Module 2

Poverty Alleviation, Livelihoods and Social Sector Programmes of the Government

Module objectives	(i)	To recapitulate the major social sector schemes of the Central Government
	(ii)	To use participants' field experience to bring out the major issues in some of the important programmes
	(iii)	To understand the issues in livelihood and the factors critical for success of a livelihood programme
Essential reading	(i)	The section on multi-dimensional poverty
	(ii)	The section on health
	(iii)	The section on Sarva Shiksha Abhiyan
	(iv)	Case studies in the livelihoods section
Learning activities	(i)	A brief introduction to the multi-dimensional aspect of poverty
	(ii)	Ask participants to consider the questions raised in Ex.2.1 and jot down their points
	(iii)	Drive a discussion in the class room on Ex.2.1 and the trainer should note the points emerging from the discussion on the board/flip-chart
	(iv)	Summarize the discussion
	(v)	Two groups to discuss the issues on NRHM (Ex.2.2) and two other groups to discuss issues on SSA (Ex.2.3)
	(vi)	Groups on NRHM should present their views on Ex.2.2. After this there should be a discussion in the class on the two groups' presentation. The members of the other two groups are also encouraged to participate. The trainer should note the points on the board. After discussion the trainer should summarize the points.
	(vii)	Groups on SSA should make their presentations on Ex.2.3. After this there should be a discussion in the class on the two groups' presentation. The members of the other two groups are also encouraged to participate. The trainer should note the points on the board. After discussion the trainer should summarize the points.
	(viii)	Provide Ex.2.4 to all the participants in the class and ask them to read it and reflect on the issues.
	(ix)	Drive a participatory session on the case. The trainer should note the points on the board. After discussion the trainer should summarize the points.
	(x)	Provide Ex.2.5 to all the participants in the class and ask them to read it and reflect on the issues.
	(xi)	Drive a participatory session on the case. The trainer should note the points on the board. After discussion the trainer should summarize the points.

1. Poverty Allevation

1.1 Poverty

1.1.1 Poverty has been no less difficult to define as alleviate. Income approaches define poverty in terms of inability to achieve a minimum income necessary to meet the basic ends of life. Consumption poverty on the other hand is defined in terms of inability to meet a basic mix of consumption goods, which enables a person to maintain her bodily and mental functions necessary for earning a livelihood. Multidimensional evaluation of poverty goes beyond income or consumption and looks at various kinds of deprivation that poverty entails. Poverty indeed is multidimensional and the strong association of being poor with lack of housing, lack of basic medical care, lack of access to drinking water and sanitation, lack of educational facilities and so forth is indisputable. Poverty, as lived, is often the lack of care of every conceivable kind. The attempts to reduce poverty to a minimum consumption or income are attempts at simplification, which is necessary or more often, convenient, for policy formulation and programme implementation. Poor countries at the initial stages of economic development have often defined poverty in consumption terms as their fiscal situation constrained them to tackle poverty in its multidimensional aspects.

1.2 Poverty Line

1.2.1 The Planning Commission's Task Force on Poverty defined poverty in 1978 in terms of a person's inability to consume 2400 kcal per day in rural areas and 2100 kcal per day in urban areas. The calorific requirements were then converted into consumption baskets valued at prices prevailing then. The resultant amounts (Rs.49.09 per month per person for rural areas and Rs.56.64 in urban areas) indicated the minimum consumption expenditure that person must make in order to remain out of poverty. This set the poverty line. Since then the poverty line is being updated for changes in price level. At present the poverty line stands at Rs. 368 and Rs. 559 per person per month for rural and urban areas.

1.3 Status of Poverty in India

1.3.1 The following table sets out the extent of poverty in India. Note that in terms of number of poor, we are almost where we were in 1973-74. Population explosion is undoubtedly a factor accounting for the downward rigidity in the number of the poor.

Extent of Poverty in India

Year	% Population below the poverty line	Number of poor (millions)
1973-74	54.9	321.3
1977-78	51.3	328.9
1983	44.5	322.9
1987-88	38.9	307.1
1993-94	36	320.3
2004-05	27.5	301.7

1.3.2 Further, in 1999-2000 71.65% of India's poor and more than half of India's population were located in the seven states of (i) Uttar Pradesh (including Uttaranchal), (ii) Bihar (including Jharkhand), (iii) Madhya Pradesh (including Chhatisgarh), (iv) Maharashtra, (v) West Bengal, (vi) Orissa and (vii) Assam. These states accounted for 73.3% of India's poor in 2004-05. In 1973-74 50% to 66% of the population of these 7 states were below the poverty line. In 1993-94 about 35% to 55% of their population was still in poverty. The problem of poverty in India, to a great extent, is the problem of chronic poverty in these States.

1.3.3 Another aspect of poverty in India is mobility of the people in and out of poverty. NCAER Panel Data for 3139 households from 260 villages of India shows that more than half (52.61%) of the households

remained in poverty, 47.39% of poor households escaped from poverty and 25.74% of non-poor households entered poverty. This shows that efforts to reduce poverty can be made highly effective by preventing the non-poor from entering into poverty.

1.3.4 Caste, tribe and household demographic composition are important determinants of poverty. The probability of being chronically poor is higher for:

(a) Casual agricultural labour,
(b) Landless households,
(c) Illiterate households,
(d) Larger households with more children.

1.3.5 Factors that help people out of poverty are:

(a) Increased income earning opportunities,
(b) Proximity to urban areas,
(c) Improved infrastructure,
(d) Initial literacy status of the household head,
(e) Ownership of or access to income from physical assets such as cropland, livestock, house etc.

1.3.6 Non-poor are often pushed into poverty by shocks such as:

(a) Crop failure,
(b) High health care costs,
(c) Adverse market conditions,
(d) Loss of assets,
(e) High interest from private moneylenders,
(f) Social expenses on deaths and marriages.

1.3.7 It may be noted that 80% of India's population earn less than 2 dollars (PPP) a day. This means that a large section of the non-poor is clustered around the poverty line and is therefore highly vulnerable to shocks. Policies that reduce health care related costs, insure the poor against adverse market conditions or crop failure and help the poor stay away from high-interest debt can prevent entry of the non-poor into poverty.

1.4 Human Poverty : Deprivation in Multiple Dimensions

1.4.1 Poverty means a much wider range of deprivations than merely inadequate income. Illiteracy, high levels of mortality, poor infrastructure, poor access to resources such as land, water and forests, lack of voice etc. are integral aspects of poverty. It is important to know about the extent of deprivation in non-income aspects of poverty since mere increase in income is not adequate to remove many non-income deprivations. Human Development Indicators such as HDI (Human Development Index) captures health status and educational attainments in addition to income. At very low levels of income, however, it is observed that HDI closely follows income. As per Planning Commission's study, in India, among the 15 large states, with exception of Andhra Pradesh, Kerala, Rajasthan, Tamil Nadu and Maharashtra, performance in HD closely follows income poverty. The question therefore is: "why then should we track non-income dimensions of poverty?"

Group exercise 2.1: Non-income aspect of poverty: Discuss the following questions

(i) Is it necessary to separately redress non-income deprivations of the poor?

(ii) Is it better to identify the poor by multiple deprivations rather than just the poverty line? If this has been attempted in your State, what is your experience?

(iii) What non-income indicators can be used to identify the poor and/or address these deprivations?

(iv) Why do you think large sections of people repeatedly keep moving in and out of poverty?

(v How is your State tackling the multidimensional aspects of poverty? What constraints you face in these efforts?

1.5 Poverty Alleviation in India

1.5.1 Poverty alleviation programmes in India can be divided into four broad categories:

(a) Self-employment programmes

(b) Wage employment programmes

(c) Public distribution systems and nutrition programmes

(d) Social security programmes

1.6 Self-Employment Programmes

Integrated Rural Development Programme (IRDP., discontinued):

1.6.1 The IRDP was the first major self-employment programme started in 1970s. The programme aimed at providing assistance to beneficiaries in the form of bank credit and government subsidy in order to enable them acquire sustainable income generating assets. The programme was initially started in 20 districts on pilot basis but was extended to all blocks in the country. The target group of the programme was BPL families in rural areas.

1.6.2 The programme was later supplemented by TRYSEM (Training of Rural Youth for Self-Employment) in 1979 to provide training to beneficiaries of IRDP and Development of Women and Children in Rural Areas (DWCRA) in 1983 to focus on women and children.

1.6.3 The TRYSEM programme aimed at providing basic technical and entrepreneurial skill to the rural poor in the age group of 18-35 years enable them take up income generating activities (self/wage employment). TRYSEM stipulated that the coverage of youth from SC/ST communities should be at least 50% of rural youth trained, while out of the total beneficiaries, at least 50% should be women.

1.6.4 DWCRA was aimed to improve the socio-economic status of the poor women in the rural areas through creation of groups of women for income-generating activities on a self-sustaining basis. The main strategy adopted under the programme was to facilitate access for poor women to employment, skill upgradation, training credit and other support services so that the DWCRA women as a group could take up income-generating activities for supplementing their incomes. It sought to encourage collective action in the form of group activities that were known to work better and were more sustainable than the individual effort. It encouraged the habit of thrift and credit among poor rural women to make them self-reliant.

1.6.5 All the programmes, namely, IRDP, TRYSEM and DWCRA were later merged into Swarnajayanti Gram Swarojgar Yojana (SGSY) from April 1999.

1.6.6 Data shows that 54 million people had been assisted under the programme till March 1999. Total credit mobilized under the programme was Rs.22, 542 crore and total investment including subsidy amounted to Rs.33,953 crore. Till March 1999, 45.56 lakh youth were trained under TRYSEM and 2.73 lakh women groups with 41.45 lakh members were formed under DWCRA.

1.6.7 Though successes of the programmes to some extent cannot be disputed, the programme has been heavily criticized on the following grounds:

(a) There were enormous leakages, misappropriations, violations of programme guidelines, selection of non-poor as beneficiaries, absence of proper records and accounts.

(b) According to an evaluation by Jean Dréze (i) even if the programme were flawlessly implemented it could not have made the radical reduction of poverty that is claimed (ii) in large parts of India, with the exception of WB and few other States, the selection of beneficiaries were indiscriminate and at worst biased against the poor (iii) there is no solid evidence of the actual impact of IRDP on the living standards of participating households

(c) The programme resulted in considerable weakening of the health of banks, as the recovery rates were dismal at just 41% (as in March 1996).

Swarnajayanti Gram Swarojgar Yojana (SGSY, discontinued))

1.6.8 SGSY was launched with effect from April 1, 1999 by restructuring and amalgamating IRDP, TRYSEM, DWCRA and MWS (Million Wells Scheme) into a single programme. SGSY aims at establishing a

large number of micro-enterprises in the rural areas by building upon the potential of the rural poor. SGSY is a holistic programme covering all aspects of self-employment such as organization of the poor into Self Help Groups (SHGs), training, credit, technology, infrastructure and marketing. The scheme is being implemented with cost sharing between centre and states on 75:25 basis.

1.6.9 SGSY is being implemented by the DRDAs through the Panchayat Samithis. SGSY lays stress on the cluster approach. What this means is that instead of funding diverse activities, each block should concentrate on a few select activities (key activities) and attend to all aspects of these activities, so that the Swarozgaris can draw sustainable incomes from their investments. These key activities are generally taken up in clusters so that the backward and forward linkages are effectively established.

1.6.10 Up to the end of the financial year 2001 a total of 4.93 lakh SHGs were formed comprising 6.87 million members. Individual swarojganris covered in the scheme numbered 3.43 lakh.

1.7 Wage Employment Programmes

1.7.1 In this segment notable programmes are Maharashtra Employment Guarantee Scheme, National Rural EGS and the erstwhile Employment Assurance Scheme (EAS). The primary purpose of rural EGS is to generate gainful employment and generate public goods. The objective is to create productive assets for sustainable employment.

Maharashtra EGS

1.7.2 The scheme provides guarantee of unskilled manual work to adults over 18 years of age in rural areas. The main features of the scheme are:

(a) To provide gainful productive employment

(b) The works undertaken should produce durable community assets.

(c) Wage to material ratio is 60 to 40. The typical works under MEGS are minor irrigation, water and soil conservation, nalla building, canal excavation, land development, afforestation etc.

(d) MEGS is financed by taxes on professions, trade, motor vehicles, sales tax, irrigated agricultural land, land revenue and matching contribution from State.

1.7.3 The scheme was implementation through a collaborative partnership between the centre, state governments, panchayats, and the local community. Each Gram Panchayat was required to prepare a development plan based on recommendations of Gram Sabha and maintains a shelf of works to be taken up when demand arises. For demand to arise people must know their Rights under the Act, so Communication and Publicity are necessary and an effective multimedia campaign is needed.

1.7.4 The types of work listed in the scheme were:

a) Water conservation
b) Renovation of traditional water bodies including desilting of tanks
c) Irrigation, including micro and minor works
d) Land development
e) Flood control and protection/drainage works in water logged areas
f) Rural connectivity to provide all weather access
g) Any other which may be notified

An evaluation of MEGS shows that the programme has:

(a) Reduced unemployment in Maharashtra,
(b) Increased incomes of many participating households,
(c) Provided insurance,
(d) Made positive impact on agricultural growth and wages,
(e) Made the rural poor a political force, and
(f) Made considerable impact on women's empowerment.

1.7.5 However, MEGS too had its shortcomings as following:

(a) Original scheme required registration of all those who wanted work. Hence data was available about those who wanted but not given work. This was a strong feature of the scheme as the panchayats would be under pressure to keep the gap between the number of people wanting work

and the number given work as low as possible. Later the requirement for registration of those who wanted work was done away with. This was substituted with the requirement of registering only those who were given work. This resulted in lower volumes of work and employment. It has been alleged this change was brought about by the sugar lobby in Maharashtra, since the original scheme lead to rise in wages for working on sugarcane field (especially during sugarcane cutting season) as people preferred to work in MEGS projects at much better wages. Now practically, the work to be sanctioned depends on the judgment of panchayats and not on the demand for work.

(b) The calculation of wages was based on piece rate and not daily wage rate. The calculation depended largely on the gang leader.

(c) The scheme was also not women friendly for the following reasons:

(I) Work is done by a group of both men and women, so calculation of the individual share of wages, especially of women is somewhat subjective and depends on the team leader who is usually male, as well as the other co-workers.

(ii) Maternity benefits did not reach women as women needed to prove 75 days work to avail this. There was no way of showing stipulated days of work due to shifting work sites and inadequate records.

(iii) Shelters and crèches not provided as work sites are temporary.

(iv) Toilets are rarely provided on/near EGS sites and there is total lack of privacy.

How Maharashtra EGS Works

All adult residents of villages and 'C' class municipal towns are eligible to apply for jobs under this programme. A minor within the age group 15–18 years too can apply if the family does not have the support of any older earning member.

The Talathi or Gram Sevak is the authority with whom the job seeker has to register and seek employment under the EGS from the Tahsildar by undertaking to work for a continuous time interval of at least 30 days. The job seeker is to be provided employment within fifteen days, failing which the applicant is entitled to an unemployment allowance of two Rupees per day. Interestingly, an increase in this amount was never sought, nor given.

Upto 60 per cent of the total cost of a work is earmarked for wages. Any work spot has to employ a minimum of 50 persons. The programme guarantees work but it is restricted to unskilled manual work in the local district. Generally jobs are offered at sites within the Panchayat Samiti area. If the work sites fall beyond a distance of eight kilometres from the residence of the job seeker, then the Act provides for camping arrangements and travel expenses.

Government departments like Irrigation, Public Works, Agriculture, Forest and Zilla Parishads implement the programme seeking to ensure the durability and reliability of the system.

The EGS permits only productive works. The overriding concern is to insulate the vulnerable population and the economy against the harmful effects of drought. Hence, priority is attached to projects concerned with conserving moisture and water.

From this perspective, the public works are ranked as follows: highest priority is assigned to labour intensive pieces of major and medium irrigation projects, canal works, minor irrigation, percolation and storage tanks and underground bandharas.

Next in order are works related to soil conservation and land development, afforestation and social forestry, roads and flood protection.

Choice of projects for the EGS is restricted to those involving intensive use of unskilled labour.

Towards this end, the programme stipulated a wage component of at least 60 per cent for the cost structure. For exceptional cases like canal works of major and medium irrigation projects, the floor is set at 50 per cent. Wages are fixed on a piece rate basis, with reference to tasks like digging, breaking rocks, shifting earth and transplanting. Rates are fixed such that an average person can earn by putting in seven hours of work or at least an amount equal to the minimum wages prescribed for agricultural labour in the corresponding zone till 1983. Earlier, this parity was avoided to ensure that labour did not flow out and away from agricultural operations.

EGS programmes are implemented with reference to a plan and work schedule.

The beneficiaries are provided with drinking water, shelter for rest, First Aid Box, crèches and shelter, ex-gratia payment to workers in the event of death or injuries during work since all work is manual and virtually unskilled in nature. There is an arrangement for maternity benefit of 15 days leave of absence to those female labourers who have worked for an uninterrupted interval of 75 working The resources for this programme are raised by special taxes on professions, trades, callings and employment. Additional tax is by way of cess on motor vehicles and on Sales Tax, a special assessment of irrigated agriculture land, surcharges on land revenue and a tax on non-residential urban lands and buildings under Maharashtra Education Cess Act. A matching contribution annually from the State Government equal to the net collection from these sources is provided.

(Source: Maharashtra HDR, 2002)

Jawahar Gram Samruddhi Yojana (JGSY, discontinued)

1.7.6 Jawahar Rojgar Yojana (JRY) was restructured in 1999 and renamed as Jawahar Gram Samruddhi Yojana (JGSY) from April 1, 1999. It aims to ensure development of rural infrastructure at the village level by restructuring the erstwhile Jawahar Rozgar Yojana (JRY) and Employment Assurance Scheme (EAS). Both Jawahar Rozgar Yojana and Employment Assurance Scheme resulted in the creation of durable assets in the form of school buildings, roads and other infrastructure. However, under these programmes, the generation of wage employment was getting overriding priority and the effort was to see that in the process of creating employment, durable assets were created. It was, however, felt that a stage has come when the development of village infrastructure needs to be taken up in a planned manner leading to restructuring of JRY and EAS into SGSY. JGSY is dedicated entirely to the development of rural infrastructure at the village level and is being implemented by the village panchayats.

1.7.7 The main emphasis of the programme is to create demand-driven rural infrastructure, including durable assets at the village level and assets to enable the rural poor to increase the opportunities for sustained employment. The secondary objective is generation of wage employment for the unemployed poor in the rural areas.

The following are its main features:

(a) The main emphasis of Jawahar JGSY is to create rural infrastructure at the village level Implementation of the Jawahar Gram Samruddhi Yojana entirely by the Village Panchayat. Priority is given to building of infrastructure for SC/ST habitations, education and public health

(b) Direct release of funds to the Village Panchayats by District Rural Development Agencies (DRDAs)/Zilla Parishads (Zps). Village

Panchayats is the sole authority for preparation of Annual Action Plan and its implementation with the approval of Gram Sabha. Gram Sabha is empowered to approve schemes/works.

(c) Village Panchayats can execute works/schemes up to Rs. 50,000/- without technical/ administrative approval.

(d) The programme also provided assets to individual SC/ST families and 22.5% of the funds are earmarked for them.

Sampoorna Gramin Rozgar Yojana (SGRY)

1.7.8 The Prime Minister in his Independence Day speech, on 15.8.2001 announced the introduction of a Universal Food for Work Programme to be called "Sampoorna Gramin Rozgar Yojana" in all the States/UTs for organizing various employment generation programmes. Under the Scheme, 50 lakh tonnes of foodgrains is to be allotted to the States/UTs free of cost by Ministry of Rural Development. Ministry of Rural Development reimburses the cost of foodgrains at economic cost prevailing at the time. The Ministry of Rural Development, which is the nodal Central Ministry for the programme launched the scheme on 25.9.2001

Evaluation of Erstwhile JRY

1.7.9 An evaluation (1994) of JRY indicates that:

(a) 77% of the programmes works were being executed by panchayats and only 2% of the works were executed by contractors.

(b) A substantial amount of JRY funds were spent on roads and buildings.

(c) Wage to non-wage ratio was 53:47 percent

(d) Quality of majority of assets was found to be good and only in 0.41% of the cases the assets were found to useless.

(e) Seventy six percent of assets were maintained by the panchayats and 86% of the assets were reportedly durable.

(f) On an average the employment generated under JRY during the 30 days preceding the date the survey was 11 days (2001).

Evaluation of SGRY

1.7.10 Since inception in 1999 till 2001, a total of 15.7 lakh works have been completed, including 5.98 lakh works under individual beneficiary scheme. The basic problem with the scheme is that the amount being allocated to gram panchayat is extremely meager, even Rs.5000/-. With such meager amounts it is hardly possible do any meaningful work.

National Rural Employment Guarantee Act

1.7.11 Notified on 7th September 2005, the National Rural Employment Guarantee Act aims at enhancing the livelihood security of the people in rural areas by guaranteeing hundred days of wage employment in a financial year, to a rural household whose adult members volunteer to do unskilled manual work. NREGA has been extended to 330 most backward districts. The Government has however taken a decision to extend NREGA to the rural areas of all the remaining districts in the country.

1.7.12 During 2006-07, the Act provided employment to 2.10 crore rural households, in the first phase districts, creating 90.50 crore person days, on which more than 60% share was of ST and SC groups and 40% of women. During this period 8.00 lakh works were taken up, of which 54% pertained to water conservation and water harvesting. There is also increasing evidence of stemming distress migration and improving land productivity. An amendment to the schedule of the Act now permits works pertaining to land development, horticulture, plantation, minor irrigation on the land holdings of not just SC/ST families but also all BPL families, thereby directly linking wage employment with agricultural productivity. The scheme gives utmost priority to vigilance and monitoring. Concurrent monitoring of all NREGA districts is undertaken through independent monitors and independent studies have also been undertaken. Programme processes are sought to be made transparent through social audits, which actively involve civil society organizations. The RTI Act has been effectively used for NREGA, creating a strong environment of public accountability. All critical data has been placed in public domain through a web enabled MIS. The muster rolls are being placed on the website for citizens' scrutiny.

Performance of NREGA as at Jan 24, 2008

Employment Demanded by households	2.61 Crore
Employment provided to households	2.58 Crore
Person days [in Crore]	
Total	102.13
SCs	23.29 [22.8%]
STs	43.06 [42.16%]
Women	38.04 [37.24%]
Others	35.78 [35.04%]
Total works taken up (number)	12.43 Lakhs.
Works completed (number)	3.78 Lakhs.
Works in progress (number)	8.65 Lakhs

(Source: NREGA website)

1.8 Food Security and Nutrition Programmes

Public Distribution System

1.8.1 Government has been supplying six essential commodities through PDS: (i) wheat, (ii) rice, (iii) sugar, (iv) edible oils, (iv) kerosene and (v) soft cake. The access to system was universal until 1997. Initially, PDS operated more as price stabilization than an anti-poverty programme. The welfare thrust to PDS came in the sixth plan.

Evaluation of PDS

1.8.2 PDS has been effective in drought years, for example, during 1979-80 and 1987-88. It has also been effective in transferring food grains from surplus regions to deficit regions. However, it is estimated that PDS has benefited the poor only to a limited extent due to (i) enormous leakages, (ii) diversion of commodities to open market and (iii) higher prices, especially in recent years. There has also been regional mistargetting. Off-take has been high in case of states such as Kerala and AP, where the state has absorbed price hikes, but low in poor states such as Bihar, Orissa and MP. This may indicate that off-take is strongly correlated with prices. In majority of states BPL families have only very limited access to PDS.

Revamped PDS

1.8.3 In 1997 the government revamped PDS in which the essential commodities were made available at 50% of economic cost to BPL families and at economic cost of APL families. The per person quota for BPL families have been hiked. This policy has led to appreciable increase in issue prices. The Central Issue Price (CIP) for wheat for the above poverty line (APL) families, which was Rs 450 per quintal in January 1999, had been initially increased in two steps to Rs 682 per quintal on April 1, 1999 and further to Rs 900 per quintal on April 1, 2000. Likewise the PDS issue price for Grade A rice for above poverty line families was initially increased from Rs 700 per quintal to Rs 905 per quintal in February 1999, and this was increased further to Rs 1180 per quintal on April 1, 2000. It may be seen that increase in the issue price of wheat was much steeper than that of rice. Certain rice consuming states have partly absorbed increase in prices of rice through increase in state level subsidies. A steep fall in off-take of wheat has also been noticed. However, in case of rice despite the price rise in 1999, PDS offtake during 1999-2000 was almost unchanged.

1.8.4 Higher support prices coupled with low off-take of food grains have resulted in bludgeoning food stocks with FCI. This has also had deleterious impact on the food subsidy bill. Though there has been a lot of debate into the causes of decline in off-take, the discourse has become polarized into two camps: one that attributes the decline in off-take mainly to increase in prices. The other school attributes this phenomenon to change in dietary habits as a result of higher family incomes.

- Highlights of NSSO Survey of PDS (2004-05)
- Holding of Ration Cards by Households
- 81% of rural households and 67% of urban households held ration cards. Below Poverty Line (BPL) cards were held by 26.5% of rural households and 10.5% of urban households.

- In rural areas BPL cards were held by 43% of "agricultural labour" households and 32% of "other labour" households. BPL cards were held by 40% of Scheduled Tribe (ST) households, 35% of Scheduled Caste (SC) households, about 25% of Other Backward Classes (OBC) households, and 17% of the remaining households. In urban areas, however, it was the Scheduled Castes which had the highest percentage (17%) of households holding BPL cards, while ST and OBC households had about 14% each.
- As many as 51% of rural households possessing less than 0.01 hectares of land had no ration card at all, while in all other size classes 77-86% households held a ration card of some type. In respect of ration cards meant for the poor, the class possessing "0.01-0.40 hectares" was the one with the highest proportion of cards (32%).
- Among the top 5% of rural population ranked by monthly per capita expenditure (MPCE), an estimated 11% of households held BPL ration cards. Among the next 5% of rural population, 14% of households held BPL cards, and among the next 10% of rural population, 18% of households held BPL ration cards.
- Consumption of Rice, wheat, Sugar and Kerosene from PDS
- The major State where consumption of rice from PDS was most common was Tamil Nadu (rural: 79% households consuming from PDS; urban: 48%), followed by Andhra Pradesh (rural: 62%; urban: 31%), Karnataka (rural: 59%; urban: 21%) and Kerala (rural: 35%; urban: 23%). Even in Gujarat and Maharashtra, where rice is not the major cereal food, 32% and 28% households, respectively, consumed PDS rice. On the other hand, PDS rice was consumed by only a small proportion of households in West Bengal (rural: 13%; urban: 5%), Assam (rural: 9%; urban: 2%) and Bihar (rural: 1%; urban: 0.7%), though rice is the major cereal food in these States.
- PDS consumption of wheat/atta was most common in Karnataka (rural: 46%; urban: 15%), rural areas of Gujarat (29%) and Maharashtra (26%), and in Madhya Pradesh (rural: 20%; urban: 10%).
- As in case of rice, PDS consumption of sugar, too, was most prevalent in Tamil Nadu (rural: 65% households; urban: 64%), followed by Assam (rural: 40%; urban: 16%) and Andhra Pradesh (rural: 36%; urban: 15%). On the other hand, in both rural and urban areas, less than 1% households con sumed PDS sugar in Punjab, Haryana, Bihar and Jharkhand, and fewer than 2% in Orissa and Uttar Pradesh. The all-India proportions of households were 16% for rural areas and 12% for urban.
- Over 55% of rural households used PDS kerosene in all major States except Punjab and Haryana. Use of PDS kerosene was most common in West Bengal for both rural areas (91%) and urban areas (60%).
- Among the four commodities, kerosene had a much larger share of quantity of consumption coming from PDS – 77% for rural and 57% for urban India. For rice the share of PDS in total quantity consumed was 13% for rural and 11% for urban; for wheat it was 7% for rural and 4% for urban, and for sugar, 9½% for rural and about 6½% for urban India.
- Households holding a BPL ration card exhibited a much greater degree of dependence on PDS than the population as a whole. This was most marked in case of wheat, where, for both rural and urban areas, as much as 28% of quantity consumed by such households came from PDS compared to 7% for the rural population as a whole and 4% for the overall urban population. For rice and sugar, the percentage contribution of PDS purchases to total consumption (in quantity terms) for these households was double the percentage share of PDS in consumption of the general population in rural areas and three times the percentage share of PDS for the general population in urban areas.Source: Public Distribution System and Other Sources of Household Consumption, 2004-05, National Sample Survey Organisation, June 2007

Integrated Child Development Services Scheme (ICDS)

1.8.5 The average Indian child has a poor start to life. Both infant and under-five mortality rates for Indian children – at 67 and 93 respectively – are higher than the developing country average. One in four newborn is underweight. Only about one in three is exclusively breastfed for the first six months. Nearly one in two children under five years of age suffer from moderate or severe malnutrition. One in three children does not get a full course of DPT (diphtheria, pertussis and tetanus immunization), and only one in three has the opportunity to be in an early learning programme. Just about one in five is protected against vitamin A deficiency. Their parents and caregivers experience grave disadvantages too. Forty-four per cent of India's people live on less than $1 a day. Less than 30 per cent have access to adequate sanitation facilities. The country has high maternal mortality ratio of 540 deaths per 100,000 live births.

1.8.6 Against this backdrop, the Government has supported a monumental effort to improve the life chances of children. Integrated Child Development Services (ICDS) in India is the world's largest integrated early childhood programme, with over 40,000 centres nationwide. UNICEF helped launch the ICDS programme and continues to provide financial and technical assistance along with the World Bank.

1.8.7 The purpose of ICDS is to improve the health, nutrition and development of children. The programme offers health, nutrition and hygiene education to mothers, non-formal preschool education to children aged three to six, supplementary feeding for all children and pregnant and nursing mothers, growth monitoring and promotion, and links to primary healthcare services such as immunization and vitamin A supplements. These services are delivered in an integrated manner at the anganwadi, or childcare centre. Each centre is run by an anganwadi worker and one helper, who undergo three months of institutional training and four months of community-based training. The cost of the ICDS programme averages $10-$22 per child a year.

Evaluation

1.8.8 According to UNICEF:

(a) The programme today covers over 4.8 million expectant and nursing mothers and over 23 million children under the age of six. Of these children, more than half participate in early learning activities.

(b) Studies have found that, despite some unevenness in the quality of services, the ICDS programme has had a positive impact on the survival, growth, and development of young children. For example, a study conducted in rural areas of three southern states (Tamil Nadu, Andhra Pradesh and Karnataka) found that the programme had a significant impact on the psycho-social development of children, for both boys and girls. The study also showed that undernourished ICDS beneficiaries attained higher developmental scores than well-nourished children who were not enrolled in the programme.

(c) A national study conducted in 1992 by the National Institute of Public Cooperation and Child Development confirmed the positive impact of ICDS. Where the programme was operating, there were lower percentages of low-birth-weight babies, lower infant mortality rates, higher immunization coverage, higher utilization rates for health services, and better child nutrition. The percentage of severely malnourished children declined, the positive effects of preschool were evident, and a larger percentage of mothers were getting their children medically examined.

(d) However, as per World Bank-GOI review carried out in 1997:

(I) There are problems in delivery, quality and coordination,

(ii) The programme has failed to effectively address the issue of prevention, detection and management of the under-nourished child/mother

(iii) Children 6-24 month age groups /lactating mothers did not come to anganwadi. Available food was being shared mostly between 3-5 years old children irrespective of their nutritional status.

(iv) There is no focused attention and management of severely malnourished children.

(v) No attempt was made to give ready mixes for 6-24 month children 3-4 times a day.

(vi) Nutrition education was not focused on

meeting nutritional needs of the child from family pot.

(vii) Child care education of the mother was non-existent.

Mid-day Meal Scheme

1.8.9 The Mid-Day Meal Scheme was launched by the Ministry of Human Resource Development (Department of Education) with effect from 15th August, 1995 for the benefit of students in primary schools under Employment Assurance Scheme (EAS)/earlier Revamped Public Distribution System (RPDS) blocks (2368). The Scheme covers students of Class I-V in the Government Primary Schools / Primary Schools aided by Govt. and the Primary Schools run by local bodies. It has since been extended to cover all students upto Class VIII.

1.8.10 Foodgrains (wheat and rice) are supplied free of cost @ 100 gram per child per school day where cooked/processed hot meal is being served with a Minimum content of 300 calories and 8-12 gms of protein each day of school for a minimum of 200 days and 3 kgs per student per month for 9-11 months in a year, where foodgrains are distributed in raw form. In drought affected areas the mid day meal is distributed in summer vacations also.

1.8.11 States/UTs are required to make provision for minimum mandatory contribution towards cooking cost in their State/UT Budget 2008-09 separately for both primary & upper primary stages:as under: -

(a)	States in North Eastern Region	Minimum of 20 paise per child per day
(b)	For Other States & UTs	Minimum of 50 paise per child per day

As per MDM Guidelines 2006, the States/UTs shall not reduce their own budgetary allocation for MDM programme in any year below the level of BE 2005-06. Further, States/UTs have to make corresponding provision in their respective Budgets for utilization of Central Assistance towards (a) Management, Monitoring and Evaluation Cost (b) Transport Assistance (c) Construction of Kitchen Sheds-cum-Stores and (d) Procurement of Kitchen Devices.

Evaluation

1.8.12 Recently, there has been criticism from several quarters that number of children availing mid day meal as quoted by the States/UTs are not realistic. Questions are raised on the reliability of this number, which is a vital parameter for allocation/release of Central Assistance. In the case of several States, the number of children quoted by the States/UTs while seeking Central Assistance is higher than the population of children in the relevant age group.

1.9 Social Security Schemes

1.9.1 The "National Social Assistance Programme" was the first social security scheme introduced in India in 1995 and represented a significant step towards fulfillment of Directive Principles in Articles 41 and 42 of the Constitution. It introduced a national policy for social assistance benefit to poor households in case of old age, death of primary bread winner and maternity. The programme comprises three schemes, National Old Age Pension Scheme, National Family Benefit Scheme and National Maternity Benefit Scheme.

National Old Age Pension Scheme

1.9.2 Under this scheme, the benefit available is Rs.400/- per month for persons above the age of 65 years and having an annual income not exceed Rs.11,000/- per annum. Income and residence certificate for the purpose is issued by the Tahsildar and veracity of particulars furnished is to be obtained from MP/MLA/ Gazetted Officers.

1.9.3 A major constraint of this scheme is that the selection of beneficiaries is periodical and depends on the number of deaths and vacancies which cannot be assessed accurately and on availability of funds.

National Family Benefit Scheme (NFBS)

1.9.3 Under this scheme, the surviving head of a house is entitled to some monetary assistance in case of death of the primary breadwinner due to natural or accidental cause subject to the conditions that the death of such primary breadwinner occurs while he or she is more than 18 years and less than 65 years of age and whose earnings contribute substantially to the household income and the bereaved household qualifies as one below the poverty line according to the

criteria prescribed by the Government of India. The amount of benefit under the scheme is Rs. 10,000/-.

National Maternal Benefit Scheme

1.9.4 National Maternity Benefit Scheme is a Social Assistance Scheme meant for providing some financial assistance to a pregnant woman of a BPL household. To be eligible for assistance the woman should be a permanent resident of a village and belong to a BPL category. The benefit is available only during her 1st and 2nd pregnancy and one can apply during 8 - 9 months pregnancy only.

1.9.5 Under this scheme, rural women below poverty line would get Rs. 500 at the time of delivery. In case the delivery is conducted at the Health Centre, an additional financial assistance of Rs. 200 would be given. In case she undergoes laproscopy or tubectomy, soon after, Rs. 150 would be provided under the family planning scheme.

Evaluation

1.9.6 The amount under NMBS is too meager to really make any meaningful difference. In large number of cases, the beneficiaries spend the amount for food consumption of the family. Majority of women do not use the amount for the required purposes. Studies from Bihar and Jharkhand reveal that 72% of beneficiaries had paid speed money, of which 85% of such payment ranged between less than Rs. 51 to Rs.200. Another notable feature brought out was that in all cases the speed money was paid to block level functionaries and middlemen and in no case was paid to panchayat functionaries.

1.9.7 The evaluation suggested that (a) assistance should be given in two parts, 50% in pre-natal period and 50% in post-natal period, (b) higher post-natal assistance be given in case of female child. (c) amount be given through account payee cheque to avoid corruption ant to ensure proper utilization.

Social Security Scheme for Unorganised Sector Workers

1.9.8 This is a fully funded scheme managed by the Employees Provident Fund Organisation with its post BPR countrywide information and communication technology. Initially, the scheme will be implemented on a pilot basis for 25 lakh workers in 50 districts of the country for two years and will be jointly reviewed by the Ministries of Finance and Labour. The basic features of the scheme are as follows:

- It will cover the workers in the unorganised sector drawing pay/wages/income not more than Rs. 6500/- per month. All eligible workers in the age group of 36-50 have an option to join the scheme within five years from the date of commencement of the scheme provided they have identifiable employers and they too pay the contribution.
- Self-employed workers may also join this scheme provided they pay employers' contribution also.
- A Fund will be created out of the contributions at a rate of Rs.50/- per-month by every worker Rs.100 in case age group 36-50. Employer will also pay a like amount. However, self-employed persons and workers with no identifiable employer shall pay a minimum contribution of Rs100/- per month.
- The Central Government shall contribute at the rate of 1.16 per cent of monthly wages of enrolled workers taking as base the average national floor wage as notified by the Central Government from time to time.

1.9.9 The scheme provides triple benefits to the workers comprising

(I) A Pension Scheme with a minimum pension @Rs.500/- per month at the age of 60 years or permanent /total disablement and family pension in case of the death of the worker with a provision for enhanced or reduced pension based on the contribution;

(ii) A Personal Accidental Insurance cover of Rs. 1 lakh; and pension from the time of attaining the age of 60 years. In case of accidental death of the worker the widow is entitled to payment under accident insurance of Rs. 1 lakh and to pension on her attaining the age of sixty years.

(iii) Medical Insurance Coverage under the Universal Health Insurance Scheme (UHIS) for a family of five including member, providing for reimbursement of hospitalization expenses upto Rs. 30,000/- in a year and, a compensation of Rs. 50/- per day upto a maximum of 15 days in case of earning head of the family is hospitalized due to accident/ illness and coverage of death of the earning head of the family due to accident of Rs. 25,000/-.

2. Health

2.1 Impressive Record

2.1.1. Over the past six decades, India recorded impressive achievements in the health sector. Smallpox and Guinea Worm have been eradicated from the country; Polio is on the verge of being eradicated; Leprosy, Kala Azar and Filariasis can be expected to be eliminated in the foreseeable future. There has been a substantial drop in the Total Fertility Rate and Infant Mortality Rate. The successes of the initiatives taken in the public health field are reflected in the progressive improvement of many demographic /epidemiological infrastructural indicators over time.

This improvement in health indicators is the outcome of specific health initiatives as well as other complementary initiatives in the developmental sector. One of the happy features of health care in modern world is that mankind is getting ever closer to full potential in terms of health, quality of life and life span. Most of preventable disease and avoidable suffering can now be eliminated or controlled. Health technologies can be transplanted with relative ease even on otherwise underdeveloped societies. Most effective health interventions are relatively inexpensive and can be widely applied to large masses of people. Modern communications revolution too makes it easy to generate demand for better health, and disseminate information on healthy practices. The real challenge is one of creating and sustaining viable, effective and responsive health delivery systems.

Achievements in Health Sector - 1951-2000

Indicators	1951	1981	2000
Life Expectancy	36.7	54	64.6(RGI)
Crude Birth Rate	40.8	33.9(SRS)	26.1(99 SRS)
Crude Death Rate	25	12.5(SRS)	8.7(99 SRS)
Infant Mortality Rate	146	110	70 (99 SRS)
Epidemiological Shifts			
Malaria (cases in million)	75	2.7	2.2
Leprosy cases per 10,000 population	38.1	57.3	3.74
Small Pox (no. of cases)	>44,887	Eradicated	
Guinea worm (no. of cases)		>39,792	Eradicated
Polio		29709	265

(Source: National Health Policy – 2002)

2.1.2. India enjoys a somewhat privileged position among developing countries though our level of health is still well below many other societies. We have impressive technical capabilities and manpower availability compared to most poor countries. We have over half a million trained allopathic physicians. This is considered more than adequate for our current economic status. In fact Sri Lanka, which is ranked higher than India in HDI, and whose health indicators are far superior to ours in many respects, has only 36 physicians per 100,000 population.

2.1.3 Similarly, India has impressive health research capability with goof infrastructure, manpower and capability for quality research.

2.1.4 Yet another advantage is the impressive pharmaceutical industry in India which makes us largely self reliant in drug production. Our industry has the resilience, skills and capability to serve our needs at reasonable costs.

2.1.5 Finally, the diagnostic and therapeutic skills of Indian medical manpower are second to none. The cost of sophisticated medical and surgical interventions in India is only a fraction of that in the developed countries, while our safety and success rates are comparable with the best in the world.

2.1.6 These are impressive achievements for an otherwise poor country with relatively low level of human development. We need to build on these strengths and capabilities while devising and implementing effective strategies for ensuring a healthy future for all our citizens.

2.2 Economic Growth and Health

2.2.1 That economic prosperity and the state of health of a community go together is a self-evident proposition. As access to safe drinking water and sanitation improves, most of the water-borne diseases disappear. With education come health awareness and skills to combat disease. And as more resources are devoted to public health, there is better immunization coverage, and greater access to primary and secondary health care. Much of health improvement witnessed in India too followed the same pattern.

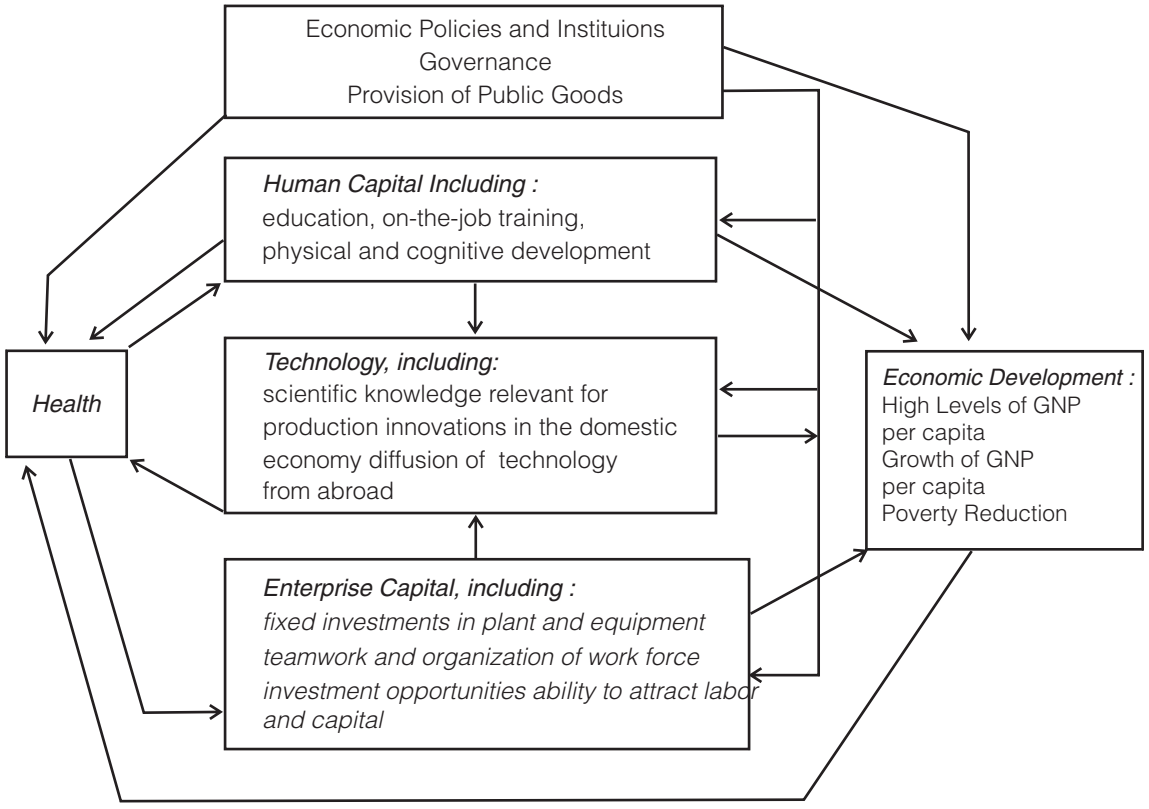
2.2.2 However, the relationship between economy and health is not a one-way street. Just as prosperity improves health, better health promotes economic growth. High incidence of disease forces a society to spend disproportionate sums of money on health care, starving other critical sectors. The lessons of the past six decades are clear. Human development is the precondition for prosperity. In the 50's, wide prevalence of malaria in Punjab meant that there were not enough workers on the farms. Sickness obviously reduces productivity. Once malaria was brought under control, farm productivity went up. Health improvement was one of the significant factors behind the green revolution. At the level of the individual and family, the impact of poor health on economic well-being is even more pronounced.

2.2.3. Sickness forces poor families to sell their precious, and often productive, assets to pay for medical care. Poor families in India spend 7 to 8 percent of their annual household income on health care. World Bank studies show that hospitalized Indians spend 60 percent of their total annual expenditure on medical care, and a large share of this comes from borrowed funds. Sickness is thus one of the biggest contributors to impoverishment and indebtedness. When infant mortality is high, parents tend to have more children, as they do not expect all children to survive. The resultant population growth and consequent pressures on scarce resources and limited opportunities are only too evident in India. According to one estimate, malarial countries would be twice as prosperous today if the disease had never existed.

2.2.4. The Commission on Macroeconomics and Health, chaired by Jeffrey Sachs in its report has succinctly summed up the interrelation between health and economic development:

2.2.5. "Because disease weighs so heavily on economic development, investing in health is an important component of an overall development strategy. This is especially true in poor countries where the burden of disease is very high. But investments in health work best as part of a sound over-all development strategy. Economic growth requires not only healthy individuals but also education, and other complementary investments, an appropriate division of labor between the public and private sectors, well-functioning markets, good governance, and institutional arrangements that foster technological advance. Private sector–led growth in the business sector must be complemented by an active role of government in several areas: ensuring core investments in health and education, guaranteeing the rule of law, protecting the physical environment, and working in cooperation with the private sector to foster scientific and technological advance. We are not claiming that investments in health can solve development problems, but rather that investments in health should be a central part of an overall development and poverty reduction strategy."

Health as an Input into Economic Development



(Source: Macroeconomics and Health for Economic Development, Report of The Commission on Economics and Health, World Health Organisation, 2001. p.26)

2.3 Efficiency of Health Expenditure

2.3.1 However, the relationship between economic condition and the health of a community is not always straight-forward. Kerala, Sri Lanka and Malaysia, showed significant improvement in health indicators even by 1980, despite relatively low levels of prosperity. Similarly, China and many communist countries showed health improvements faster than economic growth. Even relatively low levels of health expenditure can yield high returns in terms of health.

2.3.2 The total health expenditure (public and private) in India (at 6% of GDP according to World Development Report, 1993; 5.2% of GDP according to National Health Policy, 2002) is higher than expenditures in China, Sri Lanka and Indonesia in per capita terms. And yet, each of these countries is ranked higher than India in health terms, as measured by Disability Adjusted Life Expectancy (DALE). Clearly, higher per capita income and high expenditures do not ensure better health. Conversely, lower expenditure on health can yield better results if the resources are utilized wisely.

2.3.3 Significant improvements in health can result by merely changing the pattern of expenditure, with little or no addition of resources. This was dramatically illustrated by the Tanzania Essential Health Interventions Project (TEHIP) in two rural districts. Five years ago, the annual health spending in Tanzania was about $ 8 per head. An additional $2 per capita was infused through TEHIP, on condition that it was spent rationally, the amount of money spent battling a particular disease reflecting the burden of that disease imposed on the local population. Researchers found

that in TEHIP area, "the amount the local health authorities spent on each disease bore no relation whatsoever to the harm which the disease inflicted on local people". Some diseases were neglected. Malaria, which accounted for 30% of the years lost, received only 5% of the 1996 health budget. A cluster of childhood problems, including pneumonia, diarrhoea, malnutrition, measles and malaria, constituted 28% of the disease burden, but received only 13% of the budget. Other conditions attracted more than deserved attention. Tuberculosis, which accounted for less than 4% of the years of the life lost, received 22% of the budget.

2.3.4 With the infusion of additional $2 per head, the health authorities could redirect spending to reflect the disease burden, without trimming any successful programmes.

2.3.5 This tiny cash infusion smoothed the transition to a more effective approach to health care. Health workers, mostly nurses or paramedics rather than doctors, were given a simple algorithm to show how to treat common symptoms. For example, if a child arrives coughing, and with a running nose and a hot brow, the nurse is instructed to work through a checklist of other symptoms to determine whether it is merely a cold or something worse. If the child is breathing more than 50 times a minute, for example, he is assumed to have pneumonia, given an antibiotic and checked again after two days.

2.3.6 In most cases, the cheapest treatments are offered first. Children with diarrhoea are given oral rehydration salts, which cost a few cents. If the salts don't work, the child is referred to a clinic and put on a drip. For malnutrition, the first treatment offered is advice on breast-feeding. When this is not enough, cheap vitamin-A pills are prescribed. AIDS is tackled through education, condoms and antibiotics to heal open sores caused by other venereal diseases, which present the virus with an open door into a new bloodstream.

2.3.7 Perhaps most importantly, Health centres in Morogoro encourage people to use bednets impregnated with insecticide, which bash mosquitoes in several ways. If the bug hits the mesh, it dies. If it merely flies close to the bednet, it feels dizzy, and either falls to earth, where it is eaten by ants, or buzzes off to rest and recuperate, which means that it will bite no one that night. A bednet's mosquito-repelling effect stretches for 500m in all directions, so netless villagers gain some protection from their better-equipped neighbours.

2.3.8 The results of all this were stunning. Infant mortality fell by 28%, from 100 deaths per 1,000 live births to 72. The proportion of children dying before their fifth birthdays dropped by 14%, from 140 per 1,000 to 120. In nearby districts, and in Tanzania as a whole, there was no evidence of a similar improvement over the same period.

2.4 Health Financing System and Inequity

2.4.1 There is ample evidence of inequitable access and delivery of health services in India. The poor suffer greater burden of disease than the well off. Worse still, the poor end up paying more and suffering more for the same affliction in most cases, because of poor access and indifferent delivery. The lost time and productivity have often a devastating impact on the lives of the poor, leading to impoverishment and indebtedness.

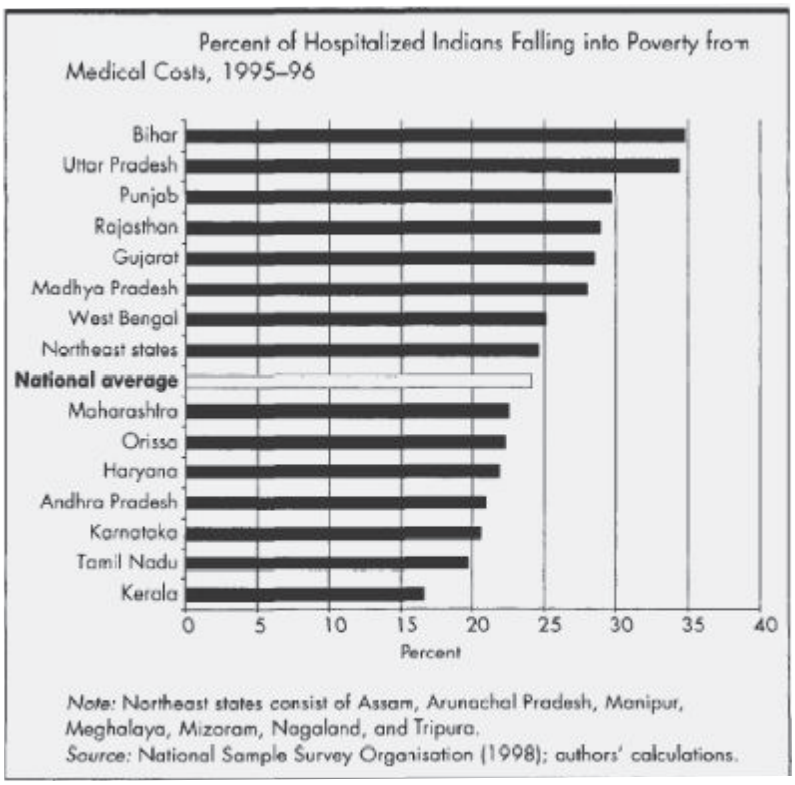
2.4.2 NHP – 2002 admits that while the public health investment in the country over the years has been comparatively low, as a percentage of GDP it has declined further from 1.3 percent in 1990 to 0.9 percent in 1999. Out of this, about 17 percent of the aggregate expenditure is public health spending, most of the balance being out-of-pocket expenditure. This declining public spending on health (less than 1 percent of GDP) places India in the bottom 20 percent of countries.

2.4.3 India spends where current levels are far below what is needed to provide basic health care to the population. The bulk of public spending on primary health care has been spread too thinly to be fully effective, while the referral linkages to secondary care have also suffered. Preventive health services take a back seat to curative care."

2.4.4. According to NHP-2002, the central budgetary allocation for health over the period 1990 – 99 has been stagnant at 1.3% of the total budget. At the same time the fiscal pressures led to a reduction of

States' public health expenditure from 7 percent to 5.5 percent. The current annual per capita public health expenditure in India is around Rs. 200. Of this, about 15 percent is contributed by the Union government.

2.4.5 The high reliance on private, out-of-pocket payments in health in India impose a disproportionate burden on the poor. The poorest 20 percent Indians, for example, have more than double the mortality rates, malnutrition, and fertility of the richest quintile. The only countries with higher proportions of private payment on health than India are countries that have undergone civil conflict and collapse of the public sector, like Georgia, Cambodia, Myanmar and Afghanistan. As a result, "India's current health financing system places people at risk of financial ruin should they become sick, and is inefficient and inequitable."



2.4.6 While the States share 75 – 90 percent of public health expenditure, most of these funds are tied up in salaries, leaving few resources for essential drugs, supplies, operations and maintenance 97 percent of all public expenditure is for consumption purposes, and only 3 percent for capital expenditure. 60 percent goes in wages and salaries and only 35 percent for material and supplies, drugs, and transport. Out of the limited public health budget, curative services including hospitals and dispensaries, insurance schemes, and medical education and training account for 60 percent, leaving only 26 percent for public health and family welfare, and 14 percent for administration and miscellaneous services.

2.4.7 Curative public services largely favour the rich, with Rs 3 spent on the richest quintile for every Rs 1 spent on the poorest 20 percent.

2.4.8 As nearly all the private spending is out-of-pocket, the poor are highly vulnerable to health risks. The poor generally avoid hospitalization because of their inability to pay and lack of risk pooling. Hospitalization frequently means financial disaster. As the World Bank document shows :

Only 10 percent of Indians have some form of insurance, and most of this is inadequate. Hospitalized Indians spent more than half (58%) of their total annual expenditure on health care. More than 40 percent of those hospitalized borrow money or sell assets to cover expenses. At least one quarter of hospitalized Indians fall below poverty line because of hospital expenses

2.4.9 Evidence from NSS surveys shows that the private sector accounts for most of the curative services. However, the poor still depend on the public sector for most health services, except out-patient care. 81 percent of out-patient care is provided by private sector. In the inpatient care too, the share of public sector has fallen from 60 percent in 1986 – 87 to around 45 percent in 1995-96.

Public- Private sector use for patient care- All India

(percentage distribution)

	Rural		Urban	
	1986 - 87	1995 - 96	1986 - 87	1995 - 96
Out-patient care				
Public sector	25.6	19.0	27.2	19.0
Private sector	74.5	80.0	72.9	81.0
In-patient care				
Share of public sector	59.5	45.2	60.3	43.1
Share of private sector	40.3	54.7	39.7	56.9

2.4.10 Yet another well-known inequity in health sector is that rural areas with 73 percent of the population account for only 33 percent of government health resources. Urban population has thus received more than 5 times what the rural population received in per capita terms. Consequently, the attainment of health indices has been very uneven across the rural-urban divide.

2.4.11 Equally glaring, the health expenditure and quality of services is highly variable across the states. While costs of family planning, maternal and child health care, and immunization are almost entirely borne by the Union government, health expenditure on hospitals, primary health care facilities and insurance are mostly financed from the States' budgets. As the per capita State Domestic Product varies significantly (Maharashtra enjoys 3.4 times that of Bihar), the annual per capita expenditure on public health too varies widely. The central funds too are transferred not on the basis of the needs of individual states, but often uniformly on population basis, and sometimes on 50-50 cost sharing basis (eg. Malaria eradication). These factors, coupled with the historical development patterns over the decades and their cumulative impact make it necessary to recognize the need for different approaches in different states. World Bank classified the states into four categories based on the stage of health transition and institutional capacity.

Major Indian States : Stage of Health Transition and Institutional Capacity

Stage of Transition Degree of Capacity	States	India's Population (percent)
Middle to late transition moderate to high capacity	Kerala, Tamil Nadu	9.1
Early to middle transition, low to moderate capacity	Maharashtra, Karnataka, Punjab, West Bengal, Andhra Pradesh, Gujarat, Haryana	39.1
Very early transition, very low to low capacity	Orissa, Rajasthan, Madhya Pradesh, Uttar Pradesh	33.1
Special cases : instability, high to very high mortality, civil conflict, poor governance	Assam, Bihar	13.3

2.4.12 All the evidence thus shows that higher and better-directed public expenditure is a necessary prerequisite for significant health improvements. In India, the share of public health expenditure is 1.3 percent of the central budget and 5.5 percent of state's budgets. The weighted average is probably close to 3 percent of the total government expenditure,

2.5 Our Strengths and Opportunities

2.5.1 Despite the low level of health of the community, India has several strengths on which we can build a healthy future.

- We have a fairly large, highly skilled health manpower. This manpower structure is skewed - there are fewer nurses and paramedics than necessary.
- We have significant research capability to address our own health problems.
- There is an impressive and growing hospital infrastructure with high level of capability for sophisticated medical interventions. The cost of many diagnostic, therapeutic and surgical procedures is only a fraction of that in the advanced countries.
- The pharmaceutical industry is mature and sophisticated, and has the capacity to produce drugs to meet our requirement at a relatively affordable cost.
- Democratic system, free media and vigorous public discourse offer us priceless opportunities to influence public policy.
- With improved literacy, modest rise in incomes, and rapid spread of satellite television, there is greater awareness and increasing demand for better health services.
- The high proportion of private, out-of-pocket health expenditure (80%) indicates that even the poor, are willing to pay for better health services.
- While rapid growth of population has posed a formidable challenge to our health care and development efforts, recent breakthroughs in the major states of Tamil Nadu and Andhra Pradesh, and to an extent Karnataka raise realistic hopes of combating population growth effectively in a reasonably short time span.
- India has demonstrated the capacity to launch military-style campaigns with wide reach and efficacy. Successful population control measures in A.P despite low level of literacy and other social indicators is a good illustration of the efficacy of the mass campaigns to achieve select goals. Similarly the recent national drive to administer oral polio vaccine to all vulnerable children has been very effective, and polio is on the verge of being eradicated. These successes indicate that select campaigns can be launched against dreaded diseases, and to contain population growth.
- There is a wide network of semi-qualified private medical practitioners who are often the first point of contact for most rural patients. Estimates indicate that about 500,000 such rural practitioners exist. While they are often untrained, there is a vast potential to involve them in effective health care delivery through imaginative partnerships.

2.6 Challenges of the Future

2.6.1 **Preventive Vaccination:** The levels of immunization of children and pregnant mothers against preventable diseases for which effective and inexpensive vaccines are available are still unsatisfactory. (T.B: 68 %; Measles: 50 %; DPT: 70 %). Only about a third of the children are fully protected against common preventable diseases. This is clearly the first, relatively simple and easy challenge we have to confront. The campaign mode with effective primary health services would be able to expand immunization coverage to all children.

2.6.2 Prevention and early treatment of major infectious diseases: There are four major preventable infectious diseases that cause significant morbidity and mortality - Malaria, Tuberculosis, HIV/AIDS and Rheumatic Heart Disease.

- There is evidence to suggest that malaria is under reported. Human Development Report 2002 reports only 193 cases of malaria per 100,000 population. In contrast, Sri Lanka, which has a

much higher level of health and human development reports 1,111 cases of malaria per 100,000 population. The ubiquitous swarms of mosquitoes and anecdotal evidence from physicians suggest that malaria is far more prevalent than is reported. Reports suggest that nearly 50% of malaria in recent times is caused by the dangerous plasmodium falsiparum. Also in pockets of east and northeast India there are reports of chloroquin-resistant malaria. Serious public health efforts to control mosquito and malaria, and accelerated research to develop and popularize the anti-malarial vaccine are of great importance to the future of public health in India.

- Tuberculosis remains a major challenge, and India is host to the largest number of cases in the world. The recent multi-drug therapy has been quite effective, and there are signs of significant improvement. But opportunistic infections on account of immunity suppression in AIDS patients are on the rise and pose a grave challenge. Drug resistance has also been a major threat for long.
- HIV/AIDS is spreading rapidly, and nearly 0.8 percent of all adults between 15 and 49 are believed to have been infected by HIV. Given the obvious dangers, prohibitively costly treatment after infection, and social disruption on account of widespread AIDS, the current campaign needs to be stepped up. The recent successes in Tamil Nadu in AIDS education and prevention are a valuable model for replication.
- Rheumatic Heart Disease (RHD) is one of the easily preventable, but widely prevalent major health problems in India. Studies in Kanpur and else where indicate that about 4 to 5 cases of RHD are prevalent among 1000 school children. This is an unacceptably high incidence of a disease caused by simple, preventable or easily curable streptococcal throat infection in children between the ages of 5 and 15. Primary prevention (prompt antibiotic treatment of sore throats in children) and secondary prevention (prolonged and sustained long acting antibiotic therapy in children with rheumatic fever) are very effective and relatively inexpensive. Untreated RHD leads to damage to heart valves, and needs expensive surgery which may not always be effective.

2.6.3 **Preventable Blindness:** An estimated 10 million people suffer from preventable blindness in India. Most of them are on account of deficiency of Vitamin A, which can be supplemented very cheaply. Similarly simple, easily treatable infectious like Trachoma contribute significantly to blindness. Glaucoma is another silent and common cause of blindness which can be easily prevented by early detection and treatment. Special efforts including massive public education and expansion of access to eye care facilities are vital to prevent blindness.

2.6.4 **Population Control:** The states of Kerala, Goa and Tamil Nadu have achieved impressive levels of performance, and are already at stable population level. Andhra Pradesh, Karnataka, Himachal Pradesh and Punjab too achieved a satisfactory couple protection rate and will soon reach stable population level. While Total Fertility Rate has declined from 3.4 in 1993 to 2.9 children (NFHS-2) in 1999, it is still well above the replacement level of just over two children per woman. The states of Uttar Pradesh, Rajasthan and Madhya Pradesh have fertility rates of 3.3 or more children. As they constitute about 40 percent of India's population, special efforts are required in these populous states to bring population to stable levels. About 40 percent births in these states are fourth or higher-order births compared with 7 - 9 percent in Kerala, Goa and Tamil Nadu. There are thus large variations in fertility and family planning practices. The experience of the southern states, particularly Andhra Pradesh, show that improved access to family planning services, massive campaigns, public education, and political will can reduce fertility levels significantly even with relatively low literacy levels. The Kerala and Tamil Nadu model of high literacy, better health care and improved social indicators is obviously the ideal mode of population control.

2.6.5. **Increased Public Health Expenditure:** National Health Policy - 2002 set the goal of increasing public health expenditure from 0.9 percent of GDP to 2 percent GDP by 2010. The state sector health spending is proposed to be increased from 5.5 percent (of total budget) to 7 percent by 2005, and 8 percent by 2010. This means the Union expenditure, which is at 1.3 percent of the budget should be between 7 and 8 percent in order to reach the public health expenditure target of 2 percent of GDP.

However, increase in expenditure must be accompanied by better utilization of resources, with emphasis on preventive and primary health so that the benefits reach the poor and needy, and we get best value for the money spent.

2.6.6 **Sanitation:** It is well recognized that drinking water and sanitation are two vital requirements to good health. Governments have been paying serious attention to drinking water problem, and 88 percent of Indians have access to improved water sources. But the condition of sanitation is appalling, and only 31 percent have access to a safe, hygienic toilet. 69 percent of Indians are forced to defecate in public, with grievous consequences to health, hygiene and human dignity. No serious efforts are made to combat this problem, which particularly causes severe inconvenience to women, children, the aged and the disabled. The cost of a modern, scientifically designed, hygienic toilet is no more than Rs 3000. Sulabh International and many other organizations demonstrated the efficacy of low-cost household toilets. The problem is one of ignorance, habit, poverty and unavailability of the material to build the toilet. Habits change with time and persuasion, and people always prefer better lifestyles. Ignorance can be overcome by a massive public education campaign. Government needs to come forward with a programme for toilet for every household.

2.6.7 **Accountability:** The greatest challenge in our health services is enforcement of accountability. While the health infrastructure is inadequate and there is shortage of personnel, even what is available is not put to good use. Inadequate access and poor usage indicate a high level of mistrust and generally unsatisfactory performance of the public health care delivery system. In public health, the problems are corruption, neglect, lack of community participation and ownership, and ineffective monitoring. We need to evolve participative models of management, with local governments having substantial say in managing primary health care and the first tier of hospital care (Rural and Community hospitals). People value health even more than education because the returns are immediate and the suffering is felt intensely. Therefore local political control can significantly improve the quality of services and accountability.

2.6.8 **Financing Mechanisms:** As we have seen, over 80 percent of health expenditure is in private sector, and almost all of it is out-of-pocket expense. 60 percent of annual income is spent on medical care in cases of hospitalization, forcing many people into poverty. There is no risk pooling, and for most of the poor and low or middle-income people sickness means financial catastrophe. While public expenditure, which is at a low level of 0.9 percent of GDP, needs to be enhanced to 2 percent, most health expenditure will continue to be private. Therefore innovative, effective and equitable ways of health financing need to be evolved. Collection of user fees in public hospitals will augment resources, give ownership to people, improve accountability, and enhance demand for better standards and quality of care. Once the paying patients demand better quality, the non-paying poor will also benefit from improved health care. In order to give ownership, even the poor can be charged a nominal user fee.

2.6.9 Health insurance so far has been ineffective in India. In general, insurance coverage is available to only organised sector employees, and a small number of high-income persons. The Central Government Health Scheme (CGHS) covers 4.5 million families (20 millions persons), and the statutory Employee State Insurance Scheme (ESIS) covers 6.6 million families (29 million persons). Both CGHS and ESIS are publicly managed, and are severely criticized for their sloth, incompetence, inadequacy and corruption.

2.6.10 The real challenge however is in respect of the families of the workers in unorganized sector, and unemployed and indigent persons. These categories probably cover 90 percent of the population. About 10 – 15 percent of them are self-employed and can be eventually covered by health insurance schemes. At present such coverage extends to a very small number of persons, but it is reasonable to expect insurance to be expanded to cover all those who can afford to pay premiums out-of-pocket. That still leaves the unorganized and poor who are unlikely to benefit from centrally organized health insurance services. And yet they are most in need of risk pooling and health coverage.

2.6.11 Innovative, decentralized, community managed health care programmes, local risk pooling,

and effective and accessible public health services and public-private partnership are the only viable solution for the bulk of Indians. There are many local innovations which a, substantial provisioning has to be made by the state to support these community based primary and hospital care services.

2.6.12 **Alternative Systems:** India has a large number of trained and untrained practitioners of Homeopathy and weaknesses of various systems of medicine brings us to the inescapable conclusion that these are not alternatives to each other, but have a complementary role to play in promoting the health of the community.

2.6.13 There is a broad spectrum of disease that cannot be combated by western medicine any better than other systems. Many life style diseases including migraine, backaches, diabetes and hypertension, several neurological disorders, allergies, degenerative disorders like arthritis and several psychosomatic and mental illnesses can probably be managed better by changes in diet and other systems of medicine.

2.6.14 **Unqualified Private Medical Practitioners (PMPs):** There are about 500,000 PMPs working mostly in rural areas, often serving as the first point of contact to patients. Many of them have some exposure to simple diagnostic tools and drugs. The attitude of the medical establishment so far has been to either ignore them, or treat them as pariahs and use the instrument of law to prevent their practice. Banning of such practice has not worked. There is need to find innovative ways of integrating the better skilled and genuine, though formally unqualified, practitioners into our health care system. For instance, all such persons with some experience of working with a qualified medical practitioner can be given a test. Those who clear the test can be given a certificate and allowed to practice as village health workers with a clearly defined mandate. Their licenses can be renewed every three years subject to successful participation in refresher courses conducted by approved agencies. Such courses can be self-financing as the village health workers have both licensing and professional and financial incentives in acquiring knowledge and skills.

2.6.15 **Regional Inequalities:** As pointed out earlier, within the country there are glaring disparities in health status and fertility levels. These disparities exist between social groups (upper castes vs. dalits), economic classes (rich vs. poor), habitats (urban vs. rural) and regions (Kerala vs. Bihar).

2.6.16 Region-specific and sometimes group-specific models are required to overcome these disparities and provide satisfactory health care to the whole community. While the best standards may not be accessible to all, the minimum acceptable levels of health should be regarded as the entitlements of every citizen, irrespective of birth and economic or social status. Such healthcare systems should also take into account local food habits, natural resources, cultural practices and social customs (eg: consanguinous marriages). Effective public education, counselling, replacement therapies and treatments should be standardized to suit the requirement of each region and group. Development of these protocols is primarily the responsibility of the public health system, and private health care sector will follow the standards set by the state. Public health budgets too should reflect the local needs, instead of allocations being made on per-capita basis.

2.7 Successful and Replicable Innovations

2.7.1 In the ultimate analysis there are four critical issues of health care confronting us:

a) How do we involve the community in rural health care delivery and provide effective, responsive, acceptable, good quality care at low cost?

b) How can we provide effective, responsive, good quality family care to urban populations at affordable cost?

c) How do we promote public–private partnerships for promoting the health care goals?

d) How can sophisticated, high quality, specialist care be made accessible to all those in need of it? Can the poor get the same standard of care without having to pay economic costs?

2.7.2 The future of health care delivery in India largely depends on the answers to these questions. In our present health care system, the poor are largely left out because of poor accessibility and low quality of public health services and the unaffordable cost of private health services. Clearly far- reaching reforms

are needed to set right the situation, and build an equitable, efficient and responsive health care delivery system. Such reforms will need resources, but the failure to reform will impose far greater burdens on society. Happily, the experience all over the world and in India shows that if health care systems are sensibly designed, the costs can be kept at reasonable levels.

2.7.3 In addition, in India we must take into account the demographic and health transition. As population growth is slowing and average life span increasing, the burden of disease is undergoing slow changes. Similarly as more and more infections are controlled, and as prosperity increases, life-style diseases are becoming more important. Health financing and delivery systems should adapt to these shifts. While the state's role in primary health care, policy, planning, monitoring, training, setting standards and information systems is critical, the government should acquire the capacity to harness the skills and energy of private sector, while checking its excesses.

2.7.4 Happily there are many successful and sustainable innovations in health sector. Indian governance system has not always exhibited the capacity for replication of such best practices. And yet many successful innovations are amenable to institutionalization and replication. Health care is a politically and socially sensitive issue; people respond positively to responsive and efficient systems, since the results are felt and appreciated almost instantly. This is the great difference between education, which has long gestation and requires high motivation, and health care, whose benefits can be reaped instantly and there is great incentive to sustain good health care systems. Four successful and sustainable innovations are presented below as brief case studies. They offer tremendous scope for replication and large-scale application, and can provide solutions to many of our dilemmas.

I. Comprehensive Rural Health Care Project, Jamkhed

II. Voluntary Health Services, Chennai

III. Tuberculosis Control – Public –Private partnership, Hyderabad

IV. LV Prasad Eye Institute, Hyderabad

I. Comprehensive Rural Health Care Project (CRHP) – Jamkhed

2.7.5 The most pioneering and successful rural health care model in India has been that of Dr Arole in Jamkhed, Maharashtra. Drs. Raj and Mabelle Arole, started the CHRP in 1970 with the realization that the western style of curative and clinic based medicine doesn't serve the needs of the rural poor. Their deep insights into the health problems of the rural poor convinced them that what is needed is a community based primary health care model, with emphasis on gender equity, backed up with a first class referral hospital.

2.7.6 They understood that the majority of health problems in rural areas are simple, preventable and amenable to health detection and these problems can become worse and may even cause death if not identified and treated at the onset. CRHP was started to provide health care to rural communities, keeping in mind the realities described above. It developed a comprehensive, community-based primary health care (CBPHC) approach. CRHP is located at Jamkhed, which is far away from a city and is typically rural, drought-prone and poverty stricken.

2.7.7 The project began with a view to develop a health care delivery programme best suited to the needs and resources of this rural area. With the active involvement of the community the following priorities for health care and integrated rural development are identified:

A. Health Care Priorities

1. Simple symptomatic primary care available in the individual village at all times.
2. Care of pregnant and lactating mothers and deliveries.
3. Care of pre-school children (Nutrition, Immunisation and Treatment of simple illnesses)
4. Family planning (Health education, Availability of all supplies at local levels and Sterilisation facilities at the base hospital)
5. Control of chronic illnesses such as Leprosy, Tuberculosis (Early identification, Regular treatment and Rehabilitation at village level)

6. Prevention of Blindness (Nutrition, Infection and eye injuries, Surgery for cataracts, glaucoma, etc.)

B. Integrated Rural Development

1 Animal health care
2 Income generation programmes, especially for women
3 Watershed development
4 Ensuring clean environment, safe drinking water and sanitation
5 Non-formal education
6 Alternate energy
7 Afforestation

2.7.8 In order to achieve effective health care, the project works at three different but interrelated levels:

1- Community – Village Health Worker (VHW) supported by Farmers' Clubs and Women's Clubs
2- Mobile health and development team
3- Hospital and training centre

1) Community – Village Health Worker. In every village a local woman is selected and given training as a VHW. She is trained to be the person of first contact for the community for all health related issues. The VHW is trained in all the basics of preventive and primary health care including family planning and pre natal care and is accessible to the community at all times. 80% of the health problems are taken care of by the people themselves with the help of their VHW.

2) Mobile Team – This consists of a doctor, nurse, social worker and paramedical worker, and its purpose is to support the VHW and supervise development activities in the village, and to be the liaison between village and health centre. The team visits the different villages everyday in the morning and is in contact with the communities. Any problems needing solution beyond their level are referred to the centre.

3) Hospital and Training Centre – The hospital acts as referral for health problems that cannot be dealt with in the village. Only 20% of the patients are from the project villages, as most health problems are resolved at the community level.

2.7.9 Low-cost secondary care is practised. The hospital is simple in appearance and has modern diagnostic equipment, surgical facilities and inpatient beds for surgery, obstetrics, child health and other areas. It has a capacity to take care of 40 in-patients and has an average of 100-150 outpatients per day. There is a referral system for cases that cannot be handled there. Low cost is achieved by having a basic facility (building, furnishings, equipment and supplies), using effective but inexpensive medicines, and keeping costs down in surgery and other areas. The patients' relatives help the nurses in the care of the patients. Patients are charged basic fees for the services, in order to support the hospital as well as to avoid the problems that often arise with giving care free of charge.

2.7.10 The training centre provides basic training in knowledge, skills and personal development to VHWs and other villagers, as well as seminars on various topics, including health, agriculture, credit and loans, income-generating programmes, government schemes, watershed management. The role of this health centre is also to network with government and other agencies and to identify resources for training and community projects.

2.7.11 CRHP initially covered 8 villages. By 1980 it expanded rapidly to cover 70 villages with 100,000 population. By 1985, 250 villages in Karjat and Jamkhed talukas were covered, serving a population of 250,000 people. In another area, a six-hour drive from Jamkhed, CRHP works in a tribal area in the hills known as Bhandardara, with 30 villages with 50,000 population. Table 9 below gives a snapshot of major health indicators in the project area over the past 3 decades:

Cost of care

2.7.12 In discussion with the community, CRHP has set patient fees within the ability of the poorer sectors to pay. About 10 % of patients cannot pay for the services and the farmers' clubs/mahila vikas mandals identify such persons and work out ways of meeting the costs. Since 1989, CRHP has been gradually withdrawing, as many of the communities have become self-reliant. CRHP now remains as a networking organization, providing the secondary and tertiary support services whenever needed.

Year	1971	1976	1986	1993
Infant Mortality Rate	176	52	49	19
Crude Birth Rate	40	34	28	20
Children Under Five Immunization DPT & Polio	0.5%	81%	91%	92%
Malnutrition: Wt for age	40.0%	30%	5%	5%
Maternal Services	0.5%	80%	82%	96%
Prenatal Care Deliveries by trained attendants	<0.5%	74%	83%	98%
Couples practicing family planning	<0.1%	38%	60%	60%
Leprosy Prevalence(/1000)		2	1	0.1

Source: Comprehensive Rural Health Care Project (CRHP), Jamkhed

2.7.13 The Jamkhed model demonstrated that ensuring community participation, involvement of women and establishment of good referral system could enhance health indicators of a society significantly at a low and affordable cost. This is a replicable model with enormous implications for rural health care delivery all over India.

(II) Voluntary Health Services (VHS), Chennai

2.7.14 The Voluntary Health Services (VHS), Chennai, is a non-profit society providing comprehensive health care services to the residents of surrounding areas of Chennai. Primary health care is delivered through a number of Mini Health Centers (MHC), and more specialized care is available at the VHS hospital and Medical centre, which serves as a referral centre for the MHCs. The 14 MHCs of the VHS cover a population of around 100,000 serving the rural community of eastern parts of Kancheepuram District. Community participation is the nucleus of the project. Apart from enrolling families as subscriber to the plan, community participation is ensured in several ways such as

(a) Formation of local action committee consisting of local leaders, panchayat members, officials and other residents

(b) Making the community provide accommodation and minimum furniture free of cost for accommodating the Mini Health Centre

2.7.15 A Mini Health Centre is a unit catering to the health needs of 1000 families or 5000 population resident in a social area of rural or urban setting taking the family as a unit. The programme aims at rendering comprehensive, continuous, co-operative community care. Every type of preventive and curative services that can reasonably be expected to be done with minimum facilities as under, rendered by the Mini Health Centres:

(a) Maintenance of health records which include physical examination for each member of the family and preparation of "at risk register", nutritional assessment for every member in the family.

(b) Maternity services – The Multipurpose Health Worker Female and Public Health Nurse/Lady Health Visitor provide ante-natal, natal and post-natal services for pregnant women and side by side offer family planning advise to eligible couples. Each mother is visited approximately once a month during the period of pregnancy and lactation.

(c) Child Welfare Services – Maintenance of record of normal growth and development of child

Preventive services consisting of immunization procedures like Triple Antigen, Oral Polio on a priority basis and other when indicated.

Preventive procedures for nutritional diseases like vitamin deficiencies, calorie protein mal-nutrition, etc. is undertaken by giving nutritional supplements like Vitamin A concentrate and advice regarding the utilization of locally available foodstuffs.

(d) Family Welfare Planning advice is offered to all eligible couples as part of the package of services including the regular health care and preventive services depending upon the need and acceptability of the families.

(e) Medical Care – regular clinics are conducted for out patients for three hours a day for three days in a week by a qualified medical practitioner. The paramedical staff is available all days of the week. Medical care in this project is offered to attract the people so that then other preventive services can be pushed through more effectively.

2.7.16 Under the Mini Health Centre scheme there are four health posts manned by Lay First Aiders. The health posts function at the extreme periphery each post ideally serving a population of about a thousand; Health Posts are not required for the 1000 population immediately adjacent to the health centre.

2.7.17 The Lay first aider is envisaged to function as a first aider to the persons in the immediate neighbourhood and what is more important as a first informant of the happenings in the village to the health team. She also helps the health team on their periodic visits to the particular villages by rounding up the children in need of immunization, the pregnant women in need of antenatal care, the eligible couples for family planning and generally the person at risk. All the above categories of workers including the doctors must under go the prescribed taining and continuous in service training during their work at the VHS.

2.7.18 Financing Pattern of VHS: VHS believes that community members should actively participate in the provision of health care. VHS policy is the belief that health care is not a "free commodity"; consumers should pay for it, as they do for other essentials. The level of financial contribution is, however, dependent on the consumer's ability to pay. Poorer members of the community are expected to contribute a nominal sum towards costs; the higher the income of the consumer, the higher the contribution towards costs. The higher income groups are expected to pay more than the cost of the health care they receive, so that they subsidize the care poorer groups receive.

2.7.19 The actual out of pocket collections made from the patients are classified into 2 categories:

i. Medical Aid Plan (MAP)
ii. Service user charges

2.7.20 Medical Aid Plan: The MAP is a simple form of low cost health insurance. The annual premium per household is graded according to the joint monthly income. The income categorization and corresponding membership fees is as follows:

Medical Aid Plan for VHS

Monthly income (Rs.)	Annual fee (Rs.)	Plan Group
0-500	75	C1
501-1000	120	C2
1001-2500	150	C3
2501-3500	300	C4
3501-7000	500	C5
7000-10,000	600	C6
10,000 > above	700	C7

(Source: VHS, Chennai)

2.7.21 Membership to the scheme entitles all household members to a free annual health checkup and curative and diagnostic services are offered at a concessionary rate.

2.7.22 User Charges: Fees are levied for all direct personal services. There is a two-tier tariff schedule. First, charges are graded on the basis of membership to MAP scheme and second, according to income. There is hence, a sliding fee scale for both subscribers and non-subscribers of MAP.

2.7.23 In addition, VHS also operates several commercial schemes with the sole purpose of income generation for cross-subsidization purpose. VHS also receives support from the government of Tami Nadu and other multilateral funding agencies in addition to philanthropic contributions.

2.7.24 **Conclusion:** In VHS model there is active participation of the community in providing health services. Community is involved in determining the user fees that need to be levied for the health services provided. Cross subsidization of health care for poor takes place as the higher income groups pay more than the costs of health care they receive.

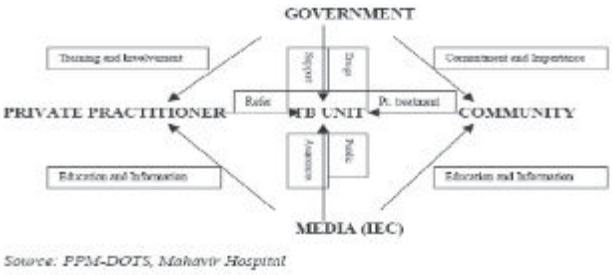
(III) Mahavir Hospital – Public-Private Mix model, Hyderabad

2.7.25 As part of the Revised National Tuberculosis Control Programme (RNTCP), Mahavir Hospital in Hyderabad has successfully adopted and implemented a Public-Private Mix (PPM) model in conjunction with a Direct Observed Treatment Short course (DOTs) to combat TB effectively. The aims of the programme are:

a. Early detection and diagnosis of all infective patients in the community and treatment in the programme with no out of cost expenses

b. Work with the private practitioners in the community and ensure that maximum number of TB patients are cured.

c. Actively involve all health care providers to participate with early and high referrals of patients.



Source: PPM-DOTS, Mahavir Hospital

PPM - TB Healthcare Dispensing Model

2.7.26 With the involvement of the community, private practitioners and NGOs, Mahavir acted as a facilitator in implementing the program successfully.

Public and Private Mix DOTs (PPM-DOTs)

2.7.27 It is known that 60-70 % of the patients in the community first visit private doctors in the neighbourhood therefore establishing them as the first point of contact. Private practitioners are unable to diagnose TB early because the diagnostic tool employed by them (X-ray) is non-specific. Sputum Microscopy is far more reliable tool for early diagnosis. Delayed diagnosis results in the patients shopping around at the cost of indebtedness and advancement of disease.

2.7.28 Realizing this Mahavir felt that it is necessary to involve private health care providers fully in the program by sensitizing and obtaining their commitment and participation. There can be two approaches in involving private practitioners – one active, that involves case detection and treatment and the second, passive which means only referral by private provider to the facility and allowing their premises for neighbourhood DOTs centre. Mahavir employed the latter approach as it was found to be most acceptable to the private providers.

2.7.29 As the table in next page shows about fifty percent of referrals come from private practitioners. The data demonstrates that the approach of involving the private providers for referral and of the government for providing drugs – PPM is a workable proposition for TB control and are able to achieve estimated cure and detection rates of more than 85% and 70% respectively.

Referrals by Private Practitioners

Total Referrals				Referrals by Private Practitioners		
Year	Male	Female	Total	Male	Female	Total
1995	11	9	20	6	3	9
1996	43	51	94	18	39	57
1997	192	204	396	128	124	252
1998	290	260	550	150	127	277
1999	648	536	1184	279	235	514
2000	751	606	1357	270	237	507
2001	753	597	1350	298	282	580
2002 QI	187	177	364	87	75	162
2002 QII	184	155	339	73	59	132
Total	3059	2595	5654	1309	1181	2490

(Source: PPM-DOTS, Mahavir Hospital, 2002.)

2.7.30 This is an example of synergies between private practitioners and public health services. While the public health goals are achieved, practitioners gained in terms of good will and popularity in the community.

(IV) LV Prasad Eye Institute (LVPEI), Hyderabad

2.7.31 LVPEI was founded in 1987 with a mission to provide quality comprehensive eye care to all those who need, regardless of age, sex, creed, nationality, and the ability to pay for its services. The main activities of the institute can be classified into:

- Eye Hospital
- Education
- Eye Research
- Rehabilitation & Low Vision
- Community Eye Health
- Product development

2.7.32 Since inception, the Institute has provided out- patient service to over 1.8 million people, and surgical care to over 190,000 patients- and 54% of these have been free of charge. Currently the institute has 11 satellite affiliates spread over 8 districts of Andhra Pradesh.

2.7.33 Financing: The bulk of capital expenditures including start-up funds, expansion, and equipment purchases were made through donations and grants. The Institute maintains relations with philanthropic organizations and is in the process of establishing an endowment for the future financial health of its programs. This effort comprises 1% of the Institute's expenses. Today, donations comprise twenty five percent of the Institute's funds (25% national, 75% international). LVPEI secures donations of equipment from corporations eager to showcase their instruments in a training institution. Approximately 25% of equipment is donated, 50% is obtained at or below cost, and 25% is purchased at market price. LVPEI's programs of research, rehabilitation, and rural outreach compete for and receive grants including sums from the U.S. and Australia. Although grants provide 17% of the Institute's annual revenues, these divisions of the Institute are still dependent on the Institute's fee generated income.

2.7.34 Based on current levels of billing, fees generate the majority of the Institute's income. Paying patients are classified according to four tiers of financial ability. Non-paying patients consist of approximately 38% of outpatient services and 50% of surgical patients. Inability to

pay is based on eligibility for government ration cards, and hospital staff is authorized to change a patient's status to non-pay at any time. Given the existing fee schedule, a 1:1 ratio of non-pay to pay patients sustains patient care and the bulk of research, rehabilitation and outreach expenditures. All patients – paying and non-paying - get the same quality of care.

Replicable Model

2.7.25 Based on its own experience, LVPEI has developed a comprehensive and replicable model to make high quality eye care services available, accessible and affordable to all through a sustainable delivery system in underserved areas. The comprehensive model is designed to serve a population of 500,000 initially. This model envisages the following:

- Close linkage with a training / tertiary care centre
- Linkage with the local community
- Good infrastructure
- High quality training of all personnel & working conditions
- Prompt and high quality service

2.7.36 All members of the staff, with the likely exception of the ophthalmologist, should be selected from the local community. LVPEI provides all the requisite training for the entire "eye care team" required to staff such a centre.

2.7.37 LVPEI is a good example of a non-profit organization developing a world renowned institution providing high quality secondary and tertiary care, access to the poor through cross-subsidization, fiscal solvency, excellent clinical research, quality training to meet the needs of the whole sector, creating models of sustainable high quality primary and secondary eye care and effective leadership in expanding community eye health. This centre of excellence proved that privately funded quality health care in India can be both sustainable and equitable.

2.7.38 The lessons of these four innovations are self-evident. Jamkhed proves that low-cost, high quality primary health care is possible through community ownership and local talent effectively harnessed. Most health interventions are simple,inexpensive and effective, and do not need highly trained physicians. The remarkable and durable improvement of health indicators proves its efficacy. Even more significantly, community ownership of good health care can have other social and economic consequences promoting equity, gender sensitivity, education, initiative and entrepreneurship. If the state does not exhibit a hostile attitude, and collaborates through provisioning, training and monitoring, this can be a replicated in most of India. Citizens' initiatives, voluntary organizations, local panchayats and community co-operatives can play a seminal role in expanding and improving primary health services if the state has the will and wisdom to play a supportive and catalytic role.

2.7.39 Voluntary Health Services achieved three goals - accessible, reliable and affordable family health care, risk-pooling and high quality hospital care, and partial public funding coupled with voluntarism and cost-effectiveness. This model can be easily replicated in most urban settlements. The state can transfer its infrastructure of urban dispensaries and provide funds for basic maintenance.

2.7.40 Mahavir Public-Private model provides a viable model for public private partnership in implementing state's priority health programmes. In achieving key goals, the state and private sector can join forces to bring synergies. The goodwill and patient contact are the gains to private practitioners and better reach and coverage, identification of target patients and better achievement of declared goals are state's gains. Such programmes can be replicated all over the country once the state is ready to commit its resources and puts the infrastructure for specific services in place.

2.7.41 Provision of specialized, high-quality eye care services by a non-profit society combining excellence with cross-subsidization ensuring uniform quality of service to all is the model offered by L V Prasad Eye Institute. This is a model of tertiary care, research, training and leadership for health care in a defined geographic area that has great potential for replication. Hospital care needs to be taken out of for-profit corporate sector and brought into the fold of

highly professional, non- profit sector. Generous philanthropy from individuals and groups with a concept of social capital, broad support from the state, and willingness of public health sector to accept leadership of professional initiatives and forge partnerships will yield best health dividends in such cases well beyond hospital care.

2.7.42 All these are models of effective health delivery, low-cost, public-private partnership and community ownership. These are the directions in which future health care delivery should move if we are to ensure acceptable standards at affordable costs

2.8 Politics, Governance and Health

2.8.1 Health is a key ingredient of happiness. And governance is about reconciling conflicting demands, and allocation of limited resources to meet the unlimited needs through prior prioritization. The art of governance lies in efficiently managing institutions to give the best value for the money spent, and to create systems of accountability and people's participation.

2.8.2 Given the systemic rigidities and prior commitments without reference to returns to society, there are very few possibilities of significant increases in budgetary allocations to the social sector. Mere tinkering here and there will not release the much-needed resources for health care. And people who are helpless victims of corruption, maladministration and poor quality of services are not going to meekly accept higher taxation. More borrowings are not sustainable, and will lead us into vicious debt trap. In any case, more resources without better utilization will only encourage profligacy and does not guarantee results. It is this vicious cycle that the political process has to reverse.

2.9 National Rural Health Mission (NHRM)

2.9.1 NHRM was launched in 2005 with the objective of providing effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. The 18 states covered under NRHM are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

2.9.2 The scheme aims to correct the architecture of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.

Healthcare Strategy in NRHM

(a) Provision of a female health activist called ASHA (Accredited Social Health Activist), who will act as a link among beneficiary at village level, Anganwadi Worker and ANM in each village.

(b) Preparation of health plan for every village through a local team headed by the Health & Sanitation Committee of the Panchayat.

(c) Preparation and implementation of an intersectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation and hygiene and nutrition;

(d) Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services;

(e) Strengthening sub-center through an untied fund to enable local planning and action (each sub-center will have an Untied Fund for local action at Rs. 10,000 per annum). This Fund will be deposited in a joint bank account of the ANM and Sarpanch and operated by the ANM, in consultation with the Village Health Committee.

(f) Provision of 24 hour service in 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower;

(g) Integrating vertical Health and Family Welfare programs at National, State, Block, & District levels.

(h) The scheme also looks to strengthen the rural hospitals for effective curative care and make them accountable to the community through Indian Public Health Standards. Another aspect of the programme is that it brings about an integration of many vertical health & family welfare programmes and thereby ensuring optimal utilization of funds and infrastructure.

Group Exercise 2.2

Based on NHRM Mission Document (provide the document to all group members):

a) Identify the strengths of the scheme and comment on how it is different from the existing health care system in rural India.

b) Identify the constraints and drawbacks of the scheme

c) Identify ways to improve the programme.

d) Discuss your experience of implementing the programme.

e) Suggest how you can improve implementation of the existing programme

f) How do you dovetail the NHRM programme in the A

3. Education

3.1. Government Programmes For Education

Sarva Shiksha Abhiyan (SSA)

3.1.1 Launched in 2001, SSA is Government of India's flagship programme for achievement of Universalization of Elementary Education (UEE) in a time bound manner, as mandated by 86th amendment to the Constitution of India making fee and compulsory Education to the children of 6 14 years age group, a Fundamental Right. SSA is being implemented in partnership with State Governments to cover the entire country and address the needs of 192 million children in 1.1 million habitations. The programme seeks to open new schools in those habitations which do not have schooling facilities and strengthen existing school infrastructure through provision of additional class rooms, toilets, drinking water, maintenance grant and school improvement grants. Existing schools with inadequate teacher strength are provided with additional teachers, while the capacity of existing teachers is being strengthened by extensive training, grants for developing teaching learning materials and strengthening of the academic support structure at a cluster, block and district level. SSA seeks to provide quality elementary education including life skills. SSA has a special focus on girl's education and children with special needs. SSA also seeks to provide computer education to bridge the digital divide.

3.1.2. The objectives of Sarva Shiksha Abhiyan are:

a) All children in school, Education Guarantee Centre, Alternate School, ' Back to School' camp by 2003;

b) All children complete five years of primary schooling by 2007

c) All children complete eight years of elementary schooling by 2010

d) Focus on elementary education of satisfactory quality with emphasis on education for life

e) Bridge all gender and social category gaps at primary stage by 2007 and at elementary education level by 2010

f) Universal retention by 2010

3.1.3 The objectives are expressed nationally though it is expected that various districts and States are likely to achieve universalisation in their own respective contexts and in their own time frame. 2010 is the outer limit for such achievements. The emphasis is on mainstreaming out of school children through diverse strategies, as far as possible, and on providing eight years of schooling for all children in 6 14 age group. The thrust is on bridging of gender and social gaps and a total retention of all children in schools.

SSA Strategy

3.1.4 The broad strategies to meet SSA goals are the following

a) Institutional Reforms – As part of the SSA, the central and the State governments are required to undertake reforms in order to improve efficiency of the delivery system. The states will have to make an objective assessment of their prevalent education system including educational administration, achievement levels in schools, financial issues, decentralisation and community ownership, review of State Education Act, rationalization of teacher deployment and recruitment of teachers, monitoring and evaluation, status of education of girls, SC/ST and disadvantaged groups, policy regarding private schools and ECCE. Many States have already carried out several changes to improve the delivery system for elementary education.

b) Sustainability – In order to make SSA a sustainable programme both the Centre and the States need to have a long-term perspective on financial partnership between the Central and the State governments. Improvement in quality requires a sustainable support system of resource persons and institutions.

c) Community Ownership – The programme is based on community ownership of school based interventions through involvement of women's groups, VEC members and members of Panchayati Raj institutions. The SSA works on a community based approach to planning with habitation as a unit of planning. Habitation plans will be the basis for formulating district plans.

d) Community Based Monitoring – SSA envisages a community based monitoring system. The Educational Management Information System (EMIS) will correlate school level data with community based information from micro planning and surveys. Besides this, every school will be encouraged to share all information with the community, including grants received. A notice board would be put up in every school for this purpose. SSA also envisages cooperation between teachers, parents and PRIs, as well as accountability and transparency to the community.

e) Improving Mainstream Educational Administration –SSA calls for improvement of mainstream educational administration by institutional development, infusion of new approaches and by adoption of cost effective and efficient methods.

f) Focus on Girls and Special Groups – Education of girls, especially those belonging to the scheduled castes and scheduled tribes and minorities, will be one of the principal concerns in Sarva Shiksha Abhiyan.

g) Pre Project planning – The pre project phase of SSA included a large number of interventions for capacity development to improve the delivery and monitoring system. These include provision for household surveys, community based micro planning and school mapping, training of community leaders, school level activities, support for setting up information system, office equipment, diagnostic studies, etc.,

h) Thrust on Quality – SSA lays a special thrust on making education at the elementary level useful and relevant for children by improving the curriculum, child centered activities and effective teaching learning strategies.

I) Role of teachers – SSA recognizes the critical and central role of teachers and advocates a focus on their development needs. Setting up of Block Resource Centres/Cluster Resource Centres, recruitment of qualified teachers, opportunities for teacher development through participation in curriculum related material development, focus on classroom process and exposure visits for teachers are all designed to develop the human resource among teachers.

j) District Elementary Education Plans – Under the SSA framework, each district will prepare a District Elementary Education Plan reflecting all the investments being made and required in the elementary education sector, with a holistic and convergent approach. There will be a Perspective Plan that will give a framework of activities over a longer time frame to achieve UEE. There will also be an Annual Work Plan and Budget that will list the prioritized activities to be carried out in that year. The Perspective Plan will also be a dynamic document subject to constant improvement in the course of Programme Implementation.

Private Public Partnership

3.1.5 Elementary school education is largely provided by the government and government aided schools. Poorer households are not able to afford the fees charged in unaided private schools in many parts of the country. Unaided private schools that charge relatively modest fees and where poorer children also attend, many a time, are marked by poor infrastructure and low paid teachers. While encouraging all efforts at equity and 'access to all' in well endowed private unaided schools, efforts to explore areas of public private partnership will also be made. Depending on the State policies, DIETs and other Government teacher training institutes could be used to provide resource support to private unaided institutions, if the additional costs are to be met by these private bodies.

3.1.6 Financing Aspects

a) The assistance under the programme, including support for salary teachers' appointed under this programme, was on a 85:15 sharing arrangement during the IX Plan, 75:25 sharing arrangement during the X Plan, and there 50:50 sharing between the Central government and State governments. Commitments regarding sharing of costs would be taken from State governments in writing.

b) The State governments will have to maintain their level of investment in elementary education as in 1999 2000. The contribution as State share for SSA will be over and above this investment.

c) The Government of India would release funds to the State Governments/Union Territories only and instalments (except first) would only be released after the previous instalments of Central government and State share has been transferred to the State Implementation Society.

d) The National Programme for Nutritional Support to Primary Education (Mid Day Meal) would remain a distinct intervention with foodgrains and specified transportation costs being met by the Centre and the cost of cooked meals being met by the State government.

e) District Education Plans would inter–alia, clearly show the funds/resource available for various components under schemes like PMGY, JGSY, PMRY, Sunishchit Rozgar Yojana, Area fund of MPs/MLAs, State Plan, foreign funding (if any) and resources generated in the NGO sector.

f) All funds to be used for upgradation, maintenance, repair of schools and Teaching Learning Equipment and local management to be transferred to VECs/ School Management Committees/ Gram Panchayat/ or any other village/ school level arrangement for decentralisation adopted by that particular State/UT. The village/ school based body may make a resolution regarding the best way of procurement.

g) Other incentive schemes like distribution of scholarships and uniforms will continue to be funded under the State Plan. They will not be funded under the SSA programme.

Second Joint Review Mission's Evaluation of SSA

3.1.7 Overall, there is evidence to suggest that the country is steadily moving towards universalization of elementary education. As of 2004 05 of the estimated 201 million child population in the age group of 6 14 years, approximately 94 per cent are reported to be enrolled in schools including alternative educational centres. Of these, over 64.4 lakh children are enrolled in alternative systems. The number of out of school children has reduced from 25 million in 2003 to about 13.5 million as on March, 2005. Girls' share in total enrolment has improved from 44 per cent in 2002 03 to 47 per cent in 2003 04 at primary stage. For the upper primary stage, it was reported to be 45 per cent in 2003 04. As a result, the gender parity has improved from 0.88 to 0.90 in the case of primary and from 0.78 to 0.82 in the case of upper primary. The share of SC students in primary level has increased from around 19 per cent in 2002 03 to 21.3 per cent in 2003 04, while that of ST students has remained the same. At upper primary level, SC and ST students accounted for around 19 per cent and 8.2 per cent of total students respectively. The share of Children with Special Needs (CWSN) has increased from 0.6 per cent in 2002 03 to 1.2 per cent in 2003 04. As regards dropouts, although the estimates vary depending on the definition and methodology used, there is a drop of 4 percentage points for the primary stage and 2 percentage points for the elementary stage as a whole in the year 2002 03 compared to the previous year. The gender gaps with respect to dropouts at primary stage have reversed (SES, 2002 03). With respect to the specific development objectives agreed with the Development Partners, the target of reducing out of school children by 9 million has already been exceeded.

3.1.8 Access to schooling has improved substantially. Against a target of 65,301 schools, 63,793 schools have been provided at the primary level, which amounts to 98 per cent of the target and 53,878 schools at the upper primary level accounting for 94 per cent of the target. A variety of alternative education interventions to take care of the marginalized groups have also come up in different states/UTs. A total of 1,29,432 EGS centers are being additionally provided of which 38,384 of these centers have been upgraded into regular schools and a total of 17 lakh children have been mainstreamed. The gap in teacher shortage has been addressed considerably with 3.86 lakh teachers having been appointed under the program. 29 states/UTs/UTs have already improved their average PTRs to less than 40:1.

3.1.9 A large number of innovations have come about in different areas. Some areas include access (including efforts for girls and weaker sections); design of buildings, use of material, construction

systems in civil works; use of information technology in planning, management and fund flow; computer education in selected schools etc. Evidence of increased convergence and networking with government departments as well as with the private sector is also noticed.

3.1.10 The trend towards greater decentralization and community participation is evident. Household surveys are becoming a feature of planning and village education committees are slowly taking charge through construction of schools and managing of teacher and school grants under the program In addition, in several instances, VECs are also making their own contributions towards the local schools in terms of labour, finances, material and time.

3.1.11 Clear improvement in fund flow is evident with release of 48 per cent of Central Budget amounting to Rs. 3432 crores right in the first financial quarter of FY05 06. Compliance with the Financial Management and Procurement Manual developed in 2004, is improving and audits have been carried out in shorter time frames. MHRD has put in place an independent concurrent financial review system by IPAI. This is also a commendable monitoring activity.

3.1.12 The review indicates wide inter state and inter district variations across the country in terms of progress on indicators.

3.1.13 Since quality is so closely inter linked to all parameters, there is a need to now look at the impact of the various inputs given under the program in the classroom practice including a sample based study of the 'time on task' spent by children.

Government of India's Economic Survey 2007-08 on Sarva Shiksha Abhiyan (SSA)The Sarva Shiksha

Abhiyan (SSA) is being implemented in partnership with States to address the needs of children in age group of 6-14 years. The achievements under SSA up to September 30, 2007, include construction of 1,70,320 school buildings, construction of 7,13,179 additional classrooms, 1,72,381 drinking water facilities, construction of 2,18,075 toilets, supply of free textbooks to 6.64 crore children and appointment of 8.10 lakh teachers besides opening of 1,86,985 (till 31.3.07) new schools. About 35 lakh teachers receive in-service training each year. Central allocation for SSA in 2007-08 was Rs. 10,671.With significant success in enrolling children in schools; the SSA's thrust areas are now on reduction of dropouts and improving quality of student learning.

Group Exercise 2.3

Ask the group to how will they deal with the following challenges facing the SSA

Harness social capital within the communities for programme implantation

Many innovative initiatives in different parts of the country in both government and non government sectors are happening. The challenge is to mainstream replicate and up scale these initiatives.

After 7 years of implantation, do you think it is time to shift focus from enrollment rates to more critical parameters such as retention/drop out, attendance, transition and learning levels. How can this be achieved?

What are the data issues and how the data can be more reliable and comprehensive?

4. Livelihood

4.1 Introduction to Livelihoods

4.1.1 Livelihood is:

- A set of economic activities, involving self-employment and/or wage-employment
- by using one's endowments (human and material)
- to generate adequate resources (cash and non-cash)
- for meeting the requirements of self and the household,
- usually carried out repeatedly and as such become a way of life.

Ideally,

- a livelihood should keep a person meaningfully occupied,
- in a sustainable manner,
- with dignity

Livelihoods, therefore, go far beyond generating income. A livelihood is much more than employment.

4.2 Why Promote Livelihoods?

4.2.1 In the current decade, according to estimates of the Planning Commission for the Tenth Five Year Plan, more than 10 million people in India will be seeking work every year. This means that more than 10 million new livelihoods will have to be generated every year. Given the magnitude of the problem, and the dearth of resources for livelihood promotion the task of promoting livelihoods become all the more urgent.

4.2.2 The primary reason to promote livelihoods is the belief in the essential right of all human beings to equal opportunity. Poor people do not have life choices nor do they have opportunities. Ensuring that a poor household has a stable livelihood will substantially increase its income, and over a period of time, asset ownership, self-esteem and social participation.

4.2.3 The second reason for livelihood promotion is to promote economic growth. The 'bottom of the pyramid' comprising nearly 4 billion out of the 6 billion people in the world, who do not have the purchasing power to buy even the bare necessities of life – food, clothing and shelter. But as they get steadier incomes through livelihood promotion, they become customers of many goods and services, which then promote growth.

4.2.4 The third reason for promoting livelihoods is to ensure social and political stability. When people are hungry, they tend to take to violence, crime.

4.2.5 Thus, we see that there are idealistic, utilitarian and plain self-interest based arguments for livelihood promotion. But whatever be the reason, we need to worry about – how to promote livelihoods?

4.3 What is a Livelihood Intervention?

4.3.1 Livelihood interventions are conscious efforts by an agency or an organization to promote and support livelihood opportunities for a large number of people (other than those directly or indirectly employed by them). Government of India has been one of the largest agencies involved in such livelihood promotion efforts. However, the cooperative sector, the corporate sector as also the NGO sector has also contributed to promoting livelihoods.

4.3.2 Examples include:

i) Government program for development of irrigation. India has added over 40 million hectares of irrigation since independence; largest in human history. This has generated or stabilized the livelihoods of millions of people.

ii) In agriculture, the predominant livelihood interventions covered irrigation through large dams and canal systems till the 1960s, followed by the introduction of the high yielding varieties package during the Green Revolution, impacting

the livelihoods of over 40 million farmers and a similar number of landless laborers.

iii) Government programs such as the erstwhile National Rural Employment Program (NREP)/ Sampoorna Gram Samriddhi Yojana (SGSY), the NREGA

iv) Government programs such as the erstwhile Integrated Rural Development Program (IRDP), refashioned as the Swarna Jayanti Grameen Swarozgar Yojana (SGSY), to promote self-employment among the poor through acquisition of an income generating asset with the help of a bank loan and a government subsidy

v) Special government programs, run in specific states, to promote both wage employment, such as the Employment Guarantee Scheme (EGS) of Maharahstra and to promote self-employment through highly subsidised asset acquisition, such as the World Bank sponsored District Poverty Initiatives Program (DPIP) in AP, MP and Rajasthan.

vi) Programs run by sectoral institutions such as the National Dairy Development Board, the Central Silk Board, the Coir Board, the National Horticultural Board, and the Development Commissioners for Handloom and Handicrafts

vii) Programs run by non-governmental agencies, for promoting livelihoods in different regions and sectors, such as by SEWA, BAIF, MYRADA, AKRSP, PRADAN, RGVN and BASIX.

viii) The Self Employed Women's Association (SEWA) works with over 750,000 self-employed women of low-income households

ix) Bhartiya Agro-Industries Foundation's (BAIF) program supporting one million livelihoods, comprising cattle cross-breeding, pasture development, horticulture, etc.

x) Venkateswara Hatcheries intervention to develop the poultry sector, culminating in the National Egg Coordination Council, which serves over 200,000 poultry producers.

xi) Various micro-finance interventions by banks and NGOs have influenced the livelihoods of more than twelve million people.

4.4 Various Types of Livelihood Interventions

4.4.1 Livelihood interventions can be in many forms and go far beyond running an income-generation program. Some of the approaches of livelihood interventions in India are:

4.4.2 Spatial Approach

- Promoting livelihoods in a specified geographical area, such as a region, sub-region, command area or a watershed.
- Supporting locally inter-dependant economic activities, based on a leading intervention, as done by various state governments in the irrigation command areas – the Indira Gandhi Canal in Rajasthan, or the horticulture based DHRUVA project of BAIF in Valsad, South Gujarat
- Supporting livelihoods in a degraded watershed or degraded forest area, such as MYRADA's PIDOW project in Gulbarga, Ralegaon Siddhi in Maharashtra and the numerous joint forest management projects supported by AKRSP in Gujarat. Intervention in a cluster of enterprises, such as Ludhiana for hosiery, Badohi-Mirzapur for carpets, Kancheepuram in Tamil Nadu and Sualkuchi in Assam for silk sarees, and so on.

4.4.3 Segmental Approach

- Promoting livelihoods for a vulnerable segment of the population, such as landless households, tribals, women and the disabled.
- Supporting livelihoods of the poor through micro-credit, for example by SEWA, SHARE, CASHPOR and BASIX
- Investing in human development - nutrition, health, education, and institutional development (for example CARE's Women's Income and Self-Help project, Jharkhand).
- Asserting the rights and entitlements approach of the poor – whether to minimum wages, land tenure or access to public services, for example the National Association of Street Vendors of India asserted the rights of livelihood of street vendors.

4.4.4 Sectoral Approach

- Promoting livelihoods along a sector of the economy such as agriculture, or a sub-sector such as cotton.
- Sub-sector Interventions, such as dairy, fishery, and sericulture, usually covering the value chain from primary production to the ultimate consumer, e.g. NDDB in dairy.
- Intervention along a Vector (something which cuts across all sectors): such as water, power or market linkages. E.g. MART, which has worked on rural haats – local markets.

4.5 Spatial Interventions

4.5.1 Many livelihood interventions have a spatial a geographical boundary. It may be a single village, a watershed, a river basin, a block, taluka or a district or a region. The main difference between other approaches and a spatial (or area development) approach is that it tries to tackle all the sectors and segments of the population in that area.

4.6. Area Development with a Leading Intervention e.g. Irrigation

4.6.1 This approach has been followed by governments in a number of ways – initially to develop the "command area", that is area irrigated by a canal system of a major dam. Most of these projects began in the 1950s and 60s. The leading intervention here was flow irrigation, and it was supplemented with on-farm development such as land leveling and bunding, building drainage channels, training of farmers in irrigated agriculture through extension services, ensuring the availability of tractors, supply of new water responsive varieties of seeds, setting up outlets for fertilizers and pesticides, and finally marketing, in the form of rural roads, warehouses and market yards. This then led to the development of the local economy in an inter-dependent manner. Over a period, non-farm activities, based on agro-processing, took off, as also those, which supplied goods and services to increasingly prosperous farm households. While irrigation changed the livelihoods of millions of farmers for the better, it also led to a rise of inequalities, particularly for those who did not have any land.

4.6.2 Even programs such as Drought Prone Area Program (DPAP) were spatial interventions in livelihoods.

4.7 Watershed Development Approach

Why Watershed Development?

4.7.1 A watershed is a catchment area feeding into a single identifiable drainage system, such as a stream or a river.

4.7.2 Out of a total geographical area of 329 million hectares, approximately 170 million hectares of land in India is classified as degraded. Half of this land falls in undulating semi-arid regions, where rain fed farming is practised. Much of this degradation is due to inappropriate use of land and inadequate protection. The introduction of appropriate physical barriers to soil and water flows, together with re-vegetation and institutional arrangements for their conservation, can improve the productivity of land. Typically, a watershed program includes some or all of the following interventions:

- Soil and land management;
- Water management;
- Crop management;
- Afforestation;
- Pasture/fodder development;
- Livestock management;
- Rural energy management;
- Other farm and non-farm activities;
- Community mobilization.

4.7.3 While these components are often understood in general/standardized terms, there is scope for technology development and adaptation.

Mainstreaming the Watershed Approach

4.7.4 The Government of India started recognising the value of using a watershed as a unit of intervention in the early 1980s. Over the last two decades it has set aside substantial budgetary provisions for micro-watershed rehabilitation and development.

Challenges Faced by Watershed Approach

4.7.5 Enabling local participation: different

institutional arrangements exist for attracting local participation, but the challenge of effective community participation in conceptualizing, planning and implementation of watershed projects remain.

4.7.6 Sustainability issues: (i) how will the treatments undertaken be maintained? (ii) how to meet the costs of post-implementation phase? (iii) can maintenance funds be generated during implantation phase? (iv) can the institutions created during the implementation phase remain vibrant with just maintenance or can they also take up other development programmes? etc.

4.8 Cluster-Based Spatial Intervention

4.8.1 Another way of supporting a large number of livelihoods is supporting activities in a cluster. Usually a cluster arises around a particular activity, and eventually a number of related and supporting activities emerge leading to all round livelihood promotion. The activity may be agricultural, such as sugarcane cultivation in the Kolhapur district of Maharashtra around which sugar mills, agro-service centres and retail markets have emerged. A cluster may emerge around a non-farm activity such as stone quarrying and polishing. For example, in the Bethamcherla cluster in Andhra Pradesh, growth of 250 stone polishing units has spurned 100 polished slab-trading companies and 50 rough-stone slab traders in the area. Not only that, various other support enterprises, such as transport companies, transport repair workshops, equipment supply, repair enterprises and small road-side restaurants have also sprung up in the area, supporting large numbers of livelihoods. These enterprises closely depend on each other for sustenance.

4.8.2 The advantage of growth of such a cluster is that, related and supporting services become available to all participants, reducing the transaction costs for all. The cluster attracts various suppliers to the area, as it provides economies of scale. The strong competition attracts consumers, who are assured of choice, competitive quality and price. Growth of clusters attracts policy attention increasing the availability of skilled workers. Clusters also enhance ability to cope with changes in the environment as information flow becomes faster.

4.8.3 There are several such clusters in India, which are known for their products, such as, Shivakasi for matchbox, firecrackers, Ludhiana for woolen garments, Patiala for machine tools, Moradabad for brassware, Ulubedia for badminton shuttle corks, Lonavala for Chiki, groundnut molasses sweetmeat, Tirupur for hosiery, Kanchivaram, Varanasi and Dharmavaram for silk weaving, Kolhapur for leather slippers, Kanpur and Agra for various leather goods, Bellary for jeans, and Bikaner for Bhujiya, ready to eat extruded products.

4.9 Developing the Local Economy

4.9.1 At the workshop that brought together livelihood practitioners to reflect on their experience many agreed that linking poor producers to expanding markets was the key. But some differed.

4.9.2 How reliable are these markets? To what extent do they reduce the risks that producers face? While access to these markets can increase the share of consumer's rupee to rural producers, it often pushes the locus of control and/or decision making away, and reduces their role to mere suppliers of labour from equity holders in their own small little business.

4.9.3 There have been many cases, where the rural producers, especially the smaller ones have fallen pray to market vagaries. Thousands of farmers were forced to burn their sugarcane crops. Several hundred cotton farmers committed suicides when the crop failed. Tons of malta was thrown into the Ganges when the prices collapsed. Similarly, the carpet industry in Rajasthan faced a serious set back, when the European market stopped buying carpets, due to a change in their import policy in relation to child labor.

4.9.4 To find some answers to this question, let us look at a simple example that effectively illustrates how making an economy self-reliant makes the money go longer.

4.9.5 If the income of one person is spent within the local economy itself, it becomes the income of another within the same economy. For example, if a dairy farmer, Ram buys the fodder from a neighbouring farmer, Shyam, the money Ram spends on buying fodder becomes income of Shyam. This can have a perceptible implication for the economy as a whole. Let us examine how.

4.9.6 Let us assume that Ram, Shyam, Laxman, and Bharat live in a village where only 20 percent of the goods required by anybody are available within the local economy. So, in this village, when Ram spends Rs 100, he buys goods worth Rs 20 from within the village itself, say from Shyam. Thus, Shyam has an income of Rs 20. Take this logic further.

	Total income	Amount spent within the economy	Amount spent outside the economy
Ram's income	100.0	20.0	80.0
Shyam's income	20.0	4.0	16.0
Laxman's income	4.0	0.8	16.0
Bharat's income	0.8	0.16	0.64
Total income gemerated	124.8		

4.9.7 The table shows that this Rs 100 generates an income of Rs 124.80 for the four of them. Now let's imagine if they could get 50 per cent of what they required locally

	Total income	Amount spent within the economy	Amount spent outside the economy
Ram's income	100.0	50.0	50.0
Shyam's income	50.0	25.0	25.0
Laxman's income	25.0	12.5	12.0
Bharat's income	12.5	6.25	6.25
Total income gemerated	187.5		

4.9.8 Their income would have gone up to Rs 187.50. Therefore, another way of enhancing income could be to produce more and more of the local requirements locally, and building a self-sustaining economy.

4.9.9 If Ram could buy more fodder locally instead of buying cattle-feed from the town, the economy would have become stronger. To move towards this, we could train someone to produce better fodder locally. We could also train someone else to use the cow-dung to make compost, which in turn could be used for fodder production by other farmers. We could also train a boy locally to cut chaff. This would keep the money flowing within the local economy and generate more income than before.

4.9.10 The underlying principles of such a model are to:

- Use local resources to meet local needs
- Maintain diversity within the local economy to reduce risks
- Ensure money circulates within the local community
- Enhance the control that the community has over its local resources.
- Enhance financial and other assets within the community that can generate future income streams
- Reducing the risk arising from the vagaries of distant markets faced by poor producers
- Organizing poor producers so that they have greater control over their livelihoods now and in the future.
- Increasing the bargaining power of the producers.

Group Exercise 2.4: Case Study - Livelihoods

A Case Study of Nandipeta Village in Mahabubnagar District

This was a participatory exercise involving members of several SHG members in Nandipeta village in Addakula Mandal of Mahabubnagar. This exercise raises several issues of concern in livelihoods planning. The notes the exercise are as following.

I. The exercise started with preparing a broad social map of the village on which groups of households belonging to different castes were mapped. While the normal tendency was to aggregate the caste

groups into SCs, BCs and OBCs, in this case further classification in terms of specific caste names was made. Twenty three such castes were identified in the village. Caste-wise break up of members in each of the SHG were prepared and representation of each caste in these SHGs noted.

ii. In an exercise similar to wealth ranking, the castes were then grouped into three categories viz., the poor, the middle ranges and the non-poor category based on subjective judgment of the participant group.

iii. Most of the caste groups identified as poor are skilled workers providing their services to the community in the past under 'Jajmani system'. Payment to these services was mostly made in kind. These service castes have not been receiving grain as the farmers say the yields are low. Their caste occupations lost their markets and patronage in course of time. This has happened in several ways: new technology, new culture, new products coming into the local markets, reduction in the availability of raw materials and erosion of traditional patronage.

iv. The number of families in these caste groups is also very low - one or two, mostly. The immediate shift of these castes is towards agriculture labour and migration.

v. The SHGs have mixed membership in terms of different castes / wealth. (The above understanding is sketchy and by no means, is complete. Mapping the individual households in the social map, instead of broad caste groups would give a more comprehensive picture.)

Castes	Households	Membership in SHG		Occupation
		Female	Male	
Green Colour :				
Komati	*3*	*2*		*Business*
Vadde	*2*	*2*		*Stone cutting*
Mola (muslim)	*1*	*1*		*Meat*
Saale	*2*	*1*	*1*	*Tailor, Kirana shop*
Kurva	*42*	*16*		*Agriculture, sheep rearing*
Kummari	*1 (of 2)*	*1*		*??*
Balija	*2*	*1*	*1*	*Agriculture*
Reddy	*57*			*Agriculture*
Kammari	*1 (of 2)*		*1*	
Golla	*13*	*9*	*3*	*Agriculture, Labour*
Goud	*2*	*2*	*1*	*Toddy*
Boya	*15 (of 45)*	*21*	*6*	*Agrl*
Blue Colour				
Besta	*8 (of 9)*	*1*	*1*	*Agrl, labour*
Chakali	*5*	*3*	*1*	
Maala	*3*	*3*		*Agrl, Labour & migration*
Vadla	*1*	*1*	*1*	*Carpenters*

Red Colour				
Madiga	*50*	*9*	*2*	*Labour, migration*
Erukali	*1*	*1*		*Basket making*
Kummari	*1*			
Kammari	*1*			
Boya	*30 (of 45)*			*Migration*
Tenugu	*1*			*Agrl Labour*
Uppari	*1*	*1*		*Construction workers*
Tammali	*1*	*2*	*1*	*Hotel (locally)*
Kattika	*5*	*3*		*Butchery*
Jamgam	*1*	*1*	*1*	*Priests, Begging*
Avuchula	*2*	*3*		*Gold smith* *Agriculture*

Occupational Profiles – Time Transect:

	Caste group	**Previously (20 years before)**	**At present** (fig in brackets - % income)
1	Vadla	Agrl implements Household things	Agrl labour (75%) Agrl. Implements (25%)
2	Kummari	Pottery (75%)	Agrl & other labour (75%) Pottery (25%)
3	Kammari	Agrl implements	Agrl labour Agrl implements
4	Chakali	Washing clothes Agrl labour	Washing clothes Agrl labour
			Migration
5	Vadde	Stone cutting (80%) Agrl labour	Stone cutting Agrl labour Migration
6	Erukali	Basket making (75%) **Animal health** Agrl labour Piggery	Basket making (50%) **Animal health (10%)** Agrl labour (40%)
7	Madiga	Caste occupation (??) Agrl labour (25%) Shoe making (90%)	Migration (70%) Shoe making (10%)
8	Telugu	Fishing (70%) Agrl labour (30%) Dry land agriculture	Fishing (10%) Migration Agrl Labour
9	Kurva	Sheep rearing Agrl Labour Woolen Blanket weaving	Sheep rearing (60%) Agriculture Migration
10	Golla	Agriculture Goatery Labour	Agriculture Goatery Labour

11	Tammali	Leaf plates Agrl Labour Sannai (marriage bands) *Basingalu*	Leaf plates (50%) Agrl Labour Migration *Basingalu*
12	Katika	Butchery Labour	Butchery Labour Migration
13	Mangali	Barber Labour	Barber Labour & migration
14	Maala	Work in Grave yard Agrl labour Dryland agrl	Work in Grave yard Agrl labour Migration
15	Padmasali	Clothes business Kirana shop	Kirana shop Tailoring
16	Komati	Kirana Money lending	Kirana Migration (for better business)
17	Avusula	Jewelry Agriculture	Migration Agrl labour
18	Reddy	Agriculture	Agriculture Dairy Agrl labour Driving, Migration
19	Jamgam	Priest Begging (locally in the village)	
20	Balija	... not clear	
21	Molla	Sheep rearing	Fuel wood business migration

The process of de-skilling and shift in occupations is quite visible from the above table.

A focused analysis of the Madiga Community reveals the following.

i) Most of the able bodied families seasonally migrate with the labour contractor leaving the old people behind. The leave the village in Dasera (September - October) and return after rains.

ii) A typical migrating family takes loan to the extent of Rs.20,000 (for a male and female) from the labour contractor before migrating. During the work they are paid Rs.750 per month per person. Their food and other needs are taken care of by the contractor. Even after returning to the village, they would not be able to pay-off the loan completely. In case the family chooses a different labour contractor, they borrow money from him and pays off the debt. Thus, there is always some debt on the family (around Rs.6,000 to 7,000) which keeps them bonded to the migration.

iii) Most of the Madiga families have some assigned land - now fragmented. Few families have good land. On the whole there is around 70 acres of land belonging to these communities, but much of it is not cultivable at present for lack of adequate treatment and irrigation.

iv) All the Madiga families have access to drinking water

v) They get their fuel wood from the farmers' lands or from commons.

vi) Few families have plough bullocks but none of them have milch cattle.

vii) Incidentally, the Sarpanch of the Gram Panchayat is a Madiga (being a reserved Panchayat)

vii) Caste discrimination or untouchability is practiced in the village in subtle ways.

In the above scenario, your group is required to consider what are the development options for the Madiga community?

Group Exercise 2.5: Case Study in Participatory Management of Water Resources: Paliganj Vitrani Krishak Samiti *(Use participatory learning in class room)*

Part I

Paliganj Vitrani Krishak Samiti (hereafter referred to as PVKS) is a water users' association working for irrigation management of Paliganj distributary system in Paliganj, a subdivision that is around 80 km from Patna in Bihar.

Paliganj distributory is an offshoot of Patna Canal, 75 km downstream from its mouth/head from Sone Barrage (near Indrapuri in the Rohtas district of Bihar). It has two sub distributaries: Chandos and Bharatpura. The total length of the system (including sub distributaries) is around 40 km and it irrigates 4500 ha of agricultural land. The system's channels meander through Paliganj and Dulhania Bazar blocks of Patna district and Alwar block of Alwar district covering more than 50 villages.

Table 1
Paliganj Vitrani (Distributory): Some Facts

Geographical Span	52 villages in three blocks of two districts
Agricultural Land	12000 Hectares (approx)
Command Area	6000 Hectares (approx)
Total length of distributaries (including two sub distributaries)	40 km
Annual demand of *Patwan Kar*	Rs.10,00,000 (approx)
Number of farmers who benefit from the water supply	10,000 (approx)

The Paliganj distributary started to sicken in the later part of the 70s when the authority of the government was reduced considerably due to socio-political reasons. The farmers

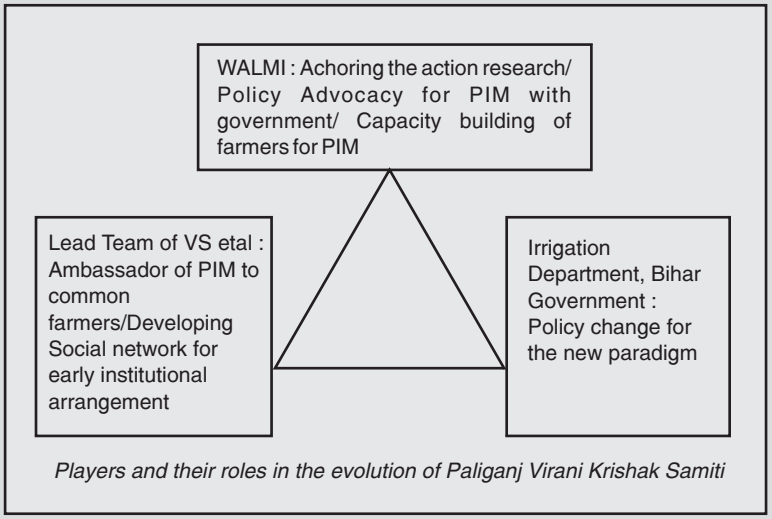
were not paying irrigation taxes and became increasingly indifferent to frontline staff. The staff began to avoid farmers after the area came under the influence of naxal movement. In the absence of effective government presence, the farmers began to take the water supply for granted. Wastage became rampant and cases of conflicts became common which often resulted in violence. The lower order farmers of were the first to feel the ill effects of this transition as more often than not water was either used up or wasted before it reached them.

As the state government's financial condition worsened, maintenance became infrequent and the system plunged into total disrepair. Siltation and breaches in the embankments made it almost non-functional. But according to the people the blame for the sorry state of affairs was squarely on the government. Over time they lost any hope that things would change for the better.

Process of Change

In 1988-89 Water and Land Management Institute (WALMI) was established in Patna, which initiated an action research on the management of sick irrigation systems with support from USAID. Four irrigation systems were taken up for this action research including Paliganj and Garachoube distributaries of Sone Canal, Jamunia branch canal (Gandak river), and Asarganj distributory (Badur stream). The action research was aimed at developing a participatory management framework for the sick irrigation systems both for its management and more equitable use.

Among the four systems taken up for the action research, Paliganj distributory had the advantage of relative proximity to WALMI and the action research work started here. The action research team was formed under the guidance of Dr L P Srivastava (LPS), the then director of WALMI. WALMI conducted a benchmark baseline survey of the system and the area to understand the perspectives and concerns of farmers towards the management of the distributory.



Players and their roles in the evolution of Paliganj Virani Krishak Samiti

The early meetings were extremely unruly as the farmers thought the WALMI team represented the water resources department and vent all their anger and frustration. Slowly, the team started a dialogue with the farmers about how things could be changed for better. At the same time, WALMI team was roping in influential persons to accelerate the process of social mobilisation in favor of a new paradigm for managing the distributory. They came to know about Valmiki Sharma (VS) who was then a local leader in the Congress Party and contacted him for support. He enthusiastically got involved in the campaign for organising village meetings and started the process of convincing farmers for PIM(Participatory Irrigation Management) of the Paliganj distributory.

Later, an ad hoc eleven-member DLC was constituted in the presence of WALMI team in a meeting attended by farmers from different villages. This mostly had those farmers who were playing a very active role by then and were willing to work for the cause. The ad hoc DLC later became a tentative institutional vehicle which represented farmers' interests and concerns and which, along with the WALMI team worked to reach farmers in more villages through a series of village meetings.

In less than a year time, twenty village level committees (VLC) were constituted in villages where farmers got interested. The VLC was supposed to be a forum, which would represent the interests of the farmers in a more participative management of the distributary. Each VLC had 11 members: one president, two vice presidents, one secretary, one treasurer, and six other members. The committee was constituted in the presence of the DLC representative by reaching a consensus and if there was any disagreement the constitution was to be delayed until a consensus was reached.

By 1992-93, 45 village level committees were constituted and it was felt that the ad hoc DLC should be replaced with the elected DLC. The presidents of all VLCs constituted the general body of the DLC and the executive body of DLC was formed by a consensual selection of five office bearers: the president, two vice presidents, secretary, and treasurer and six non-office bearer members. Valmiki Sharma was chosen as the secretary.

Farmers also directly started to get involved in the maintenance of PVKS. Grain (chanda) was collected from households and labor, volunteered for desilting and repairs of the distributary. A team of farmers (mostly from lower reach) used to keep an eye on wastage and misuse. This effort, for the first time helped the water to reach the tail-end of the distributary, for irrigation. This change multiplied support of the villagers for PVKS. The department staff now started to work actively with PVKS. The policy advocacy of WALMI with the state government got strengthened with the encouraging signs of potential improvement in the management of distributaries by involving the users.

On 25th February 1997, the PVKS signed a Memorandum of Agreement (MOA) with the water resources department, Government of Bihar. Under this agreement, the maintenance and operation of Paliganj distributary was handed over to PVKS and it was authorised to collect irrigation taxes from the farmers. The PVKS had to give 30% of the irrigation taxes to the government in exchange for its responsibility to manage and maintain the parent canal. The MOA was under observation for a period of three years after which a review was to be done.

In 2000-01, there was a review of the new arrangement by the government, which recommended that in view of the satisfactory performance of PVKS the arrangement should be extended.

Text Box 1
Evolution of PVKS: A Time Line

Year	Landmarks/Achievements
1989-90	WALMI started ideating with farmers of the command area in village meetings. The first meeting was held in Ullar village. LPS et al met VS and encouraged him to participate in the social mobilisation for the new paradigm. VS became interested and later took a lead role in selling the idea in numerous village meetings. An ad hoc distributary level committee (DLC) of farmers was constituted who was willing to devote time to work for the cause.
1990-91	WALMI organised training programs and exposure visits for the farmers especially lead /active farmers. The ad hoc DLC campaigned in the villages for formation of village level committees (VLC). A formal DLC was constituted out of representation from these VLCs.

1991-92	The DLC along with VLCs mobilized farmers to contribute in grain and labour (*Chanda & Shramdan*) for desilting of the distributary and repairs of breaches in its embankments before the onset of the monsoon season. For the first time in more than ten years the water managed to reach the end of the distributary. DLC/VLCs worked with the front line staff of the department for management of the distributary.
1992-93	The department started to assist and support DLC. Gradually, DLC started taking the center stage in the management of distribuary.
1993-94	The DLC got registered as Paliganj Vitrani Krishak Samiti (PVKS) under societies registration act, 1860.
1996-97	The management and maintenance of the distributary was formally handed over to the PVKS on a pilot basis for a period of three years.
2000-01	The department evaluated the operation and functioning of PVKS and decided to continue with the new arrangement.
2003-04	The management was visited by important dignitaries from the planning commission

The operational system of PVKS is aligned with its four broad categories of activities:

Distribution of Irrigation Water among Users

There is a working committee dedicated to distribution of irrigated water among users, appointed by the executive body of PVKS (also known as DLC). This committee oversees the distribution of water in cooperation with the VLCs and a team of volunteers (15-20 farmers mostly from the lower reaches). Besides volunteers there are also 2-4 mates (temporary workers during peak *kharif/rabi* seasons) who keep a constant and close watch on the delegated stretch for any breach of the distributory / agreed distribution norms. If the mates find difficulties in dealing with the situation, they inform the concerned VLC/the team of volunteers who become active to correct the natural breaches with shramdan and to resolve breaches of distribution norms through negotiation and social pressure.

The fundamental distribution norm, which has wide acceptance over years since PVKS took over, is equity in distribution of irrigation water among different users to the extent possible. This acceptance has reduced distribution related conflicts and violence. Innovative ways have been devised to achieve equitable distribution with minimum social turbulence. One such way is time division. A broad agreement has been reached among users that the farmers from the upper reaches would irrigate their field during the convenient day time (sunrise to sunset) while those on the lower reaches would irrigate the fields during the inconvenient night time (sunset to sunrise). One may find this arrangement unfair to the farmers from the lower reaches. But the same arrangement had made the upper reach farmers to collectively conform to the time division norms. The physical-natural advantages of the upper reach farmers not only gives them first access and availability of irrigation water from the distributory, it also gives them leverage over he availability of irrigation water to the lower reaches. The lower reach farmers are aware of this and have accepted the inconvenient time slot in return for a more predictable availability of irrigation water. The upper reach farmers feel their obligation towards the lower reach farmers for having acceded the convenient time slot to them and hence have agreed for not irrigating after sunset and before sunrise.

Any disagreement, in case of scarce water in the distributory or more need of irrigation to a given field, is resolved through impromptu negotiation among users, which may be moderated by representatives of VLCs/DLC.

As PVKS chose not to exclude anyone from using the water, the operational responsibility of the PVKS in distribution is more of minimising wastage and as an arbitrator/moderator of any disagreement/conflict among users in irrigating their fields.

Repairs & Maintenance of the Distributory System

There are two kinds of repairs and maintenance works. One is routine work like repairing small breaches and the other is annual maintenance work before the monsoon, which is done by volunteers and mates as mentioned earlier. The DLC core team does a walk through over the distributory to assess the type and cost estimate of annual maintenance works like desilting, clearing the sides from weeds, strengthening of embankment walls etc. along different stretches. The concerned persons from the given VLC under which the stretch falls are entrusted with the responsibility of maintenance.

Assessment & Collection of Patwan Shulk

After the end of a season (rabi/kharif), an assessment of the irrigated area of individual farmers is done and the demand for the season is prepared by the VLCs. The DLC has appointed authorized collection agents for different clusters of villages who collect patwan shulk for individual farmers against the demand. These collection agents then submit the amount to the DLC and are paid a commission of 5% of the collected amount.

Accounting & Record-keeping

The PVKS has one full-time accountant for accounting and record-keeping work, who reports directly to the secretary of PVKS.

Institutional Arrangement of PVKS

As per the bylaws, the PVKS has a two-tier structure of VLCs and DLC. VLCs are village level units and any user, by paying a membership fee, can become the member of its general body. The general body then chose an 11-member executive body, president, secretary, and treasurer; two vice presidents and six other members.

All presidents of different VLCs constitute the general body of the DLC, which again elects an 11-member executive body. The DLC is registered under Societies Registration Act, 1860.

The secretary of DLC works as the chief executive of PVKS who works with the executive body/VLC to manage the system in the larger interests of users.

The executive body and general body are expected to meet every fortnight and every month respectively for required discussion and deliberation.

Mapping the change: before and after PVKS

Before PVKS

- Water didn't reach beyond the first half stretch of the distributory in sufficient quantity. The villages near the tail end of the canal got little or no water.

- There were 17-18 blockage points/flash points. These were villages along the distributory that used to stop the water flow by felling trees, a source of bitter resentment for villages on the lower reaches. These issues frequently led to conflicts and sometimes even violence.
- Farmers inhabiting the upper reach villages used to waste a lot of water, as they didn't feel any obligation/responsibility to the farmers on the lower reaches. Very often such wastage reduced availability of water to the lower reach farmers.
- The distributory was not considered as a reliable source of irrigation. Those who didn't get water from the distributory had to use bore well. The high cost of irrigation meant reduced income from agriculture.
- Farmers didn't deposit water tax (the collection dropped to less than 5%) and the department didn't have enough money for proper maintenance and management of the system.

After PVKS

- Water began to reach full the stretch, especially the lower reach and farmers from even the tail-end villages once again started to irrigate their fields from the distributory.
- The number of blockage points are reduced to only a few, which are resolved without any conflict or violence.
- The water wastage has been reduced substantially by peer pressure and by a feeling of shared responsibility.
- The distributary became a more reliable source of irrigation. The total acreage effectively irrigated by the distributory increased resulting in better and more yield.
- More agencies like TIFAC, ICAR started their work in the area in partnership with the PVKS.

Questions to consider

What are implications of the case to farmers?

What are the implications for policy?

What were factors in favour of PVKS?

Do you think that the water distribution rules were discriminatory and did not provide equal incentives to all?

Part II

Some incidental factors

Technology Information Forecasting Assessment Council (TIFAC) started its work from WALMI premises and was working on some pilot projects. They came to know about PVKS through WALMI and assigned it a project. PVKS was able to impress through its performance. As a result, TIFAC, New Delhi decided to work directly with PVKS in more projects.

PVKS got a revolving fund of Rs. 2 lakhs from TIFAC to provide high quality inputs to the farmers. PVKS along with TIFAC, now regularly organises extension fairs, exposure visits, and training programs to equip farmers with better technologies. ICAR / TIFAC are also helping PVKS to promote breeders' societies of progressive farmers to multiply seeds of high yielding paddy from breeders'/ foundation seed.

Before becoming the president of India, Mr. Kalam was associated with TIFAC. During his first visit to Bihar in May'03, he expressed his willingness to visit Paliganj (TIFAC project) and to meet farmers. During the process of interaction, the farmers demanded a paddy procurement centre for FCI at Paliganj that immediately got the President's approval. On the President's instructions, the FCI opened its Paddy Procurement Centre in 2003-04. In its first year, it procured 29,000 quintals of paddy @ Rs. 550 per quintal.

Question to consider

What were factors in favour of PVKS – (a reconsideration)?

Is this a replicable model?

Is this a sustainable model?

Part III

Revenue Model

The only important source of revenue to the PVKS is the patwan shulk collected from the farmers and the major expenditure is payments made to the government and the expenses incurred on the maintenance of the distributory.

As per the agreement with the Bihar Government, the PVKS would deposit 30% of the demand with the government and would keep 70% to meet expenditures incurred on maintenance and management of the distributory. At the prevailing collection rates, it would simply not be possible to follow this rule as the revenue in that case would be far less than the minimum annual expenditure. So, they convinced the government to relax this rule till such time as the collection increases and accept 50% of the total collection instead of 30% of the total demand in the meanwhile. A representative estimate of revenues and expenditure are given in the following table.

Table 2
An Approximate View of Annual Cash Flow
(Source: VS, PVKS)

Revenues		Expenditure	
Heads	Amount(Rs)	Heads	Amount(Rs)
Collection of *patwan shulk (*taking collection as 30% of the total demand of Rs 1000,000*)*	300,000	Payment to Bihar Govt.	150,000
		Staff salary	40,000
		Repairs & Maintenance	70,000
		Overseeing water distribution (jeep/diesel) cost	10,000
		Collection commission and mates' labor	35,000
		Miscell. & office maintenance	5,000
Total	300,000	Total	310,000
Deficit at current collection	10,000		

Table 3
Collection from 1997-98 to 2003-04
(Source: PVKS)

Year	Demand (in lac)	Collection (in lac)	Collection efficiency%
1997-98	7.96	2.3	28.9
1998-99	8.62	2.98	34.6
1999-00	6.73	3.1	46.1
2000-01	8.1	3.21	39.6
2001-02	8.19	3.08	37.6
2002-03	10.91	1.94	17.8
2003-04	10.96	2.21	20.2
1997-04(Cumulative)	61.47	18.82	30.6

NB 1: Collection after 1997-98 includes collection due in the year, some over-dues from previous year(s), which materialised in the given period.
NB 2: Increase in demand in the year 2002-03 is due to increased *patwan kar* rate of Rs 88 per acre from Rs 70 per acre for kharif season and that of Rs 70 per acre from Rs 60 per acre for rabi season. The rate for rabi season was further increased from Rs 75 per acre in the subsequent year 2003-04 and further increasing the demand.

Questions to consider

Is the revenue model sustainable?

How can the revenue model be strengthened?

Can the Govt. provide ant financial help?

5. Trainers' Notes

Trainers' Notes (questions in Part I)

What were the Implications?

Win-win Situation for the Government and the Farmers

It was a win-win situation for all. The government incurs no cost for the routine management and maintenance of the distributory. But it is getting half of the taxes collected, which amount to around 15% of the demand. The users without any incremental cost get more water for irrigation for more area in a more reliable way.

Policy Implication

The action research at Paliganj was meant to explore workability of Participatory Irrigation Management Approaches in reviving and revitalising sick irrigation systems at distributory and sub-distributory levels. Although, out of the four systems adopted for WALMI action research, only Paliganj reached a logical conclusion. The encouraging results of working with PVKS changed the attitude of the department towards PIM.

An apex body was constituted (that included development commissioner, the department secretary, representatives from NGOs etc.) to work towards overseeing PIM across the state. The department had also formulated guidelines for expeditious replication of the Paliganj models.

According to Mr. I. C. Shukla, anchor of PIM at WALMI, "More than 600 irrigation systems (at distributory /branch and sub-distributory levels have been earmarked for PIM). In 80 of the systems, distributory level committees have been constituted out of which around twenty DLCs have registered under Society Registration Act, 1860. Since the review of first pilot transfer of Paliganj distributory in 2000-01, eleven more systems have formally been handed over to the DLCs (9 in 2002-03 and 2 in 2003-04)."

The PVKS has been visited by a number of national and international agencies like the Planning Commission, World Bank, ISPAN, and WAPKOS. A team from the Planning Commission (Lakshami Ratan Saha et al.) visited Paliganj in 2004 to study the model. Apparently they appreciated it and would incorporate its learning for formulating strategy to give a new policy thrust towards PIM in the five-year plan.

Livelihood Implication

Reduced Cost of Irrigation

Besides the distributory, the area is also endowed with deep bores owned by relatively big and prosperous farmers. When the distributory was sick, the farmers would source irrigation water from the bore-wells by paying a rent to the owners and incurring the cost of diesel used in the pump systems (as the electricity supply was either absent or highly erratic, the diesel engines were used). But when the distributory again became functional the farmers save almost all the cost which they incurred on rent or in purchasing diesel.

More and Better Yield

After the revival of the distributory, the acreage, especially under rabi crops have increased. The crops productivity has increased (which are up to 50% in case of paddy) which partly can be attributed to availability of irrigation water especially during the critical crop periods.

Increased Wages

There has been a trickle down effect for the farm labor. More and better yield means farmers are in a position to pay the higher wage demanded by the farm labor (the area is under the influence of militant leftists).

Change in Pansui Village

The Pansui village, home of the president of PVKS Sri Gopal Singh Yadav, is located near the tail end of Bharatpur branch of the Paliganj distributory. The

neighbouring village, Bharatpur, is the stronghold of the CPI-ML.

A visit to the village revealed the farmers' perspectives on the change in the management of Paliganj distributory. Although the farmers are apparently happy, there were complaints about the free-loaders who neither volunteer time nor give patwan shulk. One of them quips, "Small and marginal farmers of the village are more active and forthcoming in volunteering their time. This lot has also benefited the most from the new arrangement as big farmers are now becoming less inclined to agriculture and giving their land for sharecropping in face of labor problem and naxalite unrest."

According to the farmers, "The cases of conflict are rare and any such case is resolved with impromptu negotiation and understanding of mutual concerns."

Gopal Singh Yadav further adds, "The cases of increased conflicts and violence were the result of the gradual ineffectiveness of the department in managing the system after mid-70s and the void thus created encouraged "free-for-all" behavior on part of the users who often clashed in the absence of any regulation/arbitration by an authority." The emergence of PVKS has given them a compromise and negotiation platform for a long-term collective interest.

Trainers Notes (questions in Part II)

What made PVKS Click?

Effective Leadership

It was a stroke of chance that WALMI was able to find an effective leader in Mr. Valmiki Sharma (VS) who was instrumental in the social mobilisation process and encouraged the acceptance of WALMI initiatives. This can be gauged from the fact that out of the four systems taken up for the action research only Paliganj reached a logical and beneficial end. The reason for failure in the other three cases could be attributed to the lack of effective leadership.

Effective Maneuvering by WALMI

The WALMI action research team was in constant touch with the ground realities with frequent visits/interactions with the lead farmers. This was possible as Paliganj was relatively closer to WALMI. The other areas where action researches were taken up were distant and hence didn't enjoy this advantage.

The then director of WALMI Dr L P Srivastava was personally involved in it's the Paliganj project and was impressed with the encouraging response from the farmers. He enjoyed good rapport with the senior officials of the irrigation department where he had worked as chief engineer. The lead team of VS et al also considered him as their mentor and guide.

Dr Srivastava also ironed out the last minute hitches by using his personal rapport e.g. he case where there was a disagreement over the acreage being irrigated by the distributary. As the lead farmers were involved in managing the distributary before the official transfer they knew that the acreage is less than what is mentioned in MOU for the official transfer. Dr Srivastava had to make the farmers agree to the increased acreage as the irrigation department refused to accept the reduced acreage.

Early Positive Results

The lead team of VS et al brought early tangible results. They mobilised public support for shramdan and chanda for desiliting and repair works of the distributory in 1992. This was followed by monitoring of water usage through a team of volunteers to minimise wastage. And the results were spectacular. For the first time in more than a decade water reached villages at the end of the distributory. This started a virtuous cycle of gaining credibility and confidence with more and more farmers.

Incidental factors in favour of PVKS

- PVKS had quite a few chance occurrences in its favor. One of which was partnership with Technology Information Forecasting Assessment Council (TIFAC) . TIFAC started its work from WALMI premises and was working on some pilot projects. They came to know about PVKS through WALMI and assigned it a project. In 2002-03, Dr S R Singh (State Director of TIFAC) left TIFAC. PVKS was able to impress through its performance. As a result, TIFAC, New Delhi decided to work directly with PVKS in more projects.
- PVKS got a revolving fund of Rs. 2 lakhs from

TIFAC to provide high quality inputs to the farmers. PVKS along with TIFAC, now regularly organises extension fairs, exposure visits, and training programs to equip farmers with better technologies. ICAR / TIFAC are also helping PVKS to promote breeders' societies of progressive farmers to multiply seeds of high yielding paddy from breeders'/ foundation seed. The extension services of PVKS-TIFAC have greatly increased (up to 50%) the yield of paddy in the area and reduced the cost (e.g. by propagating reduced seed rate for nurseries and the system of rice intensification).

- The most important of coincidence that was in the favor of PVKS is its association with President APJ Kalam. Before becoming the president of India, Mr. Kalam was associated with TIFAC. During his first visit to Bihar in May'03, he expressed his willingness to visit Paliganj (TIFAC project) and to meet farmers. And this gave PVKS (VS et al) direct access to the first citizen of India. During the process of interaction, the farmers demanded a paddy procurement centre for FCI at Paliganj that immediately got the President's approval.
- On the President's instructions, the FCI opened its Paddy Procurement Centre in 2003-04. In its first year, it procured 29,000 quintals of paddy @ Rs. 550 per quintal. This stabilised the procurement price of the paddy in the area and benefited the farmers with an average price advantage of Rs. 75 per quintal from the previous year. Cumulatively, this amounted to an incremental income of more than Rs. 20 lakhs to the farmers.
- In July'03 some farmers visited President Kalam in the Rashtrapati Bhavan on the his invitation. During the meeting the President exhorted them to start cultivation of medicinal and aromatic plants.
- Valmiki Sharma gleefully informs, "A representative from the State Bank of India has approached us to finance the cultivation of medicinal and aromatic plant if such projects are forwarded to them for a loan." Valmiki understands the significance of such a polite and courteous offer from a banker.

Concerns and limitation of the case

Vicious Circle of a Leadership Trap (Need for institutionalizing interventions)

The core contribution of WALMI (a lot of credit goes to the then director Dr. L. P. Srivastava) in the Paliganj Action Research is identifying, motivating, and capacity building of the core team of Valmiki Sharma et al and using the same as a key driver for the social acceptance of the new paradigm. Later the same team formed the backbone of the formal institutional arrangement in the DLC/PVKS.

The active involvement of VS et al may have either not left enough space for others or else have imparted a sense of complacency in the other participants. The PVKS active team has mostly remained restricted to VS et al. Many of the farmers who were earlier active are no longer taking any interest. On the other hand, as VS et al may also argue, that such involvement from their side is warranted in view of the fact that not everyone is forthcoming.

One such case is the contribution of the farmers (Rs. 2.09 lakhs), which was mobilised and deposited with the government to qualify for a functional grant. VS et al arranged the money on their own as PVKS wasn't in a position to do so. Such steps, while well-intentioned and operationally expeditious, may further alienate other farmers and reduce their ownership.

The PVKS has been able to develop a minimal operational apparatus. But institutionally it has not been able to grow and mature. Although PVKS bylaws (formulated by WALMI) had provisions for institutional processes and structure, VS is looked upon and asked for every little thing and has achieved larger-than-life image. This was also an important concern for Dr. Srivastava, who frequently urged the PVKS about the need for a second rung of leadership. Even now the PVKS has not been able to discover/develop a second rung of leadership.

However its long-term sustainability as a users' forum would be possible only under strong institutional context (norms, processes, systems and a clear strategy and vision for future) with broad based participation. To reach such an institutional state;

Declining Participation

Presently, the DLC/PVKS has become more of an interface between farmers and the government. Although the farmers acknowledge the positive difference and appreciate the role of PVKS in it, the number of farmers who actively participate in the affairs of PVKS has gradually declined.

During the formative days of PVKS, the people's participation was relatively greater and direct. They had new hopes when water started reaching the tail end and its use began to be peer-monitored and negotiated in an agreed value system. This furthered enhanced credibility of PKVS and its leadership in the eyes of farmer-users.

From 1991 to 1996, the distributory was maintained by the contribution of user-farmers in the form of grains (paddy/wheat) and shramdan (volunteered labor). In Feb 1997, the water resources department (Government of Bihar) official handed over the distributory to PVKS for its management, maintenance, and collection of water tax. This was a milestone in formalising the process, which was underway for 6 years.

Ironically after this, some farmers became complacent as they thought that those who are at the helm of the affairs at PVKS should be making money from the collection of water taxes. And also when PVKS/DLC started collecting water taxes it was their responsibility to maintain and manage the distributory.

From 1997 to 2000, the distributory was in a dilapidated condition and hence maintenance cost was high. The poor collection of water tax was not enough to meet maintenance and management expenditure.

In 2000, the distributory was renovated by the government at an expenditure of more than one crore which reduced the maintenance cost, manageable at the given level collection. And the system of chanda (contribution of grains) and shramdan (volunteered labor) had discontinued.

Missing Incentives/ Disincentive

What would make them pay/participate?

The present collection of the patwan kar (irrigation tax) is around 30% against the total demand. One of the reasons for the poor collection may be attributed to the absence of any incentive/disincentive between those who pay and those who don't. The greater challenge is dealing with the social realities of naxalism and violence. The PVKS has consciously chosen to be very inclusive and is hopeful that over a period of time, users would start appreciating the need to pay for the benefits they enjoy.

VS commented that many of the farmers who had earlier been very active were no longer involved. They had expected some incentives for their active roles and involvement. Such incentive might be necessary in long term.

Trainers' Notes (questions in Part III)

Possible Avenues for a Healthier Revenue Model for PVKS

Inputs/credit intermediaries

The PVKS has a reach of around 50 villages and ten thousands farmers. The PVKS is working with TIFAC and organising different events like extension fairs, training programs etc. that keep it in regular contact with the farmers of the area. Its VLCs are present in 48 villages and could form an effective supply point. Its collection agents and labor mates, who primarily work in two seasons (around six months) and are idle for the rest of the year, could also double as collection of payment and orders.

Looking at some rough estimates, the total input cost of agriculture in a year is (assuming paddy and wheat as two crops sown in an acreage of 10,000 and 8,000 acres respectively with an input cost of Rs 800 per acre for paddy and Rs 1200 per acre for wheat) more than two and half crores. If we can conservatively assume that PVKS supply only 25% of the inputs with 10% margin the total revenue earned by it would exceed four lakhs.

Using the land strip

The distributory has a strip of land running parallel to it, which has a width of six to twelve feet on each side. This land has not been handed over to the PVKS. This land can also be a substantial source of income by the temporary lease out or cultivating medicinal and

aromatic plants as the President had suggested to the farmers. But this would require making the government agree to the same.

Increasing collection

Increasing collection is urgently required. VLCs need to be presented with incentives to achieve this end. The option "only payers use" which would have brought an immediate improvement in the collection in not viable for technical reasons (it would be difficult to ensure that a person who does not pay, is not allowed to use irrigation water in so large an area)

Trainer's Notes on group exercise 2.1

I. Poverty line in India, it is widely (but not unanimously) believed to well below true essential consumption needs. Just by bridging the poverty line gap, we cannot remove many poverty related deprivations. Hence so long as income transfers are related to the present poverty line, we need to do more. If, the poverty line were to be higher than what it is and income transfers (such as PDS) were meant to bring the poor above this line, mere transfer of income could remove many poverty related deprivations. We therefore need to assess non-income deprivations and tackle these separately.

ii. Certain deprivations, such as lack of voice or lack of access to quality healthcare or poor access to water and sanitation need not to go away except at fairly high levels of income.

iii. The premise that income is an adequate indicator of human development renders the whole idea "human development" redundant. While income may be a good indicator of extreme poverty, to address the deprivations that poverty entails we need to attack poverty in its different dimensions. Policies to address non-income aspects of poverty cannot be made unless we have systematic information about these deprivations.

iv. The following indicators of non-income dimensions of poverty can be used:

   a. Percent population in the age group 11-13 years attending school
   b. Percent female population in the age group 11-13 years attending school
   c. Female literacy
   d. Number of teachers per school
   e. Infant mortality rate
   f. Percent population with access to safe drinking water
   g. Agricultural productivity (yield)
   h. Percent population with access to PDS
   i. Percent of women-headed households
   j. Incidence of illness in family

Trainer's notes Group Exercise 2.2

Drawbacks of the scheme (Submitted by Dr. Umesh Kapil, Professor, Public Health Nutrition, Department of Human Nutrition, All India Institute of Medical Sciences)

The programme, it has been pointed out by experts, suffers from the following constraints:

a) There is no data from pilot studies on the technical, operational and administrative feasibility of NRHM implementation in any state of the country. There is no corrective action plan in case of failures.

b) Increasing budgetary allocation is not sufficient to ensure success of a program. For instance, for making institutional deliveries a reality it would require availability of all weather roads and transport facilities from the villages to the hospital where patient friendly trained proactive staff with support facilities are available to conduct the deliveries. However in reality, it would not be uncommon to find the SC/PHC / CHC tangentially located in a rural area because of the political consideration rather on population needs. Beneficiaries still have to travel long distances to reach these health centers to avail facilities. The strengthening of infrastructure such as the FRUs under CSSM and RCH-I programmes remain under or non-utilized. The new mission is being launched without taking stock of our failures with previous programs.

c) The currently available regular village level health functionary (at a salary of Rs. 8-10 thousand per month) is infrequently available. It is envisaged that this lacunae will be bridged by ASHA, who being a local resident would be available in the

village and act as a link in the provision of primary health care services to the community. Infact, the introduction of ASHA rather than enhancing the ANMs performance, may actually increase the existing indiscipline amongst the regular village level health functionaries. There appears to be some ambivalence in the role and location of the ASHA. She is to act as a bridge between the ANM and the village and, at the same time, she is to be accountable to the panchayat. When the ANM (who is a functionary of the Health Department) herself is not accountable to the panchayat, how is the ASHA supposed to do the balancing act between the ANM and the panchayat?

d) ASHA and Voluntary Health Guide (VHG) scheme launched in 1977 are almost similar in characteristics and philosophy (peoples' participation in the care of their own health). The fate of the VHG scheme is well known. It is not clear if the lessons learnt from that failure have been taken into account when planning to launch the NRHM.

e) For village level health functionaries, a better vigil with inbuilt mechanism for prompt disciplinary action, including termination of job of the offender is urgently required, which should not be mixed up with politics and personal vendetta. Local populace and the care seekers have stopped airing their views and problems, which if at all are more often than not, never heard and no remedial action is instituted.

f) The NRHM ignores the urban population which constitute now more than 30% of the population. The health parameters in the urban population is similar or at times even.

g) The mission has a high priority on training, especially as new components such as supply of AYUSH drugs have been added. According to the projections made, for an unit of 100 ASHAs which would be in each block of 100,000 population the total cost of training would be Rs. 741,500. In a district with 12-15 blocks, about 1 crore of Rupees will be available for training of ASHA. As with most programs in the past, a greater part of the mission's tenure may be spent on training with little or no time to assess the impact.

A few suggestions for improving NRHM (Submitted by Dr. Umesh Kapil, Professor, Public Health Nutrition, Department of Human Nutrition, All India Institute of Medical Sciences)

a) The NRHM should have active participation of Academic Community from Medical Colleges in the country. At least senior faculty member with interest in Public Health should monitor 2-3 districts and facilitate the implementation of the NRHM. The faculty of Medical Colleges should be given responsibility to visit the district and provide catalytic role in training of the ASHAs.

b) A system of concurrent evaluation of the Mission activities needs to be developed and data should be generated for undertaking immediate corrective action.

c) For implementation of NRHM, more flexible and be user friendly guidelines should be made for the State / District / Block rather than the central monolithic norms which are routinely issued by Government Of India. This would help in judicious utilization of funds. The benefits of the underprivileged population should be main considerations rather then procedural formalities while implementing the mission.

d) The ASHA should not be confined to dispensing services for a few selected vertical programs over the larger part of 12 months, as it will result in the neglect and erosion of other components of primary health care. A prime example is the erosion of routine immunization services related to intensive pulse polio immunization resulting in stagnation in under-5 and infant mortality and reemergence of vaccine preventable diseases such as Diphtheria And Pertussis.

e) The ASHA should be given a reasonable sum to support herself and her family so that she should not be made subservient to the ANM and the Anganwadi Worker.

f) What is presently needed is developing a comprehensive strategy and deciding what are our health priorities. Increasing budget and number of functionaries is not the answer to health problems faced by rural population. There is an

urgent need of motivating and tightening of the regular health functionaries of the existing system. ASHA would be of great help to the remote villages but cannot be a replacement of the regular trained health functionaries of the health system. If the health functionaries are busy for 8 month for one communicable disease and one micronutrient, all the other component of primary health care would definitely neglected.

Trainer's Notes on Group Exercise 2.3

Drive a group discussion with a view bring out the issues and suggestions from the experience of the participants.

Concerns

While there is no doubt that the program is making strides, certain concerns discussed below need to be addressed in order to ensure attainment of the SSA goals. Targets may be over ambitious given the time frame.

(a) A review of the progress demonstrated by the districts that were supported under DPEP I for over 10 years indicates that despite impressive progress, universalisation, even of primary education in all its dimensions, is yet to be achieved. School effectiveness as a systemic issue which is intimately linked with teacher absenteeism, is yet to be tackled in all its dimensions. The issue that emerges is if we want accelerated progress to ensure realisation of the SSA goals, does the solution lie in 'doing more of the same thing' or is there a need for reappraisal of the strategies and implementation mechanisms of different interventions?

(b) Social capital available within the communities needs to be harnessed fully in program implementation. Selective experiences around the country indicate the effectiveness of the use of social capital in improving the school system. For example, in Nagaland, under Communitisation of Nagaland Public Institutions and Services Act, 2002, the user community has been empowered to take charge of the management and day today functions of managing the schools. This includes the power to receive salary funds from the government and disburse to teachers after exercising the powers of 'no work, no pay'. Impact assessment of the program in 2004 has indicated that the dropout rate has reduced to zero in an overwhelming majority of the sampled villages. There is a sizeable impact on teacher absenteeism. The enrolment has significantly gone up and so have the pass percentages. A reverse enrolment shift has been noticed from private to government schools. Again, in Karnataka, there are certain villages where the extent of out of school children has been reduced to zero because of a community activist or a change agent who has made personal efforts to tackle each case of dropout or teacher absenteeism. Examples of community empowerment can be cited from other states/UTs too including M.P. and Tamil Nadu. The learning from these experiences is that the community (through Village Education Committee, School Management Committee, Parent Teacher Association and Mother Teacher Council) should own and manage the school or at least should be made responsible to monitor pupil attendance as well as teacher attendance. However, for this they will have to be empowered preferably through legislation as has been done in Nagaland or through government orders as been done in Tamil Nadu.

(c) While many innovative initiatives in different parts of the country in both government and non government sectors are happening, these need to be mainstreamed, replicated and up scaled. Innovative efforts shared with the Mission towards improving quality of learning include the Quality Improvement Program (QIP) in Andhra Pradesh; the Gujarat Achievement Profiles (GAP); The School Development Index in Uttaranchal. There are laudable initiatives in the NGO sector as well public private partnerships. Improving management and delivery of schools through community empowerment and raising levels of learning through targeted quality improvement programs throughout (and not as isolated, innovative examples) is an immediate imperative. This should be facilitated by SSA through facilitation of cross state learning, sensitization of

decision makers, incentivising such reforms and appropriate advocacy. The program, through its Innovation fund has provided opportunity for creative initiatives in specified areas. Some of these initiatives carried out under this provision, such as computer education, use of GIS technology, ECCE need to be now mainstreamed. The Innovation Funds should be used for context specific 'out of the box' initiatives.

(d) While the program has demonstrated a fair degree of progress with regard to universalising enrolment time has come now to make a clear shift in focus towards addressing the other more critical parameters such as retention/drop out, attendance, transition and learning levels. While the definition and methodology of computation of dropout rates needs to be standardized, the existing data indicates a clear decline in drop out rates over the years. The national figures (SES 2002 03) indicate a four percentage decline in drop out rates at primary stage from 39 per cent in 2001 02 to 34.9 per cent in 2002 03. For the elementary cycle as a whole, there is a decline of 2 percentage points from 54.6 per cent to 52.8 per cent between these two years. A rough estimation using UNESCO method which excludes repetition data from 461 districts (DISE 2003 04) indicates that the drop out rate for primary stage for 2003 04 is under 20 per cent.

(e) There is still no reliable benchmark on the achievement levels of children across the states/UTs. The present system of undertaking pupil evaluation as has been done in NCERT to test overall levels of learning and measure progress from time to time ought to be reviewed. The National Expert Group for Assessment in Elementary Education that has been constituted by NCERT may do this on a priority basis. There is also a need to simplify the assessment process and communication of its output to the parents in terms of the broader functional skills rather than isolated competencies. This is particularly important in the context of promoting community ownership of the schools and their involvement.

(f) Since quality is so closely inter linked to all parameters, there is a need to now look at the impact of the various inputs given under the program in the classroom practice including a sample based study of the 'time on task' spent by children. There should be an increased focus on better monitoring of planned expenditures in quality related areas.

(g) Intervention for universalisation for upper primary stage needs more attention. Issues brought out by appraisal teams such as a re look at existing CRC/BRC support arrangement, completion of training modules, and training strategy in states/UTs for this stage of education are important. These too have to be addressed in a short time frame.

(h) The review indicates wide inter state and inter district variations across the country in terms of progress on indicators. The averages mask the ground realities. More than 50 per cent of the out of school children are only in three states/UTs viz. UP, Bihar and West Bengal. There is an immediate need for identification of the states/UTs, districts and blocks which are lagging behind at respective levels for targeted attention and monitoring.

(I) Making available data which is consistent, reliable, timely and comprehensive and amenable to use at appropriate levels remains an important challenge. At present the principal tool for measuring progress towards enrolment, retention, completion, transition, school facilities, quality etc. is DISE which covers a large number of variables annually covering 97 per cent of the country's population. It is expected to be operationalised throughout the country in the next one year. It is commendable that DISE has resulted in reducing the time lag between collection of data and its analysis to about one year, which earlier, in SES (the only other source of national level data) used to take 7 or 8 years. DISE data is in respect of government schools and recognized private schools. A good number of students study in alternative schooling system. This is expected to be captured in DISE from next year onwards. Another set of data, which measures certain parameters of universalisation (enrolment, out of school children), comes from household survey

data. The household surveys are done every five years but some data sets are updated every year. Household surveys have proved to be a good mechanism to estimate number of habitation–wise children in different categories of schools and characteristics of out of school children. The frequency, vigor and methodology of such surveys across states/UTs is however varied. Another major concern is that there are significant variations across the three sources (SES, DISE and household survey). Correspondence between these data sets would be a reasonable expectation. The objective of such data is (i) to track progress at different levels towards super goals of SSA as well as on the input indicators; (ii) to provide feed back on different components of the programme and thus to be a useful tool for planning and appraisal systems; (iii) to be used for the purposes of research and evaluation. These objectives can only be realised if the data is consistent, of reliable quality, is available timely and is being used at appropriate levels. For addressing these problems the Mission recommends that a multi disciplinary expert group comprising of national and state level representatives as well as from outside the government system be constituted to review these issues for remedial action. The group may also look at the innovative experiences in data management being attempted by some states/UTs such as Karnataka and the state experiences in child tracking. The provision for 5 per cent sample check for ensuring quality should be made compulsory for all states/UTs. In addition to the EMIS system and household survey data independent studies/surveys by credible organisations such as NSSO should be periodically carried out to assess progress towards milestones. GOI should also consider asking states/UTs to get a household census conducted during 2006 07 which can provide comparable results across the country. It would be important to identify a core set of information at the national level for the purpose. It would be useful for GOI to work towards development of an Educational Development Indices (EDI) and bring out an annual National Elementary Education Report to include the position on educational as well as input indicators. This will help monitor and review the SSA goals and objectives and will be a source of credible information for the entire country.

(j) Although there are variations across states/UTs, in many states/UTs the unrecognised schools represent substantial enrollment which does not get captured in the EMIS. A recent study by NIEPA in Punjab has indicated that such schools cover 26 per cent of the total enrolment. This is an anomalous situation which cannot be ignored any further and needs to be studied and addressed.

(k) It has been recognized that most challenges related to education delivery lie at the district, block and school levels and the capacity at these levels needs to be augmented. It is for this purpose that a chain of SCERTs, SIEMATs, DIETs, CRCs and BRCs has been designed for resource support. However, the efficacy of this arrangement needs improvement through better alignment between the SSA and the elementary education system at all levels including the national level, and through building capacities of these resource institutions. At the national level, the TSG has played a crucial role in capacity building throughout the country and providing support to the program in diverse functional areas as well as in monitoring, appraisal, cross state learning, etc. It is satisfying to note that nearly half of the positions in TSG lying vacant for a considerable period are expected to be filled up shortly. While this is a positive development, a reassessment of the TSG strength in terms of the emerging expectations needs to be carried out and consultants recruited at appropriate, preferably, market rates of compensation to attract talent. Capacity of the system can further be augmented by pooling resources from civil society institutions and corporates some of whom may even be willing to assist on volunteer basis. It should be possible to create a national resource pool of institutions and civil society organizations that will help in capacity building in SSA at the national, state, and district level in a planned manner.

(l) Funds required for meeting the infra structural needs are inadequate. Infrastructure is an

important component in SSA to facilitate access, in view of the fact that elementary education is a Fundamental Right. The gap in infrastructural requirements is staggering. The ceiling of 33 per cent (extendable to 40 per cent of the project cost in certain cases) is clearly insufficient to meet the needs. There are encouraging examples of convergence such as in Andhra Pradesh. However, a sizable gap still remains. It is necessary to assess the gap and locate sources of funds to meet the cost of infrastructure particularly the civil works. A Sub Mission under the SSA Mission is on 'provision of basic minimum conditions including physical infrastructure and teachers'. The Sub Mission or a Task Force may assess the requirements and availability of funds from different sources such as Finance Commission Award, provisions under State Budget under non plan and plan heads, funds under PMGY or other Rural Development sector schemes, possibilities under RIDF, community contribution, NRI support etc. The GOI may in addition to promoting "convergent planning" at the district level also consider incentivizing state's efforts at mobilising additional funds. The GOI may also consider providing additional funds for civil works in relaxation of the prescribed ceilings for exceptionally deficient districts.

(m) Urban children need a special focus. In respect of urban education, some states/UTs have submitted plans for about 10 cities. This can be seen as a positive step. In a way, this also reflects a poor response from the states/UTs to SSA guidelines. The issues of urban education in many ways are different, if not more complex, from the rural. In cities where traditionally urban local governance has been strong, especially in Western India, the schools are better than in other cities. But generally, urban government schools are a picture of "poor schools for the poor". Urban poor particularly suffer because of (I) non–empowerment of urban local bodies (ii) a large number of urban poor are located in unrecognised slums and /or overcrowded localities which are not planned for (iii) their invisibility to surveys due to their exceptional situations such as child labour, beggars, shifting populations etc. Planning and provisioning for these children would require more creative solutions. There is a need to accelerate work in urban areas and the Mission hopes the GOI will consider addressing urban issues in one of the sub missions of SSA.

(n) State shares are not always timely. An impressive financial system has been put in place in SSA which is enforced in all the States/UTs except a few. Personnel have been put in place and have been trained. Innovative ways of on line and telegraphic transfer of funds in some States/UTs have come about in the last three years. There are certain problems however. There are 6 States/UTs who have not provided matching assistance of 25 per cent on time during 2004 05. The Mission was informed that a separate budget line already exists in all States/UTs and the Planning Commission ensures allocation of funds for the purpose at the time of Annual Plan discussions with the States/UTs. The Mission suggests that a list of defaulting states/UTs may be shared with the Planning Commission and the Finance Ministry so that plan releases to the States/UTs are curtailed/ withheld.

(o) IPAI has noted that the governing organizational structure needs to function more effectively in some states/UTs. For example, Governing Council in Assam has met only once in four years and has never met in Kerala and Haryana. States/UTs have to pay attention to these facts. Monitoring by the Centre will also help. The concurrent IPAI reports indicate that internal audit systems need to be strengthened considerably. This will help in timely monitoring of the quality of expenditure.

(p) Stability in tenure of key functionaries is a must for program implementation. There are instances of frequent shifting of personnel at different levels. For example, all data management personnel were shifted in Manipur soon after they were trained. Frequent shifting of SPOs and other functionaries are also cases in point. An MOU with states/UTs in this respect may be considered by the GOI.

(q) The research and evaluation component is presently narrowly interpreted and under utilised. There is a need to widen and deepen the range of investigations to include empirical studies,

analysis of available data, assessment of impact of program interventions and factors influencing the achievement of program objectives. The program could also encourage production of research based manuals and digests for dissemination of research.

(r) The performance levels of some states/UTs especially West Bengal, Arunachal Pradesh and Bihar is a matter of serious concern. These states/UTs have reflected very slow progress on different parameters and these needs to be put in the category of Special Watch States/UTs (Appendix 2).

The performance levels of some states/UTs especially West Bengal, Arunachal Pradesh and Bihar is a matter of serious concern. These states/UTs have reflected very slow progress on different parameters and these needs to be put in the category of Special Watch States/UTs (Appendix 2).

Recommendations of the Second Joint Review Mission

a) There is a need to increase the focus on weaker performing states, districts and blocks where progress towards the program goals is slowest

b) The gap in overall infrastructure provisioning needs to be addressed

c) Greater degrees of community empowerment need to be facilitated to allow for local level management and supervision of schools, including the attendance of both teachers and students.

d) A multi disciplinary expert group, comprising the national and state level representatives, including members from outside the government system should be constituted to undertake a comprehensive review of data management in SSA. This should include inter alia, revisiting the definition and methodology used to compute drop out rates.

e) There should be an increased focus on better monitoring of planned expenditures in quality related areas.

f) A 'time on task' study should be commissioned that examines the extent to which learners in elementary classrooms are engaged in learning.

g) Immediate action should be taken to improve the process of obtaining a reliable national benchmark to assess and evaluate progress towards learning achievement.

h) It is recommended that district level staffing be augmented (within SSA norms) to monitor BRC/ CRC/ VEC accounting and provide basic guidance.

Trainer's Notes on Group Exercise 2.4

There are two critical bottlenecks:

a) A debt burden of Rs.6000 to 7000 keeps them perpetually bonded to migration. More interaction with these families may through further light on this aspect

b) Their only asset base is land - though fragmented, the community together has around 70 acres of land. Proper treatment of this land with adequate investments on increasing its productivity and helping them to cultivate the land may provide a good starting point.

The discussion may be guided to consider the following leads:

(i) Is there an enterprise option to these Madiga communities – predominantly migrating and in perpetual debt burden?

(ii) Can a mixed SHG provide a basis for the Madiga women to take-off - particularly, in a society (and the group members) practicing untouchability in one way or other? That is can livelihood issues be dealt with independent of social issues?

(iii) What can be done to keep at least some of the migrating families to agriculture?

Key learnings from exercise are:

(I) The case study highlights the need for a rigorous methodology to understand the livelihood systems and changes happening over time.

(ii) The Livelihood Action Plans should be based on

such a detailed understanding. Otherwise they would only benefit a few upwardly mobile groups in the village and bypass the real target poor groups. A case in example is Dairy – in this village mostly Reddy and other communities in the 'Green' category are only the partners.

(iii) Identifying and focusing on the Poor and building on their resource base should be the major consideration in livelihoods planning.

(iv) Addressing livelihood issues may not yield results without attending the social issues.

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