNTCP) has achieved **coverage of 632 districts in the world's largest, fastest expansion of population coverage** for any tuberculosis programme implementing the WHO's Directly Observed Therapy Short-Course (DOTS) strategy. Since the programme began expanding in 1997, the RNTCP has trained more than half a million staff, evaluated more than 30 million people with suspected TB, examined more than 100 million sputum slides, treated more than eight million patients, and prevented more than 1.4 million TB deaths. The RNTCP has established an effective drug logistics management system: quality-assured drugs are available throughout the entire country free of charge for patients. A case detection rate (CDR) of 70 per cent and a treatment success rate of 86 per cent were attained in 2007. This approximates to the internationally established benchmarks for case detection and treatment success.

In order to preserve and strengthen these very substantial achievements, it is important to address early warning signs of programmatic deterioration and address **emerging challenges such as drug resistant tuberculosis and TB-HIV co-infection**. The rapid expansion of the programme has outpaced the capacity of centre and state to effectively supervise and ensure programme quality. The rapid expansion has also revealed and **been limited by the weaknesses of the general health system**. Although some states are generally performing well, insufficient central and state-level capacity has led to an overall decline in case detection, a small but discernible decrease in cure rates and increase in treatment default rates in some areas over the past two years. This could result in avoidable transmission of TB and TB-related deaths.

Systems for efficient procurement, human resource development (HRD) and monitoring need to be further strengthened. Without ongoing financial and technical support, the existing systems at national and state levels may not be able to maintain and improve the programme to achieve a long-term impact. There is **limited effectiveness of activities in the community to increase awareness of the location of services** for free diagnosis and treatment of TB and to increase community ownership of tuberculosis control. Although the framework of the National Rural Health Mission (NRHM) calls for convergence and integration, staff shortages, frequent transfers and other weaknesses of the general health system present major challenges for the programme, particularly in certain states.

Policy Recommendations

The quality of services in poorly performing states/districts must be improved and primary health weaknesses addressed. Large geographic areas with remote and difficult to access village communities are covered by the programme; to enable its effective implementation, there must be continuous monitoring of the scheme as well as regular training of staff, doctors and lab personnel to ensure that the international DOTS Plus Programme is adhered to and implemented. A mass campaign should be launched to control the spread of TB, including Multi-Drug Resistant (MDR) and Extensively Drug Resistant (XDR) strains. One of the most significant challenges to TB control is widespread misconception about the disease and lack of co-operation in following the sometimes arduous treatment regime. When medication is discontinued, TB is easily spread within the community. However, with knowledge and information support from an integrated and holistic care base, treatment at home will be wholly effective and the disease can be contained.

Long-term financial and human resource sustainability of the Programme must be addressed by ensuring that sufficient financial resources for the Programme are included in the MOHFW budget lines, at both central and state levels. Long-term sustainability will require independence from external funding and collaboration with external technical and financial partners.

TB control must remain a high priority in the NRHM with guaranteed core full-time staff, TB-specific reporting and financing, and central level anti-TB drug procurement. The NRHM must be used to identify and address weaknesses in the health

system, including frequent transfers and widespread vacancies of key staff (notably laboratory technicians [LTs] and medical officers [Mos]).

With the expanding opportunities for the Programme under the NRHM, it is essential to increase capacity at central and state levels to supervise and ensure programme quality. To achieve this, government must:

- Increase the responsibility assigned to, and improve the capacity of, State TB Control cells and existing State Tuberculosis Demonstration and Training Centres (STDCs);
- Ensure identification and vigorous follow ups in districts where reports are found to be inaccurate and continue until inaccuracies are resolved, with the involvement of political and administrative leaders of districts and states; meanwhile, institute a process to identify and reward consistently well-performing or rapidly improving districts.
- Install further laboratories with equipment to detect drug resistant TB. This will allow health bodies to better calculate the scale of the disease and resources can be focused on high risk areas.

Programme effectiveness and case detection will be improved by enhancing training of general medical officers and paramedical staff, and by implementing interventions such as systematic screening for cough by non-medical and paramedical staff. The involvement of all health sectors including PHCs, TB hospitals, NGOs and other providers must also be increased.

For TB-HIV, a **TB-HIV technical working group** should ensure implementation and scaling up of collaborative activities outlined in the National Framework for Joint TB/HIV Collaborative Activities. An action plan should be drawn up to **integrate and improve management of TB-HIV patients**, particularly in areas with large numbers of HIV infected people. Coordination mechanisms must be improved and sustained to ensure an effective two-way referral system.

Simple administrative and environmental control measures to reduce transmission of TB must be implemented**,** such as training of healthcare workers, rapid assessment of cough/prompt diagnosis of TB, collection of sputum in an open environment, limitation of hospitalisation for TB patients, improvement in ventilation of hospitals and use of hospital cleaning techniques that limit potential aerosolisation of *M. Tuberculosis.*

Given that India is one of the world's leading manufacturers of generic medicines, it is especially important for national industry (government and pharmaceuticals) to invest in **research and development** (R&D) into neglected diseases that primarily affect less developed economies. India is well positioned to boost innovation in **new diagnostic tools that are simple, reliable and field-adapted** to settings where resources are poor; more **powerful and efficient drugs** that would work over a shorter course of treatment and therefore address the problem of drug-resistant TB, and an **effective vaccine** to prevent TB infection.

American Thoracic Society, ***Extremely Drug Resistant TB, A Growing Problem in India*** *(May, 2007).*

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Goal 7: Ensure Environmental Sustainability

Overview

According to the Human Development Report 07-08, "superimposing incremental climate change risks on this large human development deficit would compromise the ambition of inclusive growth set out in India's Eleventh Five-Year Plan". Surface temperatures across India have already increased by approximately half a degree centigrade during the second half of the century, whilst periods of intense heavy rainfall have been increasing over the last ten years. Last year, nearly 8,000 square miles of agricultural land were inundated by heavy and unpredictable monsoons, more than 130,000 houses destroyed, 1428 people were killed and 20 million affected. Crop yields in South Asia could decrease by 30 per cent halfway through this century: the hunger problem is therefore likely to be severely exacerbated if governments do not immediately take steps to mitigate the damage caused by climate change and lay the foundations for appropriate adaptive procedures. The Intergovernmental Panel on Climate Change (IPCC) has emphasised that it is ultimately the poorest people who will be most affected by inadequate policies related to environmental sustainability. It is the poor and disempowered who lack insurance or social security, whose housing and livelihoods remain precarious and who possess few opportunities for alternative employment once the disaster has taken place; it is they who stand in the way of extracting natural resources and who most suffer the effects of harmful environmental outputs. Measures towards achieving environmental security must therefore consider both vulnerable populations and conservation, and it is imperative that these should not be forced into conflicting poles. Whilst environmental protection is necessary to guarantee the rights of present and future generations to enjoy a healthy life in a healthy environment, a safe and peaceful environment where human lives are valued is also essential for local conservation.

UN Targets and Indicators

Target: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources **Target:** Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation **Target:** By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	▪ Proportion of land area covered by forest ▪ Ratio of area protected to maintain biological diversity to surface area ▪ Energy use (Kg oil equivalent) per $1 GDP (PPP) ▪ Carbon dioxide emissions and consumption of CFCs ▪ Proportion of population using solid fuels ▪ Proportion of population with sustainable access to an improved water source & sanitation, urban and rural ▪ Proportion of households with access to secure tenure

Status

Indicator	Value according to United Nations data	2015 target	Status (based on UN projected values)
Population with sustainable access to improved water sources	Total: 86 per cent, Urban: 95 per cent, Rural: 83 per cent (2004)	Urban: 94 per cent, Rural: 80.5 per cent	On track
Population with access to sanitation	Total: 33 per cent, Urban: 59 per cent, Rural: 22 per cent (2004)	Urban: 72 per cent, Rural: 72 per cent	Off track

At their current rate, CO2 emissions are projected to treble by 2050. According to recent statistics, India is the fourth largest greenhouse gas emitter in the world.

And this is despite the fact that India is particularly vulnerable to the effects of climate change and exceptionally **prone to natural disasters such as floods, cyclones, droughts, earthquakes and landslides**. 'Surface temperatures in most parts of India have increased by half a degree centigrade during the second half of century;' says Professor Srinivasan of the Centre for Atmospheric and Oceanic Sciences in Bangalore, adding that 'the surface air temperature in the Himalayas has increased by one degree during the same period" (Oxfam, 2006). This is leading to the rapid melting of the glaciers in the Himalayas, which is contributing to changes in the monsoon season. Periods of heavy rainfall over a very short space of time have been increasing over the last ten years; in 2007 nearly a third of India's meteorological districts received higher-than-average rainfall, according to government figures. Nearly 8,000 square miles of agricultural land were inundated since the start of last year's monsoon, more than 130,000 houses destroyed, 1,428 people killed and 20 million affected.

According to Jacques Diouf, Director-General Food and Agriculture Organisation of the United Nations, "India **could lose 125 million tons of its rain-fed cereal production,** equivalent to 18 per cent of its total production."

The Intergovernmental Panel on Climate Change (IPCC) has predicted in a 2008 report that wheat yields could decrease by 5-10 per cent for every degree increase in temperature. The United Nations has highlighted the vulnerability of Indian agriculture in the light of climate change, as 60 per cent of the agriculture is rainfed. "Rain-fed agriculture in marginal areas in semi-arid and sub-humid regions is mostly at risk."

If greenhouse gas emissions continue to increase at their current rate, leading to a global temperature rise of 4-5° C, scientists have predicted that the South Asia region will be faced with **12.5 crore climate migrants.**

Dr. Sudhir Chella Rajan, Professor of Humanities & Social Sciences at IIT Madras, has predicted mass displacement owing to sea level rise and drought. He adds that if efforts succeed to contain global warming below the 2° tipping point, then the number of displaced people will be reduced by 95

The National Biodiversity Strategy and Action Plan reported **losses of half of India's forests, forty per cent of its mangroves and a great proportion of its wetlands.** Several hundreds of plant and animal species are under threat of extinction.

Loss of biodiversity has been exacerbated by the heavy use of pesticiders and fertilisers, often aggressively marketed to farmers by large corporations and big agribusiness, whilst local and traditional food produce has been neglected for supposedly more profitable crops and monocropping.

India has 16 per cent of the world's population, but only **4 per cent of its fresh water sources**. The UN reports that water coverage has increased from 18 per cent to 95 per cent in the last 30 years, but adds that government data shows a subsequent decline to 85 per cent. **By 2025, the per capita availability of water is likely to slip below the critical mark of 1,000 cubic metres.**

The UN also points out that actual access to safe drinking water is significantly less due to seasonal water scarcity and other factors. And, with 82 per cent of villages overdrawing groundwater and cities ferrying water from peri-urban areas, India is close to exhausting its groundwater reserves. Rates of household tap water vary among social groups, and the disparity is significant between urban and rural areas. Among social groups, Muslims have the lowest access to tap water in rural areas (18 per cent) and SC/ST groups have the least access to tap water in urban areas (about 62 per cent). Water tariffs have remained lowest in the country's urban centres. In Delhi, Mumbai and Chennai, water is supplied at Rs 0.5, 1.6 and 2.7 per cubic metre respectively. This means that the rich often pay a fraction (less than 10 per cent) of the actual cost of producing potable water, which encourages wastage. However, an estimated 170 million people in urban areas have no access to safe water, and the total subsidy on water is accumulating at $1.1 billion a year. The poor, on the other hand, pay 8-20 times what the rich pay for water from unreliable sources.

About 4 in 5 households in India and over half of schools do not have toilet facilities. Access to toilets is even worse among Scheduled Caste/Scheduled Tribe households.

Access to sanitation facilities is a particular problem for women and girls, given the social emphasis on privacy and seclusion. Having to go out exposes them to harassment, with women and girls living in

urban slums most vulnerable. The relationship between water, sanitation and health is correlative. The Ministry of Rural Development has stated that the "consumption of unsafe drinking water, open disposal of human excreta, lack of personal and food hygiene have a direct bearing on the high infant mortality rate, are the causes of a host of medical problems…and result in the indirect loss of working days." There is wide variation amongst states: in Haryana nearly all schools have toilets, compared with just 13 per cent in Bihar and 18 per cent in Gujarat.

Under a third of villages in India have access to drainage systems. 85 per cent of villages in Haryana and Punjab have drainage systems, with less than 10 per cent in Chhattisgarh and Orissa.

India is facing a huge problem with **waste generation and disposal.** According to GOI statistics, 86 per cent of the population have access to safe water. However, this still leaves **2 million communities with chemically or bacteriologically contaminated drinking water**.

The Planning Commission's latest assessment report on water supply and sanitation (2002) states that "morbidity and mortality due to waterborne diseases have not declined commensurate with increases in availability of potable water supply, largely owing to the fact that quality of water is not maintained at consumer point and that safe water may become contaminated during storage due to poor handling practices and poor personal hygiene." Incidence of water-borne disease remains grossly underreported, with community studies revealing that children under 5 years of age have 2-3 episodes of diarrhoea every year. Therefore, hundred millions of cases occur annually, with only a marginal proportion detected and reported through routine surveillance.

Case Study: Coca-Cola in Kerala

The Hindustan Coca-Cola Beverages Pvt. Ltd moved into a 40-acre plot (previously multi-cropped paddy lands) in the Palakkad District, Kerala, about 5 kms west of the Tamil Nadu border. More than 65 bore-wells were sunk to extract 15 million litres of free groundwater each day for production of Coca-Cola soft drinks. Chemical bottle washing released effluents into the ground water, contaminating sources of fresh water and creating a water crisis for Tribals, Dalits and farmers. Meanwhile, slurry waste was "sold" as fertiliser to unsuspecting farmers and then distributed "free" of cost, until, after a series of objections, the foul smelling waste was surreptitiously dumped on lands at night or distributed to adjoining villages in Tamil Nadu. Livelihood resources have also been affected due to the abandonment of the paddy fields. Although glossing over many case-studies, a recent Energy and Resources Institute report (2008) records how water scarcity and pollution are serious problems in every place where the company is operating its bottling plants.

With increases in use of private transport, **Delhi has already countered the environmental benefits of CNG technology.**

The Economic Survey of Delhi reported that the city had 1.60 million cars and 3.34 million two-wheelers in 2006-07, with 1000 new cars added to the city's roads every day. Air pollution levels have increased by 55 microgrammes per cubic metre since the introduction of CNG, after an initially impressive 40 microgramme drop.

Background

"It took Britain half the resources of the planet to achieve this prosperity. How many planets will a country like India require?"

Mahatma Gandhi

The **Tenth Plan** promised to provide every village with sustained access to potable drinking water. The **Eleventh Plan** looks to establish sanitation facilities for all communities by the end of the plan period, and to provide all schools in rural areas with a water supply and toilet facilities. Targets are placed for 33 per cent forest and tree cover by 2012 and the cleaning of all major rivers by 2007/other notified stretches by 2012. The need to check the heightened problem of urban solid waste management is also discussed.

The **National Common Minimum Programme (NCMP)** formalises the government's promise to provide drinking water to all urban and rural areas, to protect forests and the rights of forest dwellers, to safeguard the rights of tribes over their own resources and to pay special attention to the needs of slum dwellers. The strategy concerns rain water harvesting and the potential for river linkages, and it promotes encouraging women to manage drinking water/sanitation facilities and thereby access control over local resources.

Key achievements include the **Total Sanitation Campaign,** which improved access to drinking water at elementary level schools from 44 per cent in 1993 to 70 per cent in 2003 and access to sanitation from 8 per cent to 51 per cent. However, there remain concerns about the quality and usage of these facilities: the Planning Commission has reported that rural families are often reluctant to regularly use toilets and other critical hygiene practices when they are in place. There is therefore a continued need for community driven education programmes, as well as an increased focus on sustainability and maintenance. There are also no sanitary landfills or regulated infrastructure for waste disposal at a household level. Meanwhile, according to the Department of Drinking Water Supply under the Ministry of Rural Development, 55,067 previously uncovered habitations of the Comprehensive Action Plan 1999 (CAP99) have been reached under the **Accelerated Rural Water Supply Programme** over the last 3 years. The Programme has enabled the installation of more than 37 lakh hand pumps and 1.73 lakh piped water schemes. However, effective coverage has slipped from 95 per cent to 85 per cent because of declining water tables and ageing hand pumps (UNICEF), signalling an immediate need for reconsideration of water management strategy.

Government policy is also beginning to reposition its approach in line with more **community-driven, participatory responses** for rural water supply, sanitation and environmental management. Decentralisation to local government bodies (Panchayati Raj Institutions) will enable demand-responsive strategies. The GoI has recently announced that it will train and appoint two community leaders in each gram sabha, male and female, on climate change. These "climate managers" will raise awareness and initiate changes for sustainable development at the local level, and will also be trained to handle natural disasters. The course modules were due to be finalised in April, 2008.

Current Policy

73rd and 74th Amendment and The Panchayat Extension of Scheduled Areas (PESA) Act, 1996

PESA's purview is to vest legislative powers in the Gram Sabha in:

- development planning;
- management of natural resources;
- dispute resolution.

The Gram Sabha is responsible for **preserving and safeguarding the traditions, identity and resources of the indigenous people,** and hence under the terms of the Act is empowered to approve development projects, plans and programmes and identify beneficiaries for poverty alleviation and other programmes. Either the Panchayat at appropriate level (PAL) or Gram Sabha will be involved in consultations before land acquisition takes place for development and/or resettlement projects, and the respective local authority must also make recommendations before granting licenses or mining leases. Both Gram Sabha and PAL prevent alienation of land in Scheduled areas and take measures to restore such land where necessary, and manage local plans and resources.

Under PESA, it is essential that the Gram Sabha approves all plans and projects. However, as the PAL may be the body who has previously taken responsibility for consultations and planning, it is **not clear what happens should the Gram Sabha not approve the plans.** There are also no guidelines for identification of beneficiaries or awarding certification for utilisation of funds and it is unclear whether the Gram Sabha is expected to be involved in budget making processes, which should be a necessary outlay for the realisation of participatory and transparent governance. The Gram Sabha is also typically denied the right to take decisions related to stewardship, management or sustainable harvesting of minor forest produce, the responsibility for which implicitly remains with the State. This transfers only a very limited sort of "ownership" to the village representative body.

In several states (Himachal Pradesh, for instance), the Gram Sabha is consulted before acquisition of land in Scheduled Areas or resettlement takes place, but is not involved in the actual planning and implementation of the projects in the scheduled areas. These responsibilities are centred at state level. One detailed report of several Panchayats in Uttar Pradesh found that the Gram Sabhas were rarely involved in any assigned roles, and meetings were a rare event announced only under external compulsion. The Panchayat was found to be primarily identified with the office of the Pradhan and the Pradhan was itself subsidiary to the bureaucratic functionaries, whose motivations were frequently reported to be

questionable. In many cases, the process of gaining consent from the village Gram Sabha simply does not take place with notable and well publicised instances of this neglect occurring during the construction of the highly controversial Narmada Dam (see the Indian People's Tribunal on Environment and Human Rights [IPT] report, 2006). The PESA Act was designed to protect the interests of vulnerable Adivasi communities and to give them a voice in the wake of attempts at forced displacement. **When this is not implemented, the state is tragically abdicating its responsibilities to protect the rights of India's most vulnerable citizens.**

On their side, Gram Sabhas must also perform as **well-functioning representatives** of the people: this means **ensuring transparency in all decision making and fiscal processes**. The people must therefore be **informed of their entitlements under the Right to Information Act, 2005** and have sustained access to Panchayati Raj institutions (PRIs). The GoI issued a circular in 1997 which suggested all states pass orders to enhance transparency and accountability in local bodies. The recommendations were to:

- display all vital information related to development projects for the benefit of the public, especially receipt of funds and disaggregated expenditure;

- make all relevant records open for inspection;

- permit members of the public to obtain photocopies of documents pertaining to matters of general public interest at a nominal charge.

Most importantly, all bills, muster rolls, vouchers, estimates, measurement books, criterion and procedure for selection of beneficiaries and lists of current/past beneficiaries should be openly available in an accessible public location. This will target allegations of corruption by those who feel money allocated to local bodies tends to disappear into the coiffeurs of local officials and bureaucrats. There is also a question of what to do with "parallel bodies" and committees, many of which are perceived to overlap with and sometimes contradict the PRIs. One strategy implemented in Uttaranchal was to merge these Committees with the PRIs, so that they in effect become Standing Committees with powers of fund management. Of course it is equally important to ensure that these Committees are representative, i.e. with women's reservation and appropriate reservation for SC/ST/OBC.

Whilst the **73rd and 74th Constitutional Amendments** have secured political decentralisation - albeit of somewhat inconsistent effectiveness - fiscal and functional decentralisation has of yet varied immensely across states. Kerala, Madhya Pradesh and Uttar Pradesh have made the greatest head roads in operationalising devolution, but many states have demonstrated minimal commitment to empowerment of the local people. PRIs are also suffering from lack of resources: very few states have followed the recommendations of State Finance Commissions and ensured fiscal viability of the PRIs. Rather, limited communication routes are being established with highly **minimalistic interpretations of the law**, thereby circumventing the representative bodies and centralising power in the fingertips of bureaucrats and a handful of non-elected officials. Overseeing this process and ensuring empowerment and informed involvement of the local people will be essential for just and sustainable management of local resources and conservation efforts, as well as all other development activities – particularly in those poor performing states where accountability appears to be low on the agenda.

The Scheduled Tribes and Other Forest Dwellers (Recognition of Forest Rights) Act 2006

The Scheduled Tribes (Recognition of Forest Rights) Bill, 2005, seeks to recognise the rights of forest dwelling Scheduled Tribes (FDSTs) who have occupied forest land on a long-term basis (specified as October 25, 1980.)

Pre and post independence, marginalised forest dwelling communities (and particularly tribals) have been denied their rights to forest land, use of resources and traditional activities. As their rights have never been formally transcribed, they have been treated as "illegal encroachers" on "Government Forest" which has resulted in brutal displacements and forced evictions, as well as significant destruction of livelihoods without compensation. Granting absolute power to the forest authorities has also prevented regulation and conservation exercises.

The Forest Rights Act attempts to remedy this situation by entitling eligible families to a maximum **of 2.5 hectares of the land.** An FDST nuclear family would be provisionally granted rights to the land currently occupied over a period of five years, until which time they are entitled to relocation and compensation in the case of removal. Permanent rights are granted after the five year period. Responsibility for deciding eligibility remains with the village Gram Sabha, as well as the management of forests, monitoring of processes that could threaten forest-dwellers' habitats and protection of indigenous knowledge. The Act should provide **heightened livelihood security for forest-dwellers and prohibit forced displacement without compensation**.

Whilst these are all positive measures that protect the rights of local people to cultivate their immediate environment, critics have expressed concerns that **certain development projects are excluded from the purview of the Act** (for example, road construction). The Bill also grants rights to Scheduled Tribes only in areas where they are officially scheduled, and e**xcludes communities who are not Scheduled Tribe or forest-dwellers** but who may be similarly dependent on forest land for survival and livelihood purposes. This is the case in areas of Chattisgarh and Uttaranchal.

At the beginning of this year, the situation was further complicated when the Union government demarcated the twenty-eight existing tiger reserves and eight new proposed tiger reserves as critical tiger habitats under the amended Wildlife Protection Act, 1972. The tiger lobby had argued that it would be difficult to remove people from parks and sanctuaries once the Forest Rights Act was operationalised. There is justification for concern: the Forest Rights Bill states that responsibilities and duties regarding conservation are applicable to all activities except those that are permitted as rights, but does not clarify what would take priority if these same perceived rights were ecologically destructive. Clear provisions would need to be made for Gram Sabhas to deal with such conflicts of interest, with input from NGOs and environmental/wildlife experts, as even non-commercial activities could potentially be unsustainable when a given species is threatened with extinction. However, this does not necessarily infer that the Forest Rights Bill should be overwritten in order to co-exist with conservation efforts. A **united front which sees a clearly defined and mutually accountable role for local bodies, wildlife conservationists, communities and wildlife officers** could secure tribal rights and conservation.

One final problem concerns **vagaries regarding implementation** of the Act. Institutional arrangements for enforcement are not covered, whilst existing laws to protect forests, wildlife etc are not currently converged. There is no exposition of restrictions on permitted methods of removal of non-eligible forest-dwellers, the exact nature of the compensation for FDSTs removed from National Parks and Sanctuaries is not specified and redressal mechanisms are not referred to. Given previous fiascos like the mass displacements caused by the construction of the Narmada Dam concerns have rightly been raised about the probability of legal and effective large-scale relocations. There are also **no monitoring authorities** to ensure that forests are being adequately protected. Whilst the Bill was drawn up to supposedly protect the rights local people over traditional knowledge and the land which they have worked for generations, **conservation is not explicitly placed within the scope of the Gram Sabha or the local people** who have historically faced interference and exploitation by external agents. This would be feasible if the Gram Sabha was delegated sufficient responsibility, whilst also being accountable to local wildlife officers.

The Biological Diversity Act, 2002

The Biological Diversity Act evolved in response to unsustainable use of natural resources, specifically the growing issues of **biopiracy and bio-trade** - as well as the dramatic damage being wrought on ecosystems and wildlife habitats. It followed the National Biodiversity Strategy and Action plan (NBSAP), 2000, which also promoted ecological security, i.e. climate stabilisation, improved rainfall patterns and soil quality, and developed strategies for the protection of the enormous biodiversity in India on which millions depend for livelihoods. Together these represent a shift in policy direction towards **mainstreaming environmental concerns and the rights of indigenous people over their own land**, and to make these central to all planning processes.

Products that hinder biodiversity are regulated under the Act, a National Biodiversity Authority (NBA) was established in Chennai, and State Biodiversity Boards are being set up across the country and filter into Biodiversity Management Committees (BMCs) at panchayat, district council or municipality levels. However, the role of communities is not necessarily fully developed and **the law merely regulates rather than conserves biodiversity**, with agriculture and the indigenous knowledge which this may encompass not covered and the **thorny issue of patents on lifeforms implicitly permitted**. Once again, the emphasis is on industry rather than community based protection mechanisms. Indian companies are entitled to certain privileges under the terms of the Act, and the exact process for making and monitoring patent applications is overtly outlined.

The Act provides a framework, but sufficient ambiguities about implementation strongly favour agribusiness and corporations over indigenous people and their right to protect local knowledge and bioculture.

National Biofuel Policy

A draft National Biofuel Policy is currently sat with a Group of Ministers (GoM) headed by the agriculture minister, Sharad Pawar. This policy announces rapid development of the renewable energy sector and develops plans for capacity building and research and development.

Proponents of biofuels claim that "clean" energies can help feed the world's growing demand for energy supply and security with minimal risks to the environment, whilst in the Indian context these techniques could provide a self-sufficiency that would alleviate India's dependence on the external markets for fossil fuel. In India the demand for energy is only mounting with rapid economic growth, and domestic **crude oil supplies are meeting just one fifth of the country's needs.**

The government's plans for cultivating Jatropha over 11 million hectares are critical to all goals of energy independence, hoped to be achieved by 2012, and state governments have already been formulating and implementing plans for Jatropha cultivation. However, critics suggest that most of the **converted "waste lands" are actually grazing lands, common pastures, degraded forests and lands of small and marginal communities** on which significant numbers of people may depend for their livelihoods. One further problem is that it is being planted in areas where it is not suited, i.e. because the environment cannot provide the high levels of water it requires, and yet farmers are not receiving adequate advice in relation to the suitability of the climate/conditions etc.

One study has shown that the indigenous plants and livelihoods of indigenous tribals in Chattisgarh were stripped to make room for Jatropha **without consultation with the Gram Sabha** or local people (Navdanya, 2007). The government has also not been clear on intentions towards the possibility of corporate patents on biofels grown on these lands, which would further exacerbate the problem of ownership and distance natural resources from the local people.

The issue of biofuel technology has been internationally contentious in recent months. An OECD report (2007) has indicated that increased biofuels production could actually be **energy inefficient**, causing water shortages and undermining food output. Nobel Peace Prize winner and climate change scientist Rajendra Pachauri has warned of the potential **links between biofuels and rising food prices** (April 2008) – of particular concern for a country like India that is still struggling to feed its own people.

National Climate Action Plan, 2008

This year the Prime Minister's Council on Climate Change announced the establishment of **a separate division to act on climate change,** along with the arrival of a climate action plan. The plan has revealed that activities will include:

Creating eight missions for "multi-pronged, long-term and integrated strategies" for tackling climate change. These include energy conservation, agriculture, water management, solar energy, protecting Himalayan ecosystems and the "Green India" project, which aims at restoring forestry to six million hectares of degraded forest land: one of the world's most extensive afforestation efforts.

Collaborating with the private sector for R&D in terms of providing carbon efficient power.

Making water use more efficient through pricing and regulations.

Initiating research and development into crops and agricultural methods capable of withstanding extreme weather conditions and volatile monsoons.

The Plan demonstrates a **very positive commitment by the UPA government** that recognises the strategic importance of acting on climate change before it is too late. However, it focuses on adaptation and mitigation **without giving concrete targets for emissions reductions**. The government's stance remains in line with the view that developed countries need to first of all set and abide by more ambitious targets, given that their carbon contribution has been (and is) so much more immense. The document therefore emphasises that 8 per cent growth is essential if India is going to be able to work towards poverty reduction and environmental sustainability, and **refuses to commit to endeavours that avoid tying development into the use of carbon-intensive technologies and patterns**. The danger is that industry will remain largely uncapped and unregulated. Whilst there is truth in India's international justification for limited action, it is still necessary to set targets and place an onus on industry to work towards mitigation rather than playing the "blame game" - particularly given the scope of India's population growth and the vast expansion of its metros.

Policy Recommendations

Best practice: *Since 1992 a number of Brazilian states have been applying an ecological value added tax (Imposto sobre Circulação de Mercadorias e Servicos, ICMS-E), which compensates for additional expenditure incurred because of preservation of large conservation areas. 25 per cent of the revenues from the ICMS-E is allocated to municipalities based on how well they perform against a set of environmental criteria. Increased revenue generation has provided both incentives for protection of biological resources (rather than additional expenditure) and enhanced the potential for development of ecotourism activity. Such a prospect encourages increased participation of both community and private partners.*

Source: United Nations Task Force on Environmental Sustainability

Mitigation

For low to medium stabilisation targets to be achieved, developed countries should be aiming to reduce their emissions below 1990 levels: 10-40 per cent by 2020, 40-95 per cent by 2050. For developing countries such as India, emissions need to deviate below their projected baseline within the next few decades. This requires significant effort to avoid tying development into the use of carbon-intensive technologies and patterns. The government must include these targets in a revised **National Climate Action Plan (NCAP),** and there needs to be a strong focus on immediate action to prevent climate change. It is only by prescribing and sticking to a rigorous timeline that temperature rises may be minimised to the 2°C limit prescribed by United Nations scientists. This must be drawn up after public debate and consultation with stakeholders, and include **quantified and time-bound objectives** plus indicators for monitoring. It must also identify policy and investment needs to improve environmental management and sustenance of environmental resources, as well as evaluating impacts of proposed strategies related to other working groups. A **working group on environmental sustainability** should be established to assist in furthering this process: they will be responsible for drawing up full and detailed needs assessment documents which consider mid and long-term objectives.

Industry should be encouraged to document existing practices, offer staff training and reward staff for good practices (e.g. climate friendly transportation) and reduce energy use**. Incentives and voluntary agreements** are both means of achieving this, raising awareness and potentially facilitating development and application of the best available technology with subsequent reductions in emissions.

Policies that incorporate the real or implicit cost of carbon can encourage producers and consumers to factor environmental concerns into their decisions. For example, the City of London introduced a congestion charge to reduce the amount of traffic within Central London and promote the use of public transport. In 2008 it was announced that vehicles with the lowest CO_2 emission rates will be exempted, whilst those with higher rates will pay a higher charge. This can also be applied to taxes on vehicles, and would be particularly valuable in very heavily congested cities such as Mumbai.

More needs to be invested in public transport infrastructure, and road planning needs to move away from catering to the needs of private vehicles. Delhi has rightly allocated dedicated bus lanes to ensure safety and efficiency for its buses and other cities need to follow suit, with plans for bus lanes, metro and/or monorail. It is also necessary to build dedicated cycle lanes within the cities and ensure that low pavements are maintained for pedestrians and people boarding buses.

The IPCC recommends financial incentives for improved land management, i.e. maintaining the carbon content of soil and efficient use of fertilisers and irrigation.

Energy:

The government needs to invest in research to evaluate the potential **for sustainable and renewable energy.** Globally, government funding for most energy research programmes has been in decline (even after the formation of the UNFCC), and, according to the IPCC, is now half of the 1980 level. People are currently massively affected by lack of adequate power supplies, and reports have indicated that up to **60 per cent of India's energy could be provided by renewable sources by 2050** (Oxfam, 2006). Successful programmes have included the use of energy efficient lighting in Binoa in the Gurgaon district of Haryana, the Tata Energy and Resources Institute's (TERI) campaign to "light a million lives" through solar technologies in selected villages, and subsidies in Rajasthan to solar power technology in areas where power was deficient. Germany has already incentivised renewable energy. Feed-in tariffs will promote renewable energy technologies, along with subsidies to producers.

The Bureau of Energy Efficiency's suggestion of the Bachat Lamp Yojana should be implemented, which would provide Compact Fluorescent Lamps at the price of normal bulbs to domestic households. The price difference can be recovered owing to lower energy consumption of CFLs.

Adaptation:

Adaptation means making adjustments to reduce vulnerability and potential damages experienced or predicted as a consequence of climate change and associated events. Adaptive measures would include public and private initiatives and anticipatory and reactive actions, relate to management, infrastructure and policy, and tend to be ongoing processes measurable in terms of short/mid/long term timeframes. France, Finland and the UK have already developed national strategies to develop adaptive frameworks, whilst the state of New York has developed a nine-step assessment procedure to tackle complications with water supply within changing climate conditions (IPCC).

Districts need to be identified which are most and least able to adapt to regional climate change, whether this be droughts or monsoon variability. Vulnerability mapping will allow effective targeting at a state level. Public **investment in strengthening agricultural research and extension services** must be increased, particularly in lieu of the risks to national food security and dry land agriculture**. Farmers need to receive guidance and advice**, in the wake of changing climate conditions.

Decentralised food and energy systems will enable communities to more directly tackle the impact of climate change, enhance their environment and minimise impact to supply and distribution. Local people and committees must also be trained in **natural resource management**, which relates also to the protection of biodiversity.

Emergency preparedness and response is critical. The introduction of district "climate managers" is a welcome step. However, there also needs to be a **national adaptation strategy and guidelines for the case of disaster, outlining India's strategies for dealing with the effects of climate change**. The increased risk of outbreaks of diarrhoeal diseases alone requires intensive interventions to ensure access to safe drinking water, improved environmental sanitation and diarrhoea management.

Sanitation and Access to Water

The government must provide ***sustained*** **information and education about sanitation**. Research has shown that without these measures, there will be little change in attitudes or behaviour towards rural sanitation.

Plans must be developed for **effective solid and electrical waste management.**

Pollution control norms need strict enforcement in industries to ensure that effluents are appropriately treated before being released into water. There is currently a lack of regulation of the activities of industries in this regard, and reports suggest that state authorities are often unwilling to take action against larger companies/projects. There also needs to be **proper regulation of the use of fertilisers, pesticides, weedicides and insecticides,** which infect surface and groundwater bodies. **Water pollution charges** are one method of both raising awareness and containing pollution.

The **process of water distribution** needs to be reviewed to create greater equitability. There needs to be an integrated water management approach, outlining regulatory frameworks and entitlements.

There is enormous potential in India for **rainwater conservation**. This is something that needs to be encouraged at both national and community levels, and co-operation with neighbouring countries on issues of water management should be a focus.

Tank revival can be a focus of the NREGA programmes. In certain areas, Maharastra in particular, many dams have fallen into disrepair and disuse, and this is in some of the most drought-prone parts of the country.

Displacement:

The Forest Rights Act needs to clarify that "livelihood needs" refers to **sustainable use of resources for survival and basic livelihoods**, rather that potentially unsustainable commercial enterprise and large-scale business. "Irreversible damage" should be broken down and "potential damage" to the environment explicitly legislated against, i.e. when scientific trends or historical evidence suggests that an activity will cause **permanent damage** to an environment.

Committees made up of local and scientific experts need to be able to make the decision as to whether such destruction is taking place. The **Gram Sabha**

should be explicitly granted responsibility for such decisions about conservation and community welfare in forest areas, which will require representation from ecological experts as well as those with knowledge of local traditions and practices.

The Act must be **correlated with other laws**, including the Biodiversity Act.

Gram Sabhas need to be empowered to extend eligibility to certain groups, e.g. those ST who may not be scheduled in the specific area to which they are resident or certain excluded groups who are dependent on the forest but not officially ST/forest dwellers.

There needs to be explicit guidelines for the removal of non-eligible forest dwellers

Guidelines should be drawn up in regard to the processes for non-approval of development projects under PESA. The Gram Sabha of an affected area should be involved in the planning stages as a matter of course.

Biodiversity:

Localised research should be performed to assess suitability, risks and effect of monocropping for all stakeholders. The government should also be cautious about the introduction of genetically modified organisms (GMOs) into the environment, and more proof is required to ensure that GMOs are environmentally safe and fit for human consumption. Commercial farming of genetically modified cotton has been discovered in states without governmental approval; increased regulation is essential to ensure longer term sustainability before the risks have been fully assessed.

Budgets must prioritise biodiversity and make substantial allocations to conservation efforts/research and development.

Commercial development must be explicitly prohibited wherever there is a need for ecological security.

Wildlife protected areas must be accompanied by **strict penalties for appropriation of resources/unsustainable activity.**

Unsustainable farming methods should be discouraged in favour of **diverse crop cycles**, where unsustainable methods include those that demand extremely high volumes of water and excessive use of pesticides.

Bioenergy plantations can restore degraded land and retain soil carbon. However, there needs to be extensive research on the full impact of biofuels before plans for subsidies are implemented and planning needs to be extensive before any national initiatives are introduced, which must also be localised to the area in which it is being planted. The **net energy service** of the biofuel should be calculated to weigh its efficiency in comparison with other fuels. Any Biofuel Policy must prioritise food security and make this the focus of research and planning, and this must also feed down to a local level. **Areas critical to food security must be identified** and preserved for this purpose, with all biomass activity prohibited in these areas. "Wasteland" should be clearly defined to prevent conversion of agricultural land, forest land and land essential for livelihoods.

Governance

Local people must be **informed of their entitlements under the Right to Information Act, 2005** and have sustained access to Panchayati Raj institutions (PRIs). In concordance with GoI recommendations dating back to 1997, **all states must pass orders to enhance transparency and accountability in local bodies.**

Display all vital information related to development projects for the benefit of the public on a board that is communally accessible, such as the local school. This should detail receipt of funds and disaggregated expenditure

Make all relevant records open for inspection, including accounts, criteria for eligibility of beneficiaries, past and present beneficiaries etc.

Permit members of the public to obtain photocopies of documents pertaining to matters of general public interest at a nominal charge.

Train civil servants and all those involved in decision-making processes, policy makers included, in environmental management.

All project proposals and strategy papers must include an assessment of their **environmental impact.**

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Goal 8: Develop a Global Partnership for Development

Overview

Developing countries are running a race that has already been fixed: they face highly subsidised competition from some of the world's biggest agribusinesses and corporations as well as high tariffs on their exports. Meanwhile aid is generally targeted towards countries which best match the strategic interests of "donor" countries - which is why Israel receives more in "Official Development Assistance" from the US than the entire continent of Africa. Internationally, India has a sufficient range of products and adequate safeguard mechanisms to protect the interests of its farmers, assuming appropriate and effective domestic policy. However, the government must represent the position of the poorest countries, including its less privileged neighbours, in international negotiations. In coming years, trade within the South Asian block must be a key priority for India. Intraregional trade makes up less than 2 per cent of GDP, compared to more than 20 per cent for East Asia, whilst the cost of trading across borders is amongst the highest in the world. India – with 80 per cent of the total GDP in South Asia - must play a critical role in instigating and sustaining reform across the region and rendering movement more efficient. Globalisation renders further challenges to India, particularly in terms of migration of skilled labour to the North (doctors, health workers etc) and ensuring employability for what is at present a predominantly unskilled labour force. On a national level, the government must ensure that adequate incentives and safeguards are in place to retain its professionals and also develop innovative strategies and concrete plans to generate purposeful work to furnish a healthy economy: one of the biggest obstacles to India's "inclusive growth" will be ensuring that its youth is employable in a market that is increasingly demanding skilled labour.

UN Targets and Indicators

Target 1: Develop further an open trading and financial system that is rule-based, predictable and non-discriminatory, includes a commitment to good governance, development and poverty reduction nationally and internationally

Target 2: Address the least developed countries' special needs. This includes tariff- and quota-free access for their exports; enhanced debt relief for heavily indebted poor countries; cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction

Target 3: Address the special needs of landlocked and small island developing States

Target 4: Deal comprehensively with developing countries' debt problems through national and international measures to make debt sustainable in the long term

Target 5: In cooperation with the developing countries, develop decent and productive work for youth

Target 6: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Target 7: In cooperation with the private sector, make available the benefits of new technologies especially information and communications technologies

Target 1: Open a trading and financial system that is rule-based, predictable and non-discriminatory…

Developing countries are in an uncomfortable position when it comes to international trade negotiations; still they face unfair and heavily subsidised competition along with high tariffs on their exports, which currently raise more money for "donor" countries than is granted in aid. In 2006, the USA imported goods to the value of US $37 billion from France and collected $367 million in tariff revenues; it collected exactly the same amount of tariff revenues from Cambodia from $2 billion of imports. The USA collected similar tariff amounts from the UK and from Bangladesh, although the former's imports were worth seventeen times as much (International Poverty Centre). Charging high taxes on imported goods means that poor countries are restricted to exporting raw materials, which have lower returns than finished and manufactured products. At the moment, poor countries export the ingredients to the developed countries, who then convert these to valuable consumable items (e.g. chocolate from cocoa, clothes from cotton). And bilateral trade deals and conditionalities on loan/aid ensure that developing countries keep their markets open to exports of these finished goods from developed countries.

Global trade conferences repeatedly discuss iniquities arising from high levels of protectionism on agriculture in developed countries, and yet levels of protection (to the value of US $300 billion) are still approximately three times higher than what is given in Official Development Assistance (ODA). Subsidies encourage over-production, which has led to "dumping" of surplus highly subsidised agricultural produce in developing countries; local farmers cannot compete with artificially cheap imports and subsequently go out of business. For example, each cow in the EU receives US $2 a day in subsidies; over-production of milk has led to mass dumping of EU powdered milk products in developing countries. One proposed Free Trade Agreement between Peru and the US would lift taxes on American imports into the US, which would allow massively subsidised American cotton to flood the market and ruin 28,000 Peruvian cotton farmers.

The international development organisation, Oxfam, estimates that in 2001 US subsidies cost sub-Saharan Africa US $301m in lost revenue, equivalent to almost one quarter of what it receives in American aid. American farmers earning under US $2.6 million a year could until recently receive subsidies; it is now $1.5 million and equates to more than $50,000 per farmer, with almost three quarters of the money received by the top ten agribusinesses (Saubhik Chakrabarti, The Express, 22/05/08). Subsidies are now being defended by some developed countries on the back of the food crisis and soaring food prices, the argument being that subsidies depress the cost of agricultural produce and help alleviate the effects of the market crisis. This, however, is a sophistic argument, presenting an artificial solution that can only have short-term benefits, with the real causes of the food crisis still unaddressed. Perpetuating iniquities and protecting rich farmers and agribusiness will only exacerbate poverty in the long term.

Internationally, India has a sufficient range of products and adequate safeguard mechanisms to protect the interests of its farmers. Moreover, unlike some of her neighbours (Sri Lanka, Bangladesh, Asean countries), the government has the flexibility to impose addition duties over bound duties, although any such activities must consider the impact of additional tariffs on India's poorer neighbours. On a local level, improving trade and the infrastructure to facilitate trading with the South Asian block must be a priority for India over the coming years. SAARC (South Asian Association for Regional Cooperation) was established in 1985 for precisely this purpose, with India, Pakistan, Bangladesh, Sri Lanka, Nepal, the Maldives and Bhutan as its original members and Afghanistan joining in 2007. Progress has been somewhat slow. The South Asia Free Trade Agreement came into effect on January 1st 2006, which reduced duties imposed by member countries to 20 per cent in 2007. The final phase will eliminate all duties by 2012 in a series of annual cuts, with three years leeway for the least developed countries in the region (Nepal, Bhutan, Bangladesh and the Maldives).

India has also proceeded to lower tariffs bilaterally with SAARC members. The Government of India already provides market access free of customs duties for all articles manufactured in Nepal, whilst Nepal provides a flat-rate concession of 20 per cent on all imports from India.

However, despite such gestures, intraregional trade makes up less than 2 per cent of GDP, compared to more than 20 per cent for East Asia. The cost of trading across borders in South Asia is amongst the highest in the world, and energy trade in the region is virtually non-existent with only India, Bhutan and Nepal currently trading electricity. 71 per cent of international telephone conversations are regional in East Asia; in the South Asian block, this diminishes to 7 per cent (World Bank). The lack of integration amongst SAARC countries is often attributed to political and military tensions between India and Pakistan. However, there are a number of infrastructural failings that will need to be

addressed to foster regional cooperation, and India – with 80 per cent of total GDP in South Asia - must play a critical role in instigating and sustaining reform across the region.

Standards must be harmonised, transaction costs lowered, more effective management of cross-border resources instigated, transport improved and efficiency in customs' procedures heightened. Currently only about 63 per cent of roads in India are paved (World Bank, 2005), and, even before taking into account the rise in global oil prices, the costs of road transportation in the region are already remarkably high, in part because of the added expenditure on vehicle maintenance. Average costs between Kolkata and Petrapole amount to Rs 2543, almost twice as much as on other highways (Das and Pohit, 2004). A recent inquiry study report (filed in April 2007) has suggested that crossing the Assam-West Bengal border will cost a truck driver around Rs 3000 by the time he has paid all government and non-government agents along the way. Cross-border crossings are also remarkably slow: queues on the Indian side of the border with Bangladesh often exceed 100 trucks and it can take around 100 hours to make the crossing. Different classification systems are used by different countries which hinders transparency efforts, and each country also demands separate documents at both sides of the border: between India and Bangladesh, 22 documentations are required, over 55 signatures and a minimum of 116 copies (RIS, 2004). This has obvious implications, not only financially but also in terms of the quality of the transported produce. The lack of integrated transport networks causes immense rises in costs, and goods must frequently be transshipped through a third country. Potentially trade could be doubled if movement could be rendered more efficient. India's Electronic Data Interchange (EDI) technology enables a more streamlined and transparent system and thus a practical solution would be to fully integrate this across the region.

There are other infrastructural issues hampering regional development, however, which will require immense investment to secure sustained investment and long-term economic development. South Asia is the only region in the world where no city can provide 24/7 piped water, and, indeed, water management is becoming a highly critical problem in the bloc. Cross-border management of water resources between India and Nepal, and Afghanistan and Pakistan would create substantial benefits for all countries involved, allowing collaboration on flood control, hydropower and dry season water augmentation.

Landlocked countries and subregions including India's North-Eastern territories stand to benefit most from improving transport links, improving connectivity both within the nation and with neighbouring countries. As oil prices rise close to US $200 a barrel, it may no longer be viable to transport food across India north to south, east to west, and therefore trade routes between neighbouring countries must be secured and improved -- particularly with Nepal and Bangladesh.

On a national level, India must be wary of continued subsidy shifts from the public to the private sector. These are in many ways a continuum of restrictive conditions attached to World Bank Structural Adjustment Programmes (SAP), which imposed cuts in public sector spending. This is a particular problem in healthcare, where the government has granted land subsidies for the construction of private hospitals, cuts in import duties on drugs and equipment, private contracting and outsourcing of services. The GoI has intentions of making its private hospitals a world class destination for medical tourists, but, without equal investment in accessible public healthcare, this could well be at the cost of its own citizens.

Target 2: Address the least developed countries' special needs…

In 2005, the leaders of the G8 countries promised to double aid to Africa whilst the UN World Summit would increase total official development assistance (ODA) by around US $50 billion a year by 2010 - representing at least 0.5 per cent of donor countries' gross national product (GNP). This was the amount deemed to be necessary for the attainment of the Millennium Development Goals.

The prescribed target is 0.7 per cent GDP by 2015 and a number of European Union countries have pledged to reach this target, but current trends would seem to refute any evidence of this. Norway currently gives 0.95per cent, Sweden 0.93 per cent and Luxembourg 0.9 per cent. The UK has reached half-way, with 0.36 per cent of GDP. At the bottom of the table, the US gives only 0.16 per cent of GDP to aid. There are no sanctions for countries who fail to meet these promises.

One problem is that several donor countries continue to bilaterally negotiate aid arrangements with developing countries, often with conditions attached, rather than work through multilateral agencies. Donor self-interests are therefore preserved and recipient countries selected on the basis of who can best serve these motives, which explains why the 63 poorest countries receive less than half of all ODA. The United States currently awards Israel US $5 billion in aid each year, which exceeds US aid granted to the whole continent of Africa. To create a fairer global system, allocations

should have to be made against pre-defined criteria through official channels; resources should also be untied for use alongside national development strategies and human development outcomes on a country-by-country level. Poverty Reduction Strategy Papers (PRSPs) must be drawn up internally to assess needs and targets, and these must represent the citizens of the respective country. For this reason, PRSPs must only be created after substantive consultation with civil society and proposals for reform should also be assessed by independent committees prior to agreement of a PRS -- many of which more often than not represent the views of the IMF, World Bank or other external agencies.

Developing country ownership of development processes is integral for both citizens and governments, with plans more closely correlated with national budgets and strategic objectives. Developing credible and mutually agreed monitoring mechanisms will make it easier to assess performance whilst enhancing national transparency and accountability related to poverty alleviation. In turn, donors must align their programmes with country priorities, increase local harmonisation and alignment action plans, reduce the use of project implementation units and integrate those remaining into the relevant national ministries. Crucially, aid must also be predictable and regular, and donors will have to increase efforts to share information regarding aid flows and timings.

One possible solution would be for rich countries to make compulsory contributions, the amount to be decided on the basis of their relative wealth and pooled into an international aid fund large enough to meet the needs of the least developed countries. Governments of donor and recipient countries would then have to meet to assess the way in which the funds should be spent, with an autonomous Aid Office to oversee this process.

There is also a need to finance global public goods and advancements, such as vaccine development and medical research. The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI) all require more funds. Other issues that could be addressed might include arms control, landmines, environmental management and drugs trafficking, to name just a few.

Target 4: Deal comprehensively with developing countries' debt problems…

India must fully support debt cancellation for the HIPC (Heavily Indebted Poorest Countries) through the Multilateral Debt Relief Initiative, and this should also be accompanied (as it currently is not) by increased Official Development Assistance to repair, sustain and inaugurate infrastructural development. The international community should also be pushing for the extension of debt relief to other Least Developed Countries (LDCs) where debt burdens are seriously hampering efforts to attain the Millennium Development Goals. As an example, Kenya is not eligible for multilateral debt relief but in 2006/7 spent more paying off existing debt than on healthcare. Under insistence from the IMF, public spending in the LDCs has faced enormous cuts as debt burdens have risen in order to make repayments and "balance the books". The poorest countries – Bangladesh included - have been spending over US $100 million every day on debt repayments when 50 million Bangladeshis live below the poverty line and half of all Bangladeshi children are underweight. Where debt has been cancelled, citizens have seen an immense boost to the quality and accessibility of public services. When Zambia's debt was cancelled in 2005, user fees were abolished for all healthcare in the country, enabling access for millions of people in the country, and 4,500 new teachers were trained for Zambian schools.

Illegitimate and unpayable debts must be terminated, but this has to be free of external conditions and must not impact upon aid relief and access to cheaper loans. The Inter-American Development Bank (IADB) finally agreed to cancel debts to five of the poorest countries in 2007 but only at the expense of aid and cheap loans. In effect, this will mean that countries will be up to US $5 million worse off than they were before the debt cancellations.

Conditionalities from creditors along these lines – as well as insisting on privatisation of services – are unacceptable and unsustainable, and at present there is no regulatory framework for ensuring that private monopolies do not become a condition and side effect of debt cancellation. To qualify for debt relief, Nicaragua was forced to privatise its electricity supply and Tanzania had to privatise the water supply in its largest city. Costs skyrocketed and access was denied to thousands of people, whilst in both cases service quality showed a remarkable decline.

When debt is cancelled, the money gained from this process must also be accounted for to ensure that it is being spent on public services, and there must be an international regulatory framework in place – with clear outlines of monitoring and evaluation protocol - to oversee this continuity.

Target 5: Develop decent and productive work for youth…

The International Labour Organisation (ILO) has produced a recent report which found that one in three

young people worldwide (aged 15-24) is seeking but unable to find work, has given up on jobhunting altogether or is living on or below subsistence wages. 44 per cent of unemployed people but only 25 per cent of the total working population fall into the youth category, and unemployment rates among young people are increasing far more rapidly than amongst their adult counterparts. The youth population is also growing, with a 13.2 per cent increase between 1995 and 2005. In Asia alone it is predicted that there will be an additional 245 million young people seeking work by 2015 (S. Sethuraman). According to a report by the Confederation of Indian Industries in 2006, the demand for skilled labour is going to rise and the unskilled increasingly superfluous over the next 20 years.

Currently, less than one third of adolescents are in school, and, even if children do complete 10 or 12 years of schooling, there are very few higher education institutions or routes into vocational training. This has not been helped by substantial cuts in government subsidies to technical and higher education. A poor education system swells the numbers of unemployable youth. Only 5 per cent of young people have received vocational training; as a point of contrast, in developed countries this figure rises to 60-80 per cent. After Class VIII, it is essential that the government provides a variety of good quality options for students, including skills and livelihoods based training. It may also be possible to consider Self-Help Groups, flexible short duration vocational courses that will not interfere with education or earning capacity, education regarding marketing and production technology and training support that leads to absorption into a specific industry. This process can be assisted by collaboration with NGOs and civil society, and in some cases it may be possible to co-ordinate such efforts with the NREGA.

Young people are particularly vulnerable to exploitation in the labour market and often take up informal employment with poor working conditions and low pay. There needs to be substantive national and international efforts to ensure that productive work meets labour requirements, i.e. minimum wage and guaranteed social protection. India must lead the way in enhancing social protection for Asia's youth and finding ways of guaranteeing an efficient labour market for both informal and formal sectors. A white paper should be drawn up, detailing innovative strategies and concrete plans for generating purposeful work. Sustaining India's growing number of young people must be a vital priority over the coming years.

Target 6: Provide access to affordable essential drugs in developing countries…

Currently half of all people living with HIV/AIDS depend upon Indian generics for their medicines and India is the world's biggest producer and exporter of generic medicines to developing countries, particularly Africa. Historically, government research institutions such as the Central Drug Research Institute, Lucknow and the National Chemical Laboratory, Pune established processes for producing most of the world's essential medicines. Indian drug companies were manufacturing new medicines when they were patented for 10-12 years elsewhere in the world. This situation allowed the Indian generic industry to flourish, and its capacity is now impressive. However, India signed the World Trade Organisation (WTO) agreement in 1995, which brought India's 1970 Patent Act under the remit of international law. This forced amendments which allowed patents on medicines and enabled multinational pharmaceutical companies to import patented medicines directly without competition from the Indian generic market.

In 2007, a critical ruling by the Madras High Court affirmed India's right to apply and use provisions under Section 3 (d) of India's Patent Act, which aims to limit the scope of patentability and thereby protect patients' rights, particularly in developing countries. Under 3 (d), flexibilities are acknowledged which are permitted under the Trade-Related Aspects of Intellectual Property Rights Agreement (TRIPS), as agreed by the WTO. Swiss pharmaceutical company, Novartis had challenged India's right to use these safeguards when the Indian Patents Office (IPO) rejected a patent application on life-saving cancer drug Glivec. Current Indian law limits patentability on pre-existing substances or substances that have undergone only slight modification; this is to curtail the trend of "ever-greening", whereby companies modify and re-patent medicines in order to extend their monopoly and cut supplies of affordable generics. If Novartis had won this case, access to affordable medicines would have been jeopardised for millions of people in the world's poorest countries.

Post-Doha, employment of TRIPS flexibilities have been critical to implementation of TRIPS in developing countries. The judgement of the Madras High Court upheld the constitutional validity of Section 3 (d) and in so doing gave an enormous lift to the Indian generic market; the next step is to ensure that India's domestic pharmaceutical industry is capable of making full use of limited patentability and can continue to supply generic medicines to the developing world. The Patents Office must now take care to unilaterally apply 3 (d) case by case as patent applications are considered.

Increased government investment can enhance domestic research and development and ensure a greater extent of control over the kinds of diseases (including neglected diseases) for which drugs are developed. National legislation must also protect the rights of patients in India, which at the moment means prioritising the passage and enforcement of appropriate legislation to control the spread of spurious drugs and improving access to essential medicines. Despite the extent of India's export market, about 67 per cent of India's own population cannot currently obtain essential medicines. Excessive pricing and lack of price control is one factor that denies access to lifesaving drugs, a situation which is exacerbated by the fact that the price control list of essential medicines is not regularly reviewed. There must be periodic reviews of all medicines with regular weeding out of irrational and spurious drugs, and marketing/unethical promotion of medicines must be regulated by the State.

The lack of regulation in the private healthcare sector in particular has led to overuse of medicines and unnecessary use of antibiotics, i.e. the irrational use of rational drugs, which has helped contribute to the increasing resistance of some disease-causing bacterium. According to the World Health Organisation (WHO), 35% of the world's spurious drugs are produced in India. The national pharmaceutical policy proposes to impose price control, i.e. price capping mechanisms, on 354 essential drugs. The Standing Committee has not yet introduced its recommendations. The Spurious Drugs Bill will prescribe penalties for makers and sellers of fake drugs, whilst the Drugs and Cosmetics (Amendment) Bill, 2007 aims to replace the Drugs Technical Advisory Boards for allopathic and Indian systems of medicine with the Central Drugs Authority (CDA), which will license manufacturing, distribution, sale, import and export of drugs and cosmetics and regulate clinical trials. These duties are currently the responsibility of state governments. The Bill also proposes the establishment of consultative committees to steer both CDA and governmental (state and national) bodies. However, the Bill does not address how regulations may be strengthened at the state level, which will be crucial for effective oversight and implementation of CDA policy.

Target 7: Make available the benefits of new technologies…

India's Information and Communication Technology (ICT) industry has undergone an incredible transformation in a remarkably short space of time, with IT software and services in particular attracting huge investment for its invaluable potential for onsite, offshore expertise and manpower resources.

Meanwhile, tariffs for telecommunications have declined dramatically, whilst the share of the private sector has rapidly increased: according to the Millennium Development Goals Country Report produced by the Ministry of Statistics and Programme Implementation (MSPI), 2005 there has been a strong correlation between the growth of the telecom sector and Gross Domestic Product. The total number of cellular phone subscribers increased from 1.2 million in 1999 to 55 million in 2005 and 260 million in 2008. The Indian telecom sector has registered more than 90 per cent year on year growth over the last 5 years, facilitated by enabling government policy and increased private sector participation.

In terms of internet access, the government has repeatedly expressed its aspiration to improve the lives of Indian people using ICT. The National Common Minimum Programme (NCMP) incorporates a National e-Governance Plan (NeGP) to provide e-governance across the country, delivering services through State Wide Area Networks (SWAN), National Data Banks/State Data Centres (SDCs) and Common Service Centres (CSCs). Community information centres have been placed in hilly, far-flung areas of the country, providing increased internet access to isolated communities so as to enhance governance procedures, increase transparency in all aspects of government activity and to supply access to information, resources and government services. However, the MSPI estimates that just 1 in 35 people across the country is an internet user - much less than in developed countries, though still rapidly increasing year by year. Infrastructure will need to be developed to incorporate complex databases and multimedia, and policy will have to set the way for geographical and human databases - termed "National Information Infrastructure."

The government had plans of 9 million broadband subscribers by 2007 and 20 million by 2010. In January 2008 there were 3.24 million subscribers, which is quite significantly below target. Broadband is important in modern society to contribute to economic growth through marketing, provision of fast and efficient e-services and communications to citizens across the nation. If the present growth rates of 8% quarter on quarter are sustained, there will be a mere 10.06 million in 2010. This is partly because of the fact that, even after deregulation of the telecoms industry, consumer electronics have generally remained expensive and out of reach for the mass population. As prices are reduced, this will have an impact on the reach of broadband services. Service providers such as state-run BSNL have already started to lower their prices and launch promotional campaigns that offer PCs and internet access at an aggregate cost that is as little as US $10 per month.

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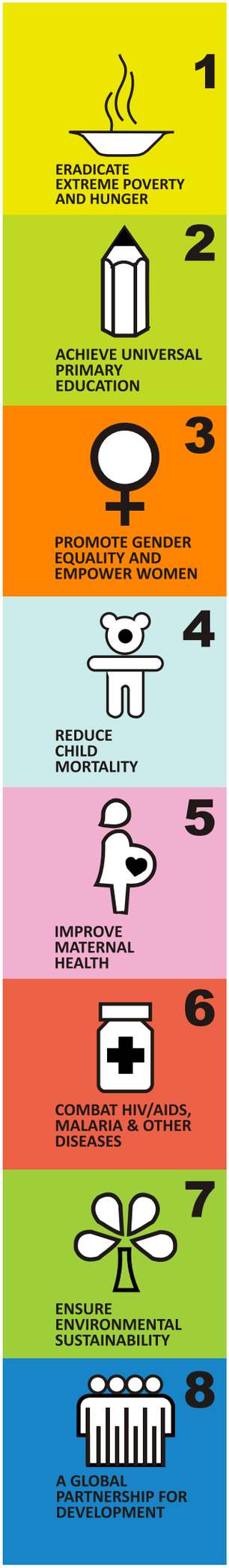
Acronyms

AAs	Appropriate Authorities
AAY	Antyodaya Anna Yojana
AEP	Adolescent Education Programme
AIDS	Acquired Immune Deficiency Syndrome
ANMs	Auxiliary Nurse Midwives
ART	Anti-Retroviral Treatment
ARVs	Anti-Retrovirals
ASHAs	Accredited Social Health Activists
BPL	Below Poverty Line
CABE	Central Advisory Board on Education
CAG	Comptroller Auditor General
CDA	Central Drugs Authority
CDR	Case Detection Rate
CFCs	Chlorofluorocarbons
CHCs	Community Health Centres
CNG	Compressed Natural Gas
CO2	Carbon Dioxide
DFPD	Department of Food and Public Distribution
DOTS	Directly Observed Therapy Short-Course
ECCE	Early Childhood Care and Education
EGS	Education Guarantee Scheme
EPI	Expanded Programme on Immunisation
FDSTs	Forest Dwelling Scheduled Tribes
FPS	Fair Price Shops
FSWs	Female Sex Workers
GDP	Gross Domestic Product
GMOs	Genetically Modified Organisms
GNP	Gross National Product
GoI	Government of India
GoM	Group of Ministers
GR	Government Resolution
HDR	Human Development Report
HIPC	Heavily Indebted Poorest Countries
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Series
ICPS	Integrated Child Protection Scheme
ICT	Information Communication Technology
IDUs	Injecting Drug Users
ILO	International Labour Organisation
IMCP	Intensified Malaria Control Project
IMF	International Monetary Fund
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IMR	Infant Mortality Rate
IPCC	Intergovernmental Panel on Climate Change
IUD	Intra-Uterine Device
JSY	Janani Suraksha Yojana
KGBV	Kasturba Gandhi Balika Vidyalaya
LDCs	Least Developed Countries
MDGs	Millenium Development Goals
MDMS	Mid Day Meals Scheme
MDR	Multi-Drug Resistant
MFIs	Micro-Finance Institutions
MFOs	Micro-Finance Organisations
MIS	Management Information Systems
MMR	Maternal Mortality Rate
MMR	Measles Mumps and Rubella
MoHFW	Ministry of Health and Family Welfare
MoRD	Ministry of Rural Development
MOs	Medical Officers
MoWCD	Ministry of Women and Child Development
MSMs	Men who have Sex with Men
MSPI	Ministry of Statistics and Programme Implementation
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NCAP	National Climate Action Plan
NCERT	National Council of Education and Research Training
NCMP	National Common Minimum Programme
NFHS	National Family Health Survey
NGOs	Non-Governmental Organisations
NMBS	National Maternity Benefit Scheme
NMR	Neonatal Mortality Rate
NPEGEL	National Programme for Girls at Elementary Level
NPP	National Population Policy
NREGA	National Rural Employment Guarantee Act

NREGS Scheme	National Rural Employment Guarantee
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organisation
OBC.	Other Backward Classes
ODA	Official Development Assistance
OECD	Organisation for Economic Co-Operation and Development
PAL	Panchayat at Appropriate Level
PC	Planning Commission
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PDS	Public Distribution Scheme
PESA	Panchayat Extension of Scheduled Areas
PHC	Primary Health Centre
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
PPP	Purchasing Power Parity
PRI	Panchayati Raj Institution
PRSPs	Poverty Reduction Strategy Papers
RCH	Reproductive and Child Health
RCHP	Reproductive and Child Health Programme
RIS	Research and Information System
RNTCP	Revised National Tuberculosis Control Programme
RTE	Right to Education
SAP	Structural Adjustment Policies
SC	Scheduled Caste
SCs	Sub-Centres
SFCs	State Financial Corporations
SHGs	Self Help Groups
SSA	Sarva Shiksha Abhiyan
ST	Scheduled Tribe
STDCs	State TB Training and Demonstration Centres
STI	Sexually Transmitted Infection
TB	Tuberculosis
TPDS	Targeted Public Distribution System
TRIPS	Trade Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFCC	United Nations Framework on Climate Change
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPA	United Progressive Alliance
VCT	Voluntary Counselling and Testing
WEF	World Economic Forum
WHO	World Health Organisation
XDR	Extensively Drug Resistant



Parliamentarians' Group on MDGs (PG-MDGs)

Handbook for Parliamentarians on the Millennium Development Goals (MDGs)

Political Support & Action

The PG-MDGs is a unique forum of proactive Parliamentarians, who are willing to take up critical issues related to human development within India's legislative/policy making spaces. The Group of Parliamentarians promises to work for emerging developmental needs in order to fulfil the commitments made under the MDGs. In years to come, the world will judge India's accomplishments in relation to these eight critical targets.

CLRA has taken the initiative to organise the PG-MDGs while engaging more proactively with parliamentarians in the policy making process. CLRA builds a close working collaboration with a focused group of MPs to facilitate easier access to policy making spaces. The promotion and strengthening of democratic accountability is fundamental for securing civil society interaction with governance institutions, as well as providing a platform to make social and human development the starting point for the nation's representative governing bodies.

For more information, contact:

Centre for Legislative Research and Advocacy (CLRA)
160, South Avenue, New Delhi-110011, India
Tel: 91-11-23792862
E-mail: info@clraindia.org
www.clraindia.org

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