

Madhya Pradesh and UN Millennium Development Goals (MDGs)

Status and Progress at Half Way Mark (2007)

A snapshot

In September 2000, the world leaders representing 189 countries adopted the United Nations Millennium Declaration, calling for stronger global efforts to reduce poverty, improve health, and promote peace, human rights and environmental sustainability. The UN Secretary-General at the behest of the UN General Assembly prepared a road map for achieving the commitments made in the Declaration-resulting in the Millennium Development Goals (MDGs). The Goals reflect key aims of various UN development conferences in the 1990s. They also built on the International Development Goals created by the Organisation for Economic Co-operation and Development (OECD) in 1996. The Millennium Development Goals include all but one of the OECD International Development Goals. The Millennium Development Goals were affirmed at the March 2002 Monterrey Conference on Financing for Development, the September 2002 Johannesburg Declaration on Sustainable Development, and the June 2003 G8 summit in Evian. The Goals are now widely accepted as a framework for measuring development progress. Bilateral and multilateral institutions, including the World Bank, have made the MDGs a central focus of their development assistance.

The overall aim of the MDGs is to reverse the spread of poverty and disease by 2015. The eight goals are backed by a plan of action that sets out 18 quantifiable targets. Each target is using specified indicators. Three goals and four targets are directly related to health. The focus of the health-related Goals, as of the MDGs in general, is on poor tropical countries where 99 percent of world-wide maternal deaths occur.

Madhya Pradesh and MDGs

Objectives

The main objectives of the report are to look into the state of progress that has been made in attaining the MDGs, thereby bringing out constraints and future concerns. Specifically it attempts: (i) to assess and analyse the progress towards MDGs using selected indicators to judge the progress and; (ii) to identify and analyse the key indicators which require urgent policy attention.

The report relies on secondary source produced by the State Government, websites, civil society assessments and academic literature. Interaction with people is also reflected in the report. Madhya Pradesh was reorganised in 2000 and so the report reflects the situation of the new state only. This is also because of data formats availability. It may be mentioned here that data were difficult to organise for most indicators from 1991. The state departments have limited information to provide on the concerned variables. Time was another constraint that limited the in-depth review of few variables. The literature on Madhya Pradesh was used.

Goal 1: Eradicate Extreme Poverty and Hunger

A secure, stable and sustainable livelihood that provides employment and helps grow and live with dignity is crucial for human development. If people have secure livelihoods, then they can have access to facilities like education, health care and safe habitats.

Madhya Pradesh has 89.8 percent of the population in rural areas employed in agriculture, mining and related areas.

The tertiary sector employs around 26.5 percent and 53.2 percent are employed in secondary sector.

The growth rate of state income has been fluctuating over the years since the formation of the new state in 2000. Data shows an inconsistent performance of the economy. The per capita income at 1993-94 prices was Rs.9305 in 1999-2000 that went up to Rs.9279 in 2005-06.

Agriculture is still the mainstay of majority with declining income accruing from it, and the income of the rural communities is reducing. In many districts, forest based activities provide employment to a significant proportion in rural areas.

State has preponderance of marginal and small farmers. There are 28.38 lakh marginal farmers with 13.98 lakh hectares land, 19.51 lakh small farmers with 28.28 lakh hectares land, and the others are 25.71 lakh farmers with 121.45 lakh hectares land.

The rural poverty line in 2004-05 was defined as Rs.327.78 and urban as Rs.570.15 (Rs. per capita per month). Overall, the number of population below poverty line in Madhya Pradesh in 2004-05 as per MRP (mixed recall period) were 210.97 lakh or 32.4 percent. The corresponding figures for rural areas are 141.99 lakh or 29.8 percent. In urban areas the number of poor people are 68.97 lakh or 39.3 percent. Rural poverty is far less compared to urban poverty.

The number of population below poverty line in Madhya Pradesh in 2004-05 as per the URP (uniform recall period consumption) were 249.68 lakh or 38.3 percent. The corresponding figures for rural areas are 175.65 lakh or 36.9 percent. In urban areas the number of poor people are 74.03 lakh or 42.1 percent. Thus, rural poverty situation is marginally better than urban poverty situation.

The monthly per capita expenditure (MPCE) of 58.3 percent in rural Madhya Pradesh is below Rs.410 and only 4.6 percent have MPCE of Rs.890 or more. In urban Madhya Pradesh, the corresponding proportions are 53.5 percent and 6.7 percent. The rural conditions are appalling as 21.1 percent have MPCE of Rs.270 or less. This would reflect in nutrition intake of the rural population.

For the year 2004-2005, 47 percent of villagers were living below the MPCE level of Rs.365 or Rs.12 per day and 21 percent are living below the MPCE of Rs.270 or Rs.9 per day. In urban areas, 43 percent of urban dwellers live below the MPCE of Rs.580 or Rs.19 per day and 18 percent live below the MPCE of Rs.395 or Rs.13 per day.

Almost 97.9 percent villagers and 96.1 percent urban dwellers live on Rs.38.50 per day that is less than a dollar a day. The average MPCE in rural areas is Rs.439.06 with a Lorenz ratio of 0.269 while urban MPCE is Rs.903.68 with Lorenz ratio of 0.397.

As regards the food inadequacy prevailing in Madhya Pradesh in 1993-94 and 1999-2000, in rural areas, the percentage of households where all the members got enough food everyday throughout the year declined from 97.0 percent to 96.3 percent during the period from 1993 to 2000.

In urban Madhya Pradesh, the percentage of households where all the members got enough food everyday throughout the year marginally declined from 98.8 percent to 98.2 percent during the period from 1993 to 2000.

Overall, the perception of the people in Madhya Pradesh in 1999-2000 was that they were generally getting enough food everyday throughout the year, though some deterioration has occurred in both rural and urban areas. The position of rural households with low MPCE was bad in the sense that food inadequacy was prevalent during July- September period.

As per the NFHS-2 for 1998-99, 35.2 percent of ever-married women were with Body Mass Index (BMI) of below normal and this percentage did go down to 40.1 percent, which is still high by 2005-2006 (NFHS-3). The rural situation (44.2%) is worse than urban situation (28.7%).

Among women, as per the NFHS-3, education plays an important role in improving the nutritional status. 44.5 percent of women having BMI of below normal had no education as against 20.0 percent women with 10 years complete or above education. The impact of education is visible only after 8-9 years of education.

In case of men, as per the NFHS-3, 36.3 percent ever married men had BMI of below normal; rural 41.1 percent and urban 22.8 percent. Education is important here too. 45.5 percent of men having BMI of below normal had no education as against 19.2 percent men with 10 years

complete or above education. The impact of education is visible only after 8-9 years of education.

Considering that over-weight or obesity as another indicator reflecting on nutritional status, in 1998-99, only 6.8 percent ever-married women were over-weight or obese. The deterioration is observed in this indicator in 2005-06.

Obesity is mainly an urban problem- 22.8 percent urban compared to only 3.5 percent rural area.

The regional proportions were 13.3 percent urban and 2.6 percent rural. Higher the education higher is the chance of obesity in both rural and urban areas. 27.2 percent women and 15.0 percent men with 10 years complete or above education are obese compared to 4.6 and 1.9 percent with no education.

Goal 2: Achieve universal primary education

This goal of universal primary education target (number 3) by 2015 children everywhere, boys and girls alike, to be able to complete a full course of primary schooling. The suggested indicators are net enrolment ratio in primary education, proportion of pupils starting grade 1 who reach grade 5, and literacy rate of 15-24 years olds.

As regards the status of elementary education in terms of major educational indicators, there are 81335 Government Schools, 961 Aided Primary Schools, 13221 Private Primary schools, 24293 Government middle schools, 370 Aided middle schools, 11236 Private middle schools and 878 *Ashram Shala* (elementary level) in Madhya Pradesh presently. In addition to the formal schools, primary education facilities have been started to ensure that the children who are out of the ambit of formal education, also get an opportunity to education facility that will ultimately lead to their mainstreaming in the formal education stream. There are 6595 Non-residential bridge courses benefiting 156260, 602 Residential bridge courses befitting 37187, 2734 Madrasa under modernisation of *madrasas* scheme befitting 151775, 96 Sanskrit schools befitting 2846, 306

Human development centres for urban deprived children 12011, 400 Transitional education centres (TEC) under INDUS project befitting 2000, and State open schools befitting 17138.

In 2005 as per the DISE data, there were 76296 primary only schools, 16111 primary with upper primary schools, 2983 primary with upper primary and secondary/ higher secondary schools, 14090 upper primary schools, 1261 upper primary with secondary/ higher secondary schools. In all there were 111727 schools.

There has been an increase in rural schools and at a faster pace than urban schools. Urban primary schools observed a decline by 3.2 percent during 1993-2002. There is, thus, some improvement in primary school infrastructure in terms of availability of schools in rural areas.

As per DISE 2005 data, percentage share of enrolment in pre-primary classes to total enrolment at primary level was 23.59 percent and 19.30 percent in primary with upper primary level and 20.87 percent in primary with upper primary and secondary /higher secondary level.

As per the DISE data, in 2005, GPI in classes I-V was 0.90 and 0.74 in classes VI-VIII and 0.86 in classes I-VIII. In case of rural schools, GPI in classes I-V was 0.90 and 0.70 in classes VI-VIII and 0.85 in classes I-VIII.

As per the Seventh School Education Survey 2002, at the primary level in 2002, the enrolment was 27.82 lakh with gender ratio of 0.92. The rural gender ratio is marginally lower compared to urban gender ratio. As one moves to upper primary level, the enrolment goes down to 24.06 lakh and the gender ratio too declines to 0.70. The decline is across regions and it is significant. This trend continues at the secondary level too and at the higher secondary level. The gender ratio declines to 0.59 at the higher secondary level. In rural areas, the gender ratio is 0.41 and the urban gender ratio is 0.69, much higher.

Trends indicate that enrolment of girls after primary level goes down significantly in rural areas, but suddenly improves at the higher secondary level. In urban areas, the enrolment of girls is much lower compared to rural areas, but it improves up to upper primary level and then declines

at secondary level to improve significantly at higher secondary level. It is also reflected in marginal improvement in gender ratio and in improvement in school infrastructure.

Higher education is more concentrated in urban areas.

Class-wise enrolment figures reveal that boys outnumber girls in enrolment in all classes (I-V) and there is not much difference in gender ratio across classes and regions, though a dip is observed in class IV.

A significant finding is that a clear continuous decline is visible in enrolment of boys since class I from 671057 to 560836 in class IV in rural Madhya Pradesh, but improved in class V.

In case of girls, enrolment declined since class I from 610752 to 464752 in class V in rural Madhya Pradesh. In urban areas the pattern is slightly different after class IV. Gross enrolment figures show that at the primary level, the percentage of girls is 46.44 percent rural and 45.91 percent urban. There is a decline in percentage of girls enrolled in classes VI-VIII, IX-X and XI-XII in rural Madhya Pradesh. The pattern in urban areas is similar.

In rural Madhya Pradesh, the enrolment of girls improved by 49.79 percent at the primary level (I-V), by 135.36 percent at the upper primary level (VI-VIII), by 131.61 percent at secondary level (IX-X) and by 126.32 percent at higher secondary level (X-XII) between 1993 and 2002.

In urban Madhya Pradesh, the enrolment of girls improved at much slower rates across classes. For instance, enrolment increased by 18.24 percent at the primary level (I-V), by 42.34 percent at the upper primary level (VI-VIII), by 43.25 percent at secondary level (IX-X) and by 41.45 percent at higher secondary level (XI-XII).

Pratham reports that in rural Madhya Pradesh, 81.5 percent of children aged 3-5 are either in anganwadi or school and this percentage varies between 100 percent in Rajgarh and 46.5 percent in Panna district in 2006.

Of the children aged 6-14 years, 3.9 percent are out of school and 11.5 percent are in private schools. The percentage of out of school children is the highest in Sidhi (10.5%) and none in Betul. There are 16 districts where proportion of out of school children is higher than the state average.

Privatisation of schooling appears to be significant in quite a few districts meaning that five districts (of 45 districts) have 20 or more percent children in private schools (highest percentage being in Dewas-29.8%), and 21 districts have 10 or more percent of children in private schools in rural Madhya Pradesh. Only Rajgarh district has 0.2 percent children in private schools.

ASER 2005 of *Pratham* reports that in rural Madhya Pradesh of the 477 schools visited, percentage of enrolled children attending (average) is 66.2 and percent of schools with less than 50 percent of enrolled children attending is 16.4 in schools with standard I-IV/V. The corresponding percentages in case of schools with standard I-VII are 67.8 and 12.9 percent. The proportion of teacher's attendance is 76.1 and 73.5 in both the cases respectively.

ASER 2005 report that in 2005, 1.9 percent boys and 2.5 percent girls age 6-10 year were out of school compared to 5.6 percent boys and 8.5 percent girls in the age group of 11-14 years in rural Madhya Pradesh. Government schools are the major players in school education for both boys and girls though across age groups, the proportion of girls going to government schools is higher in the age group of 6-10 years compared to age group of 11-14 years. The overall percentage of children going to government schools in 6-10 years age group is 93.2 percent as against 87.3 percent in the age group 11-14 years.

The status of out-of-school children reveals that in 2004-05, 1.98 lakh boys and 2.30 lakh girls with a total of 4.28 lakh children were out of school and the corresponding figures for 2005-06 were 2.33, 2.39 and 4.72 lakh respectively. The out-of-school children comprise of never enrolled and dropout children.

The age wise details help in planning strategies. Out-of-school children in the age group of 5-11 years in 2005-06 were 3.34 lakh and boys and girls were almost equal in proportions. However,

out- of- school -children in age group of 11-14 years was much lower at 1.39 lakh with girls outnumbering boys.

Another significant issue that emerges is that in the age group 5-11 years, never enrolled children were much higher than drop out rates. This is where the state is required to intervene to achieve education for all. These children should be in schools.

During 2005-06, at primary level 99826 children dropped out of schools while these numbers are 41728 at the upper primary level. The analysis of reasons of children being out of school clearly reflects that it is the economic related factors that prevent the children from attending the school.

Data shows that about 71 children (boys and girls in both rural and urban areas) out of 100 reached class V in 2005. More boys (74) survived up to class V compared to their girl counterparts (68). The gap is not much. Further, only 44 children out of 100 reached class VIII in 2005 and this number was 50 for boys and 38 for girls. Here the gap is more than that was in class V.

On the learning achievements, there is high percentage of children who cannot read. For instance, 37.6 percent of children cannot read level 1 (ability to read a small paragraph with short sentences of std 1 level difficulty) and 55.3 percent children cannot read level 2 (ability to read a story text with some long sentences of std 2 level difficulty) in age group of 7-14. ASER 2005 finds that performance in private schools is relatively better compared to government schools in rural Madhya Pradesh in case of reading and solving written numerical sums.

A factor that has been reported to be of importance in ensuring school attendance and retention of pupils is mid day meal scheme. In Madhya Pradesh, the number of schools increased from 79936 in 2002-03 to 86191 in 2003-04, but declined to 83343 in the next year.

The number of students covered improved from 7579750 in 2002-03 to 7729652 in 2003-04 and fell to 7649784 in 2004-05. A similar pattern in coverage is observed in case of scheduled caste and tribe students over these years.

Some of the problems cited in case of this scheme are deficiencies in terms of nutritional content of the food served to children, difficulties in implementing the programme in those schools, which are served by one or two teachers. This is coupled by caste prejudices. However, all is not well with mid-day meal scheme. There are complaints of corruption, poor quality grains being used and food cooked in unhygienic conditions. Also no teaching takes place after lunch.

The state has made progress in terms of providing access and enrolment of children; however concerted efforts are required to improve the status of retention and learner's achievement in the State.

Goal 3: Promote Gender Equality and Empower Women

This goal calls for elimination of gender disparity in primary and secondary education by 2005 and in all levels of education no later than 2015. The suggested indicators are ratio of girls to boys in primary, secondary and tertiary education, ratio of literate women to men aged 15-24 years, share of women in wage employment in the non-agricultural sector, and proportion of seats held by women in national parliament (local levels).

Gender disparity in education

Overall literacy rates in 2001 were 76.80 percent for males and were much higher than female literacy rates of 50.28 percent giving gender difference of 26.52 percentage points. The gender difference has reduced between 1991 and 2001.

At the district level, the highest male literacy level in 2001 was in Narsimhapur at 86.79 percent and the lowest literacy rate was recorded in Jhabua at 48.20 percent. The female literacy rate of 69.02 percent was the highest in Narsimhapur and the lowest in Jhabua at 25.5 percent. The minimum gender difference in literacy rate was observed in Jhabua at 12.70 percentage points in 2001 and the maximum in Morena at 34.16 percentage points.

Another point noticed is that in 20 districts of the 45 districts in 2001 the gender literacy difference was higher than the state average.

During the nineties gender disparity in literacy in Madhya Pradesh had declined. Interventions like SSA and other programmes have made a marked impact on literacy rates in the nineties. Across the districts there is improvement in both male and female literacy rates. However, there are still grey areas and certain districts have lagged behind in female literacy especially Barwari, Sehore, Chhatarpur, Sheopur among others.

In 2001, Madhya Pradesh saw observable rural-urban differences in literacy rates, both males and females. The gender difference in rural areas varies between 38.51 percentage points in Neemach and 18.64 percentage points in Narsimhapur. The urban variation is between 26.30 percentage points in Sheopur and 12.39 percentage points in Jabalpur. This implies that rural areas requires added attention if Madhya Pradesh wants to improve its literacy situation.

Elementary Education and Girls Literacy in Madhya Pradesh: *In order to study the impact of various schemes related to elementary education in Madhya Pradesh in the context of girls' literacy, 50 teachers, 100 parents, 50 Panchayati Raj representatives and 30 educated villagers were surveyed. It was found that there are three types of teachers- 48 percent Shikshakarmies, 46 percent Assistant Teachers and 6 percent Head Masters. Of all the teachers, 74 percent are male, 70 percent teachers are graduates and above and 40 percent teachers are trained. All the teachers are of the view that they do survey of school going age children in the villages and 60 percent teachers are of the view that the children are enrolled according to survey list. Reasons of girl child absenteeism are mainly - household activities/ care of siblings (76%), they remain busy with works related to agriculture and labour (62%), lack of attention from parents/ lack of self interest (14%) while reasons of non-enrolment of girl child are lack of awareness among parents/ illiteracy of parents (60%), low socio-economic status which leads to labour work (20%), household activities keep them away (18%). On the other hand, reasons for dropout of girl child are- involvement in labour and agriculture work keeps them occupied (56%), works related to household activities/ care of sibling (42%), engagement/ marriage (24%), repeated failure in one class (16%), eve teasing keeps them away (10%). The level of interest shown by parents for girl child education is moderate (70%) and 90 percent teachers have approached the parents of those children who are often absent or dropped out. The government schemes related to elementary education known to teachers are - Scholarship (76%), Mid day meal scheme (48%) , Book bank scheme (32%), School Uniform (26%), Free education (8%) and Don't know about any scheme (20%). 74 percent teachers perceive the schemes to be useful/ beneficial. The reasons of low educational status in Madhya Pradesh given by the teachers are- lack of education among parents (44%), education level at grassroots is not up to the mark/ lack of facilities (26%), conservative attitude of parents (22%), involvement in agriculture (18%) and child*

marriage (4%). Teachers suggested that for the betterment of the girl child education, the steps could be- parents, specially women should be made aware (30%), female teachers should be appointed (20%), schools up to middle and above should be opened in villages (20%), schools should be fully equipped (20%), involvement of teachers in extra educational activities should be minimised (16%), there should be separate schools for girls (12%), education should be made compulsory (12%), more schemes should be operated (10%) and social evils like child marriage etc. should be strictly prohibited (10%).

The response of parents reveals that 74% are engaged in agriculture and 18% are labourers. Further, 34% parents are illiterate, 32% are educated up to primary level, 17% are just literate, 12% are educated up to middle and rest 5% are educated up to higher secondary. 82% respondents (husband/ wife) are illiterate, 6% are just literate, 9% are educated up to primary and rest 3% is educated up to higher secondary. The majority is of illiterates i.e. 91 percent respondents are illiterate male. 71% respondents have family size between 5 and 7. The reasons for not sending the girl child to school are - they are involved in household work/ care of sibling (11%), involvement in agriculture and labour work (8%), tradition does not allow girl child to go out (3%), engagement/ marriage (2%). The opinions of parents about girl child education reflect that girls should be educated to understand their routine work only (28%), girls should be educated as much as possible (25%), girls should be educated so that they may become self dependent (17%), education should be given up to primary level only (12%), girls should not be educated (8%) and girls should be educated up to the availability of school in the village (4%). The government schemes for elementary education known to parents are Mid day meal scheme (51%), Scholarship (27%), Free books (11%), Free education (7%), School uniform (6%) and Don't know about any scheme (41%). The reasons of low educational status in Madhya Pradesh given by parents are agriculture class is very large and it involves children in agriculture (19%), child marriage/ conservative society (16%), labour and poor class is big in number (14%), level of awareness among parents is low/ illiteracy is high (14%), insincerity of teachers (5%), inadequate facilities in villages (4%) and 30 percent parents are not in a position to give the reasons for low educational status. The suggestive measures for the betterment of girl child education given by the parents are: parents and villagers should be made aware (14%), schools up to middle and above should be opened in villages (13%), more schemes should be implemented (12%), separate girls schools should be opened (7%), female teachers should be appointed (3%), special efforts should be made by Gram Panchayat/ Sarpanch (3%), social taboos should be removed (2%), education should be made compulsory (2%) and 48 percent respondents are not in a position to give any suggestion (Source: Planning Commission's website).

The largest category facing discrimination, though they can scarcely be considered a 'group' since they constitute half the population, are women.

Women in work force

Women constituted 37.09 percent of all workers in Madhya Pradesh in 2001. The corresponding proportions in rural and urban areas were 41.49 and 18.12 percent. This means that women constitute a higher proportion in the work force in rural areas compared with urban areas.

At the district level, it is observed that the highest percent of female in work force is in Dindori at 48.05 percent and the least is recorded in Gwalior at 20.35 percent. In 26 of the 45 districts the percentage of female workers is higher than the state average. In rural Madhya Pradesh, it is observed that the highest percent of female in work force is in Dindori at 48.79 percent and the least is recorded in Raisen at 27.6 percent. In 25 of the 45 districts the percentage of female workers is higher than the state average. In urban Madhya Pradesh, it is observed that the highest percent of female in work force is in Tikamgarh at 30.61 percent and the least is recorded in Morena at 11.64 percent. In 23 of the 45 districts the percentage of female workers is higher than the state average.

Women's participation in work has another dimension. NSSO data for 1999-00 reports that only 24.6 percent women in Madhya Pradesh are willing to work within household compared to 33.2 percent at the national level in rural areas (3.15%). The corresponding proportions in urban Madhya Pradesh are higher at 31.6 percent compared to 29.9 percent in India.

These women in rural Madhya Pradesh work in tailoring activity followed by dairy. In urban Madhya Pradesh, the most preferred activity is again tailoring followed by spinning and weaving. This shows that women still feel comfortable with activities that require skill learnt from early childhood.

Crime and Violence

The National Crime Records Bureau reports that in 2005, 14529 crimes were committed against women, constituting 9.35 percent of crimes committed against women in India. This also means that 39.81 crimes are committed against women every day. The three major cities Indore, Jabalpur and Bhopal recorded 1301 crimes against women. The violent crime includes rapes, murders, culpable homicides and dowry deaths. Women are often beaten up and murdered.

On domestic violence, NFHS-2 (1998-99) finds that in Madhya Pradesh, there is widespread acceptance among ever-married women that the beating of wives by husbands is justified under some circumstances. Almost two-third of ever-married women (72%) accept at least one of six reasons as a justification for a husband beating his wife. 21 percent of ever-married women in Madhya Pradesh have experienced beating or physical mistreatment since age 15, and 56 percent experienced such violence in the last 12 months preceding the survey. Most of these women have been beaten or physically mistreated by their husbands. The battering is more in families with low standard of living index. It is irrespective of whether the women had children or not (the proportion of wife battering is almost same), no religious or caste or regional differences, but recently married are experiencing less this situation. Education helps in reducing incidence of violence against ever-married women as NFHS- 2 reports that only 8.7 percent affirmed wife beating who are high school complete and above as against 23.6 percent of illiterate women. Family violence is more committed by the husband on his wife than in-laws or other persons. The incidence of wife beating is relative more in case of nuclear families.

As per the NFHS-3 (2005-2006), 45.8 percent of ever-married women experienced spousal violence. It was relatively less in urban areas compared to rural areas. Only 17.8 percent affirmed wife beating who are high school complete and above as against 51.2 percent of illiterate women. This indicates that woman's education help in reducing spousal violence.

Democratic Institutions Representation

The issue of gender representation have been at centre stage since the *Panchayati Raj* institutions and urban local bodies were given constitutional protection of one-third representation to women under the 73rd and the 74th amendments to the constitution. There are 108898 women office bearers and members of the *Panchayati Raj* bodies as on 1.4.2004 in Madhya Pradesh and majority were *Gram Panchayat* members (106491 or 51.11%) followed by 2159 (50.24%) intermediate *Panchayat* members and 248 (51.03%) district *Panchayat* members. Women account for 51.09 percent of all *Panchayat* representatives and it is much higher than the stipulated requirement.

Madhya Pradesh has become second state to provide 50 percent reservation for women: Madhya Pradesh has accepted Bihar initiative for 50 percent reservation of seats for women in all three tiers of Panchayats. The state legislature, on 30 March 2007, adopted amendments in the relevant local government acts to increase the quantum of reservation for women. Along side, some inconvenient provisions were also removed. The two-child norm for elected local government representatives has been withdrawn. Similarly, there is now no compulsion for an elected panchayat representative to have a flush toilet within one year after being elected. Henceforth, no-confidence motions can be brought against Sarpanch and deputy Sarpanch only after they have held their posts for a minimum period of two and a half years. However, such a motion may be brought next time after months from the day when the first no-confidence was defeated. Earlier, at least one year had to elapse between two no-confidence motions. All panch, members of Gram Sabha committees and officials and employees of Panchayats have been made personally accountable for any pecuniary loss to the Panchayat. The quorum of the Gram Sabha has been reduced. Now, one-tenth of Gram Sabha members or five hundred members form the quorum. (Panchayati Raj Update, March 2007).

The women representation in the *Lok Sabha* is negligible from Madhya Pradesh.

Other Indicators of Women Empowerment

Traditionally, women in Indian society had limited role in household decision making. There are rural-urban differences. NFHS-2 (1998-99) reveals that 12.5 percent of ever-married women aged 15 plus reported no involvement in any decision-making at home. Younger women (27.1% aged 15-19), urban located (13.6%), high school plus educated (13.1%), Hindu (12.3%), and high status (17.5%) were never involved in decision-making compared to other categories. Women are involved in decision-making- what to cook (69.2%), own health care (21.5%), purchasing of jewellery (10.6%), staying with her parents/ siblings (12.4%). In all this, more years the women is married greater is her involvement as she is further into her cycle- young wife, mother or may be mother-in law. Her earning capacity also furthers the cause of participation in decision-making. All indicators show that how a woman is placed and what stage is her married life determines her involvement in decision-making. Education and economic capacity do play a positive role.

As per the NFHS-3 (2005-2006), 46.7 percent women usually participate in household decisions. This proportion is lower in rural areas compared to urban areas and more among high school plus educated.

It is those governments that have achieved the desired results have provided universally available essential services which work for women and girls; abolishing fees in health and education and subsidising water and sanitation services; building long-term public capacity to deliver services; expanding services into rural areas; investing in teachers and nurses; and strengthening women's social status and autonomy as users and providers of services.

Goal 4: Reduce Child Mortality

This goal calls for reducing under-five infant and child mortality rates by two-thirds between 1990 and 2015. The suggested indicators are under-five mortality rate, infant mortality rate and proportion of 1-year-old children immunised against measles.

In 2004, percentage of infant deaths to total deaths in Madhya Pradesh was 25.5 and the rural percentage was 26.6 compared with urban percentage of 19.6. Also the infant mortality rate (infants deaths in less than one year) in 2004 was 79 and varied from 84 in rural areas to 56 in urban areas. The gender dimension is that in 2004, 82 male infants died compared with 75 female infants. A similar trend is visible in both rural and urban areas though infant mortality is much higher in rural areas of both male and female infants.

Sample Registration System data shows that in 1992-94, the average infant mortality rate was 102.7 that came down to 76.5 in 2002-04 (Madhya Pradesh includes Chhattisgarh). In rural areas the decline during the period was from 109.0 to 80.8 compared with decline from 66.0 to 52.3 in urban areas.

Percent of deaths of children below age five to total deaths in Madhya Pradesh as per SRS 2004 was 35.8 (India 24.4) and it varied from 37.7 in rural Madhya Pradesh (India 26.5) to 25.6 in urban Madhya Pradesh (India 16.5). This situation is worst among all major states.

The death rates for children below age 5 years were estimated at 26.9 (India 17.0) that are highest amongst all states. The male children have slightly lower death rates of 26.7 (India 16.6) compared with female children deaths of 27.1 (India 17.5). In rural Madhya Pradesh, the rate is 30 across the board (highest amongst all states) when at the national level the estimates are 19.1, 18.7 and 19.6 for total, male and female children respectively. The urban Madhya Pradesh rates are almost half that of rural rates (15.0, 14.2 and 15.8 total, male and female respectively). Here again the rates at all India level are lower than that for Madhya Pradesh. Also these rates are better than only those in Uttar Pradesh among all states. This means Madhya Pradesh has a long way to go to fulfil the MDG on infant mortality and more so in rural areas. The health and population policies have apparently no visible impact in Madhya Pradesh.

The regional infant mortality rates are Malwa 93, Vindhya 92, Central 86, Northern 84, South 80 and South Western 50 and total 84.

In 1998-99, number of infant deaths per 1000 live births declined from 118 during 1984-88 to 86 during 1994-98. The urban infant mortality rate declined from 101 during 1984-88 to 62 during 1994-98 while the rural infant mortality rate is still high though it declined from 123 during 1984-88 to 93 during 1994-98.

There is no significant change in infant mortality 1992-93 and 1998-99. The infant mortality rate of 86 for the period 0-4 years before 1998-99 is almost unchanged from the infant mortality rate of 85, 0-4 years before 1992-93.

The under-five mortality rate of 138 for the period 0-4 before NFHS-2 (1998-99) is somewhat higher than the under-five mortality rate of 130 for the period 0-4 years before 1992-93. Rural areas lag far behind in any improvement that has occurred over time. Overall, it is clear that infant and child mortality in Madhya Pradesh remains high. With 1 in every 12 children born during the five years before NFHS- 2 dying within the first year of life, and 1 in every 7 children dying before reaching age five, it is clear that child survival programmes in Madhya Pradesh require intensification.

The infant and under- five mortality rates are much higher in rural areas compared with urban areas. It is also significant in Vindhya. In case of educated mothers, the infant and under-five mortality rates are lower compared with illiterate mothers. Hindu children have higher infant and under-five mortality rates as against Muslim children. Scheduled tribe children have the highest under-five mortality rate among all social groups. Low-income status families have higher infant and under-five mortality rates. Remoteness of habitations further complicates the situation. It is the poor who suffer the most by private service failures. Child survival programmes might usefully focus on specific groups of children with particularly high infant and child mortality rates, such children belong to the scheduled tribes, whose mothers are illiterate, children living in rural areas, and children from households with a low to medium standard of living.

Reduce Child Malnutrition by Two-thirds during 1990-2015

Nutrition of the child is important for his/her survival, and for this mother's health also has to be good.

Although breastfeeding is universal in Madhya Pradesh, most children do not begin breastfeeding immediately after birth (9.9% in the first hour after birth and 29.3% do so within one day of birth).

As per NFHS- 2 in 1998-99, 54 percent of children under age three years in Madhya Pradesh are underweight (too thin for age), 49 percent are stunted (too short for age), 20 percent are wasted (too thin for height). In the year 2005-2006 (NFHS-3), the corresponding percentages are 60, 40 and 33 percent are underweight, stunted and wasted respectively. This shows some improvement in nutritional level in 2005-2006 over 1998-99.

The most important indicator influencing child's nutrition status is mother's body mass index. In Madhya Pradesh, female children are much more likely to be under nourished than male children according to all three measures. Children of under nourished mothers and children born less than two years after a previous birth are also more likely than other children to be under nourished according to most indicators. Also children from families with low standard of living, belonging to scheduled castes or tribes and having illiterate mothers are more likely to be under nourished.

71.3 percent children aged 6-35 months were anaemic in 1998-99 and this proportion deteriorated to 82.6 percent in 2005-2006. Female children are more likely to be anaemic. The anaemic tendencies are more among rural children, and proportion is also high.

Illiterate mothers are more likely to have anaemic children compared to more educated mothers. The tendency to being anaemic child reduces with improvement in household standard of living. Children of anaemic mothers are more likely to be anaemic themselves than are other children.

Immunisation of children is an important component of child survival programmes in India. The focus is on six serious but preventable diseases viz., tuberculosis, diphtheria, pertussis, tetanus, polio, and measles. In Madhya Pradesh, 23 percent of children aged 12-23 months are fully vaccinated as per NFHS-2 and this proportion improved to 40 percent in 2005-2006 (NFHS-3). The improvement in full vaccination in rural is from 17 percent to 32 percent during the same period while the improvement in urban areas is from 41 to 69 percent. This status is result of very limited reach of the measles vaccine and the third dose of the DPT vaccine. Only 34.1 percent of children aged 12-23 months received measles vaccine in 1998-99 and in 2005-2006 the percentage was 61.4 percent, a much-improved situation. Another 35.8 percent children aged 12-23 received DPT vaccinations in 1998-99 and the proportion went up to 49.8 percent in 2005-2006. The effect of Pulse Polio Immunisation Campaign is quite visible. In 1998-99, only 56.6 percent children aged 12-23 had got three doses of polio vaccine, but in 2005-2006 the percentage went up to 75.6 percent. This is far from what is targeted. However, urban coverage is better compared to rural coverage. Thus, stress is required for greater rural coverage in a mission mode.

Child under five years should receive oral doses of Vitamin A every six months starting at the age of nine months. In Madhya Pradesh, only 16.1 percent of children aged 12-35 months have received any Vitamin A supplement in 2005-06 in the six months preceding the survey. In 2005-2006, only 14.6 percent rural children received a dose of vitamin A in the six months preceding the survey and urban areas performed better than rural areas with 21.0 percent children receiving the dose of vitamin A.

On childhood diseases, in 1998-99, 29 percent of children under age three were ill with fever during two weeks preceding the survey and 58 percent children who were ill with Acute Respiratory Infection (ARI) were taken to a health facility. This proportion was 68.7 percent in 2005-2006. It could mean that health facility availability has improved over the period or more children were affected by ARI. In 1998-99, 60.1 percent of children who were taken ill with diarrhoea were taken to a health facility and this percentage was 60.1 in 2005-2006. Rural areas still suffer from lack of facilities as the numbers show.

In Madhya Pradesh, since 2000 measles cases have gone down but are not out. Diarrhoea cases have increased over the years.

Goal 5: Improve Maternal Health

This goal calls for reducing maternal mortality ratio by three-quarters between 1990- 2015 and the suggested indicators are maternal mortality ratio and proportion of births attended by skilled health personnel.

NFHS-2 shows that mothers in Madhya Pradesh received antenatal check-ups for only 61 percent births during the three years preceding the survey (1998-99), up slightly from 55 percent in 1992-93 (NFHS-1). Mothers received antenatal check-ups from doctors for 37 percent births, from other health professionals (ANM/ nurses/midwives/ LHV's and others) for 14 percent births, and check-ups exclusively at home from a health worker for 10 percent of births. The likelihood that mothers received antenatal check-ups does not vary much by age but does go down steadily with birth-order. By caste/ tribe, the likelihood of having received any antenatal check-up, as well as the likelihood of having received an antenatal check-up from a doctor, are lowest for births to scheduled tribe mothers and the highest for births to mothers who do not belong to a scheduled caste, scheduled tribe or an other backward class. The economic status of household is an important determinant it appears.

Rural women use antenatal services less than urban women may be because they are engaged in low paid jobs and taking leave affects their income. The economic status of the household also

determines utilisation of ANC services. It is invariably illiterate poor young women who do not register for antenatal care and also had three or more children. Among births to mothers living in households with a low standard of living, 49 percent received antenatal check-ups and 27 percent received antenatal check-ups from doctors. By comparison, among births to mothers living in households with a high standard of living, 88 percent received antenatal check-ups and 66 percent received check-ups from doctors.

Education of the mother is an important social variable that has positive bearing on utilisation of maternal and child services. The proportion of pregnant mothers receiving an antenatal check-up increases sharply with mother's education and that too from a doctor. For instance, 26 percent of births to illiterate mothers received antenatal check-ups from a doctor compared to 83 percent births to mothers who have at least completed high school. Conversely, the percentage of births for which mothers received home visits only from a health worker declines with mother's education from 11 percent for births to illiterate mothers to 2 percent for births to mothers who have completed at least high school. Muslim mothers received an antenatal check-up for 83 percent of births compared to Hindu mothers who received an antenatal check-up for 59 percent of births. In brief, women in Madhya Pradesh did not receive an antenatal check-up for almost two out of every five births in the three years preceding the survey (1998-99). Women not receiving antenatal check-ups tend disproportionately to be women of high parity, women from scheduled tribes, illiterate women, women from the Vindhya region and poor women. Evidence also exists that women undergoing second or third delivery utilised antenatal care the least. Awareness regarding antenatal care and the need for trained birth assistance is greater among women with educated spouses. Access to health care facilities in terms of distance and who provided health care also influence utilisation of services. This suggests improving the coverage of antenatal programmes requires special efforts to reach high-parity women and women who are socio-economically disadvantaged and also young.

As per the SRS report 2004, 14.7 percent of live births received medical attention at time of delivery in government hospitals and the proportion was 50.5 percent in urban areas compared to mere 6.9 percent in rural areas. Another 6.9 percent live births received medical attention in private hospitals at time of delivery with urban proportion being 14.0 percent and rural only 5.3 percent. 27.8 percent mothers at the time of delivery were provided medical attention by qualified professionals and the percentage in urban areas was 15.6 percent and 30.4 percent in

rural areas. The concern is that untrained functionaries handle still 50.6 percent mothers at the time of delivery of live births. The rural proportion is higher at 57.3 percent compared with much lower proportion of 19.9 percent in urban areas. This data says that there is no excuse for not having a government hospital service and trained professionals in rural areas.

Reduction of maternal mortality is an important MDG.

In Madhya Pradesh, NFHS-2 (1998-99) shows that 58 percent of births received two doses of TT injections, while 55 percent received IFA tablets/syrup.

The utilisation of ANC services for the last birth in Madhya Pradesh is 61 percent and this relatively inadequate utilisation is attributed to inadequate outreach services. 38.5 percent women did not receive prenatal care from anyone and 10 percent did receive it at home from health workers while another 37 percent received it from a doctor. Those who did not receive antenatal check-ups at home or at health facility did not consider it necessary are 56 percent.

Costs account for 16 percent of cases and distance and lack of transport account for 6 percent of cases that did not avail the antenatal check-ups while 10 percent cited reasons as customary or family did not allow.

The results also reveal that urban women are more likely than rural women to say that antenatal check-ups were not necessary or customary, and rural women were more likely than urban women to cite costs, transport, or distance as reasons. These results reinforce the fact those women and their families' needs to be informed about the benefits of ANC services. As about one-fourth of the reasons reported deal with problems of accessibility, quality, and cost of services, utilisation of antenatal care services could also be increased by lowering direct and indirect costs, improving quality and making services more accessible.

World wide more than 50 million women suffer from serious pregnancy related illness and disability. Every year more than 0.5 million women die from complications of pregnancy and child birth. What makes maternal mortality such a compelling problem is that it strikes young women experiencing a natural function of life. They die because they are poor, malnourished, or

weakened by disease, and exposed to multiple pregnancies. They die because they lack access to trained health care workers and modern medical facilities.

Only one-fourth of women in Madhya Pradesh received first antenatal check-up in the first trimester of pregnancy when the first antenatal check-up should take place at the latest during the second trimester of pregnancy. Check-ups during first trimester were much more common in urban areas (46%) than in rural areas (21%). So the effort should be to see that more women receive first antenatal check-ups in first trimester.

As per the NFHS-2, little more than half the women had abdominal examination, 37 percent had their blood pressure checked up, 42 percent had their blood tests and urine tests conducted while 22 percent had internal examination and 31 percent had height measurement done. The type of advice received for the last birth showed that dietary advice was given more often than other advice. 20 percent women received advice on the danger signs of pregnancy.

It is internationally recommended that at least four antenatal check-ups, one each during the third, sixth, eighth and ninth months of pregnancy are must. In India, RCH programme recommends that a pregnant woman should have at least three ANC check-ups. Also two tetanus toxoid injections and a full course of iron and folic acid supplementation for each pregnant woman is the goal of RCH programme.

Place of residence is an important indicator of accessibility as health institutions/ facilities are located more in urban areas than rural areas. Cultural taboos in rural areas coupled with lack of knowledge among pregnant mothers are also the reasons for low utilisation of ANC. In Madhya Pradesh, urban women have more ANC check-ups compared to their rural counterparts. More women belonging to other caste have gone for more number of ANC check-ups than their scheduled castes and tribes counterparts.

Women from lower economic strata went for less than three ANC check-ups compared with women from higher economic strata. ANC check-ups are more among younger women *vis-a-vis* older women.

In Madhya Pradesh, non-working women are more likely to go for ANC check-ups than working- women. Also literate women go in for more ANC check-ups than the illiterate women and so is the case with exposed to media.

Education of the spouse is also important as in Madhya Pradesh, women with more educated husbands are more likely to have more number of ANC check-ups compared to illiterate husbands. This is also natural as educated husband must be engaged in better job, so higher income and so could afford visits to a medical institution. This situation also happens with nucleation of family structure more, where the role of the spouse in decision-making for pre-natal care becomes important. The birth order is negatively associated with the number of antenatal check-ups. Women with lower birth order seem to go for three or more ANC check-ups than women with higher order of birth. This could be because of perceived complication at birth being more at lower birth order compared with higher birth order.

NFHS-2 reported that only 9.2 percent women reported spacing as unmet need for family planning and this percentage was 5.5 percent in NFHS-3. The corresponding percentages for unmet need for limiting family were 7.9 and 6.3 percent respectively. There is still need for strengthening outreach services to reduce fertility which 3.12 in 2005-2006, though slightly lower from 3.43 in 1998-99. It would also help reduction in mortality of mother and children.

NFHS-2 reports that in Madhya Pradesh, 22 percent births took place in health facilities, a figure much lower than the national level (34%). This percentage rose to 29.7 percent in 2005-06. Also, more deliveries take place in the care of health professionals in urban areas (59.9%) in comparison with rural areas (20%) as per the NFHS-3. As per the NFHS-2, utilisation of hospitals or health professionals is greater among women from other caste (38.4% from other caste and 16.1% from SC and 7.3% from ST).

51.3 percent women from higher economic strata utilised hospital services or assistance of health professional during delivery than 10.1 percent women from lower economic strata. 17.9 percent women in Madhya Pradesh utilised health care facilities for delivery were aged 20 or less while only 21.3 percent did so in the age group of 20-34.

More literate women utilised delivery care (71%) compared to illiterate women (11.8%). Women whose spouses have high school and above education are more likely to have utilised more delivery care facilities compared those with spouses with up to middle level education and illiterate spouses.

Relatively more not-working- women would utilise delivery care compared to working- women. This appears to be because of younger women delivering in hospitals etc. as noticed above. It is also the case with women exposed to media using delivery care services and lower birth order (below 3). Women with 3 or more ANC check-ups used more delivery care (53%) *vis-à-vis* women with less than 3 ANC check-ups (23%).

The latest survey, for the year 2005-2006 (NFHS-3), reports that 29.7 percent ever-married women had delivery in a hospital or other institution. The urban areas outscore rural areas in this regard (significant proportion in urban areas-59.9% and only 20.2% in rural areas). It is further observed that in 37.1 percent delivery cases, a doctor/ nurse/ LHV/ ANM/ other health personnel assisted. This proportion was 28.9 percent in 1998-99.

There are wide rural-urban differences (66.4% urban against 28.0% rural) pointing to the fact that rural health infrastructure is still poor. Women with at least 3 antenatal care visits for their last birth constituted 40.2 percent as per the NFHS-3 and it is a significant improvement over 1998-99.

58.4 percent women in urban areas had at least 3 antenatal care visits for their last birth compared to 34.6 percent rural women. IFA consumption is still low as only 11.8 percent women reportedly consumed IFA for 90 days or more when they were pregnant with their last child. In urban areas, women fare better than their rural counterparts. Women who received postnatal care from a doctor/ nurse/ LHV/ ANM/ other health personnel within 2 days of delivery for their last birth constituted only 27.9 percent with 53.4 percent urban women and only 20.1 percent rural women.

It is noticed that hospital care is still a distant dream for a rural women and even in urban areas not all women avail the facilities available. Rural-urban disparities are very wide in Madhya Pradesh.

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

This goal calls for halting by 2015 and begun to reverse the spread of HIV/ AIDS. The suggested indicator are HIV prevalence among pregnant women aged 15-24 years, condom use rate of the contraceptive prevalence rate (condom use at last high risk sex; percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS; and contraception prevalence rate) and ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years.

It is surprising that in India proper data on persons affected by HIV/AIDS are not available.

National Family Health Surveys do provide information on awareness. As per the NFHS- 2 for the year 1998-99, only 23.7 percent ever-married adults women aged 15-49 ever had heard of AIDS and this percentage went up to 45.3 in 2005-2006 (NFHS- 3). The rural urban proportions are 35.0 and 74.1 percent respectively in 2005-06.

Thus, awareness building among women had improved significantly, but still especially in rural areas lot needs to be done. As regards, ever-married adult men aged 15-49 years, the NFHS- 3 reports that 68.3 percent of them have heard about AIDS and this proportion is 94.8 percent in urban areas compared to 58.8 percent in rural areas.

Many studies have made direct links between the consumption and trade in wild animals and various diseases like HIV/AIDS (MDG 6). The most recent debate focuses on the transmission of avian influenza between wild species and humans. It also argued that loss in bio-diversity impinges on potential cures of AIDS.

The aspect of bio-diversity that has link with HIV/AIDS, involves search for medicines from natural sources to treat the disease. The story of the potential anti-HIV drug Calanolide provides a tragic reminder of what we risk losing with species loss. Chemists from the US National Cancer Institute identified a novel agent (Calanolide A) from the leaves and twigs of a tree Calophyllum langiurum found in Sarawak that the original tree was gone and that other C. langiurum trees could not be found. It was not clear whether the species was extinct. A close relative C. teymannii was identified and was found to contain a weaker drug, called Calanolide B, which, while having anti-HIV activity and the same mechanism of action, nevertheless was not as potent as Calanolide A. Calanolide B is currently in clinical trials, the result of a successful venture between MediChem Research and the Government of Sarawak (Brodnig, 2006).

The goal 6 also calls for halting by 2015 and begun to reverse incidence of malaria and other major diseases. The suggested indicators are prevalence and death rates associated with malaria, proportion of population in malaria-risk areas using effective malaria prevention and treatment measures, prevalence and death rates associated with tuberculosis, and proportion of tuberculosis cases detected and cured under DOTS (internationally recommended TB control strategy).

The malaria cases in the state have fluctuated over the years, though the deaths due to malaria have reduced from 81 in 2000 to 36 in 2004 and none reported in 2005.

Goal 7: Ensure Environmental Sustainability

This goal calls for reversing the loss of environment resources. To look at this one is expected to use indicators like proportion of land area covered by forest, ratio of area protected to maintain biological diversity to surface area, energy use (kg oil equivalent) per \$1 GDP (PPP), carbon dioxide emissions per capita and consumption of ozone and proportion of population using solid fuels.

In 2005-06, Madhya Pradesh had a forest cover of 94689.38 sq.km. Of this 61886.49 sq.km (65.35%) are reserved forest, 31098.04 sq.km (32.84%) of protected forest and the remaining unclassified forest area (1.8%). Some districts of Madhya Pradesh have always been rich in forest produce. The rural population being largely tribal, dependence on forests is significant.

Forests are revered and also depicted by songs. There are hardly any organisations of tribals to protect the forests. The traders exploit the tribal population.

Goal 7 also requires halving by 2015 the proportion of people without sustainable access to safe drinking water and sanitation. For this purpose, the suggested indicators are proportion of population with sustainable access to an improved water source, urban and rural, and proportion of population with access to improved sanitation, urban and rural.

In 2001, Madhya Pradesh had 10919653 households with drinking water source and 24.57 percent had drinking water source within the premises while another 51.17 percent had a source near the premises and the remaining 24.26 percent had a source that was away from the living space. In rural areas, of the 8124795 such households, only 14.03 percent had drinking water source within the premises while 58.64 percent had a source near the premises and the remaining 27.33 percent had a source that was away from the living space. In urban areas, of the 2794858 such households, 55.24 percent had drinking water source within the premises while 29.44 percent had a source near the premises and the remaining 15.32 percent had a source that was away from the living space.

What is the source of water supply? Madhya Pradesh, in 2001, had only 25.31 percent households had tapped water supply and this percentage was only 10.62 percent in rural areas compared to 67.91 percent in urban areas. Nearly 39 percent households in Madhya Pradesh depend on hand pumps for water supply and this percentage is 48 percent in rural areas and 13.5 percent households in urban areas. Wells are still in currency in Madhya Pradesh as 29 percent of households depend on wells for drinking water supply. This proportion is 35.66 percent in rural areas and only 9.91 percent in urban areas. Just 2.58 percent households still rely on tanks, ponds, lakes, river, canal, spring and other sources with 2.94 percent such households in rural areas compared to only 1.54 percent urban households. This reveals that rural areas still has a long way to go get potable drinking water in Madhya Pradesh.

Intensifying a drive for better hygiene at rural levels, the Madhya Pradesh government has started to act on its threats against panchayat leaders who fail to do away with the unhealthy system of dry toilets. The state assembly had amended the Madhya Pradesh Panchayati Raj and Gram Swaraj Act, 1993, to stipulate that panchayat - village council - representatives must build toilets with a flush in their homes within a year of being elected. The axe fell upon Mangobai, president of the Chandankheda panchayat, who was removed from her post for failing to construct a toilet at her home, disqualifying her to remain in office as per the provisions of the act. So far, only 76114 of the state's 324,167 panchayat representatives have built toilets at their homes. The remaining defaulters were slapped show-cause notices with most having no excuse except that of ignorance. The act aims to promote sanitation and discourage the practice of women going to answer nature's call out in the open. Statistics reveal that close to 30 million people in rural areas in India suffer from sanitation-related diseases. About 0.4 to 0.5 million children die of diarrhoea alone each year, with most deaths taking place in villages. Annual expenses incurred on sanitation-related diseases are reportedly to the tune of Rs.12 billion.

The 2005-2006 National Family Health Survey (NFHS-3), reports that 71.4 percent of households have electricity- 95.1 percent urban and 62.1 percent rural. A very low percentage of households in Madhya Pradesh have piped drinking water (25.0%) and this proportion is 68.1 percent in urban areas and only 8.1 percent in rural areas. Toilet facilities are also meagre as only 27.0 percent households have access to a toilet facility and this proportion is 71.2 percent in urban areas and only 9.6 percent in rural Madhya Pradesh. Except for provisioning of electricity, in all other indicators Madhya Pradesh is far behind the national averages. This shows that Madhya Pradesh has still long way to make these basic facilities available to its population.

Slum population

Goal 7 also requires by 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

Madhya Pradesh in 2001 had slum population of 24.17 lakh in 43 towns with 95.60 lakh population. There was 1.60 crore urban population in Madhya Pradesh. This means that slum population constituted 25.2 percent of population of cities reporting slums and 15.1 percent of all urban population. It is quite surprising that literacy rate of slum population in 2001 was 74.9

percent when male literacy rate was 83.9 percent and female literate rate of 64.9 percent. The gender difference recorded was 19.0 percent. At the national level, 640 town/ cities had 4.26 crore slum population that constituted 15.0 percent of urban population and 23.1 percent of population of cities reporting slum population. The data shows that scheduled tribes constituted only 7.9 percent of slum population in Madhya Pradesh and merely 2.4 percent at the all India level. However, 21.1 percent slum population is scheduled caste in Madhya Pradesh and 17.4 percent at the all India level. The literacy rates at all India level are lower at aggregate level and for males compared to Madhya Pradesh, but higher for female literacy. The gender differential is also lower at the all India level at 16.4 percent. In 2001, Madhya Pradesh had slum population of 1.9 percent of the total population. At the all India level, total slum population is 4 percent. The sex ratio among the slum population in 2001 was higher at 948 compared to non-slum sex ratio of 935. The male literacy rate among the slum population was 85.5 percent while the female literacy rate was 63.4 percent.

There are cities/towns in Madhya Pradesh like Burhanpur that have 100 percent population living in slums followed by 79.9 percent in Morena and 79.4 percent in Jaora. The least slum population is in Singrauli- 1.7 percent. There are eight towns of the 12 towns in Madhya Pradesh that have higher proportion of slum population compared to the state slum population. These data indicate severe problem that Madhya Pradesh has to tackle in coming years to improve the lot of slum dwellers. The problem of housing, water and sanitation are prime problems that would require serious interventions when there is high slum population that is almost three-fourth of a population.

National Sample Survey results on December 2003 report that 68.9 percent slums in Madhya Pradesh were notified slums while another 31.1 percent were non-notified slums. In Madhya Pradesh, only 1 percent of the notified slums were on private land and 99 percent on public land. The corresponding estimates for the non-notified slums are 8 and 92 percent respectively. Railways and local bodies mainly own the public land. All slums are residential in nature and the surrounding area is mainly residential. Slums have three types of structures of housing viz., kacha, pucca and semi-pucca. 23 percent of the notified and 6 percent of non-notified slums had a pucca house, with 76 percent of all houses in notified slums being semi-pucca and this

proportion was 92 percent in non-notified slums. There were 3 percent slums with kucha houses in non-notified slums.

Supply of safe drinking water to all has been one of the commitments in several five- year plans. In 2002, 68 percent notified slums had tap water while 20 percent has tube-well water and 12 percent relied on wells. In case of non-notified slums, 75 percent had access to tap water compared to 25 percent access to tube-well water. Electricity connection in the slums may be of different type viz., for the household use, streetlight, or both. 89 percent households in notified slums had electricity for household use and street and 1 percent had electricity for households only and 10 percent slums that electricity for streetlights only. Streetlight is usually available only on some locations inside or at the boundary of the slums. In case of non-notified slums, 34 percent had electricity for households use and streetlight and 21 percent for household use only,

Data on nature of roads/ lanes/ paths within the slums reveal that 28 percent of notified slums had pucca road within the slum and this proportion was 14 percent for non-notified slums. As regard the pucca approach road to slum, 54 percent notified slum had this facility (motorable), but 65 percent non-notified slums had motorable pucca approach road to the slum. However, 14 percent notified slums had non-motorable pucca approach road to the slum. Further, 34 percent of notified slums are affected by water logging during monsoon compared to only 44 percent non-notified slums. Also 12 percent notified slums had no access to latrine and 75 percent of the non-notified slums had no access to latrine. This means that 16 percent notified slums had access to septic tank or flush latrine compared to 25 percent notified slums. This would also mean that all notified slums had open type drainage while the proportion was 59 percent in case of non-notified slums compared to 54 percent notified slums. The underground drainage was available in 15 percent of notified and just 2 percent non-notified slums. Besides, 24 percent were lucky to have underground sewerage in notified slums and none of the non-notified slums. What is the situation regarding the garbage collection? It is reported that in 2002, 59 percent notified slums were fortunate that government agencies collected garbage once at least in 7 days and this proportion was 37 percent in non-notified slums.

In case of notified slums, 98 percent had a primary school within 1 km with 2 percent having such facility at more than 1 km. However, 94 percent non-notified slums had a primary school within 1 km. In case of notified slums, 74 percent had a government hospital within 1 km with 26 percent having such facility at more than 1 km. However, all but 2 percent non-notified slums had a government hospital at more than a 1 km.

On improvement of facilities, if any, during last 5 years in these slums, 25 percent notified slums reported had a road within the slum (none in case of non-notified slum), 36 percent had improved water supply, 13 percent improved electricity, streetlight and drainage, 15 percent improvement in latrines, 10 percent in sewerage and 34 percent in garbage disposal. The improvement was little poor in all the facilities in case of non-notified slums. There was improvement only in approach road to slum (31% slums), water supply (5%), electricity (8%), streetlight (27%), latrine (82%), drainage (48%) and garbage disposal only 3 percent. Whatever improvement took place in facilities was due to government. However, NGOs have played a role in drainage and garbage disposal improvement. Residents themselves have played a major role in latrine condition/access improvement. There was no notified slum reporting deterioration of facilities during last 5 years, though 10 percent observed deterioration in pucca road, 16 percent in drainage, 11 percent in sewerage and 10 garbage disposal. However, 4 percent non-notified slums reported deterioration in water supply. This does imply that government did not take care of facilities in the non-notified slums and there was no private intervention too.

The problem of slums further gets complex as most have high density. For instance, 53 percent slums are located on an area of below 2 hectares.

Future Direction

Madhya Pradesh has to go a long way to achieve MDGs. It is despite the fact that Madhya Pradesh is a smaller state and governance should have been better, but the performance has been slow.

Poverty in Madhya Pradesh is still huge especially the urban poverty. The decline in poverty is slow. Urban poverty is also the fall out of rural poverty as very and poor move to urban slums to eke out livelihood. The present situation does not reflect that poverty goals can be fulfilled by 2015. Efforts are required to enhance livelihood avenues in rural areas. Non-farm sector development and industrialisation needs to be given adequate attention. Piece-meal approach cannot help to alleviate poverty. The per capita income is still low compared to the national level and with declining share of agriculture in state income and 80 percent population dependent on agriculture and allied activities, rural situation would worsen if concerted efforts are not made. Then there are regional and social group variations in income and asset possession. Enhanced investment in agriculture is also required to raise productivity of agriculture. If incomes are low, then consumption pattern is also affected. The household food security then is at a risk. MPCE levels in both rural and urban areas are low because of low incomes of large number of people.

On the education front, efforts are required to make investments for schools so as to increase access to education system, provisioning of facilities in the school, proper implementation of various schemes like mid-day-meal in schools to give boost to nutritional status of children and improve attendance in schools. Regular medical check-ups are also to be built into the system. To improve quality of school education, curriculum development requires attention, early childhood education requires attention, and improvement in surroundings of the schools is must. It is also must that teachers attend schools to impart education and teacher training has to be redesigned or introduced. If teachers do not go to school then no amount of investment in school infrastructure can ensure complete enrolment of children in schools. It is also important to retain children in schools, especially girls. Drop out rate has to be reduced.

Hospital number has to increase in rural areas especially providing greater access to vulnerable people. Also qualified doctors and staff manning these facilities have to be increased. The

present health policy does not ensure. More women hospitals are required in rural areas. Equipment is also necessary. A greater regulatory system is required to be put in place to control female infanticide and then to raise the sex ratio. Declining sex ratio need to be corrected. More attention is required to provide care to pregnant women. Antenatal check-ups required to be undertaken religiously.

To improve nutrition status of women and girl child, food security at household level has to be improved and sustained. Market can destroy the access to poor of basic nutrition requirements by excluding from the system. Privatisation in the country has led to rising prices and many commodities are out of reach of poor in Madhya Pradesh.

User fee charges also exclude poor from hospital services. Private hospitals have become costly and out of reach of most poor. There should be no fee from poor for use of hospitals. Drug policy also has to tune itself to achieve the MDGs. Most medicines are also becoming out of reach of poor. Polio control programme has to be more rigorous and Madhya Pradesh has not been able to cover all eligible children.

In order to improve access to healthy delivery services, incomes of the poor has to improve and livelihood of poor in rural areas to be ensured. Forest produce usage should be in favour of tribals and locals as they can manage minor produce to generate income. Exclusion of people from forest would not help them. Employment guarantee scheme has to be implemented more properly. Labour market information has to be improved and migration controlled.

Financing is a major problem. Funds need to be properly utilised for social sector. There has to be short-term, medium-term and long-term plans for financing health related projects. Finances have to be mobilised from both public and private sources. The inter- linkages of various sectors and linkage of economy with outside are important. Trade can work both ways, but efforts should be to use it effectively for betterment of poor. Tax structure requires a re-look to mobilise more resources for investment in social sector.

Institutions delivering services are weak and they need to be strengthened and new one created to have greater efficiency. Costing of specific intervention also require attention as it would depend up on institutions and policy environment. Selecting the best delivery system/ mechanism will reduce costs. Most MDGs cost estimates use a one-size fit all approach, based on linear relationships, which may not be true always. The cost of expanding the coverage of a service in health and education by an extra ten percentage points, for instance would depend on whether the country's coverage moves from 50 to 60 percent or from 90 to 100 percent. Privatisation is no solution. Local community should run local health centres. State should create the infrastructure with people's partnership and leave its management to the people.

HIV/AIDS has not received the attention due to it. We have still put it under the carpet and prevention measures are half hearted. The use of condom is not universal as shown by NFHS surveys. The major reason is the cost of a condom and familiarity with its use. Women must be educated to use it and force their spouses use them. If we can reduce price of condom and make it accessible, then we can inch towards achieving the goals. Exclusion of HIV patients should be stopped. Awareness building is required more in villages where knowledge is still limited. Here the use of ANM and other para-medical staff and civil society organisation should be made.

The area under forests has to increase by efforts of the forest department and also by making joint forest management scheme more effective. Each village should have a green belt and it should be made mandatory under the PRI system. Water conservation requires added efforts. Agriculture practices also may require a change, but it has to be carefully followed and marginal and small farmers to be protected.

Serious efforts are, thus, required in Madhya Pradesh to achieve all the MDGs by 2015. Government, civil society organisation and community itself have to pitch-in in this effort.