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ECONOMIC, SOCIAL AND CULTURAL RIGHTS

A Study to Assess the Realisation of Economic, Social and Cultural Rights in India

RESEARCH REPORT

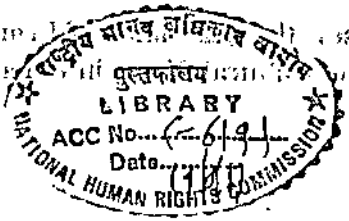
Submitted

To

NATIONAL HUMAN RIGHTS COMMISSION

NEW DELHI

National Centre for Advocacy Studies, Pune



A Study to Assess the Realisation of Economic, Social and Cultural Rights in India

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FOREWORD

The International Covenant on Economic, Social and Cultural Rights to which India is a party, recognizes the right of every one to be free from hunger. It also recognizes the right of every one to education and asserts that "Primary Education shall be compulsory and available free to all". It further recognizes the right of every one to the enjoyment of highest attainable standards of physical and mental health.

In India, Economic, Social and Cultural Rights were regarded as rights which require resources and policy initiatives on the part of the Government for their realization and were therefore put in - - Part IV of the Constitution. Some aspects of these rights are considered to be within the concept of life and liberty as envisaged in Article 21 which is a fundamental right. It is now clearly recognized that division between Civil and Political Rights on one hand and Economic, Social and Cultural Rights on the other is an artificial one. They are indeed indivisible and interdependent. Despite the enactment of a large number of social welfare legislations, there still exist large gaps in the realization of economic, social and cultural rights which need immediate attention and redressal.

Recognizing the crucial importance of research in the field of Economic, Social and Cultural Rights and also the need for collaborative efforts with NGOs, the Commission entrusted a Research Study in this regard to the National Centre for Advocacy Studies, Pune. It sought to analyze the Government's initiatives and interventions for realization of Economic, Social and Cultural Rights and in particular the right to food, education and health in Maharashtra, Karnataka and Chhattisgarh. In particular, the study focused on the realization of these rights by persons belonging to vulnerable groups like Dalits, other backward castes and marginalized groups.

There is a need to carry out in-depth research on the realization of Economic, Social and Cultural Rights by the people and in particular the most vulnerable sections. Documentation of gaps in the realization of these rights would go a long way in strengthening the efforts towards their protection. The Commission sincerely hopes that this study would prove useful to Policy planners, Government authorities, academics, NGOs, human rights activists and others. In light of findings brought out by this Research Study, the Commission hopes that authorities concerned would take necessary legislative, executive and other measures for the realization of economic, social and cultural rights particularly for people belonging to vulnerable sections.

(S. Rajendra Babu)

5th December, 2007

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NCAS would sincerely like to thank the National Human Rights Commission (NHRC) for opportunity given to NCAS to explore and study the realisation of social, economic and cultural rights in Indian states. The research project was initiated in 2003 and took around two years to be completed.

We express our sincere gratitude for the organizational support provided during field data collection to REACH in Karnataka, LAHAR in Chhattisgarh and SHRAMAJEEVI SANGHATANA and VIDHAYAK SANSAD in Maharashtra. We would like to extend our special thanks to their committed activists who were a great help during collection of primary information in all the three states- Karnataka, Maharashtra and Chhattisgarh.

We are also grateful to the Public Service Department officials in District and Block offices for providing us the BPL list of villages and reports of various schemes, and also to the School teachers, Doctors and Medical Staff, Anganwadi Staff and PDS in-charges from all three states for providing relevant information. We also would like to thank Sarpanch and Secretaries of Panchayats of the villages studied for providing information of schemes implemented in particular villages.

Words are inadequate in expressing our sincere gratitude towards the people who have sincerely taken out time from their busy schedules and co-operatively responded to our questions.

Finally, a very special thanks to John Samuel (Former executive Director of NCAS), for conceptualizing and taking up this research project to explore the actual realisation of Human Rights in the daily lives of socio-politically marginalized people and communities.

Needless to say, like always, NCAS team has been a source of solid support during the demanding research period.

PREFACE

The National Centre for Advocacy Studies (NCAS) has been working for the past fifteen years as a resource centre for social change and is committed to a human rights framework. Over the years, our attempt has been to systematically strengthen the human rights discourse as an integral and inalienable part of the democratic ethos of the country, with a special emphasis on Economic, Social and Cultural rights. As part of this endeavour, NCAS is delighted to share a report on the 'Study to Assess the Promotion of Economic, Social and Cultural Rights in India' with you.

This study focuses on three crucial rights essential for life with dignity, namely, the right to education, right to health and the right to food, with particular reference to the marginalized sections (dalits, adivasis, women and children). The study was conducted in three States of India: Maharashtra, Karnataka and Chhattisgarh.

In an era, when the dominant socio-economic and political paradigm is of efficiency and economic growth, a study on the promotion of Economic, Social and Cultural Rights becomes significant. Hopefully, the research findings and recommendations would help us in building a stronger discourse on Human Rights and facilitating the access of Economic, Social and Cultural rights for every citizen, particularly the marginalized.

We would also like to sincerely thank and acknowledge the support of the National Human Rights Commission (NHRC) for this study. The personal interest of the NHRC in this study was overwhelming. This opportunity of working with the NHRC is crucial for NCAS as we believe that it is imperative for all State and non-State actors committed to Human Rights to work in alliance for building a just and 'rights based' society.

In solidarity,

Amitabh Behar
Executive Director
National Centre for Advocacy Studies (NCAS)

EXECUTIVE SUMMARY

Human Rights are inherent, inalienable and universal in nature. Rights give entitlements and put corresponding obligations on the State and other actors to respect, protect and promote human freedom and dignity. For freedom and life with dignity, certain basic rights like the to life, to freedom of speech and expression, to adequate standard of living, to housing, work, food, health, education, etc are essential. It is the responsibility of the State to ensure that all those living within its ambit enjoy a certain level of social and economic security.

Human rights perspective entails that all people have the right to food and not to starve, the right to health and not to suffer from preventable disease, the right to education to have access to knowledge and information, and to decide on anything that affects their life. However, in developing countries like India, the growing capability deprivation, exacerbated by the new economic reforms and structural adjustments, cannot be addressed by only securing civil and political freedom, but by addressing the issues of socio-economic and cultural deprivation, and investing in the realization of these rights.

The present study was undertaken to analyze government initiatives and interventions for realization of Economic, Social and Cultural Rights (ESCR) with a focus on the right to food security, elementary education and health care services. The study was conducted in three Indian states: Maharashtra, Karnataka and Chhattisgarh with a focus on the ESCR of the Dalits, Adivasis, Other Backward Castes (OBC) and other marginalized groups.

Methodology of the study

The study is based on primary and secondary data, with a survey research design for collecting primary data, and review of literature from the government for secondary data. Literature on the goals and benchmarks, laws, policies, budgetary allocation and other process initiatives of the government to respect, protect and promote ESCR in India was reviewed extensively. Primary data was collected from 10 villages from each of three blocks, namely, Harapanahally block in Devangiri district of Karnataka, Wada block in Thane district in Maharashtra, and Bodla block in Karwardha district of Chhattisgarh. The blocks were chosen randomly from a list of blocks that had a majority of either Scheduled Castes (SC) or Scheduled Tribes (ST).

Findings of the study and recommendations

The major thrust of India's education policy at the primary level is on improving enrolment, retention, and achievement of children in the 6-14 years age group in school. The focus is on reducing disparities among different segments of the population and eliminating gender disparity. However, inadequate budget allocation, dismal school infrastructure in rural areas, high dropout rates, caste-bias, gender-bias etc have become the hallmark of the Indian education system.

The study shows that the number of girls who have never gone to school is more than the boys in all categories (SCs, STs and OBCs) and the total literacy campaign has lost its momentum. Much improvement is needed in infrastructure of schools, their physical accessibility, the student teacher ratio and exploration of alternative teaching methods. The mid-day meal programme also needs to be improved. Greater awareness has to be generated among the people about the importance of schooling, particularly among the marginalized sections.

The Indian health system is highly privatized even though about half of the poor depend on public sector hospitals for care. The privatization and deregulation of the health system has resulted in rising medication and drug prices. Access to health care is limited by the fact that sufficient numbers of medical and paramedical staff are not available in government health centres.

The study shows that the health of STs is really perilous when compared to others, and systems need to be put in place to provide health care even to the remotest regions where many of them live. States need to improve the quality of health infrastructure, the training provided to paramedical staff, and the number of hospitals and primary health centres. The concept of a user fee was promoted to increase the efficiency of the health services, but it has proved to be a deterrent in access to government health services. The mushrooming private health care sector needs to be better regulated in terms of quality and quantity of service, and some provision must be made to ensure that it also caters to the poor. Simultaneously, traditional healing systems need to be rejuvenated and should be used as a support system for modern medicine.

With regard to the **right to food**, it is clear that there is no need for more food related schemes; what is essential is to make a concerted effort to implement the already existing schemes, so that they achieve what they are expected to. The right to work is the best protection against hunger and poverty, and in order to secure the right to food, right to gainful employment needs to be addressed simultaneously.

The study has found that to improve nutrition, the focus should be on providing nutritional cereals such as millet, *bajra* and *jowar*, instead of wheat and rice, under various nutrition schemes. An efficient mechanism for spreading information about the existing schemes and current entitlements is also necessary. The distribution of food grains needs to be scrutinized in the context of large amounts of money being spent on overflowing food godowns and their maintenance. Below-poverty-line (BPL) families need to be correctly identified and the process of identification must be transparent and accountable.

Under the influence of the policies of globalization, the Government of India is cutting down the welfare budget on the insistence of the World Bank and the International Monetary Fund. India is thus trailing behind in achieving the Millennium Development Goals (MDGs) as public health budgets are slashed. Based on the research findings of the

study we make the following broad recommendations for the realization of the ESCR of Dalits, Adivasis, OBCs and other marginalized people:

- Integration of rights perspective and approach to plans, policies, programmes and processes
- Strengthening civil society interventions to promote and ensure ESC Rights
- Greater public awareness and education on ESCR so that people demand their rights.
- Greater accountability of the authorities involved, and a sense of ownership among the beneficiaries of the various programmes for realization of ESCR.

CHAPTER 1:

INTRODUCTION TO THE STUDY

1.1. HUMAN RIGHTS: RESPECT, PROTECTION AND FULFILMENT

Human Rights are inherent, inalienable and universal in nature. All struggles for human rights strive to create a condition where every individual can live a life of dignity. Freedom from fear and want are the basic requirements for living a life with dignity. Freedom from fear and want encompass certain basic rights such as the right to life, freedom of speech and expression, adequate standard of living, housing, work, food, health, and education. Rights give entitlements and put corresponding obligations on the State and other actors to respect, protect, and promote human freedom and dignity.

But throughout human history, it is the rights of the mighty that have been upheld. The poor have never been free from fear and want. The suppression of liberty, the lack of equality and human dignity, perennial hunger and malnutrition, morbidity and mortality, have been the lot of the poor throughout history. Religious dogma or coercion prevented large numbers of people from determining their own destiny. People were forced to accept the suppression of their freedom and lowering of their dignity as a *fait accompli*. However, history has also been witness to the protests of the poor and marginalized against the unjust social order whenever their backs were pushed to the wall.

The root of human rights and dignity was found in natural laws; and all religions and epics directly or indirectly valued human rights and the dignity of the individual. It was western political philosophers such as Thomas Hobbes and John Locke who initiated the modern discourse on human rights. They reinterpreted the notions of natural law and articulated what can be termed the liberal position on rights. This position emphasized the right to life, liberty, secure possession of property, freedom of speech, freedom of association, etc. The predominance of individual rights, and the stress on the right to property was, in many ways, reflected in the intellectual context of the Enlightenment, and the economic context of the rise of Capitalism (Samuel 2003).

Capitalism created a large army of the labour class to run its big industrial houses. To maximize profits, labourers were kept in abject poverty and penury. This created unrest and resentment among them and led to outbursts in various parts of Europe and North America in the eighteenth and nineteenth centuries.

Along with the labour class, the peasant class also started pressing for control over production of what they were producing in order to better their living conditions. Gradually, masses joined hands with labour and peasant class movements and this snowballed into freedom movements across the world that demanded better living conditions (food security, health care, and freedom of expression, etc.).

These developments laid the groundwork for the praxis of human rights across the world. It could therefore be said that the growth of capitalism, directly or indirectly paved the way for human rights discourse across the world. Economic, Social and Cultural Rights (ESCR) grew as a reaction to the exploitative capitalist regime. However, it will not be out of context to say that Civil and Political Rights (CPR) was promoted by the industrialists since it served to protect them from State intervention.

Human rights were codified with the establishment of the United Nations Organization (UNO) in 1945. The UNO, for the first time, listed a number of basic necessities, which are considered fundamental to human dignity and human rights. The UNO list was elaborated in the Universal Declaration of Human Rights (UDHR) in 1948. The UDHR was a ray of hope to millions whose freedom and dignity had been suppressed throughout human history. It endorsed a new humanistic vision and set of principles to respect, protect and fulfil universal human rights. Articles 1 to 22 of the UDHR emphasize civil and political rights, while the other articles emphasize economic, social and cultural rights. The UDHR was important because it recognized basic necessities as human rights and put corresponding obligation on States to respect, protect and promote these rights. By putting obligation on States, the UDHR sought to fix responsibility for violations of human rights and to provide an appropriate response.

These basic rights were further concretized in the International Convention of Civil and Political Rights, 1966 (ICCPR) and the International Convention of Economic, Social and Cultural Rights, 1966 (ICESCR). The ICCPR and ICESCR conferred legal status on Civil and Political Rights (CPR) and Economic, Social and Cultural Rights (ESCR), making these an integral part of International human rights laws. The international human rights law recognized the indivisibility and interdependence of CPR and ESCR. The ICESCR imposes not only the obligation of conduct ('to promote and to respect') but also the obligation of results ('to fulfil'). The human rights perspective entails that all people have the right to food and not to starve, the right to health and not to suffer from preventable disease, the right to education to have access to knowledge and information, and to decide on anything that affects their lives (Cheria et all 2004:1). These laws have put legal bindings on all States to take initiatives to guarantee all these rights to their citizens and to respect, protect and promote the universality of human rights and dignity.

1.2. RELATION BETWEEN CPR AND ESCR

Any human rights approach should be comprehensive, stressing the importance of all human rights, be they civil and political or economic, social and cultural. This approach not only recognizes the equal value of each right, but it is also more realistic. Rights are inextricably intertwined with one another, and the full enjoyment of one right often requires the full enjoyment of another (Artis et all 2003). The relation between CPR and ESCR is thus complementary and contributory. The preamble of the Quito Conference[1] declared that enjoyment of ESCR is essential to the effective, egalitarian and non-discriminatory enjoyment of CPR. The promotion of CPR without considering the full enjoyment of ESCR ignores social inequities and permits intolerable discrimination favouring those sectors that benefit from the unequal distribution of wealth (*ibid*).

Although the UDHR accorded equal weightage to both CPR and ESCR, over the years an artificial wall has been erected between CPR and ESCR, and more patronage has been given to CPR over ESCR. Supporting the prominence given to CPR over ESCR, a section of people argue that CPRs are negative rights and only restrain States from doing certain things. Hence, States do not need to allocate any extra money to ensure these rights. But ESCRs are positive rights and require States to allocate more and more resources. Therefore, there is no mandatory obligation on States to implement ESCR. This view forgets that the concept of negative and positive rights appeared to be a misnomer. Both CPR and ESCR have certain positive and negative, ingrained, characteristics. For CPR, as for ESCR, States have to allocate money to maintain courts, police forces, etc.

1.3. RELEVANCE OF ESCR

ESCR are basic entitlements that people can claim as human beings. Its constituents are very important for freedom and dignity. Nobel Laureate Amartya Sen has said that the lack of schooling, meagre health care and inadequate economic opportunities can impede human freedom and dignity (2003: iv). Supporting the arguments of Sen, the UN Committee on ESCR opined that the right to live a dignified life can never be attained unless all basic necessities of life - work, food, housing, health care, education and culture - are adequately and equitably available to everyone (www.unhchr.ch, General Comments). It implied that ESCR are ingrained in the human rights principles and are essential for protecting and upholding human dignity.

Human dignity and integrity could be impaired by social and economic factors such as hunger, homelessness, and deprivation of other basic necessities of life. The ESCR have a value and are an end in themselves. The enjoyment of ESCR enhances the freedom of individuals by increasing their capabilities and their quality of life (www.hrusa.org/hr materials). Greater literacy and educational achievements of dis-advantaged groups can increase their ability to resist oppression, to organize politically, and to get a fairer deal (Sen

[1]QUITO DECLARATION: On the enforcement and realization of economic, social, and cultural rights in Latin America and the Caribbean (July 24, 1998)

and Dreze 1998:11). ESCR have a direct relationship with the concept of empowerment. As individuals begin to regard ESCR as entitlements, they no longer tolerate the inaction or neglect of their governments on these social issues. They start to mobilize and demand that their governments fulfil their obligations to the people (Artis et all 2003).

1.4. STATES' OBLIGATION IN IMPLEMENTATION OF ESCR

Article 2 (1) of the ICESCR has dealt with the implementation of ESCR and put an obligation on States to implement the proviso of the convention:

> 'Each State party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'

The Article has some vague words like 'to the maximum of its available resources' and 'progressively'. These words have made it very difficult to hold the State responsible for the violation of ESCR, although many States delayed the implementation of ICESCR, citing reasons like scarcity of resources.

But the State cannot ask its people to wait indefinitely for access to basic rights like right to food, right to education, right to health, etc when it is spending millions of rupees for defence and other expenditure. The UN Committee on Economic, Social and Cultural Rights is very categorical about the responsibility of States in implementing ESCR. Danilo Turk, the UN Special Rapporteur on ESCR has said that States are obliged, regardless of their level of economic development, to ensure respect for minimum subsistence rights for all (Centre for Economic and Social Rights 2000). Along the same lines, the UN Committee has affirmed that a State in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education, is, *prima facie*, failing to discharge its obligations under the Covenant (www.unhchr.ch,Gerneral Comments No 3).

The General Comments No 3 of ICESCR held the State to be the primary agency for protecting and realizing human rights; attaining minimum levels of ESCR is a core obligation of the State. It considered that breaches to these very minimum levels of obligations constitute violations of these rights. Violation can occur through the direct action of the State (act of commission) and also due to the State's failure to take steps that are required under ICESCR (acts of omission).

Within the progressive realization paradigm, there are two types of policies that always constitute violations of ESCR. First are policies that deprive people of a basic level of subsistence necessary to live with dignity, ie, the principle of minimum core content. Second are measures that actually worsen people's access to ESCR, ie, the principle of

non-regression (Centre for Economic and Social Rights, 2000).

1.5. STATUS OF ESCR IN THE LAST 55 YEARS

Although the UDHR, the ICESCR and other international human rights conventions, treaties and declarations accorded equal importance to ESCR and CPR, in practise ESCR remained a policy mirage. Both CPR and ESCR were entangled in the mess of cold-war politics amidst claims and counter-claims. The Quito Conference of July 1998 commented that during the last 55 years, ESCRs have not only been systematically threatened and violated, but were also widely unknown and ignored. As a result, unlike CPR, ESCR does not have a cohesive, comprehensive or recognizable framework, but rather exists as bits and pieces of programmatic objectives, which States may treat as negotiable and which therefore can be withdrawn or otherwise compromised (Mariama 1998).

ESCR was buried in the slush of cold-war politics. As a result, the jurisprudence for ESCR was not created. Hence, it was very difficult to fix responsibility for violations of ESCR. At the same time, there was also no pressure from civil society to force policy makers to respect and promote ESCR. People were given to understand that CPR alone is human rights and that ESCR will follow CPR.

In India, people were soon disillusioned with this approach when post-1980s it was seen that advocacy of the growth-based development model along with priority of CPR could not provide dignity and freedom to millions of people whose rights were snatched away.

The international community realized that until and unless priority is shifted towards human development and promotion and fulfilment of ESCR, human dignity and freedom of marginalized people could not be protected and ensured. This realization of the international community was articulated in all international conferences and conventions sponsored by the United Nations. Meanwhile, the United Nations Development Programme (UNDP) came out with a new Human Development Index (HDI) and published its first Human Development Report (HDR) in 1990. The HDR included all the major provisos of the ICESCR.

However, civil society organizations have realized the limitation of micro-level development interventions and poverty eradication programmes in questioning the politics and policy framework that perpetuate deprivation. They played a major role in creating a discourse that made ESCR an integral part of the human rights praxis.

1.6. RECOGNITION OF ESCR IN INDIA

India signed the ICESCR in 1979. However, long ago, the Indian Constitution incorporated all the major provisions of UDHR, ICCPR and ICESCR in Chapter III and Chapter IV of the Indian Constitution. Unlike in UDHR, in the Indian Constitution, a distinction was made between CPR and ESCR much before the international community

divided these two sets of rights in 1966 into two international conventions - ICCPR and ICESCR.

All the components of CPR were incorporated under the category of Fundamental Rights (FR) in Chapter III of the Indian Constitution, and all the components of ESCR were incorporated under the category of Directive Principles of State Policy (DPSP) in Chapter IV. India's Constitution makers gave the upper hand to fundamental rights over the directive principles by making implementation of fundamental rights obligatory and justiciable, and implementation of the directive principles optional and non-justiciable.

Interpreting the nature of the directive principles, the chairman of the constitution drafting committee, B R Ambedkar, opined that the directive principles would be the guiding principles of governance, and each successive government would have to implement these principles under public pressure. Article 37 of the Indian Constitution says that the directive principles are fundamental in the governance of the country, and it shall be the duty of the State to apply these principles.

However, there is no gainsaying that the Indian government never whole-heartedly pursued the implementation of the directive principles. Rather, the government dilly-dallied on the implementation of each principle pleading a lack of resources. The Indian legislature also did not pass strictures against the government for not taking the initiative to implement the provisions of the directive principles.

The DPSP started getting some importance when the judiciary chipped in and interpreted its underlying principles. When the Emergency imposed in the mid 1970s was lifted, the courts played a significant role in promoting ESCR by accepting Public Interest Litigation cases (PIL). The PIL has provided a legal framework for ESCR in India. The Supreme Court, while delivering judgments in Mathew, J. in the Fundamental Rights case, ruled that, in building up a just social order, it is sometimes imperative that fundamental rights should be subordinated to directive principles (Ravindran 2000:879). In another case, Justice V R Krishna Iyer commented that fundamental rights and the directive principles are complementary, neither part being superior to the other (V R Krishna Iyer, J in State of Kerala vs N. M Thomas, 1976) (*ibid*:367). In the case of Francis Coralie Mullin vs the Administrator, Union Territory of Delhi (1981, 2 SCR 516) (*ibid*: 529), the Supreme Court declared:

> 'The right to life includes the right to live with human dignity and all that goes with it, namely, the bare necessaries of life such as adequate nutrition, clothing and shelter and facilities for reading, writing and expressing oneself in diverse forms, freely moving about and mixing and commingling with fellow human beings.'

The Right to Education was upheld for the first time in India in Unni Krishnan vs State of AP ([1993] 1 SCC 645) which raised the right to compulsory education up to the age of 14 years, to the level of a fundamental right. Similarly in Bandhua Mukti Morcha vs

Union of India, in 1984, the Supreme Court held that the 'right to life' must include the right to health for the enjoyment of human life with dignity; and that '...neither the central government nor any state government has the right to take any action which will deprive a person of the enjoyment of these basic essentials' (Sengupta 2004).

Thus, the courts in India have related healthcare, food security and elementary education to the right to life (Article 21) under the Constitution making these rights justiciable. These judgements enabled civil society organizations to mount pressure on the government to make all these rights fundamental rights. For example, under the 86th constitutional amendment, elementary education has been made a fundamental right under the Constitution. Now civil society organizations are demanding that the right to healthcare and the right to food be made fundamental rights (Art 21) under the Indian Constitution.

1.7. RELEVANCE OF STUDY ON ESCR IN INDIA

Any study on ESCR serves two purposes: one, that civil society organizations and common people will come to know what steps the State has taken to fulfil the provisions of ICESCR, and two, the State also comes to know how far its initiatives in providing ESCR to its citizens have been successful.

On the basis of the findings, the State's accountability towards fulfilment of ESCR to its citizens can be understood. As the Human Development Report 2000 states, information and statistics are a powerful tool for creating a culture of accountability and for realizing human rights (UNDP 2000). Otherwise, countries that ratify or accede to specific human rights instruments cannot assess their own performance in promoting meaningful realization of the enumerated rights. Further, without effective monitoring, States cannot be held accountable for implementation of, or be made liable for, violations of these rights (Chapman, R A, www.aaas.org)

Indian society is a highly inequitable society where the richest 10% per cent consumes 33.5% of resources and the poorest 10% gets only 3.5% of resources (UNDP 2003). Around 233 million people are chronically hungry. As per the recent estimate of the National Sample Survey Organization, 16 families out of 1000 in rural areas and three families out of 1000 in urban areas do not have two square meals throughout the year. The Government of India claims that only 26% people are living below the poverty line. However, according to the Alternative Economic Survey 2000-01 based on the National Sample Survey Organization figures, the number of people living below the poverty line in rural areas increased from 35% in 1990 to 45.3% in 1998. In the urban areas the number remained roughly the same at 35% over the same period (Alternative Economic Survey 2000-01). The World Bank estimates that 34.7% of the population is living below the poverty line (under $1 a day) in India (UNDP 2003).

Around 51% of the population does not have sustainable access to affordable essential drugs. The infant mortality rate is 68 per 1000; the under-5 child mortality rate is 93 per 1000; 26% of children are underweight and 24% of the population is undernourished.

The maternal mortality ratio is 440 per 1,00,000, and 72% of the population does not have access to improved sanitation. A total of 16% of the population does not have access to sustainable water sources. Mortality due to malaria is 3 per 1;00,000 population, mortality due to tuberculosis is 42 per 1,00,000, and out of 1,00,000 population, 199 persons suffer from tuberculosis (UNDP 2003). In India, women are discriminated against in every nook and corner of the country. Women and children account for 73% of those living below the poverty line.

Around 35% of the population is still groping in the darkness of illiteracy. About 50 million children are out of school. Among children between six and ten, the total enrolment is 86%. Even if the enrolment is high, the dropout rate is over 50% by the time the students move to high school. The Gender Parity Index is 0.82; that means that for every 1000 boys enrolled, there are 820 girls seeking admission (UNDP 2003).

Due to the onset of globalization, the Government of India is cutting down its welfare budget on the insistence of the World Bank and the International Monetary Fund (see Table 1 below).

Table 1: Central Government expenditure

Types of Expenditure	Pre-reform period 1985-90		Reform period 1991-97	
	% to total expenditure	% to total GDP	% to total expenditure	% to total GDP
Plan Expenditure	33.5	6.8	28.3	4.8
Development Exp.	56.4	11.5	49.0	8.5
Capital Expenditure	30.1	6.1	22.7	4.0

The table shows that development expenditure has fallen by as much as 3% of GDP, the bulk of which comes from a drop in welfare expenditure. (www.peoplesmarch.com, *Economic and Political Weekly*, March 4, 2000.)

The Indian government is boasting that the Indian economy is booming with a growth rate of 8%, but the deteriorating social sector in India punctures the boast of a 'feel good' economy. Only last year, in 2006, 1.25 million children died. India is trailing in fulfilling the Millennium Development Goals (MDGs) because of non-allocation of requisite money; India needs only US $900 billion to meet the MDGs.

Against this backdrop, this study has been undertaken to find out to what extent India has fulfilled its obligation of providing ESCR to its citizens under the proviso of ICESCR. The study focuses on three rights: the right to education, the right to health and the right to

food. The study has documented the various goals set by the government (laws and policies, budgetary allocation, building of infrastructure, available human resources, etc) and programmes initiated to meet the goals and whether people are enjoying these rights.

1.8. OBJECTIVES OF THE STUDY

The objectives of the study are:

- To analyse the Government's initiatives and intervention in terms of allocation of resources for the realization of ESCR, especially the rights to food, health and education, with particular reference to the marginalized (Adivasis, Dalits, women and children);
- To understand how far people are getting benefits from government initiatives pertaining to ESCR.

1.9. METHODOLOGY OF THIS STUDY

1. Research Design

We have adopted the survey research design to collect the primary data. Besides, we have done an extensive review of the literature to know the goals and benchmarks, laws, policies, budgetary allocation and other process initiatives of the government to respect, protect and promote the ESCR in India. Further, we have scanned literature of the government and other sources to document the macro-level outcome related to ESCR in India. We have also resorted to case study research design to understand the role of civil society groups in facilitating people to claim on ESCR.

2. Area of the study

The study was conducted in three states of India: Maharashtra, Karnataka and Chhattisgarh. From these three states, primary data was collected from Harapanahally block of Devangiri district in Karnataka, Wada block in Thane district in Maharashtra, and Bodla block in Karwardha district of Chhattisgarh. These blocks have been chosen randomly from the list of blocks that have a majority of either Scheduled Castes (SC) or Scheduled Tribes (ST).

3. Selection of Respondents

The respondents of the study were selected in the following ways:

- Ten villages were selected randomly from each selected block.
- From the selected villages, a list of BPL cards was collected.
- From the BPL list the name of SC, ST and Other Backward Castes (OBC) families were identified.
- From the identified families 10% of families were selected applying the simple

random sampling method.

- Thus the sample in each state is 100 (10x10) families, and the total sample for the study is 300 (100x3) families.

4. Data Collection

Secondary data has been collected through review of literature from the government and other reports brought out by other civil society organizations. Primary data has been collected through a structured interview schedule. Besides, researchers undertook lengthy discussions with the people to cross-verify data.

5. Focus of the Study

Unlike other development research, human rights research focuses on the rights of the marginalized that have been denied them. Hence, the study focuses on the ESCR of the Dalits, Adivasis, OBCs and other marginalized people.

1.10. LIMITATIONS OF THE STUDY

ICESCR covers a large area. Besides, there is no standardized concept to conduct study on each provision of ICESCR. However, due to the paucity of time we could only cover Right to Education, Right to Health Care and Right to Food. Besides, this study covered three states; and primary data was collected only from one development block from each state. Another major limitation of the study is prevalence of either of the required population of SC/ST/OBC in the studied states, Chhattisgarh, Karnataka, Maharashtra.

1.11. CONCLUSION

In this Chapter, we have set the background for the study of economic, social and cultural rights. In the following chapters we go into the three rights that are the focus of this study namely, the right to education, the right to health care and the right to food. In Chapter Two, the realization of the right to education is examined using both primary and secondary data. The Chapter three deals with the right to health care, and Chapter four, the right to food. In the concluding Chapter, an assessment is made with regard to these rights.

CHAPTER 2:

RIGHT TO EDUCATION

2.1. INTRODUCTION

Education is a fundamental human right. It is considered central to the realization of both ESCR and CPR. It is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to partici-pate fully in their communities. It has a vital role to play in empowering women, safeguarding children from exploitative and hazardous labour and sexual exploitation, promoting human rights and democracy, and protecting the environment. (General Comments of UN Committee on ESCR No 13,1999).

2.2. INTERNATIONAL INITIATIVES

The UDHR, the ICESCR, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on Elimination of all forms of Racial Discrimination (CERD), the Convention on the Rights of the Child (CRC), etc have unequivocally recognized this right. Articles 13 and 14 of the ICESCR have dealt at length with the State's obligation to respect, protect and fulfil the right to education of its citizens. The Committee on Economic, Social and Cultural Rights, in its General Comments (11 and 13), specifies the responsibilities of States in providing education to all. Besides, the General Comments provide a framework for launching any study on right to education.

In the World Conference on Education for All (EFA), held at Jomtien in Thailand in 1990, 155 countries, including India, made a joint declaration to provide primary education to everybody by the year 2000. In the Dakar Conference, held in Senegal in 2000, a framework of action, popularly known as the Dakar Framework of Action, declared that every child, youth, and adult should get education by 2015 (see Box 1).

Box 1:

Global Initiatives

Article 28 of the Convention on Rights of the Child (CRC), 1989, says that the State shall do the following:-

- Make primary education compulsory and available free to all.
- Encourage the development of different forms of secondary education (including general and vocational education) and make them available and accessible to every child. The State is also expected to introduce free education and offer financial assistance to those who need it.
- Make higher education accessible to all.
- Make educational information and vocational guidance available and accessible to all children.

The World Conference on Education for All, held in 1990 in Jomtien, Thailand, marked a joint commitment by 155 nations and the United Nations to universalize basic education and eradicate illiteracy. The vision of the Jomtien Conference was:

- Expansion of early childhood care and developmental activities, especially for poor, disadvantaged and disabled children
- Universal access to, and completion of, primary education by the year 2000.
- Improvement in learning achievements. Reduction of adult illiteracy rates by one half of its 1990 level by the year 2000, with sufficient emphasis on female literacy.
- Expansion of basic education and training in other essential skills required by youths and adults, and increased acquisition by individuals and families of the knowledge, skills and values required for better living and sound and sustainable development, made available through all education channels including the mass media, other forms of modern and traditional communication and social action.

182 countries attended the World Education Forum at Dakar in Senegal, in 2000. The Dakar Framework of Action has been adopted by all of them.

- It recognizes the right to education as a fundamental human right.
- It reaffirms commitment to the expanded vision of education as articulated in Jomtien.
- It calls for renewed action to ensure that every child, youth and adult receive education by 2015.

2.3. NATIONAL INITIATIVES

In India, under the colonial regime, different Education Commissions and Committees laid emphasis on elementary education for every child. The Hunter Commission, way back in 1882, had recommended that the State give maximum emphasis to elementary education. At the Congress meeting in Wardha in 1937, a committee was constituted under the chairmanship of Dr Zakir Hussain, which argued for eight years of education. The Kher Committee set up in 1938-39 argued for eight years of compulsory education for children between the ages of 6-14 years. The Inter-University Board suggested eight years of compulsory education starting from the age of five. The Central Advisory Board of Education (CABE) set up by the British government in 1944, recommended free primary education for all children between the ages of 6 and 14. The CABE emphasized the importance of universalization of education and human resources development.

After independence, our constitution makers accorded the highest importance to education and inserted various provisions in the constitution (see Box 2). Article 45 of the Constitution assumes special importance because among all the provisions of economic, social and cultural rights which were included in the Directive Principles of State Policy, a specific time frame was given only to provide elementary education to all children.

To streamline the education policy, the Government of India (GOI) constituted the Education Commission (1964-65), popularly known as the Kothari Commission, which recommended five years of primary education for all children to be achieved within 10 years, and seven years of elementary education within 20 years. The GOI declared the National Policy on Education (NPE) in 1986, which set the target of achieving universal primary education (for age-group 6–11 corresponding to classes 1-V) by 1990, and Universal Elementary Education (for age-group 6-14 corresponding to classes 1-VIII) by 1995.

Additionally, the GOI participated in the Jomtien Conference and agreed to implement the vision of the conference. Accordingly, the GOI modified the national policy on education in 1992 through another Programme of Planning (POP), to achieve this objective. The Supreme Court of India, in the Unni Krishnan case in 1993, declared education as a fundamental right.

Box 2:

Indian Constitution and the Right to Education

Part III: Fundamental Rights

Article 28: Freedom as to attendance at religious instruction or religious worship in certain educational institution.

Article 29(2): No citizen shall be denied admission into any educational institution maintained by the State or receiving aid from the State on the grounds of religion, race, caste, language, or any of them.

Article 30: Rights of minorities to establish and administer educational institutions.

Part IV: Directive Principles of State Policy

Article 41: Right to work, to education and to public assistance in certain cases.

Article 45: Free and compulsory education for children within a period of 10 years after the enforcement of the constitution.

Article 46: Promotion of educational and economic interests of Scheduled Castes, Scheduled Tribes and other weaker sections.

The GOI also sent its representative to the World Education Forum at Dakar, Senegal in 2000. Back home, the GOI launched the Sarva Shiksha Abhiyan (SSA) in 2000 (see Box 3). Elementary education has been made a fundamental right under the 86th amendment to the Constitution. Besides, a central legislation, the Free and Compulsory Education Bill 2004, has been introduced to provide and ensure education for all children. And a total of 19 states have passed legislations related to compulsory education (see Table 2).

Box 3:

Sarva Shiksha Abhiyan (SSA)

- All children in school, Education Guarantee Centre, Alternative School, 'Back to School' Camp by 2003
- All children to complete five years of primary schooling by 2007
- All children to complete eight years of schooling by 2010
- Focus on quality elementary education with emphasis on education for life
- To bridge all gender and social category gaps at primary stage by 2007 and at elementary education level by 2010; and universal retention by 2010.

Table 2: States and the Right to Education

No	States	Name of the Act and Year
1	Andhra Pradesh	The Andhra Pradesh Education Act, 1982
2	Assam	The Assam Elementary Education Act, 1974
3	Bihar	The Bihar and Orissa Primary Education Act, 1919, as amended in 1946
4	Chandigarh	The Punjab Primary Education Act, 1960
5	Delhi	The Delhi Primary Education Act, 1960
6	Goa	The Goa Compulsory Education Act, 1995
7	Gujarat	The Gujarat Compulsory Primary Education Act, 1961
8	Haryana	The Punjab Primary Education Act, 1960
9	Himachal Pradesh	The Himachal Pradesh Compulsory Primary Education Act, 1961
10	Karnataka	The Karnataka Education Act, 1983 (Act No 1 of 1995)
11	Kerala	The Kerala Education Act, 1958
12	Maharashtra	The Bombay Primary Education Act, 1947
13	Orissa	The Bihar and Orissa Primary Education Act, 1919, as amended in 1946
14	Punjab	The Punjab Primary Education Act, 1960
15	Rajasthan	The Rajasthan Primary Education Act, 1964
16	Sikkim	The Rajasthan Primary Education Act, 1964
17	Tamil Nadu	The Tamil Nadu Compulsory Primary Education Act, 1994
18	Uttar Pradesh	The Uttar Pradesh Primary Education Act, 1919
19	West Bengal	The West Bengal Primary Education Act, 1973

As far as the budgetary allocation for education is concerned, Table 3 shows the resource allocation in all the five-year plans in India.

Table 3: Expenditure during the plan periods on education

Five-year plans (outlay)	Plan expenditure on Elementary education (in Rs crores)	Plan total expenditure on different sectors of education (in Rs crores)
First Plan (1951-56)	870 (57.6%)	1,510
Second Plan (1956- 61)	950 (34.8%)	2,730
Third Plan (1961-66)	2,010 (34.0%)	5,890
Fourth Plan (1969-74)	3,743 (48.0%)	7,774
Fifth Plan (1974- 79)	5,913 (51.7%)	11,435
Sixth Plan (1980- 85)	8,414 (32.0%)	26,187
Seventh Plan (1985- 90)	28,494 (37.0%)	76,329
Eighth Plan (1992- 97)	1,03,940 (47.7%)	2,18,001
Ninth Plan (1997- 2002)	1,63,696 (65.7%)	2,49,084
Tenth Plan (2002- 2007)	2,87,500 (67.0%)	4,28,500

Source: Five-Year Plan Documents, Planning Commission and Analysis of Budget Expenditure, Ministry of Human Resource Development.

The above table shows that the first five-year plan allocated 57% of the total allocation on education to elementary education. However, from the Second plan onwards, budgetary allocation for elementary education came down till the Eighth plan. The proportion of budgetary allocation for elementary education picked up from the ninth five-year plan. The Tenth five-year plan allocated 67% of the total allocation on education to elementary education.

The election manifesto of every major political party has emphasised raising the public expenditure on education up to 6% of GDP. Yet the ratio of public education expenditure to GDP has actually declined in the 1990s under successive governments, from a peak of 4.4% in 1989 to 2.75% in 1998-99. The state governments have tended to refrain from major expansions of public expenditure on education. As a result, public expenditure on elementary education declined in the majority of states in the 1990s (Dreze and Sen 2002:170).

Table 4: Decline in states' expenditure on elementary education

STATES	% share of elementary education expenditure in net state domestic product	
	1990-91	1997-98
Maharashtra	1.2	1.3
Orissa	2.5	2.8
Assam	2.6	3.7
Karnataka	2.0	1.9
Himachal Pradesh	4.1	N/A
Rajasthan	2.4	2.5
Haryana	1.2	1.1
Gujarat	1.9	1.6
Tamil Nadu	2.3	1.8
Madhya Pradesh	2.0	1.9
Andhra Pradesh	1.5	1.2
Kerala	3.3	2.1
Bihar	3.3	3.6
Uttar Pradesh	2.5	2.0
West Bengal	1.5	1.0
15 states combined	2.0	1.8

Source: India Development and Participation (2002), pp-169.

Box 4: Expenditure on Education, Art and Culture

The combined expenditure (on education, art and culture) in central and state budgets has registered a significant decline from 3.3 % of GDP in 1999-2000 to 2.8 % in 2004-05 (BE). This confirms the fears expressed by many that even though the Union government has been stepping up its budgetary allocations for education in the recent past, the overall allocations for this sector could have fallen because of cuts in social sector spending by the states. This is a consequence of the fiscal crisis of the states in the post-liberalization era, especially since the late 1990s.

Table 5 Expenditure on Education, Art and Culture in Union and state budgets (1996-97 to 2004-05)

Year	Expenditure from the Union budget on Education, Art & Culture (Rs. crore)	Expenditure from budgets of all the states on Education, Art & Culture (Rs. crore)	Combined expenditure from Union and state budgets on Education, Art & Culture (Rs crore)	GDP at current market prices (Rs. crore)	Expenditure from Union budget is as % of GDP	Expenditure from budgets of all states as % of GDP	Combined expenditure from the Union and state budgets as % of GDP
1996-97	4158.98	33640.62	37154.14	1368208	0.30	2.46	2.7
1997-98	5216.58	37640.44	42312.8	1522547	0.34	2.47	2.8
1998-99	7027.33	46401.72	52695.66	1740985	0.40	2.67	3.0
1999-00	8090.8	56486.8	63173.73	1936831	0.42	2.92	3.3
2000-01	8730.15	56707.84	63756.02	2089500	0.42	2.71	3.1
2001-02	9002.95	60313.02	67881.45	2271984	0.40	2.65	3.0
2002-03	10177.01	61271.51	71117.36	2463324	0.41	2.49	2.9
2003-04 (RE)	11379.77	70144.88	81221.99	2760025	0.41	2.54	2.9
2004-05 (BE)	12390.71	73876.64	85711.73	3108561	0.40	2.38	2.8

Notes:

(1) In the figures for Combined expenditure from Union and state budgets, inter-governmental transfers like grants and loans to the states have been netted in the process of consolidation.

(2) GDP at current market prices refers to the 1993-94 series released by the Central Statistical Organization.

(3) Expenditures from the Union Budget, presented above, include those of the Union Territories, which do not have legislatures. Delhi has been included in the states.

Source: Amitabh Behar, Subrat Das, Debdulal Thakur, 'Reaching the Excluded: Need for "New Imagination"', NCAS- CBGA, 2006

2.3.1. India's progressive achievement towards education

Reach and access to elementary schools: As per government estimates, India has made progress towards Universalization of Elementary Education (UEE) (see Table 6).

Table 6: Result of government efforts towards UEE

	1950-51	1995-96
Number of Institutions (in lakhs)		
Primary Schools (I-V)	2.10	5.90
Upper Primary Schools (VI-VIII)	0.13	1.71
Total	2.23	7.61
Number of Teachers (in lakhs)		
Primary Schools (I-V)	5.38	17.40
Upper Primary Schools (VI-VIII)	0.36	11.65
Total	6.24	29.05
Gross Enrolment		
Primary Stage		
Total Enrolment (in million)	19.2	109.73
Gross Enrolment Ratio percentage	43.1	104.30
Upper Primary Stage		
Total Enrolment (in million)	3.1	41.01
Gross Enrolment Ratio percentage	12.0	67.20

Source: www.un.org.in/janshala/jan1999

However, many villages in India do not have primary and elementary schools within reach. According to the Sixth All India Educational Survey, out of the 10.6 lakh rural habitations, 8.84 lakh (83.4%) had primary schools within the national norm of 1 km. Thus, 16.6% of habitations were not served by primary schools within a distance of 1 km. In case of upper primary schools, about 23.85% of habitations were not served by upper primary schools within the official distance of 3 km. Further, with the setting up of more and more primary schools, physical distance might have receded but what about the social distance?

In many areas, villages are divided into separate hamlets and children from one hamlet may be reluctant or unable to go to school in another hamlet due to caste and other social disparities. Only half of all hamlets in rural India have primary schools, and in states like Uttar Pradesh, the proportion of such hamlets is as low as 30% (PROBE Report 1999:1). A total of 4.3% girls and 3.5% boys have never gone to school because schools are far away from their homes. Besides, 5.9% of girls in rural areas have dropped out for the same reasons (National Family Health Survey - II 1998-99, www.indiastat.com).

Infrastructure in schools: The Sixth All India Educational Survey also revealed that about 41,198 primary schools and 5,638 upper primary schools were being run in

thatched huts, tents and open spaces; about 4,000 schools were without teachers; and single teachers were running 1.15 lakh primary schools. As per recent statistics, around 5% of primary schools do not have any classrooms at all, and another 15-20% have only one classroom. About 40% of schools do not have safe drinking water, and only 15-20% of schools have separate toilet facilities for girls.

Only 15% of schools have two classrooms, two teachers, basic learning kits and teacher training orientation (Govinda 2002:12). Some 20% of primary schools are run by a single teacher; 61% of primary schools have no female teacher, and 26% of schools have a teacher-pupil ratio above 1:60 (Dreze and Sen 2002:167).

- **Dropout rate in schools:** Even those who are enrolled are not finishing their elementary education. The first-ever Human Development Report of India (2001) mentioned that even those who are enrolling in school do not continue with their education. As per the recent statistics available, of the students enrolled in classes I-V, over 40% dropped out in 1999-2000 as against 38.2% in 1997-98, and nearly 55% of students enrolled in classes I-VIII dropped out in the same year as against 50.7% in 1997-98.

Table 7: Reasons for children not attending school in India (1998-99)
(Children who have never attended school)

Reasons	Rural		Urban		Total	
	Female	Male	Female	Male	Female	Male
School too far away	4.5	3.8	2.8	1.3	4.3	3.5
Transport not available	0.7	0.6	0.6	0.2	0.7	0.6
Education not considered necessary	13.1	7.8	12.9	6.1	13.1	7.6
Required for household work	15.5	6.7	9.6	4.6	14.9	6.4
Required for work on farm/family business	3.4	5.2	1.2	2.8	3.2	4.9
Required for outside work for payment in cash or kind	2.6	4.3	2.9	4.6	2.6	4.4
Costs too much	23.8	25.8	30.1	28.5	24.5	26.2
No proper school facilities for girls	2.6	0.0	1.1	0.0	2.5	0.0
Required for care of siblings	3.0	0.9	1.7	0.6	2.9	0.9
Not interested in studies	15.9	25.7	15.7	26.5	15.8	25.8
Other	12.8	17.0	18.6	21.9	13.4	17.6
Don't know	2.1	2.0	2.8	3.0	2.2	2.2
Total percent	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: 'Women and Men in India', 2001, Ministry of Statistics and Programme Implementation, Govt of India

A National Sample Survey Organization (NSSO) survey for the year 1995-96 showed that the dropout rate increases cumulatively with the level of education. It was estimated that of the ever-enrolled persons in the age group 5-24 years, 21% dropped out before completing primary level education. Half the children dropped out after attaining middle level school; over three-fourths dropped out before attaining secondary level, and 9 out of 10 persons ever enrolled could not complete their schooling. The children from poorer sections of society drop out in the early stages of education, while those from the better off sections drop out at later stages (Planning Commission 2001:56).

Table 8: Reasons for children not attending school in India (1998-99)
(Children who have dropped out of school)

Reasons	Rural		Urban		Total	
	Female	Male	Female	Male	Female	Male
School too far away	5.9	1.0	1.0	0.2	4.8	0.8
Transport not available	1.6	0.4	0.2	0.1	1.3	0.3
Further education not considered necessary	4.3	2.3	5.4	2.4	4.5	2.4
Required for household work	17.3	8.7	14.7	5.7	16.7	8.0
Required for work on farm/family business	2.9	9.2	1.6	4.7	2.6	8.0
Required for outside work for payment in cash or kind	3.7	9.9	3.0	11.3	3.5	10.3
Costs too much	11.4	13.3	17.0	15.2	12.6	13.8
No proper school facilities for girls	3.5	0.0	1.2	0.0	3.0	0.0
Required for care of siblings	2.3	0.6	1.5	0.2	2.2	0.5
Not interested in studies	24.8	40.0	30.2	42.5	26.0	40.6
Repeated failures	3.7	5.3	6.1	6.0	4.2	5.5
Got married	8.5	0.2	4.9	0.1	7.7	0.2
Other	6.2	5.3	8.2	5.8	6.6	5.5
Don't know	4.0	3.8	5.1	5.7	4.2	4.2
Total percent	100.0	100.0	100.0	100.0	100.0	100.0

Source: 'Women and Men in India', 2001, Ministry of Statistics and Programme Implementation, Govt of India

Elementary education of girls: Nearly 46% of women are unlettered in India. Only 43.6% of girl children take admission in primary school. Of these, only 40.1% take admission in middle schools (see Table 9). The dropout rate is higher for girls. It was 42.3% for classes I-V and 58% for classes I-VIII in 1999-2000 (Planning Commission 2001). Intra-female disparities between rural-urban areas and among the general population, Dalits, Adivasis, Other Backward Castes (OBCs) and some minorities are sharp.

Table 9: Percentage of girls' enrolment at Elementary stage

Years	Primary School(I-V)	Middle School(VI-VIII)
1950-51	28.1	6.1
1960-61	32.6	23.9
1970-71	37.4	29.3
1980-81	38.6	32.9
1990-91	41.5	36.7
1997-98	43.6	40.1

Source: Department of Education (various years), Ministry of Human Resource Development (GOI) as reported in India Education Report 2002.pp-37.

Around 15% of girls have never gone to school because of the pressure of household work, and currently, 17% of girls are not going to school after being enrolled for the same reason (National Family Health Survey - II 1998-99, www.indiastat.com).

Elementary education of Dalits: In the mid-1990s, barely 41.5% of Dalits in rural India were literate, and only 62.5% of children in the 6-14 age group had been enrolled in school at any point of time (Nambissan and Sedwal 2002:72). The progress of schooling among Dalit children (5-14 years) has been relatively poor compared to that of the general population. School attendance rates in rural areas in 1993-94 were 64.3% for Dalit boys as compared to 74.9% for non-Dalit boys. A total of 66.6% Dalits dropped out in 1997-78 as compared to 60.5% for the general population (Planning Commission 2001). There are more non school-going children and dropouts among Dalits. A total of 49.35% of Dalit students drop out at primary level, 67.77% at the secondary level, and only 22.35% Dalit students cross the secondary education (*ibid*).

Elementary education of Adivasis: The Sixth All India Educational Survey (1998) shows that 78% of the Adivasi population and 56% of Adivasi habitations have been provided primary schools within the habitation area. Another 11% of the Adivasi population and 20% of Adivasi habitations have schools within a 1 km radius. The proportion of Adivasi girls being educated has increased from 36.5% in 1989-90 to 43% in 1997-98 at the all-India level. Still, the literacy rate of Adivasis was only 29.50% in 1991.

The gap in literacy of Adivasis and non-Adivasis has also increased from 22.50% in 1971, to 33.05% in 1991. Female literacy among Adivasis is substantially lower than male literacy. It was only 18.19% in 1991 (Sujatha 2002:87-94). In 1900-91, a total of 65.52% Adivasi students dropped out at the primary level, 78.57% at the middle level and 85.01% at the secondary level of schooling.

Education of disabled children: There are 10 to 15 million children with disabilities in India. Of these, only about 60,000 get an education in about 1,400 special schools, and

about 50,000 disabled children are in the integrated education programme. The present coverage of disabled children under the umbrella of education is not more than 1% (Dasgupta 2002: 45).

2.4. FINDINGS OF THE STUDY

In this study we set certain common parameters to fathom the status of right to education in the selected three states. These parameters are adult literacy (age above 14 years), enrolment, children never gone to school, dropout rate, reasons for dropping out, incentives given to retain children in schools, etc.

2.4.1. CHHATTISGARH

Chhattisgarh was created on November 1, 2000. The government of Chhattisgarh has taken a policy decision that there should not be any primary school without adequate number of teachers. The teachers were appointed for three years in three different grades - Rs 3,000 per month, Rs 2,500 per month and Rs 2,000 per month. The plan outlay on education for 2001-02 as a percentage of total plan outlay for the state was 15%, which was much higher than most of the BIMARU states such as Orissa (9.94%), Bihar (8.18%) and Uttar Pradesh (4.44%).

This study found that the government of Chhattisgarh has also adopted some measures to ensure right to education of all children (see Box 5).

Box 5: Educational programmes in Chhattisgarh

- The Rajiv Gandhi Education Mission focuses on increasing the reach of primary education services and creating the requisite environment for education. Around 85% of the project funds are spent in increasing educational levels in rural areas
- The District Primary Education Programme (DPEP) runs in 15 districts of the state and focuses on regions of extreme poverty and low female literacy.
- The Education Guarantee Scheme (EGS) aims to ensure that primary education is available within one kilometre of every habitation, and that there should be a minimum of 40 children (25 in the case of tribal habitations) in the 6-14 age group.
- The state government is also running a pilot scheme for imparting distance learning education in collaboration with the United Nations Educational Scientific and Cultural Organization (UNESCO).

1. Literacy rate of adults (14 years and above)

The literacy rate in Chhattisgarh is 65.18%. Male literacy is 77.86% and female literacy is 52.40%. Chhattisgarh recorded a jump of 24.87% in literacy among women from 1991 to 2001. However, in Kawardha district where this study was done, the literacy rate is

55.38%. It is 71.35% for men and 39.60% for women. This means that in Kawardha the literacy rate is almost 10% lower than the state and national rates, and there is a wide gender gap of 31.75%, much higher than the national gap of 21%.

Table 10: Educational status of respondents (above 14 years) in Kawardha

Class	SCs (%)	STs (%)	OBCs (%)
Primary	12.19	6.89	18.18
Middle	9.75	0.57	13.63
High School	0	0	0
Higher Secondary	2.43	0.57	0
Degree	0	0	0
Post Graduate	0	0	0
Illiterate	75.60	91.95	68.18
Any other	0	0	0
Total	100.00	100.00	100.00

Source: Primary Data

The literacy gap is more glaring among the marginalized sections in Chhattisgarh. As can be seen from Table 9, 76% of SCs, 92% of STs and 68% of OBCs are illiterate in Kawardha district.

2. Availability of primary schools and higher primary schools in villages

The ICESCR stipulates that it is obligatory for the State to ensure that there are a sufficient number of schools. As per government norms there should be one primary school in each village. As per the 1991 census, Chhattisgarh has 20,279 villages of which 19,720 are inhabited. As per the 2001 census, there are 24,594 primary schools and 5,406 higher primary schools in Chhattisgarh. This is interesting because we have more than one primary school in a village. If we go by government statistics, all villages have schools. But each village is composed of many hamlets that are set at a considerable distance from each other. Also the terrain is arduous for children to negotiate.

Table 11: District-wise schools in Chhattisgarh

Districts	Pre-Primary	Primary	Middle	Literacy rate (in %)
Bastar	21	2643	376	45.48
Bilaspur	100	2183	561	63.68
Dantewada	10	1250	205	30.01
Dhamatri	15	713	42	75.16
Durg	98	2283	755	75.84
Jangir	29	1520	393	66.26
Janshpur	25	1137	233	65.37
Kanker	61	1026	237	73.31
Kawardha	3	873	137	55.39
Korba	0	892	183	63.24
Korea	37	792	190	63.44
Mahasamund	1	1206	258	67.64
Raigarh	52	1852	425	70.5
Raipur	27	2292	521	68.98
Rajnandgaon	0	1254	361	77.58
Surguja	49	2678	529	55.37
Total	528	24594	5406	65.18

Source: State Education Department and 2001 Census

However, the study found that 92% of villages have primary schools and 8% of villages still do not have primary schools. Setting up schools for the sake of it is not enough; there should be a school building with drinking water, toilet facilities, sitting arrangements, adequate number of rooms, adequate number of teachers, etc. The study found that students of different standards are squeezed together into a single filthy classroom. There is no space to sit comfortably. One teacher teaches the students of one class, and simultaneously he teaches the students of other classes also. There are almost two or three times more children per teacher than the prescribed norm. Most teachers are male, and absenteeism among teachers is rampant. There is no stringent monitoring mechanism to oversee the functioning and performance of each school. The government is irregular in providing textbooks to the students though there is provision for providing books to every student; students manage by either borrowing or buying their textbooks.

In terms of availability of higher primary school, the state level data shows that the ratio of higher primary schools to primary schools is 1:5. In Kawardha district, it is 1:6.

From this ratio, one can infer that students will drop out before reaching class VIII. This study found that 80% of villages do not have higher primary schools. Some 27% of respondents said that they would have to trudge more than five kilometres along a hilly road to reach a higher primary school if they wanted to continue their education after the primary level. To achieve universal elementary education, it is necessary to have a higher primary school in the vicinity.

3. Accessibility of schools in Chhattisgarh:

In Chhattisgarh, the study found that about 94% of Dalit, Adivasi and OBC children study in government schools.

Table 12: Accessibility of government schools in Chhattisgarh

Type of School	%
Government School	93.87
Government Alternative School	2.04
Private School	4.08
Schools run by NGOs	0
Total	99.99

Source: Primary Data

According to the Economic Survey 2000-01, during 1998-99 the gross enrolment ratio for primary school children in Chhattisgarh was 92.14%. But for the upper primary level (classes 6 to 8), the enrolment ratio was only 58% during the same period.

Table 13: Children enrolment and retention rates in Chhattisgarh

Districts	Child Enrolment (1998)		Retention rates (1994-95)	
	Male	Female	Male	Female
Bastar	44.00%	30.00%	31.30%	23.10%
Bilaspur	81.60%	49.10%	47.70%	42.90%
Dantewada	44.00%	30.00%	31.30%	23.10%
Dhamatri	85.60%	58.50%	66.20%	58.20%
Durg	77.90%	58.30%	67.90%	64.80%
Jangir	81.60%	49.10%	47.70%	42.90%
Janshpur	79.20%	36.90%	54.80%	49.50%
Kanker	44.00%	30.00%	31.30%	23.10%
Kawardha	67.20%	47.60%	59.50%	45.10%

Korba	81.60%	49.10%	47.70%	42.90%
Korea	72.20%	43.70%	70.40%	60.20%
Mahasamund	85.60%	58.50%	66.20%	58.20%
Raigarh	79.20%	36.90%	54.80%	49.50%
Raipur	85.60%	58.50%	66.20%	58.20%
Rajnandgaon	67.20%	47.60%	59.50%	45.10%
Surguja	72.20%	43.70%	70.40%	60.20%

Source: Chhattisgarh, A State in Born, 2001 Census

Table 14 shows that the number of children continuing with education from ST families is less than in the SC and OBC families. From ST families, 44.27% boys and 41.33% girls, in the age of 6-14 years, are out of school. Of the children from the surveyed families and falling in the age group of 6-14 years, 69% belong to ST families, 12.9% belong to SCs, and 16.12% to OBC families and the remaining 1.9% are from the open category. Among the said percentages, only 63.87% children go to school, 20% have never ever gone to school and 16.13% are dropouts.

Table 14: Children continuing with education (%)

	SC		ST		OBC	
	Male	Female	Male	Female	Male	Female
Children of school going age (6-14 years)	8.38	4.52	39.35	29.67	9.68	6.45
Children continuing with education	7.09	3.22	21.93	17.41	7.09	5.16
Percentage (%) of children continuing with education / children in school going age	84.60	71.23	55.73	58.67	73.24	80.00

Source: Primary Data

Of the ST families surveyed, the percentage of ST children who have never gone to school and who are dropouts is also much higher than the SCs and OBCs. Another striking outcome reflected in the table is that the number of girls who have never gone to school is more than those who have dropped out. With boys it is the opposite, the dropout rate is higher and the percentage of those who have never gone to school is less (See Table 15).

Table 15: Children never gone to school and dropouts (age group 6-14 years)

	SC%		ST%		OBC%	
	Male	Female	Male	Female	Male	Female
Children never gone to school	0	6.45	41.93	35.48	9.67	6.45
Children dropouts	8	0	56	32	4	0

Source: Primary Data

4. Dropouts

The dropout rate is an important indicator to measure the performance of states in fulfilling the right to education to all its citizens. In 2000-01, the school dropout rate (Class I-8) in Chhattisgarh was 47.15%. The dropout rate was higher among SCs (49.95%) and STs (63.68%). In Kawardha district, enrolment of boys was 67.20% and of girls, 47.20% (Census 2001). There was a difference of almost 20% between enrolment of male and female children. Out of the enrolled children, the retention rate was only 59.50% in case of males and 45.10% in case of females. This implies that 40% of male children and 55% of female children drop out from school in the district before they complete their elementary education. This study revealed that 60% of Dalit children drop out from class 2. Among Adivasis, on an average, approximately 55% of children leave school from class 3 (see Table 16).

Table 16: Dropouts class-wise

Class	SC dropout rates %		ST dropout rates %	
	Male	Female	Male	Female
Class I	26.66	0	21.66	23.21
Class II	60	0	25	17.85
Class III	13.33	0	51	58.92
Class IV	0	0	1.66	0
Class V	0	0	0	0
Class VI	0	0	0	0
Class VII	0	0	0	0
Class VIII	0	0	0	0

Source: Primary Data

The study reveals that migration of parents is the major reason for dropouts in the state, followed by inability to afford education.

Table 17: Reasons for dropout

Reasons	Percentage of dropouts
Migration of parents	17.80
School is not affordable	15.06
Have to look after young sibling	15.06
Education is not important	13.69
Have to earn money for the family	12.32
Have to work in household chores	9.58
Cattle grazing	8.29
Schooling is not interesting	8.29

Source: Primary Data

The Government of Chhattisgarh has itself confessed that the reasons for most of these dropouts is the extreme poverty in rural areas and the pressure to work in the fields and in household activities, to earn a livelihood and ensure sustenance. Migration, looking after young siblings and cattle grazing are major reasons for children dropping out of school in Chhattisgarh. Dropout rates are highest among girls primarily because they have to look after their younger siblings at home while their parents are out working, or because the school is located far from their homes, or because a girl is considered more fit for menial work in the house and sending her to school is considered a waste of time and resources.

5. Retention of children

In Chhattisgarh we found that all the children are given only cooked rice as their mid-day meal. They are told to bring the vegetables, dal and salt from home. Only 13.48% of respondents said that the school provides school bags and books. Some 2.24% of children get scholarships. Only ST girls are given scholarships of Rs 250 per year.

2.4.2. KARNATAKA

In Karnataka, the total literacy rate is 81.05% with male literacy at 86.85% and female literacy at 74.87%. Here the gender gap is only 11%. The total literacy rate in rural areas is 59.68% and in urban areas, 67.04%. The number of primary schools in Karnataka went up from about 25,800 in 1960 to over 46,900 in 1997-98. The Sixth All India Education Survey, 1993 indicated that nearly 91% of the population was served with primary schools within the habitation itself, and over 96% have schools within one kilometre. Over 60% of the population is served by upper primary schools within the habitation area and 85% have upper primary schools within three kilometres. Enrolment at primary level went up from 23 lakh in 1959-60 to 82 lakh in 1999. Karnataka has over 50,000 schools of which 22,342 are Government Lower Primary Schools and 26,374 are Government Higher Primary Schools

(Human Development in Karnataka, 1999).

The departmental expenditure on elementary education is Rs 1,758 crore as against a total educational expenditure of Rs 2,886.65 crore. Elementary education gets 54.5% of this, followed by secondary education at 32.7%. The per capita expenditure on education in the state is Rs 493.9. Karnataka spends 3.2% of its State Domestic Product on education, and 90% of this goes towards teachers' salaries.

There is no dearth of infrastructure in schools. There is lack of adequate education material and appropriate teaching staff alongwith close monitoring. The researchers were surprised to find that those who were recruited as Hindi teachers were unable to speak Hindi or understand it. When the researchers started talking in Hindi to the students for whom Hindi is a compulsory subject, they discovered that the students did not understand anything. The same is the case with English. The researchers also noticed that in most of the Lambani dominated villages, children are neither able to speak or understand Kannada, yet the teacher speaks only Kannada and teaches only in Kannada.

According to the Human Development Report for Karnataka (1999), out of a total estimated child population of 94 lakh in the 6-14 age group, 26 lakh children are out of school. Estimates of out-of-school children in the state range from 3 million or 27.7% of the total child population in the 6-14 age group, in the Human Development Report (HDR) for Karnataka 1999, to 11.12% as per a government of Karnataka report. According to the HDR report, 43.71% of the enrolled children drop out before they reach class 7. Out of every 100 children who join primary school in Karnataka in class 1, 50 have left by the time they reach class 6. Only eight out of every 100 children finish twelve years of schooling. In rural areas, the figures are even more dismal: only three out of every 100 children who join school in class 1 finish twelve years of schooling (Sixth All India Education Survey, 1997).

1. Literacy Rate of Adults (14 years and above)

Table 18: Educational status of respondents (above 14 years) in Karnataka

Class	SCs	STs	OBCs
Primary	6.38	15.38	6.17
Middle	4.79	0.96	3.70
High School	5.85	7.69	8.64
Hr Secondary	6.39	3.85	2.47
Degree	0	0	0
Post Graduate	0	0	0
Illiterate	76.06	72.12	79.02
Any other	0.53	0	0
Total	100.00	100.00	100.00

Source: Primary Data

A total of 76% of SC 72% of ST and 79% of OBC respondents were illiterate.

2. Availability of Primary and Upper Primary Schools

The Sixth All India Education Survey, 1997, found that 85% of schools have two rooms or less, and of these schools, 38% have 50 children, and 41% have 100 children. Eighty-nine per cent of schools have two or less teachers. The majority of schools have books, but the cramped conditions of the schools makes it impossible to store or utilize the books properly. Only 36% of the schools have playgrounds, which are in a usable condition, 23.94% have drinking water and 4.57% have toilet facilities.

In field investigation the researchers found that all the villages have a government primary school with sufficient rooms and a concrete structure. But most of the schools do not have drinking water and toilet facilities. However, recently, the state government declared that each school would be given Rs 25,000 for construction of toilets and Rs 10,000 for providing drinking water. In some schools the researchers found that the government has supplied musical instruments and in some schools the government has supplied a tape recorder with transistor for using the school radio programm 'Keli-Kali'. However, teachers rarely used the transistor. About 80% of schools the researchers visited had a playground. Teaching instruments were supplied regularly. The researchers found that in one higher primary school, students were drawing with computers supplied by the Azim Premji Foundation.

Box 6:
'Keli-Kali' Educational Radio Programme

'Keli-Kali' is a radio program on AIR, covers about 50,000 schools and 70 lakh children. The broadcast started from ten stations of AIR in 2000-01, aiming at Classes III-V of the schools in some of the backward north-eastern districts of the state.

http://www.sristi.org/rjmc/shiksha

The study found that all the villages have primary schools within 1 km, and 67.27% villages have upper primary schools within 1 km of their villages. A total of 6.36% respondents said that they have to walk around 5 km to reach the nearest Higher Primary School. Teacher-student ratio is almost 1:50 in all schools. Most of the primary schools are being converted to Higher Primary Schools.

3. Accessibility of schools

The Karnataka State Plan of Action for Children (KSPAC, 2003-2010) claims that 98% of the population has accessibility to a Lower Primary School within 1 km of their habitations and to a Higher Primary School within 3 km.

Table 19: Accessibility of government schools

Type of school	%
Formal school run by the government	97.74
Non-formal school run by the government	2.25
School run by NGOs	0
Total	100.00

Source: Primary data

The study found that 97.74% children study in formal schools run by the government. The researchers didn't find any private school or school run by an NGO in the villages where the study was conducted. Only one NGO 'REACH' was running two pre-primary centres and non-formal schools for child labourers.

Table 20 shows that 78.06% of boys and 69.41% of girls in the age group of 6-14 years and from SC families are out of school. In the same age group, 50.05% of ST boys and 46.75% of ST girls, and 22.21% of OBC boys and 55.60% of OBC girls are not in school.

Table 20: Children continuing with education

	SC%		ST%		OBC%	
	Male	Female	Male	Female	Male	Female
Children of school going age (6-14)	27.70	33.11	10.81	10.14	12.16	6.08
Children continuing with education	6.08	10.13	5.40	5.40	9.46	2.70
Percentage (%) of children continuing with education / children in school going age	21.94	30.59	49.95	53.25	77.79	44.40

Source: Primary data

The Karnataka field survey shows that among SCs, more girls drop out of school than boys. The ratio of boys never enrolled in school education is more than that of girls. Table 21 reveals that in ST families, the dropout percentage is more among both girls and boys. In the case of OBC families, the data collected shows that the children who are out of school are those who have never gone to school, and girls are more likely to drop out after some classes.

Table 21: Children never gone to school and dropouts

	SC%		ST%		OBC%	
	Male	Female	Male	Female	Male	Female
Never gone to school	47.37	21.05	5.26	5.26	21.05	0
Dropouts	32.39	42.25	9.85	8.45	0	7.04

Source: Primary data

4. Dropouts

In standard 2, more children among SCs drop out, both boys and girls, while more boys among STs and girls among OBCs, drop out. More girls among STs are prone to drop out in standard 1.

Table 22: Dropout Status

Standard	SC Dropout Rates %		ST Dropout Rates %		OBC Dropout Rates %	
	Male	Female	Male	Female	Male	Female
Class I	16.66	13.79	41.66	79.16	0	6.25
Class II	47.5	48.28	43.75	20.83	0	62.5
Class III	35.83	37.93	14.58	0	0	31.25
Class IV	0	0	0	0	0	0
Class V	0	0	0	0	0	0
Class VI	0	0	0	0	0	0
Class VII	0	0	0	0	0	0
Class VIII	0	0	0	0	0	0

Source: Primary data

This study was conducted in a drought-prone region of Karnataka where migration is a common problem. People migrate just to earn Rs 50-60 per day. In Harapanahalli, the daily wage is just Rs 20 for men and Rs 10-15 for women. Therefore, people migrate to get minimum wages. But this migration causes major problems for the children, and 20% of the children drop out of school because of the parents' migration. The researchers felt that the low minimum wage is the root cause for dropouts in this part of Karnataka. Both mother and father work not less than 12 hours a day to earn only Rs 35-40 per day. During their absence, the eldest child, girl or boy, looks after the younger siblings and does the housework. It is because of the perennial poverty that parents send their children to earn extra money despite knowing the importance of education. For them, today's food is more important than tomorrow's empowerment and capabilities.

Table 23: Reasons for dropouts in Karnataka

Reasons for dropouts	Percentage (%)
Migration of parents	20
School is not affordable	19
Have to look after young sibling	17
Have to do household work	13
Have to earn money for the family	12
Schooling is not interesting	8
Education is not important	6
Cattle-grazing	5

Source: Primary data

5. Retention of children

The Government of Karnataka provides free uniforms and textbooks to all children in classes I-IV (in government schools). SC/ST children in classes V-VII are also given free uniforms and textbooks. SC and ST girls studying in classes V-VII are provided a school bag as an incentive to continue their education beyond the lower primary level. Health cards have been provided to all schools. Each child in classes I-IV is given a health check up (Karnataka Human Development Report 1999).

All the schools provide a mid-day meal (cooked rice with *sambar*) to all children. The children find the rice with *sambar* very delicious because at home they eat only *ragi ki roti* with chilly chutney. It is because of the mid-day meal that many children are coming to school. However, after lunch, many children disappear from school to look after young siblings and contribute to household work.

The researchers found that this year (2003) the state government has not provided school uniforms and school bags. There was no health check-up for the children either.

2.4.3. MAHARASHTRA

In Maharashtra, 77.27% of the people are literate; male literacy is 86.27% and female literacy is 67.51%. In Thane district, where this study was conducted, there was 81% literacy - 86.06% male and 75% female, all of which is higher than the state average. Thane district has 40,516 villages, and 36,982 villages have primary schools, 17,621 villages have upper primary schools, 6,821 villages have secondary schools and 1,234 villages have higher secondary schools (1993 figures from www.indiastat.com). The state government has fixed the norm of one primary school for every 1.5 km of habitations with a minimum population of 200. For tribal areas, this applies to every one kilometre with a population of 100.

Since 1985-86, education up to standard 12 has been free for girls in the state. Education up to standard 10 has been free for boys since 1996-97. The expenditure incurred by the government per student in 1996-97 was Rs 1,579 for primary schools and Rs 2,046 for secondary schools. The proportion for elementary education was around 45% of the total education budget from 1988-89 to 1995-96. In 1996-97 to 1998-99, it increased to around 50% of the total expenditure on education. The education budget was 17.3% of the state budget (Human Development Report Maharashtra, 2002).

Table 24: Actual expenditure on Elementary education

Description	Actual expenditure 1996-97	Actual expenditure 1997-98	Actual expenditure 1998-99
Total expenditure on education	36,869.9	43,040.4	46,564.9
Expenditure on elementary education	18,698.0	21,482.2	23,271.9
Percentage (%) of expenditure on primary education to total expenditure	50.71	49.88	49.98

Note-Expenditure is Rupees in million

Source: Human Development Report Maharashtra, 2002.

1. Literacy rate of adults (14 years and above)

Table 25: Educational status of respondents (above 14 years) in Maharashtra

Class	STs
Primary	8.68
Middle	6.94
High School	7.98
Higher Secondary	1.38
Degree	0.69
Post Graduate	0.34
Illiterate	73.95
Total	100.00

Source: Primary data

In Maharashtra, 73.95% of ST respondents were illiterate. Data for SCs and OBCs is not given because responses were not statistically significant since the study was mainly conducted in a place that is inhabited by Scheduled Tribes.

2. Availability of primary school and higher primary school in villages

The study found that all the villages had a primary school run by the government. However, all the villages did not have a higher primary school. In 60% of the villages, children had to walk two to three kilometres to reach the nearest higher primary school.

3. Accessibility

Table 26: Accessibility of schools

Type of school	%
Government school	95.45
Government alternative school	0
Private school	1.14
School run by NGOs	3.41
Total	100.00

Source: Primary data

The study found that 12.77% ST boys and 14.72% of ST girls had not gone to school. Whereas in the surveyed OBC and SC families, all children in the age group of 6-14 years were continuing their education (See Table 26).

Table 27: Children continuing with education

	SC%		ST%		OBC%	
	Male	Female	Male	Female	Male	Female
Children of school going age (6-14)	2.25	0	52.80	38.20	3.37	3.37
Children continuing with education	2.25	0	46.06	32.58	3.37	3.37
Percentage (%) of children continuing with education / children in school going age	100	0	87.23	85.28	0	100

Source: Primary data

In Maharashtra, the state of elementary education was found to be more satisfactory than in Chhattisgarh and Karnataka. No SC or OBC child in the families interviewed was a dropout. As discussed earlier and presented in Table 27, all children from these two categories and in the 6-14 age group are in school. But the situation does not seem to be equally promising for children in ST families. Of the total number of children out of school in this category, 33.33% boys are dropouts and 66.67% boys have never gone to school, whereas 55.55% girls in the same category are dropouts.

Table 28: Children never gone to school and dropouts

	SC		ST		OBC	
	Male	Female	Male	Female	Male	Female
Never gone to School	0	0	66.66	0	0	0
Dropouts	0	0	33.33	55.55	0	0

Source: Primary data

4. Dropouts

The dropout rate at the state level is 34% for boys and 32% for girls. In Thane district, it is 44% for boys and 33% for girls (HDRM 2002: 91). Only 19% males and 17.8% females have completed primary school, and 16% males and 10.8% females completed middle school (*ibid*). However, another source reported that the state-wise gross dropout rate in standards 1-8 during 1999-2000 and 2000-2001 in Maharashtra was 53.72% for boys and 60.92% for girls. Total dropout rate is 53.72% (www.indiastat.com). As per the available data for the year 1998-99, of 100 students who got enrolled in Std 1, only 85% of boys and 86% of girls remained till they reached Std 4. The dropout rate increases in Std 7 and only 69% of boys and 66% of girls continue schooling (HDRM, 2002). Dropout rates for boys and girls are quite similar up to Std 4 but diverge as the children progress to higher classes. (See Table 29). In Maharashtra, the gross dropout rate up to 1999-2000 was 57.1%, which is almost 10% less than the national average dropout rate.

Table 29: Dropout Status

Gross drop-out rates in classes 1 - 8 in Maharashtra(1999-2000 & 2000-2001)

	Year	Boys	Girls	Total
Maharashtra	1999-2000	53.72	60.92	57.1
India	1999-2000	66.58	70.6	68.28

Source: Annual Report 2001-02, Ministry of Human Resource Development, Government of India.

Table 30: Dropouts among STs

Class	Drop outs %		
	Total	Male	Female
Class 1	13.33	11.11	16.67
Class 2	6.66	0	16.67
Class 3	26.66	33.33	16.67
Class 4	20.00	22.22	16.67
Class 5	20.00	11.11	33.33
Class 6	6.66	11.11	0
Class 7	0	0	0
Class 8	6.66	11.11	0

Source: Primary Data

The study revealed a startling fact: that the majority of children are dropping out from school because schooling is not interesting. It implies that there are some fundamental problems with the teaching method, which does not conform to the values and ethos of the students. Another serious impediment to schooling was the fees; more than 17% of children gave up schooling because they couldn't afford it. This punctures the big boast of the government that it is providing free education to all children.

Table 31: Reasons for dropouts

Reasons for dropouts	% (Total)
Schooling is not interesting	34.78
Have to look after young siblings	21.73
School is not affordable	17.89
Have to earn money for the family	17.39
Migration of parents	4.34
Education is not important	4.34

Source: Primary data

5. Retention of children

In Maharashtra all the children were given a cooked lunch. Around 28% of respondents said that their children were given uniforms, and 37% of students were getting books. Around 11% students were getting yearly scholarships from their schools (see Table 32).

Table 32: Incentives to retain children

Incentives provided at govt school	%
Cooked food	57.84
Cooked food, uniform, bag and books	17.64
Cooked food, bag and books	10.78
Cooked food, uniform, bag, books and scholarship	6.86
Cooked food and uniform	2.94
Cooked food, bag and books, scholarship	1.96
Cooked food and scholarship	1.96
Total	100.00

Source: Primary data

The Union ministry of human resources development has pulled up the Maharashtra government for not doing enough for primary education. In 2003-04 , the state government spent only 7% of the funds allocated to it under the Sarva Shiksha Abhiyan (SSA). Of the Rs 620 crore it was allocated, the state spent only Rs 45 crore till March 2004. (quoted in *Times of India*, March 18, 2004).

2.5. CONCLUSION AND RECOMMENDATIONS

- **Adult Literacy Rate:** It is acknowledged both by the government and the people that the Total Literacy Campaign lost the momentum it had gathered from 1989-1992. Consequently it became a routine government programme for the bureaucracy. The impact of the literacy campaign is marginally significant in the disadvantaged strata of society, especially the tribals in remote areas. In Chhattisgarh, the adult literacy rate is very low among STs at 8% compared to 24% for SCs and 32% for OBCs. In Karnataka, the literacy rate is 24% for SCs, 28% for STs and 21% for OBCs. In Maharashtra, almost 95% of respondents were STs and the adult literacy rate was only 16%.

- **Infrastructure facilities and retention of study among children:** In Chhattisgarh, the ratio of higher primary schools to primary schools is 1:5 and in Kawardha it is 1:6. In Kawardha district, 8% of villages do not have even a primary school. Geographical conditions were the main reason for children not continuing their education from primary to higher primary. For a child in the age of 6-14 years, hilly forested roads are difficult to traverse as is the distance of five kilometres from home to school. This discourages ST families from allowing their children to continue their studies. Schools in Chhattisgarh do not have enough classrooms to accommodate all the children, and in many places the higher primary school is run in a panchayat building. Lack of drinking water and toilet facilities in schools are common and there are few playgrounds.

  The teacher-student ratio of 1:50 is almost the same in all three states. Karnataka is better in terms of availability of higher primary schools; approximately 67% of villages have one within a distance of 1 km. But for 6.36% of respondents the distance was not less than 5 km. The school structure in Karnataka was good with a sufficient number of classrooms. The government also provides musical instruments, transistors and tape recorders to schools as teaching aids. In Karnataka, 80% of schools have playgrounds.

  Maharashtra is better off than the other two states. Villages selected for the study had primary schools and there were higher primary schools at a distance of 2-3 km from the children's homes. However, there were not enough classrooms and toilet and drinking water facilities were poor. Only 50% of schools had drinking water facility of any kind and almost 70% of schools had no toilet facility.

  The teacher-student ratio was unsatisfactory; in all three states one teacher handles two to three classes.

- **Accessibility:** In all three states the majority of children attending school were found studying in government schools. In government-run schools enrolment was 94% in Chhattisgarh, 97% in Karnataka and 95% in Maharashtra.

- **Dropouts:** In Chhattisgarh, greater numbers of SC and OBC children are in school, but 44.27% ST boys and 41.33% ST girls are out of school. The percentage of dropouts and children never gone to school is also more among ST families. The government of Chhattisgarh accepts that the reason for school dropouts is the extreme poverty in rural areas. The pressure to work in the fields, perform household chores and share the burden of earning a livelihood for the family keeps children out of school. Another major reason identified in the study was migration of parents, affordability of school education, taking care of siblings and taking cattle for grazing. The importance attached to a school education is still not recognized in ST families. Thirteen per cent of the families of children not attending school think that school education is not important and 8% of families did not find schooling interesting. The distance of the school from the home was another major reason why girls did not pursue a school education.

  In Karnataka, of the total number of children in SC families in the age of 6-14 years, 76% boys and 69% girls were out of school. Among ST families, 50% boys and 46% girls were not in school. Among OBCs, 55% of girls and 22% of boys were not in school. Among SC and OBC families the number of girls dropping out was more than of boys. Among ST families, the number of dropouts and of children who had never gone to school were equally high for girls and boys. The migration of parents was a major reason for children dropping out in Karnataka. Besides this, not being able to afford a school education, the need to look after siblings and to earn in order to augment the family income were other important reasons for children not continuing with school education. For girls, housework was a major reason for discontinuing their education.

  In Maharashtra, children in the school-going ages of 6-14 years continued their education except 12.77% boys and 14.72% girls from ST families. The dropout rate among ST boys and girls is more than the rate of children never admitted to school. In Maharashtra, the dropout continued till Std 8 whereas in Karnataka and Chhattisgarh children dropped out mainly in the primary classes. One of the major reasons for non-attendance is that the school is not interesting. Besides, looking after siblings, being unable to afford school education, and contributing to the family income were other important reasons for dropping out.

  While the gross enrolment rate has increased significantly over the years, retention and completion rates are still a cause for concern. Even among those who survive the first five years of school, achievement levels are deplorably low. The National Sample Survey Organisation (NSSO) 52nd round data reported that almost 47% of children who drop out of school cite inability to cope academically and lack of interest in studies as the predominant reasons (India Education Report, 2002).

- **Retention of children in school:** From 1995, the government of India began implementing a national mid-day meal programme in all states as one of the

strategies to bring more children to school and to attend to their health and nutritional needs. In practice, the mid-day meal provides little in the way of nutrition. In Chhattisgarh, only rice is served. In Karnataka and Maharashtra, the mid-day meal scheme was found to be operating well.

To bring greater numbers of children from disadvantaged sections to school, free books, school uniforms and scholarships are to be distributed by state governments. In Chhattisgarh, it was found that merely 13.48% of children get bags and books. Girls from ST families receive a scholarship of Rs 250 per year as against Rs 318 per year which the National Council of Applied Economic Research estimates is the requirement for primary education. State governments must provide school uniforms to girls and books to SC and ST children but in 2003 no books and uniforms were distributed. Karnataka provides books and uniforms, but in 2003, the supply had not reached the schools. The Karnataka government has also initiated a health card scheme for regular health check-ups, but no check-ups were done. In Maharashtra, 37% of students were getting books, 11% of students were getting scholarships and 28% were getting school uniforms.

The UNDP Human Development Report 2003 says that the costs associated with education discriminates against the poorest people by eating up a large share of limited household budgets. Uniforms are often the biggest cost for parents. In eight states in India together containing two-thirds of Indian children out of school, uniforms are one of the largest out-of-pocket education expenses.

From the study it is clear that India has to go a long way to realize the dream of achieving Universalization of Elementary Education (UEE). One-third of its population (34.62%) in the age group of seven years and above is illiterate (Census 2001). The Approach Paper of the Tenth five-year plan estimates that 80 million children are not in school. The Millennium Development Goals campaign says that despite promises made in the Sarva Shiksha Abhiyan to achieve 100% enrolment by December 2003, about 50 million children are still out of school. The Education For All (EFA) monitoring report, released by UNESCO on November 6, 2003, cautioned that India is "at risk of not achieving the goal by 2015".

India has miserably failed to fulfil the right to education of girls, Dalits, Adivasis, and the disabled. Now under the Sarva Shiksha Abhiyan, the central and state governments are promoting low cost second track education schemes like Education Guarantee Scheme, Non Formal School, Shiksha Karmi Project etc, under mounting pressure from national and international campaigns to provide elementary education to all children. But the second track education is gradually turning to second grade education jeopardizing the quality, equity and sustainability of education. This system of education poses the real danger of diluting the right of underprivileged children to quality education (Dreze and Sen 2002:170).

As per the ICESCR and the Constitution of India, children are supposed to get free elementary education up to 14 years, and the government claims that children are given

free education. But the reality belies the claim of the government.

2.6. CIVIL SOCIETY INITIATIVES IN EDUCATION

The Right to Education has been at the centre of Human Rights discourse for reasons that it would enhance understanding of life and situations among the citizens of the world. This has been recognised by the practioners of education as a means of political education and aware citizenship in every country. On one hand where the state responsibility in ensuring and imparting proper education to its citizen stands imperative, on the other hand the initiatives started by concerned civil society individuals and groups suggesting better educational models and providing education to all is added value to the ongoing efforts on education. The analysis of the State initiatives on education represents the larger picture; nonetheless, it is important to understand civil society initiatives for improving the access and quality of education. This section documents some of the key and innovative civil society initiatives for guarantying education for all.

Bhonga Shala: Education Model for Migrant Children

Vidhayak Sansad of Maharashtra created a model for education of migrant children with the Bhonga Shala project in 1995-96. Bhonga Shalas are special schools for migrant, tribal child labourers working in brick kilns in Thane district in Maharashtra. Bhonga Shalas are temporary structures constructed of reeds and grass where classes are held.

Female teachers are appointed from the concerned village, who stay with the children for six months full time and are also responsible for inculcating cleanliness and hygiene in the students. Due to the similarity between their homes and these structures, children who may otherwise be scared of formal school buildings, feel at home. Teaching methods use song and dance for improved retention and interest in the students.

The ultimate aim of these schools is to integrate children into the mainstream formal education system and the number of such children is increasing.

The year wise status of Bhonga Shalas

Year	No of schools	Enrolment	Appeared for exam	No of passed	% Passed
1995-96	05	457	255	218	85
1996-97	11	1133	662	590	89
1997-98	22	2093	967	827	85
1998-99	30	2080	1015	922	91
1999-2000	44	2784	1481	1422	96
2000-2001	60	3500	-	-	-

Source: Data from the education department of Vidhayak Sansad

Kerala Sastra Sahitya Parishad: Campaigning for literacy

In 1989, the Kerala Sastra Sahitya Parishad (KSSP), one of the pioneering People's Science Movements (PSMs) in the country, undertook a massive literacy campaign in the district of Ernakulam in collaboration with the district administration. KSSP made use of its time-tested medium of *kalajathas* (cultural caravans) to reach every nook and corner of the district to create awareness of the literacy programme. The district administration and KSSP, along with various other voluntary and mass organizations worked hand in hand on the platform of the now famous Zilla Saksharatha Samithi. Hundreds and thousands of young men and women became voluntary literacy teachers. The campaign approach of Ernakulam proved to be a major success as there was a substantial response to literacy efforts in the district.

Later, in 1989, when the National Literacy Mission (NLM) decided to replicate the Ernakulam experiment nationwide with the idea of a broad-based experiment for propagating literacy, the All India People's Science Network (AIPSN), at the request of the Government of India, decided to form the Bharat Gyan Vigyan Samithi (BGVS) with the primary responsibility of placing literacy on the national agenda.

Source: http://www.kssp.org.in

Bharta Gyan Vigyan Samiti: Mass Literacy Movement by Civil Society

A voluntary agency, Bharat Gyan Vigyan Samiti (BGVS) formed in 1989 with the primary objective of creating an environment conducive to literacy. This initiative was to facilitate mass literacy with an understanding that it will provide necessary vigour and capability for rapid change. Started under umbrella of the 'People's Science Network' (PSN) this initiative was aimed to facilitate political, social and scientific education to masses. BGVS considers literacy as a possible starting point for social transformation, and a means for a crusade against conditions that maintain illiteracy, communalism, and dependence & oppression. The central slogan of BGVS has been "science and literacy for national integration and self-reliance". Through this, it seeks to capture the "emotional" support of the people. It is intervening in areas such as universalisation of elementary education, science popularisation, participatory watershed development programmes, rural enterprise programmes, library and cultural movements, health, environment protection and sustainable models of development.

The need for initiating mass action for bringing about change in the social order BGVS has been involved in large-scale mobilizations for literacy through the powerful medium of kala jathas. One of the most significant outcomes of the literacy campaign of BGVS in 1990's has been the formation of 'Samata', a campaign under which a large number of community-based women's organizations have come together to collectively address issues related to women and to transform it into a women's movement. Today, BGVS has units in 22 states and union territories and plays an active role in supporting the TLCs (Total Literacy Campaign's) in more than 250 districts.

Source: http://www.kssp.org.in and http://www.dorabjitatatrust.org/annual_rep

Centre for Learning Resources: Early Childhood Development and Elementary Education Initiative

The CLR is a non-profit, non-governmental organisation (NGO) located in Pune, India. It is working in early childhood care and development and elementary education since 1984 in Maharashtra and other. Set up as a resource centre to support efforts in early and primary education, the Centre has developed resources for materials development and training of teachers, as well as supervisory staff. Especially rich in mathematics material for primary school, the Centre has recently developed material for the education of tribal children, a particularly difficult area of work.

Source: www.clrindia.net

Ekalavya: Institute For Educational Research And Innovative Action

In the early years of the decade of the 1980s, a group of educationists and social activists met to discuss the possibility of setting up an institute for educational research and innovative action in the Indian state of Madhya Pradesh. This group had a long association with a pioneering science education project that had started in 1972 and was then running in around 225 middle schools of Hoshangabad district of Madhya Pradesh. Known as the Hoshangabad Science Teaching Programme (HSTP), this project was a collaborative venture between two non-governmental organisations, Friends Rural Centre (FRC) and Kishore Bharati (KB), and the education department of the Government of Madhya Pradesh.

The continuing impact of Eklavya's interaction with people's science movements was seen in the early half of the 1990s with the establishment of a vibrant network of nearly 100 'Chakmak clubs', beginning with the Dewas region and later spreading around the field centres in Hoshangabad district (1992). These clubs, run entirely by local students and village youth, served as out-of-school meeting points for students to pursue creative activities and projects and develop their leadership qualities. The children themselves began organising activities that the Eklavya field centres had been conducting earlier in villages, such as bal-melas, creative workshops, study groups, libraries, etc.

The Chakmak clubs in Hoshangabad were later modified into 'Bal-samoohs' (2000), which are essentially centred around libraries run by village youth from their homes. The activities of each Bal-samooh are managed by a team of three or four youths and this forum, like the Chakmak clubs, provides an outlet for channelising the creative faculties of children in villages and developing the leadership abilities of the organising team.

http://www.eklavya.in

M V Foundation: Education of Child Workers in Andhra Pradesh

The M V Foundation is an organisation active in the field of education of child workers. Foundation organises regular 'camps', where working children find a supportive,

stimulating atmosphere in which they learn a surprisingly great amount in the short duration of three months. MVF today works in 491 villages of Ranga Reddy district of Andhra Pradesh. It has so far withdrawn 100,000 children out of work and retained them in schools. In 169 villages in the project area all children in the age group 5-14 years are in school.

Though there are no monetary incentives for parents sending their children to the camps, the demand for these camps has grown dramatically, as also the number of volunteers or motivated teachers. A very high percentage of children who attend these camps acquire a minimum learning level as well as the motivation to go back to school. One of the key reasons for this success is the nature of the relationship established between teachers and children during the camp.

Source: http://education.nic.in and www.mvfindia.in

CHAPTER 3:

RIGHT TO HEALTH

3.1. INTRODUCTION

Every year, across the globe, more than 10 million children (30,000 a day) die of preventable illnesses. In Sierra Leone alone, an estimated 18% children do not live long enough to reach their first birthday. The maternal mortality rate of 50,000 women per year is a matter of shame. Such alarming statistics show that health, which is central to human and social development, is well beyond the reach of millions of people worldwide. A burgeoning population, high maternal mortality rates and the heavy burden of both communicable and non-communicable diseases are the daunting challenges that the world still faces. And it defies the historic global pledge of 'Health for All by 2000' set at Alma-Ata 25 years ago.

The fact that, in many countries of the world, health systems have deteriorated-access is poor, quality is poor, and drugs are not available proves that we have not made substantive improvements in the main underlying determinants of health. Unacceptably high levels of poverty, a widening gap between the rich and poor nations, drastic depletion of natural resources and a further degradation of the global environment pose serious threats to human health.

Around 54 countries are poorer now than they were in 1990. The last decade has also seen East Asia and the Pacific, led by China, reducing their poverty levels to almost half, whereas extreme poverty still reigns in South-Asia. South-Asia remains one of the world's poorest regions with more than one-third of South Asians lacking access to improved sanitation, one-third living in poverty, one-quarter hungry, one-fifth of children out of primary school and almost one-tenth of children dying before the age of five. Inequity in accessibility to health care thus remains vital in achieving the Human Right to Health.

3.2. WORLD HEALTH SCENARIO

Due to the persisting and increasing gap in access to health care, a pregnant woman in Sub-Saharan Africa is a hundred times more likely to die of pregnancy related diseases

than a woman in a high-income OECD (Organisation for Economic Cooperation and Development) country. Thus, an analysis of the health situation and its determinants is a story of inequality and unequal distribution.

In the quest for health care delivery, privatization of health services is an easy solution. However, privatization poses more threats to accessibility of health care services as a large section of the poor population cannot afford expensive privatized health services. Specialized health services are meant for the affluent section of the population while a much larger section is left to the mercy of public health care services, which are being rendered ineffective by declining public expenditure. Poverty remains the major cause of ill health across the globe leading to the socio-economic marginalization and diminishing participation of poor people in the political process. Economic vulnerability surely contributes to the resulting inequality in health outcomes. People living in absolute poverty are five times more likely to die before reaching five years of age than those in higher income groups. This is a central issue of human rights and social justice.

The World Health Report of 1999 rightly says that because ill health traps people in poverty, sustained investment by States in the health of the poor could help alleviate persistent poverty. If a nation invests in the health of its citizens it improves productivity and creates wealth. On the contrary, what we see today around the world is a growing resurgence of 'diseases of poverty', mostly infections and parasitic diseases, as well as women's reproductive health problems and chronic diseases. Cancer, hypertension, diabetes, obesity, accidents and depression have become serious public health problems worldwide. Third world countries are faced with the double burden of rising incidence of infectious and chronic diseases. Combating this requires investment and upgrading of public health services, but this is impossible given the economic and political constrains they face.

There has also been a resurgence of 'old diseases' such as tuberculosis, malaria and vaccine-preventable diseases. This is a direct result of increasing poverty, deteriorating living conditions and inadequate health services. New diseases such as HIV/AIDS have appeared and are spreading most rapidly where social and gender inequalities are the greatest. Increasing crime and violence add to this growing health crisis. The same is true for substance abuse, increasing violence, suicide and other 'diseases of despair.' Far from reaching the international goal of 'Health for All by the Year 2000,' the health of humankind is sadly compromised.

3.3. HEALTH: A COMPONENT OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS

The World Health Organization (WHO) defines health as a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity. This holistic health concept views health as a state of equilibrium between a human being's external and internal environment. Health thus is a balanced state or condition of body and

mind which defines the ability of a person within his/her respective situation, to exercise the choices available for purposes of personal, professional, emotional and spiritual growth or to protect himself/herself from any ill or diseased environment.

The word 'healthy' denotes the security and successful functioning of the human mind and body. Absence of sufficient income to maintain subsistence requirements of food, shelter and clothing, and insufficient access to essential services of safe drinking water, sanitation, health services and education, accompany poor health. A poor health outcome is the result of socio-economic deprivation, which in turn results in deterioration of economic status partly due to loss of earning and partly due to the heavy cost of health care. Thus health is a fundamental human and social right to strive for.

The WHO's definition of health lays the foundation for right to health as a fundamental human right. This has been carried forward and discussed in important human rights documents including the UDHR. Article 12.2 of the ICESCR acknowledges that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

Realization of the right to health is closely related and dependent upon the realization of other human rights as contained in the International Bill of Rights, including the right to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information and the freedom of association, assembly and movement. These and other rights and freedoms address integral components of the right to health. In fact, the right to health, linked to the fulfilment of basic needs – food, shelter, education, etc, is an integral part of the right to life that demands a life with dignity and self esteem.

Good health, 'a balanced body and mind', contributes to economic stability and political consciousness and enhanced social status. Good health is an asset for humans, and it is the State's responsibility to assure health protection, timely and appropriate health care, and also address the underlying causes of ill health of all its citizens.

3.3.1. Human rights and health as enshrined in international treaties

In 1946, WHO defined health in its Constitution, and in 1948, the UDHR reaffirmed this by saying that everyone has the right to a standard of living adequate for the health, medical care and economic and social security in times of sickness or disability as explicitly embedded in Article 25. In 1978 this vision was emphasized in the call for 'Health for All by 2000 AD' of the Alma Ata Declaration. Alma Ata stated that Primary Health Care is the key to attaining health for all as part of overall development. It defined primary health care as 'essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that community and the country can afford.' Alma Ata was the first to recognize health as a

fundamental right.

The right to health also finds mention in Article 5 of the Convention on Elimination of Racial Discrimination and Article 24 of the Convention on the Rights of the Child. Twenty-five years after Alma Ata, the Millennium Development Goals (MDGs) once again extended the scope for the realization of the right to health and health care. Agreed to and endorsed by 149 countries, the MDGs explicitly indicate the commitment of the international community to uplift millions of people living in poverty and to create an equitable and just space for them in the process of development. Of the MDGs to be attained by 2015, three specifically call for health improvements: reducing child deaths, lowering maternal mortality, and stopping the spread of HIV/AIDS, malaria and tuberculosis. However, the achievement of other MDGs - particularly eradicating poverty and hunger, achieving universal primary education and empowering women - to a greater extent depends on better health status of the people.

The right to health clearly establishes the fact that health is one of the imperative conditions for the realization of socio-economic and cultural rights. The right to health requires countries to do more than merely provide for comprehensive systems of health care delivery and insurance. It obligates them to undertake measures aimed at promoting individual and community health and at preventing diseases, removing other external causes of morbidity and mortality, eliminating health inequalities and improving the conditions that may hamper achievement of the highest attainable level of health.

The right to health imposes three types of obligations on countries: obligations to respect, to protect and to fulfil human rights. Obligations to respect require countries to refrain from interfering with individual's rights and dignity; obligations to protect require them to prevent third parties from violating individual's rights and dignity; and obligations to fulfil require them to take all appropriate legislative, administrative, budgetary, judicial and other measures to ensure progressively greater satisfaction of human rights.

3.3.2. Human Right to Health?

Every woman, man, youth and child has the human right to the highest attainable standard of physical and mental health, without discrimination of any kind. Enjoyment of the human right to health is vital to all aspects of a person's life and well-being, and is crucial to the realization of many other fundamental human rights and freedoms. Human rights relating to health are set out in basic human rights treaties (see Box 11).

Box 7 : The human rights at issue

- The human right to the highest attainable standard of physical and mental health, including reproductive and sexual health.
- The human right to equal access to adequate health care and health-related services, regardless of sex, race, or other status.
- The human right to equitable distribution of food.
- The human right to access to safe drinking water and sanitation.
- The human right to an adequate standard of living and adequate housing.
- The human right to a safe and healthy environment.
- The human right to a safe and healthy workplace, and to adequate protection for pregnant women in work proven to be harmful to them.
- The human right to freedom from discrimination and discriminatory social practices, including female genital mutilation, prenatal gender selection, and female infanticide.
- The human right to education and access to information relating to health, including reproductive health and family planning to enable couples and individuals to decide freely and responsibly all matters of reproduction and sexuality.
- The human right of the child to an environment appropriate for physical and mental development.

3.4. GOVERNMENTS' OBLIGATIONS TO ENSURE THE HUMAN RIGHT TO HEALTH

The State's obligation to respect the right to health prohibits it from taking action that would directly injure health. The obligation to protect suggests that the State must offer some redress that people know about and can access if violation of the right does occur (Gruskin and Tarantola, 2002). Similarly, the obligation to fulfil the right to health, apart from the obligation to facilitate and to provide, also incorporates an obligation to promote because of the critical importance of health promotion. The immediate obligations include the guarantees of non-discrimination and equal treatment as well as the obligation to take deliberate, concrete and targeted steps towards the full realization of the right to health, such as the preparation of a national public health strategy and plan of action (*ibid*).

To determine which actions or omissions amount to a violation of the right to health, it is important to distinguish the *inability* of the State from the *unwillingness* of the State to comply with its obligations (Sengupta, 2004). Article 2(1) of the ICESCR obliges each State party to take necessary steps to the maximum of its available resources. Violations of the right to health can occur through the direct action of States or other entities insufficiently

regulated by the State. A State that is unwilling to use the maximum of its available resources for the realization of the right to health is violating its obligations under Article 12 of ICESCR. If resource constraints render it impossible for a State to comply fully with its obligations, it has to prove that every effort has been made to use all available resources at its disposal in order to satisfy, as a matter of priority, these obligations. However, the General Comment 14 clearly states that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations, which are non-derogable.

3.4.1. Government's commitment to ensure human right to health

The State's obligations to right to health determine the commitments from the States to respect, protect and fulfil. States have committed themselves to assure the right to health in different international declarations. In *Agenda 21*, health is seen more in relation with the right to development, and States have agreed that there is insufficient and inappropriate development leading to poverty. In *Habitat Agenda*, State parties have agreed to the view that "human health and quality of life are at the centre of the effort to develop sustainable human settlements." States have committed to the goals of universal and equal access to the highest attainable standard of physical, mental and environmental health, and to the equal access of all to primary health care, by making particular efforts to rectify inequalities relating to social and economic conditions, without distinction as to race, national origin, gender, age, or disability. It was acclaimed that good health throughout the life-span of every man and woman, good health for every child are fundamental to ensuring that people of all ages are able to participate fully in the social, economic and political processes of human settlements. And sustainable human settlements depend on the policies to provide access to food and nutrition, safe drinking water, sanitation, and a universal access to the widest range of primary health care services. It is therefore recognized distinctively in *Habitat Agenda* that it is essential to take a holistic approach to health.

3.5. RIGHT TO HEALTH IN INDIAN CONTEXT

3.5.1 Right to Health and Constitution of India

The Constitution of India also has provisions regarding the right to health. They are outlined in the Directive Principles of State Policy (DPSP) - Articles 42 and 47, in Chapter IV, and are therefore non-justiciable.

Article 42: The State shall make provision for securing just and human conditions of work and for maternity relief.

Article 47: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties, and in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health.

The above articles act as guidelines that the State must pursue towards achieving

certain standards of living for its citizens. It also shows clearly the understanding of the State that nutrition, conditions of work and maternity benefits are integral to health.

The Right to Life in Article 21 of Fundamental Rights in Chapter IV has been extended to include the right to health and health care in its periphery in several judicial decisions. The recognition that the right to health is essential for human existence and is, therefore, an integral part of the right to life, is laid out clearly in Consumer Education and Resource Centre vs Union of India. It is also held in the same judgment that humane working conditions, health services and medical care are an essential part of Article 21.

In spite of the constitutional provisions in India, the State's economic incapacity is always presented as the main cause for its failure to fulfil its socio-economic commitments. In truth, the lack of substantial progress is due to the lack of political will on the part of government and inappropriate policy decisions.

3.5.2. Trends in policy development in India

The focus of the National Health Policy (NHP) of 1983 was the formulation of an integrated and comprehensive approach towards the development of health services, appropriately supported by medical education and research, with special emphasis on PHC and related support services. During the Seventh five-year plan, a great deal was done to establish a health infrastructure, especially in rural areas. The Eighth five-year plan (1992-97) identified 'human development' as its main focus, with health and population control listed as two of the six priority objectives. It was emphasized that health facilities must reach the entire population by the end of the plan period. The plan also identified peoples' initiative and participation as a key element. With the enactment of the 73rd Constitutional Amendment Act (1992), Panchayati Raj Institutions (PRIs) were revitalised, and a process of democratic decentralisation was ushered in, with similar provisions made for urban local bodies, municipalities and *nagarpalikas*.

Recognising the importance of sustainable development, a national conservation strategy and a policy statement on environment and development were formulated in 1992 to bring environmental considerations into the developmental process. Linkages were drawn between poverty, population growth and the environment. The National Health Policy identified nutrition as a problem needing urgent attention, and in 1993, a National Nutrition Policy was formulated with long and short-term strategies.

The vertically structured family welfare programme needed to be replaced by a more democratic, decentralized alternative. In 1994 a draft National Population Policy was submitted to Parliament as well as a revised report in 1996. It advocated a holistic, multi-sectoral approach towards population stabilization, with no targets for specific contraceptive methods except for achieving a national average Total Fertility Rate (TFR) of 2.1 by the year 2010. This has resulted in a radical shift in implementation from centrally fixed targets to a target-free dispensation through a decentralized, participatory approach. A Population and Social Development Commission was also established in support of the

population policy.

India accepted the recommendations of the International Conference on Population and Development (ICPD), 1994, and has also ratified various international conventions for securing equal rights for women. Following the World Summit on Survival, Protection and Development of Children in 1990, India formulated a Plan of Action for Children in 1992 with actions that directly and indirectly affect child health.

Despite the commitment to Health for All, enormous health problems still need to be addressed. While overall mortality has declined considerably, living standards are still among the poorest in the world. The major constraints facing the health sector are lack of resources, lack of an integrated multi-sectoral approach, insufficient information, education and communication (IEC) support, poor involvement of NGOs, inadequate laboratory services, a manually operated Health Management Information System (HMIS), poor disease surveillance and response systems, and the heavy investments needed in dealing with non-communicable diseases. The problem of gender disparity still manifests itself in various forms as evidenced by the declining female to male population ratio, social stereotyping, violence at the domestic and social level, and continuing open discrimination against the girl child, adolescent girls and women.

In order to address concerns regarding the non-attainment of goals set for 'Health for All by 2000 AD', the government initiated a new policy, the National Health Policy, 2002. 18 years after the first policy. The main objective of the new policy is to achieve an acceptable standard of good health in the general population of the country. It is to be achieved through increase in access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions.

However, the goal of 'providing universal, comprehensive primary health care services', as stated in the 1983 policy, does not find mention in this new policy document. The new policy acknowledges that India's public health care system is grossly short of defined requirements, its functioning is far from satisfactory, that morbidity and mortality due to diseases that are curable continues to be unacceptably high, and resource allocations are generally insufficient.

The NHP 2002 is quite explicit in its acknowledgment of the poor state of affairs in the health sector. It also recognizes globalisation as a concern, takes a critical view of Trade Related Aspects of Intellectual Property Rights (TRIPS) and its impact, envisages regulation of the private health care sector, and proposes to increase the expenditure on primary health care. It recommends increasing public health expenditure from the present 1% of GDP to 2% of GDP by 2010. The NHP 2002 expresses a valid concern regarding inefficient use of resources of various kinds in the running of the programmes sponsored by the central government, eg, the wastage on account of vertical disease control programmes. But it is silent when it comes to making concrete and worthwhile policy suggestions to improve the situation, and also on the overshadowing of the public sector by

the private sector.

Moreover, it is biased towards urban-centric, specialist-based health care by ignoring the pressing needs of primary health care services. It proposes privatization of secondary and tertiary level care, ignores the simple fact that 45% of the poorest in the country continue to depend on public hospitals for critical indoor care (Qadeer 2002). It also proposes to use Indian health facilities, particularly in the private sector, to attract patients from abroad. It suggests that the income derived from this can be termed 'deemed exports' and should be exempt from taxes. Such a policy is subservient to the interests of the rich and powerful in the global health market but denies minimum health care entitlements to the large numbers of the poor and less well off sections.

Another important point is that the NHP 2002 proposes to strengthen the provision of user fees in public hospitals with the qualification that it will target those who can pay. However, a recent study of user fees in Gujarat, Madhya Pradesh, Orissa, Rajasthan and West Bengal shows that they do not contribute more than 2% to the hospital budget (Sen, Iyer and George, 2002). Moreover, identification of those 'who can pay' is an exceedingly difficult task, and often large sections of the vulnerable may get left out of the count of those who cannot pay. Further, strengthening of user fees will inevitably result in driving out substantial sections of the poor from the public health care system.

3.5.3. Expenditure and allocation on health in India

The pattern of public expenditure on health in India speaks volumes about the status of the health sector. Allocation of funds for health programmes in consecutive five- year plan periods shows a steady increase, but in percentage (of GDP) terms, it has declined. This has been due to increased attention to and funding of selective health services from the mid-60s. The introduction of Structural Adjustment Programmes (SAP) sharpened this trend of long focused vertical health programme interventions with service charges in public services, and handing over more responsibility to the private sector. The consecutive plan outlays openly advocate the expansion of private investment in curative care while restricting public spending in preventive services, ie, public health.

The table below shows the declining trend in plan expenditure for public health in different plan periods.

Table 33: Plan allocation for expenditure on health

Plans	Health outlay(in Rs crore)	Outlay as % of total
First Plan (1951-56)	65.2	3.3
Second Plan (1956-61)	140.8	3.0
Third Plan (1961-66)	225.9	2.6
Annual Plans (1966-69)	140.2	2.1
Fourth Plan (1969-74)	335.5	2.1
Fifth Plan (1974-79)	760.8	1.9
Annual Plan (1979-80)	223.1	1.8
Sixth Plan (1980-85)	1,821.1	1.9
Seventh Plan (1985-90)	3,392.9	1.9
Annual Plans (1990-92)	1,965.6	1.6
Eighth Plan (1992-97)	7,575.9	1.7

Source: Fifteenth Report of Pricing and Availability of Drugs/Pharmaceuticals, Ministry of Chemicals & Fertilizers (Department of Chemicals & Petrochemicals).

In the Ninth five-year plan (1997-2002), the allocation of funds for health was Rs 5,118.00 crore while for family welfare it was Rs 15,120.00 crore. This increased to Rs 27,125.00 crore for family welfare in the Tenth five-year plan (2002-07), whereas the allocation for health was raised to only Rs 9,253.00 crore.

Table 34: Allocation of funds for Health and Family Welfare (in Rs crore)

Allocation	Ninth Five Year Plan (1997-2002)	Tenth Five Year Plan (2002-2007)
Health	5,118.00	9,253.00
Family Welfare	15,120.00	27,125.00

Source: L.S. (U.S.Q. No. 1413), dated November 27, 2002, answered by A Raja, Minister of State in the Ministry of Health and Family Welfare. Aditya Yogi raised the question. (Parliament Digest, winter session 2002, published by NCAS)

It is to be noted that while every high-income country spends at least 5% of its GDP on public health care, India, as a developing country, spends only 0.9% of its GDP on health. The expenditure on health as a share of the aggregate annual public expenditure on health is 96.9% in China, but in India it is a meagre 17.3%. According to the Human Development Report of 2003, India's GDP ranked 0.56 in the world GDP index. But its public expenditure on health amounts to a low 0.9% of GDP whereas private expenditure on health as share of GDP is 4%. Comparatively, a country like Bangladesh, with only 0.46 GDP index, spends 1.5% of its GDP on health and allows private expenditure amounting to only 2.6% of its GDP.

3.5.4. Availability of essential drugs

The availability of essential drugs in India does not present a different picture. It is said that in countries with a high human development index, almost the entire population has access to essential drugs whereas in countries with a low human development index, the situation is the reverse. In India, less than 50% of people have access to essential drugs. But Bhutan, with a low human development ranking, succeeded in providing essential medicines to 80-94% of its population.

In India, the systematic deregulation of the pricing of drugs is another reason for pushing up costs in the health sector. When the Drug Price Control Order was issued in 1970, all drugs were under price control. In 1979, only 347 drugs were under price control. This number was almost halved to 163 by 1987, and subsequently brought down to 76 in 1995. The Pharmaceutical Policy of 2002 reduced this number further, to 35 drugs. Today India is the fourth largest drug producer (by volume) in the world, exporting 45% of its total production (Duggal 2004).

Per capita drug sales in India have now increased to Rs 300 annually. Research shows that this is more than sufficient to cater to the needs of primary health care of all the people, provided drug production and use is scientifically managed. As of today, only about 20% of patients go to public health facilities for out-patient care. The Tamil Nadu Medical Service Corporation, a public body working for the Tamil Nadu government, has been buying quality, tested drugs in huge quantities directly from the drug companies at tender rates which are *one-tenth to one-fiftieth* of retail- market prices. This practice can be implemented by public health bodies in other stats and can help to reduce the disparity in accessibility to essential drugs. (JSA, 'Press Release, 'Ensure People's Right to Essential Drugs', 2004)

Based on statistical estimates received from WHO's country and regional offices and through the World Drug Situation Survey carried out in 1998-1999, the Department of Essential Drugs and Medicines Policy of the WHO divided countries into four categories of classification for people's access to essential drugs. Countries such as USA, UK, Australia and even Sri Lanka have shown the best (95-100% access); China, Indonesia, etc came in the 80-94% category; Pakistan, Myanmar and Bangladesh were in the 50-79% category; and India fell in the last (0-49%) category (HDR 2002).

The National Health Surveys provide clear evidence of the declining use of public health services, from 60% for hospitalizations in 1986-87, to 45% in 1995-96, and for out-patient care, from 26% to19% during the same period (Duggal 2004).

3.5.5. Private health sector in India

In India, the availability of data on the share of the private health sector in total health infrastructure is both inadequate and unreliable, and this is an area demanding urgent attention from both the government and research institutions (India Health Report, 2003).

The spatial distribution of private facilities and doctors between the states, and between the urban and rural areas is also not according to the policy norms of equal access. For example, 12% of Himachal Pradesh's hospitals are in the private sector as compared to Kerala's 95%. Himachal Pradesh and Madhya Pradesh have negligible presence of qualified medical private practitioners, as compared to developed states such as Kerala, Maharashtra, and Punjab. But unexpectedly, private hospitals are relatively less urban biased than public hospitals: about 31% of private sector hospitals and 29% of its beds are in rural areas, while only 25% of public sector hospitals and 10% of its beds are in rural areas (Directory of Hospitals in India, 1998; Nandraj 2000).

The utilization pattern of private health care in India is dominant in both out-patient (OP) and in-patient (IP) care. Reasons for the poor use of public facilities are many, and across India, the perception is that the private sector responds better to the patient's interests than the public sector. Data from the National Sample Survey 52nd round reveals that 44% of patients chose the private sector because the doctor was more easily available, 36% because they were not satisfied with the treatment in the public sector and 7% because medicines are not available. Distance and long waiting time are also quoted as reasons for the poor use of public health facilities. The private sector accounts for 82% of all out-patient visits at the all-India level, with no significant variations by income group. The range is from 79-85% from poorest to richest quintile, by urban and rural, by gender, caste, or tribe. While the private sector shows a slight edge over the public sector in hospitalizations and institutional deliveries, there is dramatic decline in antenatal care and immunization.

Table 35: Share of public and private sector service delivery

Services	Private sector (%)	Public sector (%)
Immunization	9	91
Antenatal care	40	60
Institutional deliveries	50	50
Hospitalization	55	45
Out-patient care	82	18

Source: Mahal et al., 'Who benefits from public health spending in India', NCAER, 2000

During the 1990s the public health system was collapsing due to under financing of public health services. The SAP and economic reform programmes, which began in 1992 after the 1991-92 fiscal crises, further shrank resource allocations for public health services. The national health surveys reveal that the rate of hospitalization has very strong class gradients with the top quintile reporting over ten times the hospitalization rate of the bottom quintile. This is because of increasing dependence on the market for health care, which makes the poor delay their decision to seek medical care. However, it was the

decline in public investment in health care and the introduction of user fees that was the final blow for the poor who make the most use of public health facilities (Duggal 2004).

Table 36: Health expenditure in India as a ratio to Gross Domestic Product (GDP) at current prices 1975-2002 and hospitals and beds in the private sector

	1976-76	1980-81	1985-86	1991-92	1995-96	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02
Public %GDP	0.98	1.07	1.32	0.88	0.86	0.82	0.82	0.91	0.89	RE 0.87	BE 0.81
Private %GDP	3.13	3.88	3.45	2.60	2.94	2.92	3.30	4.09	4.76	4.72	4.98
%Hospitals		43		57	68						76
%Beds		28		32	37						55

(Source: Duggal, 2004)

The few studies that estimate health expenditure at household level show that 7-9% of annual household consumption expenditure is on health care needs; about 85% of which goes to the private sector (Bhat 1993). The growing trend to over-refer, over-test, over-medicate and over-use diagnostic techniques in the private sector has been making health care unaffordable and a major drain on the resources of the poor. Since economic liberalization, India opened the door to private partners in health care as well as in other sectors, but appropriate legislation is lacking to effectively regulate the private sector and its high charges. There is a growing need to regulate the quality and quantity of the mushrooming private health sector and fix its social responsibility to the 20-30% of poor for which they it getting tax exemption.

3.5.6. Health sector development In India

India was a pioneer in focusing on primary health care, and did so even before the Alma Ata Declaration. In 1946, the Health Survey and Development Committee recommended establishing a well structured and comprehensive health service with a sound primary health care infrastructure (the Bhore Report). The primary responsibility for building the infrastructure and manpower rests with the state governments and is supplemented by funds from the federal government and external assistance. Major disease control programmes and family welfare programmes are centrally funded (some with external assistance) and implemented through the state infrastructure. Food supplementary programmes for mothers and children are funded by state governments and implemented through the centrally funded Integrated Child Development Services Programme (ICDS) infrastructure. The Department of Urban and Rural Development and the Department of Environment (both centrally and in the states) fund programmes for safe drinking water and environmental sanitation.

Universal coverage of the population through primary health service facilities in rural

and urban areas is one of the seven Basic Minimum Services (BMS) identified for priority attention under the Minimum Needs Programme (MNP). It is estimated that a properly functioning universal primary health care infrastructure providing integrated promotive, preventive, curative and rehabilitative services would meet over 80% of the health care needs of the population. The remaining needs would be met through referral to secondary or tertiary health care institutions.

Inadequate and an ill-equipped public health infrastructure is unable to meet the health needs of the people. A national survey of public health infrastructure in 1999-2000 revealed that critical public health facilities were grossly inadequate (Duggal 2004). The table below illustrates this.

Table 37: Percent of different units adequately equipped (having at least 60% critical inputs)

Units	Infastructure	Staff	Supply	Equipment	Training
Dist hospital	94	84	28	89	33
FRUs	84	46	26	69	34
CHCs	66	25	10	49	25
PHCs*	36	38	31	56	12

(Source: Duggal, 2004)

The national norm for primary health care in rural areas is a three-tier infrastructure of Sub-Centres (SCs) covering a population of between 3,000-5,000, Primary Health Centres (PHCs) covering a population between 20,000-30,000, or nearly six sub-centres), and Community Health Centres (CHCs covering four PHCs). The table below showing the status in 2001 of the availability of government health care institutions in rural India reveals that the numbers fall short of the requirement.

Table 38: Number of SCs, PHCs and CHCs required and resulting shortfall in India (As on March 31, 2001)

Centres	Required	In Position	Shortfall
Sub Centre	1,34,108	1,37,311	7,325
PHCs	22,349	22,842	1,776
CHCs	5,587	3,043	2,596

Source: Annual Report 2002-03, Ministry of Health and Family Welfare & Govt. of India.

The major impediments to people's social development are widespread under-nutrition, low levels of literacy, poor infrastructure in the health sector and high mortality rates among the poorest sections including the rural Scheduled caste and Schedule Tribe populations.

Box 8: India's Health Report Card

- Of 25 million children born in India every year, nearly 2 million die before reaching their first year.
- Of 16 million tuberculosis cases world wide 12.7 million are in India.
- Water born diseases like diarrhoea, typhoid, cholera and infectious hepatitis account for 80% of India's health problems; every fourth person dying of such a disease is an Indian.
- Every third person suffering from leprosy is an Indian.
- More than 90% of the world's polio cases exist in India.

Source: Health Action, September 2003

India has been a party to the commitments made at the World Summit for Social Development in Copenhagen in 1995 to address the "profound social problems" confronting, in particular, the marginalized and disadvantaged groups. Among many other desirable goals of the Summit, India too, agreed and committed itself to universal access to education and primary health care. But the fact is that there is a yawning gap between rural and urban health infrastructure as a result of which millions of the rural poor are denied even basic health care facilities (Table 39).

Table 39: Health Scenario

Health Infrastructure	Rural (per 1000 population)	Urban (Per 1000 population)
Hospital beds	0.2	3.0
Doctors	0.6	3.4
Public expenditure	Rs 80,000	Rs 5,60,000
Out of pocket expenditure	Rs.7,50,000	Rs 1,50,000
Infant Mortality Rate	74/1000 LB	44/1000 LB
Under 5 Mortality Rate	133/1000 LB	87/1000 LB
Births attended	33.5%	73.3%
Full immunization	37%	61%
Median ANCs	2.5	4.2

Source: Duggal 2003

In India, access to basic health care, especially in the rural areas, remains unavailable to a large majority. On the one hand the overall share of communicable diseases in rural India's death profile fell from about 47.7% in 1969-71 to 22.1% by the mid-1990s, but on the other hand, the share of non-communicable diseases in rural mortality rose from about

35.9% in 1969-71 to 54.9% in 1994-95.

The underlying emphasis of government health programmes remains family planning or population control. There is also the skewed rural-urban divide in public health services. The primary health care approach has failed to improve people's access to health care. Due to the lack of integrated and comprehensive health services, the Indian health system still remains selective, programme-oriented and fragmented. There is very little attempt to involve the community in health care services. Though there is development of health infrastructure, the quality and availability of even minimal services cannot be guaranteed in the absence of drugs, materials and equipment.

Table 40: The gap between 'Health for All' targets and performance

Indicators	Status in 1983	Target set	Status in 1998
Infant Mortality Rate	125	<60	69
Under 5 Mortality Rate	140	<70	105
Crude Death Rate	14	9	9
Life Expectancy	54	64	63
Maternal Mortality Rate	450	200	410
Crude Birth Rate	35	21	25
Total Fertility Rate	3.8	-	3.1
Immunization (BCG)		100%	79%
Immunization (DPT)		100%	73%
Immunization (Measles)		100%	66%
Pregnancy – TT		100%	80%
Trained Dai or Inst. Deliveries		100%	34%

Source: Jan Swasthya Sabha, National Co-ordination Committee, 2000

No wonder, then, that the Indian health scenario looks grim. India's infant mortality rate is still pinned at 67 per 1,000 live births whereas under-5 mortality is at 93 per 1,000 live births. It is estimated that by 2025, India would have 110 million people affected by the HIV virus (reducing life expectancy by 13 years).

Box 9: Expenditure on medical, public health, sanitation and family welfare

The combined expenditure on medical, public health, sanitation and family welfare in central and state budgets has stagnated at the level of 1.3 % of GDP over ten years, from 1996-97 to 2004-05. The expenditure in state budgets registered a decline from 1.17 % of GDP in 1998-99 to 1.07 % in 2004-05 (BE).

Expenditure on '*Medical, Public Health, Sanitation and Family Welfare*' from Union and state Budgets (1996-97 to 2004-05)

Expenditure on Education, Art and Culture in Union and state budgets (1996-97 to 2004-05)

Year	Expenditure from the Union budget on Medical, Public Health Sanitation and family Welfare (Rs. crore)	Expenditure from budgets of all the states on Medical, Public Health Sanitation and family Welfare (Rs. crore)	Combined expenditure from Union and state budgets on Medical, Public Health Sanitation and family Welfare (Rs crore)	GDP at current market prices (Rs. crore)	Expenditure from Union budget is as % of GDP	Expenditure from budgets of all states as % of GDP	Combined expenditure from the Union and state budgets as % of GDP
1996-97	3209.76	14576.38	16120.42	1368208	0.23	1.07	1.2
1997-98	3813.71	17012.69	18999.63	1522547	0.25	1.12	1.2
1998-99	4794.42	20296.09	22805.73	1740985	0.28	1.17	1.3
1999-00	5869.96	22380.74	25365.26	1936831	0.30	1.16	1.3
2000-01	6251.62	23722.26	27186.63	2089500	0.30	1.14	1.3
2001-02	6979.7	24562.44	28439.75	2271984	0.31	1.08	1.3
2002-03	7698.96	25201.98	29419.86	2463324	0.31	1.02	1.2
2003-04 (RE)	8396.8	30952.56	35792.48	2760025	0.30	1.12	1.3
2004-05 (BE)	9938.86	33212.72	39381.91	3108561	0.32	1.07	1.3

Notes:

(1) In the figures for combined expenditure from Union and state budgets, inter-governmental transfers like grants and loans to the states have been netted in the process of consolidation.

(2) GDP at current market prices refers to the 1993-94 series released by the Central Statistical Organization.

(3) Expenditures from Union Budget presented above include those of the Union Territories, which do not have legislatures. Delhi has been included in the states.

Source: Amitabh Behar, Subrat Das, Debdulal Thakur, 'Reaching the Excluded: Need for "New Imagination"', NCAS- CBGA, 2006

3.6. FINDINGS OF THE STUDY

Are there different ways of reforming the system so that people's access to health care is improved and patients' rights are strengthened? Are the existing models of health service delivery easily accessible to the people? Are people benefiting from available health services in their time of need relative to their socio-economic condition? This study attempts to take stock of the current health scenario vis-à-vis the present health provisions and commitments. The health aspect is configured around availability of health services in villages and the health needs of the people. This part of the chapter deals with the state scenario in brief and study findings in detail with the key results of the study.

3.6.1. CHHATTISGARH

According to the 2001 Census, the total population residing in Chhattisgarh was 207.95 lakh, that is, 2.03% of the population of India. The state of Chhattisgarh was carved out of 30.49% of the land area and 26.6% of the population of the undivided Madhya Pradesh in 2000. Out of 146 development blocks, 88 are predominantly Schedule Tribe, with 20% of the population being Scheduled caste. Only 20.08% of the population lives in urban cities whereas 79.92% lives in villages. Of the total population, 32.5% are STs and 12.2% are SCs. As shown in Table 40, the basic health indicators related to birth rate, death rate, infant mortality rate (IMR), etc in Chhattisgarh is far behind the national average.

Table 41: Health indicators in Chhattisgarh (2001)

Indicators	India	Chhattisgarh
Human Development Index	45.0	39.0
Birth Rate (1997)	27.2	28.3
Death Rate (1997)	8.9	10.6
Total Fertility Rate (1997)	3.3	3.6
Infant Mortality Rate (1997)	71.0	84.0
Couple Protection Rate (By Sterilization %)	30.2	29.5

Source: Chhattisgarh Government, 2001

Table 42 presents some basic health indicators from the 1991 Census. The life expectancy at birth in Chhattisgarh is better as compared to Madhya Pradesh. In 1991, while life expectancy in Chhattisgarh was 61.4 years, it was 57.3 years for the whole of Madhya Pradesh. What is also very encouraging is that female life expectancy is higher than that of males in Chharttisgarh: Chhattisgarh's sex ratio is also much better than other better off states: in 1999 it was 985 females per 1000 males, which improved to 990 per 1000 males in the 2001 Census.

Mortality indicators are still very high in Chhattisgarh. The infant mortality rates of 12 and 47 achieved by Kerala and Maharashtra respectively shows the long gap Chhattisgarh

has to fill. Other mortality and fertility indicators tell the same story. Basic primary health care, pre- and post-natal care, nutritional status and preventive care are the essential requirements of the new state. Long distances, large forest cover, and a large number of forest villages and remote villages make access and delivery of health care a crucial issue.

Table 42: Health indicators in Chhattisgarh (1991)

Indicators	All	Male	Female	Rural	Urban
Mean Age of Marriage	25.4	25.5	25.3	25.4	25.2
Total Fertility Rate	4.3	-	-	4.3	4.2
Infant Mortality Rate	85.0	88.0	83.0	92.0	52.0
Life Expectancy at Birth	61.4	60.9	62.0	60.0	69.6
Population expected to survive beyond 20 years	0.173	0.168	0.178	0.185	0.109
Child mortality up to 5 years	129.0	134.0	124.0	141.0	79.0

Source: www.chhattisgarh.gov.in

The current primary healthcare infrastructure in the state comprising 512 PHCs and 3,818 sub-centres is inadequate to cater to the needs of the vast rural population. A poor transport network, remote villages and dense forest cover deter the government's efforts to deliver health services to all people of the state. The state also lacks quality health infrastructure, and the number of hospitals and primary health centres are inadequate. Paramedical staff is also inadequately trained in providing health services to the population.

At present, 38.91% of the state's population is below the poverty line. The ratio of number of hospital beds to total population in Chhattisgarh is 1:33 (Vision Document: Chhattisgarh 2010, 2001). In 2001, Chhattisgarh had only one medical college when the requirement was for three colleges. There are no district hospitals in 10 out of 16 districts; no CHCs in 54 out of 146 blocks; and 400 PHCs are needed. Five hundred posts for doctors are vacant in the public sector; there are inadequate and inefficient paramedics; and there are very few qualified doctors and paramedics in the private sector in rural areas (GOC 2001).

Box 10:

Innovative health schemes initiated by the Government of Chhattisgarh

- **Mitanin Programme:** In the local language 'mitaan' means a friend. The government of Chhattisgarh started the Mitanin programme under the Indira Swasthya Mitanin Yojana in 2001 to cater to the health needs of villagers specifically those who live far from the health centres. The state has 20,379 villages, 54,000 habitats and 3,818 sub-centres; many of these villages are not accessible and

difficult to reach in the rainy season. This programme was started in 14 development blocks of Chhattisgarh.

In the Mitanin programme, the community selects a woman health volunteer to help develop a village health plan, and she has to help in community actions related to health. The programme helps reduce the gap between the local people's understanding of health problems and the available health services. It thus decentralizes health knowledge and health services by using the Mitanin for information and communication. The target was 54,000 Mitanins by May 2002.

- **Rajiv Jeevan Rekha Kosh:** This programme was launched on November 1, 2001 to provide financial assistance to the poor living below the poverty line for treatment of serious illness.
- **Ayushmati Yojana:** This programme was launched to support poor girls and women who could not afford treatment. The patients are given free treatment and free board and lodging facility when admitted to health care centres. But this scheme applies only in selected health centres in development blocks.
- **Life Line Express:** The Lifeline Express is another initiative to provide health care to the poor and needy people from rural areas.

1. Health Care Services

For 48% of respondents the nearest health service was available at a distance of 0-5 km. This health centre is the government run community health centre. For 22% of the respondent families, the nearest health centre was 15-20 km away. For 4% it was more than 20 km away. For 68% of Schedule Tribe families, the nearest health centre was not less than eight kilometres away. For the rest it was between 0-8 km. Thirty-two per cent of the total respondents paid for visits made to government hospitals.

Table 43: Distance and availability of health centres

Distance in km	SCs (%)	STs (%)	OBCs (%)
0-2	80.00	19.05	52.94
2-4	20.00	1.59	35.29
4-8	0.00	11.11	5.88
More than 8	0.00	68.25	5.88

Source: Primary data

If they fall ill, 73.33% of SCs said they preferred to go to private medical clinics for treatment, whereas 61.9% of STs preferred going to government hospitals, and OBCs frequented both equally (47%).

Table 44: Preference for public and private health care

Preference	SCs (%)	STs (%)	OBCs (%)
Govt hospital	26.67	62.90	47.06
Private medical clinic	73.33	33.87	47.06
Govt doctor practising privately	0.00	3.22	0.00
Village vaidya	0.00	0.00	5.88

Source: Primary data

Of the respondents interviewed, 73.33% SCs, 62% STs and 75% OBCs showed reluctance to take sick persons to government hospitals. The reasons stated were poor treatment provided in such hospitals and the non-availability of doctors.

Table 45: Reluctance to visit Public Health Centre

Preference	SCs (%)	STs (%)	OBCs (%)
Yes	73.33	61.91	75
No	26.67	38.18	25

Source: Primary data

2. Prenatal and Postnatal Care

Some 83.3% of SCs register cases of pregnancy in government hospitals whereas approximately 92% ST families and 58.24% OBC families have never registered in a hospital. Those who registered agreed that periodic examination was done.

Table 46: Pattern of pregnancy registration in government hospital

Pregnancy registered	SCs (%)	STs (%)	OBCs (%)
Yes	83.33	8.06	41.18
No	16.67	91.93	58.82

Source: Primary data

Around 56% of the respondents said that a child was born in their family in the last three years, while the remaining 44% said no child was born in the last three years in their families. Of the 56%, the majority of the births were at home (94.34%), out of which 53.85% were attended by an untrained dai and 30.8% by a trained dai. Further, 74.18% of ST families and 50% OBC said that an untrained dai had attended the delivery, while 85.7% of SCs said that the delivery was through a trained dai. No health worker had visited after delivery in 88.24% of cases and this was confirmed by the rest.

Table 47: Child delivery attended by

Delivery attended	SCs (%)	STs (%)	OBCs (%)
ANM	0.00	0.00	20.00
Trained dai	85.71	12.90	20.00
Untrained dai	14.29	74.19	50.00
Other	0.00	12.90	10.00

Source: Primary data

Sixty-nine per cent of respondents admitted that they didn't practise family planning. However, 82% of the ST respondents said they didn't practise it because of a government ban since they belong to the Baiga tribe that is in danger of being extinct.

3. Child Immunization

Only 21.92% of respondents admitted having a health card. Of these, 50% were STs, 13.33% SCs and 7.14% were OBCs. That means that 86.7% of STs, 50% of SCs and 83% of OBCs do not have a health card. The rate of immunization is 82.67%. As regards the follow up, the respondents in all three categories said that there are no follow-ups.

4. Disease Control

In case of outbreaks of diseases, 82% said that no health visitor has ever visited their house. While 47% admitted incidences of illness in their families recently, 46.6% visited private hospitals for treatment. Another 13% preferred government hospitals, or those run by charitable institutions, or else were treated at home. To meet the expenses, 28.57% SCs borrowed money from a moneylender or from other sources and 66.67% met the expenses out of their savings. Fifty per cent of OBCs arranged for money from moneylenders and an equal number used their savings.

5. General Health Awareness

Nutritional awareness level was very low in all three categories of respondents, SCs, STs and OBCs, but it was a little better in SCs (33.33%) compared to the others. Only 3% of ST families had any nutritional awareness, which is almost negligible. Similarly only 8% of STs had any kind of understanding about prenatal and postnatal care of women. Among STs, 92% of respondent families were completely ignorant of it. Family planning got a good response in terms of awareness: a majority in all three categories knew about it.

There was very little awareness about diseases like tuberculosis, leprosy and AIDS. Around 0-4% of STs, 5-11% of OBCs and 20-46% of SCs were aware of the diseases. Programmes for immunization were known to 93% of SCs and 76% of OBCs but to only 36% of STs. Polio drop awareness was high in all three categories. Table 48 shows that SCs and OBCs have better awareness about health than STs. Sanitation awareness

ranged from 53% in SCs to 11% in STs and 47% in OBCs. The use of safe drinking water was well known to the SCs and OBCs, but 87% of ST families said they had no knowledge about the harmful effects of unsafe drinking water. The level of awareness about diseases was low in all three categories.

Table 48: Level of health awareness

Awareness	Opinion	SCs (%)	STs (%)	OBCs (%)
Nutrition	Yes	33.33	3.17	17.64
	No	66.67	96.82	82.35
Prenatal and post natal care of women	Yes	66.67	7.93	47.05
	No	33.33	92.06	52.94
Family planning	Yes	73.33	63.49	82.35
	No	26.67	36.50	17.64
TB symptoms and treatment	Yes	46.67	4.761	11.76
	No	53.33	95.23	88.23
Leprosy	Yes	46.67	3.17	11.76
	No	53.33	96.82	88.23
AIDS	Yes	20	0	5.88
	No	80	100	94.11
Immunization Programme	Yes	93.33	36.50	76.47
	No	6.67	63.49	23.52
Polio drop	Yes	93.33	90.47	100
	No	6.67	9.52	0
Health Care	Yes	66.67	25.39	58.82
	No	33.33	74.60	41.17
Sanitation	Yes	53.33	11.11	47.05
	No	46.67	88.88	52.94
Use of safe drinking water	Yes	66.67	12.69	58.82
	No	33.33	87.30	41.17
Diseases	Yes	40	4.76	11.76
	No	60	95.23	88.23

Source: Primary data

3.6.2. KARNATAKA

Where does Karnataka stand as far as human development is concerned compared to the rest of the country? A look at four indicators gives us an idea of how far Karnataka has gone in providing basic health facilities to its people. The indicators are gender ratio, infant mortality rate, maternal mortality rate and life expectancy at birth.

As far as the gender ratio is concerned only Kerala has come closer to the levels attained in developed countries. According to the 2001 census, Kerala's ratio was 1058 females per 1000 males. In Karnataka, it is 964 females to 1000 males. According to the National Family Health Survey II (NFHS-2), 1998-99, the overall sex ratio for Karnataka is 983 females per 1000 males. The sex ratio is 996 in rural areas and 960 in urban areas. The reason for the lower sex ratio in urban areas is the disproportionate migration of males to urban areas.

In NFHS-2 (1998-99) infant mortality estimates for Karnataka are slightly lower than recent estimates for the Sample Registration System (SRS) of the Office of the Registrar General. The average SRS estimate for the year 1998 is 58, which is slightly higher than the NFHS-2 estimate of 51.5 per 1000. The infant mortality rate for Karnataka for the five-year period immediately preceding the survey is estimated to have been 52 per 1000 live births. This means that 5 out of every 100 children born in Karnataka did not survive until their first birthday. Child mortality for this period was 19 per 1000, and the under-five mortality rate was 69 per 1000. Thus, approximately one in 14 children died before completing 5 years of age.

There has been a decline over the three five year periods in most of the mortality rates. Declines in neonatal mortality and infant mortality have, however, not been steady. As SRS estimated, the infant mortality rate in Karnataka is 58 per 1000 live births in 1998; but the estimates of 70 for rural areas and 25 for urban areas reveals the still large rural-urban difference that is typical of the country as a whole. The urban IMR in Karnataka in 1998 was lower than that in all states except Kerala where it was 17. The country level IMR in 1998 was 72; it was 77 in the rural areas and 45 in the urban areas.

Recent data shows that in 2001 Karnataka's infant mortality rate was 58/1000 live births, which was lower than the country's infant mortality rate of 67. In 2001 the under-5 mortality rate was 69/1000 live births. The following table gives a good idea about the state of affairs as far as Karnataka's health profile is concerned.

Table 49: Health indicators of Karnataka in 2001

Indicators		2001
Infant Mortality Rate		58 / 1000 live births
Under–5 Mortality Rate		69 / 1000 live births
Crude Birth Rate		22.3 / 1000 population
Crude Death Rate		7.7 / 1000 population
Maternal Mortality Rate		195 / 1,00,000 live births
Life Expectancy at Birth	Male	61.7 years
	Female	65.4 years
Total Fertility Rate		2.13
Percentage of institutional deliveries		51.1
Percentage of safe deliveries		59.2
Newborns with Low Birth Weight		35 %
Percentage of mothers who received ANC		86.3
Percentage of eligible couples protected		59.7
Percentage of children fully immunized		60
Anaemia among children (6 – 35 months)		70.6%
Nutritional status of children	Severe under-nutrition	6.2%
	Moderate under-nutrition	45.4%
	Mild under-nutrition	39.0%
	Normal	9.4%
Sex (Gender) ratio	964F / 1000M	
Sex (Gender) ratio, 0-6 years		949F / 1000M

Source: Karnataka Human Development Report, 2002

Anaemia, haemorrhage, eclampsia, obstructed labour, infection and abortion account for 80% of maternal deaths in India. A 1993 survey of the Registrar General of Births and Deaths indicates that haemorrhage alone may account for 23% of these deaths. UNICEF (1992) had made a comparison of maternal health statistics throughout the country and pointed out that 450 out of 100,000 women die of causes connected to pregnancy and childbirth in Karnataka. This is higher than the average for the fifteen major states.

The International Conference on Population and Development (ICPD) resolved in 1994 to target a life expectancy of 70 by 2005 and of 75 by 2015. Against this, Karnataka

achieved in 2001 life expectancy at birth for males of 61.7 years and for females, 65.4 years. In all districts, without exception, life expectancy at birth was higher for women than for men but differences between life expectancy for men and women varied from one district to another. The difference in life expectancy for men and women was about nine years in Kolar and Hassan districts and only 0.62 years in Bangalore (Urban) district as per the 1991 census.

Table 50: Fertility rates

	1991	1995	1996	1997	1998
Crude Birth Rate	26.9	24.1	23.0	22.7	22.0
Crude Death Rate	9.0	7.6	7.6	7.6	7.9
Natural Growth Rate	17.9	16.5	15.4	15.1	14.1
Infant Mortality Rate	77	62	53	53	58
Total Fertility Rate	3.1	2.7	2.6	2.5	NA

Source: Census of India1991

However, improvement in critical health indicators such as life expectancy, birth rate, infant mortality rate and death rate is to some extent the result of improved health infrastructure in the state. However, Karnataka has a large share of infectious diseases characteristic of the underdeveloped world, as well as degenerative and other diseases common in industrialized and affluent societies. The old scourge of tuberculosis and malaria continues. HIV infection has been contained to some extent. Under the National Malaria Eradication Programme, although the number of blood smears collected and examined increased, the number of positive cases increased six fold between 1991 and 2000 (almost 1,00,000 cases annually). The number of patients who were given radical treatment, as well as the slide positive rate, also increased.

The size of the private health sector in India, as in Karnataka, is much larger than generally believed. According to a survey conducted in 1995-96 by the Centre for Symbiosis of Technology, Environment and Management (STEM), Bangalore, the private health sector in Karnataka, including the not-for-profit voluntary sector, is comprised of 1,709 medical institutions (clinics, nursing homes, hospitals, etc). A vast majority of private hospitals provide curative health care, while public hospitals provide promotive, preventive and curative services in rural areas and only curative services in urban areas.

Per capita government health expenditure in Karnataka is Rs 154 less than the national average of Rs 167. The total number of primary health centres in Karnataka is 1,676. Table 51 shows the rural health infrastructure in Karnataka.

Table 51: Rural health infrastructure in different centres in Karnataka (as on March 31, 2001)

State	Service delivery infrastructure			
	SC	PHC	CHC	RFWCs
Karnataka	8143	1676	249	269

Source: Ministry of Health and Family Welfare, Government of India, 2002

Karnataka has a set of regulations relating to health care that can be broadly divided into three categories: drug related (eg the Pharmacy Act, the Drugs and Cosmetics Act and the Dangerous Drugs Act), practice related (eg the Consumer Protection Act of 1986, the Indian Medical Council Act and the Human Organ Transplant Act), and facility related (eg the Nursing Homes Act, and the Nurses, Midwives and Health Visitors Act).

Box 11: Karnataka task force on health and family welfare

The government of Karnataka constituted a task force in 1999, under the chairmanship of Dr H Sudarsan, to address the health sector issues confronting the state, and to make specific recommendations. After 59 sittings the task force submitted a report to the government of Karnataka in 2001 with extensive and detailed recommendations. The report of the task force was accepted by the government and is being implemented.

Source: India Health Report, 2003

The private health sector has been brought under the Consumer Protection Act, but more awareness is needed of the various regulations so that quality of service and better provider-patient relationships are maintained.

In Karnataka, primary, secondary and tertiary care services are available through public, voluntary and private sectors. But the commercialization of medical care has created problems. The middle class mindset of policy and decision makers blinds them to the needs of the poorest of the poor. With globalization of medical care, the cost has gone up. The affluent can afford the care, but the very poor cannot. They need social security to ensure that they get medical and health care when they need it.

1. Health care services

The average number of villages covered by a primary health centre (PHC) in Karnataka is 16.55. However, among the families surveyed, 40% said that the nearest health centre was at a distance of 2-4 km. These are either government run sub-centres or taluka hospitals. For the majority of ST families (73.33%), the available health care service was at a minimum distance of 4-8 km. Payment of user charges or registration fee was

common as approximately 86% of the respondents admitted to paying some kind of fee - 37.5% said it was a user fee and 25% said it was the doctor's fee and for buying medicines. The remaining paid for either of the above reasons or a combination of these.

Table 52: Distance of hospital from households

Distance in km	Respondents (%)
0-2	11.82
2-4	40.00
4-6	6.36
6-8	30.91
8-10	10.91

Source: Primary data

The Karnataka field study showed that 68.22% of families were reluctant to visit a government hospital in case of illness. Around 26% said this was because there were no doctors, and no free medicines, and 19.18% added poor treatment to the other two reasons.

When asked where they preferred to take patients, 61.29% SCs, 70.59% OBCs and 33.3% STs preferred private hospitals. But a large section of STs, around 43.3%, preferred government hospitals. The rest went to quacks. The general tendency was to go to a private hospital. Approximately 55% preferred to visit a private practitioner in comparison to only 33% who preferred to visit a government hospital.

Table 53: Different categories preference for treatment

Preference	SCs (%)	STs (%)	OBCs (%)
Government hospital	29.03	43.33	29.41
Private medical practioner/ rural medical practitioner	69.35	33.33	70.59
Government doctor practicing privately	1.61	0.00	0.00
Village vaidya	0.00	23.33	0.00

Source: Primary data

2. Prenatal and Postnatal Care

The reporting of pregnancy cases is generally low. Around 79.82% had not registered their pregnancies. Among those registered almost 90.42% had regular check-ups. The examinations were conducted mostly by ANMs (around 94%). Those who had registered availed the facilities of periodic examinations, iron tablets and TT injections, but 66.67% reported that no health worker ever visited their house for a medical check up.

In 72.48% of families no child was born in the last three years. In the 27.52% families

that had a child birth, 76.67% of the births were in the house. All of these were attended by untrained dais. Some 60.39% of families said they had not undergone any family planning exercise. This means that only 39.60% practised family planning. Of those who practised family planning, 70.73% said that they received this service through a doctor. Almost all the families (84.62%) had a health card for their children. Of those having health cards, the ST respondents were only 25%.

Table 54: Place of child born in last three years

Birth place	SCs (%)	STs (%)	OBCs (%)
PHC	0.00	16.67	0.00
Private Maternity Home	6.67	0.00	20
Home	93.33	66.67	60
Any other	0.00	16.67	20

Source: Primary data

3. Child Immunization

The immunization rate was quite good with 92.5% of children under the age of five years being immunized. Most of the immunizations – 58% - took place at the school, 34% at home and the rest 8% at the sub-centre. Follow up visits by a health worker after immunization was very low; 56.75% of respondents said no health worker had visited.

Table 55: After immunization follow-up visit status of health worker

Health worker's follow up visit	SCs (%)	STs (%)	OBCs (%)
Yes	50	20	33.33
No	50	80	67

Source: Primary data

4. Disease Control

When there is an outbreak of any disease, 88.57% of people said no government health worker visited their home. Of the families questioned, 91.43% said there was no incidence of disease in their families recently, while 66.67% of those who were affected by diseases consulted a private practitioner for treatment. Many of these families (60%) met hospital expenses by borrowing money from the moneylender.

5. General Health Awareness

The awareness levels about good health and nutrition varied from 44.44% to 46.77% in all three categories, SCs, STs and OBCs. Prenatal and postnatal care of women was 53.23% to 66.67% in the same categories. About 64.52% of SC families were aware about

family planning programmes whereas 61.11% of OBC families were ignorant about it. Between 91.94% and 94.44% of respondents had no information about the symptoms or treatment of tuberculosis. Around 98.39% to100% families had no information about leprosy, and the ignorance about AIDS was the same – ranging from 88.79% to 100%.

As many as 55.56% OBCs, 58.06% SCs and 86.67% STs were ignorant about the immunization programme. Around 72.22% to 93.33% families were aware about polio and polio drops. Around 98.39% of SC and 100% ST and OBC families were found to have almost no information about health care. About 60% of respondents were aware about sanitation and 66.13% to 80% families knew about safe drinking water.

Table 56: Level of health awareness in different categories

Awareness related	Opinion	SCs (%)	STs (%)	OBCs (%)
Nutrition	Yes	46.77	46.67	44.44
	No	53.23	53.33	55.56
Prenatal and postnatal care of women	Yes	46.77	33.33	44.44
	No	53.23	66.67	55.56
Family planning	Yes	64.52	46.67	38.89
	No	35.48	53.33	61.11
TB symptoms and treatment	Yes	8.06	6.67	5.56
	No	91.94	93.33	94.44
Leprosy	Yes	1.61	0.00	0.00
	No	98.39	100	100
AIDS	Yes	3.23	0.00	11.11
	No	96.77	100	88.89
Immunization programme	Yes	41.94	13.33	44.44
	No	58.06	86.67	55.56
Polio drop	Yes	91.94	93.33	72.22
	No	8.06	6.67	27.78
Health care	Yes	1.61	0.00	0.00
	No	98.39	100	100
Sanitation	Yes	61.29	60.00	61.1
	No	38.71	40.00	38.89
Use of safe drinking water	Yes	66.13	80	77.78
	No	33.87	20	22.22

Source: Primary data

3.6.3 MAHARASHTRA

How close are the health attainments in Maharashtra to the Alma Ata Declaration (1978) of health for all by 2000? The Maharashtra Development Report 2002 says that Maharashtra has improved on two counts: raising life expectancy at birth and reducing the infant mortality rate (IMR). From 105 per 1000 live births in 1971, IMR declined to 48 per 1,000 live births in 1999. Though the overall IMR has gradually declined, the gap in accomplishment between urban and rural regions is marked. In 1999 the IMR in the rural population was 58 while in the urban population it was 31. In the rural areas, the number of deaths per 1,000 live births within a month of life is twice of what prevails in towns and cities.

To understand the health status of a population, the morbidity profile is relevant, being a subjective phenomenon influenced not only by actual burden of illness but also by education, exposure to healthcare services and health expectations. Preventable diseases that are common here are typhoid, pneumonia, tuberculosis, gastro-enteritis, cholera, dysentery, jaundice and fevers including influenza. Diseases preventable by immunization are common here such as measles, whooping cough, diphtheria, polio and tetanus.

In Maharashtra another critical area of concern is nutrition. Maharashtra's Human Development Report 2002 says that more than half the households in the state fall below the prescribed standard norm for nutrition, and these households receive less than 90% of the required level of 2,700 calories per day per consumer.

Maharashtra's population suffers high levels of malnutrition. The victims of malnutrition are mostly women and children. The National Family Health Survey-II (1998-99) data shows that 40% of women in the reproductive age group (15-49 years) have a body mass-index (BMI) of less than the threshold of 18.5 kg per mt sq. This is a catastrophic situation according to the WHO, because low BMI indicates chronic energy deficiency. The sex ratio, too, is of serious concern; in 1990 it was 934 women per 1000 men, and that fell to 922 in 2001 (Census 2001, Government of India), and it is lower than Karnataka and Chhattisgarh.

As regards the availability of health structures in rural Maharashtra, according to recent data (HDR Maharashtra 2002), there are 1,762 PHCs, 169 PHUs, 61 mobile health units and 9,752 sub-centres in rural areas. Under the minimum need programme of the 1980s, rural hospitals were set up. There are 345 rural hospitals catering to the needs of 1,50,000 population each, or one per five PHCs.

Both quantitatively and qualitatively, there is a wide gap in the health care infrastructure available in the rural and urban areas. For example, in the year 2000, the number of doctors per 1,00,000 population in urban areas was 139.8 compared to a mere 23.7 in rural areas. Disproportionately, over 80% of beds in public hospitals are in urban areas whereas only 42.4% are in rural areas. Health facilities in public and private sector are also varied, private sector sharing 61% of hospitals, 90% of dispensaries and 48% of

beds available in total. Maharashtra has the largest private health sector in India. In lieu of tax benefits the private hospitals are supposed to provide free services to 20-30% of their total clients. But in reality, not all such free services accrue to the poor, though they are entitled to it.

Table 57: Sample Registration Scheme estimates

Health	1961	1971	1981	1991	1996	1998
Hospital	NA	299	530	768	741	843
Dispensaries	NA	1372	1776	1896	1423	1683
Beds per lakh of population	NA	88	114	144	143	1396
Birth rate	347	284	285	262	232	
Death rate	138	100	96	82	74	-
Infant mortality rate	86	65	79	60	48	-

Source: www.maharashtra.gov.in

The rural-urban ratio is drifting in Maharashtra state. Infant mortality in Maharashtra was as high as 56 and 33 per 1000 in rural and urban areas respectively in 2000. Around 50% of children less than three years of age are underweight.

The level of public spending in Maharashtra on health care is one of the lowest in the country at just 0.6% of state GDP. Between 1985-86 and 1989-90, it was scaled up to one per cent, but has declined thereafter. Rural-urban disparities need much more attention, but this does not imply that urban health services are good. Inter-regional disparities are also an area of concern. There is a clear need for more resources for health care in the public domain to achieve better quality and equity in health services.

1. Health care services:

Among the families surveyed, 76% said that the nearest health centre was at a distance of 0-4 km. These were either government run or private centres. The most commonly accessible centre was a government run sub-centre. Payment of user charges or registration fee was a common practice as approximately 76% of the respondents admitted paying a user fee. The average expenditure on medication was around Rs 100. This could be for the doctor's fee, medicine or diagnostic tests.

Table 58: Distance of nearest hospital from house

Distance (in km)	Percentage (%)
0-4	76
4-8	11
8-12	9
12-16	4
Total	100

Source: Primary data

A majority of villages in India have no readily accessible health care facilities and Maharashtra is no exception. Of the 30,000 revenue villages in the state only 12,000 have either a primary health centre or a sub-centre. An earlier study of health care services in Nasik district by the Bharat Vaidyaka's Primary Health Care Group (a voluntary group), found that all health facilities are clustered in just 14% of villages. This and the present study show that health care services are not equally distributed.

It was also found that people are generally reluctant to visit government doctors, and this tendency is high among SCs, STs and OBCs. Fifty per cent of SCs, 40% of STs and 85.72% of OBCs showed reluctance to visit government hospitals. Various reasons were cited, the most common being lack of transport. The other reasons are that doctors are not available, or the treatment is poor.

Table 59: Reluctance to visit government hospital

Category	Reluctant (%)	Non-Reluctant (%)
SC	50	50
ST	40	60
OBC	85.71	14.28

Source: Primary data

ST families are more likely to visit government hospitals for economic reasons. The study found that 31.3% of ST families visited government hospitals while only 16.67% SC and 25% OBC respondents did so. Most STs are daily wage labourers, farm labourers or fisher folk, and their low earnings leave them little choice.

2. Prenatal and Postnatal Care

Pregnancies are generally reported. Around 82.2% of the 45 families that were questioned said this. Among these, 90% said they had periodic examinations. About 73.33% of the respondent families with reported or unreported pregnancies said that they had children under the age of three years. Of these, 84.28% were delivered at home of which 67.74% were attended by untrained dais. Of the respondents who had registered the pregnancy, 57.58% said that no health worker had visited their home after the delivery.

Table 60: Place of child delivery

Place of delivery	Deliveries (%)
Government-run hospital SC/PHC/CHC)	0
Private maternity home	12.50
Home	84.38
Other	3.13

Source: Primary data

Table 61: Child delivery attended by

Attendants	Deliveries (%)
ANM	3.23
Trained dai	12.90
Untrained dai	67.74
Other	16.13

Source: Primary data

However, the fertility rate in Maharashtra is declining. The field data shows that the practise of family planning is not geared well. Only 34% said yes to any kind of family planning practise, and most of these (65.91%) had received service or counselling from the nearest sub-centre.

3. Child Immunization

Almost all the children were immunized - 80% of them were immunized at the anganwadi or at school. Some 78.95% of families said they had a health card for their children. As regards immunization follow-up, only 50% of respondents had received a visit from the health worker. Awareness about child immunization was high: 56% of families said they were aware about the importance of immunization for their children, and 94% knew specifically about the polio drop.

4. Disease control

A substantial number of respondents from the studied area said no health worker had visited them after an outbreak of any disease for giving any kind of information. People prefer to be treated in government hospitals for diseases such as malaria, jaundice, tuberculosis (TB) and dysentery because the treatment is cheap. These diseases take a long time to cure and most of the medicines are free in government hospitals under national health programmes.

As shown in Table 62, in case of a disease outbreak, 25% said that no government health worker visited their house, while 25.26% denied receiving any prior information about the disease. Some 32.18% of the families said a member had been a victim of diarrhoea, dysentery, malaria, jaundice or TB recently. Of these, 68.97% preferred visiting private hospitals whereas only 13.79% visited government hospitals and 10.34% went to hospitals run by religious organizations. The average money spent was around Rs 245 to 5,316 with 35.71% of respondents saying they paid this from their savings and 21.43% said they borrowed the money from the moneylender or relatives.

Table-62: Choice of institution preferred in case of outbreak of dysentery/diarrhoea/malaria/jaundice/TB

Institution	Families (%)
Government hospital	68.97
Private hospital	13.79
At home	10.34
Any of the above	6.90

Source: Primary data

5. General health awareness:

The level of general health awareness varied in different categories. Nutrition awareness levels were better among OBCs (62.5%) as compared to SCs and STs (ranged between 33.33% and 44.70%). There was also little awareness of prenatal and postnatal care of women among SCs and STs while it was comparatively good among OBCs. All the SC families denied any detailed knowledge about family planning, while 55% of STs and 37.5% of OBCs said they knew about family planning programmes. Awareness about diseases such as TB, leprosy and AIDS was very low in all three categories. Level of awareness about immunization and polio drops was high among STs and low among SCs. There was adequate awareness about safe drinking water and sanitation.

Table 63: Level of health awareness in different categories

Awareness related	Opinion	SCs (%)	STs (%)	OBCs (%)
Nutrition	Yes	33.33	44.70	62.5
	No	66.67	55.29	37.5
Prenatal and postnatal care of women	Yes	16.67	44.70	62.5
	No	83.33	55.29	37.5
Family planning	Yes	0	55.29	37.5
	No	100	44.70	62.5
TB symptoms and treatment	Yes	16.67	23.52	12.5
	No	83.33	76.47	87.5
Leprosy	Yes	16.67	40	25
	No	83.33	60	75
AIDS	Yes	16.67	24.70	0
	No	83.33	75.29	100
Immunization programme	Yes	33.33	63.52	62.5
	No	66.67	36.47	37.5
Polio drop	Yes	33.33	64.70	37.5
	No	66.67	35.29	62.5
Health care	Yes	0	24.70	37.5
	No	100	75.29	62.5
Sanitation	Yes	66.67	67.05	75
	No	33.33	32.94	25
Use of safe drinking water	Yes	66.67	82.35	87.5
	No	33.33	17.64	12.5
Diseases	Yes	33.33	23.52	0
	No	66.67	76.47	100

Source: Primary data

3.7. CONCLUSION AND RECOMMENDATIONS

- **Difficulty in accessing health care services.** This is the most common problem for people in all three states. People living closer to PHCs utilize their services more than people living on the periphery. The accessibility of health services is better in Maharashtra. For 76% of families it is within a distance of 0-4 km. In Karnataka and Chhattisgarh, 52% of families have to travel 4-5 km or more to access health services, and of these, 73.33% and 68% respectively are ST families. Again, in Chhattisgarh, these 68% ST families have to travel a minimum distance of 8 km and beyond to access any health service.

  Ensuring access of health care services is integral to the effective functioning of a health care system. Systems need to be put in place to provide health care even to the remotest regions of the states.

- **The reluctance of patients to visit government hospitals.** The space-time factors are the determinant proxies for the physical accessibility of health care (Joseph and Phillips 1984). It implies that the distance between the health care provider and the patient's home, the time spent in travelling and the waiting time to access the health services, determine the choice of health care provider. The greater the distance between the patient's home and the government health care provider, the less likely he/she is to choose the government health care provider.

  This is evident from the findings in Chhattisgarh and Karnataka where 66% and 68.22% of families respectively were reluctant to visit government hospitals for reasons varying from poor treatment to non-availability of doctors, to the distance of the hospital from their home. Whereas in Maharashtra, only 38.46% of families appeared to be reluctant to visit government hospitals, and the reason for this was the availability of private hospitals within accessible distance. It is important to note that the patient is much more sensitive to the time spent on travelling (and also the availability of public transport in remote areas) rather than the time spent on waiting to obtain health care services.

  However, in all three states, STs have ranked government hospitals as their first priority. The reasons are poverty and the lack of private doctors in the remote areas where they live. The fact that they visit government hospitals does not mean that they are unmindful of the long distances they have to travel; on the contrary, it reduces the frequency of their visits, and they visit only when the illness is acute, reducing chances of a quick or complete cure.

  In spite of the fact that some state governments (Maharashtra, Karnataka and Orissa) had initiated several measures, including mandatory rural service, to contain absenteeism in doctors and to fill the posts of medical officers in remote areas, the attendance of doctors in rural health centres and hospitals is dismal.

- **The payment of a user fee:** This is yet another impediment in access to health care. In all three states, the respondents have admitted paying a user fee for medical examinations: 32% in Chhattisgarh, 86% in Karnataka and 76% in Maharashtra have made payments either for user fee, doctor's fee or buying medicines. The justification for a user fee is to facilitate efficiency and impart quality health care, but this is not so in practice.

- **Non-institutional pregnancies:** The study showed that most women delivered their babies at home, attended largely by untrained dais. In Chhattisgarh 93.34% of deliveries took place at home. For Karnataka, the figure was 72.48% and in Maharashtra, 84.28%. Of these, 53.85% deliveries in Chhattisgarh, 72.48% in Karnataka and 67.74% in Maharashtra were conducted by untrained dais. Since childbearing is a major determinant of women's health, programmes aimed at improving maternal health should focus on the period of pregnancy, delivery, and the post-partum period. This means that focused and intensive training of ANMs, dais and anganwadi workers in hygienic deliveries, newborn care, and management of infections is a must. Follow up visits by health visitors is also essential.

  Registration of pregnancy was also found to be very low. As many as 72.92% of respondents in Chhattisgarh, and 79.82% in Karnataka had not registered pregnancies with government hospitals. The situation was better in Maharashtra.

- **Good rate of immunization:** The rate of immunization was generally good but there has to be more regular monitoring by the health worker. In Karnataka, 84.62% of families possessed a health card and in Maharashtra 92.5% had a card. But in Chhattisgarh only 21.9% families reported the possession of a child health card. However, the immunization coverage in all three states is good covering 82% to 99% of under-fives. This is due to the full-fledged national immunization programme intended to cover children under the age of five.

3.8. CIVIL SOCIETY INITIATIVES ON HEALTH

Privatization and deregulation of the health system have resulted in rising medication and drug prices; it has also impacted public health services at large. A critical factor in the access to health care services is the lack of medical and paramedic staff in government health centres. The government is doing its bit by appointing medical professionals in government health centres but still in remote rural areas lack of proper health care services and staff is a reality. On one hand where the state responsibility in ensuring and imparting essential health care to its citizen stands imperative, on the other hand the initiatives started by concerned civil society individuals and groups suggesting better health services models is added value to the ongoing efforts on health. The analysis of the State initiatives on health services represents the larger picture, nevertheless, for a comprehensive picture we are enlisting some of the key civil society initiatives on ensuring right to quality health services.

Jan Swasthya Abhiyan:-A National Health Movement

'Jan Swasthya Abhiyan' is the Indian circle of the People's Health Movement, a worldwide movement to establish health and equitable development as top priorities through comprehensive primary health care and action on the social determinants of health. It is a coalition consisting of over 20 networks and 1000 organisations as well as a large number of individuals.

It aims to draw public attention to the adverse impact of the policies of iniquitous globalization on the health of Indian people, especially on the health of the poor. It aims to establish the Right to Health and Health Care as basic human rights In India, the campaign expresses the need to confront commercialization of medical care owing to privatization, and to establish minimum standards and rational treatment guidelines for health care. The Jan Swasthya Abhiyan emphasizes the urgent need to promote decentralization of health care and build up integrated, comprehensive and participatory approaches to health care. It seeks to unleash a wide variety of people's initiatives that would help the poor and the marginalized to organize and access better health care, while contributing to building long-term and sustainable solutions to health problems.

Source: http://phm-india.org

Jan Swasthya Sahyog in Chhattisgarh: A Silent Revolution

'Jan Swasthya Sahyog (JSS) was established in 1996 and registered in Delhi by a group of socially-conscious health professionals who shared a common concern about healthcare facilities, particularly in rural areas. The group turned a set of rundown buildings belonging to the irrigation department into a healthcare and referral centre, providing a ray of hope to communities from far-flung villages having no access to any medical facilities in Ganiyari, a far off village of Bilaspur District in Chhattisgarh.

The Referral Centre at Ganiyari village not only provides low-cost, quality healthcare but also trains village health workers in delivering primary healthcare. JSS has been equally active in developing low-cost technology for rural health — simple diagnostic and other kits that are user-friendly for the illiterate or semi-literate village healthcare workers, many of them women. These kits are used to diagnose a range of diseases (urinary tract infection, anaemia, sickle cell anaemia, tuberculosis, diabetes, vaginal infections, respiratory infections and so on) that are widely prevalent in the region.

JSS has also developed simple-to-use apparatus to detect water contamination, to purify water, stadiometer to measure height, easy-to-read thermometers and blood-pressure gauging instruments, and stethoscope.

JSS is doing service in the more than 53 villages surrounding Ganiyari. The circumstances have been stark for the villagers trapped between an overburdened and dysfunctional public healthcare system and private doctors. The deadly Falciparum malaria rampant in the tribal areas of Chhattisgarh has been dealt by the multi-pronged efforts of

JSS. Mortality due to this disease has reduced significantly in and around Bilaspur district. Besides offering timely diagnosis and treatment, JSS has developed low-cost mosquito repellent creams and oils based on herbs obtained from this herb-rich State.

Source:http://www.thehindubusinessline.com/life/2007/08/24

Jamkhed (Maharashtra): An innovative project

In the Jamkhed community development block, Ahmednagar district, in one of the poorest regions of Maharashtra state a Comprehensive Rural Health Project (CRHP) is been continuing. The project is a community-based primary health care and development program. Since 1970, its focus is on preventing disease at the community level using local resources. CRHP has three-tier approach: the community which involves the village health worker and women's and men's clubs and is the focal point of the project; the mobile health team whose primary role is to support the VHW and facilitate health and development activities; and the hospital and training center. In this initiative one can see an enormous vision turning into reality which has transformed the lives of 250,000 poor and marginalized people in and around Jamkhed since this project's inception. Infant mortality, a reliable health indicator, has been reduced from 176 to 19 per 1000 births; birth rates have fallen from 40 to 20 per 1000 population. The guidance and inspiration for this pioneering work by CRHP was provided by Mabelle Arole.

Mabelle Arole, together with her husband Rajnikant, demonstrated that health can be an entry point into socio-economic development. They worked closely with government health programmes in the area, particularly in family planning, immunization, leprosy, and tuberculosis identification and care. CRHP has trained hundreds of government PHC doctors, nurses and matrons, as well as medical and paramedical students.

At Jamkhed, a unique process in community action has been nurtured to result as one of the best primary health projects in the world. This project has evidences of bringing down infant mortality and child mortality down drastically. Jamkhed Project has demonstrated that health could be an entering wedge into total socioeconomic development. It has proved that the very poor have a capacity for change and can effectively take positions of leadership if given a chance and some support. Illiterate and outcaste rural women can become leaders and address international conferences and advise the Prime Minister of India.

Source: http://www.indianngos.com/issue/health/jamkhed.htm

SEARCH: Pioneer in Addressing Child Malnutrition in Gadchiroli

Society for Education, Action and Research (SEARCH) in Community Health is a non-government organisation founded in 1985 by a doctor couple, Dr. Abhay Bang and Dr. Rani Bang in a place 17 Km from Gadchiroli.

Well known for exposing the Hidden Child Mortality in Maharashtra in 2001 this couple had brought out first ever community-based estimate of the magnitude of gynaecological problems in rural women in 1989 which paved the way for the international policy shift to women's reproductive health. The organisation worked in developing a surveillance system to record births and deaths, and determines causes of death in children. Their innovations led to developing a simple device – Breath Counter, to enable illiterate TBAs diagnose pneumonia in children and also a five year field trial of home-based neonatal care to reduce neonatal mortality. They have been working through village health workers and traditional birth attendants to diagnose and treat diarrhea and minor ailments for children under 5 years age. Constantly exposing rural health issues to larger health sector the organisation is working in 37 tribal villages (population 10,000) of *Dhanora Tahasil of Gadchiroli district* through village level workers and "Danteshwari Sewaks", the village volunteers selected and partially supported by the community to work on Malaria prevention and control and other community empowerment issues.

http://www.searchgadchiroli.org

SATHI CELL: Training Village Health Workers in Collaboration with State Departments

Support for Advocacy and Training to Health Initiatives (SATHI) is an initiative of CEHAT, an NGO working on health rights in Maharashtra. It was an initiative thought to be integrated with the Pada Swayamsevak Scheme (PSS) or Hamlet Health Volunteer Scheme, started by the government of Maharashtra for tribal areas. However, the scheme being functional for 6 years it was felt that the training given under this scheme was extremely perfunctory and hence it has not led to significant improvement of village level health services. CEHAT working in tribal areas of Maharashtra proposed that the definite potential of well trained CHWs in tribal areas will be able to provide basic health services at the hamlet level, in an accessible and affordable manner.

A two years pilot project, an improved and upgraded version of the PSS (Hamlet Health Volunteer Scheme) later also called *Pada Arogya Sathi* was planned in 2003 to strengthen village level health services in a selected tribal talukas in Maharashtra by CEHAT with support from the Tribal Development Department and Health Department of Maharashtra Govt.

Right from the stage of selection, the community was involved directly in supporting and monitoring the work of the PSS. A five-member Jan Arogya Samitis at the Pada level facilitated support to the PSS. The Health Calendar programmes to improve utilisation and develop community monitoring of village health services by ANMs / MPWs were organised at the Pada level by the PSS along with the Jan Arogya Samiti.

After a successful intervention in Dahanu Taluka of Maharashtra the project spread to new areas under Sathi Cell of CEHAT -

- Dahanu and Jawhar talukas, District, Thane, Maharashtra
- Aajra taluka, District Kolhapur, Maharashtra
- Sendhwa-Khargone region, Madhya Pradesh

Source: http://www.cehat.org/as/as.html

IHMP (Pachod): Comprehensive Health and Development Project

The Marathwada, one of the most underdeveloped regions of Maharashtra experienced the worst famine of the century for a period of three years, from 1971 to 1974. A young medical graduate keen to start a community health programme heard about the need for health services in this drought hit region. IHMP (Institute of health management) began in 1975, with the provision of curative health services from a 5-bed hospital at Pachod, a small village in Aurangabad district. The focus was on maternal and child health services.

By early 1977, a team of health professionals consisting of two doctors, a nutritionist and a demographer had got together to initiate a Comprehensive Health and Development Project in 52 villages with its base at Pachod.

Over the years of work IHMP has developed community based surveillance and management systems for immunisation, women's health and child health. A system for the management and care of neo-nates has also been developed. District level management systems for different components of primary health care have been developed by IHMP. It has established a preventive model for malnutrition in children under three years. A programme of imparting life Skills for Adolescents by IHMP is based on the evidence that literacy and education improves the health and social status of women. This programme focuses on sexuality education, anaemia prevention and improvement of the reproductive health of adolescent girls.

Source: http://www.ihmp.org

CHAPTER 4:

RIGHT TO FOOD

4.1. INTRODUCTION

Food is a basic human necessity. It is basic not only to the active life of individuals but also to their very survival. Everyone has a fundamental right to be free from hunger and have access to sufficient, safe and nutritious food and its effective utilization for an active and healthy life. There can be no place for hunger in a modern world in which science and technology have created conditions for abundance and equitable development.

In the welfare framework within which Indian democracy functions, the State is responsible for ensuring food security to all citizens. The thinking of the Indian Constitution[1] makers in this regard was articulated in Article 21, which states that no person shall be deprived of his life or personal liberty except according to procedure established by law. Article 39 more explicitly states that the State shall, in particular, direct its policy towards securing: (a) that the citizens, men and women equally, have the right to an adequate means of livelihood; (b) that the ownership and control of the material resources of the community are so distributed as best to subserve the common good.

Also noteworthy is Article 47 that gives direction to the State to raise the level of nutrition and standard of living of its people and to improve public health, and to make these among its primary duties1. What further makes it binding on the Indian State to do so is its adherence to international treaties such as the Universal Declaration of Human Rights (UDHR) and the International Convention on Economic, Social and Cultural Rights (ICESCR).

Article 25 (1) of the UDHR says that everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing,

[1] Other provisions of the Indian Constitution that have implications for the right to food are the Preamble that talks about guaranteeing social, economic, and political justice, and intends to make India a socialist country; Article 21 that speaks of the right to live with human dignity, and Article 38 which holds that the State shall strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social and economic, shall inform all the institutions of national life.

and housing. Article 11 of the ICESCR holds that the State parties recognize the right of everyone to an adequate standard of living for himself and for his family, including adequate food, clothing and housing. Paragraph 2 of the same article says that the State parties shall recognize the fundamental right of everyone to be free from hunger, and lists measures to be taken individually and through international cooperation in order to bring hunger to an end. Concerns regarding right to food also find a special place in many other international agreements such as the Convention on the Rights of the Child, Convention on the Protection of Migrant Workers, Convention on the Elimination of All Forms of Discrimination Against Women, and many conventions of the International Labour Organization.

Speaking about the meaning of the right to food, the ICESCR says that the right to adequate food is realized when every man, woman and child, alone or in community with others, has physical and economic access at all times to adequate food, or means for its procurement. The right to adequate food shall therefore not be interpreted in a narrow or restrictive sense, which equates it with a minimum package of calories, proteins and other specific nutrients. The right to adequate food will have to be realized progressively. However, States have a core obligation to take the necessary action to mitigate and alleviate hunger, even in times of natural and other disasters.

The core content of the right to adequate food implies the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, acceptable within a group culture, and the accessibility of such food in ways that are sustainable and that do not interfere with the enjoyment of other human rights (ECOSOC.1999). The World Food Summit in Rome in 1996 held that food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life (http:/www.fao.org).

4.2. MEANING OF FOOD SECURITY

The concept of food security could be interpreted in many ways. At the most basic level, it could be taken to refer to absence of hunger. In this sense, there still are households in India that do not get a square meal a day. Official data taken from the National Sample Survey in 1983 shows that the proportion of households reporting availability of adequate food throughout the year was 81.1% in rural India and 93.3% in urban India (NSS 50th Round, GOI, 1998:61). However, data taken in 1993-94 shows an increase for both the rural and the urban households - 94.5% for rural households and 98.1% for urban households. This household level data, however, conceals the individual-level hunger that happens as a result of discrimination within the household and among those who live without shelter (destitute) etc.

A second way of looking at the same issue would be to ensure that the nutritional intake enables an individual or a household to lead a healthy and active life. The India

Human Development Report released by NCAER in 1999 reveals that the average per capita consumption of food grains in India is 14 kg per month for rural India as a whole, which corresponds to 467 grams a day. This estimate is less than the nutritional norm for the rural population (NCAER 1999). The National Nutrition Monitoring Bureau and the National Family Health Survey that provide data on nutritional status in general as well as in vulnerable groups, show that the instance of under-nutrition among children and chronic energy deficiency among the rest of the population, even though slowly declining, is still alarmingly high in the late nineties, and its incidence is higher than that of income poverty.

A third way of looking at food security could be to focus on the share of different segments of the population in the food produced by the community or the nation as a whole. High production alone does not guarantee that food is available to all adequately. Since poor people cannot afford to buy adequate quantities of high cost food grains, at times there is a highly deceptive situation of food surplus. Therefore, simply focusing on national food supplies is not enough to solve the problem. Food security is not just about growing more food, but also about who can buy that food and where the food is available; it is also about who eats what kind of food and when. In this sense, policy interventions should target the chronically undernourished people (whose calorie intake is below specified minimum energy requirements), those who suffer from hidden hunger (unbalanced diets leading to vitamin A, iodine and iron deficiencies) as well as those who are food insecure due to exposure to recurrent disasters.

4.3. FOOD POLICY OF INDIA

The concept of food security in India has undergone considerable changes since the First five-year plan. In the earlier years, the focus was on achieving self-reliance in production, to ensure equitable distribution, and to bring about price stability in the context of both production and distribution (VIth five year plan, Planning Commission, GOI). Thus, the focus was on building buffer stocks of food grains, maintenance of adequate stocks and on open market operations with a view to correcting adverse price trends. In other words, food security was defined in terms of self-sufficiency of the country in production, high/low quantities of production, national food availability and stability.

It was the Ninth five-year plan that took a broader view of food security by focusing on nutritional security and speaking of ensuring availability, accessibility, acceptability and affordability of a balanced, nutritious diet for all. The Tenth five-year plan (2002-07) envisaged an intensification of nutrition and health education, intensified health monitoring, especially among vulnerable segments, the elimination of iodine deficiency diseases and vitamin-A deficiency, and substantial reductions in the prevalence of underweight children and anaemia.

India has the world's largest officially supported food and nutrition security programme. The most noteworthy programme is the Public Distribution System (PDS). Public distribution of essential commodities is not a recent phenomenon. It can be dated back to 1943 and the Bengal famine, when the colonial government decided to develop a

comprehensive food policy for the country. However, the system evolved and acquired a different face in the post-colonial period both in terms of area covered, quantity of food grains it handled, and the costs involved.

Since the mid-1960s, it has been seen as a scheme that helps cope with emergency situations (such as droughts, floods and cyclones), distributing food at fair prices to vulnerable people and guaranteeing remunerative prices to farmers. Till the late 1970s, it was mainly confined to urban and food deficit areas with emphasis primarily on price stabilisation. The welfare dimension of the scheme became prominent during the early 1980s, and its coverage has been extended to rural areas, tribal areas and other such areas with a high incidence of poverty[2].

It was during the Ninth five-year plan period (1997-2002), that targets were shifted to focus on people living Below the Poverty Line (BPL), and to increased availability of food. This assigned a new role to the PDS by making it not only an instrument for sustaining food production, but also a mechanism for supplying food grains to consumers at subsidized rates. Besides the Food Corporation of India, the State Trading Corporation of India, the National Consumers Cooperative Federation and various public sector oil companies are entrusted with the task of supplying commodities at prices fixed by the central government.

Box 12: Food Corporation of India

The Food Corporation of India (FCI) was set up under the Food Corporations Act 1964, in order to fulfil the following objectives of the Food policy.

- Effective price support operations for safeguarding the interests of the farmers.
- Distribution of food grains throughout the country for Public Distribution System; and
- Maintaining satisfactory level of operational and buffer stocks of food grains to ensure national food security.

At present, FCI is the primary agency for procurement, storage, preservation and distribution of food grains in the country. FCI operates through a countrywide network with its corporate office in New Delhi, five zonal offices, 22 regional offices practically in all the state capitals, one port operation office, 173 district offices and over 2,178 depots.

The total stock in the central pool as on 30/11/2003 is 25.43 Prov./million tonnes. The total stock of rice with FCI is 5 million tonnes and wheat is 4.32 million tonnes. The mode of operation of FCI is public distribution of food grains through the 4,50,000 fair price shops spread all over the country.

A very significant function of the FCI is to maintain buffer stocks. The buffer stock amount as of October 30, 2003 was 5.00 million tonnes rice and 4.32 million tonnes wheat

Source: http://www.fciweb.nic.in

[2] Most significantly, the GoI launched the Revamped Public Distribution System (RPDS) in 1992 in 1775 blocks that targeted the poor in tribal, hilly, drought-prone and remotely located areas. The scale of ration was fixed at 5 kg per head subject to a maximum of 20 kg per family per month. In 1997, Targeted Public Distribution System (TPDS) was started with a view to focus on the people living Below the Poverty Line (BPL).

The food policy of India today broadly seeks to address three categories of food insecurity:

1. Chronic food insecurity (through food distribution and food for work programmes);
2. Nutritional insecurity of vulnerable groups such as pregnant women and children (through supplementary and mid-day meal programmes);
3. Transitory food insecurity (through food assistance for disaster relief, and long-term disaster prevention and preparedness programme).

Some of the major food-related schemes with the entitlements are given below.

National Programme for Nutritional Support to Primary Education

Started in 1995, the National Programme for Nutritional Support to Primary Education, popularly known as the Mid-Day Meal Scheme (MDMS), sought to introduce cooked mid-day meals in all government primary schools within two years. The state governments, in the meanwhile, were allowed to distribute monthly dry rations to the children instead of cooked mid-day meals. Responding to a petition from the Peoples' Union for Civil Liberties (PUCL) of April 2001, regarding non-implementation of food schemes, including the MDMS, the Supreme Court instructed the states to introduce it within six months. This, according to the court, was to be done in two phases: by February 28, 2002 for those districts that had started distributing the dry rations, and by May 28, 2002 for the rest of the districts.

The allocation for the scheme is made by the centre through the FCI to each district in the form of a quantity of 100 gm of grains per child per day. The allocation is made based on the off take of the previous term. The district collector coordinates the scheme with the department of education and the Gram Sabhas on issues of logistics. Cooked meals with a content of 300 calories and 8-12 gm of protein are to be provided to all primary school going children (Std I-5). The meals are to be provided on every working day of the school and for at least 200 days a year to students having a minimum of 80% attendance in the previous month. Where dry rations are given, 3 kg of wheat or rice per month is to be provided to every child with 80% attendance for 10 months in a year.

Initially started as a scheme that aimed to check the dropout rate, it is increasingly being seen as a scheme that has the potential to handle food security problems faced by children belonging to the marginalized sections.

Targeted Public Distribution System (TPDS)

The scheme was introduced in 1997 to target disadvantaged and poor people across the country. The TPDS offers two separate distribution channels: one aimed at the BPL households, and the other at the Above Poverty Level (APL) households. The BPL households are to be identified on the basis of household surveys. The BPL families are given a card of a different colour to distinguish from the APL families. Under the channel for BPL households, the central government transfers wheat and rice at about half the

Central Issue Price (CIP) set for the PDS to the state governments. The total number of families to be covered by TPDS in each state is chosen by the Expert Group of the Planning Commission. Initially, the monthly ration under the TPDS was kept at 10 kg per poor household, and was increased to 20 kg per family with effect from April 1, 2000. This was further increased to 35 kg of wheat/rice per month.

Responding to the PUCL petition, the Supreme Court, on November 28, 2001, ordered states to complete the identification of the BPL families, issue cards, and commence distribution of 25 kg of grain per family per month.

Despite the orders of the Supreme Court, identification of the BPL families remains incomplete in many places. What was also seen during the field survey was the discrimination in identification and distribution of the cards. In many places people who were close to local politicians and local decision-makers got the BPL and Antyodaya Awas Yojana (AAY) cards while those who were entitled to them did not. Also noteworthy are the problems relating to the accessibility of the shops in terms of distance. Lack of availability of commodities and closure of the PDS shops also posed a problem.

Antyodaya Anna Yojana (AAY)

Introduced in 2000, this scheme seeks to provide food security to destitute households. It must be remembered that PDS has always been supplemental in nature and has never met the full requirements of any section of the people.

Under this scheme, provision has been made to identify one crore families to receive a special Antyodaya card, with which they can claim the grain from the local ration shop. The identification of the families is to be done by Gram Sabhas. Initially, the cardholders were to be provided 25 kg of grains each month at the price of Rs 2 for one kilo of wheat and Rs 3 for one kilo of rice. This was later increased to 35 kg of wheat/rice per month at Rs 2/3 per kilo.

AAY is a significant scheme as it extends the scope of PDS by reducing hunger among the poorest segments of the BPL population. The coverage of the scheme has been a subject of debate. As it exists today, 5% of the rural population benefits from this scheme. Recommendations have been made to increase this to10% of the rural population. The scheme also needs to be extended to cover vulnerable sections of society.

Annapoorna Scheme (AS)

The scheme was introduced in 2000, keeping in view the elderly persons who do not have income of their own and are obliged to depend on pension from the government. Under it, 10 kg of food grains (rice or wheat) per month is to be provided free of cost to eligible senior citizens (above 65 years) who are below the poverty line and remain uncovered under the National Old Age Pension Scheme. The total number of beneficiaries is not to exceed 20% of the old age pensioners within a state. The Gram Sabha identifies the beneficiaries who get a card that entitles him/her to receive the food grains - rice or

wheat - depending on the local staple diet. The Department of Rural Development is responsible for releasing the funds to the State Food and Civil Supplies Department, which coordinates with the FCI and other agencies concerned. The State Department of Public Distribution is the nodal agency.

Integrated Child Development Scheme (ICDS)

This scheme was launched in 1975 following the adoption of the National Policy for Children (1974). It provides a package of services comprising supplementary nutrition, immunization, health check-up, referral services, pre-school education and health and nutrition education for the mothers.

In each ICDS project, there are on an average 140 anganwadi centres that are focal points for delivery of services under the scheme. The grassroots level unit of ICDS is the anganwadi in rural, tribal or slum areas. An anganwadi is generally established in a rural/slum area having a population of about 1000, while in the tribal areas, it is set up for a population of about 700. An anganwadi worker and an anganwadi helper manage each anganwadi. The worker monitors and promotes the growth of children with active participation of the community/mothers.

At an anganwadi, the worker provides services to about 60 children below 6 years of age and 12 pregnant and nursing mothers. The Child Development Project Officer is in charge of an ICDS project and provides the link between ICDS functionaries and the government administration. Being a centrally sponsored scheme, the full cost of operational requirements of ICDS is borne by the centre while the state provides funds for meeting the cost of supplementary nutrition.

According to the scheme, children up to 6 years are to be provided 300 calories and 8 to10 gm of protein. Adolescent girls are to be provided 500 calories and 20-25 gm of protein per day. Pregnant and nursing mothers get 500 calories and 20-25 gm of protein per day. Malnourished children are entitled to double the daily supplement provided to the other children (600 calories and/or special nutrients on medical recommendation).

Acting on the PUCL writ, the Supreme Court had issued instructions to the states and the union territories to implement the ICDS in full and to ensure that every ICDS disbursing centre in the country shall provide each child up to 6 years of age to get 300 calories and 8-10 grams of protein, each adolescent girl to get 500 calories and 20-25 grams of protein, each pregnant woman and each nursing mother to get 500 calories and 20-25 grams of protein, each malnourished child to get 600 calories and 16-20 grams of protein. Direction was also issued to have a disbursement centre in every settlement.

National Old Age Pension Scheme

Introduced under the National Social Assistance Programme on August 15, 1995, this scheme is meant for people (aged 65 years or above) with little or no regular means of

subsistence of their own and no financial support from family members or other sources. The basic pension is Rs 75 per month per beneficiary. State governments may add to this basic amount from their own re sources. The central government sets an upper ceiling on the number of beneficiaries for a state/union territory.

National Family Benefit Scheme

This scheme provides assistance to BPL households in the event of death of the primary breadwinner (aged 18-64) in the family. The amount of assistance to be given is fixed at Rs 10,000. This family benefit is paid to such surviving member of the household of the deceased who, after local inquiry, is determined to be the head of the household.

National Maternity Benefit Scheme (NMBS)

This scheme entails a cash assistance of Rs 500 to be provided to pregnant women of BPL households provided they are 19 years of age or above. The benefit is available up to the first two live births, and aims at handling the pre-natal and post-natal maternity care. The benefit is disbursed 8-12 weeks prior to the delivery. In case of delay, the benefit may be given even after the birth of the child.

Scheme for Supply of Food grains to SC/ST/OBC hostels

Introduced in 1994, this scheme comes under the Ministry of Social Justice and Empowerment. The residents of the hostels having two-third students belonging to these categories are eligible to get 15 kg food grains per resident per month.

Food for Work (FFW)

This scheme comes under the employment assurance programme for rural areas, and is linked to other such programmes as the Employment Assurance Scheme (EAS), and the Jawahar Gram Samridhi Yojana (JGSY). The EAS sought to create additional employment opportunities during the period of acute shortage of wage employment through manual work for the rural poor living below the poverty line while the JGSY intended to create need-based rural infrastructure at the village level. The Food for Work scheme was started in January 2001 by the Ministry of Rural Development to meet the high demand for wage-employment and food security due to occurrence of calamities. The scheme provides additional allocation of food grains (rice and wheat) free of cost to the states and union territories as an additional resource. Five kilos of food grains are to be ensured per man-day to all unemployed rural workers. The remaining part of the wages is to be paid in cash. In 2002-03, the Food for Work programme in drought-affected areas was continued under the special component of Sampoorna Gramin Rozgar Yojana.[3]

4.4. THE PARADOX

In 2003, the production of food grains was 182.57 million tonnes, and the present

[3] Sampoorna Grameen Rozgar Yojana was started on September 25, 2001, and all the wage employment schemes were merged in it.

stock position as available from the FCI database is 25.43 million tonnes (for 2002-03). If this is compared with the buffer stocking policy of food grains, we find that there is a burgeoning stock of food grains in the central pool. This observation becomes more valid in view of the fact that no import of food grains had taken place during 2001-02. On the other hand, wheat and rice were being offered for export to PSUs/agencies/private parties. A total of 38.22 lakh million tonnes of wheat for export was lifted by PSUs/agencies/private parties from the central pool during 2001-02. Some 19.87 lakh million tonnes of rice was lifted by exporters during 2001-02 (GOI, Publication Division 2003). The buffer stock norms as per the policy should be as under:

Table 64: Buffer stock norms (in million tonnes)

Food grains	July 1	Oct 1	Jan 1	Apr 1
Rice	10.0	6.5	8.4	11.8
Wheat	14.3	11.6	8.4	4.00
Total	24.3	18.1	16.8	15.08

The Indian food situation, however, presents a paradoxical situation if we look at the fact that India is not only a food surplus country that can help other countries by way of food aid, but is also an exporter of food grains. What is also pertinent is to have a look at the statistics of food-related deaths presented chiefly by civil society organizations, the media and autonomous agencies.

Box 13 : Starvation Deaths

- In its first report, the Tribal Research and Training Institute, Pune, held that 75% of the deaths in its sample study were malnutrition related (Tribal Research and Training Institute, Pune, 6.5.2002). In its second report, it was pointed out that the cause of death as revealed by the government doctor of Khaneevali Primary Health Centre did not rule out malnutrition in respect of the 26 deaths surveyed (TRTI, Pune, 25.11.2002).
- Four starvation deaths were reported and were also documented by a team from Gram Swaraj Abhiyan and Delhi School of Economics in Manatu, Jharkhand (*The Pioneer*, July 23, 2002).
- 10 people died after eating rotten food, not being able to afford edible food in Rayagada, Kashipur block, Orissa (*The Hindustan Times*, August 27, 2002).
- About 60 people died because of malnutrition in Kisanganj, Rajasthan (*Dainik Navijyothi*, October 10, 2002).
- Media reports stated that around 50,000 people in Orissa, most of them from Kalahandi district, were starving and needed emergency feeding (Indo-Asian News Service, July 29, 2003).
- The Jan Sunwai held in Delhi on January 10-11, 2003 revealed that people belonging to communities such as Sahariyas and Musahars are prone to chronic hunger. Murari Ganapat, a Sahariya of Mudiar village in Baran district, Rajasthan, said that he, the sole breadwinner in his family, had fallen ill and was unable to work for three months. His family had tried to survive on *sama* grass seeds, but one by one, his father, wife, daughter and mother died (Chamaraj 2003).

What emerges is that the problem of hunger in India is more in terms of chronic food insecurity than primary association with poverty and inadequate diet, or deaths due to what is called transitory food insecurity[4]. Studies also state that under-nourishment is severe among women and children (International Institute of Population Studies 1998-99).

4.5. FINDINGS OF THE STUDY

One of the main aims of the study, as has already been mentioned in the first chapter, was to assess whether the people, especially the marginalized sections of society, received the benefits of the food policies and schemes. The study was conducted in 10 villages in each of the three states of Maharashtra, Chhattisgarh and Karnataka. The respondents were chosen so as to include Scheduled Caste and Scheduled Tribe families who lived below the poverty line. The questionnaire on food security was set keeping in mind awareness of the schemes, accessibility of the people to the schemes, availability of commodities and the cultural acceptability of the food distributed.

4.5.1. Awareness of the schemes

Any discussion on the success of government schemes has to make reference to the role of information and public awareness of the initiatives. This is particularly true for the food schemes as these cannot be successful unless the beneficiaries have knowledge about their entitlements. Our study found differences in the level of awareness of various schemes in the three states.

Table 65: Awareness of schemes (%)

Schemes	Chhattisgarh	Maharashtra	Karnataka
MDMS	100	100	100
TPDS	98	100	98
NMBS	18	31	2
AP	25	28	NA
AAY	77	75	80
FFW	97	54	57

Source: Primary data

Table 66 shows that awareness of the mid-day meal scheme (MDMS) was 100% in all the three states. This could be regarded as an achievement for the government. Discussions with the respondents revealed that the teachers in the schools paid special attention to the distribution of information regarding the mid-day meal. It must be remembered that the mid-day meal scheme was initiated to check the dropout rate for

[4] Transitory food insecurity is associated with the risks related to either access or the availability of food during off-season, drought and inflationary years.

which the teachers are accountable.

As far as the **targeted public distribution system** was concerned, the level of awareness at 98% in Chhattisgarh and Karnataka, and 100% in Maharashtra, could be considered as a success. One of the chief reasons for this is the fact that the scheme has been functional for quite a long time though under various names such as Public Distribution System, the Revamped Public Distribution System and the present Targeted Public Distribution System. The respondents, however, said they were not aware of the change in the quantity of their entitlements. Of the 30 villages surveyed, only six panchayats had displayed the rates of the commodities, and none had displayed the complete Supreme Court guidelines and list of the current public distribution entitlement. None of the panchayats visited by our investigators in Chhattisgarh had put up the list of schemes or rates of the commodities. Some village panchayats in Karnataka had displayed the schemes with the rates of grains. These, however, were not based on the modified current amount of entitlement. The investigators felt that panchayat members were not keen to make the village people aware of the schemes.

Schemes such as the **Annapoorna** and the **National Maternity Benefit Scheme** were little known among the public. The percentage of respondents who spoke positively about having knowledge of the National Maternity Benefit Scheme for Chhattisgarh, Maharashtra and Karnataka were 18%, 31% and 2% respectively. Twenty-five per cent of respondents in Chhattisgarh and 28% of respondents in Maharashtra had knowledge of the Annapoorna scheme. Given the fact that these two schemes are meant to benefit two very crucial disempowered sections of our society - senior citizens without any other source of income, and pregnant women of BPL households - the low percentage of awareness raises a number of doubts about the efficiency of agencies such as anganwadis and Gram Panchayats.

A look at the awareness levels of the Scheduled Castes, Scheduled Tribes and the Other Backward Classes shows that the Scheduled Tribes have slightly lower levels of awareness.

Table 66: Awareness of schemes among SCs, STs and OBCs

Schemes	Maharashtra (%)			Chhattisgarh (%)			Karnataka (%)		
	SC	ST	OBC	SC	ST	OBC	SC	ST	OBC
MDMS	100	100	100	100	100	100	100	100	100
TPDS	100	100	100	100	100	100	100	100	100
NMBS	20	33.72	12.5	40	11.47	17.64	1.61	-	5.55
AS	-	30.23	37.5	26.66	25.39	17.64	-	-	-
AAY	100	72.09	87.5	40	80.95	64.7	90.32	60	77.77
FFW	60	53.48	50	100	95.23	88.23	67.74	36.36	55.55

Source: Primary data

Interactions with the respondents revealed that distribution of information or lack of it is used by vested interests to serve their own political ends. Food policy, since the very beginning, has been an issue of populist politics. Cheap food is among the promises that politicians make to try and win elections. In this sense, food policies that can be best used to build vote banks are often given more importance. Another fact that investigators debated was who was to be held accountable for not spreading accurate information regarding the entitlements to beneficiaries under the various food schemes? In Karnataka, for example, none of the panchayats visited by the investigators had displayed the Supreme Court directives.

4.5.2. Accessibility of the schemes

Data projected by the Indian government regarding production of food grains and the mounting buffer stocks gives the impression that the problem of food security is solved at least at the national level. The truth is something else. The problem lies more in food distribution than in food production. Careful consideration of food security related problems needs a focus that goes beyond food production and recognition of the low income of the poor. This section attempts to focus on this aspect.

As far as the mid-day meal scheme is concerned, the problem of accessibility is linked to the attendance levels of the students. In Karnataka, the investigators found a trend of low level of attendance by girl students, which was attributed to their gender role of taking care of their siblings. The study attempted to understand the other possible impediments. The regularity of the distribution of food - whether it is every day, once a week, or once a fortnight - was quite satisfactory in all the schools surveyed. Almost 100% of respondents were satisfied with the form - cooked/uncooked - in which the food is distributed. Respondents in Karnataka stated that though dry ration was distributed earlier, at present all the schools provided cooked food. In all the surveyed village schools, there was no caste-based discrimination in the distribution of food.

Te best way to investigate the accessibility of the targeted public distribution system was to find out how many households had a ration card, and the distance of the fair price shops that distribute the rationed commodity from people's homes. The issue of owning a ration card by a BPL family is important because various agencies, including the commissioner's report to the Supreme Court in the Right to Food case, have highlighted the flawed methodology and the defective implementation of surveys to determine households that are to benefit from the schemes.

Table 67: Percentage owning a ration card

States	% owning ration card
Chhattisgarh	78
Maharashtra	100
Karnataka	100

Source: Primary data

In Chhattisgarh, 78% of households owned a ration card. The 22% per cent that did not have ration cards said they had no time to chase government agencies to procure the cards, or did not know the procedure.

Table 68: Reasons for not having a ration card

Reasons	% of respondents
No proof of residence	4.5
Could not give bribe	23
Not aware	14
Panchayat did not issue	27
Any other	31.5

Source: Primary Data

As shown in Table 67, 4.5% of the respondents said they were not eligible for ration cards - which is essential for receiving the rationed commodities - because they did not have proof of residence. This was due to their migrant status. Twenty-three per cent of respondents said they could not afford the bribe demanded and 14% said they didn't know they were required to get a ration card. As many as 27% of the respondents said they had gone to the panchayat to get a ration card but were not provided one and 31.5% could not give any specific reason for not having a ration card. It should be remembered that the respondents chosen for the study in all the states belonged to the marginalized sections of society. In Chhattisgarh, respondents included members of the extremely deprived Baiga community.

Another yardstick by which the government's sincerity in making schemes accessible to marginalized people can be measured is the distance of the fair price shop from people's homes.

Table 69: Distance of PDS shops (%)

Distance	Chhattisgarh	Maharashtra	Karnataka
Less than 2 km	10	74	55
More than 2 km	90	26	45

Source: Primary data

In Chhattisgarh, only 10% of respondents stated that the fair price shop was situated within 2 km of their home. Investigators observed that the normal distance of PDS shops from Baiga-inhabited villages was 15 to 17 km. In Maharashtra, 74% of respondents said that the distance from their homes to the nearest PDS shop was less than 2 km. In Karnataka, 61% of respondents said that the distance was less than 2 km.

For the Integrated Child Development Scheme to be successful, what is most important is the accessibility of the ICDS homes or anganwadis to the target groups. The issue becomes all the more important as the scheme is primarily to benefit pregnant women, infants and adolescent girls who belong to the most vulnerable sections of society.

Sixty per cent of respondents in Chhattisgarh stated that the distance of the anganwadi from their homes was less than 2 km while 40% reported it as more than 4 km from their homes. There were no ICDS homes or anganwadis in villages inhabited by the Baigas. In Maharashtra, 84% of respondents reported the distance as less than 2 km from their homes. The anganwadis in Maharastra seem to be well spread out as all the villages visited had anganwadis nearby. In Karnataka, 81% of respondents reported the distance to be less than 2 km, 13% stated it to be more than 2 km but less than 4 km, and 6% said that the anganwadi was more than 4 km from their homes.

4.5.3. Availability of commodities

What is most significant for a study that intends to examine the outreach of government initiatives for the people is the form in which it reaches the beneficiaries. The issue of availability of food, for the purpose of our study, focuses on the actual amount (of food grains/money) received by the beneficiaries as entitlements.

In the mid-day meal scheme, the regularity with which food was distributed was found to be quite satisfactory in all the three states under study. Discussions with the respondents, however, revealed that there was a lot to be desired in what was actually provided in the name of a mid-day meal. In most schools, children were given either only rice and onions, or only *khichdi* (rice and dal cooked together). In Nare and Biloshi villages in Maharashtra, interactions with students revealed that the food was cooked without any oil and smelt of turmeric and was often not cooked properly. In Kandla village of Maharashtra, students complained that there was not enough food to go around. They also revealed that the students were frequently sent during school time to get fuel-wood.

In Karnataka, the schools served rice and *sambhar*. Most respondents in Maharashtra and many in Karnataka revealed that the school asked them to get raw vegetables from home that could be cooked as a side dish, or to get money. Discussions with teachers pointed to the inadequate monetary allocation for fuel and the side dish. This was particularly the case in Chhattisgarh. In Karnataka, the food that remains after feeding the target group was distributed among the sixth and seventh standard students. All the schools visited by investigators had hired cooks from the village. Cooks in Chhattisgarh complained that they were not paid their salaries regularly.

The investigators in all the three states observed that the mid-day meal scheme should be seen only as a scheme that focuses on lowering the dropout rate, and could not be termed as a major food scheme. This observation came out of the fact that children are provided food only on working days, and not even on Saturdays (half-working day). In this sense, the focus of the scheme was not the nutritional requirement of the children but only

the attendance levels.

In assessing the efficiency of the targeted public distribution system investigators focused on the regular availability of essential commodities such as rice, wheat, sugar, edible oils and kerosene in the PDS shops.[5] Discussions with the respondents revealed that PDS shops not staying open regularly was one of the most significant reasons for the failure of the PDS in India.

Table 70: Frequency at which the shops open (%)

Regularity	Chhattisgarh	Maharashtra	Karnataka
Every working day	22	50	19
Once a week	22	10	19
Once a fortnight	0	18	27
Once a month	0	22	15
Cannot say	56	0	28

Source: Primary Data

In Maharashtra, 50% of the respondents stated that the PDS shops in their areas were open on every working day, 10% said they were open once a week, 18% said the shops in their areas were open only once a fortnight, and 22% reported that the shops were open only once a month. Interactions with the respondents revealed that agencies taken by members of marginalized communities were open more regularly while those owned by influential sections of society focused more on selling non-PDS items. Many respondents belonging to the tribal community in Nare village of Maharashtra said that *"Jevha aaamchakade paise astat, tevha tenchakade ration naste. aani jevha tenchakade ration aaste tevha aamchakade paise nastat"* (when we have money, they don't have rations and when they have rations, we don't have money).

In Karnataka, 19% said that the shops were open on every working day, 19% said they were open once a week, 27% said the shops opened once a fortnight while 15% said they were open just once a month. What is most significant in this investigation is the percentage of people who reported not having any idea of the number of days the shops were open - 56% in Chhattisgarh and 25.45% in Karnataka.

Many respondents from the Baiga community in Chhattisgarh said that their long working hours (from early morning till late evening) did not leave them with much time to go to the PDS shop and wait in the long queue. What also made it difficult for members of this

[5] The above-mentioned five commodities are considered as key essential commodities to be procured and supplied to the states by the Government of India while the state governments are free to include, in their respective public distribution systems other such commodities for which they are supposed to arrange, on their own, procurement and distribution with a view to make more commodities of mass consumption

community to avail of their rations was that the PDS shops were located in places that were far from their villages. Most PDS shops in these areas, in fact, opened only on the haat (market) day, that is, twice a week. In some villages of Karnataka, rice was not distributed through PDS shops but through the panchayats. Instead of resolving the problem, this has created conflicts among members with regard to owning responsibilities.

To gauge how much the respondents depend on the government's TPDS scheme, they were asked what commodities were available in the PDS shops. The tables below show the results.

Table 71: Dependence of the respondents on the PDS shops in Chhattisgarh

Commodities	Percentage of respondents
Rice	1
Wheat, rice, sugar	5
Wheat, rice, kerosene	2
Wheat, rice, sugar, kerosene	82
Wheat, rice, sugar, kerosene, any other	7
NA	3

Source: Primary data

In Chhattisgarh, 82% of the respondents who said they depended on PDS shops reported getting wheat, rice, sugar and kerosene quite regularly. Only 1% said they got only rice while 5% said they got wheat, rice and sugar from the shops. Two per cent of respondents reported depending on PDS shops for wheat, rice and kerosene.

Table 72: Dependence of the respondents on PDS shops in Maharashtra

Commodities	Percentage of respondents
Wheat	7
Wheat, rice	18
Rice, kerosene	6
Wheat, rice, sugar	8
Wheat, rice, kerosene	20
Wheat, rice, sugar, kerosene	32
Wheat, rice, sugar, any other	3
Wheat, rice, sugar, pulses, any other	2
Wheat, rice, sugar, kerosene, pulses, etc.	1
NA	3

Source: Primary data

In Maharashtra, as suggested by the table above, 7% of the respondents reported relying on PDS shops for wheat, 18% said they bought wheat and rice regularly, 6% bought rice and kerosene, 8% wheat, rice and sugar, 20% wheat, rice and kerosene, 32% wheat, rice, sugar and kerosene, 3% wheat, rice, sugar and other items, 2% bought wheat, rice, sugar, pulses and other items, and 1% bought wheat, rice, sugar, kerosene, pulses and other commodities. While the respondents were not dissatisfied with the commodities being distributed by the shops, they were bothered by the fact that the shops were frequently closed. .

Table 73: Dependence of the respondents on the PDS shops in Karnataka

Commodities	Percentage of respondents
Wheat, rice	11
Wheat, rice, sugar	2
Wheat, rice, kerosene	1
Wheat, rice, sugar, kerosene	85
NA	1

Source: Primary data

In Karnataka, 85% of respondents reported depending on PDS shops for buying wheat, rice, sugar and kerosene, 11% reported getting wheat and rice regularly, 2% got wheat, rice and sugar while only 1% depended on the shops for wheat, rice and kerosene. Availability was not a problem in PDS shops here; low purchasing power was what prevented people from buying the commodities. It should be noted that the villages visited by the investigators were in drought-prone areas. The inability of the government to provide relief had led to a number of farmer suicides in this region. It is thus important to not only lower the price of essential food commodities but also to provide support to the poorest families by giving the PDS items in instalments and extending the Food for Work and other such schemes. The provision of instalments was not being practised in the villages surveyed in Karnataka.

Anganwadis in Maharastra had stocks of medicines meant for women, *rawa* and proto-vita. Respondents were satisfied with the services provided by anganwadi workers, though respondents in one village complained that the worker was selling off the proto-vita and other items. The survey revealed that the National Maternity Benefit Scheme was one of the most neglected of the food schemes. In Chhattisgarh, only 2% had benefited from the scheme,

Box 14: Employment Guarantee Scheme: The experience of Maharashtra

The Employment Guarantee Scheme (EGS) in Maharashtra came into force as an act in 1978. It aimed to give legal sanction and make provisions for an adult living in rural Maharashtra and willing to work but unable to get work near his/her village, to demand work from the government. The government is bound under this scheme to provide work within 15 days to anyone who has applied for it. If the concerned authority in a particular case is unable to provide work, then the labourer who has demanded work is entitled to an unemployment allowance.

The public works that would be undertaken under the scheme would build rural infrastructure and be productive assets that would further rural development, like irrigation schemes, roads, soil and water conservation measures. The scheme guarantees work and wages as per the Minimum Wage Act and also provides for basic facilities and amenities for the workforce at the work site. The Scheme is applicable to all of rural Maharashtra: 33 districts and 322 blocks and 162 'C' category municipal towns.

The unique features of the scheme are:

- Self selection of the needy, no criteria for selection
- Dedicated funds
- No separate bureaucratic structure, no contractors
- It is an Act and therefore legally enforceable.

The funds for the scheme come from a special, dedicated fund through professional tax paid by the earning, mainly urban, population. This professional tax revenue is added to other similar taxes and this entire amount is matched by the state to constitute the EGS fund.

Percentage of female person days generated

Division	1995-96	1996-97	1997-98	1998-99
Konkan	41.10	58.99	49.00	73.00
Nashik	26.85	59.00	49.00	73.00
Pune	35.80	59.00	49.00	72.99
Aurangabad	49.74	59.00	49.00	73.00
Amravati	20.52	59.00	49.00	73.00
Nagpur	33.17	59.00	49.00	73.00
State	37.94	53.54	49.00	73.00

Source: 'Does EGS require restructuring for poverty alleviation and gender equality?' by M Krishnaraj, D Pandey, A Kanchi; EPW, April 24, 2004.

Source: Ashwini Kulkarni, VACHAN

reportedly receiving Rs 390 on an average from the government. In the surveyed villages of Maharashtra, 26% of respondents said they had received an average of Rs 385 as the entitlement. The amount fixed by the government is Rs 500. In Karnataka, only one respondent had been informed by the anganwadi worker that she was eligible for the scheme, though she had not received any money.

The survey found 7% beneficiaries of the **Annapoorna Scheme** for elderly persons in Maharashtra. The average grain they received in the past month was 7.28 kg as against the government stipulated entitlement of 10 kg. The scheme was not applicable to the villages surveyed in Karnataka during the period of the study.

Assessment of the **Antyodaya Anna Yojana** meant for the poorest of the poor households revealed that the average quantity of food grains received by the beneficiaries was below the government stipulated amount. In Chhattisgarh, 19% of beneficiaries were found to have received 29.47 kg of food grains per month. In Maharashtra, 25% of beneficiaries reported having received 22.92 kg of food grains per month. In Karnataka, our investigators found 24% beneficiaries who had got 33.45 kg of food grains. Many respondents in Karnataka expressed their displeasure at the way Antyodaya families had been identified. This was the case in Maharashtra too.

The study found the **Food for Work** scheme being implemented in all the three states. In Chhattisgarh, the 82% of beneficiaries reported having received 53.39 kg of food grains and Rs 73.58 on an average from the government. All of them said they had got the money after a long wait of one year. In Maharashtra, there were 19% beneficiaries who had reportedly received 10.57 kg of food grains and Rs 25.47 on an average. In Karnataka, 60% beneficiaries had reportedly been provided 5 kg/of rice along with Rs 15 on an average per working day. It was clear from interactions with the respondents that the Food for Work schemes helped them a lot, and all the respondents felt that such schemes should be continued. In Karnataka, the minimum wage for men was Rs 20, while for the same work, women got Rs 15.

4.5.4. Acceptability of the schemes

Acceptability of the schemes is not much of a problem for people who find it a struggle getting two meals a day. Acceptability encompasses a cultural element into it. In all three states, the food children get under the mid-day meal scheme is acceptable even if it is only rice. Parents do have some concerns about the way the food is cooked, but they do not see it as an entitlement.

The acceptability of the quality of food grains provided by the PDS and in the Food for Work programme is also not a problem. In Chhattisgarh, the respondents from village Prabhatola said that earlier the food they were getting under the food for work programme was spoiled, but since a new government came in after Chhattisgarh became a separate state, the quality of food in the PDS is much better. Respondents had more difficulties with the delay in the availability of grain in the PDS than its cultural acceptability.

4.6. CONCLUSION AND RECOMMENDATIONS

- This research clearly makes a link between right to food and right to employment. In India, lack of food is more related to the purchasing capacity of the people rather than to food production. Such concerns have also been expressed by both civil society organizations involved in the struggle for right to food and independent reports. The right to work is indeed the best protection against hunger and poverty. Access to gainful employment is also an important basis of participation in society.

- Closely related to right to food is the issue of awareness of the schemes. In almost all the villages, there were no systematic and sincere attempt on the part of the concerned authority to inform people of the schemes and their rights. The schemes and the entitlements of the people are still seen as gifts from the government, which is a deliberate ploy by local politicians to get votes. Documents relating to food are not made available to the public or to the investigators. In all three states, there was a high degree of awareness about the two populist schemes – mid-day meal and targeted public distribution - but there was little awareness about the maternity benefit scheme (in Karnataka only 2% of respondents knew about the scheme and in Chhattisgarh only 18% of respondents). Whereas Antyodaya Awas Yojana and Food for Work are moderately well known to people, in Karnataka 43% and in Maharashtra 46% of respondents did not know about it. The Annapoorna scheme is not applicable in Karnataka, and in Maharashtra 28% of respondents and in Chhattisgarh 25% of respondents knew about it. Not very surprisingly, 14% of families in Chhattisgarh didn't know that they were eligible for a ration card that would get them subsidized food.

- What needs to be done is to develop an efficient mechanism within the existing structure that will be accountable for spreading information about the schemes and current entitlements. As has already been discussed, the mid-day meal scheme is a success largely because the responsibility is on the teachers.

- The food security problem in India is currently a problem of accessibility, as a sizeable share of the population lacks economic and physical access to sufficient food. The distance of a PDS shop from the household is a major deterrent. For 90% of families in Chhattisgarh, 26% in Maharashtra and 45% in Karnataka, a PDS shop is more than 2 km from their homes. Tribal Baiga families in Chhattisgarh have to travel five or six kilometres. Anganwadis meant for children under the age of three and for nursing and pregnant mothers, are more than four kilometres away for 32% of families in Chhattisgarh and 6% of families in Karnataka.

- An examination of food availability and accessibility reveals a fundamental contradiction in India's food policy. India's policymakers, operating through the Food Corporation of India, are pursuing conflicting objectives by attempting to provide low-priced food for consumers while increasing the support prices paid to

farmers. It should be kept in mind that the domestic agricultural sector has a major influence on food availability. Imports currently play a small role in domestic food supply because of the government's orientation toward food self-sufficiency.

- Food insecurity in India can best be described as chronic rather than acute, and manifests itself at least as much in poor nutritional balance as in calorific shortages. Food insecurity in India must also be seen in terms of its location— rural and urban. This study focuses on the rural poor who are primarily wage labourers and marginal farmers, ie, those with limited ownership of assets including land. Overall, SCs and STs constitute about 25% of the rural population but account for more than 42% of the poor.

The improvement and universalization of anganwadi services, the adoption of a National Employment Guarantee Act and robust social security entitlements for destitute households can be secured through deliberate planned interventions. India is home to the largest number of hungry people in the world - 233 million. India has a long tradition of maintaining buffer stocks (reserves) of food, usually at public expense (UNDP 2003). It is maintaining food stocks since the 1970s, but it is critical that food stored should be affordable for poor households, whether through the public distribution system or release of grains into markets. That is something the Indian government has failed to do in recent years. The reason for it is more urban centric plans like PDS, which recede to the rural areas lately.

Much more is required to secure the right to food in the full sense of the term. Ultimately, the right to food needs to be linked with other economic and social rights, such as the right to education, the right to work, the right to information and the right to health. These economic and social rights complement and reinforce each other. Taken in isolation, each of them has its limitations, and may not even be realizable within the present structure of property rights. Taken together, however, they hold the promise of major changes in the balance of power in Indian society.

4.7 CIVIL SOCIETY INITIATIVE ON RIGHT TO FOOD

Accountability in the authorities involved in government schemes and a sense of ownership among the beneficiaries is more important in ensuring food security to the people. The analysis of the State initiatives on food security in this chapter represents one part of the story. For a holistic understanding of the right to food discourse it is important to take note of the PIL filed by a civil society group (PUCL) in Supreme Court in 2001, which really paved the way for enshrining the idea of right to food. This section briefly presents the PUCL initiative.

Initiatives by Civil Society: The PUCL Case

There is a strong right to food campaign going on at the national level that is being led by non-governmental organizations. It started with a writ petition submitted to the Supreme

Court by the People's Union for Civil Liberties (PUCL) in April 2001. The petition linked right to food of the Indian citizen with right to life enshrined in the Indian constitution (PUCL Vs. Union of India and Others, Writ Petition [civil] No. 196 of 2001). Essentially the petition argued that the right to food is a fundamental right of all Indian citizens and demanded that the country's gigantic food stocks should be used without delay to prevent hunger and starvation. The petition highlighted two aspects of the state's negligence in ensuring food security: the breakdown of the PDS system and the inadequacy of relief programmes in drought affected areas. The petition on the whole demands judicial intervention in directing the government to:

- provide immediate open-ended employment in drought-affected villages
- provide gratuitous relief to persons unable to work
- raise the PDS entitlement per family
- provide subsidized food grain to all families
- provide supply of free food grain for these programmes

Through its various hearings held at regular intervals, the Supreme Court has passed interim orders directing the Indian government to work towards effective implementation of the existing policies relating to food. Most noteworthy among these is the order dated November 28, 2001 whereby directions were issued to implement eight food-related schemes fully as per the official guidelines. This, in effect, converted the benefits of these schemes to legal entitlements of the Indian citizens. The schemes included in this order were the Mid-day Meal Scheme (MDMS), Targeted Public Distribution Scheme (TPDS), Antyodaya Anna Yojana (AAY), Annapoorna Scheme (AS), Integrated Child Development Scheme (ICDS), National Old Age Pension Scheme, National Family Benefit Scheme, and National Maternity Benefit Scheme (NMBS).

Converting the food schemes into legal entitlements has the following implications:

- The constitutional provisions as well as international agreements that speak of the duty of the Indian State to provide food to the citizens are, no more, mere instructions to the state government. They are no longer gifts from the State, but are to be treated as rights of the citizens, which if violated, could be challenged in the court of law.
- If freedom from hunger is a basic right of all the citizens, what follows from it is the duty of the State to have effective mechanisms for achieving a food secure India.

A range of activities has been initiated to make the Right to Food a 'political priority': public hearings, rallies, *dharnas*, *padyatras*, action-oriented research, media advocacy, lobbying of members of parliament, etc

Source: www.righttofoodindia.org/

CHAPTER 5:
CONCLUSION AND RECOMMENDATIONS

5.1. INTRODUCTION

Economic, social and cultural rights are 'demandable' rights as opposed to 'positive' civil and political rights. It means people can ask but never insist, because their demands can only be met if there are resources to match. The strained superiority conflict between Civil and Political Rights (CPR) and Economic, Social and Cultural Rights (ESCR) was on hold amidst the claims and counter claims of the cold war between Western and Eastern Europe. Moreover, the continuing and important struggle between these two-generation rights involves a political angle because addressing ESCR would mean addressing the enormous and growing inequalities at all levels of human society. This is why there is greater support for CPR from developed countries and for ESCR from developing countries.. The debate over what should come first - removing poverty and misery or guaranteeing political liberty and civil rights for which poor people have little use - was one of the main issues between first and third world countries in the Vienna Declaration of 1993.

The Paris Principles that talk of interdependency and indivisibility of human rights, overlaps the issue of priority between different generation of rights, and this applies to CPR and ESCR as well. CPR has little meaning when people live in poverty and degradation. Actions to promote ESCR - health, education, food security and social security measures - are more important than mere claims of political freedom. Freedom from fear cannot be justified in isolation from freedom from want. On the other hand, civil and political freedom creates a society where economic, social and cultural rights of the people can be met easily. Instead of prioritizing rights in isolation of each other, it is more important to look at how they complement each other.

In developing countries like India, the growing capability deprivation, which is due to the new economic reforms and structural adjustments, cannot be addressed by only securing civil and political freedom, but by addressing issues of socio-economic and cultural deprivation, and investment in the realization of these rights. For the developing world, where deprivation is the key word in people's lives, investment in securing socio-economic and cultural rights is investment in human capabilities.

How these rights can be assured by the states where the progressive realisation aspect of it is imperative. By creating a condition of human security - to protect people

against chronic threats like hunger, disease and repression and to protect people against sudden and damaging changes in their daily lives, whether it is in the home, at the workplace or in the community. This pre-supposes security at different levels for all members of society - security from physical danger and threats, income security, security in education, housing security, health security and environmental security (Social Watch, 2004). However, it has been observed that the most deserving population is pushed to the periphery, and the rich and the affluent usurp all security levels. A denial of ESCR will always prove to be an obstacle in the achievement of CPR for scores of Dalits, Adivasis, Minorities, women and even children.

5.2. HIGHLIGHTS OF THE STUDY AND RECOMMENDATIONS

This study was undertaken to analyze government initiatives and intervention for realization of ESCR with reference to food security, elementary education and health care services. The study attempted to understand how much people were benefited from government initiatives pertaining to the promotion of ESCR. The study's outcome shows that the reluctance of State parties to accept responsibility for the fulfilment of ESCR is mainly due to a lack of political will and commitment, a paternalistic approach, the attitude of decision makers, lack of accountability in governance and, most importantly, absence of prioritization in planning and budgetary allocation.

Right to Education

The elementary education system in India is the second largest in the world. The major thrust of India's education policy at the primary level is on improving enrolment, retention, and achievements of children of the 6-14 years age group. The focus is on reducing gender disparity and disparities between different segments of the population (Sengupta, 2004). The central government scheme, Sarva Shiksha Abhiyan (Education for All), has seen an increased allocation of Rs 15.12 billion (USD 328 million) but has hardly achieved the stated goal of having all children below 14 years in school by December 2003 (Social Watch Report, 2004). Out of every 200 million children in the age group 6-14 years, only 120 million children are enrolled (*ibid*). Inadequate budget allocation, dismal school infrastructure in rural areas, high dropout rates, caste-bias, gender bias, etc have become the hallmark of the Indian education system.

This study shows that the number of girls who have never gone to school is more than the number of boys in all categories (SCs, STs and OBCs). The dropout rate among boys and girls, too, presents a dismal picture. Retention schemes to keep children in school at primary level were not helpful because more than the existence of schemes, it is their applicability that must be focused on. The distribution of free books and uniforms to the children doesn't happen to the extent required. The focus in case of the mid-day meal scheme needs to be changed from merely increasing the school attendance levels of children, to fulfilling the nutritional requirements of the children. It therefore should be extended to students studying in higher classes too. Here the suggestions given in the report

of the Commissioner to the Supreme Court also assumes importance (Third Report of the Commissioner to the Supreme Court in the PUCL vs GOI and Others, submitted on May 1, 2003):

> "The potential for using mid-day meals as a means of protecting children from under-nutrition is vastly under-utilised. Earlier experience shows that substantial results can be obtained, at relatively low cost, by combining nutritious mid-day meals with supplementary health and nutrition services such as de-worming, health check-ups, vitamin supplementation, etc... There is also a strong case for the continued provision of cooked mid-day meals during the school vacations, especially in drought-affected areas where the school meal is often the square meal in the day for deprived children."

The curriculum for Scheduled Tribes should be designed to take their cultural and living conditions into account and not that of the urban middle class. It seems that the total literacy campaign has lost its momentum and has become merely a bureaucratic programme and not a means of empowerment. This is obvious from the fact that literacy among ST adults in all three states surveyed is very low and is the lowest (at only 8%) in Chhattisgarh. The availability of schools, too, is inadequate: there is still a ratio of 1:5 for higher primary and primary schools in all three states.

- School infrastructure needs improvement. Sufficient number of classrooms to accommodate all children, drinking water on the school premises, toilet facilities and playgrounds need to be provided within the school premises.
- Student-teacher ratio needs to be improved as it was observed that in all three states one teacher handled two to three classes.
- Alternative teaching methods need to be explored. The teaching methods used often don't conform to the values and ethos of students living in different cultural environments.
- Girls drop out of school often due to the distance of the school from the home. Therefore ways must be found to make schools more physically accessible. Incentives and motivation should not be looked at in terms of providing scholarships only, but should also look at accessibility of schools, especially for girls.
- The mid-day meal programme needs to be improved, as it does not adequately address the nutritional needs of the children, particularly in Chhattisgarh. The scheme has been used politically to fill nutritional gaps in rural children.
- The importance of school education is still not recognized adequately, and such awareness is mandatory for securing the right to education of all children. Making the right to education a fundamental right does not fulfil the dream of compulsory education till 14 years of age. but programmes should be put in place to facilitate that. And state governments should be held accountable for failure on this front.

Right to Health

The Indian health system is one of the most privatized health systems in the world. Of the aggregate expenditure on health, 83% is allocated to private spending, while 43% of the poor depend on public sector hospitals for care (Social Watch Report, 2004). Privatization and deregulation of the health system have resulted in rising medication and drug prices. The National Health Policy of 2002 is loud in favouring privatization of health services. How is this privatization of basic health services going to benefit the deprived? For instance, in case of safe deliveries in all three states, 72-93% were home deliveries, and of these, most were attended by untrained dais. Even the registration of pregnancy was found to be very poor in Karnataka and Chhattisgarh. All this in spite of the fact that the ICDS is in place to keep a check on the health status of pregnant and lactating mothers, including that of children under the age of three years, and also having provisions for a PHC, SC and CHC to provide RCH services.

A critical factor in the access of people to health care services is the lack of medical and paramedic staff in government health centres. The government does its bit by appointing medical professionals in government health centres but the rampant absenteeism and non-professional attitude of the medical staff goes largely unchecked. The study shows that the majority of respondent families in all three states were reluctant to visit government hospitals, yet the option - of going to a private medical practitioner – was too expensive. The government regulation on private practitioners and their social responsibility needs to be questioned. Promoting privatization of basic health services is not the answer to promoting health care because it does not take into account economic inequalities among the population.

The introduction of the user fee was supposed to increase the efficiency of the health services and was regarded as a 'partial support programme' advocated in the health policies of 1983 and 2002. But nowhere does this seem to be helping the poor gain better access to better health services. From the study it can be seen that a user fee deters access to government health services. Also, the rejuvenation of traditional healing systems should be part of the policy document and should be used as a support system for modern medicine.

The health condition of scheduled tribes is perilous when compared to others. A separate Tribal Development Planning Cell has been functioning under the Ministry of Health and Family Welfare since 1981 to co-ordinate the policy, planning, monitoring and evaluation of health care schemes for the welfare and development of scheduled tribes (Tenth five-year plan). Government health centres do not reach out to areas where tribal habitations exist. Mobile health check-ups of tribals as proposed in government plans and schemes like the RCH, and health and nutrition programmes under the Minimum Need Programme do not seem to be reaching the beneficiaries. None of the three states covered by the study had the mobile health check up facility.

- Systems must be put in place to provide health care even to the most remote regions where there are tribal habitations. Health care should not be looked upon merely as a programme that delivers immunization, but requires a more comprehensive approach. State governments should design health programmes after assessing prevalent health problems of specific regions.

- States need to improve the quality of health infrastructure, particularly the training of paramedical staff, and the number of hospitals and primary health centres. More personnel are required in every health centre to ensure that people get care whenever they need it. Denying anyone access to health care in his or her time of need should be taken as gross violation of human rights and the state should take responsibility for it.

- Focused and intensive training of ANM's, dais and anganwadi workers in hygienic deliveries, newborn care and the management of infections is a must. Follow up visits by health visitors also need to be addressed.

- Programmes focusing on improving the awareness on post and prenatal care, the use of services of trained dais, uses of safe drinking water need to be intensified.

- The traditional healing system needs to be put in the policy document and should be used as a support system to modern medicine.

- The aim of the user fee needs to be implemented with the focus on facilitating efficiency and not impeding access to health care. If the practice of the user fee is adopted, appropriations under it should be made accountable and open to public scrutiny. The user fee should not hinder accessibility to health care for the poor.

- The quality and quantity of the mushrooming private health sector must be regulated and its social responsibility of catering to the needs of the poor must be defined. The private health sector should be accountable to the public and there should be strict rules and regulations if it does not fulfil its public responsibility.

Right to Food

The results of the field survey gives the impression that while some of the schemes, such as the mid-day meal scheme, are doing quite well, a change of approach is required. What is more important than just making the food schemes work is to bring about accountability in the authorities involved and a sense of ownership among the beneficiaries.

The focus should not be on feeding the poor, but on enabling them to feed themselves with dignity. This could, most probably, be done through self-help groups and agricultural cooperatives. People must be made aware that accessibility and availability of food is a right of all citizens. This would mean a change in the attitude of all those involved in the distribution of food and related commodities.

The need today is certainly not having more food related schemes, but a concerted effort to implement the already existing schemes to achieve what they are expected to. The need becomes urgent in the face of globalization, privatization and liberalization. To improve nutrition, the focus could be more on providing nutritious cereals such as millet, bajra and jowar, instead of wheat and rice, under nutrition schemes. The distribution of food grains also needs scrutiny; it is not only about safeguarding food godowns and spending on their maintenance. More than genetically improved cash crops for export purposes, it is the proper distribution and affordable price mechanisms that need to be the focus of policy makers.

Decentralization of the distribution network is also important. Having local food banks and arming panchayati raj institutions with legal, financial, technological and managerial resources could enhance the distributional aspect of food security.

- An efficient mechanism for spreading information about the schemes and current entitlements is needed. There is nothing to celebrate in India being self sufficient in food when malnutrition and chronic hunger are prevalent among large sections of the poor.
- Chronically undernourished people, those suffering from hidden hunger, and those who are food insecure due to recurrent disasters, need to be specifically identified and targeted for interventions.
- Proper identification of BPL families needs to be undertaken and the process needs to be made transparent and accountable to eliminate discrimination in identification and distribution of cards.
- The right to work is the best protection against hunger and poverty and in order to secure the right to food, right to gainful employment needs to be addressed simultaneously.
- The improvement and universalization of anganwadi services, robust social security entitlements for destitute households, assured employment are needed through deliberate planned interventions.

Ultimately, the right to food needs to be linked with other economic and social rights, such as the right to education, the right to work, the right to information and the right to health.

5.3. SUMMING UP

The State's responsibility to protect, promote and fulfil economic, social and cultural rights is based on the assumption that the State, through its taxing authority, has far greater resources than do individuals, and that through these resources the State has the ability to ensure that all those living within its ambit enjoy a certain level of social and economic security. The economic, political and social context within which human rights have been

historically recognized has been undergoing enormous changes in the past decades. These changes, in turn, have had and will have profound implications for efforts to promote ESC Rights.

A pro-people policy approach requires government functionaries to be committed to the socio-economic uplift of the population whom they represent, and to whom they are accountable. Merely chalking out strategies for promotion of the most basic of ESCRs is not enough. Society and governments at all levels should learn from the past by systematically evaluating and disseminating information about what works and what does not. Only then can sectoral reforms be scaled up to improve the lives of millions of poor in India. The challenge is formidable, as making health, food and education rights accessible to all involves changes not only in public sector institutions but also societal attitudes. Therefore, the priorities are:

1. Integration of rights perspective and approach to plans, policies, programmes and processes
2. Strengthening of civil society interventions to promote and ensure ESCR
3. Public awareness and education on ESCR so that people demand their rights.

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APPENDIX

INTERVIEW SCHEDULE

SECTION I

General Information

Date of Interview: Name of Investigator:

Village: Panchayat: Block:

District: Total Village Population:

Number of BPL Families in Village:

Number of SC/ST BPL Families in Village:

Household Information

House Number (if any):

I. Information about Householders /House

Name of household head	Sex	Social Category (SC/ST/ General/ OBC)	Land owned (in Acres /Hectares)	Principal occupation	Type of house (Hut/ Kucha/ pucca)	Source of drinking water

II. Information about Adult Family Members:

Sr. No	Name	Sex	Age	Relation with head of household	Educational qualification	Occupation	Monthly Income (Rs)
1							
2							
3							
4							
5							
6							
7							
8							
9							

SECTION II

(Fill the option number in the respective box)

Education

I. Is there a government run primary school (Std I to IV/ Std. I to V) in your village?

(1) Yes ☐ (2) No ☐

If yes, how far is it from home (in kms):

II. Is there a government run higher primary/ high school (Std IV to VII/ Std.VIII to X) in your village?

(1) Yes ☐ (2) No ☐

If yes, how far is it from your home (in kms):

If no, how far is it from your home (in kms):

III. Children's Educational Particulars

Sr.No	Name	Age	Sex	Educational qualification			Type of school			
No				Current Std	If dropout, what Std.	Not gone to school	Govt. school	Govt. alternativ school	Private school	School run by NGO/ charity organization
1.										
2.										
3.										
4.										
5.										

IV. If some children are going to government school, what incentives are they getting?

(1) Cooked food ☐ (2) Clothes ☐ (3) Bag & books ☐

(4) Scholarship ☐ (5) None ☐ (6) Any other (specify) :

V. If children are not going to government schools, what are the reasons for this?

(1) Teachers are not sincere ☐ (2) Poor quality of education ☐

(3) School is far away from home ☐ (4) Teachers beat up students ☐

(5) Drinking water not available ☐ (6) Toilet not available ☐

(7) Absence of lady teacher n (8) Any other (specify):

VI. How much money do you spend per month for the education of each child?

Rs : (Specify expense on what) :

SECTION III

Food security

Questions relating to Mid-day Meal Scheme

I. Do you get food in your school? (1) Yes ☐ (2) No n

II. If yes: (1) On all school days ☐ (2) Once a week ☐
(3) Once a fortnight ☐ Any other:

III. In which form do you get food: (1) Cooked ☐ (2) Dry ration ☐

IV. Have you ever been denied food: (1) Yes ☐ (2) No ☐
If yes, specify the reasons:

V. Do you like the food given at school: (Focus on menu) (1) Yes ☐ (2) No ☐

Specify reasons for like / dislike:

VI. Have you ever been asked to make any payment for the food?

(1) Yes ☐ (2) No ☐

If yes, specify reasons :

VII. Does any NGO / charity organisation / religious group in your village provide Mid Day Meal?

(1) Yes ☐ (2) No ☐
If yes, specify :

Questions about Targeted Public Distribution System

VIII. Have you heard about the Targeted Public Distribution System?

(1) Yes ☐ (2) No ☐

IX. Do you have a ration card? (a) Yes ☐ (b) No ☐
(A) If yes, what is the colour of your ration card:

(B) If no, what is the reason for your not having a ration card:
(1) It was not issued ☐ (2) It has been mortgaged ☐ (3) It is lost ☐
(4) Any other reason (specify) :

X. If a ration card has not been issued to you, what are the reasons?
(1) Lack of residential proof ☐ (2) Not able to give bribe ☐

(3) Do not have time to chase ☐ (4) Not aware about ration card ☐ (e) If any other reason, (specify) :

XI. How far is the nearest PDS shop?

(1) Within your village ☐ (2) Outside your village ☐

XII. If outside your village, how far :

Less than 1 km ☐ Less than 2 km ☐ More than 2 km ☐

XII. How many days in a month is the PDS shop open :
(1) Every working day ☐ (2) Once a week ☐
(3) Once a fortnight ☐ (4) Once a month ☐

Any other, (specify) :

XII. What items does the PDS shop supply?

(1) Wheat ☐ (2) Rice ☐ (3) Sugar ☐ (4) Kerosene ☐ (5) Pulses ☐

(6) All the above ☐ (7) Any other (specify):

XIV. Does the PDS shop give items in instalments? (1) Yes ☐ (2) No ☐

Questions relating to ICDS, NMBS, ANNAPOORNA, AAY, FFW

XV. Do you have an anganwadi in your village?

(1) Yes ☐ (2) No ☐

XVI. How far is the anganwadi from your house?

(1) Within 2 km n (2) 2km to 4 km ☐ (3) More than 4 km ☐

XVII. What items do children get to eat at the anganwadi?

A. B. C. D.

XVIII. How many staff work at the anganwadi?

(1) One ☐ (2) Two ☐ (3) More than two ☐

XIX. Do you know about the National Maternity Benefit Scheme?

(1) Yes (2) No ☐

XX. Are you a beneficiary of this scheme?
(1) Yes ☐ (2) No ☐

If yes, how much money have you received from government? Rs :

XXI. Do you know about the Annapoorna scheme? (1) Yes ☐ (2) No ☐

XXII. Is there any beneficiary of the Annapoorna scheme in your household?
(1) Yes ☐ (2) No ☐

XXIII. How much grain is given under the scheme (kgs/per month): Price per kg: XXIV.

Do you know about the Antyodaya Anna Yojana? (1) Yes ☐ (2) No ☐

XXV. Are you a beneficiary of this scheme? (a) Yes (b) No ☐

XXVI. How much grain is given per month
Quantity (Kg per month): Price per kg:
XXVII. Do you know about the Food for Work programme? (1) Yes ☐ (2) No ☐
XXVIII. Are you a beneficiary of the programme? (1) Yes ☐ (2) No ☐

XXIX. How many days do you get work under this programme?
(1) Once a week (2) Twice in a week ☐ (3) Any other (specify):

XXX. How much wage/grain do you receive per working day under the programme?

Wage (Rs.): Grain (Kgs):

SECTION IV

Health

Questions relating to Health Care

I. How far is the nearest hospital from your home (in Kms):

II. Who runs this hospital (1) Government (2) Private n (3) NGO ☐
(4) Religious group ☐ (5) Any other (specify):

III. If government run, is it a: (1) Sub-centre ☐ (2) Public Health Centre ☐

(3) Community Health Centre ☐ (4) Taluka Hospital ☐ (5) District Hospital ☐

IV. Do you pay money for medical care when you visit any government run hospital?
(1) Yes ☐ (2) No ☐

If yes, on an average how much money do you spend for each visit: (Rs)

V. For which of the following do you pay money in the government run hospital?
(1) Registration fees/User fees ☐ (2) Doctor fees ☐ (3) Buying medicine ☐

(4) Fees for diagnostic tests (x-ray, blood test, urine test, etc.) ☐ (5) Any other (specify):

VI. If any member of your family falls ill, where do you prefer to take treatment?
(1) Government hospital ☐ (2) Private medical clinic ☐ (3) Govt. doctor practicing privately ☐
(4) Village Vaidya ☐ (5) Rural Medial Practitioner ☐
(6) Any other (specify):

VII. Are villagers reluctant to take a patient to the government run hospital?
(1) Yes ☐ (2) No ☐

VIII. If yes, what are the reasons?
(1) Doctors not available ☐ (2) No free medicine No free diagnostic tests ☐
(3) No easy transport to reach hospital ☐ (4) Poor treatment ☐
(5) Any other (specify):

Questions related to health of women and children

IX. Do you register with a government hospital during pregnancy?

(1) Yes ☐ (2) No ☐

X. After registration, do you get periodic examination during pregnancy?
(1) Yes ☐ (2) No ☐

XI. If yes, who does the examination ?
(1) ANM ☐ (2) Health Assistant ☐ (3) Doctor ☐ (4) Trained Dai ☐ (5) Any other :

XII. After registration does the pregnant woman get free iron tablets and TT shots?

(1) Yes ☐ (2) No ☐

XIII. Has any child been born in your household within the last three years?
(1) Yes ☐ (2) No ☐

XIV. If yes, where? (1) Sub- Centre ☐ (2) Primary Health Centre ☐
(3) Community Health Centre ☐ (4) Private Maternity Home ☐
(5) Hospital run by NGOs ☐ (6) Hospital run by religious group ☐ (6) At home ☐

(7) Any other (specify) :

XV. If the child was delivered at home, who attended the delivery?

(1) ANM ☐ (2) Trained Dai ☐ (3) Untrained Dai ☐ (4) Any other (specify) :

XVI. After delivery, does a health worker visit your home to examine mother and child?
(1) Yes ☐ (2) No ☐

Immunization (for children below 5 years)

XVII. Do you have a health card for your child?
(1) Yes ☐ (2) No ☐

XVIII. Have children in your household below age of 5 years been immunized?
(1) Yes ☐ (2) No ☐
If yes, what has the child been immunized for?
1.BCG (Between 1st and 3rd month) ☐
2. DPT (Three doses in first year at 4 week intervals) ☐
3. DPV (Three doses in first year at 4 week intervals) ☐
4. TT- 2 (doses 4 weeks apart, no later than 2nd trimester) ☐
5. Polio (Three doses before age of 5 years) ☐

XIX. Where did you go for the child's immunization?
(1) Sub-Centre ☐ (2) PHC ☐ (3) Private Hospital ☐
(4) Government Hospital ☐ (5) NGO run hospital ☐
(6) Hospital run by religious group ☐ (7) At home n (8) Any other (specify):

XX. After immunization, did any health worker visit your home for a follow up?
(a) Yes ☐ (b) No ☐
XXI. Are you practicing family planning?
(a) Yes ☐ (b) No ☐
XXII. If yes, who is providing you counselling and services ?
(1) PHC ☐ (2) Sub-Centre ☐ (3) ANM ☐ (4) Other Health worker ☐
(5) Any other (specify) :

Questions relating to diseases

XXIII. When there is an outbreak of disease in the area, does a government health worker visit your house?
(1) Yes ☐ (2) No ☐

If yes, specify what reason he/she came for :

XXIV. Did any member of your family recently suffer from Diarrhoea /Dysentery/ Malaria/ Jaundice / TB / any serious ailment:

(1) Yes ☐ (2) No ☐

XXV. If yes, where did you take the patient for treatment:

(1). Sub-Centre ☐ (2) PHC ☐ (3) Private Hospital ☐ (4). Government Hospital ☐
(5) NGO run hospital ☐ (6) Hospital run by religious group ☐ At home ☐
(6). Any other (specify) :

XXVI. Approximately how much money did you spend for the treatment? Rs:

XXVII. How did you arrange for this money?

(1) Savings ☐ (2) Loan from moneylenders (3) Loan from neighbour / relative ☐
(4) Sold your land ☐ (5) Sold livestock ☐ (6) Any other(specify) :

XXVIII. Answer the following questions about health awareness:

SOURCE OF INFO/ HEALTH PROGRAMME	Yes/No	Group Sessions	Films	Posters	Other Media	Health Worker	Anganwadi Worker
Nutrition and Child health							
Pre-natal and Post-natal Care of Women							
Family Planning							
TB symptoms and treatment							
Leprosy							
AIDS							
Awareness about Immunization programmes and Schedules							
Polio Drops							
Health Camps							
Sanitation & Cleanliness							
Use of safe drinking water							
Diseases							

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ADVOCACY PERSPECTIVE

SEZ (Hindi), Forest Bill (Hindi)

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Question Hour & Adivasi Issues (2003-2006)

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OCCASIONAL PUBLICATIONS

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