Will India's Attainment of MDGs be an Inclusive Process

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**IIDS Activities**

- To conceptualise and theoretically understand social exclusion and discrimination in contemporary world.
- To develop methods and measuring tools for the study of discrimination and exclusions in social, cultural, political and economic spheres of everyday life and their consequences.
- To undertake empirical researches on measuring forms, magnitude and nature of discrimination in multiple spheres.
- To understand the impact of social exclusion and discriminatory practices on inter-group inequalities, poverty, human right violations, inter-group conflicts and economic development of the marginalised social categories;
- To undertake empirical research on the status of different excluded, marginalised and discriminated groups in Indian society *vis-à-vis* their social, cultural, political, and economic situations;
- To propose policy interventions for building an inclusive society through empowerment of the socially excluded groups in India and elsewhere in the world; and
- To provide knowledge support and training to civil society actors.

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*The IIDS Working Paper Series disseminate the findings of the core research outputs of the Institute to facilitate informed discussions among the civil society, the academia, researchers and also strive to contribute towards policy infusions.*
Will India’s Attainment of MDGs Be An Inclusive Process?

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Working Paper Series
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Foreword

Indian Institute of Dalit Studies (IIDS) has been amongst the first research organisations in India to focus exclusively on development concerns of the marginalised groups and socially excluded communities. Over the last six years, IIDS has carried-out several studies on different aspects of social exclusion and discrimination of the historically marginalised social groups, such as the Scheduled Caste, Scheduled Tribes and Religious minorities in India and other parts of the sub-continent. The Working Paper Series disseminates empirical findings of the ongoing research and conceptual development on issues pertaining to the forms and nature of social exclusion and discrimination. Some of our papers also critically examine inclusive policies for the marginalised social groups.

This Working Paper “Will India’s Attainment of MDGs Be An Inclusive Process?”, as the authors point out, the Millennium Summit of 2000 outlined a set of development and social goals called Millennium Development Goals (MDGs) that brought into focus the legitimate concerns of the developing countries. India was among the 189 nations that pledged to adopt measures to fight hunger, illiteracy, gender inequality, diseases and environmental degradation. The MDGs indicators have since then been the global benchmark for development and all countries including India are striving towards achieving them. MDGs have brought back the focus of development to social sector that need to pursued hand-in-hand with economic development. Indeed the social sector commitments need to be placed at the centre-stage as an investment, not as expenditure that drain accrued economic gains. Today, the MDGs are not only a commitment by the governments but also a measure of how well development-oriented programmes are working towards their stated objectives. MDGs targets are to be achieved by 2015, with the improvements in most indicators being measures from their 1990 levels.

The paper concludes that as per the current trends in progress on the MDGs indicators there is a sufficient ground for concern that under a business as usual scenario, significant shortfall is evident among the disadvantaged groups in India. This may occur even if most of the indicators are achieved in terms of a national average. In such a case, social disparities would continue to exist.

Indian Institute of Dalit Studies gratefully acknowledges UNDP for funding this study and Christian Aid (India) for supporting the publication of the Working Paper series. We hope our Working Papers will be helpful to academics, students, activists, civil society organisations and policymaking bodies.

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1. MDGs and Social Inclusion: The Progress So Far

The Millennium Summit of 2000 outlined a set of development and social goals called the Millennium Development Goals (MDGs) that brought into focus the legitimate concerns of the developing countries. India was among the 189 nations that pledged to adopt measures to fight poverty, hunger, illiteracy, gender inequality, diseases and environmental degradation. The MDGs Indicators have since then been the global benchmarks for development and all countries including India are striving towards achieving them. MDGs has brought back the focus of development to social sector that need to be pursued hand-in-hand with economic development. Indeed the social sector commitments need to be placed at the center-stage as an investment, not as expenditure that drain accrued economic gains. Today, the MDGs are not only a commitment by the governments, but also a measure of how well development-oriented programmes are working towards their stated objectives. MDGs targets are to be achieved by 2015, with the improvements in most indicators being measured from their 1990 levels.

A total of 8 goals and 18 targets were adopted in the Millennium Declaration. The 8 MDGs (See Annexure 1 for details) are:

- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education
- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce child mortality
- Goal 5: Improve maternal health
• Goal 6: Combat HIV/AIDS, malaria and other diseases
• Goal 7: Ensure environmental sustainability
• Goal 8: Develop a Global Partnership for Development

Various quantitative indicators are used to monitor the progress of these targets\(^1\). It is interesting to note that among the five criteria that guided the selection of these indicators, the very first one mentions that the indicator should provide relevant and robust measures of progress. The question to examine is whether the way in which the progress towards the goals is being currently achieved is relevant to the Indian context in terms of meeting the social commitments that the MDGs embody.

The goals and principles embodied in the MDGs have been reflected in India’s development priorities which are inculcated in the National Common Minimum Programme (NCMP) and the 10th Plan. They have been given further voice in the 11th Plan that has adopted several monitorable targets as key features of inclusive growth strategy. These are meant to capture the economic and social objectives of an inclusive approach to growth. In all, 27 ambitious targets have been identified at the national level, while 13 of these can be disaggregated at the level of individual states. The 27 targets identified at the national level have been placed in six major categories including: (1) Income and Poverty; (2) Education; (3) Health; (4) Women and Children; (5) Infrastructure; and (6) Environment\(^2\).

The MDGs are laudable and welcome goals which have links with a series of positive initiatives such as *Bharat Nirman*, NCMP, National Rural Employment Guarantee Scheme (NREGS) and National Rural Health Mission (NRHM). Hence the commitment of India to achieve the MDGs is not only external, but also very much internal too. However, the specification of the targets in the 10th Plan did not provide for any incorporation of differences within the population in terms of caste, race, gender, or other such basic social identities.

A review of the progress on MDGs (UN 2006) across the world reported an optimistic progress for most of the targets. Despite the targets being ‘staggering’, there were ‘clear signs of hope’. Yet there were reasons for concern since disparities continue to exist both between and within countries. There were signals that the poorest, particularly in rural areas were being left behind. A positive sign from India is that the reduction in poverty was the fastest. The proportion of people living on less than US$1 per day had declined by nearly 20 per cent between 1990 and 2002. The decline in chronic hunger was however much slower than this parameter would suggest.
Net enrollment in primary education had risen spectacularly in South Asia (72 to 89 per cent) during the period 1999-2004, largely on account of the progress in India. The review however expressed concern that India was among the six countries that had low immunisation rates among children. The India Country Report (2005) on MDGs provides a list of 16 indicators that can measure progress towards the MDGs, along with the target value to be achieved for each of these indicator achieved by 2015. A quick comparison of the targets with the values reported for 1999-2000 reveals that there is a long way to go before these targets could be. The shortfall is particularly acute for the health and poverty indicators.

Given the geographical spread of the country and the different threshold levels at which different communities and social groups within it were in 1990, it is imperative to look at the MDGs indicators in a disaggregated manner. This study is an attempt to do precisely this exercise. It is to be expected that there will be disparity in the rates at which different communities are able to reach the MDGs targets, given the differences in the baseline from where they started.

A disaggregated view of the MDGs can serve to bring these differences into limelight, so that perceptive policies could be drafted, which would seek to achieve the MDGs for all social groups, and not in terms of national averages only. Unfortunately, thus far the focus has not been on disaggregation. The India Country Report (2005) on MDGs for instance, does not take any note of the disparities that occur within the country.

In the Indian context, caste may be considered broadly as a proxy for socio-economic status and poverty. In the identification of the poor, Scheduled Castes (SCs) and Scheduled Tribes (STs) and in some cases the Other Backward Castes (OBCs) are considered as socially disadvantaged groups, which have a higher probability of living under adverse conditions and poverty (Nayar 2007). It is only when we consider the gap in achieving targets across different social groups, particularly the SCs and STs that we are able to infer on the magnitude of extra effort that is required to bring them to the required level.

For instance, Target 3 of Goal 2 asks to ensure that all boys and girls must complete a full course of primary schooling. In India, however, the dropout rates at primary levels for SCs (34.2 per cent) and STs (42.3 per cent) are substantially higher than the national average of 29 per cent (11th Plan 2008). Again, in terms of child underweight rates, the National Family Health Survey (NFHS) data reveals that while there is not much variation across economic
groups, the scenario changes when one considers social groups. The child under weightrate is higher for SCs and STs as compared to other forward castes. The relative disadvantage is more severe in the poorer states. To quote the 11th Plan “….a major weakness in the economy is that the growth is not perceived as being sufficiently inclusive for many groups, especially SCs, STs, and minorities. ….. The lack of inclusiveness is borne out by data on several dimensions of performance.”

Given the fragmentation which still persists in Indian society vis-a-vis social categories such as caste, lack of differentiation among social groups leads to the potential danger of masking the differences across them. It calls for caution in interpreting national figures, which may imply positive progress in the indicators at the cost of enhanced or continued deprivation for certain social groups. It also implies that in case certain social groups continue to be left out of the development process, the MDGs indicators will actually reflect a paradoxical situation of improved overall access with enhanced inequality in terms of basic human development for certain disadvantaged sections. As a first step towards ensuring that such a situation does not arise, it is essential to analyse the available data on indicators in a disaggregated manner, and monitor their progress in terms of relevant social groups.

As the 2015 MDGs deadline approaches the question that stares us in the face is whether the marginalised and vulnerable groups will continue to be left out. In other words will, a reasonable progress (if not actual fulfillment of the targets) be attained while those who need it the most will not be the beneficiaries? Often enough, the unserved or under-served segments of the population are the hardest to reach and it may require additional efforts and resources beyond ‘business as usual’ to ensure that they attain the MDGs.

This study, while welling upon analysing the targets set for the 11th Plan and the MDGs and concentrating primarily on three sectors, encapsulate the most pressing of the human development needs reduction in poverty (Goal 1), educational attainment (Goal 2) and attainment of good health (Goals 4, 5 and 6). The study is based on indicators which relate to the attainment of these goals, although it is to be noted that all the goals are inter-related and impinge upon each other in their impacts. For example, Goal 3 on promoting gender equality and empowering women is an essential goal that needs to be an integral part of every other goal.

Similarly, improvements in the lives of slum dwellers and raising the proportion of population with access to improved water and sanitation facilities (Goal 7)
is an essential component of addressing vulnerability faced by the poor and disadvantaged in this country. This study endeavours to throw light on the progress achieved in the indicators, particularly in terms of constituent social groups in India through the use of statistical data and methods.

2. In defence of an Equity/Rights Perspective: Making Case for Social Inclusion

The UN Millennium Declaration is a key international development that articulates people’s centrality in development processes. In it, governments commit “to promote equality and the empowerment of vulnerable as effective ways to combat poverty, hunger and disease and to stimulate development that is truly sustainable.” The Declaration also addresses “the equal rights and opportunities of women and men” and pledges “to combat all forms of violence and implement the Convention on the Elimination of All Forms of Discrimination.” Thus, the UN Millennium Declaration considers the following four fundamental values to be essential to attain the MDGs.

- **Freedom**: Men and women have the right to live their lives and raise their children in dignity, free from hunger and from fear of violence, oppression or injustice.

- **Equality**: No individual must be denied the opportunity to benefit from development. The equal rights and opportunities of women and men must be assured.

- **Solidarity**: Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with basic principles of equity and social justice. Those who suffer or who benefit the least deserve help from those who benefit the most.

- **Tolerance**: Human beings must respect one other, in all their diversity of belief, culture and language. Differences within and between societies should be neither feared nor repressed, but cherished as a precious asset of humanity. A culture of peace and dialogue among all civilisations should be actively promoted.

Therefore principles are essential ingredients for achieving all the MDGs, be it a hunger-free world, poverty eradication, protecting the human rights, or access to healthcare and other social provisions. Attempting to meet the MDGs without incorporating these basic principles will both increase the costs and minimise
success for nations. The recognition of these principles implies that differences among population groups in terms of race, ethnic, caste or gender must be taken into account. Since the MDGs are mutually reinforcing, success in meeting then for all segments of society will have positive impacts on achieving equity across the entire population. Similarly, progress towards caste/gender equality in any one area will help to further each goal. An equity based or rights perspective to human well being demands all possible efforts in promoting social inclusion as a key to achieving universally accepted human development goals.

Caste⁴, ethnic and religious identities have resulted in specific sections of the Indian population being excluded and discriminated resulting in endemic and chronic poverty, illiteracy, ill health, higher mortality rates among the (SCs), (STs) and the Muslim. These communities constitute a sizeable proportion of the population, i.e. 16.7 per cent, (SCs), 8 per cent (STs) 13 per cent (Muslim) together making about 37 per cent of the India’s population. With 65 per cent of the SCs & STs households living below the poverty line (BPL)⁵, the non-achievement of the goals by these communities undermines the achievement of MDGs by India as a whole. This is reflected in the 11th FYP called ‘Faster and Inclusive Growth’, setting the context for ensuring that excluded sections participate and benefit from the growth and development in the country.

The SCs population (Dalits) is confronted with certain issues and concerns in their experience of social exclusion, untouchability and discrimination, which need to be addressed explicitly. Gang, Ira, Sen and Myeong-Su Yun (2002) studied the difference incidence of poverty between Dalits households and non-Dalits households, and observed that the poverty rate is 16.1 per cent higher in Dalit households than in non-Dalit households⁶. Caste-based discrimination has caused social exclusion of Dalits from socio-economic-political-cultural spheres and the development process. Despite Constitutional guarantees and safeguards and state welfare schemes, untouchability and exclusion persist in variable measures. Addressing caste-based discrimination, therefore, is a critical step towards achieving equity which is the cornerstone of the MDGs. Albeit caste based reservation has empowered SCs and STs there are millions who continue to be denied economic rights and development opportunities.

The new land policies and corporatisation of agriculture are increasingly leading to dismantling of traditional economies. State withdrawal from welfare programmes has led to less availability of social security in the form of health
and educational services. With the emergence of a new knowledge and service based economy the lack of professional and market skills, computer proficiency and English language skills is increasingly pushing deprived communities to the margins.

There are serious concerns about the implementation of state programmes, as a large number of people under BPL category are not able to access the subsidised Public Distribution System (PDS), which severely undermines food security. In addition lack of empowerment prevents marginalised communities from adequately and effectively accessing the benefits of progressive legislations and programmes. Hence, there is a need for creating awareness and demand among the community about the government policies and programmes.

3. Data Related Issues

The attainment of MDGs is defined in terms of targets and indicators, based on quantifiable data which is to be representative of the entire country. However, in India, several data related problems have posed obstacles in reporting all the indicators listed under the MDGs. While some of the data which are collected in India not compatible with the formats specified, others are not available or sufficient, for example, data on the proportion of population below US$1 per day, proportion of population below minimum level of dietary consumption, ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years, proportion of population with access to secure tenure and proportion of population with access to affordable essential drugs on a sustainable basis, etc. For some of the indicators, however, we can generate indicative figures, based on large scale surveys such as the NFHSs for health data or the Sample Registration System.

Since the indicators of the MDGs are currently being measured only in terms of national level and representative figures, they fail to reveal the attainment levels of various social groups that constitute the entire nation. India being a large democracy and a culturally diverse nation has several groups that are unequally placed in terms of their access and requirements for human development. Some of the available data sources do report data by social groups, although not for all the indicators as specified for the MDGs. The analysis presented in this paper is largely based on three data and information sources: NFHS (1, 2, and 3); National Sample Survey (NSS); and the Planning Commission (Five Year Plans).
4. Tackling Poverty and Hunger (Goal 1)

Goal 1 calls for the eradication of extreme poverty and hunger. The available indicators on poverty and hunger in India present a contradictor of Dscenario. Although there was a marked decline in the proportion of people under BPL category during the 1990s, the absolute numbers in poverty remain extremely high, i.e. over 30.17 crores in 2004-05 with the majority located in rural areas. As per the official figures, the percentage of population under BPL stands at 27.5 per cent in 2004-05\(^7\) (see Figure 1).

Figure 1: Poverty Ratio in Indian States (2004-05)
What is of greater concern, however, is that the rate of decline in poverty has not been in keeping with the pace of growth in gross domestic product (GDP). It is also disturbing that there is an increase in the absolute number of poor in urban India, which is a reflection of the fact that the poor have been migrating to urban areas. It is also noted that within urban areas, the SCs are the worst off at 39.8 per cent as compared to an all India figure of 25.7 per cent Head Count Ratio (HCR). Besides, it is a matter of grave concern that poverty among STs has actually increased, primarily in rural areas.

In terms of absolute numbers, overall poverty has declined by approximately 2 crores from 32.03 crore to 30.17 crore between 1993-94 to 2004-05. However, in terms of inter-state data, the absolute number of poor have in fact increased in several states over the same period. These include Orissa, Chattisgarh, Madhya Pradesh, Maharashtra, Delhi and Punjab. In urban areas, the absolute number of the poor has increased from 7.63 crore in 1992-93 to 8.07 crore in 2004-05 and in rural areas it has decreased at an average rate of 20.1 lakh annually.

The current poverty ratio at all India level is 27.50 per cent (as per the 2004-05 estimates). The estimates on poverty show a clear decreasing trend over the time period for both rural and urban areas. The disaggregated data across social groups provides some further insights. It is clear that poverty among the STs is 46.46 per cent which is highest across the social groups at all India level. The poverty among SCs population is estimated to be 37 per cent followed by the other caste population at 22.67 per cent. This indicates the higher relative deprivation of SCs and STs population and the prevalent inequality across social groups in India (see Figure 2).
The Planning Commission in the 11th Plan has identified several time bound goals (see Annexure 2 for details) which are expected to impact on poverty. These goal span across several aspects of human well being, vulnerability and poverty. The 11th Plan also notes that the SCs and STs population suffers from multiple deprivations, particularly in terms of inequitable asset ownership such as land. Further, their health, nutrition and education indicators are much worse than those of the rest of the population, indicating higher relative deprivation.

The rising share of casual workers in the economy comprises mostly of STs and SCs population, amongst whom the landless casual workers are the poorest. Another indicator of vulnerability is the access to clean water source. While SCs’ access has improved, STs’ access continues to lag behind compared to all India access figures, as revealed through successive rounds of the NFHS. Among other targets, the 11th Plan proposes a reduction in the HCR of consumption poverty by 10 percentage points.

The MDGs target is to reduce the proportion of people living on less than US$ a day by half. This indicator is not available for India. Instead, an alternative indicator is defined in terms of the proportion of people under BPL. Halving the proportion of people who suffer from poverty between 1990 and 2015 implies that the level of poverty should reduce to about 16.51 per cent in 2015. So far, share of the poor in the population has fallen by 27.3 percentage points from 54.8 in 1973 to 27.5 in 2004. Some simple extrapolation based on existing rate of decline of poverty across social groups enables the calculation of reduction in poverty which can be expected by 2015 (hereafter called projected figures). These can be compared with the target figures for MDGs attainment (referred to hereafter as target figures).

The estimations reveal that the projected figures for reduction in poverty by 2015 fall short of the MDGs target for both SCs and STs. Alternatively, as illustrated in Figure 2, if each of the groups was to reach the overall target for poverty reduction in 2015, the fastest rate of decline is required for the STs (at 0.06 per cent per annum) followed by SCs (at 0.05 per cent per annum) as compared to a required rate of decline of 0.02 per cent per annum for the remaining population.

In rural India, data for 2004-05 clearly reveals a high degree of correspondence between high levels of poverty among SCs, STs and overall poverty (shaded in red, green and yellow respectively in Figure 1) for all those states which report poverty levels above the national average for each of these groups. These
are: Bihar, Jharkhand, Madhya Pradesh, Maharashtra and Orissa. Chattisgarh, Uttar Pradesh and Uttarakhand report poverty levels much above the national average for SCs only while Chattisgarh reports poverty levels much above the national average for STs.

It is to be noted that states which have low overall poverty levels, such as Gujarat, Andhra Pradesh and Kerala report high poverty levels for STs and similarly in the case of Karnataka and Tamil Nadu for SCs (shaded in blue in Figure 1).

**Figure 3 : Targets for Poverty Reduction (MDGs) across Social Groups**
Figure 3 illustrates that between 42 per cent to a staggering 75 per cent of the population from these categories falls under BPL in these states. There seems to be little doubt about the dismal picture that states across the country present in terms of rural poverty for the disadvantaged sections of society.

States reporting high levels of poverty in 2004-05 in urban areas for different social groups are by and large the same as those reporting rural poverty. However, the magnitudes differ. Bihar, Karnataka, Chattisgarh, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh and Uttaranchal report above national averages for all three categories, i.e. SCs, STs and overall (shaded in red, green and yellow respectively in Figure I). It is also noted that for all three groups, the number of states reporting poverty levels above the national average is much higher in urban than rural areas. The numbers for BPL range from 37.4 per cent to 72.6 per cent of the population in the respective categories for the disadvantaged groups.

Table 1: Population Percentage under BPL by Social Groups (2004-05)

<table>
<thead>
<tr>
<th>State Name</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SCs</td>
<td>STs</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>15.4</td>
<td>30.5</td>
</tr>
<tr>
<td>Assam</td>
<td>27.7</td>
<td>14.1</td>
</tr>
<tr>
<td>Bihar</td>
<td>64</td>
<td>53.3</td>
</tr>
<tr>
<td>Chattisgarh</td>
<td>32.7</td>
<td>54.7</td>
</tr>
<tr>
<td>Delhi</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gujrat</td>
<td>21.8</td>
<td>34.7</td>
</tr>
<tr>
<td>Haryana</td>
<td>26.8</td>
<td>0</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>19.6</td>
<td>14.9</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>5.2</td>
<td>8.8</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>57.9</td>
<td>54.2</td>
</tr>
<tr>
<td>Karnataka</td>
<td>31.8</td>
<td>23.5</td>
</tr>
<tr>
<td>Kerala</td>
<td>21.6</td>
<td>44.3</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>42.8</td>
<td>58.6</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>44.8</td>
<td>56.6</td>
</tr>
<tr>
<td>Orissa</td>
<td>50.2</td>
<td>75.6</td>
</tr>
<tr>
<td>Punjab</td>
<td>14.6</td>
<td>30.7</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>28.7</td>
<td>32.6</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>31.2</td>
<td>32.1</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>44.8</td>
<td>32.4</td>
</tr>
<tr>
<td>Uttaranchal</td>
<td>54.2</td>
<td>43.2</td>
</tr>
<tr>
<td>West Bengal</td>
<td>29.5</td>
<td>42.4</td>
</tr>
<tr>
<td>India</td>
<td>36.8</td>
<td>47.3</td>
</tr>
</tbody>
</table>
Among states that seem to be doing reasonably well in terms of the overall national average, Delhi, Haryana, Kerala and West Bengal reveal relatively high poverty among SCs. On an average, within these states SCs appear to be worse off in urban areas as compared to rural, while STs are doing badly in rural areas as compared to urban areas. This of course is only a comparative picture within the particular social group, but does in no way diminish the unfortunate truth that in both rural and urban areas, poverty persists in a major way. Among SCs, deprivation also shows up in the form of lack of asset ownership while for STs multiple deprivations in the form of access to education and health along with income poverty is a stark reality.

### 4.1 Malnutrition

Between NFHS 2 and NFHS 3, malnutrition indicators have hardly shown any improvement – both for adults and children. For adults, there was a decline of 3 percentage points. For under 3 children, the proportion of underweight children hardly showed any decline, 46 per cent in NFHS 3 compared to 47 per cent in NFHS 2. Mean heights and weights of children from SCs/STs and other marginalised sections are below the national averages, the disparity being higher for STs (see Table 2). Being underweight has been found to be closely associated with low incomes and poverty, which in turn, is positively correlated with the proportion of SCs and STs.

<table>
<thead>
<tr>
<th>Table 2: Proportion of Underweight Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underweight children (%)</strong></td>
</tr>
<tr>
<td><strong>Others</strong></td>
</tr>
<tr>
<td>NFHS 1</td>
</tr>
<tr>
<td>NFHS 2</td>
</tr>
<tr>
<td>NFHS 3</td>
</tr>
</tbody>
</table>

It is to note that, \textit{ceteris paribus}, the projected achievement levels for reduction in proportion of underweight children in 2015 for all the social groups falls short of the targets. The policies and programmes in place are unlikely to translate into equal achievements across social groups as expected. Extrapolation based on existing rates of achievement indicate that the gap between the target for 2015 and the likely achievement figures is highest for STs, followed by SCs and non SCs/STs. Figure 4 clearly demonstrates that the required rate of decline for reaching the target level of reduction in underweight children would be steepest for STs at 0.046 per cent per annum followed by SCs at 0.042 per cent per annum and 0.03 per cent for the rest.
In absolute terms, given the population growth rates, the numbers of children have actually been increasing that calls for urgent structural changes and programmatic interventions. The situation merits special concern since this was a period of high growth. The 50th (1993-94), 55th (1999-2000) and 61st (2004-05) rounds of NSS have pointed out that per capita consumption has been on the decline in both rural and urban areas. In terms of overall averages, this can in a small measure be attributed to diversification of dietary choices. Significantly, consumption expenditures have decreased throughout the three decades prior to 2004-05. The 11th Plan observes that the nutritional status of women SCs and STs is a reason for worry with 42 per cent of SCs women and 46 per cent of STs women having a Body Mass Index (BMI) less than 18.5, which is seen as the cut-off benchmark for malnutrition and indicates a serious problem of nutrition.

**Figure 4: Percentage of Underweight Children (MDGs) across Social Groups**

Under the Targeted Public Distribution System (TPDS), higher rates of subsidies are being given to the poor as well as the poorest of the poor. Above the Poverty Line (APL) families are also being given lower subsidy under TPDS. With only about 36 per cent of the poor having either BPL or Antyodaya cards,
and with about 40 per cent of such cards with the non-poor it is obvious that the TPDS is unable to exert real impact on the marginalised groups. The 11th Plan makes no specific provisions for SCs, STs and other marginalised groups in this regard.

Poverty continues to be closely related to the proportion of SCs and STs population in the different states in India as well. There is, therefore, a need to examine why this is so, and whether our efforts to overcome hunger and poverty call for more targeted interventions that could note of the differing baselines across social groups and within states.

5. Addressing Educational Gender Equality and Women Empowerment (Goal 2 and 3)

In this section, the educational variables relevant for India, along with the implications for gender equality is examined. In India, there are major differences in the primary attendance rates across states. But the variability gets further accentuated when one disaggregates primary education related variables by social groups and further by gender. Thus, the ratio of female to male students enrolled at the primary and secondary levels of schooling is markedly lower for STs and SCs as compared to those for other social groups (Deolalikar, 2005). It is popularly held that eliminating gender disparities in education is one of the most effective poverty reduction strategies.

As per the latest available data, SCs and STs have Gross Enrollment Rates at primary level which are comparable with the general population. These rates have risen sharply in recent years. However, the drop-out rates, before completion of five years of schooling are much higher for SCs and STs than for the general population. The dropout rates in 2004-05 at primary levels for SCs and STs are 34.2 and 42.3 per cent respectively as compared to a national average of 29 per cent (see Table 3).

<table>
<thead>
<tr>
<th>Categories</th>
<th>Primary (I-V)</th>
<th>Elementary (I-VIII)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
</tr>
<tr>
<td>SCs</td>
<td>32.7</td>
<td>36.1</td>
</tr>
<tr>
<td>STs</td>
<td>42.6</td>
<td>42.0</td>
</tr>
<tr>
<td>All</td>
<td>31.8</td>
<td>25.4</td>
</tr>
</tbody>
</table>

Source: Selected Educational Statistics, 2004-05
Several reasons have been cited as explanations for this occurrence. Among other reasons, studies have noted the prevalence of discrimination in various ways against SCs and STs in schools, and the lack of proper infrastructure such as toilets as a deterrent for girl students. In practice discrimination in education takes various forms (Nambissen 1995). For instance, there are schools where separate pots for drinking water are kept for SCs and non-SCs students. Often teachers may not be sensitised to the problems of social exclusion. Further, SCs girls may suffer from the double impact of gender and social status.

It is a widely accepted principle that at least five years of schooling needs to be completed if children are to retain literacy acquired during this period. While the disparity is very high for SCs in several states including some in which the overall human development indicators are relatively better (Himachal Pradesh, Tamil Nadu), for STs also there are significant disparities with up to two-thirds of the tribal students not completing beyond Class VIII.

State level data (see Table 4) shows that primary gross enrollment levels are below the national average in 11 out of 21 Indian states. It is alarming that in states such as Punjab and Haryana, where per capita state domestic product is among the highest in India, enrollment rates are particularly poor. In addition, the drop out rate in Punjab is also higher than the national average.

Considering social categories, approximately 50 per cent of the states have above average enrollment for SCs/STs communities and 50 per cent are below the respective community’s all India average. In most states, enrollment rates for SCs and STs communities are higher than the state average. Further light can be thrown on the situation, by taking note of the drop-out rates at primary level (see Table 5).

Out of 21 major states the number of states where drop-out rates are below the national average amongst SCs and STs is 8 and 9 respectively. In most cases, the drop-out rates are highest among STs, followed by SCs while those for non-SCs/STs are lower. Drop out rates among both SCs and STs are particularly high in Bihar, Assam, Jharkhand, Orissa, Rajasthan, Uttar Pradesh and West Bengal. Where these rates range from approximately 47 to 71. As per NSS data for 1999-2000, school drop out rates vary significantly across states, particularly with regard to gender differentials among social groups.

Obviously the matter needs to be tackling on a war footing, if drop out rates for these disadvantaged groups are to be brought down to even the national average of 26.45. To quote from the 11th Plan document; “Thus, we have a serious situation, in that in 2004-05 not only were 29 per cent of the entire
nation’s children dropping out before completing primary schooling, but the SCs and STs were doing worse” (Chapter 4, *Rapid Poverty Reduction*, page 83).

### Table 4: State wise Gross Primary Enrollment Ratio of SCs/STs/Overall

<table>
<thead>
<tr>
<th>State Name</th>
<th>2005-06</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SC</td>
<td>ST</td>
<td>Overall</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>103.8</td>
<td>101.15</td>
<td>94.87</td>
</tr>
<tr>
<td>Assam</td>
<td>153.13</td>
<td>111.83</td>
<td>107.11</td>
</tr>
<tr>
<td>Bihar</td>
<td>86.82</td>
<td>135.49</td>
<td>87.2</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>147.61</td>
<td>126.39</td>
<td>122.26</td>
</tr>
<tr>
<td>Gujarat</td>
<td>157.66</td>
<td>129.9</td>
<td>119.44</td>
</tr>
<tr>
<td>Haryana</td>
<td>107.85</td>
<td></td>
<td>79.61</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>120.59</td>
<td>140.85</td>
<td>108.89</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>113.11</td>
<td>100.92</td>
<td>100.49</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>110.61</td>
<td>122.7</td>
<td>105.19</td>
</tr>
<tr>
<td>Karnataka</td>
<td>115.91</td>
<td>111.85</td>
<td>106.19</td>
</tr>
<tr>
<td>Kerala</td>
<td>107.76</td>
<td>120.8</td>
<td>93.85</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>159.35</td>
<td>160.67</td>
<td>143.67</td>
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<tr>
<td>Maharashtra</td>
<td>151.2</td>
<td>132.79</td>
<td>132.34</td>
</tr>
<tr>
<td>Orissa</td>
<td>120.97</td>
<td>112.76</td>
<td>118.15</td>
</tr>
<tr>
<td>Punjab</td>
<td>110.64</td>
<td></td>
<td>77.46</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>127.33</td>
<td>109.08</td>
<td>121.69</td>
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<tr>
<td>Tamil Nadu</td>
<td>121.78</td>
<td>172.23</td>
<td>120.07</td>
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<tr>
<td>Uttar Pradesh</td>
<td>114.41</td>
<td>145.56</td>
<td>110.57</td>
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<tr>
<td>Uttaranchal</td>
<td>152.17</td>
<td>136.02</td>
<td>119.89</td>
</tr>
<tr>
<td>West Bengal</td>
<td>114.35</td>
<td>111.58</td>
<td>104.91</td>
</tr>
<tr>
<td>Delhi</td>
<td>76.32</td>
<td></td>
<td>115.13</td>
</tr>
<tr>
<td>India</td>
<td>118.41</td>
<td>126.36</td>
<td>109.4</td>
</tr>
</tbody>
</table>

*Source: Ministry of Human Resource Development, Government of India*

In terms of gender inequality, according to the 2001 Census, female literacy rate was 54.16 per cent and male literacy rate was 75.85 per cent. The gap between male and female literacy rate was 21.69 per cent. By 2015, the target is to maintain a gender balance at the primary level. Judging by current trends, estimates reveal that there will still be an imbalance in 2015 (ratio of boys/girls). Inequality will be more within the STs population followed by the SCs.
The major difference between these two groups is that in case of SCs relatively more girl children will be in the primary level whereas in case of STs there will be a higher proportion of boys than girls at the primary level. There is a strong possibility that the Others (non SCs/STs population) will achieve the target by 2015 (see Figure 4).

<table>
<thead>
<tr>
<th>State Name</th>
<th>2005-06</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SC</td>
<td>ST</td>
<td>Overall</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>25.49</td>
<td>49.73</td>
<td>24.75</td>
</tr>
<tr>
<td>Assam</td>
<td>55.88</td>
<td>57.12</td>
<td>52.64</td>
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<tr>
<td>Bihar</td>
<td>55.64</td>
<td>48</td>
<td>46.55</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>24.89</td>
<td>34.04</td>
<td>29.97</td>
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<td>Gujrut</td>
<td>24.93</td>
<td>40.72</td>
<td>31.58</td>
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<td>Haryana</td>
<td>7.55</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>15.44</td>
<td>-3.61</td>
<td>10.69</td>
</tr>
<tr>
<td>Jammu&amp;Kashmir</td>
<td></td>
<td></td>
<td>11.58</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>48.83</td>
<td>59.55</td>
<td>50.18</td>
</tr>
<tr>
<td>Karnataka</td>
<td>19.47</td>
<td>9.95</td>
<td>15.5</td>
</tr>
<tr>
<td>Kerala</td>
<td>-3.66</td>
<td>1.78</td>
<td>0</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>-1.85</td>
<td>-22.21</td>
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<td>Maharashtra</td>
<td>14.07</td>
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<td>Orissa</td>
<td>47.87</td>
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<td>Punjab</td>
<td>31.67</td>
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<td>23.66</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>52.37</td>
<td>54.23</td>
<td>52.84</td>
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<tr>
<td>Tamil Nadu</td>
<td>-17.42</td>
<td>32.34</td>
<td>0</td>
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<tr>
<td>Uttar Pradesh</td>
<td>51.35</td>
<td>69.62</td>
<td>9.76</td>
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<tr>
<td>Uttarakhand</td>
<td>38.37</td>
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<td>27.42</td>
</tr>
<tr>
<td>West Bengal</td>
<td>47.05</td>
<td>56.91</td>
<td>40.18</td>
</tr>
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<td>Delhi</td>
<td>18.27</td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>India</td>
<td>36.31</td>
<td>40.61</td>
<td>26.45</td>
</tr>
</tbody>
</table>

Source: Ministry of Human Resource Development, Government of India

The 11th Plan has observed that the social gap in dropout rate is acute in case of girls and that SCs and STs girls are the worst off in terms of most educational outcome indicators. It is extremely worrisome that in the critical age-group of
15-49 years, even today 73 per cent of SCs women and 79 per cent of STs women are illiterate. Among the measures taken to make progress in girls’ education, additional resources are to be targeted to Educationally Backward Blocks (EBBs) under National Programme for Education of Girls at Elementary Level (NPEGEL). Under the Kasturba Gandhi Balika Vidyalaya (KGBV) Residential Schools for girls belonging to SCs, STs, OBCs, Minorities and BPL families are set up.

**Figure 5: Target and Achievement in Gender Equality at Primary Level**

The District Primary Education Programme (DPEP) aims at holistic development of primary education covering Classes I to V. It has specific objectives of reducing the dropout rate to less than 10 per cent and reducing disparities among gender and social groups in the enrollment to less than 5 per cent. However, these targets were not achieved in the 10th Plan period. It clearly points out the need for better designing of programmes to reduce disparities. Under the 11th Plan the KGBV and DPEP schemes will be subsumed within Sarva Sikhsa Abhiyan (SSA). An encouraging development is that the Plan states the requirement of a strong rights orientation within the SSA programme. Among the Special Interventions for the Disadvantaged Groups, it is proposed to set up additional 500 KGBVs in Blocks with higher concentration of SCs, STs, OBC and Minority population and to double the funds for Special Focus Districts. Remedial coaching in schools and community support will also play a role in improving the learning levels of Disadvantaged Groups. The Jan Shikshan Sansthan (JSS) Scheme is also oriented towards educational, vocational and occupational development of socio-economically backward groups.
Inspite of all the stated good intentions, the fact remains that public expenditure (Centre and States) on education is only around 3.6 per cent of the GDP. The NCMP set a target of raising it to 6 per cent. For elementary education the 11th Plan has set a target that all gender, social and regional gaps in enrollments are to be eliminated by 2011-12.

Studies have established the significant positive association between gross primary enrollment rate and the per child government expenditure. It is found that children belonging to socially excluded groups are the only ones which remain out of school in the otherwise better performing states. This underlies the need for interventions that specifically target these groups and calls for an allocation of corresponding resources, which could be channelised through the existing programmes with a specific focus.

To the extent that there is a significant positive correlation between the educational indicators and the social groups to which the child belongs, there needs to be extra effort in channelising both financial and human resources accordingly. Further, from the point of gender disparity, one also finds that education of female children has the highest correlates with several of the other MDGs indicators. Hence, this is a high priority area.

6. Ensuring Good Health for All (Goals 4, 5, and 6)

Data on health status and on utilisation of health services by groups who are often socially excluded SCs /STs throws light on aspects of their exclusion as well as on the linkages between poverty and health. The three rounds of NFHS provide data on several health and demographic indicators by social groups and have been analysed by researchers (Acharya 2007, Nayar 2007, Ram et al 1998, Acharya 2002, Kulkarni and Baraik 2003). The same data set is used in this study.

6.1 Reduce Child Mortality (Goal 4)

_Infant Mortality Rate and Under 5 Mortality Rate_

Among SCs and STs, there have been significant gains in reduction of Infant Mortality Rate (IMR). The IMR reductions have been the sharpest among SCs communities. The relative slower reduction between NFHS 2 and 3 is however reflective of an overall slowdown in IMR (see Table 6 and Figure 6). Similar trends are evident for under-5 mortality rates. While the disparity between SCs and other groups has declined what remains a matter of concern is the increasing disparity for STs compared to other groups. Similar trends emerge
for under-5 mortality rates (U-5MR) (see Table 7 and Figure 7). However, in both U 5MR and IMR, the disparity between SCs/STs population and that of non-SCs/STs persists.

Table 6: Infant Mortality Rates in India

<table>
<thead>
<tr>
<th></th>
<th>IMR (per 1000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Others</td>
</tr>
<tr>
<td>NFHS 1</td>
<td>82.2</td>
</tr>
<tr>
<td>NFHS 2</td>
<td>69</td>
</tr>
<tr>
<td>NFHS 3</td>
<td>54</td>
</tr>
</tbody>
</table>

Figure 6: Infant Mortality Rates (2005-06)

Table 7: Under-5 Mortality Rates in India

<table>
<thead>
<tr>
<th></th>
<th>U-5MR (per 1000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Others</td>
</tr>
<tr>
<td>NFHS 1</td>
<td>111.5</td>
</tr>
<tr>
<td>NFHS 2</td>
<td>88</td>
</tr>
<tr>
<td>NFHS 3</td>
<td>73</td>
</tr>
</tbody>
</table>

Figure 7: Under-5 Mortality Rates (2005-06)
Reducing ‘Infant Mortality’ by two third is set as the target for the MDGs which was estimated to be 30.3 per 1000 live birth for India. As per the current rates of decline in IMR, the levels of IMR likely to be achieved across social groups falls short of the target. Although there seems to be a greater likelihood of convergence across social groups in IMR, Figure 8 demonstrates that in order to achieve this, the required rates of decline particularly for SCs and STs will need to be more than one and a half times the rates of decline experienced during the period 1998-99 to 2005-06.

**Figure 8: Targets for Reduction in IMR across Social Groups**

The 11th Plan goal for IMR at the national level is 28 per 1,000 live births by 2012. This is quite ambitious given that the IMR reported by the NFHS 3 is 57 per 1,000 live births and 58 per 1,000 live births according to the SRS 2005. It is pertinent to point out that the goal for 10th Plan of 45 per 1,000 live births has not been achieved. In fact, the SRS 2005 puts the IMR for rural populations at 60 per 1,000 live births. States like Punjab and Haryana have better IMR than the national average at 42 per 1,000 live births. This is in contrast with Uttar Pradesh with an IMR of 73 per 1,000 live births, while the stagnation of IMR in West Bengal is a matter of concern. States with high proportion of tribal proportion have high IMR with Madhya Pradesh and Orissa demonstrating appreciable decline while Jharkhand significantly reported a sharp increase from 54 to 69 per 1,000 live births. Similar trends hold for U - 5 MR.
It is generally agreed that IMR has been stagnating of late. Neonatal Mortality Rate (NMR) constitutes about 60 to 75 per cent of IMR across the states. History of public health development in India records that reduction in NMR is far more difficult. There is increased attention to the neonatal component of infant mortality; however, the new programmes are yet to take off to make any appreciable difference. The Home Based Newborn Care (HBNC) has been approved by the Government of India but is yet to be implemented. The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) strategy has been unrolled in selected districts. The forthcoming concurrent evaluation shall provide data on the state of implementation. Recently released data by the DLHS-3 reveal that gross public health shortcomings (infrastructure, personnel and services) continue in states that need these most.

In effect, states with the highest proportion of SCs and STs populations will have to reduce their IMR by about half from the present level. This seems to be a near impossible task. Figure 9 presents IMR for SCs, STs and Total population across Indian states.

The target is to reduce the mortality rate among children Under-5 by two thirds. The target fixed by the MDGs for ‘Under-5 Mortality’ was estimated to be 41.7 per 1000 live birth. The disaggregated figures of this estimate vary across social groups. It is to be noted that if the current pattern of decline in
Under-5 mortality rates continue, *ceteris paribus*, the likely achievement for all the social groups will fall short of the target, and the shortfall being the highest among STs. As shown in Figure 9, the required rates of decline in order to fulfill the MDGs target will be higher for SCs and STs communities (at approximately 0.06 per cent per annum) as compared to non-SCs and non-STs groups. Figure 11 clearly demonstrates the variation in inter state U-5MR.

**Figure 10: Targets for Reduction in U-5MR (MDGs)**

**Figure 11: U-5MR (NFHS-3, 2005-06), Deaths per 1000 Live Births**
**Immunisation**

Worldwide, measles immunisation rates are a sensitive indicator of performance of the routine immunisation programme. In India, there has been an increase in this parameter across the three rounds of NFHS. The increase has been most among SCs and the disparity vis-à-vis other social groups has been decreasing. The immunisation coverage rate among SCs is close to the national average. An improvement has been recorded among STs (48 per cent immunised) by the NFHS 3, although there is still a long way to go in terms of reaching the current national average where 59 per cent children have been immunised.

A matter of over-riding concern has been the decline in immunisation rates in some of the larger and better governed states. Unless the situation is urgently corrected it may be assumed that the marginalised groups would be more adversely affected.

**Box I: Polio Eradication Campaign Weakens Immunisation Coverage**

The Planning Commission, drawing upon data from the NFHS, recorded the adverse impact of Plus Polio Immunisation (PPI) on routine immunisation programmes in the 10th Five Year Plan document. The District Level Household Survey (DLHS) survey reported a decline in the proportion of fully immunised children (nationally) from 54 per cent in 1998-99 to 48 per cent during 2002-04. Over-emphasis on PPI rounds and other supplemental rounds were identified as causes of ‘fatigue’ thereby leaving vast pools of unimmunised children. Among them, SCs/STs children are likely to be a significant proportion.

As per the target set by the MDGs, the proportion of 1 year old children being immunised against measles has to be reduced by two third by 2015. Around 84 per cent of SCs parents depend on government and other charitable organisations for immunisation of their infants and children (*Dalit and MDGs*, Dalit Human Right Monitor, 2003-2006, SAKHI). The rates of increase in measles immunisation reported in the 3 NFHS rounds clearly indicate that at these rates of change achieving a target of 100 per cent children being vaccinated by 2015 will not be possible. The required rates of increase in immunisation will be much higher for all social groups, with the steepest hikes for STs and SCs (see Figure 11). The percentage of children immunised needs to increase from 0.12 per cent p.a. for STs to 0.07 per cent per annum for non-SCs/STs groups.

Among states with high proportion of SCs population, Punjab, Haryana and West Bengal clearly have high measles immunisation rates, at about 75 per
cent or more, and are ranked a step below some of the better performing states like Tamil Nadu and Maharashtra. This is in contrast with Uttar Pradesh with a corresponding figure of 37.5 per cent. Among states with high proportion of STs population, Jharkhand has coverage of 48 per cent, nearly 10 percentage points below the national average. The varying percentage of children immunised against measles across social groups in Indian states is shown in Figure 13.

Figure 12: Targets for Increase in Measles Vaccination (MDGs)

Figure 13: Percentage of Children (12-23 months) with Measles Vaccination (NFHS-3, 2005-06)
7. Improve Maternal Health (Goal 5)

7.1 Maternal Mortality Ratio

Although population growth rate in India has slowed down, it remains relatively high and shall continue to remain high for some more decades given the momentum on account of high base population. The Total Fertility Rate (TFR) was 2.9 in 2005 and it is still quite some distance to the replacement level TFR of 2.1 by 2010 as envisaged by the National Population Policy (2000). Despite some recent gains, Maternal Mortality Rate (MMR) continues to be disturbingly high. Reduction of MMR is contingent upon a range of economic, social and health service determinants such as access to trained birth attendants, facilities of and access to emergency obstetric care, (EmOC) and ante-natal care, etc. However, under-nutrition, low incomes and the disadvantaged position of women in a predominantly patriarchal society remain as roadblock (Figure 14)

![Figure 14: MMR in India: Trends Based on Log-linear Model (1997-2012)](image)

Source: Registrar General of India, 2006

The 11th Plan has set an ambitious plan for reduction of MMR from the present level of 301 per 100,000 live births to 100 per 100,000 live births. By its own admission, “at the present rate of decline, it will be difficult to achieve the goal.” For Punjab, Haryana and Uttar Pradesh—states with high SCs populations - a reduction by about two-thirds from the present level is necessary. For West Bengal, a steeper reduction is required from 194 to 64 per 100,000 live births. Similar levels of reduction are required in states with high STs populations like Chattisgarh and Jharkhand. At current trends of reduction the 11th Plan goals are unlikely to be achieved by any of these states.
7.2 Proportion of Births Attended by Skilled Health Personnel

The proportion of births attended by skilled personnel has increased overall. The improvement has been more for SCs than STs. However, in keeping with the national trend the rate of increase has been slower between NFHS 3 and NFHS 2 than between NFHS 2 and NFHS 1 (see Table 8).

Table 8: Births Attended by Skilled Personnel

<table>
<thead>
<tr>
<th></th>
<th>Others</th>
<th>SC</th>
<th>ST</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFHS 1</td>
<td>38.1</td>
<td>25.5</td>
<td>17.7</td>
<td>34.5</td>
</tr>
<tr>
<td>NFHS 2</td>
<td>47.5</td>
<td>37</td>
<td>23</td>
<td>42.8</td>
</tr>
<tr>
<td>NFHS 3</td>
<td>51.8</td>
<td>40.5</td>
<td>25.6</td>
<td>46.8</td>
</tr>
</tbody>
</table>

Ideally the set target should be that every woman should get the help of skilled personnel during delivery. But unfortunately only 47 per cent of women get this facility (2005-06) even at the all-India level. Disadvantaged social groups are deprived to a much larger extent. Estimates based on the current patterns indicate that SCs/STs would be lagging far behind in achieving an ideal target of 100 per cent by 2015, as compared to the non-SCs/STs population. By rough estimates, 31.7 per cent STs women would be able to avail the facility of skilled health personnel at birth during delivery while the corresponding figures for SCs women would be 52 per cent even by 2015. It is clear that not only is a 100 per cent target unachievable, the inequality across social groups is also likely to persist. Figure 15 reveals the implications in terms of required acceleration in the increase in births attended by skilled personnel for achieving a 100 per cent target.

Figure 15: Targets for Increase in Births Attended by Skilled Personnel
In states with high proportions of SCs population, these indicators are approximately that of the national average. In Jharkhand, this indicator is about half that of the national level. Figure 15 illustrates the inter state variation.

Figure 16: Percentage of Deliveries Assisted by Health Personnel (NFHS-3, 2005-06)

Regarding accessibility variables in general, the other castes (the upper castes) are better-off regarding treatment of diarrhoea while the proportions of SCs, STs and OBCs not availing any treatment are considerably higher. The proportion of SCs not availed any treatment for diarrhoea stands out which clearly indicates problems of accessibility and availability for these sections of the poor.

8. Combat HIV/AIDS, Malaria and Other Diseases (Goal 6)

8.1 Disease Prevalence

Prevalence data of two diseases malaria and tuberculosis (TB)-has been analysed from NFHS 1, 2 and 3 datasets. At the national level, data from NFHS 1 and 2 reveal that prevalence of malaria presents an increasing trend, increasing from 33/1000 population to 37/1000 population. For SCs, there is a decline from 38 to 36 per thousand population. For STs however, there is a steep rise from 46 to 81 per thousand population and is a matter of concern, particularly in states with higher proportion of falciparum malaria.
Increase in prevalence of TB (from 459 to 532 per 100,000 population) at the country level was a matter of concern as revealed from NFHS 1 and 2 data. However, NFHS 3 data shows a decline in the overall figure to 423 per 100,000 population. Indeed the WHO has considered the TB situation as a ‘global emergency’. The prevalence of TB among SCs and STs is much higher at 531 and 659 per 100,000 respectively. It is clear that there is considerable disparity across social groups as revealed by this indicator (see Table 9).

**Table 9: Prevalence of Tuberculosis (Per 1 lakh population)**

<table>
<thead>
<tr>
<th></th>
<th>OTHERS</th>
<th>SC</th>
<th>ST</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFHS-1</td>
<td>434</td>
<td>558</td>
<td>542</td>
<td>459</td>
</tr>
<tr>
<td>NFHS-2</td>
<td>476</td>
<td>671</td>
<td>675</td>
<td>532</td>
</tr>
<tr>
<td>NFHS-3</td>
<td>365</td>
<td>531</td>
<td>659</td>
<td>423</td>
</tr>
</tbody>
</table>

Source: Data from NFHS-1 (1992-93), NFHS-2 (1998-99) and NFHS-3 (2005-06)

IB is found to be very high amongst the poor in India, especially among the poor belong to SCs and STs categories. The target for the MDGs is to reduce the prevalence of TB to 155 per One lakh population at the all India level. However as per current trends the target seems to be difficult to achieve (see Figure 16), even at the All India level. This apart, data reveals that the various social groups are placed differently with the STs being the most vulnerable followed by the SCs.

There are considerable differences between different caste groups regarding prevalence of anaemia among women and children. The differences in the
proportion of women and children with anaemia seem to be more prominent among the STs population.

9. 11th Plan Proposals and Strategies: An Assessment

The time bound health goals identified in the 11th Plan are as follows:

- Reducing MMR to 1 per 1000 live births
- Reducing IMR to 28 per 1000 live births
- Reducing TFR to 2.1
- Providing clean drinking water for all by 2009 and ensuring no slipbacks
- Reducing malnutrition among children of age group 0-3 to half its present level
- Reducing anaemia among women and girls by 50 per cent
- Raising the sex ratio for age group 0-6 to 935 by 2011-12 and 950 by 2016-17

The goals and achievements set in the 10th Plan are given in Table:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>10th Plan Targets</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Growth (decadal rate)</td>
<td>16.2%</td>
<td>15.9%</td>
</tr>
<tr>
<td>I M R</td>
<td>45 / 1,000 live births</td>
<td>58 / 1,000 live births</td>
</tr>
<tr>
<td>M M R</td>
<td>2 / 1,000 live births</td>
<td>3.01 / 1,000 live births</td>
</tr>
</tbody>
</table>

The 11th Plan has been formulated in a manner whereby 13 of the 27 monitorable national targets have been disaggregated into appropriate targets for individual states. Among these the ones relating to health include:

- (IMR)
- (MMR)
- (TFR)
- Child malnutrition
- Anaemia among women and girls
With the Integrated Management of Childhood Illnesses (IMNCI) strategy rolling out in selected deprived states, the 11th Plan document emphasises the adoption of Home Based Neonatal Care (HBNC) as a tool for reduction of infant and neonatal mortality. The success of IMNCI and HBNC shall be critically dependent on the roles played by the ASHA and the Anganwadi Worker with referral supports available to them and the responsiveness and effective of healthcare institutions.

A few states and a quarter of the districts account for 40 per cent of the poor, half the malnourished and two thirds suffering from some of the common communicable diseases. It is of importance to recognise that public health services in states with poor governance is virtually “in shambles”, access by deprived sections of populations “especially women, SCs and STs” remains poor implying poor health outcomes and high levels of out of pocket expenditure. The unfolding of epidemiological transition with rise of tobacco related cancers, cardio-vascular diseases and diabetes mellitus along with emerging communicable diseases such as chikungunya fever may affect marginalised communities disproportionately.

The National Rural Health Mission (NRHM) was launched in 2005 throughout the country to bring in architectural corrections, decentralise the planning and implementation process and provide a set of assured health services. The proposed National Urban Health Mission (NUHM) seeks to replicate this exercise for urban areas. None of these two initiatives have sought to address the specific health concerns of the marginalised populations. However, adequate representation has been proposed for women, SCs, STs and OBCs in the Village Health Sanitation Committees (VHSC).

### Box 2: Proportion of Untreated Patients among SCs and STs

The lack of access to services for the socially backward is evident from the proportions of untreated patients among SCs and STs living in rural areas that were relatively higher when compared to other groups.

<table>
<thead>
<tr>
<th>Social Groups</th>
<th>Untreated (Rural) [%]</th>
<th>Untreated (Urban) [%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled Castes (SC)</td>
<td>18.1</td>
<td>8.4</td>
</tr>
<tr>
<td>Scheduled Tribes (ST)</td>
<td>21.5</td>
<td>9.4</td>
</tr>
<tr>
<td>Others</td>
<td>16.8</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Public health spending is proposed to be raised to at least 2 per cent of GDP during the 11th Plan period. Under the NRHM, the proposal to change the share of Centre and State Governments from the present 20-80 per cent to 40-60 per cent, is not addressing the hurdles faced by the poorer States. The Centre has tied future help to the States’ ability to raise their present levels of allocation to at least 10 per cent and later to 15 per cent and 25 per cent over the 11th and 12th Plans. Clearly, the poorer States will find it difficult to comply. As a result, the poor and marginalised may have to continue accessing informal sector facilities and resort to borrowing from private sources for meeting their healthcare needs.

The need of the hour is to formulate interventions and strategies that would pull up the performance of the socially disadvantaged groups to not just the current national levels, but to the levels of the better performing States. This is the sense by which the notion of equity should be interpreted in terms of basic human developmental goals to be achieved by all social groups.

10. Conclusion

The 11th five year plan sets targets Human Development Goal (see Annexure 3 for details) for 2012 for the country. The end date for this plan is therefore very close to the MDGs deadline of 2015. As per current trends in progress on the MDGs indicators there is a sufficient ground for concern that under a business as usual scenario, we may see significant shortfalls by disadvantaged groups in India. This may occur even if most of the indicators are achieved in terms of a national average. In such a case, social disparities would continue to exist, and find reflection in the inability to achieve the minimum levels of human development for some sections of society.

While States differ in their achievement levels, there are some States that persistently lag behind others in their achievements. These differences are largely based on differences in the baselines from where they started in 1990. However, what is of concern is the lack of disaggregation within States on the basis of social groups. This leads to a cumulative effect whereby certain disadvantaged groups may be consistently left out of the development process.

Consider for instance that poverty continues to be closely related to the proportion of SCs and STs population in the different States in India. There is therefore a need to examine why this continues to be so, and whether our efforts to overcome hunger-poverty call for more targeted interventions take
note of the differing baselines within states. Many of the MDGs indicators are inter-related and are mutually reinforcing. It has been noted by several researchers for instance that caste and poverty are important determinants of access to healthcare services.

Given the criticality of centrally sponsored schemes in helping State Governments to achieve their developmental goals, the overall allocation and design of these schemes is an important issue. There is evidence of a positive association between government expenditure and the attainment of educational goals such as primary enrollment. Again, health indicators such as the IMR are linked to government expenditure on health. There seems to be a case not just for higher allocations, but also for innovative designing of programmes which can reach specific social groups to help eliminate disparities in health and primary education. State expenditures also need to be prioritised to benefit excluded and marginalised communities, apart from specific allocated resources such as those under the Special Component Plan. Quantifiable empirical data reveals that STs and SCs suffer from multiple deprivations. Within marginalised communities, women and children are worse-off on most counts while gender based disparities need particular attention.

Thus, disaggregation by social groups constitutes a first step in assessing the progress in attainment of the MDGs for India, where diverse social groups are spread over a large geographical area. The 11th Plan’s focus on inclusive growth constitutes a recognition of special needs for socially disadvantaged groups. To quote, “The vision of inclusiveness must go beyond the traditional objective of poverty alleviation to encompass equality of opportunity, as well as economic and social mobility for all sections of society, with affirmative action for SCs, STs, OBCs, minorities and women.” It becomes as essential to target resources towards specific groups, so as to target them towards specific regions that are lagging behind in the achievement of human development goals.

Reduction of disparities within the country requires specific allocations for tackling them, based on adequate recognition of the social basis of such disparities which are often historically inherited and culturally entrenched, such as caste and tribe. It is essential to meet the MDGs in a manner that incorporates the differences among population groups in terms of race, ethnic origin, caste and gender. This is the way to go forward in taking care of the essential principles of Freedom, Equality, Solidarity and Tolerance embodied in the UN Millennium Declaration.
End Notes

1 Annexure 1 lists the goals, targets and indicators.

2 A list of the targets from the 11th Plan is provided in Annexure 2. Annexure 3 lists targets from the 10th Plan.


4 Caste constitutes the basic frame of the Indian society where Scheduled Castes (Dalits) fall at the bottom most rung and face particular prohibitions and disabilities.


7 For measuring poverty, we use the head count ratio of poverty based on the planning commission methodology, arrived at by using the available per capita consumption expenditure data from various rounds of the NSSO. It is argued that the poverty line in India as currently defined is too low and to that extent the poor are actually under-estimated.
References


11th Five Year Plan (2007-2012) Planning Commission, Government of India


NSS National Sample Survey Organisation Surveys, several rounds, MOSPI, GOI.

Ram, F, K. B. Pathak and K.I Annamma (1998) Utilisation of health Care Services by the Underprivileged Section of Population in India- Results from NFHS.


Data Sources

11th Five Year Plan (2007-2012) Planning Commission, Government of India

Will India’s Attainment of MDGs be an Inclusive Process?
Sukhadeo Thorat and Purnamita Das Gupta

NSS National Sample Survey Organisation Surveys, several rounds, MOSPI, GOI
DLHS - 3, District Level Household Survey for Reproductive Child Health, Ministry of Health & Family Welfare (MoHFW), Government of India.
Indiastat (http://www.indiastat.com/default.asp)
Selected Educational Statistics, MoHRD, Government of India
Economic Survey of India, Government of India, various issues
Economic survey of Delhi 2001-02, Department of Planning, Govt of NCT of Delhi.
Annexure 1

Millennium Development Goals, Targets and Indicators

Goal 1: Eradicate extreme poverty and hunger

Target 1: Reduce by half the proportion of people living on less than a dollar a day

- 1. Proportion of Population Below $1 (PPP) per Day (World Bank)
- 2. Poverty Gap Ratio, $1 per day (World Bank)
- 3. Share of Poorest Quintile in National Income or Consumption (World Bank)

Target 2: Reduce by half the proportion of people who suffer from hunger

- 4. Prevalence of Underweight Children Under Five Years of Age (UNICEF)
- 5. Proportion of the Population below Minimum Level of Dietary Energy Consumption (FAO)

Goal 2: Achieve universal primary education

Target 3: Ensure that all boys and girls complete a full course of primary schooling

- 6. Net Enrollment Ratio in Primary Education (UNESCO)
- 7. Proportion of Pupils Starting Grade 1 who Reach Grade 5 (UNESCO)
- 8. Literacy Rate of 15-24 year-olds (UNESCO)

Goal 3: Promote gender equality and empowerment of women

Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015

- 9. Ratio of Girls to Boys in Primary, Secondary, and Tertiary Education (UNESCO)
- 10. Ratio of Literate Women to Men 15-24 years old (UNESCO)
- 11. Share of Women in Wage Employment in the Non-Agricultural Sector (ILO)
- 12. Proportion of Seats Held by Women in National Parliaments (IPU)

Goal 4: Reduce child mortality

Target 5: Reduce by two thirds the mortality rate among children under five

- 13. Under-Five Mortality Rate (UNICEF)
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- 14. Infant Mortality Rate (UNICEF)
- 15. Proportion of 1 year-old Children Immunized against Measles (UNICEF)

Goal 5: Improve maternal health

Target 6: Reduce by three quarters the maternal mortality ratio
- 16. Maternal Mortality Ratio (WHO)
- 17. Proportion of Births Attended by Skilled Health Personnel (UNICEF)

Goal 6: HIV/AIDS/malaria & other diseases

Target 7: Halt and begin to reverse the spread of HIV/AIDS
- 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

Target 8: Halt and begin to reverse the incidence of malaria and other major diseases
- 21. Prevalence and Death Rates Associated with Malaria (WHO):
- 23. Prevalence and Death Rates Associated with Tuberculosis (WHO)
- 24. Proportion of Tuberculosis Cases Detected and Cured Under Directly-Observed Treatment Short Courses (WHO)

Goal 7: ensure environmental sustainability

Target 9: Integrate the principles of sustainable development into country policies and programmes; reverse loss of environmental resources
- 25. Forested land as percentage of land area (FAO)
- 26. Ratio of Area Protected to Maintain Biological Diversity to Surface Area (UNEP)
- 27. Energy supply (apparent consumption; Kg oil equivalent) per $1,000 (PPP) GDP (World Bank)
- 28. Carbon Dioxide Emissions (per capita) and Consumption of Ozone-Depleting CFCs (ODP tons):
Target 10: Reduce by half the proportion of people without sustainable access to safe drinking water

- 30. Proportion of the Population with Sustainable Access to and Improved Water Source (WHO/UNICEF)

Target 11: Achieve significant improvement in lives of at least 100 million slum dwellers, by 2020

- 32. Slum population as percentage of urban population (secure tenure index) (UN-Habitat)

Goal 8: Develop a global partnership for development

Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Includes a commitment to good governance, development, and poverty reduction both nationally and internationally

Target 13: Address the special needs of the least developed countries. Includes: tariff and quota free access for least developed countries exports; enhanced programme of debt relief for HIPC countries and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction

Target 14: Address the special needs of landlocked countries and small island developing States

Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term.

Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications
Annexure 2

Targets from the 11th Plan

The 27 National Targets fall in six major categories. The six categories are:

(a) Income and Poverty;
(b) Education;
(c) Health;
(d) Women and Children;
(e) Infrastructure; and
(f) Environment. The targets in each of these categories are given below.

(a) Income & Poverty

(i) Average GDP growth rate of 9 per cent per year in the 11th Plan period.
(ii) Agricultural GDP growth rate at 4 per cent per year on the average.
(iii) Generation of 58 million new work opportunities.
(iv) Reduction of unemployment among the educated to less than 5 per cent.
(v) Twenty percent rise in the real wage rate of unskilled workers.
(vi) Reduction in the head-count ratio of consumption poverty by 10 percentage points.

(b) Education

(i) Reduction in the drop out rates of children at the elementary level from 52.2 per cent in 2003-04 to 20 per cent by 2011-12.
(ii) Developing minimum standards of educational attainment in elementary schools, to ensure quality education.
(iii) Increasing the literacy rate for persons of age 7 years or more to 85 per cent by 2011-12.
(iv) Reducing the gender gap in literacy to 10 percentage points by 2011-12.
(v) Increasing the percentage of each cohort going to higher education from the present 10 per cent to 15 per cent by 2011-12.

(c) Health

(i) Infant mortality rate (IMR) to be reduced to 28 and maternal mortality ratio (MMR) to 1 per 1000 live births by the end of the 11th Plan.
(ii) Total Fertility Rate to be reduced to 2.1 by the end of the 11th Plan.
(iii) Clean drinking water to be available for all by 2009, ensuring that there are no slip-backs by the end of the 11th Plan.

(iv) Malnutrition among children of age group 0-3 to be reduced to half its present level by the end of the 11th Plan.

(v) Anemia among women and girls to be reduced to half its present level by the end of the 11th Plan.

(d) Women and Children

(i) Sex ratio for age group 0-6 to be raised to 935 by 2011-12 and to 950 by 2016-17.

(ii) Ensuring that at least 33 percent of the direct and indirect beneficiaries of all government schemes are women and girl children.

(iii) Ensuring that all children enjoy a safe childhood, without any compulsion to work.

(e) Infrastructure

(i) To ensure electricity connection to all villages and BPL households by 2009 and reliable power by the end of the Plan.

(ii) To ensure all weather road connection to all habitations with population 1000 and above (500 and above in hilly and tribal areas) by 2009, and all significant habitations by 2015.

(iii) To connect every village by telephone and provide broadband connectivity to all villages by 2012.

(iv) To provide homestead sites to all by 2012 and step up the pace of house construction for rural poor to cover all the poor by 2016-17.

(f) Environment

(i) To increase forest and tree cover by 5 percentage points.

(ii) To attain WHO standards of air quality in all major cities by 2011-12.

(iii) To treat all urban waste water by 2011-12 to clean river waters.

(iv) To increase energy efficiency by 20 percentage points by 2016-17.

The 11th Plan has been formulated in a manner whereby 13 of the above 27 monitorable national targets have been disaggregated into appropriate targets for individual States. These are:
13 State Specific Targets

1. GDP Growth rate
2. Agricultural growth rate
3. New work opportunities
4. Poverty ratio
5. Drop out rate in elementary schools
6. Literacy rate
7. Gender gap in literacy rate
8. Infant mortality rate (IMR)
9. Maternal mortality ratio (MMR)
10. Total Fertility Rate (TFR)
11. Child malnutrition
12. Anemia among women and girls
13. Sex-ratio
Annexure 3

India’s Human Development Goals: 10th Plan

In response to the UN Millennium Declaration, the Government of India in its Tenth Five Year Plan had outlined national development goals (known as India’s Human Development Goals). Most of these were related to and were more ambitious than the Millennium Development Goals.

1. Reduction of poverty ratio by 5 percentage points by 2007 and by 15 percentage point by 2012;
2. Providing gainful and high-quality employment at least to the addition to the labour force over the 10th Plan period;
3. All children in school by 2003; all children to complete 5 years of schooling by 2007;
4. Reduction in gender gaps in literacy and wage rates by at least 50 percent by 2007;
5. Reduction in the decadal rate of population growth between 2001 and 2011 to 16.2 percent;
6. Increase in Literacy Rates to 75 per cent within the 10th Plan period (2002-3 to 2006-7);
7. Reduction of Infant mortality rate (IMR) to 45 per 1000 live births by 2007 and to 28 by 2012;
8. Reduction of Maternal Mortality Ratio (MMR) to 2 per 1000 live births by 2007 and to 1 by 2012;
9. Increase in forest and tree cover to 25 per cent by 2007 and 33 per cent by 2012;
10. All villages to have sustained access to potable drinking water within the Plan period;
11. Cleaning of all major polluted rivers by 2007 and other notified stretches by 2012;

HIV/AIDS targets within the 10th Plan period:

12. 80 per cent coverage of high risk groups through targeted interventions;
13. 90 per cent coverage of schools and colleges through education programmes;
14. 80 per cent awareness among the general population in rural areas;
15. reducing transmission through blood to less than 1 per cent;

16. establishing of at least one voluntary testing and counseling centre in every district;

17. scaling up of prevention of mother-to-child transmission activities up to the district level;

18. achieving zero level increase of HIV/AIDS prevalence by 2007)

Malaria targets within the 10th Plan period

19. ABER (Annual Blood Examination Rate) over 10 percent;

20. API (Annual Parasite Incidence) 1.3 or less;

21. 25 per cent reduction in morbidity and mortality due to malaria by 2007 and 50 per cent by 2010 (NHP 2002)

Books

- Caste, Race and Discrimination - Discourses in International Context by Sukhadeo Thorat and Umakanth (Eds.), Rawat Publications, 2004
- Reservation and Private Sector - Quest for Equal Opportunity and Growth by Sukhadeo Thorat, Aryama and Prashant Negi (Eds.), Rawat Publications, 2005
- In Search of Inclusive Policy - Addressing Graded Inequality by Sukhadeo Thorat and Narender Kumar, Rawat Publications, 2008
- B. R. Ambedkar - Perspectives on Social Exclusion and Inclusive Policies by Sukhadeo Thorat and Narender Kumar (Eds.), Oxford University Press, 2008
- Bhartiya Dalit Sahitya Ka Vidrohi Swar by Vimal Thorat and Suraj Badiya, Rawat Publications, 2008
- Dalit in India - Search for a Common Destiny by Sukhadeo Thorat, Sage Publications, 2009
- Naye Shitij Ki Aur (Hindi Poems) by Jai Prakash Leelwan, IIDS and Anamika Publications 2009
- Samaye Ki Aadamkhhor Dhun (Hindi Poems) by Jai Prakash Leelwan, IIDS and Anamika Publications 2009
- Blocked by Caste: Economic Discrimination and Social Exclusion in Modern India, Sukhadeo Thorat and Katerine S. Newman, (Eds.), New Delhi, Oxford University Press, 2009

Forthcoming Books

- Dalit Human Development Report by Sukhadeo Thorat and Martin Macwan
- Dalit Art and Imagery by Gary Michael Tartakov
- Hindi Dalit Sahitya Ka Vidrohdi Swar Ed. by Vimal Thorat and Suraj Badiya, IIDS and Anamika Publications
- Ambedkar on Caste by Sukhadeo Thorat and Surinder S Jodhka

Working Papers

- Reservations in the Private Sector - Issues, Concerns and Prospects by Sukhadeo Thorat, Prashant Negi and Aryama, Volume I Number 01, 2006
- Reservation Policy in India - Dimensions and Issues by Sukhadeo Thorat and Chittaranjan Senapati, Volume I Number 02, 2006
- Dalits and the Right to Food - Discrimination and Exclusion in Food-related Government Programmes by Sukhadeo Thorat and Joel Lee, Volume I Number 03, 2006
- Health Status and Access to Health Care Services - Disparities among Social Groups in India by Vijay Kumar Baraik and P M Kulkarni, Volume I Number 04, 2006
- Rural Non-Farm Employment of the Scheduled Castes - A Comparative Study by Sukhadeo Thorat and Nidhi Sadana Sabharwal, Volume I Number 05, 2006
- Exclusion and Discrimination - Civil Rights Violations and Atrocities in Maharashtra by Sukhadeo Thorat and Prashant Negi, Volume II Number 02, 2007
- Dalit Empowerment and Vocational Education - An Impact Study by Michael Kropac, Volume II Number 03, 2007
- Reservation in Employment, Education and Legislature-Status and Emerging Issues by Sukhadeo Thorat and Chittaranjan Senapati, Volume II Number 05, 2007

Volume III

- Urban Labour Market Discrimination by Sukhadeo Thorat, Paul Attewell and Firdaus F. Rizvi Volume III Number 01, 2009
- Will India’s Attainment of MDGs be an Inclusive Process by Purnamita Das Gupta and Sukhadeo Thorat, Volume III Number 02, 2009
- In the Name of Globalization: Meritocracy, Productivity and the Hidden language of Caste by Surinder S. Jodhka and Katherine S. Newman, Volume III Number 03, 2009

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