The Halfway Mark & State of Realization of MDGs in Orissa

Katha Rakhibaa Sarakar Campaign

'Let Us Keep Promises' Campaign

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FOREWORD

It is now the exact halfway mark on the long, arduous and tortuous road to the achievement of what have come to be known as the Millennium Development Goals (MDGs). Seven years ago, 189 nations gathered at the UN Millennium Summit in 2000, and pledged to work towards the attainment of eight goals covering almost the entire spectrum of burning global issues from eradication of poverty to reining in HIV/AIDS. In doing so, they were not exactly setting any new goals, but only setting a new time frame to achieve a set of goals that had already been in the global agenda for quite some time.

Awareness about the MDGs came rather late in the day in Orissa. Though the first tentative steps were taken in 2005, a formal, organized and structured campaign took shape only in September 2006. Five organizations – Regional Centre for Development Cooperation (RCDC), Centre for Youth and Social Development (CYSD), Ekta Parishad (Orissa), Institute for Social Studies (ISS) and Concern Worldwide joined hands to form a platform and named it '*Katha Rakhibaa Sarakar'* (KRS) Campaign ('Let Us Keep Promises' Campaign). The name was chosen after prolonged deliberations. There were suggestions that it could be named '*Katha Rakha Sarakar' Campaign* ('Govt! Fulfil Your Promises' Campaign). But in the end, the views of the overwhelming majority of the founding members prevailed and it was named 'Katha Rakhibaa Sarakar' Campaign, so as not to give the impression that the onus for the onerous task of achieving the MDGs was entirely on the government. They were of the firm view that civil society has to shoulder as much – if not more – of the responsibility as the government in the race against time to achieve the MDGs. Accordingly, the objective of the campaign is outlined as 'creating an enabling environment for the realization and effective implementation of the MDGs and other related commitments made by the Government'.

It is stocktaking time the world over now. And rightly so. The Halfway Mark – that has come to be known as 'Seven Seven Seven' (07/07/07 or 7th July, 2007) – is certainly the right time to do a mid-term appraisal, assess the progress made so far, identify the shortcomings if any and to revise the agenda, if needed, so as to achieve the eight goals by the deadline set: 2005. As a small part of the global campaign for achievement of the MDGs, we at KRS also decided to do a mid-term review and chart a course of action for the remaining years of the campaign. As set out in the objective itself, we have taken into account the promises spelt out in the National Development Goals outlined in the last Five year Plan, the National Common Minimum Programme (NCMP) of the UPA government at the Centre and 'Sankalpa 2004", the election manifesto of the ruling BD-BJP government in Orissa issued at the time of the last election in the state and attempted to assess the extent to which the promises held out in each one of them has or has not been fulfilled. The purpose of the exercise is not to find fault with the government, either at the Centre or in the state, but to work in close coordination with it to plug the loopholes and fill the potholes to ensure that the rest of the road (2007-2015) makes for a smoother, easier and speedier journey. In this, we expect not just the involvement but the full and active participation of civil society organizations and individuals.

This volume has been a labour of love for us. It is a matter of great honour and satisfaction that we have managed to rope in some of the best-known names in the state as contributors to this document. Our sincere and heart-felt thanks to each one of them. We would also like to place on record our deep gratitude to all members of the KRS Campaign Core Group Members, who have worked tirelessly for the compilation of this volume and the organisation of the event today, Mr. Sandeep Sahu, who edited the articles and Mr. Ramakrishna Maharana of the RCDC Centre for Water for Life (CWL), who did the lay-out and design. We also extend our sincere thanks to the KRS Campaign Secretariat for the overall coordination towards coming out finally with such a document.

We shall consider it a job well done if this document, containing some highly informative and thought-provoking articles, inspires civil society groups and individuals in the state to join the campaign and lend a helping hand in the realization of the MDGs. On this day, let us rededicate ourselves to the task the world set itself seven years ago.

Tapan K. Padhi
KRS Campaign Coordinator

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CONTENTS

DIMENSIONS OF POVERTY IN ORISSA DURING REFORM PERIOD

By **Prof. Baidyanath Misra**

Orissa Economic Survey 2006-07 shows the incidence of poverty in Orissa since 1973-74 to 1999-00. According to the Survey, though the incidence of poverty in Orissa shows a declining trend since 1983-84, it is still the highest among all the states. As per BPL Survey 1999-00, the incidence of poverty in Orissa was 47.15 %: 48.01 percent in rural areas and 42.83 percent in urban areas. Table-1 shows not only the declining trend of poverty ratio in Orissa, since 1977-78 to 1999-00, but also the trend of the poverty ratio among the major states in India. While the all-India poverty ratio in the year 1999-00 was 26.10 %, it was the lowest in Punjab at 6.16%. Bihar, which figured just above Orissa in the list, had a poverty ratio of 42.60%. All these figures show the percentage of people below poverty line, which has been defined by the Planning Commission on the basis of consumption intake. The table further shows that the percentage of people below the poverty line in Orissa has come down from 70.07$ in 1983-84, 55.58 in 1987-88, 48.56% in 1993-94 and 47.15% in 1999-2000. The most noteworthy feature of the figures is that the decline in the incidence of poverty during the reform period has been negligible. In the period 1993-94 to 1999-00, it had reduced only marginally from from 48.56% to 47.15 %. No further data are available in the Economic Survey regarding the change of poverty incidence in Orissa beyond 1999-00. The Panchayati Raj Department has prepared a district-wise information sheet on BPL Census for the year 1997. The Survey Report (Table-2) shows that districts like Koraput, Malkangiri and Boudh have more than 80 percent BPL families. Koraput has the highest percentage of BPL families. The only district, which has less than 50 percent, is Jharsuguda. This shows that there is great gap in the poverty ratio among districts. The Panchayati Raj Department has also released figures about BPL families for the year 1992. A comparison between 1992 and 1999 shows that except two districts - Sonepur and Deogarh - all the districts have improved their position though in a varied manner.

Published data available from the 61st round (2004-05) of the National Sample Survey give a fair idea about the poverty and inequality in all states over the period 1983-2005, along with the overall change in India as a whole. But because of the difference in methodology between the 55th round (1999-2000) of the NSS and 61st round, there has been some controversy with regard to the findings of the above two survey reports. Till the 50th round (1993-94) NSS had a Uniform Reference Period (URP) of 30 days for question on food and non-food items. But he 55th round of NSS used a Mixed Reference Period (MRP). The reference periods for 1999-2000 were changed from the uniform 30-day recall to both seven days and 30 days for food and intoxicants and only 365 day questions were asked for items of clothing, footwear, education, institutional medical expenses and durable goods. Based on non-comparable data, the official estimates show a 10-percentage point decline between 1993-94 and 1999-2000. On the other hand, individual researchers have made several adjustments to make 1999-2000 data comparable with those of earlier rounds.

The NSS 61st round data on consumer expenditure for 2004-05 provide results for a uniform reference period, which can be compared with those of 1993-94. As such, there is scope to compute comparable poverty estimates for 2004-05. The 61st round also gives MRP results for 2004-05, which are also comparable with 1999-2000 data.

Himansu in his article “Recent Trends in Poverty and Inequality: Some Preliminary Results” and S. Mahendra Dev and C. Ravi in their article “Poverty and Inequality. All India and States, 1983-2005 “ have made a detailed analysis of poverty and inequality during both in pre-and post-reform periods. Even though our study refers to Orissa only, we make some general observations regarding the trends of poverty and inequality in India during pre-and post-reform period. Such general observations may give us some guidelines regarding the change that has taken place in Orissa during the period. We can also make some reference to some other states for making some comparison with Orissa.

The findings of these authors on the basis of NSS data of the 61st round show the following.

1. Inspite of higher over-all growth over the period 1983-2005, the extent of decline in poverty in the post reform period (1993-2005) has not been higher than in the pre-reform period (1983-1993), more importantly, the bulk of this decline occurred in 1999-2005, with little or no reduction in poverty during 1993-2000, confirming the earlier consensus that the 1990s were indeed the lost decade for poverty reduction (Himansu). Himansu further states that although the analysis is not conclusive, the fall in the relative prices of food and regional pattern of changes in employment and wages appear to underline these trends. In fact employment elasticity during the reform period is found to be negligible. The 61st round of NSSO survey reveals a faster increase in employment during 1999-2000 to 2004-05 as compared to 1993-94 to 1999-2000 (Vide Economic Survey 2006-07 page 208)
2. It is also evident that inequality has increased significantly in the post reform period and seems to have slowed down the rate of poverty reduction (Mahendra and Ravi).
3. However changes in poverty in the two sub-periods of the post reform era, based on mixed reference period data from the NSS suggest the extent of decline in 1999-2005 seems to have been higher than in 1993-2000, which is surprising given that the latter years witnessed slower growth in agriculture. Mahendra and Ravi suggest that this needs to be further investigated.

However when we consider comparable estimates of poverty and inequality on the basis of URP, official poverty line we find that in case of India head count ratio of poverty line, poverty gap (PG) and squared poverty gap (SPG) have, both in rural and urban areas (all in percentages) have declined between 1993-1994 and 2004-2005. Tables 2 and 4 present all these aspects of poverty of 19 major states. These tables show that head count ratio has increased in Orissa in urban areas from 40.6 percent to 43.7 percent between 1993-1994 and 2004-2005 and in case of poverty gap and squared poverty gap there is increase both in rural and urban areas during the same period. The only other state where there is increase in poverty gap and squared poverty gap both in rural and urban areas is Chhatisgarh. We should not forget to mention here that Chhatisgarh is a new state and has not been able to stabilize its economy. It is unfortunate that Orissa not only partakes the characteristics of this new state, but also shows an increase in headcount ratio of poverty during the above period. When we come to Gini ratio (again in percentages) during the above period, it is higher in the latter period in most of the states (higher in 14 states in rural areas and 18 States in urban areas) along with an increase at the all-India level both in rural and urban areas. This means higher economic development has not reduced inequality, rather increased it. At the all India level it has increased from 28.6 percent to 30.5 percent in rural areas and 34.4 percent to 37.6 percent in urban areas. And in Orissa it has increased from 24.6 percent to 28.5 percent in rural areas and from 30.7 percent to 35.4 percent in urban areas.

The Planning Commission has recently released the poverty estimates for 2004-2005 based on the 61st round Consumer Expenditure Survey (CES) of the NSS. On the basis of this, the incidence poverty (as measured by the head count ratio) in all India is only 21.8 percent in 2004-2005. If this were so, then the poverty ratio in 2004-2005 when compared to the level of 36 percent in 1993-1994 shows a decline of over 14 percentage points. But if we compare, the percentage and number of poor in 2004-2005 estimated from URP consumption distribution of NSS 61st round of consumer expenditure data (which) are comparable with poverty estimates of 1993-1994, we find that the poverty ratio in 2004-2005 was 28.7 percent in rural areas and 25.9 percent in urban areas and 27.5 percent for the country as a whole. That is the decline in comparable estimates of poverty between 1993-1994 and 2004-2005 has been less than 9 percentage points. This is noteworthy because the figure 27.5 percent for 2004-2005 is higher than the poverty in 1999-2000 which was 26 percent.

If we take head count ratio on the basis of MRP, we find significant improvement in poverty reduction in many states. At all India level poverty ratio has come down from 26.62 percent in 1999-2000 to 21.52 percent in 2004-2005 (rural areas from 27.5 percent to 21.9 percent and urban areas from 24.33 percent to 20.68 percent during the same period). There has been also some change in Orissa from 47.89 percent to 40.50 percent during 1999-2000 to 2004-2005 (rural areas from 48.73 percent to 40.7 percent and urban areas from 43.06 percent to 39.5 percent during the same period). However, poverty ratio is still highest in Orissa; the next poorest state is Bihar where it has come down from 42.99 percent to 32.94 percent. Except Haryana, Rajasthan and Tamilnadu where there has been slight deterioration in poverty level, all the other major states have recorded some improvement. Surprisingly the improvement in Assam has become highest; poverty ratio has come down from 36.6 percent (1999-2000) to 14.64 percent (2004-2005)

Since NSS had a uniform reference period till the 50th round (1993-94), we have indicated head count ratio, poverty gap, squared poverty gap (intensity of poverty) and Gini Ratio (level of inequality) of Orissa in tables 3 & 4, up to 2004-2005 for which data are available on the basis 61st round of NSS study. We have seen that there has been no significant improvement in head count ratio and in case of PG, SPG and Gini Ratio; on the other hand there has been some deterioration. These findings do not give us any hope that we can make any significant change in the poverty ratio of Orissa unless there is a substantial change in the direction and content of the economy. The following general observations are made to some how approach the Millennium Development Goals by 2015.

1) Agricultural development is a crucial factor in economic and social change in Orissa. As the Economic Survey of Orissa (2006-2007) observes, development of agriculture in Orissa has lagged behind due to several constraints such as traditional methods of cultivation, inadequate capital formation and low investment, inadequate irrigation facilities and uneconomic size of holdings. Further, the domestic sector of the state's economy has become more often than not a helpless victim of natural calamities like flood, drought and cyclone. What is therefore necessary is to accelerate the process of agricultural development by increasing both production and productivity , improving cropping pattern and agricultural practices, evolving new varieties of seeds, expanding irrigation facilities, extending the supply of institutional credit and so on. All these require more investment on agriculture along with proper use of inputs. For example, if we increase the use of fertilizer in an unbalanced manner, we cannot increase the productivity of fertilizers. The implication is not only we have to increase the use of fertilizer, but maintain its proper balance for its effective use. A change in technology is also necessary. It has been observed that in many cases due to lack of adequate knowledge and research constraint, additional application of inputs such as irrigation and fertilizers has not increased total factors productivity. It is said that there is almost a technological fatigue which has not increased productivity. On the other hand it has led to erosion of resource base of agriculture. Since in the Eleventh Plan, the Planning Commission has made a number of concrete recommendations for improving agricultural growth for an 'inclusive growth', we need not elaborate these recommendations for attaining Millennium Development Goals in Orissa.

2) Another factor, which is important and often neglected, is the pressure of population on agriculture. Nearly 85 percent of its population lives in rural areas of Orissa and most of them are dependent on agriculture and allied activities for their livelihood. Inspite of such heavy dependence on agriculture and its allied sectors, they contribute hardly 40% to 42% to NSDP in different years. And what is more, according to Agricultural Census 2000-2001 conducted by the Board of Revenue, there were 40.67 lakh operational holdings in Orissa with 50.81 lakh hectares of area. Small and marginal holdings accounted for 83.8 percent with 53.12 percent of total area. Remaining 16.2 percent of holdings belonged to semi - medium, medium and large categories with 46.88 percent of total area. Average size of operational holdings, which was 1.30 hectares in 1995-1996 Census, declined to 1.25 hectares in 2000-2001 Census. Land resources remaining almost the same, the per capita availability of land in Orissa has considerably gone down from 0.39 hectares in the year 1950-1951 to 0.14 hectares in 2005-2006 due to increase in population. Heavy pressure on land has resulted in huge unemployment and underemployment in rural areas. It is therefore essential that along with increase of productivity of land, a large number of non- farm occupations should be created in rural areas to reduce the pressure on land and improve the economic status of rural people by increasing their income. Even at present the productivity of non-farm sector in rural areas is greater than that of farm sector. Such non - farm occupations will also provide scope for application of new technology. It may also be mentioned here that agriculture and industry should not be competitive but complementary to sustain rural population with grater scope for employment & livelihood.

3) It is often argued that adequate price support should be given to farmers which will place the agricultural sector on a sound and safe footing. We will rather argue that instead of higher prices of food grains, development of sustainable technology improvement of infrastructure and increase of human skill will provide better scope for agricultural development and quality of life of farmers. For the last several years there have been large increases in the minimum support prices (MSP) of rice and wheat due to the pressure of big farmers as a result of which there was a large gap between the cost of production and the MSP. One of the important impacts of this development was the regional segmentation of the market; for example, prices of food grains in the primary grain markets remained below MSP in some northern states that substantially reduced private trade from the grain markets and excessive financial cost to the FCI for procurement and storage of food grains. Reduction of private trade in wheat and rice in the northern states of Punjab and Haryana also possibly led to crowding out of private investment in agricultural marketing channels. Market prices were often lower than the MSPs and therefore, there was unabated build up of food grain stocks with the FCI. At one point of time (June 2002) the stocks at 64.7

million tonnes were almost three times the buffer requirements that resulted in extremely high carrying costs and bloated food subsidy (Economic Survey 2005-2006, page 95-96).

In spite of higher MSP, the pressure on the part of large farmers' organizations is always there for higher support price and that, with the support of many political parties. But the economic analysis shows that the supply response of higher price in Indian agriculture is much less important than the improvement in technology, infrastructure and human capital. Dharm Narain (1976) who has made pioneering work on the supply response of Indian agriculture has pointed out "an over simplistic and therefore, excessive preoccupation with price can do more harm than good by distracting attention from the harder but more important tasks which belong in the non-price world of achieving technological breakthroughs and releasing such real constraints as stand in the way of becoming a reality in the farmers' fields'. Raj Krishna (1982) who made a survey of agricultural supply response in several developing countries found that the elasticity of output with respect to major technological shifters such as irrigation was 1.5 to 5.5 times the price elasticity. He therefore, suggested to give more attention to the development of technology (which can increase productivity), infrastructure particularly in rural areas (which will facilitate the improvement of agro-based industries thus reducing pressure on agriculture) and human capital (which will enable the farmers to improve their skill for operational efficiency). There is also great need to evolve new biotechnologies to save on chemical inputs and increase productivity in irrigated and dry land areas without associated ecological harm. The new research inputs should aim to achieve agricultural revolutions in five areas to sustain and expand the gains already achieved and improve the ecological balance which will prevent degradation of land due to depletion of soil fertility and moisture. These five areas are productivity, quality, income and employment, small farm management and enlarging the food basket along with nutritional dimension (Swaminathan). All this implies that adequate funds should be provided to improve research to evolve new technologies, create favourable institutional set up which can carry such research programmes with success and design proper incentives for the absorption of new technology for the development and diffusion of adequate new technology (Rao).

In conclusion, we can say that the prospects of agriculture is bright, provided we divert some farmers from agriculture to other agro-based rural industries by improving infrastructure, strengthen the supply side factors such as irrigation, watershed development, research and extension and credit and improve the efficiency of assets created for increasing agricultural production. Agriculture is a business now. Business principles should be applied in agriculture to improve the efficiency of assets created or projected to be created so as to strengthen income opportunities of all those who have to work in agriculture to sustain their livelihood and meet the requirements of all others who are working in different fields of activities. Take the case of efficiency. We speak of business principles because many of the assets created in Orissa do not provide adequate benefit. It is estimated that water use efficiency under the existing irrigation projects in Orissa comes to less than 40 percent. As against this, in the advanced systems of the west, as much as 60-70 percent of the water diverted in large surface system is available for plant use. Similarly a number of irrigation projects started with great gusto to be completed within a period of 5 to 6 years linger on for 20 to 25 years with an escalation of cost of 10 to 12 times In the 10th Plan, a sum of roughly Rs.10, 000 crore was spent on irrigation for India, but we succeeded in bringing only half the targeted 16 million hectares under irrigation .In the last NDC Meeting the Prime Minister has announced to set apart, a sum of Rs.25, 000 crore for agricultural development. Clearly it is not only the quantum but also the quality of spending that determines outcomes. Sheer wastes of resources are numerous in Orissa and should be avoided to improve agricultural productivity in the state. As Pandit Jawaharlal Nehru, the great architect of India's development said, all other activities can wait, but not the development of agriculture'. Therefore agricultural development should be given first priority in Orissa to sustain and improve the livelihood of vast multitude of poor people living in rural areas.

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Annexure 1

TABLE – 1				
Sl. No.	State	Percentage of Population below poverty line 1990-00		
		Rural	Urban	Combined
1	Andhra Pradesh	11.1	26.6	15.8
2	Arunachal Pradesh	40.0	7.5	33.5
3	Assam	40.0	7.5	36.1
4	Bihar	44.3	32.9	42.6
5	Chhatisgarh			
6	Goa	1.4	7.5	4.4
7	Gujrat	13.2	15.6	14.1
8	Haryana	8.3	10.0	8.7
9	Himachal Pradesh	7.9	4.6	7.6
10	Jammu and Kasmir	4.0	2.0	3.5
11	Jharkhand			
12	Karnatak	17.4	25.3	20.0
13	Kerala	9.4	20.3	12.7
14	Madhya Pradesh	37.1	38.4	37.4
15	Maharastra	23.7	26.8	25.0
16	Manipur	40.0	7.5	28.5
17	Meghalaya	40.0	7.5	33.9
18	Mizoram	40.0	7.5	19.5
19	Nagaland	40.0	7.5	32.7
20	Orissa	48.0	42.8	47.2
21	Punjab	6.4	5.8	6.2
22	Rajasthan	13.7	19.9	15.3
23	Sikkim	40.0	7.5	36.6
24	Tamil Nadu	20.6	22.1	21.1
25	Tripura	40.0	7.5	34.4
26	Uttar Pradesh	31.2	30.9	31.2
27	Uttaranchal			
28	West Bengal	31.9	14.9	27.0
INDIA		**27.1**	**23.6**	**26.1**

TABLE – 2

DISTRICT-WISE INFORMATION ON BPL CENSUS

Sl. No.	Name of the District	1992 Survey			1997 Survey			Variation in%
		Total Rural Families	No. of BPL Families	% of BPL Families	Total Rural Families	No. of BPL Families	% of BPL Families	
1	ANGUL	183237	126343	68.95	203152	120581	59.36	-9.60
2	BALANGIR	238968	181195	75.82	329700	201310	61.06	-14.77
3	BALASORE	314008	264088	84.10	349446	257606	73.72	-10.38
4	BARGARH	210971	147027	69.69	291901	176241	60.38	-9.31
5	BHADRAK	199323	179130	89.87	205185	136849	66.70	-23.17
6	BOUDH	66776	54145	81.08	89617	71872	80.20	-0.89
7	CUTTACK	253293	187783	74.14	335998	176002	52.38	-21.75
8	DEBAGARH	48237	33833	70.14	55298	43571	78.79	8.65
9	DHENKANAL	163168	137670	84.37	203032	127159	62.63	-21.74
10	GAJAPATI	87454	82478	94.31	112029	68763	61.38	-32.93
11	GANJAM	452732	340435	75.20	548308	301585	55.00	-20.19
12	JAGATSINGHPUR	161946	108827	67.20	172300	90895	52.75	-14.45
13	JAJPUR	252138	179838	71.33	280769	169595	60.40	-10.92
14	JHARSUGUDA	58439	34158	58.45	68164	33415	49.02	-9.43
15	KALAHANDI	241294	206961	85.77	307835	193054	62.71	-23.06
16	KENDRAPARA	188768	116990	61.98	219436	131424	59.89	-2.08
17	KEONJHAR	211611	175533	82.95	286923	220820	76.96	-5.99
18	KHURDA	184484	142850	77.43	226800	134192	59.17	-18.26
19	KORAPUT	188169	162931	86.59	264707	221846	83.81	-2.78
20	MALKANGIRI	79865	67737	84.81	108870	89138	81.88	-2.94
21	MAYURBHANJ	363869	315084	86.59	482176	374867	77.74	-8.85
22	NABARANGPUR	151834	137504	90.56	215429	158684	73.66	-16.90
23	NAWAPARA	94039	78652	83.64	127022	99465	78.31	-5.33
24	NAYAGARH	152455	132219	86.73	183437	124576	67.91	-18.81
25	PHULBANI	113741	100802	88.62	145335	113970	78.42	-10.21
26	PURI	207887	155279	74.69	236721	163639	69.13	-5.57
27	RAYAGADA	141862	122061	86.04	188499	135785	72.03	-14.01
28	SAMBALPUR	137286	99155	72.23	150799	90141	59.78	-12.45
29	SONEPUR	91909	57250	62.29	110098	80396	73.02	10.73
30	SUNDERGARH	225696	167622	74.27	285141	185969	65.22	-9.05
Grand Total		**5465459**	**4295580**	**78.60**	**6784127**	**4493410**	**66.23**	**-12.36**

Source: Panchayat Department, Govt. of orissa

TABLE – 3

COMPARABLE ESTIMATES OF POVERTY AND INEQUALITY

(URP, Official Poverty Lines)

Rural	Headcount Ratio %				Poverty Gap %			
	1983	1987-88	1993-94	2004-05	1983	1987-88	1993-94	2004-05
Andhra Pradesh	26.8	21.0	15.9	10.8	5.86	4.35	2.9	2.0
Assam	44.6	39.4	45.2	21.7	8.75	7.45	8.3	3.5
Jharkhand	65.5	52.8	62.3	42.9	22.00	13.56	16.2	8.9
Bihar	64.7	54.2	56.6	42.2	19.54	12.74	14.2	8.3
Gujarat	28.9	28.3	22.2	19.4	5.64	5.44	4.1	3.4
Haryana	21.9	15.3	28.3	13.6	4.28	3.62	5.6	2.2
Himachal Pradesh	17.0	16.7	30.4	10.9	3.58	2.63	5.6	1.5
Karnataka	36.3	32.6	30.1	20.0	9.73	7.88	6.3	2.7
Kerala	39.6	29.3	25.4	13.2	9.98	6.30	5.6	2.8
Chhatisgarh	50.6	46.7	44.4	42.0	12.49	10.38	8.6	9.4
Madhya Pradesh	49.0	40.1	39.2	35.8	13.95	10.64	9.8	7.8
Maharastra	45.9	40.9	37.9	30.0	11.95	9.56	9.3	6.4
Orissa	68.5	58.7	49.8	46.9	22.72	16.30	12.0	12.1
Punjab	14.3	12.8	11.7	10.0	3.03	1.97	1.9	1.3
Rajasthan	35.0	33.3	26.4	19.0	9.65	8.64	5.2	2.9
Tamil Nadu	54.8	46.3	32.9	22.7	17.39	12.65	7.3	3.7
Uttaranchal	25.2	13.2	24.8	14.9	4.00	1.99	4.4	1.9
Uttar Pradesh	47.8	43.3	43.1	33.9	12.70	10.25	10.6	6.7
West Bengal	63.6	48.8	41.2	28.5	21.06	11.58	8.3	5.4
All India	46.5	39.0	37.2	28.7	12.36	9.29	8.5	5.8
Rural	**Squared Poverty Gap %**				**Gini %**			
	1983	1987-88	1993-94	2004-05	1983	1987-88	1993-94	2004-05
Andhra Pradesh	2.00	1.41	0.87	0.65	29.7	30.9	29.0	29.4
Assam	2.63	2.04	2.21	0.90	20.0	23.0	17.9	19.9
Jharkhand	9.80	5.03	5.59	2.55	27.2	26.6	23.4	22.7
Bihar	7.86	4.32	4.90	2.30	25.9	25.2	22.2	20.7
Gujarat	1.69	1.59	1.16	0.91	26.8	26.1	24.0	27.3
Haryana	1.37	1.30	1.75	0.61	28.5	29.2	31.4	34.0
Himachal Pradesh	1.16	0.71	1.62	0.35		27.1	28.4	31.1
Karnataka	3.69	2.80	2.01	0.63	30.8	29.7	27.0	26.5
Kerala	3.62	2.05	1.85	0.98	32.0	32.1	30.1	38.3
Chhatisgarh	4.47	3.36	2.47	3.43	24.4	24.5	21.7	29.8
Madhya Pradesh	5.54	3.97	3.58	2.31	31.5	30.6	30.0	26.8
Maharastra	4.30	3.21	3.35	1.99	29.1	31.2	30.7	31.2
Orissa	10.17	6.24	4.07	4.24	27.0	26.9	24.6	28.5
Punjab	1.06	0.51	0.48	0.26	29.2	29.7	28.1	29.5
Rajasthan	3.81	3.40	1.56	0.72	34.7	31.5	26.5	25.1
Tamil Nadu	7.52	4.80	2.50	0.96	36.7	33.0	31.2	32.2
Uttaranchal	1.04	0.46	1.08	0.42	29.2	28.3	24.4	28.5
Uttar Pradesh	4.70	3.40	3.64	1.93	28.9	28.5	28.3	29.0
West Bengal	9.46	3.99	2.45	1.42	30.0	25.8	25.4	27.4
All India	4.87	3.23	2.84	1.76	30.4	29.9	28.6	30.5

Source: 2004-05 estimates are calculated from grouped data from NSSO Report 508. Estimates for 1983, 1987-88 and 1993-94 are calculated from the unit level data respectively.

TABLE – 4

COMPARABLE ESTIMATES OF POVERTY AND INEQUALITY

(URP, Official Poverty Lines)

Urban	Headcount Ratio %				Poverty Gap %			
	1983	1987-88	1993-94	2004-05	1983	1987-88	1993-94	2004-05
Andhra Pradesh	41.2	41.1	38.8	27.1	10.9	10.6	9.3	6.1
Assam	25.9	11.3	7.9	3.7	5.6	1.5	0.9	0.5
Jharkhand	40.5	34.6	26.5	20.7	10.9	7.8	5.2	4.7
Bihar	61.6	63.8	40.7	38.1	18.5	16.6	9.7	9.3
Gujarat	41.9	38.5	28.3	14.2	9.7	8.2	6.2	2.5
Haryana	26.4	18.4	16.5	15.6	5.8	3.6	3.0	3.2
Himachal Pradesh	11.0	7.2	9.3	5.0	2.8	0.7	1.2	1.0
Karnataka	43.6	49.2	39.9	33.3	13.3	14.1	11.4	8.9
Kerala	48.0	38.7	24.3	20.6	14.7	10.0	5.5	4.7
Chhatisgarh	50.7	36.0	44.2	40.7	14.5	9.8	11.5	12.9
Madhya Pradesh	56.1	50.0	49.0	42.3	16.1	14.5	13.9	12.4
Maharastra	41.1	40.5	35.0	32.8	12.1	12.4	10.2	9.2
Orissa	54.0	42.6	40.6	43.7	16.7	11.1	11.4	14.1
Punjab	22.9	13.7	10.9	5.0	5.9	2.3	1.7	0.6
Rajasthan	41.2	37.9	31.0	28.5	11.5	9.6	7.0	6.2
Tamil Nadu	51.9	40.2	39.9	24.1	15.4	11.5	10.2	5.3
Uttaranchal	22.4	20.4	12.7	17.0	5.9	4.2	3.2	3.0
Uttar Pradesh	52.7	46.4	36.1	30.7	15.1	12.7	9.3	7.2
West Bengal	33.5	33.7	22.9	15.4	8.5	7.4	4.5	2.6
All India	43.6	38.7	32.6	25.9	11.4	10.2	8.0	6.2
Rural	**Squared Poverty Gap %**				**Gini %**			
	1983	1987-88	1993-94	2004-05	1983	1987-88	1993-94	2004-05
Andhra Pradesh	4.1	3.9	3.2	1.9	33.2	36.1	32.3	37.6
Assam	1.7	0.3	0.2	0.1	26.1	31.0	29.0	32.1
Jharkhand	4.2	2.6	1.6	1.5	30.9	32.1	32.5	35.5
Bihar	7.1	5.9	3.4	3.0	28.5	26.6	28.2	33.3
Gujarat	3.6	2.6	2.0	0.7	28.5	27.8	29.1	31.0
Haryana	1.9	1.1	0.9	1.0	34.8	28.7	28.4	36.5
Himachal Pradesh	1.1	0.1	0.3	0.3	35.8	29.2	46.2	32.6
Karnataka	5.5	5.7	4.4	3.1	34.2	34.0	31.9	36.8
Kerala	6.2	3.9	1.9	1.6	38.9	36.9	34.3	41.0
Chhatisgarh	5.6	3.6	4.1	5.4	32.2	32.1	30.6	44.0
Madhya Pradesh	6.2	5.6	5.3	4.8	29.8	33.3	33.6	39.7
Maharastra	4.9	5.2	4.2	3.5	34.6	34.8	35.7	37.8
Orissa	7.1	4.2	4.3	5.8	29.0	31.0	30.7	35.4
Punjab	2.3	0.6	0.4	0.1	33.9	28.8	28.1	40.3
Rajasthan	4.7	3.4	2.2	1.9	33.9	34.6	29.3	37.2
Tamil Nadu	6.3	4.6	3.9	1.6	35.1	35.8	34.8	36.1
Uttaranchal	2.0	1.2	0.9	0.7	30.5	35.1	27.5	32.9
Uttar Pradesh	5.9	4.7	3.4	2.3	31.5	33.5	32.6	36.9
West Bengal	3.2	2.4	1.4	0.6	33.5	34.6	33.9	38.3
All India	4.4	3.8	2.9	2.0	33.9	35.0	34.4	37.6

Source: 2004-05 estimates are calculated from grouped data from NSSO Report 508. Estimates for 1983, 1987-88 and 1993-94 are calculated from the unit level data respectively.

PROMISE & PROGRESS: A CRITICAL APPRAISAL ON GIVING SECURE RIGHTS OVER LAND & LIVELIHOOD TO THE MARGINALIZED BY THE STATE OF ORISSA

By. **Sricharan Behera & Gadadhara Pradhan**

INTRODUCTION: LAND & LIVELIHOOD

Land is the most precious asset for poor farmers in rural India. It is the basis for their identity, a symbol of their social status and an expression of their political power. The value of land is deeply ingrained in the consciousness and well-being of the poor farmers. In India, agriculture is the main source of livelihood for more than 70% of the population. For the marginalised rural and backward tribal population, in particular, it is the only source of survival. Therefore, no development of these populations is possible without giving them rights and security over their primary resource base and vital source of livelihood. Agriculture is essentially a source of land-based livelihood that can be secured only through security of rights and access over land. No development activity can succeed unless primacy is given to recover lost land and provide secure tenurial rights for existing and new land.

Land creates inherent value for livelihood by providing physical, social and nutritional security. It is an invaluable asset for survival. Hence, access to land and other natural resources is essential for sustainable poverty reduction and equity. The livelihoods of rural people without or with very limited access to natural resources are vulnerable because they have difficulty in obtaining food, accumulating other assets and recuperating from distress. With the growth in population and the rising needs of the people, the pressure on land is increasing by the day.

The annals of the land rights of the marginalised and traditional cultivators is a story of their exclusion and dispossession by the ruling class: the traditional Rajas or *Zamindars*, *Muthdars* or *Gaontias*, intermediaries or *Marfatdars*, British agents or Independent Indian rulers. The land administration system of the British rule or the traditional kings was solely aimed at collection of revenue and there was no genuine concern for settlement of *raiyati* rights in the name of the landless poor. The current era of mindless globalization, based upon the idea of profit maximization, has increased the threat to the survival of the marginalised cultivators and landless poor manifold. Land, the most precious asset needed for their livelihood has now become more vulnerable. The price for the so-called national development of modern India is paid only by the marginalised. Planned development brought with it the spectre of dams, mines, industries and roads on tribal lands. With these came the concomitant processes of displacement, both literal and metaphorical - as tribal institutions and practices were forced into uneasy coexistence with or gave way to market or formal state institutions. The repercussions for the already fragile socio-economic base of the tribals were devastating-ranging from loss of livelihoods, land alienation on a vast scale, to hereditary bondage.

Despite promises and legal protection, the adivasis, dalits and other marginalised people are deprived of their entitlement over land due to displacement, mining, industries, development projects, indebtedness etc., leaving many in precarious living conditions. The present era is an era of ‘compassion and generosity’ for the mining companies and multinationals, whose only objective is to grab land and resources, without paying any heed to the life of the people who loses their land and livelihood for no fault of theirs. This trend is widening the already huge disparity between the poor and rich. The state, instead of its fulfilling its obligation to reduce poverty, has been instrumental in widening this disparity. The development model being followed in modern India is continuously and consistently snatching away the main resource base of the marginalised and is making them chronically poor. The ultimate agenda of globalisation and the new development paradigm is to grab land and establish profit maximising private enterprises or industries or other development projects to the detriment of the lifeline of the poor farmers. In keeping with its primary thrust, fertile agriculture land is going to be converted into a land of desert. People will lose their livelihood and become landless and homeless. They would be dying of not only hunger and malnutrition but for want of a drop of water to drink. The impact of this trend would be

nothing short of disastrous. The land of greenery stands to become a land of holes and rubbles. If the current trend of transfer of land to big corporate houses and MNCs continues without giving any thoughts on the future sustenance of the poor, India would very shortly be converted into another Somalia. This is the background against which one needs to attempt an appraisal of the implementation of MDGs till the year 2015 in the context of India in general and Orissa in particular.

The major issue closely knitted with poverty in Orissa is poor access and control over land among backward social groups. The distribution of land is highly inequitable in the state. While the State owns most of the land, a large chunk of population remains deprived of access to land. The denial of land rights to the poor and the marginalised is a legacy of the historical, political and land governance system that we have followed over centuries.

PROMISES MADE TO BE FORGOTTEN:

No government after Independence has ever left out eradication of poverty from its agenda of nation-building and national development. If anything, each one of them tries to outdo the preceding government in doling out promises to the poor, the dispossessed and the marginalized. If the pre-election promises and manifestoes are anything to go by, it would appear that poverty eradication is the sole agenda of each one of them. Their hearts apparently bleed for the poor. But the moot question is: why does the lot of the poor remain the same – or, as a matter of facts - gets worse after all these years of supposedly pro-poor policies.

The National Common Minimum Programme (NCMP) of the United Progressive Alliance (UPA) government certainly appeared a unique opportunity to bring the issues of people's rights and aspirations to the centre stage of governance. However, the actual functioning of the government over the past three years has made it amply clear that the governance framework rooted in people's rights and people-centric development as promised in the CMP is only an eyewash and the real agenda is to continue with the neo-liberal and pro-globalization policies pursued by its predecessor. The mood of the *aam admi* has changed from one of gung-ho enthusiasm to utter despair. It has silently enacted the Special Economic Zone (SEZ) Act 2005. The creation of SEZs is a not-so-subtle attempt to shamelessly facilitate land-grab by private interests. It is a story of brazen conversion of public resources into private profit with the State playing the role of a proactive facilitator of the process. As if illegitimate land grab is not enough, the government has also provided huge tax exemptions and benefits for SEZs with a commitment for world class infrastructural support with the purported objective of enhancing the export base of the country. But it is already having disastrous consequences on agricultural land holdings leaving farmers distraught and helpless.

The promises of the UPA govt. include launching a comprehensive national programme for minor irrigation of all lands owned by *dalits* and *adivasis*. Landless families are be endowed with land through implementation of land ceiling and land redistribution legislation. No reversal of ceiling legislation will presumably be permitted. Besides, more effective systems of relief and rehabilitation are to be put in place for tribal and other groups displaced by developmental projects. Tribal people alienated from land will be rehabilitated. Over the past 59 years in India, the country's land policy and the legislative and administrative framework that is supposed to facilitate its implementation have failed to remove the substantial obstacles in the poor gaining greater access to land. Rather, forceful land acquisition for so-called development and industrial purposes has continued unabated. There are numerous examples of the use of violence by the State to curb local protest against land grab in Kashipur, Kalinganagar, Singur, Nandigram and many other places. The hopes of land rights that the CMP had raised in the minds of the poor have now been mercilessly dashed. This became more than evident after the bloodbath at Nandigram. No wonder opposition to forced land acquisition has been growing across the nation.

The govt. had promised promotion of dry-land farming and introduction of wasteland management programmes for development of wasteland. But in practice, it has ruthlessly promoted acquisition of common and single-crop land for SEZs in sharp contrast to the CMP agenda. As many of the SEZs are coming close to urban areas, the demolition and eviction of slums and roadside vendors has left the poor people with no options whatsoever. The Government has completely failed to take into account the loss of livelihood and environment the country would incur in the process. Instead of safeguarding the rights and resources of farmers and marginalized poor for national development, successive governments have given unflinching and consistent support and protection

to the land mafia and private companies. If allowed to continue, this trend will no doubt force the poor into slavery and serfdom.

The Mughals and Britishers had invaded the country to loot the resources by enslaving Indians. But it is the Independent Sovereign State of India that is now playing the role of an 'intermediary' in rolling out the red carpet for MNCs and large Indian Corporates – enslaving the vast majority of its citizens in the process.

LAND REFORMS INITIATIVES

Even before Independence, visionary leaders and social reformers had realised very well that the only way extreme poverty and hunger can be alleviated is through equitable distribution of resources, especially land on which the vast majority of Indians depend for their survival. Since then, many legal initiatives and reform measures have been taken by various Governments through the active contribution of visionary leaders. A number of good legislations have come up in the process for providing land rights and security of livelihood to the poor and the marginalised. At the same time, many draconian laws like the Land Acquisition Act 1894, Forest Conservation Act 1980, Special Economic Zone Act 2005 etc. have been used against farmers and the marginalised community.

Vested interests have always tried and are still trying to explore the loose side of the laws and manipulate them in their own interest. The laws of the land enacted to be used for the welfare and safeguard of the poor and the marginalised have been consistently applied against them. To assess the extent to which promises made by the Indian government since independence with regard to securing land rights for the poor have been fulfilled, it is necessary to first dwell at some length on the initiatives that have been taken by the Indian government at various times. During centuries of exploitation and dominance by the feudal lords and the arbitrary nature of provincial laws under the imperialist order, there were a series of revolts for change in the economic policy and for securing equal and secure land rights and adequate means of livelihood for its citizen. As far as land rights were concerned, it was a fight against the feudal structure and the concentration of wealth in a few hands. Intermediaries had completely blocked the access of the actual tiller to land. After Independence, several initiatives have been taken up and new legislations have come up the basic objective of which was to reduce poverty and hunger by protecting the interests of the marginalised with equitable distribution of resources. The land reforms initiative was one of the major steps taken to fulfil this goal.
Land reforms have been on the agenda of rural reconstruction since Independence. The land reforms programme in the first and second five year plans had two objectives: (i) to remove the impediments to agricultural production that arose from the tenurial structure inherited from the past and (ii) to eliminate all elements of exploitation and social injustice within the agrarian system to provide security to the tiller of the soil and to assure equality of status and opportunity to all sections of the rural population.

The laws relating to land reforms have been under implementation for more than 55 years now. After more than five decades of implementation of the legislation, the cumulative impact on the rural poor has been disconcertingly meagre. It is accepted by one and all that the story of law reforms is the story of failures on all fronts. An apathetic approach to the problem, ideological gap, and non-involvement of potential beneficiaries in the implementation process are the prime reasons for this.

ORISSA LAND REFORMS ACT 1960:

The Orissa Land Reforms Act, 1960 was a landmark legislative measure enacted to ensure better rights for weaker sections by fixing a ceiling on land holdings. It was a progressive legislation aimed at agrarian reforms and abolition of intermediaries. The basic features of the OLR Act 1960 are:

i. Introduction of uniformity in the land rights or *raiyats*
ii. Provision of better rights to temporary lessees, share croppers and tenants
iii. Conferment of occupancy rights on homestead land
iv. Settlement of disputes between landlords and tenants
v. Regulation of rent
vi. Protection of Scheduled Caste and Scheduled Tribes *raiyats* from alienation of land
vii. Resumption of personal cultivation by landlords
viii. Determination of non-resumable areas for tenants and fixation of ceiling on land holdings.

The most progressive part of the Orissa Land Reforms Act, however, came in the shape of the ceiling law introduced through an amendment to the original Act in 1973. It was naturally hailed as the beginning of a renewed drive in achieving the objective of land redistribution by emphasising on all areas of land reforms, including consolidation of holdings, ceiling on land holding and distribution of surplus land. The Act was aimed at preventing the distress sale of land by the peasantry.

The distribution of Ceiling Surplus land started with effect from 26.9.1970. It was decided that 70% of Ceiling Surplus land vested in Government would be settled with persons belonging to ST & SC categories in proportion to their respective population in the village. The remaining land would be settled with other categories of landless persons. In all cases, up to a maximum of 0.7 standard acre of agricultural land was meant to be distributed on *raiyati* basis free of *salami*.

The status of the distribution of ceiling surplus land and the reason for non-distribution of Ceiling surplus land are as follows:

Table no. 1: Status of Ceiling surplus land and reason for non-distribution of already taken-over Ceiling surplus land

Status of Ceiling Surplus land	Areain acres	Reason for non-distribution of surplus land	Area in Acres
Total Area determined	183607	Area locked up in litigation[1]	11247.77
Area taken possession of	171926	Area kept for public purposes	4377.43
Area not taken over due to litigation	11681	Area to be made fit for cultivation and distribution among the landless	2039.18
Total area distributed	159173	Total Area	17664.38

The Government of India was not in favour of any relaxation in the existing ceiling laws. But it has had no qualms about putting pressure for massive land acquisition on a poor state like Orissa. On its part, the Orissa government has outdone the Union government in making the poor more vulnerable and landless. It has tactically made an amendment to the Land Reforms Act in 1993 by inserting Section-8A, which allowed conversion of agricultural land for non-agricultural purpose with effect from 01.07.1994. This has made passage of ceiling surplus land to private companies and industries considerably easier, resulting in alienation of the land of the poor. As is clearly seen from Table 1, out of the 17664.38 acres of land acquired, 4377.43 acres has been earmarked for public 9non-agricultural) purposes. While the large majority of the population still remains homeless and landless, the land acquired from the ceiling surplus category is being diverted for non-agriculture purposes in the name of public interest. This has diluted the basic thrust of the land reforms initiative - to give land to the tiller. Under Section 8(i) (C) of the original OLR Act 1960, there was a complete ban on the conversion of agricultural land for non-agriculture. The whole idea of the original Act has been diluted beyond recognition by the periodic amendments carried out by the government to facilitate diversion or alienation of land meant for the marginalized to the hands of companies or the economically rich and prosperous sections of the society.

There is a complete lack of sincere and conscious effort on the part of the government to work for speedy disposal of pending cases in the Court. Unnecessary delays and litigations are made in determination and distribution of surplus land by the revenue officers as part of their corrupt nexus with the landlords.

There is also a large gap between the annual targets and actual achievements, which unfortunately are increasing every year. While the implementation of present ceiling laws is undoubtedly overdue, it is unfortunate that an environment has been sought to be created lately for giving exemption from ceiling laws to industry and large farmers. Some State Governments have already given such relaxation without seeking Government of India's permission. *One does not have to be an expert on land reforms to recognise the rising dangers of relaxation of ceiling laws for industry. Such a relaxation will undoubtedly result in the return of the old feudal order with a new set of intermediaries replacing the old ones – making the cure worse than the disease. Under the feudal system, the tiller at least got some land to cultivate to meet his livelihood. But in the present scheme of things, corporate houses and companies will be under complete possession of land.*

1 1197 cases are pending against these lands in various Courts.

Although the Government of India has so far not been in favour of any relaxation in the existing ceiling laws, the same cannot be said about the future. In practice, it has been paving the way for companies and corporate houses to acquire the land belonging to the poorest of the poor by specifically targeting land in the backward tribal areas with an abundance of forests. Many experiences and examples are available from the recent past of ongoing movements and bloody protests against massive land acquisition in Orissa in the name of "national development". The cases of Kashipur, Gopalpur, Baliapal, Paradip (Posco), Kalinganagar, Lanjigarh (Vedanta) speak for themselves.

DISTRIBUTION OF HOUSE-SITES TO HOMESTEAD LESS PERSONS

The government has taken initiative to provide housesites up to four decimals to the homesteadless families since 1974-75. A total number of 2,49,334 such families have been identified in the State as per the enumeration made during 2003-04. Project 'Vasundhara" has been launched in a mission mode to provide all families without homestead land with housesites within a span of three years. During the year 2005-06, up to January 2006, 36,285 homesteadless families - of which 17,829 were ST, 9, 244 SC and 9212 belonged to other category - have been provided with house sites. As per the survey, 122764.86 acres of land is available in the state for distribution. Accordingly, a month-wise target has been fixed for effective implementation of the project. However, the achievement made up to September 2005 is barely 10, 821 acres against the annual target of 83,357 acres.

Looking at the ground realities, the list prepared by the government has raised enough and serious doubt on the process and the methods employed for enumeration of homesteadless families. In many parts of the state, the mutation process – like the survey and settlement process - has not been carried out for a long time. Since the main family has been divided in the meantime, there are practical difficulties in identifying genuine homesteadless families. Secondly, there is also the danger that some persons having good size of homestead land in the name of their fathers or grand fathers will also stake a claim for land. One of the key concerns in the implementation of this scheme is that a sizeable number of persons having good size of agriculture land, who have constructed houses on such land, also claim housesites since they do not have any housesite recorded in their name. To ensure equity, it is imperative for the government to find a way to exclude such undeserving beneficiaries from this scheme.

DISTRIBUTION OF GOVERNMENT WASTELAND FOR AGRICULTURAL PURPOSE

With a view to improving the economy of the marginalised and boosting agricultural production, Govt. land of up to one standard acre size is being allotted free of salami to landless persons since 1974-75. By January, 2006, a total of 3711.74 acres of government land has been distributed among 3, 896 landless families of which 1762.18 acres have been given to 1698 ST families, 733.71 acres to 820 SC families and 1219.85 acres to 1,378 landless families belonging to other categories. Since 1974-75 till the end of January 2006, an area of 7, 30,344.85 acres of govt. wasteland has been distributed among 4, 71,620 landless families. This figure includes 3,81,017.19 acres of land given to 2,28,192 ST families, 1,74,072.42 acres to 1,02,589 SC families and 1,75,255.24 acres to 1,40,839 landless families belonging to other categories. Given the political forces and local dynamics at work and the attitude of the revenue authorities, it would indeed be very difficult to identify and distribute the land among the genuine beneficiaries. In almost all the villages in tribal areas, people have been cultivating government land. There are people with possession of large sizes of non-objectionable land while some people have very meagre land, which may fall under the objectionable category. There are others, who have not encroached government. So, at the time of determining the land for settlement, the real landless may not get priority. The rich and the influential in every village will do everything possible to prevent the land under his possession from passing to the control of the government. Corrupt revenue officials, in nexus with influential people and big land owners, will settle the land in their name or in the name of their children. Thus the purpose of equity will get defeated.

CONFERMENT OF RIGHTS ABOVE 30 DEGREES SLOPES IN THE NAME OF TRIBALS:

Shifting cultivation is one of the major sources of survival for the *adivasis*, who practise cultivation on hill slopes and settled cultivation without enjoying any legal right. This situation has arisen from inadequacy in the survey and settlement operations which are intended to record and register the actual land use (irrespective of the status of the land) but have actually resulted in the erosion of tribal communal rights. The settlement operation in the past was unable to capture the rights of the tribal communities in the hill slopes and their entitlements to common property resources as the guidelines provided by the State for conduct of these surveys were unsatisfactory in identifying and recording these rights. The plain table method used only addressed land below

10° gradient and all unsurveyed land above 10° was categorised as state-owned uncultivable wasteland although much of this land is actually owned and cultivated by tribal households. Such incorrect recording, owing to inadequate and improper understanding of social customs in tribal societies, has deprived a large number of tribal households of rights over land under their occupation in almost all the hilly tracts of the scheduled areas[2]. With a view to redress the grievance and problems of the tribals, in March 2000, GOO announced its decision to confer ownership rights to all persons in Scheduled Areas cultivating land up to 30° hill slopes and to carry out a special survey of unsurveyed hill slopes in such areas. This process was done only haphazardly in Kashipur Tahasil and land up to 30° was surveyed and *dongar* pattas given to households, both in the name of husband and wife. The orders of the Revenue Department also directed that the same status rule to be extended to other tribal (scheduled) areas of Orissa. But no attention has been given to it. It has now transpired that only leases for 10 years have been given and not heritable rights and steps are now required to rectify this.[3] *If this concern of the Govt is true, it would alienate the people from their rights. The government is clearly setting an agenda for its future and easy land acquisition for the companies or mining mafias.*

LAND TRANSFER & RESTORATION: UNDER THE ORISSA SCHEDULED AREA TRANSFER OF IMMOVABLE PROPERTY REGULATION 2 OF 1956 (AMENDMENT 2002)

Orissa Scheduled Area Transfer of Immovable Property, Regulation II of 1956 has been reasonably effective in checking the alienation of tribal land in Scheduled Areas. In spite of the provisions in the Regulation, it has come to the notice of the Government that large-scale alienation of tribal land to non-tribals has taken place in the scheduled areas of the State and as such it has become a matter of great concern for the State Government as well as the Government of India. To put an end to this problem, the Government of Orissa has made necessary amendments to Regulation 2 of 1956, which came into force with effect from 4.9.2002. Under the Provision of its 2002 amendment, the Regulation prohibits, among other things, transfer of immovable properties belonging to members of STs in favour of persons not belonging to STs. In case any transfer has been made in contravention of this provision in the regulation, the competent authority either *suo-motto* or on a petition filed on that behalf, shall declare such transfer as illegal and shall restore the land to the lawful land owner or his/ her heirs. The regulation also provides for eviction of persons in forcible occupation of land belonging to members of STs and restoration thereof. The Regulation provides for penal action in respect of illegal transfer as well as unauthorised occupation.

PROPOSED AMENDMENTS OF OSATIP REGULATION (2) OF 1956:

A draconian step has been proposed by the Government of Orissa, which violates the basic principles of the Constitution as well as Scheduled Area Administration. The existing law for checking illegal transfer of land in scheduled areas in Orissa is weaker than similar laws in other States like Andhra Pradesh. In the latter, no land in scheduled areas can be transferred to non-tribals, either private or govt. land. The Orissa Schedule Area Transfer of Immovable Property (OSATIP) Regulation 2 of 1956, in contrast, merely forbids transfer of *patta* land of tribals to non-tribals. However, if we see the size of land holding in Scheduled Areas, 84% of the land area of scheduled districts belongs to the Government. Large areas of land customarily claimed by Scheduled tribes were categorized as Forest Land or Revenue Land through Survey and Settlements and forest declaration. Only 16% of the land is privately owned by the tribals. There have been huge instances (unreported) of illegal transfer of tribal land to non-tribal, violating the protective regulations (OSATIP 1956) on which the government is supposed to give special attention as part of its special Constitutional responsibility. Even with regard to officially reported cases of illegal transfer, 318 cases (out of 434) of land restoration was disposed of under the existing regulation during 1st April 1999 to 31st March 2000[4] (one year) in Kandhamal district only. This shows the existing OSATIP regulation, if implemented, can give enough protection to the tribal land. Now the government is seriously pursuing amendments of the regulation on specious grounds with an intention to easily transfer the land to the rich non-tribal and corporate houses.

The government, instead of making the OSATIP more stringent in line with the AP regulation which forbids transfers of any land in scheduled areas to non-tribals, has been working to make the law even weaker? It is simply trying to withdraw the restriction thereby forcing the poor tribals live homeless and landless, beg on the street of the non-Scheduled Areas, an occupation which is antithetical to their culture. The govt. has been eyeing the land of the poor adivasis with an escapist explanation. It has obviously not learnt from its record of illegal land transfer in the past as such transfer continues unabated even today. The table below gives the status of land transfer in just one year.

1 A NOTE ON POLICY ISSUES –REVENUE DEPARTMENT, N.C. Saxena
2 N.C. Saxena, A NOTE ON POLICY ISSUES –REVENUE DEPARTMENT,
3 Kandhamal District Profile, www.kandhamal.nic.in

Table no. 2: The status of land transfer and restoration under OSATIP

Achievements under OSATIP Regulation of 1956 During 2005-06 till December[5]

No of cases instituted	1,433
No of Cases disposed	1,109
No of ST Beneficiaries	675
Extent of land ordered to be restored (in acres)	587.00
Extent of land actually restored (in acres)	546.00

In the Tribal Advisory Council (TAC) meetings held in 2005 and 2006, the proposed amendment for further relaxation on the regulation was deferred by the members. In spite of the disagreement, the committee headed by the Chief Minster has recommended it to a Ministerial Committee.

For the proposed amendment, the govt., in its Letter No. 33698/RNDM dated 9.10.2006, has sought the opinion of the Panchayat Samiti and Zilla Parishad on the proposals that a relatively progressive section of the tribal community have expressed their view for amendment of the regulation (OSATIP 1956 amendment 2002) by which they can be allowed to **take loan from different financial institutions for health care, economic development, land donation for the development of the region or the village, land transfer to the investing / housing organizations and bank for construction of house and so on**. Here, it can be brought to the notice of the House that to tackle the issues/ causes for which the amendment is sought for, the government has launched so many development schemes and programmes, credit mechanisms, special development agencies and so on. Further, the TAC proceeding of 2006 said that "*On the one hand, there is a feeling that the implementation of the Regulation is not very effective in checking clandestine or fraudulent transfer of tribal land to non-tribals in various forms. On the other hand**, relatively progressive sections among the community feel it necessary to further relax the provisions** so as to allow transfers for certain developmental needs like higher education, investment in business or industry etc."*

The question that emerges here is what is the percentage of progressive population in this community and how far is the govt. justified in imposing the view of this miniscule percentage of (so called) progressive section on the tribal society at large? Does their view reflect the view point of the community as a whole and will it protect the interests of the vast majority of the poor of the same community? What prompted the government to only bother for a tiny number of so-called progressive sections and go against the vast number of non-progressive sections of the community? How equity concern is maintained in taking decision on the basis of the opinion of a handful of so called progressive tribals for the proposed amendments.

ORISSA (SCHEDULED AREA) MONEY LENDERS RULES, 1967:

Money lending is one of the major causes of impoverishment and land alienation in the remote, backward and poverty stricken tribal areas of Orissa. A large proportion of tribal land is transferred to non-tribals through mortgaging to seek credit from the money lenders (*sahukars*). Exploitative money lending exists as a customary practice in tribal areas and is one of the major reasons behind the chronic impoverishment in such areas. This practice catalyzes the vicious circle of poverty and makes the poor tribal more vulnerable. It has been one of the fundamental factors constraining the development in the backward tribal regions.

Living as they do in remote backward areas, the tribals are far away from access to public service delivery systems such as health care and other entitlements sanctioned by the government. They suffer from frequent malaria and other illness and diseases besides food scarcity. Due to the pressure of distress, they always prefer to go for *sahuakars,* who they feel are his real friends since they readily provide loans at the time of need. The credit taken from the *sahukars* are used to cover expenses on account of food, health care, funeral and festive occasions, etc., which are mainly for consumption. However, the *sahukars* always play it safe and ask for a mortgage which, in case of a tribal, can only be land. As a result, the only asset of their livelihood is lost through mortgage. This has been making the poor adivasis badly indebted and landless.

5 This includes previous pendency.

The Government of Orissa has a special provision for protection of the tribals from exploitation through money lending in Scheduled Areas, which is known as Orissa (Scheduled Areas) Money Lenders Regulation, 1967, besides many other protective laws. A large number of money lenders in tribal dominated/ scheduled areas are doing informal business through which they are exploiting the poor innocent tribals. No one has a license for doing the business of money lending and whoever is doing so is obviously doing it illegally. However, not a single case has been registered against them. Regulation, 1967 is not known to the scheduled tribes even four decades after its enactment. In the event, talk of filing complaints against illegal money lending sounds like a cruel joke. The question here is: in spite of the special scheduled area administration under the constitution of India, what steps have been taken by the government to address these problems on ground? What is the use of this regulation if it cannot safeguard the tribals from the exploitation at the hands of *sahukars*?

ALIENATION/ LEASE OF GOVERNMENT LAND IN FAVOUR OF OTHER DEPARTMENTS/ ORGANIZATIONS:

Vested interests are always on the lookout for ways to grab the land of the poor in the name of public institutions and places. In cohorts with the corrupt and erring officials, these elements have usurped a huge amount of land belonging to the poor and rendered them homeless and hopeless. Supposedly public services and enterprises come up on the land that once belonged to the poor. The promises given to them at the time of the takeover that they would be given preference in the new enterprise coming up vanishes into thin hair in next to no time. It is a classic lose-lose situation for the poor.

LOSS OF LAND AND LIVELIHOOD DUE TO DISPLACEMENT:

In the name of national development, the national and State governments go out of their way to provide land for mining and industrial projects, not to speak of conservation projects. A large proportion of such land is acquired in the poverty stricken backward tribal areas, which are basically resource rich and hence attractive for mining, industrial and business interests. The government moves with uncharacteristic alacrity in making land available to these interests. In astonishing contrast, it has failed to settle the rights of the people, mostly tribals and dalits, who have cultivated the land for centuries despite having all the powers to do so under the Orissa Prevention of Land Encroachment Act, 1972.

Orissa is an extremely mineral rich state. But the unfortunate part is most of the mineral wealth is concentrated in the tribal areas. No wonder almost all major industrial projects – with the exception of Posco at Paradip and the units in the Kalingnagar industrial complex – are located in these areas. Large industries like UAIL at Kashipur and Vedanta at Lanjigarh are all set to join old units like the Rourkela Steel Plant, Nalco's refinery at Damanjodi, HAL at Sunabeda. The hilly terrain and abundant availability of water also make these areas ideally suitable for reservoirs and dams. The major dam projects in Scheduled Areas are the Machkund, Salandi, Balimela, Upper Kolab, Indrawati, Mandira etc.

Nearly 1.5 million people have been displaced by development projects between 1951 and 1995, of which 42% were tribals. Less than 25% of these displaced tribals were ever resettled even partially. The indifference and casualness with which displacements of tribals have been treated is evident by the fact that out of 13 major dam projects before 1990, no data seems to be available on ST families displaced in 7 projects. Similarly out of 10 major industrial projects, no data on the proportion of STs displaced is available for seven projects. The total number of villages affected is more than 2170 and the area acquired/ affected is 1215679 hectares[6] in the state.

SOCIO-CULTURAL TYPOLOGIES OF LAND ALIENATION:

The living gods of this country are dying out of hunger but the "non-living" gods are the most prosperous landlords with all the luxuries of the world. While the poor and the homeless find it well nigh impossible to find a piece of land to take shelter, the land sharks have no problem usurping as much land as they want in the name of gods. In the capital city of Bhubaneswar itself – where land is presumably at a premium – temples sprout out of nowhere and soon start expanding in next to no time with the administration more than willing to lend a helping hand to the land mafia. Many of them have now been converted into full fledged hotels. Endowment property is one of the biggest frauds perpetrated on the people of Orissa.

6 The data about land acquired, villages affected and the number of people displaced or affected by various development projects hasn't been compiled properly till date. The data as provided may be taken as the lowest estimate and it doesn't include people affected by minor irrigation projects, infrastructure projects such as roads etc.

THE CHALLENGES AHEAD:

Clearly, it is an extremely uphill task for the vast majority of the productive class, who sacrifice their blood and sweat for the prosperity of the nation. Some of the major challenges facing them have been outlined below.

1. The improper and long delayed Survey and Settlement process has ensured that government land encroached on by the poor tribals remains unsettled in their name so that it could be handed over to mining or industrial interests or used for developmental projects. The greater the delay, the greater will be the number of people to be displaced.

2. The poor *adivasis* living for generations on forestland and solely depending on forest and forest produces for their survival are treated as encroachers. The Forest department is constantly on the lookout for ways to evict them from their homeland and livelihood.

3. The illegal transfer of tribal land to non-tribals in Scheduled Ares is still rampant. Only one out of five cases of actual illegal transfer of ST land to non-STs has been reported. Illegal transfer of land has been encouraged due to extreme poverty - food scarcity and poor health care facility being the major reasons.

4. Mutation cases are pending for ages. The genuinely poor and marginalised are not getting the benefits meant for them under the Project Vasundhara to build houses for themselves. Nor do the landless get wasteland for agriculture.

5. Land recovered under ceiling surplus category is constrained by the litigation. The litigations are consciously filed to block and delay the processes of actual land distribution.

6. Slow disposal of cases pending in the Court constrains distribution of ceiling surplus land.

7. Conversion of agricultural land for non-agriculture purposes. Ceiling surplus land is diverted for non-agriculture purposes under the 1994 amendment of OLR Act by insertion of section 8A making it easier for industry to get land.

8. Serious threat to the environment and a massive blow to the resource dependent poor with mindless land acquisition in tribal and resource rich areas.

9. The restoration and transfer of land under OLR Act in non-scheduled areas is very slow and ineffective.

10. Special health acre services and employment opportunities with viable economic alternatives (emergency social security fund within SHG) for meeting distress situations should be created without any delay.

11. Extension of the Government Circular (GOO 2000, Kashipur Survey and Settlement) to all other scheduled areas for settlement of rights over land above 10 degree slopes. For its speedy and effective implementation, a special process of Survey & Settlement should be carried out.

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HAS NREGA REDUCED POVERTY IN ORISSA VILLAGES?

By **Pradeep Baisakh**

India was conceived as a welfare state by the Constitution makers. From the early days of independence, a plethora of welfare schemes have been launched by the central and state governments to fight the prevailing widespread poverty, particularly in the rural areas where the percentage of poor people living is higher than in the urban areas. A lot of wage employment schemes have been in place to provide opportunities of unskilled work and employment to the villagers. But the problem is: almost all of them have been launched as State charity towards people. At no point of time have the rulers and lawmakers of the country realized that the citizen has a fundamental right to work, which constitutes a part of the right to life guaranteed under Part III of the Constitution. However, due to constant pressure from the civil society organizations (CSOs), the National Rural Employment Guarantee Act (NREGA) has been enacted by the State recognizing that work has to be provided to the willing sections in the villages as a matter of their right and not as State charity. The new conceptual framework assumes that only a rights-based approach can restore the dignity of labour and can effectively alleviate poverty, unemployment and starvation deaths in various parts of the country.

The Act has been in operation in Orissa since 2nd February 2006 in 19 districts, 205 blocks, 3672 Gram Panchayats and 32047 villages. Five more districts were added to the list in the financial year 2007-08.The primary objectives of the act are to provide 100 days of guaranteed employment to every rural household (HH) irrespective of whether the HH is under BPL list or not, improve the livelihood status of people, reduce distressed migration, promote women's participation in workforce, create durable infrastructure in rural areas, contribute to regeneration of natural resources etc. Legally and popularly, the Act has come to be known as Orissa Rural Employment Guarantee Scheme (OREGS) in the state.

Giving any judgment on whether NREGA/OREGS has been able to alleviate poverty of rural masses in the state would, at this juncture, be premature as the Act is in operation for just a little more than a year, which is too short a period to assess its impact. Nevertheless, Iit is possible to assess the long term impact of the Act on poverty if one critically looks into how the Act has actually operated in the state.

OFFICIAL FIGURES ON THE PERFORMANCE OF THE ACT:

According to official figures, out of Rs 888.57 crore received under the programme, Rs 706.51 crore had been spent by March 2007. By the same period, over 28 lakh households had been registered and from a list of 13.53 lakh people, 13.40 lakh were provided with work. Up to February 2007, the average number of households provided employment in a district is 68, 861 while the national average is 91,685 households. Besides, 48 thousand households have completed 100 days guarantee of employment provided in the Act.

The number of person days of employment provided in the State so far is 626.61 lakh. The average person days of employment provided in a district is 32.98 lakh compared to the national average of 36.47 lakh person days.

Official figures are not very satisfying and to a certain extent disturbing. For example, out of the 28 lakh registered HHs, only 13.53 lakh HH demanded jobs. This can be attributed to the State's inability to spread the required awareness on the Act. Interaction with the people by various organizations, study teams etc. reveal that people are under the impression that the once they get the job card, jobs would come to them on their own whereas NREGA is actually a demand driven programme. But it is not as if anybody who asks for a job automatically gets it. Official figures themselves concede that out of a list of 13.53 lakh people who asked for jobs, only 13.40 lakh were provided with work. In other words, near about o.16 lakh people were not provided with jobs despite demanding them. A substantial number of these people were legally entitled to unemployment allowance; but as per available figures, only a handful of people in one panchayat of Malkanagiri district have been given unemployment allowance - that too after they sat in dharna before the Panchayat office.

Reality checks done by various Civil Society Organizations in the form of surveys, social audits etc. in the last one year, however, provide a different picture and certainly refute the tall claims of the government, at least partially. The findings may be summed up as follows:

SUMMARY OF GROUND REALTIES ON IMPLEMENTATION:

1. All families are not registered
2. Many have not received job cards
3. There are instances of presence of ghost cards
4. In some instances, work days were already entered in the cards at the time of their issuance
5. Sometimes, the number of work days mentioned was more than what people had put in.
6. Names had been entered wrongly in some cases.
7. NREGA work had not yet begun in some areas.
8. In many cases, minimum wages were not paid on weekly/fortnightly basis or not paid at all.
9. There are allegations of discrimination against women vivs-a-vis the distribution of minimum wages.
10. In many instances, demand applications were not received by the Panchayat authorities.
11. In almost all cases, receipts with dates were not provided against the work demand application to cleverly evade the demand for unemployment allowance.
12. Application forms to get job cards were not available in some gram panchayats
13. Contractors were doing the work in many cases.
14. Village level leaders or 'Gram Sevaks' themselves sold work illegally to the traditional contractor in a few instances.
15. There were no village level vigilance and monitoring committees in some places. Wherever they existed, they consisted of hand-picked individuals or were only on pen and paper.
16. Data was not available in some GPs and blocks. Where it was available, it did not tally with data collected from the people and available in the official website on NREGA.
17. In almost all the cases *muster rolls were not available at the worksite*
18. In general, there is s*hortage of staff for implementation*

CASE STUDIES FROM THE GRASSROOTS:

Some case studies collected during field visits by survey and study teams have been given below.

A. NON-ISSUE OF JOB CARDS:

In a detailed survey conducted by Agragamee, a NGO based in southern Orissa in Koraput and Raygada districts during November 2006 to January 2007 it was found that in Tentuliguda village of Mujang panchayat in Badabagri, and Bhandisil villages of Dumbaguda Panchayat - both under Dasmantpur block of Koraput district - and in Kumbharsila village of Kashipur panchayat and block of Raygada district, there are families which have not received job cards even though they have registered along with everybody else in the village. As a result, these families are not able to avail the entitlements under the Act. Similarly, in 30 villages in Dasmantpur Block, out of 1, 336 eligible households, 125 households have not been provided with job cards. Ironically, many of these excluded families belong to the most vulnerable sections like women-headed households, or senior citizens, as per the survey.

The Act, however, mandates issuance of job cards within 15 days of registration.

B. IRREGULARITIES IN THE MAINTENANCE OF MUSTER ROLLS:

In Kudikitunda village of Kodipari panchayat under Kashipur Block of Raygada district, muster roll was not available even after two months of the beginning of work. It was also found that people were paid an incomplete amount of wages and were told that the rest of the payment would be made at the time of the final bill. Muster Rolls were not maintained properly, as a result of which people failed to get their due payment.

C. MANIPULATION OF JOB CARDS:

In Nabaguchha village under Gayaganda panchayat under Jagannath Prasad block of Ganjam district, there are allegations of job card manipulation by the Village Level Leader. Bhgyalata Jani, a woman from ST community, had worked for four days and was paid for those numbers of days, but her job card showed 12 days of work. Balaram Muduli of Kanheimunda Village under Lamtaguda Panchayat of Nabarangpur District had worked for only 1 day, but there was entry of 52 days in his job card.

D. DISCREPANCY IN JOB CARDS RECORDS AND MUSTER ROLLS:
In Khandiaguda and Bijapadar villages of Tentulikhunti Panchayat of Nabarangpur District, and in Parajabarikanta village of Dasmantpur Panchayat of Koraput District, discrepancies were found between the job card records and muster rolls. In some instances, where people had protested, the work had been discontinued.

E. NON-RECEIPT OF APPLICATIONS:
In the same survey conducted by Agragamee, it was found that there was nobody to accept applications for work in some panchayat and block offices of Koraput and Rayagada districts. This was a major difficulty which frustrated people's attempts for work and self-reliance.

F. NO WORK EVEN AFTER APPLYING FOR JOB, NEITHER ANY UNEMPLOYMENT ALLOWANCE:
Sunia Mallick of Sisuli village under Rudhapadar panchayat of Jagannath Prasad block in Ganjam district applied for job, but did not get it even after fifteen days. Nor was he given any unemployment allowance. In another instance, near about 250 people from about 24 villages of five panchayats of Jagannath Prasad block had made mass applications for job, which the BDO received in the month of August 2006, but were neither given jobs nor any unemployment allowance, whereas the Act says that the applicant has to be provided with job within fifteen days of applying, failing which s/he will be entitled to unemployment allowance.

G. NO WORKSITE FACILITIES
In an interface with Gram Vikash, an NGO working in Ganjam and Gajapati districts, people alleged that there was no facility for drinking water nor any rest shed at the worksite, which should have been mandatorily maintained at the worksites.

H. CONTRACTORS IN THE SCENARIO
There was a reported case from Mayurbhanj district showed that work had been sold to a contractor by the Village Level Leader (VLL), who is supposed to be chosen by the Palii Sabha and in whose name work order is issued. This case was reported to the collector in the district who, in turn, forwarded it to the state level. In a similar incidence in Nabaguchha village under Gayaganda panchayat under Jagannath Prasad block of Ganjam district, a work order issued in someone's name was undertaken by another person, who is a traditional contractor.

The Act is very particular in debarring contractors in any work under it.

I. POOR PLANNING
In the districts of Koraput and Raygada, most of the works undertaken were laying of roads. There has been little effort to identify works by the Palli Sabha for creation of productive assets in the villages mandated under the Act.

J. TRANSPARENCY BOARDS CARRY LITTLE INFORMATION
In many works undertaken in Koraput and Raygada districts, no transparency boards indicating the quantum of work and other details were to be found. In some cases, such boards were put in place after the work is completed. In a similar case in Nabaguchha village under Gayaganda panchayat under Jagannath Prasad block of Ganjam district, the display board failed to display very vital information like the number of person days allocated under the work etc.

K. 100 DAYS OF EMPLOYMENT NOT GIVEN TO PEOPLE IN MOST OF CASES
One financial year of NREGA has already passed. However, the majority of the villagers in the tribal districts like Koraput, Nabarangpur, Gajapati, Raygada etc have not received any employment, leave alone 100 days of employment guaranteed under the Act.

L. DISCRIMINATION AGAINST WOMEN:

In Goudabarikanta village of [which] Gram Panchayat under Dasmantpur block of Koraput district, nearly five women - namely Moti Gouda, Naveena Gouda, Pratima Gouda, Pratima Gouda and Taba Gouda, four whom are widows - have been registered under NREGA, but have not received them. They are not allowed to work under the NREGA programme.

It is also alleged that in many instances, women are being given less wages in comparison to men.

M. ALLEGED DEMAND FOR BRIBE BY THE AUTHORITIES

In the Village Pudugusil of Rayagada district, the VLL in whose name work order in the village has been issued reportedly admitted during interaction that the panchayat Secretary took Rs.500/-, the Clerk Rs.1500/- and the JE Rs.5000/- for the sanction of the work.

N. LACK OF SERIOUSNESS OF THE STATE GOVERNMENT ABOUT THE ACT

Under Section 4 of the Act, every concerned State is supposed to make a scheme within six months of the commencement of the Act. The Act was notified on September 7, 2005 and came into effect on February 2, 2006. Therefore, the State should have notified the scheme by March 2006. However, the notification was issued only on December 16, 2006 - a delay of nine months. Worse still, the notification was shrouded in secrecy. No Press release was issued nor was it put in the official website of the Panchayati Raj department, which is the nodal agency to implement the scheme.

Under Section 12(1) of the Act, every state shall constitute a State Employment Guarantee Council for the purpose of monitoring and reviewing the implementation of the Act at the State level. But in Orissa, it was notified very recently on 1st May 2007 and is yet to be constituted.

While discussing the setting up of the Grievance Redressal Mechanism in the states, the Act mandated the states to make rules for determining it at the block, district and state levels for dealing with complaints of aggrieved persons. However, the currently notified scheme talks of dealing of the complaint by the District Programme Coordinator within 15 days of its receipt.

POSITIVE STEPS TAKEN BY THE STATE:

1. REVISION OF SCHEDULE OF RATES:

Regarding the payment of wages, the Act states two simultaneous criteria. On the one hand, it speaks of payment on the basis of minimum wages and on the other it talks of payment in accordance with work done. These two seemingly contradictory positions are to be reconciled by determining proper schedule of rates keeping in view the working capability of a sound individual. However, due to the prevailing unscientific schedule of rates (SOR) in the State, many labourers were unable to get the minimum promised wage prescribed for a days work. Consequently, there was an urgent need to revise the schedule of rates. The schedule has now been revised regarding soft soil from rupees 55 to rupees 110, for hard soil from rupees 67.5 to rupees 135, for rocky soil from rupees 105 to rupees 210. As a result, it is hoped that from now on, labourers can get the minimum wages declared under the Act in the state.

2. REVISE OF MINIMUM RATES:

Even though the Act clearly mentions that the minimum wage should not be less than rupees sixty for seven hours of work in a day, the state government continued with the rate of rupees 55 for more than a year. Fortunately, the State government has now revised the minimum wage to rupees seventy.

3. CONSTITUTION OF VIGILANCE CELL

The state government has recently decided to set up a vigilance cell to monitor the quality of work under the NREGS. It has also decided to recruit in each panchayat a gram rojgar sevak with a consolidated contractual salary of rupees 2000 per month while a junior engineer will be appointed in each block and an assistant computer operator will also be attached to each block.

4. PAYMENT THROUGH BANKS/POST OFFICE

The state has provided for payment to the worker through banks and post offices. Though it would cause a little inconvenience for the workers as they have to travel a little longer distance to get the payments, it is hoped that this arrangement would at least reduce the embezzlements in payment.

However, a few token steps here and there would not make much of a difference to the ground realities. In an interface with a team from the Planning Commission that was on a mission to study the implementation scenario in Sambalpur district, the representatives from civil society organizations submitted the following set of suggestion, which may be useful for the state government to accept and implement

These are some findings from the grassroots and the policy level which show the appalling state of affairs regarding the implementation of the high profile Act. If this state of affairs continues, the widely hailed Act may turn out to be a damp squib in the days to come.

Apart from the government which, barring some few positive (inevitable) steps as discussed above has not done enough to deliver the benefits under the Act to the masses. The other players - namely the civil society organizations and the media - also have fallen short of expectation in their contribution towards the better implementation of the law. Civil society organizations, though active on the issue, should have intensified the awareness campaign on the Act to a much higher pitch and helped people get their entitlements by using various provisions of the Act starting from helping them getting job cards, applying for jobs, using grievance redressal mechanisms for addressing their problems, making use of the Right to Information (RTI) to compel the authorities to respond to their demands etc. The media coverage on the issue has been largely limited to acting as a spokesperson for the government: only highlighting the decisions taken and notifications issued by the state government under the Act. It rarely rises to the occasion in bringing to the fore the difficulties people are facing on the ground vis-à-vis asserting their rights under the Act. All in all, due to negligence of the state government, civil society organizations and the media, the path breaking Act, which has enormous potential to break the chains of poverty in the rural Orissa, falters on many counts.

Therefore, it is extremely vital for the state government to take immediate steps to facilitate better and more effective functioning of the Act.

Following is the set of suggestions submitted by the group of civil society organizations to the Planning Commission's study team which visited Sambalpur district in the month of April-May 2007 to take stock of NREGA scenario there. These suggestions need to be considered and implemented by the State government urgently to improve the situation.

SUGGESTIONS FOR CONSIDERATION OF THE STATE GOVERNMENT:

1. PRESENCE OF GHOST CARDS:

There is allegedly widespread existence of ghost cards that provides tremendous scope for manipulation and embezzlement in the scheme. It is therefore necessary that all the registrations done and the job cards issued be declared and verified in Palli Sabha meets and be disclosed in public places.

2. AWARENESS ON THE ACT:

The government needs to launch an aggressive awareness campaign by making use of various modes of communications as was done in the case of the 'Polio Immunization Programme'. Use of appealing advertisements in mass media, apart from wall paintings, using civil society organizations etc. will certainly go a long way in popularizing the scheme and disseminating minimum vital information regarding the scheme.
One single reason for many people not applying for jobs despite getting job cards is they thought they would get the job as a natural corollary to the issuance of job cards.

3. WORK IDENTIFICATION BY PALLI SABHA:

The Palli Sabha meets need to be conducted with sincerity and let people identify the work under NREGA/ OREGS in actual practice, not just on pen and paper. The scheme need to mention, with suitable amendment, that the recommendations of the Palii Sabha should not be altered in any case at any other level if it is not a technically feasible project. Then only the objective of decentralized planning can become a reality. Otherwise, planning under this scheme will continue to be a bureaucratic exercise.

4. GRIEVANCE REDRESSAL MECHANISM:

It is necessary to amend the OREGS and make proper provisions for grievance redressal mechanism as per the mandates of the Act and the central operational guideline. The role of PO, DPC and SEC must be clearly laid down and the time limit for them to hear the complaint and appeal cases be made clear.

OREGS, in fact, falters miserably on two important counts under NREGA, namely conducting social audit and the grievance redressal mechanism. In case of the grievance redressal mechanism, the Act and central operational guideline mandate that the Programme Officer, District Project Coordinator and the State Employment Council to be the authorities for dealing with the complaints of the people in a hierarchical arrangement and in a time-bound manner. But the state scheme provides only for installation of a 'complaint box' and designates the Collector as the authority at the district level for dealing with the complaints within fifteen days. It does not make any mention about the role of the State Employment Council in the matter. The idea of putting a 'complaint box' goes contrary to the provisions of the Act wherein the grievances are to be dealt in a time-bound manner. In the complaint box arrangement, there will be no provision of giving a receipt with date against the complaint of to the aggrieved.

5. ACTION TAKEN REPORT (ATR) ON GRIEVANCE REDRESSAL:

Provision should be made so that quarterly or half yearly ATR on grievance disposal is made public by way of putting them on the notice board by the concerned authorities and a copy provided to the Legislative Assembly for discussion. A complaint register should be available with each concerned authority for public scrutiny with detailed information about the types of complaint made and the action taken on the same.

6. SOCIAL AUDIT:

While the central operational guidelines on NREGA dealt in detail with the Social Audit process by the Gram Sabha, laying down a step by step procedure, the state scheme only faintly deals with the matter. Amendment is needed to the scheme to lay down clear procedure for social audit and the agencies to be made responsible for the same.

7. SPEEDING UP THE PROPOSAL FOR SOCIAL AUDIT:

The state government is urged to speed up the proposal of making social audit in two districts (Mayurbhanj and Kalahandi) on a pilot basis with the active cooperation of civil society organizations, which was notified by the government in the month of February 2007.

8. GOVERNMENT CIRCULARS MUST CONFIRM TO THE ACT AND SCHEME:

The circulars/orders of the State government must not go contrary to the provisions enshrined in the Act. It not only creates confusion among the authorities on the ground for implementation but also deprives the people of their rights provided in the Act.

For example, the government circular issued in the month of November, 2006 [No. 21702/ RE 51/05 (B) PR Dated 16.11.2006] to all Collectors and PD, DRDAs of NREGA districts of the State emphasizes the implementation of certain measures, which not only contravene the letter and spirit of the Act, but also flout the provisions made in the OREGS, notified about a month later.

9. PROPER PUBLICITY BY THE GOVERNMENT ON SCHEMES/CIRCULARS/ORDERS ETC:

The Panchayati Raj (PR) department needs to update its website on various initiatives it is taking e.g. notification of OREGS, issuance of important circulars etc. for easy access to information by the public. It needs to issue press releases on vital steps taken on the matter.

10. PROPER COMMUNICATION BETWEEN THE POLICY MAKING AND POLICY IMPLEMENTATION LEVELS:

This part is lacking as the agencies in charge of the implementation at times have no knowledge about the important developments made at the policy level. For example, the forest department, in some protected areas and sanctuaries, is refusing to allow any work in these areas. This aspect needs urgent consideration.

11. CONSIDER NOMINATING SOME SOCIAL ACTIVISTS IN THE PROPOSED STATE EMPLOYMENT GUARANTEE COUNCIL:

The government claims that it has notified the State Employment Guarantee Council. Since the role of NGOs in monitoring and review of NREGP is extremely vital, the Chief Minister, who is the chairperson of the proposed council, should consider nominating some leading social activists in the council as has been done at the Centre and in some other states.

12. CREATING A HELPLINE ON NREGA / OREGS:

This assumes importance as it will serve as a nodal information centre for removal of the doubts people and even officials have on the Act and scheme.

13. SEPARATE STAFF STRUCTURE FOR NREGA / OREGS:

Orissa needs to have a separate directorate for NREGS/OREGS on the lines of the Andhra model. Given the quantum of central finance, a separate structure at the policy level is vital for smooth implementation and monitoring of the scheme.

In view of the heavy work load of the BDO, the present arrangement of giving additional responsibility of OREGS with its plethora of paperwork to him needs rethinking. It is therefore proposed that either a full time officer of the rank of ABDO be appointed as the Programme Officer or in case of the existing arrangement, the BDO is assisted by an ABDO to relieve him of his responsibilities vis-à-vis NRGES/OREGS.

14. PREVENTING THE MIDDLEMEN IN MEDDLING WITH THE BANK ACCOUNTS OF PEOPLE:

There is an urgent need for issuance of circulars/requests from the government to the banks not to entertain the middlemen (bank agents/ dalals) between the bank and the people. While the decision to make payments through bank accounts to the workers under NREGA/OREGS is a right step in checking the manipulation in payments, necessary care is to be taken to prevent middlemen from making transactions on behalf of the people. It may be noted here that the practice is a big menace in the tribal pockets of the state and the people get exploited in the process.

IN CONCLUSION:

Not only the government, but also civil society and the media should also contribute their bit towards the execution of the Employment Guarantee Act. Right and timely decision and vigilance by the government, alertness by the media on vital lapses/decisions under the Act and vibrant reporting on the ground difficulties of people, sincere activism and advocacy by the civil society will certainly go a long way in achieving the objectives enumerated in the act.

Source: NREG Act 2005;OREGS; Advertisements by Orissa Govt on NREGA; news reports from www.orissadiary.com, The Pioneer and other dailies; writings from www.indiatogether.org; letter to the Chief Minister by Ms Vidya Das, State Advisor to Commission on Right to Food appointed by Supreme Court; Surveys and findings of different CSOs; Suggestion by CSOs to Planning Commission study group.

Pradeep Baisakh : Freelance Journalist & Social Activist

THE MILLENNIUM GOAL OF TAKING ALL BOYS AND GIRLS TO PRIMARY SCHOOL IN ORISSA

By **Dr. D. P. Pattnaik**

Today's world is an unequal world. The rich, the powerful and the affluent have appropriated the First and the Second World nomenclature for themselves. They have put the poor, powerless countries in a single basket and called it the Third World. The Third World is diverse in terms of population, environment, cultural practices, riches as well as poverty. The First and the Second World are exploiters. They speak of global co-operation but for all practical purposes, they are engaged in global policing to hold in check the development of smaller nations.

The First and the Second World are developed nations. The rest are variously called the developing, underdeveloped or the poverty-stricken world. They are the education leaders and theory builders. They set the parameters for measuring the progress of the world. The rest of the world follows them until they are proved inadequate. The first parameters were GNP/GDP. Once they were found inadequate, Physical Index of Quality of life (PIQL) was developed. When even this was found inadequate, it gave way to Human Development Index (HDI). The current measure is Millennium Development Goals (MDGs), a set of quantifiable, time-bound targets to measure progress.

Rather than get lost in the jungle of statistics relating to all the eight goals, let us restrict ourselves to education. Since the MDG restricts education to 'Universal Primary Education', it will perhaps be prudent to focus attention on this aspect of education. Universal Primary Education is not new to India. Gokhale's Bill for Universalization of Elementary Education (1909) was defeated by a large majority, whose 'priority' was higher education accessible mostly to the English-educated 'elite'. It is no different today. Politicians, bureaucrats as well as the system work together to make higher education accessible to the English educated.

UN organizes World Education Ministers' Conference every two years. After holding the event a few times, the world body decided to invite five educationists to address the meet. I was invited to Geneva as one of the five to address the meeting soon after the pledge of Education for All. The Italian Education Minister told the gathering that his country was sold to the idea of Education for All and had provided fourteen thousand dollars on this account .For good measure, he also added that more money is to be pumped into it soon.

When my turn came to address the conference, I started by quoting the Italian Minister. I said that by definition, education is education for some. 'Education for All' is an adjunct of 'education for some'. Hardly had I finished the sentence when a gentleman from the audience requested me to keep quiet for a few moments. He repeated the two sentences I had just completed. Addressing the gathering, he said, "Ladies and gentleman, if we go back to our countries with this one message, our attending to conference would have been fruitful". He was the Minister for Education of NIGERIA.

Our education systems are pyramidal in structure. At the bottom of it, there are thousands of primary schools. At the top is a handful of higher education institutions accessible only to the English educated. The top layer is the result of filtration at different levels. Out of a hundred children at the ground level, 80 drop out by the 8th standard. At the 10th standard, only 30 to 40 percent pass and nearly fifty percent of them in third class. This means that they are good for no job. Thus, those who actually make it to the institutions of higher education are from the top 3 to 4 percent of the Indian population.

India is multi-lingual, multi-ethnic and multi-cultural. It is economically, politically and educationally diverse. But even allowing for all this diversity, one is amazed at the variety of schools. The first difference is between government schools and private schools. "It is estimated that every fourth school in the country is a free charging private school" (Zacharies, 2005). The parents do not always go to private schools out of choice. "Unfortunately the private schools, as they operate in this country, are contributing to the social and economic divide by 'perpetuating inequalities' in the education system."(Panchamukhi, 1983 and Tilak and Sudersan 2001) in

Vinay K. Kanth and Madan M. Jha, Search for Rights, Equity and Social Justice: Right to Education Bill, East and West Educational Society, 2005)

There are other dimensions to diversity; Tribal schools are run by the SC & ST Welfare Department; labour schools by the Labour Department; agricultural schools by the Agriculture Department, medical and paramedical schools by the Health Department and so on. Then there are schools run by religious minorities like Anglo-Indians, Muslim and Sikh schools. The Kendriya Vidyalayas and the Navodaya Vidyalayas are affiliated to the CBSE. There are State schools of 'distinct character', which are notified by the centre as 'specified category.' There are schools run by saints or their disciples. In Orissa, there are Sobhaniya Vidyasharmas, Swami Sudhananda Schools, Bramhakumari Schools, Ramdev Schools, Satya Sai Schools, and Saraswati Vidyamandir. These are besides Vivekananda Schools, Sri Aurovindo Integral Schools and J. Krishnamurthy Schools. Very few research studies are available on the access, retention and achievements of all these varieties of schools.

There are 52,820 villages in Orissa, out of which 12, 445 have no primary schools. There are 33,221 primary and 12,449 upper primary schools making a total of 44,775 schools in Orissa. 1,889 schools have no rooms, 2,665 schools have no drinking water facilities and 39,131 schools have no toilets.

There are about 7,000 single teacher schools. This means one teacher teaches all subjects in all classes, besides doing the administrative work in each of these schools. They are asked to teach Environment Education and English in addition to the subjects they are required to teach as per the normal curriculum. To expect them to bring in more students and retain them is perhaps asking for too much.

10,000 Gram Panchayats have no high schools. About 80,000 posts of teachers, including 42,000 recently retired teachers, are lying vacant. Primary education is run by Sikshya Sahayaks, who are overworked and underpaid. No wonder one and half lakh teachers do not attend schools regularly, more than six lakh children do not attend schools and ten lakh drop out. The quality of education in these schools is not too difficult to guess. Non-functioning, low-standard government schools on the one hand and non-existing government schools within approachable distances on the other leave parents with no choice but to opt for private schools.

Enrolment in primary and upper primary formal schools in 2003–2004 was 52, 53,958 and 12, 53,051 respectively. In 2004-2005, it was boys 31, 50,320 and girls 28, 51,540. Drop-outs in 2003–2004 was: primary 32.09 percent and upper primary 49.16 percent. Between 2001-2002 and 2004–2005, drop out reduced by 9 percent at the primary level and 7 percent at the elementary level. But in the current statistics released by the Govt of Orissa in its Economic Survey Report, it has been reported that the drop out in 2005–2006 was a little over three percent .In 2004–2005, tribal student drop-out at the upper primary level was shown as 70 percent .In 2005–2006, it has dropped to 14 percent. The sudden fall in the general drop-out rate from 32 percent to 3 percent and the ST dropout from 70 percent to 14 percent within a span of just one year creates serious doubts about the veracity of government statistics.

The above state of education in the state poses serious questions about our ability to meet the millennium challenge of taking all boys and girls to primary schools in Orissa. There is neither any planned projection about achieving this goal nor is there any dependable data to engage in any meaningful plan and its implementation. A Vision-2020 document was prepared, but before the Govt could apply its mind to it, the search for a new vision has already begun. A country as diverse as India needs a common school system, if equitable education is to be imparted and all children are to be brought to school. The upwardly moving middle class is the greatest enemy of our country as well as its development. And yet one would expect the leadership of a new revolution to emerge from this middle class as has happened in the case of the French Revolution.

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RIGHT TO EDUCATION: WHOSE AGENDA?

Dr. Ambika Prasad Nanda

INTRODUCTION:

The 86th Amendment to the Constitution of India in 2002 brings in Article 21-A, which states that, "The State shall provide free and compulsory education to all children of the age of six to fourteen years in such a manner as the State may, by law, determine."

Before this significant decision, the Constitution (Forty-second Amendment) Act, 1976 brought the subject "Education" into the Concurrent List from the State List. However, there is no Central legislation so far on the subject of education in particular relation to elementary education. A follow up legislation in terms of Article 21-A, therefore, was a long felt a necessity.

The follow up legislation was the culmination of several measures taken in this direction by the federal government in the preceding years. The Central Government prepared the First Draft in July-August, 2003, as "Free and Compulsory Education Bill" and the same was placed on the HRD website. This Bill was widely criticized for being anti-child and for lacking objectivity. Subsequent to this, on 10th December 2003, the Central Government came up with the 2nd Draft of the "Free and Compulsory Education Bill". This 2nd draft Bill was again widely criticized for the same reason. Finally, on 8th January 2004, the Central Govt. came up with a 3rd draft of the "Free and Compulsory Education Bill".

With the change of Govt. at the Centre, the UPA Government reconstituted the Central Advisory Board of Education (CABE). The CABE, in its meeting on 10/11 August 2004, decided to set up as many as seven committees to deal with different issues relating to education. One of the committees was on the subject of "Free and Compulsory Education Bill and other issues related to Elementary Education" under the Chairmanship of Sh. Kapil Sibal, MoS Science and Technology. The said Committee has now come up with a draft of the Right to Education Bill, 2005 and the same has also been posted on the HRD website for public comments.

Some of the highlights of the Bill are:

- The State shall ensure a school in every child's neighbourhood. Every school shall conform to certain minimum standards defined in the Bill.
- Government schools shall provide free education to all admitted children. Private schools shall admit at least 25% of children from weaker sections; no fee shall be charged from these children. Screening tests at the time of admission and capitation fees are to be prohibited for all children.
- Government schools will be managed by School Management Committees (SMC), mostly composed of parents. Teachers will be assigned to a particular school; there will be no transfers.
- A National Commission for Elementary Education shall be constituted to monitor all aspects of elementary education, including quality.

This Bill was supposed to come up in the May 2006 session of the Parliament. But to the surprise of everyone, the UPA Government has circulated a model Right to Education Bill 2006, asking State Governments to enact a law conforming to its broad parameters, failing which the resources from SSA would be curtailed.

Upset with this decision, Prof. Anil Sadgopal, Member of the Central Advisory Board of Education (CABE), said "The Indian State cannot retreat from its promised responsibility. The Government has betrayed the people by retreating from its constitutional obligation towards a critical fundamental right such as elementary education".

The UPA government, which has come up with a progressive legislation like the Right to Employment Act, has surprisingly developed cold feet in bringing in the Right to Education Bill. The retreat of the government on this important Bill should be a wake up call for all civil society organizations to come together to fight for their rights.

EDUCATION SCENARIO IN ORISSA:

Orissa ranks 26th among states/UTs with an overall literacy rate of 63.6 per cent. Gender disparity in literacy rates in the state is a cause for serious concern. The female literacy rate in the state is 50.97 %, which is lower than the national average (54.16%). Seventeen districts out of the state's thirty districts have female literacy rates lower than the national average. The literacy rates in the 30 districts of Orissa have been given below:

Literacy rates by Sex for state/ Dist as per Census 2001(from Lower to higher)

Sl no	District	Literacy rate	Male literacy rate	Female literacy rate	Gender gap in literacy	Remark
1	Malkanagiri	30.5	40.1	20.9	19.2	
2	Nawarangpur	33.9	47	20.7	26.3	Literacy rate
4	Koraput	35.7	47.2	24.3	22.9	below 40 %
3	Rayagada	36.1	48.2	24.6	23.6	
5	Gajapati	41.3	54.7	28.4	26.3	Literacy rate
6	Nuapada	42	58.5	25.8	32.7	below 50 %
7	Kalahandi	45.9	62.7	29.3	33.4	
8	Mayurbhanj	51.9	65.8	37.8	28	
9	Kandhamal	52.7	69.8	35.9	33.9	
10	Bolangir	55.7	71.7	39.5	32.2	Literacy rate
11	Boudh	57.7	76.2	39	37.2	between
12	Keonjhar	59.2	72	46.2	25.8	51- 61 %
13	Deogarh	60.4	73.3	47.2	26.1	
14	Ganjam	60.8	75.2	46.4	28.8	
15	Sonepur	62.8	78.9	46.2	32.7	
16	Baragarh	64	77.4	50.3	27.1	
17	Sundergerh	64.9	75.3	53.9	21.4	
18	Sambalpur	67.3	79	55.2	23.8	Literacy rate
19	Angul	68.8	81.4	55.4	26	between
20	Dhenkanal	69.4	80.6	57.9	22.7	61-70 %
22	Nayagarh	70.5	82.7	57.6	25.1	
21	Balasore	70.6	81.7	58.9	22.8	
23	Jharsuguda	70.7	82.2	58.5	23.7	
24	Jajpur	71.4	81.9	60.8	21.1	
25	Bhadrak	73.9	84.7	62.8	21.9	
26	Cuttack	76.7	85.8	66.9	18.9	Literacy rate
27	Kendrapara	76.8	87.1	66.8	20.3	between
28	Puri	78	88.1	67.6	20.5	71-80 %
29	Jagatsinghpur	79.1	88.6	69.3	19.3	
30	Khurda	79.6	87.9	70.4	17.5	
	ORISSA	**63.1**	**75.3**	**50.5**	**24.8**	

As can be seen from the table, the literacy rate in the first 10 districts of the list varies between 30.5 to 55.7%. The female literacy rate in these districts is very low ranging from 20.9 to 39.5%.

STATUS OF PRIMARY EDUCATION:

Universalization of primary education has been included as an important component of the basic minimum services programme. The literacy rate in the state, as per the 2001 census, was 63.1%. Realising the importance of literacy in the development of the state, the Govt. constituted a task force to prepare a vision document on education (Vision 2020). According to draft report prepared by the task force, the educational scenario at primary level is as follows:

- The gross enrolment ratio (GER) in respect of primary school (Class I – V) in Orissa is 71.8 per cent (rural **:** 70.9, urban **:** 76.7 per cent); in upper primary schools, the GER is 44.6 per cent (rural **:** 41.5, urban **:** 61.4 per cent) [Multiple Indicator Survey UNICEF, 2000 (Preliminary data)]
- Enrolment at the upper primary level poses serious problems. The net enrolment ratio (NER) in the 11-14 age group is merely 38 per cent. In other words, 62 per cent of children are not enrolled at the upper primary level.
- **The drop-out rate** at the primary and upper primary stages is very high at **43.5 %** and **57 %** respectively
- The levels of learner achievement measured in terms of the quantum and quality of learning acquisition are abysmally low as established by the Baseline Assessment Studies conducted by DPEP. Variations in the levels of learner achievement among boys and girls, rural and urban children, children from SC and ST and non-SC/ST communities are glaring and are matters of grave concern.
- The shortfall of schools acts as a deterrent, particularly for girls, for enrolment in primary and upper primary schools.

- Number of primary schools / sections in Orissa - 42,104**;**
- The number of upper primary schools / sections is 11,510.
- Teachers in primary school: 1,14,791 (male: 86,353, female: 28,438)
- Teachers in upper primary school: 32,456 (male: 27,588, female: 4,868)
- No fresh appointments after 1993-94
- About 11,655 habitations do not have primary schools within a distance of 1 kilometer and 16,317 without upper primary schools within a distance of 3 Kms.

In 2001, about 47.1 lakh; (boys: 27.58 lakh and girls: 19.52 lakh) children were enrolled in primary school (Class I to V), (Source: School and Mass Education Department, Government of Orissa). However, irregular school attendance and drop-out from primary schools (boys: 42.3 and girls**:** 41.4 per cent) and upper primary school (boys**:** 52.9 and girls**:** 61.1 per cent) have resulted in fewer children completing the primary school cycle than were enrolled. Approximately 20 lakh children in the age group of 6-14 were out of school in 2001**.** A majority of the children in the 6 plus age group come from the poorest households. It has been estimated that out of 20 million child labourers in India in 1990, 7.30 lakhs were from Orissa (ILO, 1990). **Around 15 per cent of the child population in the 5-14 age group in Orissa is working as child labour** (MICS, 2000, UNICEF, India).

In 2001, the Government of India came up with a new education scheme, **Sarva Sikshya Abhiyan.** Sarva Sikshya Abhiyan or Education for All is the culmination of national efforts made to fulfill the goal of free education to every child in the country as enshrined in the Indian Constitution. The Sarva Sikshya Abhiyan is expected to provide useful and relevant elementary education for all children in the age group of 6-14 years by 2010.

The **objectives** of SSA are as follows:

- All children to be in school by 2003, (Education Guarantee Centres (EGS), Alternate Schools, “Back to Schools”).
- All children complete five years of primary schooling starting 2001 and by 2007.
- Focus on elementary education of satisfactory quality with emphasis on education for life.
- All children enrolled in 2003 must complete eight years of elementary schooling by 2010.
- Bridge social and gender gaps with the active participation of the community in the management of schools etc.
- Universal retention by 2010.

THE SPECIFIC OBJECTIVES OF THE PROJECT ARE:

- To activate government schools and EGS centers by entering the schools and activating the processes.
- To mobilize and elicit community involvement and participation of Dalits, Tribals and girls to enhance enrollment, retention and achievement of first generation learners.
- To form, restructure and energize Village Education Committees & Parents' Associations with adequate representation of Dalits, Tribals and Women and build their institutional capacity to play an effective role in the functioning and management of schools.
- To sensitize teachers to develop the right attitude towards learners from weaker and deprived sections of the community in the curriculum transaction process and to accept VEC and PTA members in respect of their roles and functioning.
- To promote inclusive education with emphasis on Children with Disabilities (CWDs) and girl children.
- To create an enabling environment by sensitizing various stakeholders such as PRIs and other constitutional bodies by launching an intensive awareness campaign.
- To ensure quality education linked to basic life skills.
- To influence state policies by setting up model schools.
- To facilitate budget analysis and advocacy for greater allocation of resources to elementary education.
- To build alliances with different social movements to strengthen the campaign
- To influence state and district level institutions (SCERT, DIET, SIEMAT & others) to promote Child Rights and children-friendly training to teachers and educational administrators.
- To build alliances with teachers' unions and other trade unions to lend strength to the campaign.
- To demand proper infrastructure at the school level.

COMMITMENT OF THE STATE IN TERMS OF BUDGET:

Budgetary commitment is one of the important indicators to assess the sincerity of the state in providing education to the children. By this reckoning, the record of the Orissa government has been rather poor. Given below is the trend of the budgetary allocation since 1990.

Year	In percentage	Year	In percentage
1909-91	16.45	1998-99	18.9
1991-92	16.38	1999-00	20.67
1992-93	16.97	2000-01	16.06
1993-94	16.65	2001-02	10.29
1994-95	17.41	2002-03	12.35
1995-96	18.05	2003-04	11.83
1996-97	17.79	2004-05	9.74
1997-98	18.69	2005-06	8.016

CHILD RIGHTS:

The Convention on the Rights of the Child was the first legally binding international instrument to incorporate the full range of human rights – civil, political, economic, social and cultural. Two Optional Protocols on the involvement of children in armed conflict and on the sale of children, child prostitution and child pornography, were adopted to strengthen the provisions of the Convention in these areas. These two came into force on 12 February and 18 January 2002 respectively.

The Convention on the Rights of the Child treaty spells out the basic human rights that children everywhere - without discrimination - have:

- The Right to Survival;
- The Right to Development;
- The Right to Protection
- The Right to Participation

THE RIGHT TO SURVIVAL:

The survival rights of children include provision of adequate food, shelter, clean water and primary health care. These are the basic rights to ensure the survival of a child.

THE RIGHT TO DEVELOPMENT:

The development rights of children include access to information, education, cultural activities, opportunities for rest, play and leisure and the right to freedom of thought, conscience and religion. Overall development of the child should include enabling the child to develop physically, mentally and socially in a healthy manner so that s/he becomes a better citizen in future.

THE RIGHT TO PROTECTION:

The child must be assured of protection not only from the violation of the above rights, but also from all kinds of exploitation and cruelty, arbitrary separation from the family and abuses in the justice and penal systems. Protection is also vital for especially vulnerable groups among children like abandoned children, street children, abused children, physically challenged children, displaced children etc. “Children must also be protected against the use and sale of drugs, as well as in time of armed conflicts.”

THE RIGHT TO PARTICIPATION:

The participation rights of children include their right to have their opinions taken into account in matters affecting their life and the right to play an active role in the community and society through freedom of association etc.

ROLE OF CIVIL SOCIETY ORGANIZATIONS:

CSOs have been a partner to the Government in implementing programmes related to welfare and development of children. It has been realized that for creating awareness and getting inputs from the NGOs for this endeavor, specially designed orientation programmes may be organized at the State and National level for those working for the welfare of children.

- Function as pressure groups in improving the quality of services by creating a demand for them and by motivating the community for active participation.
- Play a vital role in planning, implementation, monitoring and evaluation of the process of ensuring the rights of child.
- Recommend the Task Force to look into the gaps existing between the Constitution and the Convention.
- Raise public awareness on various national and international laws on Rights of Child.
- Protest against the policies and programmes hampering the interest of children
- Undertake advocacy and lobbing to defend the rights of child
- Sensitize the media to highlight issues violating the rights of the child
- Sensitize policy makers as well as the community at the grassroots level on the rights of children.

Universal ratification undoubtedly creates a significant global movement for children, leaving universal implementation as the ongoing challenge. The commitment of the world community to the human rights of children is fundamental. Translating this commitment into action to improve the lives of the nearly billion children in the world is a task that is incumbent on everybody. Mr. Kofi A. Annan, Secretary General of United Nations (1997) has rightly remarked **“To look into some aspects of the future, we do not need projections by supercomputers. Much of the next millennium can be seen in how we care for our children today. Tomorrow’s world may be influenced by science and technology, but more than anything, it is already taking shape in the bodies and minds of our children”**

Dr. Ambika Prasad Nanda, Programme Manager, Action Aid

GENDER EQUALITY AND WOMEN'S EMPOWERMENT: AN ASSESSMENT

By **Dr. Bedabati Mohanty**

WHY GENDER EQUALITY

Development is an integral process of economic growth and social progress. The role of women in the context of development is important not only because they constitute half of the total human resources, but also because they have to bear the brunt of the daily struggle for survival in the developing countries. No development strategy that neglects the role of women can lead to comprehensive socio-economic development of the economy.

As in many developing countries, women in India have not been able to play an effective role in the process of development - neither as contributors nor as beneficiaries. The goal of development is premised on the creation of sustainable improvement in the quality of life of all people and this can only be possible when everyone is given a chance to participate in public life. Inequalities in opportunities based on gender are not only unjust; they are also economically wasteful and socially destabilizing. Equity is complementary to the pursuit of long term prosperity. When social institutions and policies provide a level playing field, providing men and women equal chances to become socially and politically active and economically productive, sustainable growth and development become easier.

Whether it is in the field of education or health care or distribution of assets or participation in community life, women are nearly always in a disadvantageous position in our country. The wide range of biases prevailing in the society has resulted in women having fewer opportunities to develop their talents. On the one hand, the gender inequity prevailing in the field of education, health care, economic and political participation has relegated women to the status of second class citizens - making them more vulnerable and less able to protect themselves from discrimination. The development process taking place in an unequal society perpetuates the inequality. Unless elimination of inequality is viewed as a measure of development, women as a class will continue to be at the losing end. Hence the emphasis on gender equality.

WHAT IS WOMEN'S EMPOWERMENT

Women empowerment and gender equality are intrinsically related. Women need to be empowered to assert their position in the society. Empowerment is the expansion of capabilities for realizing one's potentialities. It is the expansion of assets and capabilities of a person to participate in, influence and control the institutions that affect his/her life. In the context of deprivations in different fields which women are subjected to, women's empowerment is conceived as a social process that seeks to neutralize oppression of women and achieve equity in the society. It is a state without oppression; an environment of freedom, equality and respect for individuals; a life with dignity. Realization of the full identity of women is the objective of women's empowerment.

MILLENNIUM DEVELOPMENT GOAL

Realizing the importance of gender equality and women's empowerment in the process of human development, promotion of gender equality and empowering women was accepted by all the member countries in the declaration of Millennium Development Goals at the UN summit in 2000 as one of the goals to be achieved by 2015. A target was set to eliminate gender disparity in primary and secondary education, preferably by 2005 and at all levels by 2015 towards achievement of this goal. In keeping with the MDGs, a target was set for reduction of gender gap in literacy in India by at least 50 percent by 2007 in the Tenth Five Year Plan. The Government of India, in its Common Minimum Programme, is also committed to introducing legislations for reservation of seats for women in Vidhan Sabhas and in Parliament and earmarking 1/3rd of funds flowing to Panchayats for development of women.

WHAT WE HAVE ACHIEVED

An attempt has been made here to make an assessment of the progress made in Orissa, one of the most backward States of India, in achieving the goal of gender equality and empowerment of women judged in term of their access to education, health care, economic and political participation.

EDUCATION

Education is by far the most important factor contributing towards empowerment through the development of capability. But discrimination at household level in allocation of resources has been a major factor accounting for gender inequity in education in the country, more so in the State of Orissa. It is well established that mothers'

education has greater influence on girls' schooling then the fathers' education, suggesting that not only does investment in girls' education give returns in term of improved family welfare, but also raises the inter-generational capability of women. Women's education has been a single cure for many societal ills and there is an inverse relationship between female literacy on the one hand and population growth, infant mortality rate, malnutrition and lower productivity on the other. Based on evidence from the developing world, it is claimed that the effects of mothers' education on her child's health and nutrition is so significant that each extra year of maternal education reduces the rate of mortality for children under the age of five by five to ten percent. In order that women are empowered to make positive choices and provide for themselves and their families, it is imperative that all children need to be given a fair chance to get at least primary education.

In Orissa, where a number of primary schools are run without their own buildings and where a still larger number of schools are without the required number of classrooms and teachers, quality school environment is a distant dream. But going by the rate of enrollment and drop out, a positive trend of improvement is indicated. Girls' enrollment at primary level has improved by about 6 percent and at upper primary level by 21 percent during 2001 to 2005 as reported by OPEPA. This has improved the Gender Parity Index, i.e. the number of girls to number of boys enrolled in schools.

TABLE – I

Gender Parity Index (GPI) in Elementary Education of Orissa

Year	Primary level (Age group 6 – 11)	U.P. Level (Age group 11 – 14)
1950 – 1951	0.25	0.08
1999 – 2000	0.73	0.66
2000 – 2001	0.71	0.77
2002 – 2003	0.87	0.80
2003 – 2004	0.90	0.82

Source: Human Development Report 2004, Orissa.

The table shows that the GPI, which was as low as 0.25 at the primary level and 0.08 at upper primary level in 1950–1951, had touched the level of 0.73 and 0.66 respectively by 1999–2000. The trend of improvement continued after 2000 and by 2003–2004, GPI has improved to the level of 0.90 and 0.82 respectively at the primary and U.P. levels respectively. The Mid-day meal programme introduced in the State since 1995, the District Education Programme launched in 1996–1997, provision of basic infrastructure like construction of school buildings, toilets, tubewells etc. under different programmes have no doubt contributed towards increased enrollment of girls. However, for universaliztion of Elementary Education - to which the State as well as the Nation are committed – merely increasing the access of girls and boys to enrollment is not enough. What is equally important is retaining the children longer in the school. The 'Sarva Sikhaya Abhiyan' (SSA) launched in the State in 2003–2004 has the goal of Universal Elementary Education and providing useful and quality education to all children in the age group of 6–14 years by 2010. The efforts have clearly borne fruit and there is a visible improvement in the drop-out rate in the schools as shown in Table – II.

TABLE – II

Dropout Rate (2000 – 2001 to 2005 – 2006)

Year	Primary School		U.P. School		High School	
	Boys	Girls	Boys	Girls	Boys	Girls
2000 – 01	42.3	41.4	52.9	61.1	68.0	73.4
2001 – 02	42.0	40.0	52.0	60.5	67.0	72.0
2002 – 03	32.3	36.5	57.7	60.5	65.9	68.5
2003 – 04	31.9	35.4	56.5	58.6	62.5	66.7
2004 – 05	31.4	32.7	48.2	50.1	61.0	66.0
2005 – 06	3.04	3.34	4.3	9.9	60.0	64.0

Source: Human Development Report 2004, Orissa.

The table reveals a fall in the drop-out rate during 2000–2001 to 2005–2006 among girls as well as boys. But invariably, the drop-out rate among girls has been relatively higher. The significant fall in the drop-out rate during 2005–2006 seams to have something to do with the SSA in the State. Moreover, the gender disparity in drop-out rate has been bridged to a great extent during 2005–2006. If the trend is maintained, elimination of gender gap in elementary education may not be a distant possibility in Orissa.

Condensed course of education for women in the age group of 15 years and above is under operation in the State for facilitating empowerment of women by providing education and relevant skills to them. Under the scheme, courses are offered to women to appear in formal examination extending from primary to higher secondary level. However, the achievements under the scheme have not really been encouraging.

HEALTH

Like education, health care is an important determining factor of the capability of a person. Women are discriminated against I our society in term of their access to health care, reproductive rights, proper diagnosis of disease and nutritious food. According to a World Bank estimate, malnutrition costs about ten billion US Dollars in India annually in term of loss of productivity, illness, death and is therefore regarded as a great obstacle to human development. It is true that the incidence of malnutrition is high among both boys and girls, but by and large female children continue to be more malnourished than their male counterparts. This is because when families suffer, children and women suffer the most due to their greater vulnerability and greater biological need for nutritional protection. Besides, gender disparity in nutrition among children is attributed to a deep-rooted gender bias among the mothers themselves, expressed in terms of differences in the pattern of breast-feeding adopted for boys and girls. Women in Orissa in general lack the resources and autonomy to access reasonable health care, a factor which could be responsible for the high incidence of child and infant mortality rate in the state. According to National Family Health Survey II, the autonomy of women in seeking health care is the lowest in Orissa at 14 percent as against 55 percent in Kerala.

Several schemes like Infant Mortality Reduction Mission, National Rural Health Mission are is operation in the state with the aim of providing free treatment services for slum dwellers, institutional delivery facilities to women free of cost, effective health care facilities to women and children in rural areas. Because of concerted efforts, there has been a decline in IMR in the state from 96 in 2000 to 75 in 2005. But the fact remains that it is still one of the highest in the Country. It is true that IMR among girls is a little lower than that among the boys. Even life expectancy at birth is marginally higher among women. But this is more due to the biological advantage with which women are gifted than because of their access to health care. That there is discrimination against women in access to health care is also indicated by the prevalent bias against women in accepting different modes of family planning. Though vasectomy is a comparatively easier family planning technique, tuboctomy - involving sterilization of women is more commonly accepted in Orissa. A look at the number of vasectomy and tuboctomy performed in Orissa during 2000–2001 to 2005–2006 (Table – III) gives an idea about gender bias in adoption of family planning.

TABLE – III

	2000 – 01	2001 – 02	2002 – 03	2003 – 04	2004 – 05	2005 – 06
Vasectomy	31	02	40	01	04	17
Tuboctomy	239	154	357	509	259	217

Source: Economic Survey of Orissa, 2006 – 07

WORK PARTICIPATION

Beside access to education and health care, it is essential that access to and control over the resources of women is ensured for improving their capability. Ownership and control over resources increases the self-confidence of a person, which is vital for improving his/her capability. Despite various legislations for improving women's title to land, which in closely linked with the livelihood pattern of the vast majority of people in our society, land as well as other resources are mainly owned and controlled by male persons in the society. Assets are rarely a source of income for women and it is mainly through the sale of labour that they earn. The unfortunate part is most of the labour performed by women is not saleable and as such is not considered as labour. There is therefore a gross underestimation of work performed by women.

Women joining in paid activities is an important indicator of their empowerment. The gender gap in work participation rate is a reflection of the lower status of women is the society. A look into the WPR of male and female per 1000 persons (Table–IV) reveals that the WPR of both male and female has improved during 1999-2000 to 2004–2005 in both urban and rural areas.

TABLE – IV

WPR per 1000 Persons in India

Year	Rural			Urban		
	M	F	Gender gap	M	F	Gender gap
1999-2000	531	297	23.4%	518	139	37.9%
2004-2005	546	327	21.9%	549	166	38.3%
% Change	2.8	10.1		5.9	19.4	

Increase in WPR among the females has been more pronounced than that among males, indicating an increasing awareness in the society about the need for participation of women in earning activities – a step towards their empowerment. However, the gender gap in WPR continues – while it has reduced slightly in rural areas, it has actually increased marginally in urban areas.

Distribution of the employed persons across educational levels reveals the quality of its workforce. The educational composition of workers reveals that the proportion of illiterates is much higher among women workers than among male workers (Table V). On the other hand, the proportion of those with secondary and above level of education is more among male workers. This suggests a comparatively lower level of earning for women workers vis-à-vis male workers. The 61st round of NSSO survey also reveals that the unemployment rate i.e. the number of persons unemployed per 1, 000 persons in the labour force has increased to 18 and 67 respectively in rural and urban areas during 2004 2005 from a level of 11 and 57 in 1999–2000. It indicates that the opportunities of employment for women are not increasing in proportion to their increasing participation in labour force. The situation is particularly precarious in Orissa with the employment rate for females in urban area reported to be 27 percent as against the national average of 7 percent. It suggests that the various employment generation schemes introduced in the state have not been effective in providing adequate employment opportunities for women. Moreover, with improvement in the level of education of women in urban areas, a big gap is created between the type of employment sought by women and the availability of such opportunities.

TABLE – V

Educational Composition of Workers (Aged 15 yrs. & above) per 1000 workers

		Illiterate	Up to Primary level	Middle level	Secondary & above level
Rural	Male	338	294	181	187
	Female	664	184	87	64
Urban	Male	131	227	194	448
	Female	373	230	119	305

Source: NSSO, 61st Round Survey Report

SELF HELP GROUPS AND WOMEN EMPOWERMENT:

Recognizing the importance of employment and income in women's empowerment, Self Help Groups are being promoted in the state by Mission Shakti. Through group identity and activity, it is hoped that women will be able to overcome the age-old gender bias against them. Steps are being taken for capacity building of the members and economic activities are being promoted by linking the groups to Banks and Micro Finance Institutes. The achievement in this respect has been more than what was expected. By 2005–2006, 1, 90, 785 groups have been formed in the State as against a target of 1,40, 000 SHGs set by Mission Shakti. Organization of women into SHGs has increased their knowledge and ability no doubt. But it has not necessarily given them

access to or ownership and control of resources, which improves their involvement in the decision making process, a true parameter of empowerment. In order that SHGs contribute towards empowerment of women, there is need for further expansion of economic activities of these groups.

POLITICAL PARTICIPATION

Proper representation of women in social and political organization is no less important for their empowerment than their access to education or health care. The law of the country doesn't exclude women from formal political participation. But in practice, there is a big gap between formal political equality and actual participation of women in the decision-making process. While it is broadly agreed that there is a need for practical measures to ensure gender equality in the political field, when it comes to the question of quota and reservation for women in various political and economic bodies, there is great resistance to such practical steps. In Orissa, the state that was a pioneer in introducing reservation for women at the panchayat level, it has often been alleged that the participation of women in the decision-making process at the grassroots level has been quantitative rather than qualitative. Male dominance continues at the decision-making level and victimization of elected women members proves to be a hurdle in the way of women's empowerment. It is observed that when women's' influence in public life increases, corruption decreases. But, in practice, representation of women in political bodies doesn't show any improvement. The percentage of women MLAs in Orissa, which stood at 9.52 in 2000, has in fact declined to 7.48 in 2004.

CONCLUSION

In conclusion, it may be said that the process of gender equality and women empowerment has still a long way to go. Even though government figures, which are sometimes challenged to be overestimates, suggest that gender disparity in education seems to be fast declining, there is no reason to be complacent about the achievement. Empowerment of women in the true sense of the term requires their access to better health care, ownership of resources and participation in community life and in these respects, the state is still for behind.

Targeted schemes of the government, it must be said, have had at best a limited impact on women. They have to be combined with proper macro economic policies, which could influence the condition of women in more ways than one. Policies providing for sanitation and drinking water, for example, not only improve the health condition of the family and the women, but also reduce the workload on her, thereby enabling her to spend more time on earning activities and contributing towards empowerment in the process.

Targeted schemes of the govt. for women's development, combined with proper macro economic policies and a desire as well as commitment for implementation, will help us to achieve the MDG of gender equality and women's empowerment. The society is gradually becoming women friendly. Women themselves have to overcome the gender bias and take advantage of these women-friendly policies.

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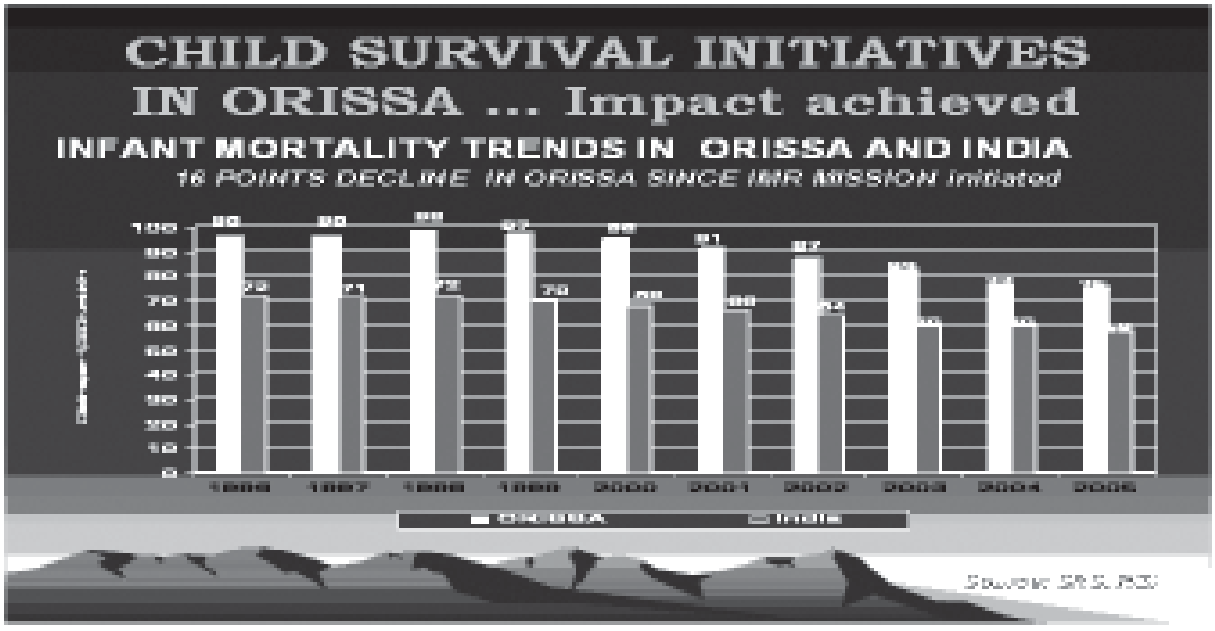
KEEPING THE BABIES ALIVE: THE CHALLENGE FOR ORISSA

By Dr. Asish Sen

BACKGROUND INFORMATION:

Infant Mortality Rate (IMR) in Orissa has dropped from 97/1,000 live births in 2002 to 75/1,000 in 2005. This significant reduction is a result of the state institutionalising the IMR Mission in 2001. However, it is the southern region when compared to the northern and the coastal regions. Between 1998/99 (RCH-I) and 2002/04 (RCH-II) the U-5 child mortality rate has fallen from more than 107 to 121 per 1000 live births. Only 52% of children in the age group of 12-23 months are fully immunized. The maternal mortality rate remains high at 358/100,000[1] births. Three factors may explain the high levels of IMR and MMR in Orissa; the level of skilled care during childbirth, the high percentage of low birth weight and lack of professional post natal care. According to NFHS-III, only 39% of the deliveries are institutional deliveries. These three factors together have a bearing on neonatal mortality which constitutes 64% of all infant deaths. Maternal malnutrition and malaria are among the main causes of low birth weight. It has been estimated that 40% of neonatal deaths occur in cases of low birth weight babies. Lack of access to safe drinking water, unhealthy hygiene practices and malnutrition are the other underlying factors behind child deaths. Out of all deaths of children under 5 years of age, diarrhoea accounts for 28%, ARI/Pneumonia 15% and measles 10%.

Between 2001 and 2005, the IMR has fallen sharply from 91 to 75 per 1,000 live births which is significant. The key interventions undertaken by the GoO that have contributed to IMR reduction are a) improved routine immunization coverage, including measles b) enhanced coverage of TT2/TTB for pregnant women and c) increased proportion of deliveries at institutions and by trained/skilled personnel.



With a per capita income of around US$ 250, Orissa ranks as India's second poorest state. The population is mostly rural, with 87 percent or around 37 million people living in rural areas. The state has one of the lowest population densities in the country (236 versus 324 per square kilometer) and certain parts of the state have fewer than 100 people/square kilometer. The state also has a low population growth rate, the result of a relatively low fertility rate (3.3) and a fairly high mortality rate. The state has one of the highest rates of poverty in India (47% versus the all-India average of 26%). Poverty is more prevalent in rural areas (48 percent) than in urban areas (43 percent). There is considerable geographical variation within the state with the coastal areas generally having a lower poverty rate, while the interior parts in southern and western areas have very high rates (in excess of 80% in some places). Scheduled tribes, who figure prominently in the state's population (23% versus the all-India average of 8%) suffer significantly high incidence of poverty (73%). Scheduled Tribes dominate

[1] *SRS 2003*

in certain district (such as Gajapati, Kandhamal, Keonjhar, Koraput, Malkangiri, Mayurbhanj, Nawarangpur, Rayagada and Sundergarh). The state has one of the lower levels of literacy (64% in 2001), but the trend is positive, albeit showing some deceleration. There is a significant gender gap in school enrolment and literacy rates.

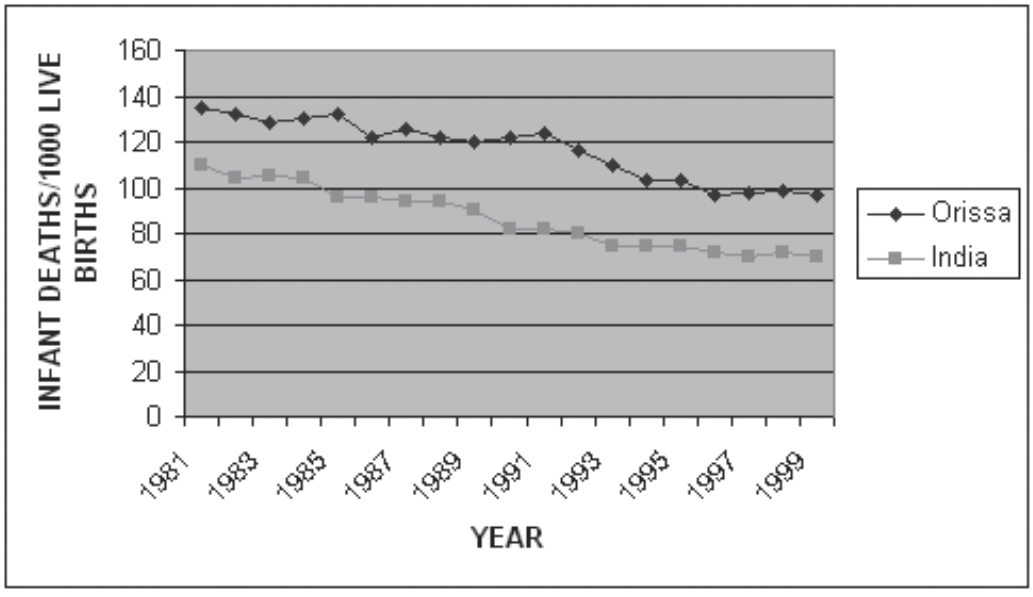
TABLE 1: INFANT MORTALITY RATES ACROSS SELECTED INDIAN STATES, 1980-2000

	1980	1990	2000	2015 (target)
Kerala	37	17	14	6
West Bengal	91	63	51	21
Karnataka	69	70	57	23
Bihar	118	75	62	25
Rajasthan	108	85	79	28
UP	150	99	83	33
MP	142	111	88	37
Orissa	135	122	96	41
All India	110	80	68	27

Source: 1980 and 1990 Sample Registration System; 2000 National Family health Survey

Infant mortality rate in Orissa has declined from 135 deaths per 1,000 live births in 1980 to 122 in 1990 to 96 in 2000. (Table 1) Despite the decline, IMR in Orissa has remained the highest in the country, almost seven times the rate in Kerala. As such, infant deaths in Orissa account for about 5 percent of all infant deaths in India.

Figure 1: Infant Mortality Rate – India and Orissa (1981 – 1999)



Source: Sample Registration Survey (2000)

II. Learning from the RCH 2002 data: District profiles

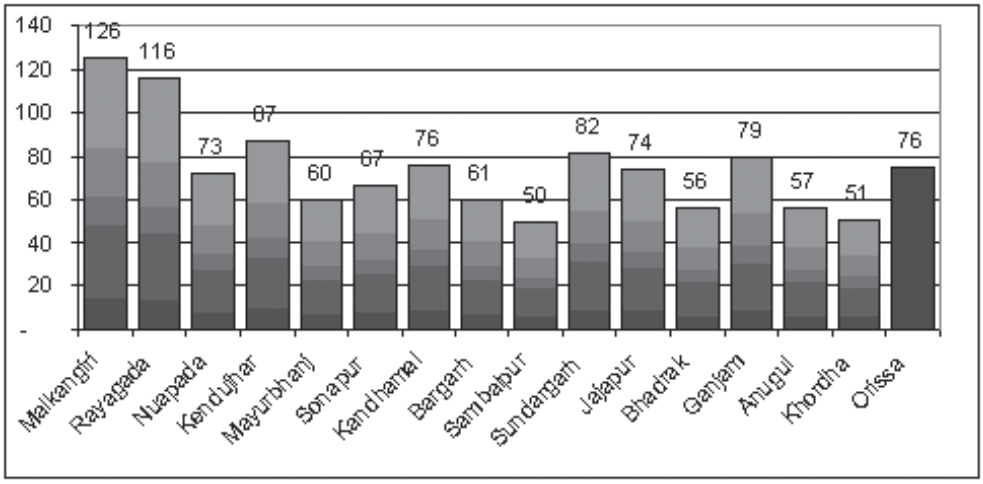
State story Between the two rounds of the RCH (1998/99 and 2002/03), there has been a significant decline in IMR from 97 to 87. The decline seems to have occurred in most districts and across both neo-natal and post-neonatal/infant mortality (to be validated on segregated data). However, neo-natal mortality remains high (around 43/1000) and is a large part (two thirds) of IMR. The potential contributory factors were a) high measles immunization coverage, b) high level of institutional delivery c) High proportion of maternal TT coverage and d) safe delivery practices.

District level estimates of child mortality in 2002 – data from 15 districts[1]: there is considerable inter-district variation across child mortality (figure 2) as well as IMR (lowest 42/1000; highest 100/1000). The variation with neo-natal deaths is comparatively lower - 28/1000 to 52/1000 (Table 2). In some districts (Khordha, Sambalpur,

Sundergarh and Sonepur), neo-natal deaths account for 80%+ of IMR. Two districts, Rayagada and Malkangiri, have very high rates of child mortality – 116 and 126 respectively. Here, neo-natal mortality rates are not particularly high compared to other districts – but post neo-natal infant mortality and mortality in the age group of 1-5 years are very high. Two other districts where child mortality rates are particularly high in the 1-5 year age period are Kendujhar and Sundergarh.

A number of districts have performed especially well in terms of IMR decline. Sambalpur, Mayurbhanj and Bargarh, in particular, have registered high rates of decline (between RCH-1 to RCH-2 surveys). Moreover, they exhibit IMR figures that are considerably lower than the numbers predicted on the basis of key poverty, education and other household characteristics (see Table 7 below).

Figure 2: Child mortality rates across districts: districts in order from poorest to better off



Source: *WB estimation using RCH II; Notes: Districts are ordered from poorest (left) to richest (right)*

Table 2: District-wise IMR, Neo-natal estimates and some key variables, Districts ranked by Poverty

Districts ranked by household wealth index (wealthiest to poorest)+	Women's education: % with at least primary schooling	Ethnicity: % of population which is scheduled tribe	Infant Mortality Rate	Neonatal mortality rate	Neonatal deaths as a share of IMR (%)
Khordha	45	3	51	41	80
Anugul	43	17	51	36	71
Ganjam	27	7	72	44	62
Bhadrak	38	3	42	28	66
Jajapur	34	9	70	47	67
Sundargarh	32	57	64	52	81
Sambalpur	31	40	42	34	80
Bargarh	25	25	54	33	61
Kandhamal	24	48	72	50	70
Sonepur	23	7	60	48	80
Mayurbhanj	34	55	55	37	67
Kendujhar	29	50	69	44	64
Nuapada	20	33	68	46	68
Rayagada	12	60	91	48	54
Malkangiri	8*	66	100	49	49
All districts	**28**	**32**	**65**	**43**	**66**

* Literacy rate among women of 11% compared to state-wide average of 42%

[1] This is the first phase of the second round of RCH data collection. District-wise data for Round 2, phase 2 have been collected (in 2004) but are not yet available for analysis. As soon as data for the other 15 district become available, this analysis will be updated to reflect the situation in all 30 districts of Orissa.

+ Since commonly used measures of long-run wealth, such as aggregate income or consumption, are unavailable in the RCH data, this analysis computes wealth based on the ownership of durable goods and housing characteristics. The durable goods used are: fans, radios, sewing machines, televisions, telephones, bicycles, motorcycles, cars, and tractors. Note that we only have information on whether or not a household owns any of these items and not the quantity or quality of the items owned by the household. The housing characteristics used are: the main source of drinking water (tap inside the residence, shared or public tap, hand-pump, etc.), type of housing material (Kachcha, Semi-Pucca, Pucca), type of toilet facility (own flush toilet, own pit toilet, shared toilet, etc.), main source of lighting for the house (electricity, kerosene, other), and main source of fuel for cooking (LPG/electricity, kerosene, wood, other). Again, note that we only have information on whether or not any of these housing materials is available in the respondent's household and no information on the quantity or quality of the materials is available. Together with the household's characteristics and ownership of durable goods, the wealth index is computed using a principle components model (see Filmer and Pritchett, 1998). Filmer and Pritchett demonstrate that their measure of long-run wealth (asset index) computed using a Demographic and Health Survey (very similar to the RCH data), performs as well as other measures of welfare, such as household per capita consumption.
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POVERTY, EDUCATION AND ETHNICITY:

Household income/wealth, mothers' education and ethnicity are all thought to be important determinants of child mortality in India. District level data for Orissa bear this out, but with one very important caveat: **when education and income levels remain constant, ethnicity as a variable ceases to be important.** The poorest districts (in the sample of 15 districts) of Rayagada and Malkangiri have IMRs of 91 and 100/1000 live births respectively; by comparison, the better off districts of Khurda and Anugul have much lower rates (51/1000). However, there are some outliers: Sambalpur, for example, has a much lower IMR - lower than its wealth status would suggest - as indeed have Mayurbhanj and Nuapada. At the other extreme, Ganjam and Sundargarh have higher IMRs than their wealth ranking would suggest.

There is considerable variation in the education status of women of child-bearing age: Khordha, Anugul and Bhadrak have relatively high levels of education, while Rayagada, Nuapada and Malkangiri have low levels of education among women. This is quite closely reflected in the district level mortality figures: generally speaking, districts with higher levels of women's education have lower IMRs, while districts having low levels of education have high IMRs.

The ethnicity story is, however, quite different. While it is true that two districts with a high incidence of ST population (Rayagada and Malkangiri) also have high IMRs, other districts with large ST populations have relatively low IMRs - Sambalpur, Mayurbhanji and Sundargarh, for example. Indeed, as will be shown later in this paper, once wealth and women's education remain constant, ethnicity falls away as an explanatory factor in IMRs.

ANTENATAL CARE, DELIVERY AND POST-NATAL CARE:

A significant number of women get at least one ANC visit (87%-NFHS 3) and more than 40% get three ante-natal check-ups. Considerable variation exists across districts – Sambalpur, Khordha, Sonepur and Bargarh are getting higher numbers of women into ANC while Malkangiri, Rayagada and Kendujhar are not doing so well. However, all districts are doing very well on tetanus toxoid (84% average coverage: Table 3).

Despite high levels of ANC visits, few women deliver their babies outside the home – 72% of all deliveries in these 15 Orissa districts take place at home. In Kendujhar, Rayagada and Malkangiri, more than 80% of all deliveries are at home. Most home deliveries are assisted by either an Untrained Dai (30%) or a relative/friend (44%). Only in Khordha District are a high proportion of deliveries undertaken in medical facilities (either government or private). The reason for this significant variation is that an over-whelming majority of women say it is "not necessary" to go to a health facility. In three districts (Bhadrak, Kendujhar and Rayagada), cost was cited as an issue though transport was rarely mentioned; poor service quality was of concern in close to ten percent of situations, with four districts recording a higher level of service quality concern (Sambalpur, Anugul, Bargarh and Bhadrak). The extent to which this pattern of home delivery in the hands of untrained health workers influences the very high levels of neonatal mortality throughout the state will be explored further later in this paper.

Table 3: Antenatal care at the District level

Districts ranked by IMR – lowest to highest	Infant Mortality Rate	% pregnant women getting Tetanus Toxiod	% pregnant women getting min. one ANC	% pregnant women getting three ANC
Sambalpur	42	94	80	54
Bhadrak	42	93	64	35
Khordha	51	88	72	41
Anugul	51	82	67	43
Bargarh	54	90	81	45
Mayurbhanj	55	92	64	35
Sonapur	60	85	78	47
Sundargarh	64	84	68	34
Nuapada	68	83	70	35
Kendujhar	69	80	54	24
Jajapur	70	81	64	30
Kandhamal	72	85	65	31
Ganjam	72	70	60	37
Rayagada	91	83	48	26
Malkangiri	100	73	34	13
All districts	**65**	**84**	**63**	**42**

DLHS data

Table 4: Mortality rates and places of delivery

Districts ranked by NNMR – lowest to highest	Neonatal mortality rate	% deliveries in medical facility	% deliveries at home	% deliveries by trained medical(Incl. Dai)
Bhadrak	28	27	67	25
Bargarh	33	28	70	33
Sambalpur	34	34	63	26
Anugul	36	29	67	6
Mayurbhanj	37	24	75	27
Khordha	41	46	53	17
Kendujhar	44	14	83	19
Ganjam	44	28	69	25
Nuapada	46	17	77	17
Jajapur	47	28	69	27
Sonapur	48	25	71	23
Rayagada	48	15	83	22
Malkangiri	49	9	90	8
Kandhamal	50	19	72	21
Sundargarh	52	23	67	26
All districts	**43**	**24**	**72**	**21**

Only a small percentage of new mothers receive a visit from the ANM (14% statewide). In a few districts, the percentage of visits is higher – Rayagada (32%), Malkangiri (25%) and Kendujhar (19%). There is evidence of additional visits in these same districts (in Rayagada, for example, 23% of new mothers receive a second visit).

CARE OF THE YOUNG CHILD: BREASTFEEDING, DIARROHEA TREATMENT AND IMMUNIZATION:

Breastfeeding of newborns shows some variation across districts. On an average, 43% of babies are breastfed within the first 2 hours of delivery – more than a half in Ganjam, Sundargarh, Mayurbhanj, and Malkangiri, but less than a quarter in Sambalpur. As for the duration of breastfeeding, while some 81% of mothers breastfeed for a few months, only 20% continue with exclusive breastfeeding for 6 months. Anugul, Jajpur, Malkangiri, Sambalpur and Sundargarh have the highest incidence of longer term breastfeeding, while in Kendujhar, Khordha and Mayurbhanj, mothers tend to introduce other foods before the child attains the age of 6 months. In Orissa, as in many places in the sub-continent, the practice of squeezing and destroying colostrum (rather than allowing the baby to absorb it) is widespread: 52% of mothers follow this practice (72% in Malkangiri): mothers in Nuapada, Khordha, Kandhamal and Ganjam are somewhat more inclined to allow the babies to have colostrum than elsewhere.

Table 5: Child Mortality and Immunization at the District level

Districts ranked by Child Mortality – lowest to highest	Child Mortality Rate	At least 6 months of exclusive breastfeeding (%)	Some knowledge of appropriate diarrhoea treatment	% of children aged 12-36 months fully immunized
Sambalpur	50	28	84	70
Khordha	51	5	100	52
Bhadrak	56	18	100	44
Anugul	57	28	100	45
Mayurbhanj	60	8	67	37
Bargarh	61	20	100	63
Sonapur	67	22	100	58
Nuapada	73	19	93	33
Jajapur	74	27	100	33
Kandhamal	76	14	100	46
Ganjam	79	16	100	49
Sundargarh	82	39	100	49
Kendujhar	87	9	100	32
Rayagada	116	13	60	45
Malkangiri	126	30	67	30
All districts	**76**	**19**	**91**	**45**

Treatment of frequently occurring diarrhoea seems well understood throughout the state with only 9% of mothers not knowing the appropriate care. There are three districts, however, which cry out for additional attention since knowledge about the disease and its cure is poorer: these are Mayurbhanj, Rayagada, and Malkangiri.

IMMUNIZATION:

The state-wide "fully immunized" rate[1], when compared between NFHS 2 and NFHS 3, shows a very positive trend: a leap of 8%. At present, around 52% of children under the age of 36 months have received all the recommended immunizations. While analyzing the performances based on RCH II data, there is some variation in district-wise performance between the two periods. While some have improved, a large number of districts have slipped. Among the different vaccinations, BCG coverage is generally good (81%) (Jajpur and Malkangiri slipping a little), DPT 3, Polio 3 and measles all similar at 62%, 61% and 58% respectively – with only Malkangiri standing out with consistently low rates of coverage and Sambalpur with consistently high rates.

ACCESS TO ICDS AND HEALTH FACILITIES:

While access to ICDS centers is pretty comprehensive throughout the 15 districts (83% of households have access to an ICDS center), access to health facilities is varied. At one extreme, the districts of Angul and

[1] BCG, DPT (3 doses), Polio (3 doses) and measles for children under 36 months.

Kendujhar have pretty good coverage in terms of both public and private facilities (see Table 6). At the other extreme, districts such as Malgangiri and Sonepur have good access to neither public nor private health facilities.

Table 6: District-wise Health Facilities, Districts ranked by Wealth

Districts ranked by household wealth index (wealthiest to poorest)+	Percentage of households having access to ICDS Center in the village	Percentage of households having access to health sub-center in the village	Percentage of households having access to PHC	Percentage of households having access to CHC/RH	Percentage of households having access to private clinic in the village
Khordha	92	22	0	25	0
Anugul	90	53	34	63	29
Ganjam	80	29	11	3	17
Bhadrak	83	26	20	1	3
Jajapur	81	33	7	25	4
Sundargarh	71	30	17	12	5
Sambalpur	81	30	15	12	19
Bargarh	87	34	24	13	20
Kandhamal	81	30	15	12	13
Sonapur	86	14	4	0	3
Mayurbhanj	94	28	5	4	5
Kendujhar	86	58	23	61	24
Nuapada	91	34	6	0	1
Rayagada	60	39	8	7	1
Malkangiri	84	15	2	0	3
All districts	**83**	**31**	**12**	**15**	**10**

A final part of the district level analysis involves an exercise whereby the actual IMRs for the districts are compared with "predicted" IMR numbers: "predicted" estimates are made by aggregating a number of household socio-economic values, such as the wealth index, women's education, ethnicity of household, type of house, drinking water and sanitation, electricity, cooking fuel and other household characteristics. In so far as these are some of the main determinants of mortality outcomes, they can be expected to predict the actual observed rates. The results are presented in Table 7: lower numbers indicate an IMR performance better than household socio-economic characteristics would suggest; a higher number (more than 100%) indicate poorer performance than household socio-economic characteristics would suggest. In this analysis, two districts stand out as having IMRs that are significantly lower than the socio-economic conditions of the population would suggest – Mayurbhanj and Sambalpur. Two others districts – Malkangiri and Rayagada - have IMRs considerably higher than observed conditions would suggest. These districts could offer interesting case studies for further investigation: the positive deviants and the negative deviants. In particular, household behaviour and health service provision vis-à-vis antenatal and post-natal care seem particularly important: Sambalpur, for example, does well with ante-natal care, deliveries in a medical facility, exclusive breastfeeding, and immunization despite being a district with average wealth and education, and a relatively high ST population (35%).

Table 7: District level performance with IMR: good and bad performers

Districts	Actual IMR	Predicted IMR	Actual IMR as a % predicted IMR*(lower figure indicates better performance)
Mayurbhanj	**57**	**81**	**70%**
Sambalpur	**51**	**70**	**73%**
Bargarh	57	68	84%
Khordha	53	61	87%

Nuapada	73	81	90%
Anugul	61	67	91%
Bhadrak	56	61	92%
Sonapur	66	71	93%
Kandhamal	79	83	95%
Ganjam	**74**	**75**	**99%**
Kendujhar	89	85	105%
Jajapur	75	66	114%
Sundargarh	89	76	117%
Malkangiri	**119**	**94**	**127%**
Rayagada	**119**	**88**	**135%**

* Predicted IMR is based on wealth (asset) index, mother's education, ethnicity of household and other household characteristics: lower numbers indicate an IMR performance better than household socio-economic characteristics would suggest; a higher number (more than 100%) indicate a poorer performance than household socio-economic characteristics would suggest.

III. LEARNING FROM THE RCH 2002 DATA: INDIVIDUAL HOUSEHOLDS

Using the framework in fig. 3 (below), let us now consider a wide range of factors and their impact on child mortality at the household level. Both linear relationships and multivariate analysis will be drawn into the discussion. (Regression tables are at the end of the paper.) While a lot can be learned from these investigations - and indeed can be used to inform policy and program design - it should be stated up-front that the explanatory power of these relationships is not very strong. In other words, there remains a lot of unpredictability in child mortality outcomes. This point in the direction of moving on multiple fronts at the same time in so far as the precise impact of any one action can not be fully predicted.

Figure 3: Framework for Assessing Impact of Various Factors on Child Mortality

Domain of Variables	Factors to consider	Health outcome: Reduced child mortality, broken down into neo-natal, infant and child
1. Condition and behavior of women / would-be-mother / mother	Education; Age at first birth, Birth spacing (use of contraception); time-use; nutrition and health status; use of pre-natal, natal and post-natal care (who, where)	Relate to neo-natal, infant and child mortality levels
2. Care of new born, young child Treatment of new-born -	washing and feeding practice; feeding and weaning of older child; immunizations; care and treatment of sick child	Ditto
3. Household behaviors and risk factors	Hygiene/Sanitation practices; disease (malaria) prevention; cooking/nutrition; migration.Attitudes to pregnancy and child bearing; health care seeking practices; health financing arrangements	Ditto
4. Household Resources	Assets (land, business, people), income, livelihoods; intra-high distribution of resources	Ditto
5. Community factors (conditions and attitudes)	Infrastructure, electricity and access to services; environment; malaria;Gender norms; Religious beliefs; Ethnic mix.Community groups (SHGs)Attitude towards government and "modern" sector	Direct effects on mortality; also indirect effects

6. Supply (and cost) of health services	Availability of facilities; staffing; quality of service – public, private, traditional; availability of medicines/ drugs, blood etc.Indirect and direct costs of using service	How accessible are health services to women? (physical) distance, social distance (esp. for poor); hours of operations
7. Supply (and cost) of other services	Education & trainingTransport (public, private)Water and sanitationAccess to market (food)	All known to be (directly and indirectly) associated with mortality levels
8. Local institutions – political and administrative; leadership structures	Decentralized planning, political and financial support for key interventions	

(I) CONDITIONS AND BEHAVIOR OF WOMEN/MOTHERS-TO-BE.

AGE AT MARRIAGE (COHABITATION) – Average 17.6 years in the RCH sample. More than a third (37 percent) of young women had started living with their husbands by the time they were 16 years old and more than 70 percent of young women were living with their husbands by the time they were 18 years old. However, the data suggest no apparent relationship between the age of marriage (cohabitation) and child/infant/neonatal mortality rates.

AGE AT FIRST BIRTH is, however, very important. Almost 12 percent of first births are by mothers who are 18 years or less. Typically, having a first birth at less than 20 years of age is associated with higher mortality. Age at first birth has a very noticeable impact on IMR, but not so much on neo-natal deaths.

BIRTH ORDER – first births are more at risk than subsequent births (irrespective of the mother's age). High order births (after 6 or 7) are also risky – but have a very low frequency. There is a higher incidence of neonatal deaths among first born children than subsequent births. But mothers carrying their first child are more likely to have ante-natal checkups and deliver in a health facility

BIRTH SPACING – While the average birth interval is in the range of 24 months, some births occur at a lower interval. Birth intervals of more than 24 months have a very significant positive impact on neonatal, infant and child mortality rates; by comparison, birth intervals of less than 24 months tend to be associated with higher mortality rates.

MOTHER'S NUTRITIONAL STATUS – International literature suggests that this is important. High incidence of under-weight women are in Orissa? (nothing mentioned in the RCH data on nutritional status of adolescent girls and pregnant/lactating women.)

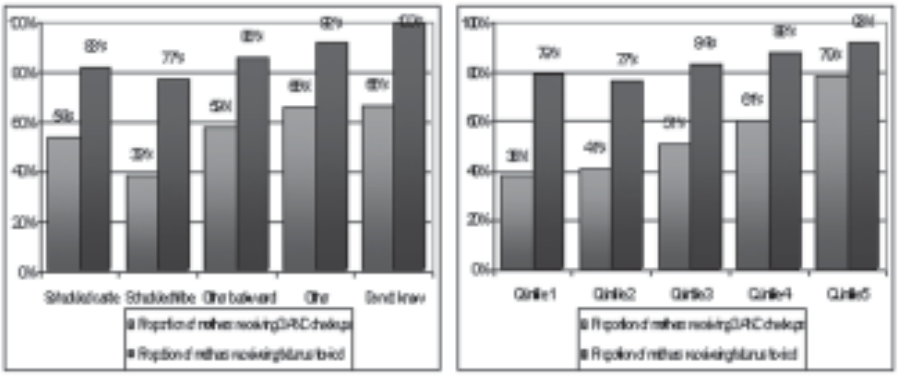
HEALTH SEEKING BEHAVIOUR OF MOTHERS-TO-BE – A little more than half of all mothers received at least 3 antenatal care check-ups during their last pregnancy. Effective pre-natal care can benefit mothers and unborn children. Complicated pregnancies can sometimes be flagged during these visits, thereby averting complications during delivery. In addition, these visits help mothers, especially first time mothers, learn about what they should and should not do to ensure a safe delivery. Also, the tetanus toxoid vaccines are generally administered during these pre-natal care visits. A very high proportion of mothers, about 84 percent, received the tetanus toxiod vaccine prior to their last birth. This high rate of coverage has no doubt had a significant impact on reducing the rate of deaths of mothers and babies due to tetanus.

Factors associated with greater number of ANC visits are: first pregnancy, ethnicity (STs less inclined to have ANC visits – but probably closely associated with education and income levels), women's education (very strong, especially among women with more than primary education) and wealth. The same factors emerge in choice of place to deliver the baby – with availability of a facility also playing a part and resulting in far more home deliveries in the rural areas.

Less than 40 percent of scheduled tribe mothers receive antenatal care while two thirds of non-backward castes receive 3 antenatal care check-ups. Although there is variation in tetanus toxoid vaccine coverage rates across caste groups, the variation is smaller than for 3 ANC checkups.

Across household welfare quintiles, almost eighty percent of all mothers receive the tetanus toxoid vaccine, while 93 percent of mothers in the richest households receive the TT vaccine. However, the disparity across welfare quintiles is stark for the proportion of mothers receiving three antenatal care check-ups. Only 38 percent of poor mothers receive 3 ANC check-ups, while 79 percent of rich mothers receive 3 ANC check-ups.

Figure 4: Proportion of mothers receiving antenatal care and tetanus toxoid vaccines across castes and welfare quintiles



Source: *WB estimation using RCH II data*

Place of delivery**: Almost seven out of every ten deliveries are conducted at home. The disparity in home-based deliveries is strong across both urban and rural areas.**

THE GOVT. OF ORISSA COMMITMENTS:

The launching of the Infant Mortality Reduction Mission in Orissa on August 15, 2001 by the Honourable Chief Minister, followed up with the launching of the Navajyoti scheme on April 01, 2005 to build on its gains were the two of the most important commitments demonstrated at the highest level of political and policy makers in the state towards reduction of child mortality. The launching of the mission and subsequent interventions have enabled the state to reduce the IMR by 16 points since 2001.

The Govt. of Orissa adopted an Integrated Management of Neonatal and Childhood Illness project as part of its child health strategy under RCH II in February 2004 and implemented a pilot project in 3 districts. Looking at the success of the project's implementation, the Govt. of Orissa has decided to extend the project to 14 more districts with high IMR and NMR rates under RCH II in 2007-2008. Besides, the Government of Orissa has, within the overall framework of NRHM, also strengthened the institutional delivery component quite significantly through the implementation of JSY and ASHA schemes in the state.

Of late, the Govt. of Orissa has demonstrated a welcome willingness to modify the existing IMR mission strategies and make them more comprehensive at the state level in the face of the emerging challenges and evidence-based global results. As for achieving MDG 4, the Govt. of Orissa has gone beyond the IMR mission implementation and has developed strategies to address the needs of children in the 1-5 year age group separately with a focus on malnutrition reduction.

Implement a comprehensive child survival package of services

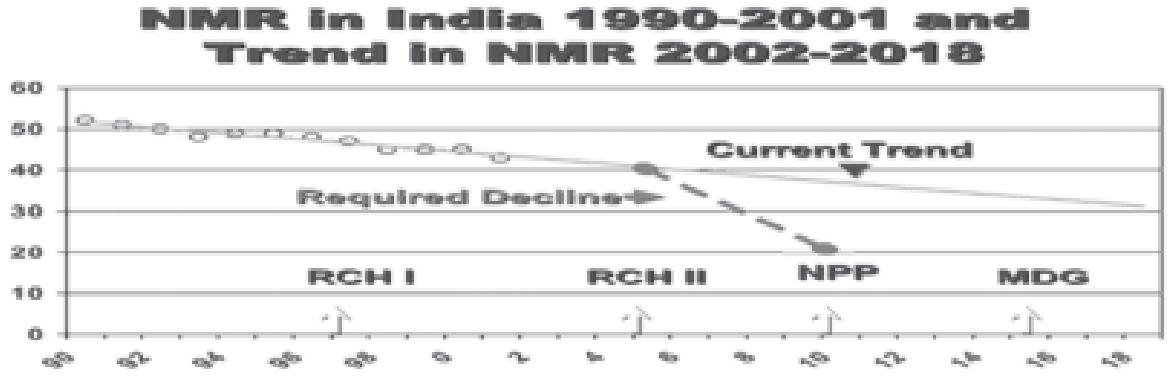
- Scaling up Integrated Management of Neonatal and Childhood Illnesses in high IMR districts
- Establish Sick Newborn Care Unit I & II networks in high IMR districts
- Strengthen Routine Immunization program implementation
- Implement state Measles control strategy
- Establish Nutrition Rehabilitation Centers (NRC)
- Roll out Skilled Birth Attendant training to improve new born resuscitation skills at birth
- Revise Malaria control program for pregnant women and infants
- Prevent Parent To Child Transmission (PPTCT) of HIV/AIDS to newborns.

CONTRIBUTIONS OF OTHER PLAYERS

The twin departments of Health and Family Welfare and Women and Child Welfare have been at the forefront of the Govt. of Orissa's drive towards reduction of under-5 child mortality in the state. The close coordination between these two departments at the state, district, block and sub block levels has been instrumental in forging strong inter-sectoral convergence. The flagship programs of these two departments share common goals while the presence of implementers at the grassroots level strengthens the implementation of all child and maternal survival programs. The participation of the Dept. of Rural Development, through its TSC mission, and the Swajaldhara flagship programs, ensuring safe drinking water and a clean environment for all, are also important partners in the drive to achieve MDG 4. The role of the Dept. of Panchayati Raj and the Dept. of Primary education in community empowerment, better livelihood and furtherance of primary education for all (the girl child, in particular) are critical towards sustainable and accelerated achievement of MDG 4.

Besides, the roles played by development partners like the World Bank, DFID, EU, UN agencies, international and national civil society organizations in providing technical support, taking up pilot project implementation, complementary funding and working closely with the Govt. of Orissa in formulating strategies towards strengthening of the Govt. of Orissa programs are also notable.

CONCLUSION



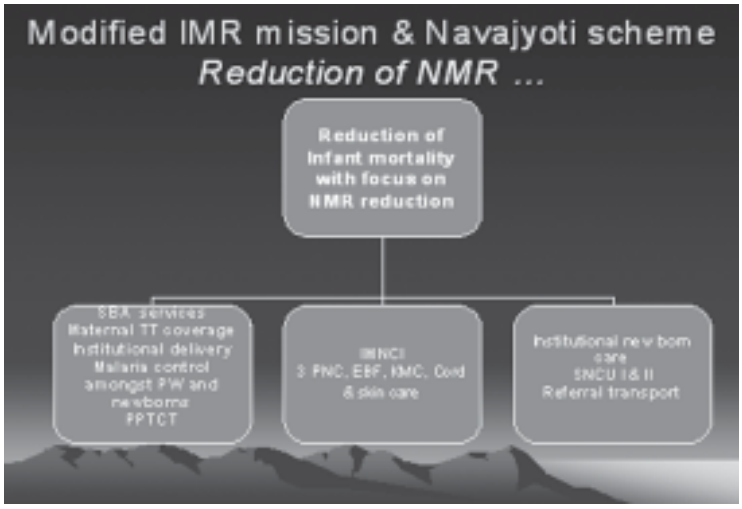
In conclusion, the state of Orissa, like most of the other states in the country, shares the problem of high neonatal mortality rate (deaths within 1 month of age) contributing to both infant mortality rates and under 5 child mortality rates. It is seen that in Orissa, the neonatal mortality rate contributes to almost *66% of the IMR* and about *50% of the under-5 child mortality rate*. This is a major challenge that requires consistent strengthening of the maternal and child health care services. The fast pace of reduction in IMR over the years has already started plateauing. It suggests that it requires accelerated and quality implementation of maternal health programs that address the perinatal (deaths after 28 weeks' gestation and 7 days after birth) mortality which has a direct bearing on maternal health. We need to ensure access and utilization of maternal health services by ensuring that the planned Fixed Health and Nutrition Day services are actually held as per plan.

Also, with the implementation of the Janani Surakshya Yojana to encourage institutional delivery and the rapid rise of institutional deliveries, the need of the hour is to strengthen the institutional care services as well as ensuring 24x7 hour services. This requires ensuring that the skills of the service providers are built up fast so that the benefits of the skilled birth attendance services can be realized by the mothers at domiciliary and institutional levels, besides ensuring proper facilities and infrastructure.

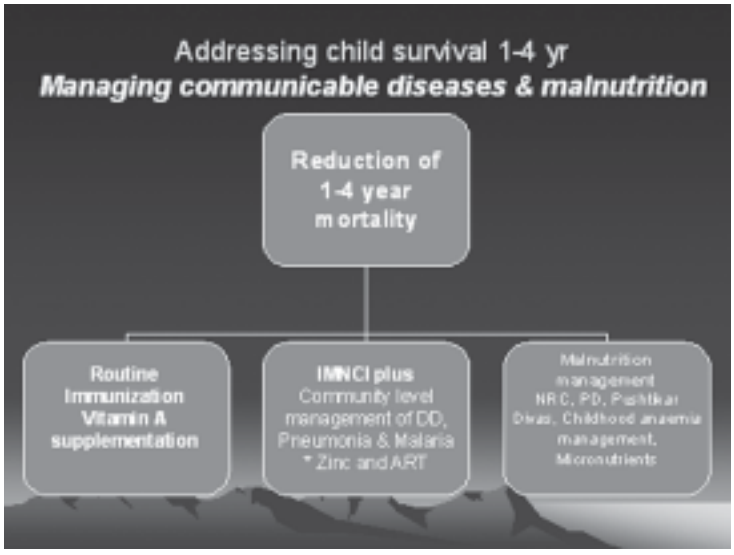
Strengthening of curative care services at the outreach and at the institutional level through skill-based training of the grassroots level service providers and the care of sick newborns and children under-5 with the establishment of the sick newborn care units in the block and districts combined with SBA training and institutional delivery, would enable the state to address neonatal deaths effectively. The other important step that would address both maternal and neonatal mortality is to ensure that every delivering woman and the new born get 3 post-natal visits of appropriate quality on Day 1, Day 3-5 and Day 7-10 by a Health worker or AWW, who is trained on post-natal complications for mother and newborn and appropriate referral chain.

Similarly, attention needs to be paid to the management of moderate and severely malnourished children in the state to reduce vulnerability of these under 5 children to sicknesses along with access to appropriate treatment by skilled workers at the village level.

Annexure 1



Annexure 2



Reference

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Dr. Asish Kumar Sen, Working in the field of Health, UNICEF

PULLING DOWN MATERNAL MORTALITY RATE WILL MISS THE 2015 TRAIN

By **Dr. Seba Mohapatra**

THE 2015 TRAIN

Millennium development Goal 5: Improve maternal health; reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

The indicator MMR, which is directly related to the target, monitors deaths related to pregnancy, delivery and post partum. Such deaths are affected by various factors, including general health status, education, gender, marriage below 18 years and services during pregnancy and childbirth. It is important to monitor changes in health conditions related to sex and reproduction. The train, which started in 1990, has reached the half way stage in 2007. It has crossed many stations of success and failures, many bogies of components have been added to this goal, many have derailed from the track. But the train is still moving to its destination. Now that it is crossing Orissa, let us pull our socks, take stock and put our baggage of analysis into it.

In a country of the size of India, levels of maternal mortality vary greatly across regions due to variations in access to emergency obstetrical care, prenatal care, anemia rates among women, education levels of women and other factors. Large studies with several hundred maternal deaths estimates the reasons for variations across regions.

MMR IN ORISSA

In India, over a 100,000 women die every year due to pregnancy or childbirth related complications i.e. one woman dies every seven minutes!

The latest report on maternal mortality in India released by the Registrar General, India shows that the MMR (maternal deaths per 1, 00, 000 live births) is 301 for India and 358 for Orissa. The improvement shown in the decline of MMR from 1998 (SRS Survey) is 407 for India and 367 for Orissa, which suggests that it has reduced by 106 points at the national level and by 9 points in the state. The declining trend of Orissa over the last decade is less than negligible. If the trend continues, then we may reduce it by another 10 points by 2015 making it 348.

The situation in Orissa is nothing short of alarming. The high incidence of maternal death is leading us to a situation where the development of the state is highly affected. The challenges thrown up by the high MMR in Orissa are varied.

WHY DO WOMEN IN ORISSA DIE DUE TO PREGNANCY AND PREGNANCY RELATED CAUSES?

The underlying causes for Maternal Mortality are poor health and nutrition, lack of physical access to health care (including transportation & finances), medical causes, health determinants and socio-cultural factors that obstruct and underplay the importance of health care for women.

Some factors leading to high Maternal Mortality are;

(i) Lack of access to and inadequate utilization of health care, especially essential or basic emergency obstetric care (BEMOC) services, is an important cause of maternal deaths.

(ii) Absence of Skilled Birth Attendants at delivery is another factor contributing to maternal deaths and complications. Skilled personnel attend to only above 40% of deliveries in Orissa. In some districts, the figure drops to 5 – 10%.

(iii) 60% of all maternal deaths occur at domiciliary set up; yet, less than 20% of women in Orissa receive any post-partum care.

(iv) Unsafe abortions contribute to nearly 10% of all maternal deaths.

(v) Lack of blood transfusion facilities at Health Centres increases maternal deaths. In Orissa, 38% die due to excessive bleeding (PPH) and 11% due to puerperal infection.

(vi) Lack of support from men and other members of the family leads to poor utilization of pre-natal, natal and post-natal services by pregnant women. Several studies and reports indicate that men do not pay much attention to the health problems of women. Only 52% of women are involved in decision making on their own health care. Participation of males is almost negligible in the reproductive life of a woman. The elders of the family also play a similar role endangering the health and life of the mother. CPR in Orissa is only 53%, where female adoption is 97% and male adoption only 3%.

(vii) Socio-economic factors like early marriage (about 50% of women in Orissa are married below the age of 18 years) results in early pregnancy, which greatly increases the risk of maternal death. It is understandably higher in tribal blocks. A disproportionately high number of maternal deaths - around 24% - occur among young mothers aged between 19 – 25 years, where use of contraceptives also lessens during this age group.

(viii) Short birth intervals results in complications that cause maternal deaths. This can be easily avoided by adopting proper family planning methods.

(ix) Care of adolescent girls is yet to be given the necessary attention and focus.

(x) Inaccessibility to health care services in tribal areas, where 22% of the population of Orissa lives.

(xi) Inaccessibility also plays a major role in poor maternal health in cut-off areas of coastal districts like Balasore, Bhadrak, Kendrapara, Jagatsingpur, Puri, Khurda and Ganjam.

(xii) Orissa being a disaster prone state declines the health status during the improvement process preventing the socio-economic status to develop.

Let us analyze the situation from a statistical point of view giving incidences of high MMR in different pockets of Orissa and their factors.

As per NFHS III, institutional delivery in the state is 38.7% and data from CNAA for the year 2005–06 shows institutional delivery at 43.05%.

MATERNAL HEALTH

Maternal well being, 2005 – 2006

Source: National Family Health Survey, Orissa

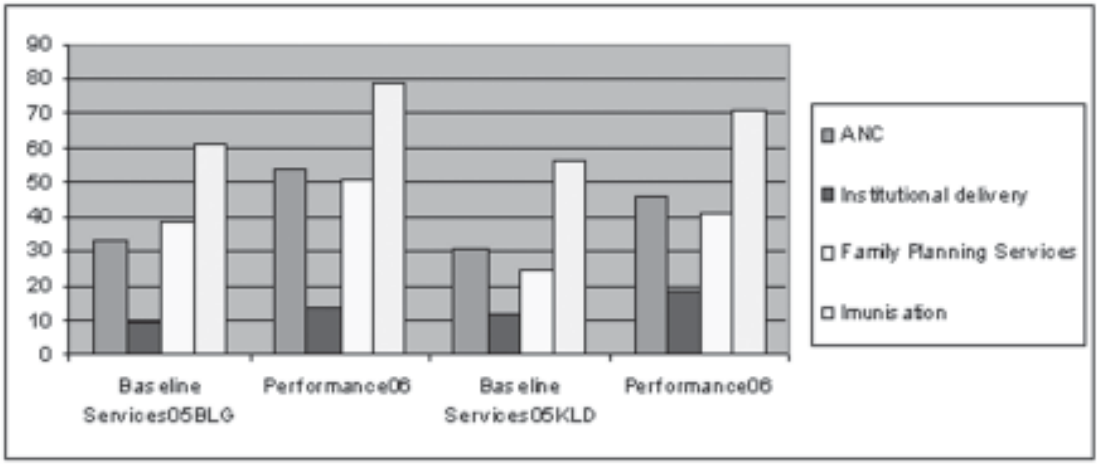
Average age at first birth for women aged 25 – 49	Percentage of mothers who had 3 or more ante-natal care visits	Percentage of pregnant women aged 15 – 49 with aneamia	Percentage of women with below normal Body Mass Index	Percentage of births attended by skilled health personnel	Percentage of institutional births	Percentage of mothers given post-natal care within 2 days of birth
20	60.9	68.1	40.5	46.4	38.7	38.3

Table 3:

Live Births, Maternal Deaths, and Maternal Mortality Ratio in India by State from 2001–2003 Special Survey of Deaths using RHIME method.

India & Orissa	Sample Female Population	Live Births	Maternal Deaths	MMR	95% CI	Maternal Mortality Rate	Lifetime Risk
India Total	5039583	459631	1383	301	(285 – 317)	27.4	1.0%
Orissa	254176	20914	75	358	(277 – 439)	29.5	1.0%

An independent study by OSCARD MNGO, which operates through 4 FNGOs in 12 Sub-centres for 60,000 population in Bolangir District and for 5 FNGOs in 15 Sub-Centres for 75,000 population in Kalahandi district says that;



WHY IS THERE DEATH OF MOTHERS IN ORISSA?

- 60% of the mothers deliver at home
- Causes have a 3C i.e. Culture, Cost and Care
- Non-availability of safe delivery services at rural areas

MATERNAL DEATHS IN ORISSA CAN ALSO BE EXPLAINED THROUGH THE CONCEPTUAL THREE-DELAY MODEL

- Delay 1: Delay in seeking care
- Delay 2: Delay in transport to appropriate health facility
- Delay 3: Delaying provision of adequate care

STRATEGY SO FAR

Taking community need assessment approach as a base, all the services were unified by the Govt. of India in October 1997 and Reproductive & child health program was started, so that reproductive health, including the period of pregnancy, child birth and postnatal period and child health, could be made available to the people. Services to be made available under this programme with an objective to decrease birth rate, death rate, infant mortality rate, child mortality rate and maternal rate and full care of pregnant women and to increases the safe delivery rate are:

1. Care of pregnant women – prenatal, natal, and postnatal services
2. Immunization against 6 vaccine preventable diseases i.e. TB, Diptheria, Tetanus, Pertusis, Polio and Measles and 5 doses of Vit A to children
3. Distribution of Iron Folic Acid tablets for Anemia against pregnant women
4. Treatment of Diahorrea and pneumonia in children.
5. Spacing methods – permanent and temporary
6. Positive male involvement
7. Provision of Contraceptives and knowledge of use
8. MTP services
9. Emergency Obstetric Care Services
10. Nutrition counseling and distribution of complementary foods
11. Environmental sanitation
12. Use of safe drinking water
13. Management of Reproductive tract infections and sexually transmitted diseases like AIDs

The RCH Program was taken over under NRHM on 17th April 2005 and its objectives were broadened and strategies made more target oriented. Reducing maternal mortality is one of the key objectives of the National Rural Health Mission (NRHM). The mission pledges commitment to a series of health system reforms and community outreach processes upgrading peripheral health centers in accordance with quality public health standards, decentralizing technical functions to the Auxiliary Nurse Midwives (ANM) and motivating women and families at the community level through a combination of awareness raising measures and incentives to access services through and after pregnancy.

THE KEY COMPONENTS OF THE NRHM ARE:

1. Creation of a cadre of voluntary, female Accredited Social Health Activists (ASHA) in Orissa. ASHAs will help and guide women to access health facilities for antenatal care, institutional delivery, postnatal care and counselling on nutrition and family planning services.
2. Creation of a village health team and preparation of a village health and sanitation plan in all districts.
3. Strengthening of sub centers by giving them untied funds of Rs.10, 000 per annum.
4. Codification of Indian Public Health Standards (IPHS)
5. Upgrading of CHCs to meet the Indian Public Health standards in all districts.
6. Establishing blood storage centers at FRUs: Timely treatment for complications associated with pregnancy often cannot be given because of non-availability of blood transfusion services at First Referral Unit (FRUs)
7. Integrating vertical health and family welfare programs and societies under the NRHM at national, state, and districts level in all states.
8. Assistance to states to operationalize 50 percent of the PHCs as 24-hour functional units in a phased manner. These PHCs will be responsible for providing round the clock delivery services, including the management of common obstetric complications, emergency care of sick children and referrals.
9. Strengthening program management capacities under NRHM at State, and District levels.
10. Institutionalizing district level health management system in the state.
11. Supply of generic drugs (both Allopathic and Ayush) to Sub Centre (SC), Primary Health Centre (PHC) , and community Health center (CHC),
12. Promotion of multiple health insurance models in all states
13. Janani Suraksha Yojana (JSY), under the overall umbrella of NRHM, has been introduced with the vision of reducing MMR and IMR and increasing institutional deliveries. JSY integrates cash assistance with antenatal care during the pregnancy period, institutional care during and immediate post–partum period in a health center by establishing a system of coordinated care by field level health workers. The JSY is a 100% centrally sponsored scheme.
14. The Government has recently issued guidelines for ANMs/ LHV / Staff Nurses to use certain drugs for specific situations as interventions. The guidelines also outline how ANMs/LHVs can perform simple procedures like active management of the third stage of labor, use of partograph for early referral of labor cases.
15. MBBS doctors at first Referral Units are to be trained in providing emergency obstetric care, which includes caesarean section and training in anesthesia.
16. Creation of multi-skilled Medical Officers and multi-skilled Staff Nurses.

INITIATIVES OF ORISSA TO MEET THE MDGS

1. Special schemes like IMNCI and Navajyoti are being developed in the state to curb infant and maternal deaths.
2. Orissa has played a pioneering role in involving NGOs in Health Sector Mission services during the last one year after the launching of national Rural Health Mission (NRHM). The State has involved 21 MNGOs and 122 FNGOS in the state covering 30 districts to provide RCH services delivery in the un/underserved sub centers identified by the state government. The idea is to address the gaps in the RCH service delivery and to enable such districts/ blocks to progressively achieve the overall RCH goal. Orissa is the only state in India where the MNGOs and FNGOs are working in all the districts of the state.
3. Intersectoral convergence with Women and Child Development, Education, Panchayati Raj and Rural Development Departments for effective implementation of schemes.
4. Public Private Partnership initiatives are also being taken in inviting NGOs for PHC management.

Despite high budgets allocated for NRHM by the Union Health and family Welfare Ministry, the maternal mortality rate (MMR) continues to be unacceptability high and has shown no signs of reduction in the past one decade.

WHERE WE ARE IN 2007?

NRHM PROGRESS

1.

Provision Of ASHA	2005-06	2006-07	Total
Target	12730	21594	34324
Placement	12730(100%)	20786(96%)	33516(97%)

2. The number of JSY beneficiaries in the state is **2,36,306,** out of which **72,428** are assisted by ASHAs
3. The status of untied fund of Rs.10, 000 for Sub Center strengthening is that so far, **5927** sub centers have received the fund leaving an utilization of **67%** by 2007.
4. Rogi Kalyan Samities are being formed at PHC to ensure better management of health services. **371** Samitis are registered and 20 are formed in PHCN.
5. Provision of Mobile Health units to provide preventive, promotive and curative health care in inaccessible areas, difficult terrains and unserved areas are under process.
6. To revitalize local health traditions, Govt. is mainstreaming AYUSH by providing infrastructure, manpower and drugs to strengthen the public health system. So far, 100 AYUSH doctors have been trained with the provision of 314 contractual AYUSH Doctors at Block PHCs / CHCs and 200 paramedics.
7. In the first phase of upgradation of PHCs to IPHS standards, 69 PHC/CHC have been upgraded.
8. To make the FRUs functional, multi skilling training of Medical Officers in Anesthesia and O & G is going on.
9. In order to enable the PHCs to provide round the clock service, staff nurses have been provided in 131 PHCs by now.
10. As a pilot initiative under Public Private Partnership, 3 PHCs have been handed over to NGOs with financial support and the state is I the process of finalizing the proposals from other NGOs/institutions/ Corporates.
11. Placement of contractual Medical Officers, Staff nurses, ANMs and MPH worker (male) is under process.
12. Advocacy, BCC and PRI sensitization initiatives have started for effective implementation of the programmes.
13. State and District level technical teams have been formed and operationalized for monitoring and evaluation.
14. Training for skilled attendance at birth is under process.

PROGRESS IN RCH II

The focus of RCH II lies in reduction of maternal mortality and morbidity with emphasis on gender, urban health care, adolescent health and public health. PPP is a supportive focus area. Flexible financing, decentralizing planning, improved management capacity are some of the innovations.

Under RCHII the progress is;

1. Renovation and repair of 404 sub centres, 35 PHCs, 30 DTUs and constructions of 55 sub centers.
2. 196 RCH camps in 30 districts.
3. 320 no. of Swastya melas in 11 tribal blocks
4. 22 number of ambulance services at Mayurbhanj, Keonjhar and Sundergarh
5. Workforce management by providing additional support to 17 districts i.e.1275 ANMs, 60 LT, 810 SN
6. 21 MNGOs, 122 FNGOs are supported with funds for better mobilization of services.

PROGRESS BY OTHER AGENCIES

1. Developmental agencies like UNICEF, UNFPA, DFID, Care and other agencies are working in tandem with the government, policy makers, bureaucrats, civil society networks and community towards meeting the target of millennium developmental goals 4 and 5.
2. Civil society and statutory bodies like White Ribbon Alliance – Orissa chapter, Nehru Yuva Kendra, Sate Commission for Women are engaged in different advocacy programs for reducing maternal and infant mortality of the state.
3. Media sensitization by different agencies is also playing a major role in working as a pressure group on the system and highlighting the policy to implementation gaps for further interventions.

RESULTS ANTICIPATED FROM INCREASING INSTITUTIONAL DELIVERIES

One has to look into the following events and set the indicators;
1. Number of asphyxiated and sick babies
2. Number of still births in the situation
3. Number of maternal morbidity

WHAT CAN BE DONE?

Governments, non- governmental organizations, international agencies and other funders must make a concerted effort to:

- **Acknowledge the social and economic benefits** of good maternal health and include efforts to ensure maternal health in all national policies and plans.
- **Allocate resources to make maternal health services available**, especially in poor and rural areas. Existing health care resources can be used to support the most cost-effective interventions.

- **Ensure that every woman has access to a continuum of good-quality safe motherhood services** offered at the community level, in health centers and in district and regional hospitals.

My way forward is to reach the unreached and guarantee access to universal quality health care services. Stopping MMR relates to safer pregnancy, which involves making them aware of their;

1. Right to life, liberty and security entitles a woman to have access to appropriate healthcare, and to guarantee that every woman can choose when and how often to bear children.
2. Right to safe birth entitles a woman to have access to good quality care before, during and after pregnancy and childbirth.
3. The right to equality and non-discrimination entitles a woman to access services such as education and healthcare - regardless of age, marital status, ethnicity or socio economic status.
4. Entitlements guaranteed under different laws, provisions, schemes etc.
5. Women have a right to make decisions about their own health, free from coercion and violence, and based on full information.
6. Women must have the right to the highest attainable standard of health. It implies appropriate health services, especially emergency obstetric care services that are adequately available, accessible and acceptable, and are of good quality.

More than good quality health services, what are required are empowerment of women and a guarantee of their human rights, right to life, liberty and security to have access to appropriate health care and the right to survive childbirth irrespective of their location and distance.

THE FOLLOWING SUGGESTIONS, IF CARRIED OUT,
WILL BRING US CLOSER TOWARDS ACHIEVING THE MDGS BY 2015.

- Empowering women in decision making and choices
- Increase in women's literacy rate
- Economic independence of women
- Removing cultural barriers and practices
- Ensuring male participation
- Make women know their entitlements and rights
- Addressing adolescent health
- Increasing nutritional and anemia factor
- Facilitation of gender equity
- Addressing the malaria problem in the state
- Improve sanitation and hygiene
- Improving accessibility of services and making them available at the doorstep.

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Awarded for best feature writing by Dharitri Golden Jubilee, 2004
Awarded by Budha Mission India (Karuna Kirti Award) for the Doctor in Social Field
Now Working under RCH & NRHM since 2003

HIV/AIDS :ORISSA'S RESPONSE TO THE BIG MENACE

By Dr. Dillip Chhotaray, Team Leader, PSU-OSACS

Already reeling under the combined impact of vector-borne and communicable diseases, the health scenario in Orissa has found the onslaught of HIV/AIDS, along with other sexually transmitted diseases, too hot to handle. Regular mass mobilization and awareness programmes have not been able to curb the spread of the epidemic and it continues to spread far and wide among the general population. Presently, Orissa is considered one of the states highly vulnerable to the twin menace of HIV/AIDS. A little complacency at this stage will ensure that it graduates from merely a high-risk state to a high-prevalence state.

Large scale migration, low literacy rates, ignorance among the tribal and backward communities and long stretches of busy National Highways are some of the major factors in the rapid multiplication of HIV infection among the general population.

ORISSA HEALTH SCENARIO

This paper discusses the health status of Orissa from basic demographic indicators. The indicators contains sex ratio, density of population, decadal growth rate (1991-2001) in percentage terms, female literacy rate, percentage of girls marrying before the age of 18 years, percentage of birth of order 3 and above, CPR, percentage of pregnant women with any ANC, percentage of safe delivery, percentage of children with complete immunization, IMR (Q1) and CBR District wise.

MALARIA

Malaria is a major public health problem in the state. Orissa contributes 23% of malaria cases, 40% of PF cases and 50% of all malaria-induced deaths in the whole country. More than 60% of people in Orissa are living in high-risk malaria areas - particularly the all tribal districts.

COMMUNICABLE DISEASES

The communicable diseases **TB, Leprosy and Filariasis** continue to be major public health hazards in the State and have been justifiably identified as priority problems by the state government.

The prevalence rate for **TB** in the State is 2.12 per 1, 000 as per the latest available figures for 1999-2000. The number of new TB cases detected were 3, 21, 999 and the number of patients treated - both old and new - was 78, 445 for the same year. The Revised National Tuberculosis Control Programme (RNTCP) is being implemented in all 30 districts of the state.

The leprosy prevalence rate (PR) in Orissa is 7.3 per 10, 000 population (2003). New leprosy cases were detected over and above the 40, 717 active cases on record in the year 1999-2000. The same year, 65, 299 and 50, 383 cases were discharged and cured in the state.

People living in the coastal areas of the state – both rural and urban – are the most vulnerable to the risk of **Filariasis**. The National Filariasis Control Programme (NFCP) is under implementation in all but four districts of the state – Bolangir, Sonepur, Kalahanadi, Nuapada and Kepjhar. As per 1999 figures, the number of blood slides examined in the state was 33, 305, the number of positive cases of Microfilaria was 460, M.F. rate 1.38, the number of positive cases 3, 347 and the disease rate 10.05.

MALNUTRITION

Malnutrition continues to be one of the most critical issues of the state and its manifestation and consequences are diverse and alarming. Over 30% of children are moderately malnourished and over 5% of the children are

severely malnourished. As per the National Family Health Survey (NFHS-II), 1998-99, 54% of all children under 3 years are underweight (weight/arm), 44% are stunted (height/age) and 24% are wasted (weight/height). Of all segments of the population, children and women appear to be more at risk than others.

Some of the deadliest killer diseases during infancy and childhood are measles (a little over 10%), Tetanus (6%), Tuberculosis infections, fever like Malaria, Typhoid and Hepatitis. In the majority of fatal cases, the common underlying factor is malnutrition. Poliomyelitis results in debility and disability rather than death. The incidence of Helminithic infestations in children also seems to be quite high. There are pockets in the state where the incidence of Ascariasis and Hookworm are very high at 40% or above

HIV/AIDS SCENARIO IN ORISSA

Since the identification of the first case of HIV in India in 1986, HIV/AIDS has been acknowledged as a serious challenge for the future economic and social development of the country. The absence of cure, the rapidity and mode of spread and its impact on the young and adolescents are factors that make HIV a major health and development challenge. In India, as per recent statistics, there are over 52 lakh positive persons. Orissa has above five thousand people living with HIV +ve status.

The infection rate in the high-risk population in Orissa has risen from 1.31% during 2001 to 2.34% in 2006. The infection in the general population has risen from 0.13% in 2001 to 0.55% in 2006. Looking at the above figures, Orissa is still a low prevalent State but highly vulnerable to STD and HIV/AIDS. VCCTC data shows a rising trend in the absolute number of HIV +ve persons, i.e., 2002- 312, 2003-687 2004-595, 2005-1251 and 2006-2217.

HIV Scenario in Orissa
(Jan 2002 to Feb 2007)
(Based on report from VCCTCs & PPTCTs)

- **Total blood samples screened – 1,05,070**
- **No. of HIV+ve cases – 5,419 (Male –3553 & Female – 1866)**
- **No.of AIDS cases - 860**
- **No. of deaths due to AIDS - 643**

In the first quarter of 2007, the state has already reported 357 of HIV +ve persons. It has recently been classified as an 'A' category state due to its vulnerability to the epidemic and the probability of affecting the general population.

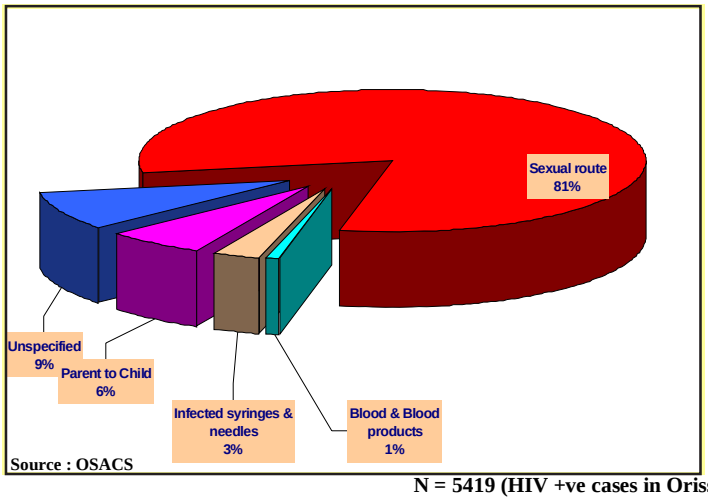
Traditional migration from districts like Ganjam, Gajapati, Kendrapara and Nayagarh; low literacy rate coupled with ignorance among the tribal and backward communities, distress migration from western and southern parts of the state due to chronic drought conditions, large displacement due to recurring disaster, rapid industrialization and booming mining activities, long stretches of busy National Highways have definite impacts resulting in multiplication of HIV infection among the general population. Rapid Industrialization and a boom in the mining sector has also caused inter and intra state in-migration to some of the districts contributing to further complication of the problem.

HIV PREVALENCE IN ORISSA

In **Orissa**, similar to national scenario, sexual route is the primary transmission mode of HIV. Data from VCCTCs for 2006 shows that the predominant mode of transmission reported by HIV positive cases is sexual route (81%).

HIV PREVALENCE AMONG GENERAL POPULATION

MODES OF TRANSMISSION
JAN 02 – Feb 07



N = 5419 (HIV +ve cases in Orissa)

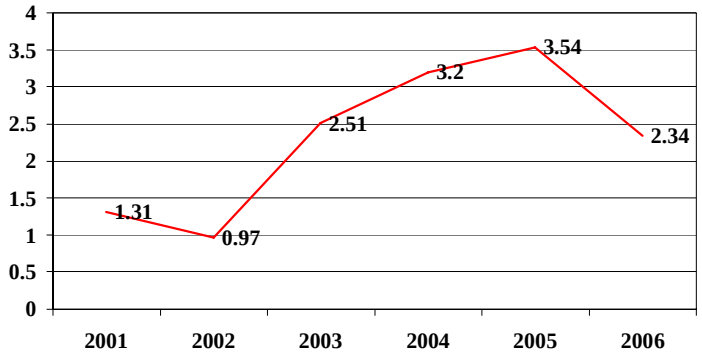
Of the state's 30 districts, 4 have HIV prevalence of 1 percent or more among ANC women. This movement of HIV out of High-risk population and into General population requires continuously expanded efforts to inform and educate the public about the threat of HIV. Surveillance is carried out annually by the Orissa State AIDS Control Society (OSACS), which tests for infection at designated sentinel sites following the methods prescribed by the NACO.

Over the last six years sentinel surveillance data in Orissa shows that prevalence in ANC attendees is increasing consistently reaching a high of 0.6 in 2005. However, in 2006 the prevalence decreased to 0.55% after ANC sites were increased from 7 to 23. This is largely due to ever increasing prevalence rate among ANC attendees in Ganjam district.

HIV PREVALENCE AMONG HIGH RISK GROUPS

Prevalence of STD attendees is taken as proxy for HIV in the High Risk Groups (HRG). The data for HIV in STD clinic attendees show a significant rise during last four years. It has increased to 3.5% in the year 2005, however declining to 2.34 in 2006.

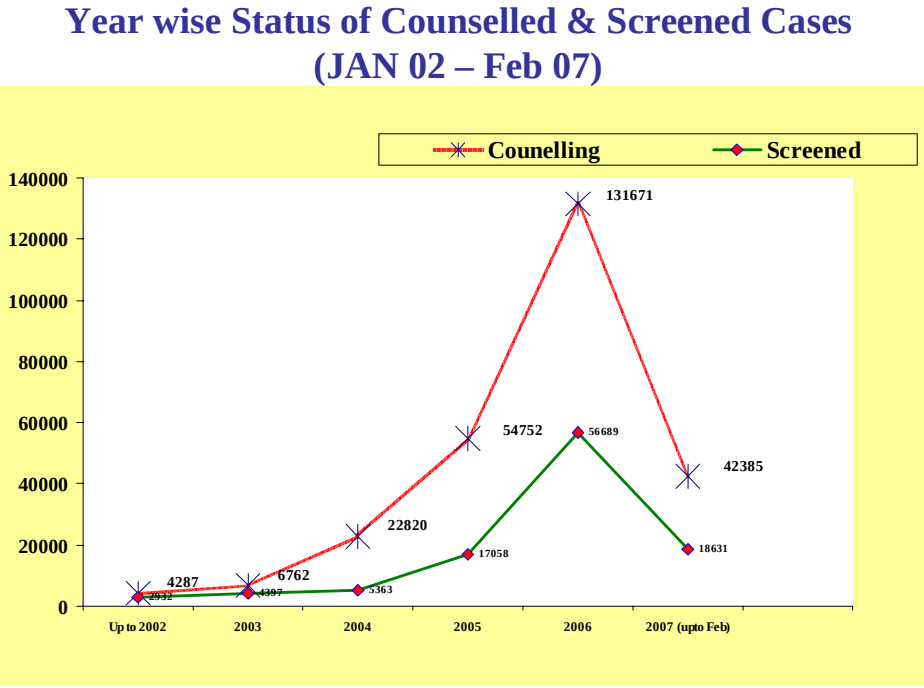
Trend of HIV Prevalence in STD Sites 2001-2006



Source : Sentinel Surveillance Report of OSACS

HIV POSITIVITY AMONG VCTC AND PPTCT ATTENDEES

Number of people found positive for HIV infection at VCCTCs and PPTCTs provides another indication of the level of HIV in the state. From 2004 to 2006, 69110 persons were tested and 4063 found positive which is 6 percent of those screened statewide.



This period reported 75 percent of the total no of HIV +ve cases reported during January 2001 -February 2007. All these information and data from VCCTCs and PPTCTs show that awareness level among common people has gone up resulting in high turn up in VCCTC in last three years.

Since HIV infection can be passed to an unborn child during pregnancy or during breastfeeding, it is critical that mothers be tested for the disease. Proper treatment can reduce the possibility of the child becoming infected. Since establishment of PPTCTs in 2006, the state has already reported 54 cases of HIV+ve among the pregnant women mostly from the district Headquarters and peripheral areas, hence the number could have been much more if facilities extended to sub district levels.

TRANSMISSION THROUGH BLOOD TRANSFUSION

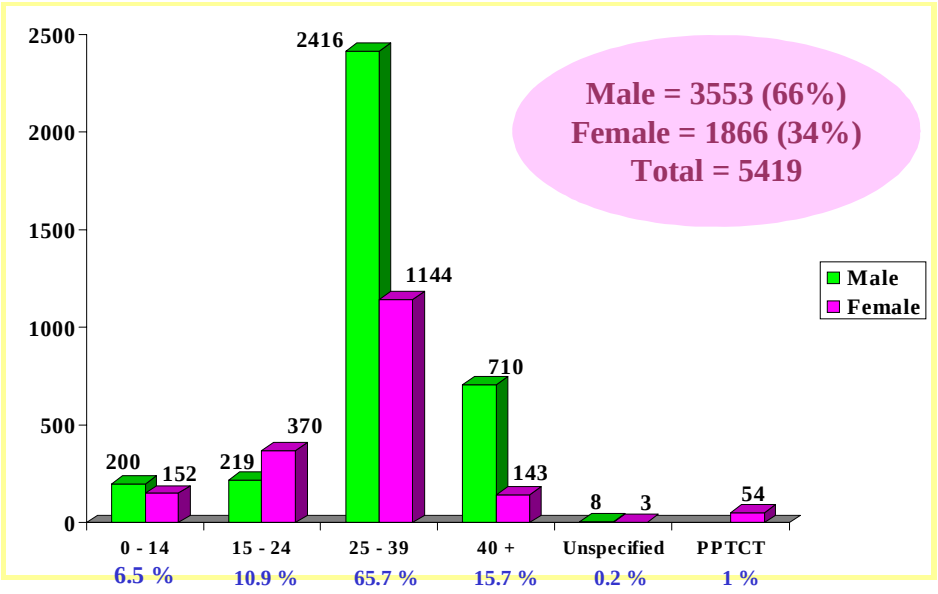
Orissa has 73 licensed Blood Banks. In line with the national strategy the state Government is promoting Voluntary Blood Donation with the active involvement of Indian Red Cross, Orissa Branch, NSS, NGOs and other voluntary organizations in the state. As a result of these efforts HIV infection through blood transfusion remains low at 1%.

YOUTH AND ADOLESCENTS

Youth in their prime age are adventurous, mobile and usually unaware of the consequences of their risk taking activities. Even though the modern youth are educated and well informed in many aspects of life, in terms of sexual behaviour Indian youth are not well informed due to the societal stigma on discussion of sex and sexuality.

As a result it was found that school and college youth are often found indulging in high-risk sexual activity acquiring HIV and transmitting the same to their casual and permanent partners. The average median age for first sexual experience is 15 yrs in the State indicates the high vulnerability of youth to HIV.

Age group wise HIV +ve
(Jan 2002 to Feb 2007)



GENDER AND HIV

In Orissa unequal power relations and low status of women, as expressed by their limited access to human, financial and economic assets, weakens the ability of women to protect themselves and negotiate safer sex, thereby increasing vulnerability to HIV/AIDS. Their biological susceptibility – at least two to four times greater than that of men – is compounded with sociological vulnerability due to poverty, illiteracy, social, cultural and economic factors.

Males who engage in high-risk behaviour act as a “bridge” population may transmit HIV to people in the low risk or general category such as their wives and spouses. In Orissa, one of the highest HIV prevalence groups are found to be wives of Migrant Labourers and truckers. This is also true for the industrial labour force.

SEX TRADE AND TRAFFICKING

Of the two million women and children trafficked annually in India, 70 per cent are trafficked from rural areas. Nayagarh, Kendrapara, Ganjam, Jagatsingpur and Jharsuguda are some of the source districts from where girls are lured through well-established networks to be trafficked to different parts of the country. There are also well-organized trafficking networks within the state to lure tribal, rural girls into flesh trade. These girls are mostly in their early adulthood and susceptible to STD and HIV/AIDS.

As per the date and reports majority of the sex workers in the state are home or family based living in slums or along the NH and some of the sex workers in major towns are brothel based being controlled by pimps and brokers. A complex mix of poverty, illiteracy compounded by gender inequalities, traditional socio-religious and cultural practices encourage sex work and provide fertile ground for traffickers who exploit the situation for profit. Traffickers come from different socio-economic background and are supported by the powerful political and business interests. Orissa has only one red-light settlement in the capital city of Bhubaneswar where 141 sex workers stay in a slum called Malisahi.

MEN HAVING SEX WITH MEN

Estimates of the size of the MSM & TG population in Orissa are varied and not very precise as many MSM practice their behaviour secretly because of the legal issues and social stigma associated with it. However, reports from different TI projects in the state indicate an estimated population of 1304 MSMs in the project area. Mapping exercises in the state will provide more accurate and complete numbers.

Using condom for anal sex is very rare among the MSMs. Use of safe water based lubricants (KY Jelly) for anal sex is almost non-existent, which indicates that this needs to be addressed along with condom use in HIV prevention programmes. As there is a higher risk of condom breakage in anal sex without use of safe lubricants, Effective BCC strategy is very important to increase use of Condoms among MSMs.

INJECTING DRUG USER

Injecting Drug Use has a significant role in the spread of HIV/ AIDS epidemic in various regions of Orissa. The probable for transmission of HIV through Intravenous drug use ranges from 20-80% against 0.02-1.00% through sexual route. HIV spread rapidly among IDUs because many of them share the injecting equipments.

MIGRANT LABOURER

Migrant Labourers, another primary stakeholder travel long distances to Surat, Mumbai, Kolkata, Chennai, Karnataka, Punjab, Manipur, Goa in search of job in cities and towns including mines and industrial hubs across the country due to poverty, Natural Disasters, family burden etc. As employed young bachelors staying away from the family, they often indulge in unprotected, multi partner sex at their work place. Lack of knowledge on STD and HIV/AIDS puts them at a very high risk of contracting the disease. They spread the deadly disease back at home to their spouse and other partners. This is a very dangerous trend of transmitting the virus to the general population. The major source districts for migration in Orissa are Ganjam, Nayagarh, Kendrapara, Kalahandi, Bolangir, Nuapada, Koraput, Bhadrak, which have high number of HIV +ve population.

TRUCKERS

Truckers, one of our primary stake holders are heterogeneous floating population with a divergent origin, language, culture and religion from different parts of India and to be very specific majority of them are from Chhatisgarh, Punjab, Maharastra, Madhya Pradesh, Bihar, West Bengal, Jharkhand and Andhra Pradesh, Tamilnadu, Karnataka, Kerala.

A major stretch of national highways including long stretches of NH-5, NH-6 etc with a number of halt-points pass through Orissa. Their job keeps them away from their family for months together. The occupational hazards coupled with alcoholism and rampart (oral) drug abuse make them highly vulnerable and put them at risk of practicing high-risk behaviour. For the purpose of recreation and relaxation they often visit sex workers en-route.

FISHER FOLK

Orissa has a long coastline of 424 kms. Large numbers of fishermen habitation have developed all along the coast. Many of the habitations have periodic and permanent settlers from Andhra Pradesh and West Bengal. High level of promiscuity, illiteracy, hazardous environment difficult livelihood exposes them to unwarranted high-risk behaviour. Interventions among fishermen have also observed high submissiveness among the women folk within the community, which increases their vulnerability to HIV. Ganjam, Puri, Jagatsingpur, Kendrapara, Bhadrak and Balasore are the coastal districts having large no of fishing communities.

MINING WORKERS

Orissa has the large deposits of minerals and mines in the central and western part of the state. Iron, coal, bauxite, mica, limestone and chromites are the major ore found in Orissa. Mining sector is divided into govt. and private ownership. The sector employs large number of skilled and unskilled labourers, who lead hazardous life. Due to the wage pattern, lack of housing facilities, heterogeneous ethnic and socio cultural practice, living conditions are mostly unfriendly. In the mining belt country liquor is a major commodity monopolized by tribal women who often indulge in casual sex with the customer mostly mining labourers and truckers. They are under constant risk of health hazards and high-risk behaviour contracting STDs and HIV/AIDS.

POSITIVE NETWORKS

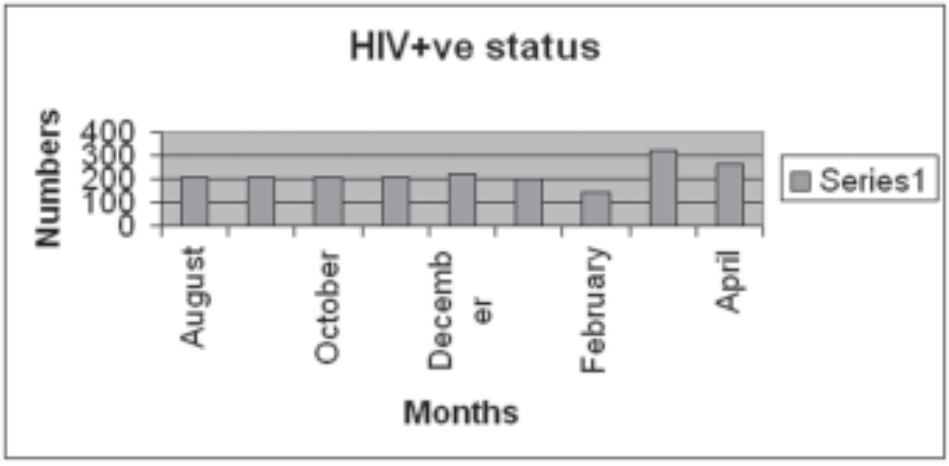
A state level positive network named Kalinga Network of Positives (KNP+) has been formed to support the positives to address care and support needs and for promotion of positive prevention. There is a Drop-in-Centre

in Bhubaneswar to address the need of PLHIV. Other networks like Utkal Network of Positive People (UNP+) in Cuttack and Rushikulya Network of Positive People (RNP+) in Ganjam and district level networks have been formed to help protect the rights of PLHIV and provide essential services to them.

CAUSES

- Ignorance and illiteracy
- Increasing prevalence of commercial sex
- Women trafficking
- Both in and out migration due to livelihood insecurity
- High incidence of STDs both among men and women
- Low rates of consistent condom use
- Child labour
- National Highways and hubs of transport sector (ports, railway stations etc)
- Gender disparity
- Social and Economic Inequalities
- Mining and Industrial growth
- Natural calamities

HIV MOVES TOWARDS A MENACE



The above table shows that the HIV positive number increased in each month and more than 200 positive persons added in each month as per the data of last one year. Here we, define that in the month of March the number reached 324 i.e., more than one from each block. The magic number of HIV positive now moves towards a menace.

RESPONSE TO HIV/AIDS

A planned response from the state started halfway through the NACPII. The summary of the response is discussed below.

NACP – I

National AIDS Control Programme (NACP), Phase – I was implemented from April 1992 in Orissa. The main thrust was to create public awareness on basics of HIV/AIDS and strengthen STD services.

NACP – II

Second phase of the National AIDS Control Programme started in November 1999 with two key objectives viz. to reduce the spread of HIV infection and build institutional capacity of Orissa to deal with the epidemic in the long term. Orissa State AIDS Cell set up in 2001 was converted into Orissa State AIDS Control Society (OSACS) 2004 to provide greater focus on HIV/AIDS control and prevention in the State. Components of NACP II were targeted

interventions aimed at reaching out to key population like Female Sex Workers (FSWs), Injecting Drug Users (IDUs), Men Having Sex with Men (MSM) and bridge groups like Truckers, Migrant Workers, Slum Women, Fisher Folk, Hotel Boys, Jail Inmates etc. Treatment of STIs and preventive measures for general population including reduction of blood transfusion related infections, increasing awareness through IEC, promoting voluntary testing and counselling, PPTCT, and providing services through STI clinics and care centres have been other programmatic interventions.

STD CLINIC

At present there are 34 STD clinics in the state. They are located in S.C.B. Medical College, Cuttack; VSS Medical College, Burla and MKCG Medical College, Berhampur; ESI Hospital, Khurda and in 30 DHHs.

VOLUNTARY CONFIDENTIAL COUNSELLING & TESTING CENTRES

Orissa has opened up 26 Integrated Counselling & Testing Centres (ICTC); 35 Voluntary Confidential Counselling & Testing Centres (VCCTC); and 32 Prevention of Parent to Child Transmission (PPTCT) centres. Till Jan 2007, 2,40,572 people have been counselled and out of 95,133 samples tested, 5267 are HIV +ve; 850 are AIDS cases; and 633 deaths due to AIDS have been reported.

CONDOM PROMOTION

Intensive Condom Promotion activities had been undertaken during NACP II through out the state due to which there has been remarkable increase of condom in the state. Social Marketing Organizations like HLFPPT, PSI, PSS and PHS have major contribution towards increased use of condom in both rural and urban Orissa.

CARE, SUPPORT & TREATMENT

PLHIV are provided treatment for Opportunistic Infections in all District Headquarter Hospitals. The Government of Orissa provides medicines for OIs up to a maximum of Rs.2000/- per course per patient but utilization of the current facility is not encouraging.

- During 2006 – 07, with approval of NACO, OSACS established **one ART centre** at MKCG Medical College, Berhampur.
- **One Drop-In centre** at Khurda through Kalinga Network of Positive People (KNP+)
- And **4 numbers of Community Care Centers** located at Khurda (Bhubaneswar), Cuttack, Ganjam (Berhampur) and Koraput.

BLOOD BANKS

OSACS provides annual grants to 50 Blood Banks in 27 districts out of 73 licensed Blood Banks. There is only one blood component separation unit in the State i.e. in Central Red Cross Blood Bank. Voluntary collection has increased from 26,291 in 2002 to 1, 11,772 in 2006. But there is a reduction in the replacement figure, which has come down to 76,858 in 2005 from 1, 19,341 in 2002.

Five more Blood Component Separation Units (BCSU) are proposed to be established along with 157 Blood Storage Units (BSU) in equal number of First Referral Units (FRU).

IEC ACTIVITIES

IEC activities conducted in the State have contributed to increase in the awareness & knowledge level among general population. Audio jingles are broadcasted through All India Radio (State hook-up) and audio-visual spots are telecasted through D.D. Oriya and ETV Oriya. Print materials like Posters, Leaflets, Booklets, Stickers for the general population and BCC materials like Flip Books, Penis model for the High-Risk population have been developed and disseminated. Village level awareness campaigns by Cine/theatre artists covering all the Gram Panchayats and ULBs of Orissa through various folk forms were undertaken in the state. Awareness messages on Post Cards / Inland letters have been contracted to the Dept. of Posts. Hoardings, bill boards, hanging Kiosk are put up in strategic location of Urban & Rural areas. Out door visibility in the form of Wall paintings were done in high-risk districts and medical institutions.

SCHOOL ADOLESCENCE EDUCATION PROGRAMME

There are 7580 schools in 30 districts including Govt., private, tribal and Seva Ashram schools. As per the mandate of NACP - II, Department of School & Mass Education is conducting School Adolescence Education Programme (SAEP) through SCERT in collaboration with Orissa State AIDS Control Society. In Orissa, UNICEF provides technical support for School Adolescence Education Programme.

HIV – TB CO-ORDINATION

State as well as District level HIV-TB Co-ordination Committee has been constituted. The training of the TB DOTS providers has been completed along with Counsellors of VCCTCs. The cross-referral of TB cases as well as HIV +ve cases is taking place, however cross-referral and trainings need to be strengthened.

HIV - NRHM/RCH-II CONVERGENCE

Officials of RCH-II and NRHM have been involved right from the preparation of the NACP-III PIP. In principle, it has been agreed upon to have convergence with NRHM. The existing implementation system of RCH-II and NRHM shall be utilized to implement the HIV/AIDS prevention programme at village level through ASHA.

INTER-SECTORAL COLLABORATION

At present, UNICEF, UNFPA, UNDP, LEPRA Society, CRS, OXFAM, Concern Worldwide India, Action aid, Satyam Foundation, KIIT Deemed University and some departments of Govt. of Orissa like W & CD, School & Mass Education, Higher Education, Works Deptt. Deptt. of Commerce & Transport, Panchayat Raj and Home Deptt. are implementing some HIV/AIDS prevention/awareness programme in some districts of the State. Other departments like Labour & Employment, Forest & Environment, Mining & Geology and different industries and corporate sectors should also take up HIV/AIDS prevention and awareness programmes in the State.

CONCLUSION

Orissa is on the dormant volcano of the menace of HIV/AIDS which is visible from the data of VCCTC and PPTCT. As we know a few people come to VCTC and PPTCT in the district head quarter. The awareness level is very low in the rural, tribal and urban slum areas of Orissa. The number of High Risk Group (HRG) is increasing day by day. One coordinated effort is required at the state level conversing all departments, NGOs, CBOs, Corporate houses and INGOs working in the state. NACP III aims at fulfilling this strategy. Experience suggests that district HIV/AIDS Plans are expected to contribute to this objective and also ensure participation of local communities for sustained impact and ownership of programme. Effective targeted interventions require high levels of coverage and saturation. In this context, the identification, reach and coverage of vulnerable risk behaviour groups remains very challenging. But we are hopeful the coordinated effort of all of us will solve the issue.

Dr. Dillip Chhotray, Ex Teamleader of PSU, Orissa

CONTAINING MALARIA IN ORISSA : THE CHALLENGES AHEAD

Dr Shantanu Kumar Kar

The Millennium Development Goals (MDGs) adopted by United Nations in 2000 place health at the heart of development. MDGS are inter-related and inter-dependent. It will be impossible to achieve reduction in poverty without taking steps to ensure a healthier population. Similarly, eliminating gender disparities and increasing enrolment rates for primary education are pre-requisites for success in improving the health of the population. The health of the population, in turn, can no longer be considered in isolation from the management of natural resources and environmental sustainability. It is important that health related MDGS are not seen in isolation, but as a result or desired outcome of a development agenda with several parts working together.

The reduction of child mortality by two thirds before 2015 is the most ambitious of the targets set in the health related agenda of the MDGs. Infant and child mortality is the most complex development indicator as it includes systemic as well as socio-economic and cultural factors.

Further, there is a world of difference in the risk of dying in pregnancy between the poorest and richest countries. Bridging this huge gap requires a drastic reduction in the maternal mortality rate in the underdeveloped and developing world. Similarly, a substantial and qualitative improvement is required in the targets and indicators in respect of other health-related issues like HIV, Malaria and Tuberculosis, improved sanitation and water resources. The fight against malaria figures very high on the agenda outlined under the MDGs since it has assumed alarming proportions globally, resulting in high morbidity and mortality rates among infants, children and pregnant mothers and thus working as a spanner in the wheel of global development. The disease caused around a million child deaths, of which 90% were children less than 5 years of age, accounting for 11% of all deaths in the pediatric age group in 2002. In view of the enormity of the problem, the MDGs have set the target of first halting and then reversing the rising incidences of malaria worldwide by 2015.

MDGs represent the world's commitment to reduce poverty and hunger and to tackle ill health, gender inequalities, lack of education, access to clean water and essential medicines, besides fighting environmental degradation. Improvements in health are important in not only their own right as development goals, but also a s major contributors to economic growth and prosprity.

Malaria is a common life threatening disease endemic in over 100 countries threatening 48% of the world's population, undermining the health and welfare of families, endangering the survival of children, debilitating the active population and stretching the scarce resources of the nation by way of excessive public health costs, low productivity and impaired growth. Every year, malaria affects an estimated 300 to 500 million people resulting in more than 1 million deaths and 46 million Disability Adjusted Life Years (DALYS). Knowledge about the disease and its control acquired over the years provides a basis for launching a global initiative for malaria control. Malaria can be curbed with present tools by local health system as some countries have shown.

The epidemiological situation of malaria worldwide is not uniform. There are areas where malaria never existed or disappeared spontaneously following social and economic developments. Also there are areas where malaria was endemic previously and apparently the risk of infection eliminated as a result of successful control and eradication efforts during the century. The development of health services and changes in social and economic conditions. Over 90% of malaria disease burden is in sub Saharan Africa and most of remaining burden is distributed between Indian Sub-continent, South East Asia, Oceania and the Americas. P.falciparum is the commonest species throughout the tropics and subtropics and predominates in sub-Saharan Africa. P.vivax has the widest geographic range and present in many temperate zones, but also in subtropics co-existing with P.falciparum. P.ovale occurs in Africa and sporadic in South-East Asia and Western Pacific. P.malariae has similar geographic distribution to P.falciparum, but for less common with patchy incidence. Due to the variability in distribution of 4 human malaria parasite, risk of contracting malaria is highly variable from country to country and even between areas within the country.

There are about 400 species of Anopheles mosquitoes throughout the world of which only 60 are vectors of malaria in natural conditions and 30 are vectors of major importance with variability of behavioral pattern between species. Highly efficient species A.gambiae, A.arabiensis predominate in sub-Saharan Africa while less efficient vectors A.stephensi, A.minimus, A.dines, A.culicifacies & A.fluviatitis predominate in Asiatic countries.

The National Vector Borne Disease Control Programme (formerly NMEP) reports 2.5 to 3.2 million parasite positive cases and about 1000 malarial deaths each year in India with an estimated 0.95 million DALYS. In India, though malaria is endemic with stable transmission in North East and unstable in peninsular regions, some mountainous regions about 1800 Meters above Seas Level (MSL) and well drained coastal areas, including island territories are relatively free of malaria. In Orissa, a part of peninsular India and with 3.74% of countries population contributed 23% of malaria cases, 40% of P.falciparum cases and around 27% malaria deaths of country, while 60% population are at risk of infection, particularly in tribal districts. Malaria post immense public health concern and continue to be major causes of significant morbidity and mortality in Orissa. The disease is prevalent in both rural and urban areas mostly among low socio-economic group of population, the marginalized and disadvantaged. The dynamics of the disease is largely determined by eco-epidemiological, socio-economic and water management system. The children and young adults representing the economically productive sections and pregnant women are most vulnerable groups although all age groups are affected. The malaria data of the year 2006 indicate high P.falciparum rate (87.1%), Annual parasite rate (9.3%), slide positively rate (7.5%) and 253 deaths due to malaria.

Due to resurgence of malaria in seventies, Govt. of India made some changes in malaria programme in form of modified plan of operation. During 1997, with financial assistance from World Bank, Enhanced Malaria Control Programme (EMCP) was launched in the State in 158 tribal dominated hardcore endemic blocks spreading over 21 districts which was later extended to 240 blocks in 26 districts, under the project State received additional support including expenses apart from supply of synthetic pyrethroids, bednets, RDK (Rapid diagnostic test kit), Arteether injections blister packs for radical treatment for adult cases. Sixteen districts have been now included under intensified malaria control project GFATM during the year 2005 to 2006. Under this project will provide finance to accelerate anti-malaria activities especially in remote and inaccessible areas. These 16 districts will get additional support with SP+ACT tablets, promotion of ITBN (medicated mosquito net) and intensification of IEC/B.C.C. activities. The EMCP has not so far been able bring about a significant decline in incidence of malaria in the State.

Govt. of India, in its National health policy has pledged commitment to reduce mortality on account of malaria by 50% by 2010 and efficient morbidity control by 2015. In this direction, GOI has launched NRHM in April, 2005. Orissa health strategy has stated in its objective to improve implementation efficiency of Malaria control programme and to reduce morbidity and mortality by 50%. Targets for 2007-08 have been kept to (i) improve Annual blood examination rate proportionately in all affected districts (ii) reduce SPR target for define for each district (iii) Reduce API by 15-30% and reduce date by 30-50%.

SITUATION ANALYSIS:

Orissa State is located between parallels of 17.49'N and 22.34'N latitude and maintains 81.27'E and 87.29'E longitude bounded by Bay of Bengal in East. Chhatisgarh State bordering West, Andhra Pradesh in South, Jharkhand in North and West Bengal in North-East. According to Forest Survey of India (2001) about 32.2% of State is covered with forest, with 450 km. of coastline. Total water bodies in State is 10.80 lakh hectares in addition to 765086 hectares covered by irrigation canals. The State is divided into 4 district geophysical zones i.e. (i) North plateau (ii) Central Table Land (iii) Coastal Tract and (iv) Eastern Ghat are highly malarious largely contribute more malaria cases and death compared to other zones coastal tracts shows variable endemicity of malaria.

Eastern Ghat includes districts like Koraput, Malkangiri, Naurangpur, Rayagada, Kalahandi, Nuapara, Phulbani and Gajapati, where tribal population is very high and height varies between 950-1350 msl. From the analysis of state data from 1997-2004 indicate higher morbidity and mortality due to malaria in South districts compared to whole State and not improved significantly (Table 1). Climate in Orissa is favourable for the perennial transmission of malaria in many parts of State. Average number of rainy days is 60-90 days; with mean annual rainfall is 1482 mm but maximum between June to September (1300.80 mm). Due to erratic distribution of rainfall in past few years, rainy day period was extended that favour vector breeding. The mean maximum temperature is 32.8° C that goes upto 45° C in April-May and minimum is 22.8° C that fall to 11° C in December.

The mean relative humidity is 61.5 – 85.7% in morning and 52.8 – 80.4% in the evening. The ambient temperature and relative humidity is conducive for persistence of malaria, since parasite development in vectors requires optimum temperature of 20-30 C with humidity of 60%.

The decadal growth rate is 15-94% (1991-20001) with population density of 236/sq.km. Many cultural and ethnic groups inhabit the State. Their health related cultures, beliefs and life style and occupational needs have direct bearing on transmission of infection. About 22.3% of total population of State is tribal with various ethnicities that include 62 tribes and 13 primitive tribes. They reside mostly in forest / forest fringe and foot hill areas having difficult accessibility causing operational problems. The vector densities are high and in certain areas vectors present throughout all seasons leading to perennial transmission of malaria infection.

Most of the population are primarily depend upon agriculture and allied activities. About 47.15% of populations are below poverty line. They are at risk of contacting disease due to poor housing, settlements near mosquito breeding sites, sleeping habits, poor clothing and exposed to mosquito biting. Non availability of work coupled with poverty has encouraged movement of surplus manpower from rural to urban areas. These new settlements have usually in sanitary conditions called urban slums. Thus there has been a significant increase of slums with no proper water supply or drainage facilities. Malaria control in these areas are difficult as neither these shelters can be sprayed nor water receptacles can be properly treated with insecticides. There has been an increase of malaria incidence in slums. Besides in search of work labour population migrates to highly malarious North East Zone, thus they not only suffer but carry infection homeland.

Literacy rate in Orissa is 63.61% comparatively low rate of literacy among women might be factor for their active participation in antimalarial activities. It is observed that tribes in Southern district cover less body parts by clothing than those in Northern districts, thus more surface area of body get exposed to mosquito bite. Social stigmas, practices influence the behavior in many tribes adversely to the malaria programme. Majority of tribes prefer to go to quasar instead of Government outlet like FTD or Drug distribution Centres. Once fever occurs, majority first consult their own community healers or practitioners / medicine shops.

In Orissa Micronutrient deficiency is very high malnutrition amongst children are widely prevalent. While 46.7% under three years age in country have moderate or severe under nutrition, in Orissa the figure is 54.4%. According to NNMB 2002, Nutrition Survey Report for children between 1 to 5 years that female children had proportionately higher frequency of under weight (68.9%), stunting (58.7%) and wasting (20.9%) than male children. High micronutrient deficiency prevalence is possibly due to poor dietary intake. Overall prevalence of anaemia is 63% among women and 73% among children. Vitamin A deficiency was found to be 3.56% among children aged 12-48 months (source N.I.N., Hyderabad). High frequency of micronutrient deficiency might be an additional factor for lower immunity and repeated attack of malaria in these population. According to weight to age 57.1% children were suffering from under weight (Mahapatra et al, 2000).

The current epidemiological situation (2006) indicate that compared to 2002 data, there has been improvement in certain Malariometric indices. The 2006 data show Annual parasite index has come down to 9.3% with reduction of number of deaths from 465 in 2002 to 253. However P.falciparum rate still remains high i.e. 87.1%, but slide positive rate (SPR) reduced from 10.3% to 7.5% in 2006.

According to action plan 2007-08 of the state, it is reported that 16 districts are more problematic needing higher attention. Out of 39 million population of state, 42% live in these 16 districts, that constitutes 43% tribes and 14% Scheduled Caste with lower literary rate.

CURRENT STRATEGY: BY EVBDCP (ENHANCED VECTOR BORNE DISEASE CONTROL PROGRAMME).

1. Early Diagnosis and complete treatment (EDCT).
2. Integrated Vector Control (IVC).
3. Insecticide Treated Bednets.
4. Larvivorous Fsh (Biological control agent).
5. Capacity Building (Training).
6. B.C.C. (Behavioral Change Communication).
7. Operational Research.

NEW INITIATIVES:

- Public- Private- Partnership.
- Computerized Management Information (CMIS).
- Monitoring and Supervision.

PROGRESS OF ANTI MALARIA ACTIVITIES:

EDCT

29803 DDC and 26261 FTD were established 402 microscopy Centres functioning at District / Block / SDH level Rapid Diagnostic .Test Kits are supplied to Districts for prompt diagnosis of suspected cases in remote and inaccessible areas. Presumptive radical treatment given to all fever cases in high risk areas. Presumptive treatment with full course given to all fever cases in low risk areas.

Chemoprophylaxis with Chloroquin is given to all pregnant women after 12 weeks of pregnancy to reduce IMR and MMR. ACT (SP + artesunate) tabs being initiated in 15 identified blocks and the adjacent blocks of chloroquine resistant areas. Integrated vector control by IRS using insecticides being done in campaign made with stringent monitoring. Around 6,25000 IYBNS were distributed in year 2005-06. At Block level 302 hatchery constructed that were activated with fish for biological control of mosquito vector. A total of 901237 nets were impregnated with insecticides at community level.

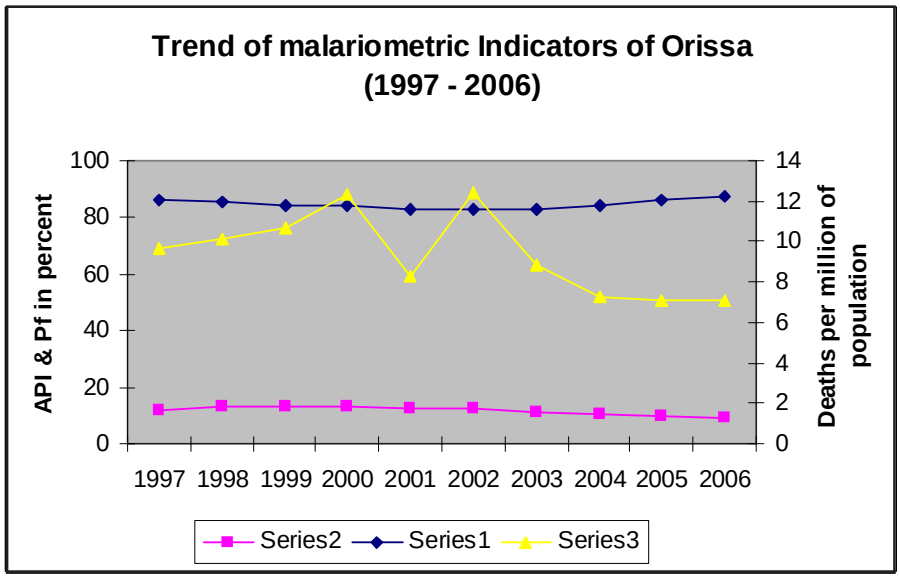
Several advocacy workshop, group meting message dissemination through media, display of holdings, sensitization workshop at all peripheral level carried out including message from Hon'ble Chief Minister and Hon'ble Health Minister published in media. Operational studies are proposed to identify drug resistant areas and vector pattern and their insecticide sensitivity that can help for more rational use of treatment as well

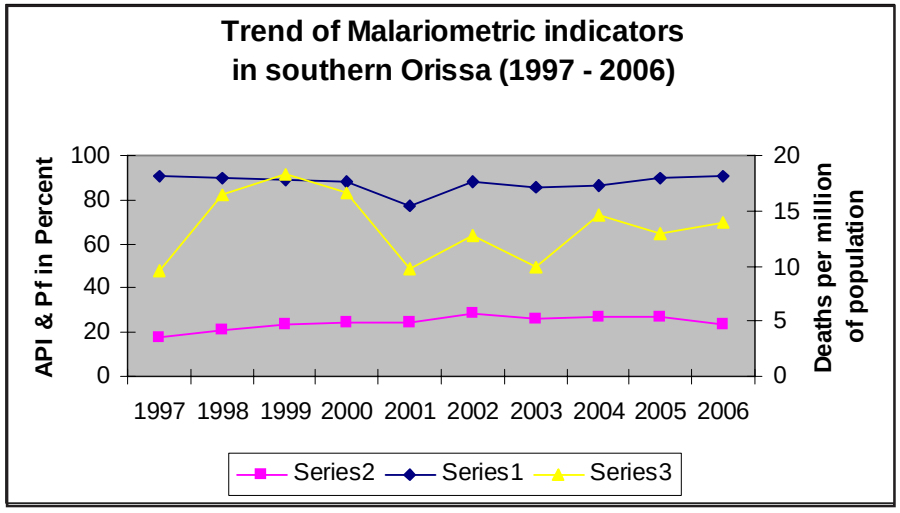
Malaria is a public health problem in about 100 countries or territories, situated in the tropical and sub-tropical zones of the world. In India except some mountainous regions above 1800msl and well drained coastal areas along the Western Ghat and Eastern Ghat including island territories of Lakhadweep ; all places are endemic for malaria. The transmission is stable in north-east region while unstable in peninsular India. According to the NVBDCP at least 2.5 to 3.2 million people are clinically affected with malaria each year in India with more than 1000 deaths. The loss of productivity in the country due to it is estimated to be 0.95 million disability adjusted life years (DALYS). Orissa with 3.74% of the country's population contributes 23% of malaria cases and 50% of malarial deaths of the country; more precisely every year around 4 lakh people gets this infection and at least 200 of them succumbed to death. All four species of Plasmodium, (*P .falciparum, P vivax, P malariae* and *P ovale*) have been reported from the state, although *P falciparum* is the dominant species (>80%) and wide spread. This is in contrast to the national scenario, where *P vivax* is responsible for 60-65% cases and *P falciparum* for 35-40% cases. But, similar situation is observed in Chhatishgarh (76.6%), Assam (71.3%), Meghalaya (85.8%) and Tripura (86.9%)

Geo-physically the state is divided in to 4 distinct regions *viz* (i) Northern Plateau (ii) Central Table land (iii) Coastal Tract and (iv) Eastern Ghat. Eastern Ghat, the mountainous range that extends from Nilgiri subdivision of Orissa to Coimbatoore district of Tamilnadu lies along the Bay of Bengal in a northwest and southwest strike and covers almost all the southern districts of Orissa(Koraput, Malkangiri,Nawarangpur, Rayagara, Kalahandi, Nuapara, Phulbani,and Gajapati).The region wise distribution of malaria (from 1997 to 2004) in the state shows that the total malaria attributed deaths were highest in eastern ghat region than northern plateau, central table land and coastal tract The morbidity due to malaria (SPR & API) and Pf % are almost same in eastern ghat and northern plateau, but high compared to central table land and coastal tract (Table 1).From the analysis it is observed that the trend in malaria morbidity as well as the mortality is always in higher side in the southern districts compared to whole state and not improved significantly since 1997.

Table 1: Malaria profile (Average) of different geographical zones of Orissa (1997-2004).

Area	ABER	SPR	Pf%	API	Deaths
Northern Plateau	19.29	12.26	92.20	24.52	978
Central Table Land	12.66	12.62	72.46	15.97	678
Eastern Ghat	19.08	14.22	89.60	28.55	1023
Coastal Tract	6.43	5.73	50.55	2.11	317





Similar is the situation in Jagdalpur, Dantawada and Kanker districts of Chhatisgarh, bordering Orissa which are on the west side of the eastern ghat region and reporting >85% of Pf and>14% of SPR. However, Andhra Pradesh, a part of eastern ghat region and Tamil Nadu ,a part of both eastern ghat and western ghat region, reports 54.8% and 6.89% of *P falciparum* respectively . The morbidity (SPR) / mortality due to malaria in these two states (2004 data) are also significantly low compared to Orissa (0.36 / 2 in AP and 0.56 / 0 in TN). The states in the western ghat region (2004 data) such as, Maharastra has reported 61 deaths, Karnataka 27 and Kerala 12, while the SPR rate/ Pf% were 2.8% / 29.3%, 0.5% / 42.8%,0.9%/25.3% and 0.2%/18.3% respectively(Table 2). The mortality due to malaria in Mizoram and Meghalaya of the north eastern region is even worse than Orissa, though the Pf% is significantly low than Orissa (Table 3). The situation of malaria is not so acute in western ghat region as Orissa in the states situated in the western ghat region. This might be due to the better health care facility awareness among the people in these states.

Table 2: Malaria in Orissa versus neighbouring states.

States	API	Pf%	Death/million
Orissa	**10.79**	**84.40**	**7.3**
West Bengal	2.60	27.28	2.16
Jharkhand	5.26	30.78	1.4
Chhatisgarh	8.28	76.59	0.17
Andhra Pradesh	0.50	54.79	0.02
Madhya Pradesh	1.97	39.59	0.53

Table 3: Malaria in Orissa versus states in the north eastern region

States	API	Pf%	Death/million
Orissa	**10.79**	**84.40**	**7.3**
Assam	2.02	71.23	1.8
Arunachal Pradesh	28.27	14.73	0
Nagaland	1.38	5.15	0.55
Manipur	1.04	28.18	3.03
Mizoram	**8.64**	**53.26**	**41.63**
Meghalaya	**7.84**	**53.26**	**12.6**
Tripura	5.37	86.99	4.91

Table 4: Malaria in Orissa versus states in Western Ghat region.

States	API	Pf%	Deaths/million
Orissa	**10.79**	**84.40**	**7.3**
Gujurat	4.11	29.83	1.64
Maharashtra	0.66	42.47	0.58
Karnataka	1.56	25.29	0.51
Kerala	0.09	18.28	0.36
Tamilnadu	0.65	6.89	0

The prevailing situation of malaria in different regions of the state seems to be influenced primarily by the climatic factors, types of vector, parasite isolates, human behaviour and availability / utilization of health care facility .The climatic factors are almost similar in different regions of the state as shown in Table 5 including the relative humidity(RH)(range 61.5-85.7% in the morning and 52.8-80.4% in the evening) and favours the development of malaria parasites in the insect vectors. Since the optimum temperature for the development of the parasite in mosquitoes is 20 to 30 ^{o}C and a relative humidity of 60%.

Table 5: Forest area & Climatic conditions in different regions of Orissa.

Geo-Physical Area	Total Forest Area(SqKm)	Average Rainy Day/ Rain Fall(mm)	Average Max-Min Temperature(0C)
Northern Plateau	12446.45	71/1509.1	32.2-19.5
Central Table Land	14302.40	64/1617.5	32.8-12.7
Eastern Ghat	23076.98	69/1479.2	32.2-18.3
Coastal Tract	8309.90	69/1628.2	31.2-22.0

There are total 15 species of Anopheles mosquitoes transmitting malaria in India (8 major and 7 local). In Orissa the major vectors are *An culicifacies , An fluviatilis , An stephensi , An annularis,* and local vectors are *An varuna, An aconitus , An jeyporinsis and An macculatus*. *An macculatus* is exclusively found in the eastern ghat region of Orissa and Meghalay. Similarly *An jeyporensis* is present only in eastern ghat region of Orissa, Chhtisgarh, Karnatak and Kerala. In Andhra Pradesh and Tamilnadu *An minimus* and *An sandaicus* are the major vectors in addition to other major vectors found in Orissa. But the number of local vectors are very few in Andhra Pradesh (*An varuna*) and Tamilnadu (*An subpictus* and *An vagus*) compared to Orissa. Therefore the local vectors are thought to play very important role in maintaining the transmission of malaria and should not be ignored during control programme. Most of the malaria vectors prefers to bite in the night in side the house and also rests in side the house. The *An culicifacies* breeds in the rice field and transmit malaria in rural areas, while *An stephensi* breeds in the overhead tanks and maintains malaria in urban areas. But *An fluviatilis*, which preferably breeds in the streams of foot hill areas bites in the in door and rests in the out door. But *An macculatus* breeds in the forest area , bites in the out side and also rests out side. Therefore the people who go to the jungles for work get the infection during the working hours. Since the southern districts are covered with more forests it is possible that *a maculatus* maintaining the transmission in these areas, because the tribals earns

their livelihood mostly working in the jungles. Hence, in the jungle areas use of mosquito repellent will be the alternative to prevent mosquito bite and check malaria transmission.

Of the 4 species human malaria parasites, *P falciparum* is most lethal and causes complicated syndromes, while *P malariae* causes glomerulonephritis. Both *P vivax* and *P ovale* are responsible for relapse malaria. The *P ovale* has been reported first time in India from Borigumma block, a part of eastern ghat region. This species is very rarely found outside Africa. The *P malariae* which is also a rare species has been reported from Northern plateau as well as Central Table land and Eastern Ghat region. Molecular analyses of *P falciparum* clinical isolates have shown more than 30 genotypes in different regions of Orissa. Among these isolates one of the strain have been found to be associated with the severe malaria. But there is no difference in region wise distribution of these parasite genotypes. All grades of resistance to chloroquine in *P falciparum* are found in Orissa. The over all frequency of RI, RII and RIII resistance in the state is 12%, 7.8% and 2.8% respectively, but the frequency may be as high as 64.7% as reported by the NMAP in Daringbadi of Kandhamal district and by RMRC in Thuamalrampur PHC area of Kalahandi district in 2004. The RIII level of resistance in Malkangiri, Kandhamal (Phiringia and Gumagarh PHC) and Boudh, RII in Rayagara and Ganjam and RI/RII resistance in Koraput of southern Orissa has already been reported since 1994.The resistance is therefore might be one of the cause of high mortality in southern Orissa.

Conclusion:

Available epidemiological data indicates that districts having high forest coverage, high tribal dominated areas are reporting more cases than areas with low forest coverage or tribal pockets. The economic loss due to each malaria attack is estimated to be Rs. 334.01 and an average loss of 8.96 man days per malaria patient compared to 3.84 man days to other family members amongst tribal communities of Orissa. This situation has not improved significantly even after launching of EMCP and continue to put a lot of burden in the economic upliftment of these communities. The transmission is stable in all zones except in coastal zone. The reason for persistence of malaria and deaths seem to be manifold. The vacancy position in health sector in remote areas need immediate attention for action that might be adversely affecting programme implementation and supervision of IRS spray activity. Health seeking behaviour in tribal and certain rural sector adversely affecting utilization of health services that has to be focused through appropriate BCC. The rising incidence of development of chloroquin resistance in many pockets need to be identified urgently to curtail death rate by instruction of 2^{nd} line drug where appropriate.

Training and motivation to grass root level workers need focus. Since incidence of severe malaria is also high, the community health centre level hospitals can be well equipped to cater to need treatment of severe malaria. The data on bionomics of vectors are required to be generated in different eco zone settings to identify appropriate mosquito control strategy and curtail transmission. Comprehensive research programme on socio-economic and cultural factors of tribals to be studied and appropriate strategy developed to be used for B.C.C.

Efficient water management to be done to prevent mosquitogenic conditions. Intersectoral co-ordination is essential and community participation approach can further strengthen the programme to achieve the targets of MDGs.

Dr. Shantanu Kumar Kar, Director, RMRC, Bhubaneswar

NATIONAL RURAL HEALTH MISSION – CONCERNS & GAPS

By **Manoranjan Mishra**

National Rural Health Mission (NRHM) was launched by the Prime Minister, Dr. Manmohan Singh in New Delhi on 12th April 2005. In Orissa, the Mission was launched by Chief Minister, Sri. Naveen Patnaik and the Union Health Minister, Dr. Anbumani Ramados on 17th June 2005. NRHM seeks to provide effective healthcare to both the rural and urban population throughout the State. But the special focus of the programme is on the backward districts with their weak human development and health indicators, especially among the poor and marginalized groups like women and the vulnerable sections of the society. NRHM seeks to integrate health with the determinants of health for which inter-sectoral convergence between departments like Panchayati Raj, WCD, Rural Development, Higher & Mass Education, Sports & Youth Affairs, Industry and Information & Public Relations is essential. The main components of NRHM are RCH-II, Immunization, National Disease Control Programme, NRHM initiatives and Intersectoral Convergence.

REPRODUCTIVE AND CHILD HEALTH:

The focus of the RCH-II programme is to reduce the Maternal & Child Mortality & Morbidity rates with emphasis on rural health care. Adolescent Health and Gender, Urban Health, Tribal Health and Public Health and Public Private Partnership are the other supportive focus areas in RCH-II. Flexible financing, decentralized planning and improved management capacity are some of the innovations which have been introduced for achieving the desired milestones. In Orissa, 21 Mother NGOs, 124 field NGOs and 2 service NGOs are complementing and supplementing government efforts in unserved and underserved areas for RCH service delivery. Orissa has become a model in the country in terms of the MNGO / FNGO Programme.

IMMUNISATION:

The present immunization coverage of children in Orissa, at 57%, is lagging well behind the goal of universal (100%) immunization. Incomplete immunization is one of the major causes of child morbidity and mortality. Keeping this in view, special and comprehensive provisions have been made under the National Rural Health Mission to achieve hundred percent immunization in the State.

JANANI SURAKSHYA YOJANA:

Janani Surakshya Yojana (JSY), under the overall umbrella of the National Rural Health Mission (NRHM), has been conceived by modifying the existing National Maternity Benefit Scheme (NMBS). JSY integrates the cash assistance with antenatal care during the pregnancy period, institutional care during delivery and immediate post-partum period in a health centre by establishing a system of coordinated care by field level health workers. The scheme is being implemented in all the 30 districts of the state. NRHM also plans to establish JSY Helpline in some tribal districts with the help of MNGOs / FNGOs. During 2006-07, 35, 000 women received JSY assistance for institutional deliveries.

INTEGRATED MANAGEMENT OF NEWBORN & CHILDHOOD ILLNESS (IMNCI):

WHO/UNICEF have developed a new approach to tackling the major diseases of early childhood called the Integrated Management of Newborn & Childhood Illnesses (IMNCI).

The IMNCI package has been developed by experts, including Child Health Researchers, academicians the Indian Academy of Pediatrics (IAP) and the National Neonatology Forum (NNF) to adapt it for the specific requirements of children in India.

ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

Currently, Anganwadi Workers (AWWs) under the Integrated Child Development Scheme (ICDS) are engaged in organizing supplementary nutrition programmes and other supportive activities. The very nature of their job responsibilities with its emphasis on supplementary feeding and pre-school education does not allow them to take up the responsibility of change agents on health in a village. Hence, a new band of community-based functionaries, named as **Accredited Social Health Activists (ASHA)** has been proposed to fill this void. The ASHA will be the first port of call for any health related demands of the deprived sections of the population, especially women and children, who find it difficult to access health services. The State has already selected more than 45,000 ASHAs working under NRHM. During 2006-07, more than 45, 000 ASHAs received performance incentives for conducting institutional deliveries and FP sterilization.

UNITED FUNDS FOR SUB-CENTERS:

As part of the National Rural Health Mission, it has been proposed to provide each Sub-centre with Rs.10, 000/- as an untied fund to meet urgent yet discrete activities that need relatively small sums of money. It has been decided that the fund shall be kept in a joint bank account in the names of the ANM and the Sarpanch of the locality. Decisions on the activities for which the funds are to be spent will be approved by the Village Health Committee (VHC) and will be administered by the ANM. In areas where the sub-centre is not co-terminus with the Gram Panchayat (GP) and covers more than one GP, the Gram Panchayat where the Sub-centre is located will approve the Action Plan. The State has released untied fund to 6, 241 Sub-Centres, but the money has not been spent in many sub centres due to several reasons.

INTEGRATED DISEASE SURVEILLANCE PROGRAMME (IDSP) :

The objective of IDSP is to establish a state-based system of surveillance through Information Communication Technology (ICT) for communicable and non-communicable diseases so that timely and effective public health action can be initiated in response to urgent health challenges. IDSP will also improve the efficiency of the existing surveillance activities of various disease control Programmes. The surveillance system will be strengthened through capacity building of medical officers and health workers and technicians, strengthening of the laboratory network and the reporting system through ICT. An IDSP cell has been established in the state to coordinate the Programme.

ROGI KALYAN SAMITI:

Rogi Kalyan Samitis (RKS) have been formed at the district, sub-division and block level health institutions. These Samitis will also be formed at all the PHCs (N) and the three Medical Colleges in Orissa. The Samiti is a registered society, which shall act as a group of trustees for the hospital to manage the affairs of the hospital. The RKS will not function as a Government agency, but as an NGO. It shall consist of members from the local Panchayati Raj Institutions (PRIs), NGOs, elected local representatives and officials from the Government sector, who would together be responsible for the functioning and management of the health unit. So far, 327 RKSs have been registered in the state.

TRIBAL HEALTH:

The rationale behind having a Tribal Health Component under RCH (II) is that tribals have poor access to health services and there is also under-utilization of health services owing to social, cultural and economic factors. Demand side barriers, structural constraints, HRD issues and the provider's attitudes affect the delivery of health services in tribal areas. The main aim, of THC, therefore, is to improve the health status of the tribal community by providing integrated, need-based and quality primary health and family welfare services with a view to achieving the socio demographic goals envisaged under National Population Policy 2002. The State has also included many innovative programmes under NRHM for tribal health. In 2006-07, 125 health Melas were conducted in the tribal areas of the state.

URBAN HEALTH:

Recognizing the seriousness of the poor urban health situation, the Government of India has identified "Urban Health" as one of the thrust areas in the Tenth Five Year Plan, National Population Policy 2000, National Health

Policy 2002 and the forthcoming 2nd Phase of the Reproductive Child Health (RCH) Programme. In Orissa, the scheme is being implemented in seven urban areas, namely; Bhubaneswar, Ganjam, Cuttack, Rourkela, Sambalpur, Balasore and Puri involving 12 NGOs. An Urban Health Technical committee has been formed to supervise the programme.

AYUSH:

The NRHM, Orissa seeks to revitalize local health traditions and mainstream AYUSH (including manpower and drugs) and strengthen the Public Health System at all levels. It has been decided that AYUSH medications shall be included in the drug kit of ASHA. Besides, additional supply of generic drugs for common ailments at SC / PHC / CHC levels under the Mission shall also include AYUSH formulations. The State Government has already decided to make all single-doctor PHCs into two-doctor PHCs by 2008 by integrating AYUSH doctors into the mainstream of health services.

INDIAN PUBLIC HEALTH STANDARDS (IPHS) :

Although a large number of sub-centres, Primary Health Centres and Community Health Centres have been established to provide comprehensive promotive, preventive and curative services to the rural people in the country, most of these institutions are at present not able to function up to the level expected of them due to various reasons. National Rural Health Mission envisages raising the profile of institutions to the optimum level by providing for infrastructure, manpower, logistics etc. to improve the quality of services and the level of their utilization. Through wide consultation with various stakeholders, Indian Public Health Standards (IPHS) have been framed for these centres after widespread consultation with various stakeholders.

Similarly, all the PHCs should function as 24-hour PHCs in a gradual manner. NRHM also envisages a functional 30-bedded rural hospital at the block level providing emergency obstetric care and neonatal care in the first instance as FRU and gradually strengthen it further to provide other specialized services as per the details in the IPHS.

SOCIAL MARKETING:

According to 'National Strategy for Social Marketing' (NSSM), social marketing for RCH aims to distribute commonly needed products at affordable prices to the less well-off (but not necessarily the poorest who may continue to rely solely on distribution by the public health delivery system) segments of the population, through commercial networks, and community/ NGO based distribution systems. The State is on the verge of developing a "Social Marketing Strategy" in collaboration with FPAI, PSI and HLPPT.

BEHAVIOUR CHANGE COMMUNICATION (BCC) :

Behaviour Change Communication speaks about putting in place a system that facilitates a process of understanding people's situations, perceptions and influences. Messages and Communication Deliverables should be prepared to respond to the concerns within those situations using various Communication Processes and Media Elements to persuade people to increase their knowledge and accordingly change the Behaviors & Practices that place them at risk A BCC strategy has been developed in the State.

PUBLIC – PRIVATE PARTNERSHIP (PPP) :

Public–Private Partnership or PPP in the context of the health sector is an instrument for improving the health of the population. PPP is to be seen in the context of viewing the whole medical sector as a national asset with health promotion as the goal of all health providers, private or public.

In Orissa, three NGOs are managing PHC (N) under PPP and the State is on the verge of handing over 35 to 40 PHCs to NGOs for their management. The government has also established a NGO-P3 cell to manage PPP activities

CONCERN AREAS AND GAPS:

Though the state has achieved some of the goals under NRHM, accessible affordable health care still remains a far cry. Some of the common concerns and gaps in State Rural Health Mission are;

a. Poor Community Participation
b. Lack of capacity of Service Providers
c. Poor Community Ownership
d. Lack of Community Empowerment Process – poor mechanism for social audit and validation of progress.
e. Lack of Intersectoral Coordination
f. Poor Public-Private Partnership Policy

1. INDICATORS OF PUBLIC HEALTH :

We take pride in saying that the number of patients availing public health services is increasing. But the efficiency of our public health system needs to be gauged by the decrease in the number of patients seeking medical consultation.

- For example ORT promotion and making ORT available and accessible at the hamlet level by health workers will reduce serious dehydration needing hospitalization. The number of indoor dehydration cases is thus an indicator of poor ORT availability and accessibility.
- To take another case, the number of hypertensive cases detected and controlled is an indicator of strokes and heart attacks prevented.
- The number of unplanned/unwanted pregnancies is an indicator of unmet need for family planning.

2. ASHA / COMMUNITY PARTICIPATION – CAPACITY BUILDING OF VILLAGE HEALTH COMMITTEE:

It is unrealistic to expect that ASHA/link worker will be able to plan for people's needs when the health department has failed to do so. To cite an example, the health department plans its target of antenatal services, immunization services, STD, family planning, malaria surveillance, HIV/AIDS education services annually. The common ailments of rural people include hypertension, arthritis, gastritis, difficulty in respiration and so on. No medicine or primary care is available in the sub-centre, but the RMP addresses this felt need. Hence, the mathematical model which assesses last year's report and service needs on the basis of the birth rate (given by the state) is ineffectual because it does not reflect villagers' aspirations and needs, which is reflected by the fact that attendance at clinics of village quacks is higher than in health sub-centres.

3. STRENGTHENING HEALTH INSTITUTIONS TO IMPROVE UTILIZATION – QUALITY LOW–COST GENERIC MEDICINES, NEED FOR REVISION OF STAFFING NORMS & ADDITIONAL SERVICES:

NHP emphasizes the need for basing treatment regimens, in both the public and private domains, on a limited number of essential drugs of a generic nature. This is a prerequisite for cost-effective public healthcare. In the public health system, this would be enforced by prohibiting the use of proprietary drugs. The private pharmaceutical sector is generally exploiting poor patients. A survey conducted by the National Council of Applied Economic Research has revealed that the expenditure incurred by the poor to meet their medical needs is the second most important cause of rural indebtedness.

4. LEAVE RESERVE CADRE:

We should seriously contemplate a cadre of leave reserve staff, which should be at the disposal of the district health management. These staff can be made available to render continuity of services when some staff are on leave, or a post is vacant (for short period). *However, mobility support and accommodation are essential for starting such a cadre. MIS on staff absenteeism (leave of any kind) will be needed to successfully manage this service of redeployment and reliability of services.*

5. STRENGTHENING SUB-CENTRES:

- Malnutrition should not be seen as the work of the ICDS sector alone. The new WHO growth charts should be introduced in all health sub-centres and monitoring of child growth, with feedback to parents in the form of a copy of the chart, given to parents.
- Regular reporting routed through health workers on assessment of activities of health related sectors by the village health committee – status of sanitation, quality of drinking water, detection of malnutrition, mid day school meals – should be initiated.
- Basic antenatal care to screen and detect complications early – weight monitoring, blood pressure measurement, urine testing in sub-centres should be operationalized and equipment supplied, if needed.

- In the absence of people's participation, the village fund is operated by the health staff and the Pradhan without consulting the people. This leads to arbitrary decisions for sub-centre improvement, which do not always reflect the needs of the people.

6. STRENGTHENING PRIMARY HEALTH CENTRES:

The post of at least one chowkidar/watchman needs to be created for efficient running of 24x7 hospitals. Also, furnished accommodation for staff in rural areas will be an added incentive for health staff to serve in villages. The provision of essential drugs at the public health service centres will create a demand for other professional services from the local population, which, in turn, will boost the general revival of activities in these service centers. The provision of medicines should also take into consideration the burden of common lifestyle diseases – diabetes, hypertension etc. - in the area.

7. STRENGTHENING CHCs FOR FIRST REFERAL CARE:

Additional service: In view of the tremendous burden of disability, there should be a physiotherapist at least at block level hospitals. WHO recommends one physiotherapist for every 10,000 population. Likewise, common mental health problems can be solved at this level by general duty medical staff. Stakeholders' committees - "Rogi Kalyan Samiti" (RKS) - will serve the interests of levying user charges for services. Nowhere have we seen RKS setting a shop for low cost generic medicines. There is no safety net for poor patients. The only motive seems to be to add assets and raise funds for running services.

8. ROGI KALYAN SAMITI (RKS)

Though RKSs have been formed in many CHCs/PHCs and District Hospitals, the meetings of the governing bodies of RKSs are not held and the money allocated to RKSs have not been utilized.

9. UNTIED FUND

Due to conflict between Sarapanches and ANMs, untied funds have remained unutilized in many sub centres. There is no clear-cut guideline issued under NRHM on how to spend the untied fund.

10. PUBLIC-PRIVATE PARTNERSHIP

Though the government is planning to handover some PHCs and CHCs to NGOs, there are no government policy guidelines about the modalities of such joint management. The PPP policy has not been approved by the Government.

11. INDIAN PUBLIC HEALTH STANDARD (IPHS)

NRHM has allotted Rs.20 lakhs to CHCs and Rs.10 lakhs to PHCs to upgrade them upto 1 PHs standard. The money has not been spent as there are no guidelines on who will undertake the construction work .In some districts, the DRDAs have been given the fund, but they have failed to respond to the need.

12. INTERSECTORAL COORDINATION

In the Health and FW Department itself, there is poor coordination among the Directors. With the introduction of a post of NRHM Director, the conflict rate has increased in the department .Inter-sectoral coordination is very poor in the State.

13. CONTRACTUAL STAFF

There is a State Programme Management Unit and a District Programme management Unit under NRHM. But due to large turn-out of the staff, the programme is not being implemented properly

14. SOCIAL AUDIT AND COMMUNITY MONITORING

This concept has not been understood by NRHM in the State and needs to be institutionalized in NRHM**.**

15. ASHA TRAINING

The one-time, 23-day training module of ASHA Volunteers is not sufficient to sustain their interest in the NRHM Programme. There is no programme mechanism to follow up on the activities of ASHAs either at state level or at the District level. Local NGOs should be involved in conducting monthly review and refresher training. ASHA Resource centres have not been established so far in the State.

16. STATE HEALTH RESOURCE CENTRE (SHRC)

So far, the state has not been able to form SHRCs, which will provide the technical support to NRHM. SHRCs should be established immediately to bridge the gaps.

17. SOCIAL MARKETING

Though the Programme has already completed two years, the state has not been able to frame the social marketing policy under NRHM

CONCLUSION

Compared to other states in India, Orissa is far ahead in the implementation of the NRHM Programme. But there is no room for complacency. The state has to increase its capacity to utilize the money for the purpose that it has been provided by the Government of India under NRHM.

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ENVIRONMENT SUSTAINABILITY IN ORISSA AND MDGS

By **Richard Mohapatra**

SYNOPSIS

The millennium development goals (MDGs) are the latest global targets in making the earth a bit more liveable for the poor. We have already crossed the halfway mark on the road to these targets. The euphoria over it is still as fresh as in 2000. How does one evaluate the achievement of MDGs in a country like India, particularly in its poorest state Orissa?

Without disparaging the initiative of setting deadlines for such crucial goals, it is safe to say that we will fail measurably in attaining these goals. The MDGs are not new goals, but just new time frames for reaching old goals. There is no state or country, which has not set such objectives within its overall governance framework. The Orissa state government, for example, set such goals way back in the 1960s. But after close to 40 years of such policy focus, the state has dropped further in the human development index. It suggests that our understanding of the state's socio-economic characteristics is flawed. If we have failed to meet the target in 40-50 years, there is no way we can achieve it in the next eight years (2015 is the deadline set for achieving the MDGs) with the same understanding. In 2000, when the heads of states agreed for the MDGs, they just set a timeline. But taking into consideration the ground realities in the country, the timeline does appear a little unrealistic.

The immediate question is: what is needed for attaining these goals? As the example of Orissa demonstrates, we have all but wasted the last four to five decades chasing these goals. The reason for this failure is the way we have gone about working towards achieving these fundamental human objectives. It follows that we cannot continue with the policies that we have followed all these years if we are to achieve the MDGs at least in the next 15-20 years. It means we need a new paradigm of developmental planning that makes these lofty goals achievable. Otherwise, we are bound to fail again.

What is this new development paradigm? To begin with, we have to redefine our development model. In a poor country like India and an even poorer state like Orissa, environment is a major source of livelihood. It determines virtually all aspects of human existence. Hence, ecology must be the axis of development as it sustains close to 60 percent of India's population. It is primarily because we have not properly understood the contours of our poverty, which is ecological in nature, that we have not been able to eradicate that. The linkages between environment and poverty in India - and particularly in Orissa - are so strong that any attempt to delink them would result in devastating socio-economic consequences.

This is more important in the case of Orissa since it is the poorest state of the country. Environmental sustainability, as we explain below, has to be the mantra for the overall development of the state and thus meeting the MDGs.

ORISSA: STATE OF POVERTY

Orissa is the poorest state in India with around 41 percent of the population below the official poverty line, according to the latest estimate. This is almost double the national average. "Orissa's economy is a classic case of the failure of trickle-down. The benefits of whatever little growth that happened did not percolate down and bring about an improvement in the social conditions of the people. It failed to generate employment, reduce poverty or improve income distribution. Even the huge investments in the mining and iron ore sector of Orissa, which have been a part of Orissa's history that should have brought about improvements in its net state domestic product, have failed to do so," says a report titled "Orissa: Challenges Ahead" by the Delhi-based Centre for Policy Alternatives. Going by the Human Poverty Index (a composite index measuring deprivation in the three basic components that constitute the human development index – a long and healthy life, access to knowledge and a decent standard of living), the state's rank was 31 out of the 32 states considered for this survey.

Within Orissa, there is significant regional disparity in distribution of poverty. The KBK (undivided Kalahandi-Bolangir-Koraput districts) is the poorest region inside Orissa. Rural poverty in the KBK region is two and a half times more than that in the coastal region. It is an irony that despite the region's huge natural resources like forests, water, land, and minerals and the consistent focus on the region's development, it remains poor. Besides other poverty alleviation programmes, the region also has an ongoing targeted long-term plan with an annual budget of Rs 250 crore since 1995. The long-term plan is being merged with another scheme during the 11th Five-Year Plan.

Close to 70 percent of this region's population is below the poverty line. The region, consisting of eight districts and spread over an area of 47,646 square kilometers, features at the bottom of the state's human development index: the eight districts are at the bottom of the district-wise human development index in the state. The long-term trends in the incidence of poverty in Orissa point to a steady decline of the poverty ratio in the state till the mid-1990s before stagnating since the mid-1990s. In the KBK region, however, poverty has actually increased between 1993-94 and 1999-2000. And this region is home to 75 percent of the state's poor. Out of them, 40% belong to the very poor category, i.e. their income is 3/4th below the poverty line.

THE ENVIRONMENT-POVERTY NEXUS

Why is Orissa, which had a much better human development status than Europe in the early 18th century, poor? To cut a long story short, Orissa is poor because its policy planners have failed to identify the reason for poverty in the state: environment. The linkages between environment and poverty in the state are very strong. Ecology sustains close to 80 percent of the state's population. Agriculture and forestry remain the two most important sources of livelihoods in the state notwithstanding the current hype on industrialization as the only way to future prosperity. Significantly, the unorganized sector accounts for 94 percent of all employment in the state. On the other hand, the mining sector employs less people now than it did a decade ago. Given that most of the unemployment is rural, industrialization will not help much. Environment-poverty linkages also explain the miserable status of MDGs in the state.

WHY IS THE KBK REGION CHRONICALLY POOR?

Environment-poverty linkages also explain the miserable status of MDGs in the state. Given these linkages, the degradation of environment has triggered poverty and the consequent low MDG rating of the state (See box on environment-poverty and MDGs linkages). Environmental degradation has also been responsible for the state's long tryst with disasters. For more than a decade now, Orissa has been reeling under contrasting extreme weather conditions: from heat waves to cyclones, and from droughts to floods. The state has been affected by disasters in 95 out of the last 105 years: floods have occurred for 50 years, droughts for 32 and cyclones have hit the state for 11 years. Since 1965, calamities have not only become more frequent but have been striking areas that never had a vulnerability record. For instance, most of the casualties during the severe heat wave in 1998 that killed around 2,200 people in the state were from coastal Orissa, a region otherwise known for its moderate temperature. Since 1998, close to 5, 000 people have died in the state due to heat wave alone.

Such extreme climates are primarily caused by the environmental degradation that the state has been undergoing for decades. Today, 52 per cent of the state's land faces erosion due to deforestation. With mangrove forests being cleared, more and more areas have come under the grip of cyclones. Rivers inundate more areas than before due to siltation. Almost 4, 90, 000 ha of fertile lands have been waterlogged, salinated or sandcasted in coastal Orissa due to cyclones and floods. Massive deforestation in western Orissa is not only destroying the livelihood of the local people, but also silting up riverbeds causing floods in the downstream coastal Orissa. Analysis shows that the forest cover in the state has come down to 4.72 million ha from about 6.8 million ha in 1960-61. Out of this existing cover, only 2.73 million ha of forests have a density higher than 40 per cent. On the other hand, barren hills lead to heavy run off of rainwater resulting in flash floods in these areas and more floods in the low coastal lands of Orissa. According to statistics made available by state's agriculture department, about 4.33 million ha of the state's 7.2 million ha of agricultural lands are under severe erosion and losing fertility. Upland of 2.9 million ha, belonging mostly to tribal and very poor farmers, is degraded and barren. With little or no effort to harvest rain, the state loses around 80 per cent of its rainwater as run off from these barren lands thus making water a very scarce commodity. This results in drought even when there is a slightly deficient rainfall. Orissa has faced droughts more frequently in the last few years than ever before due to erratic rainfall. Similarly, in coastal areas any rise in the sea level will make the region highly vulnerable as the protective

mangrove forests have vanished. Satellite pictures of the 1999 cyclone show that mangrove forests helped reduce the impact of the intense super cyclone. Ersama in the Jagatsinghpur district of coastal Orissa, without mangroves, reported 8, 000 deaths during the cyclone as tidal waves ingressed 10 km into the mainland. But the coastal district of Kendrapara, which had some mangrove left, suffered comparatively less damage. Since the 1960s, Orissa has lost 45 percent of its mangrove forests.

The KBK region is an entirely ecology-based economy. Agriculture i.e. the Kharif paddy and forest produce are the two most important crutches of the region's economy. Close to 93 percent of the people depend on these two for survival. But these two important economic factors are in advanced stages of degradation. Agriculture production is coming down very fast due to lack of irrigation and loss of soil fertility. On the other hand, access to forest has also come down due to deforestation, besides the restrictive forest policies that don't allow people to access forests for survival.

The region is going through a vicious ecological cycle. Effective forest cover in the region has come down by 33% in the last three decades. This has impacted local livelihoods significantly. Independent estimates suggest that in KBK districts like Malkangiri and Nawarangpur, 80% of the population solely depends on forests for survival. On an average, the people of the area source close to 30 percent of their annual income from forests.

BUT THE FUTURE HAS MORE

Going by the current development model, the stress on environment is going to increase further. Projects worth Rs 2, 50, 000 crore are likely to be implemented in the state in the next five to ten years, a majority of them mining projects. In the last two years, Naveen Patnaik's government has signed memoranda of understanding with 25 steel industries. If all of them indeed come up, the state will produce a whopping 24.91 million tonnes of steel each year. During 1995-1996, Orissa received the largest amount of private investment in India, both foreign and domestic, and now ranks among the top ten states in terms of investment. To attract this investment, the state has played the perfect facilitator for entrepreneurs. It acquires land around mining sites by riding roughshod over the resistance of the local people. It manages permissions for companies from the Union government. The lease procedure has also been simplified for quick processing. In fact, it has committed 18 rivers and reservoirs for the exclusive use of industry for its water-intensive activities!

Consider the scale of water use: In 2002-2003, Orissa produced over 52.21 million tonnes of coal, using up 10 million cubic meters of water - 50 times the total urban water supply in the state – in the process. How much will all the new projects guzzle together? The proposed production of steel, for instance, will require 1.2 million cubic meters of water every year, or 3,287.7 million litres per day - more than five times the total water supply to the state's 104 urban bodies, which is also mostly sourced from Orissa's 11 rivers.

Steel industries are now coming up in the river basins of the Mahanadi, Brahmani and Baitarani. According to a report by the state water resource department, by 2051, the Brahmani river system will have to import 2, 288.47 million cubic meters of water from the Mahanadi to meet its water demands. The Mahanadi's water needs for industrial use will double by that date. The figures leave no doubt whatsoever that Orissa will find it well nigh impossible to fulfill its commitment to the steel industry in respect of its water needs.

The state government justifies its industrialization overdrive on the grounds that it will provide employment. The government's rhetoric, however, is belied by hard facts. The Orissa Economic Survey, 2002 shows that the employment potential of the mining sector has actually reduced. In Dhenkanal, Jajpur and Keonjhar districts, chromite mines employed 8, 886 people in 1995-96 but only 6, 679 in 1999-2000. This is also the case in the coalmines of Anugul, Jharsuguda and Sundergarh districts.

At present, nearly 20 lakh people in the state are unemployed while another 20 lakh are underemployed. Will mining and industries change things? All the investment pledged so far in Orissa will create an employment potential of only 1, 75, 000. Consider the proposed refinery at Kashipur. It has an employment potential of only 1, 000 and that too for only 20 years. Yet, it will affect the lives of nearly 20, 000 people in 82 villages.

Even as the Orissa Government promised a cautious approach on the use of groundwater in its recently announced Water Policy, as much as 64 per cent of industrial units operating in the State are sourcing their water through bore wells. In a written reply to a query, Chief Minister Naveen Patnaik informed the Orissa

Legislative Assembly on June 25 that of the 225 industrial units, 145 were depending on groundwater, while the rest were drawing water from reservoirs, rivers and canals meant for irrigation purposes. The information sheet stated that 145 industrial units were drawing water to the tune of 10.96 million gallons per day (MGD). As many as 49 industries were relying on groundwater in Sundargarh Irrigation Division, it said. The number of industries in the division is 73. About 13.77 per cent of industrial units were allowed to source their water from irrigation sources such as reservoirs, barrages and canals.

MAKING THE FUNDAMENTAL SWITCH-OVER

MDGS AND ENVIRONMENT LINKAGES

The UN recognizes the importance of environmental regeneration as a cross-cutting issue that impacts virtually all economic sectors. The 7th of the 8 MDGs commits nations to 'ensure environmental sustainability'. Its purpose is to spur action on environmental priorities related to sustainable development and poverty reduction. This particular MDG plays a significant role in meeting the other MDGs:

MDGs	Example of links to environment
1. Eradicate extreme poverty and hunger	• Livelihood strategies and food security of the poor often depend directly on functioning eco-systems for goods and services • The poor often have insecure rights to environmental resources and inadequate access to environmental information, markets and decision making – limiting their capability to protect the environment and to improve their livelihood and well being • Lack of access to energy services limits productive opportunities for the poorest, especially in rural areas
2. Achieve universal primary education	• Time spent on water and fuel wood collection can reduce time available for schooling • Lack of energy, water and sanitation services in rural areas deters qualified teachers from teaching in poor village
3. Promote gender equality and empower women	• Women and girls are specially burdened by water and fuel collection, which reduces the time and opportunity for their education, literacy and income-generating activities. • Women often have unequal rights and insecure access to land and other natural resources, limiting their opportunities and ability to access other productive assets.
4. Reduce child mortality	• Water and sanitation related diseases and pollution related respiratory infections are two of the leading causes of under-five child mortality • Lack of clean water and adequate fuel for boiling water directly contribute to preventable water borne diseases.
5. Improve maternal health	• Indoor air pollution and carrying heavy loads of water and fuel wood adversely affect women's health and can make women less fit for childbirth and put them at greater risk of complications during pregnancy. • Lack of energy for illumination and refrigeration, as well as inadequate sanitation limit the quality of health services delivered, especially in rural areas.
6. Combat major diseases	• Up to one-fifth of the total burden of diseases in developing countries may be associated with environmental risk factors. Preventive measures to reduce environmental health hazards are as important and often more cost effective than treatment

Source: UK DFID et al 2002

As the above table shows, the eight MDGs have strong linkages to environment. In the context of Orissa, the first six MDGs have been nagging problems for the state for decades. As we have argued above, environment has to be the axis of all development. It means the state government has to look for ecological regeneration, which alone will ensure sustainable livelihood for 60 percent of its population directly dependent on it for survival. The MDGs are a chain reaction of a degraded environment in Orissa. Unproductive land means low yield from agriculture. Low yield means less income and a sure debt trap. Debt trap forces people to spend less on health and education. Also, diverting water for other uses and lack of drinking water means more burdens on health and the workload of women. This leads to women spending less time on family thus impacting on education of children. An overworked and improperly fed woman means higher infant and maternal mortality.

Fast degradation of forests has caused widespread poverty among the tribal population. Going by a recent assessment, the KBK region has close to one million chronically poor people. The chronic poor, by definition, are those who have remained poor all their life and the chances of whose coming out of the poverty cycle are slim. Forest degradation has also made people vulnerable to frequent droughts and flash floods. The current spate of floods is an indicator of this phenomenon. According to government reports, the KBK region faces a severe drought every second year. Just two decades ago, it was one in seven years.

What has contributed to the scenario is the fast degradation of the traditional, community-managed water harvesting structures. The region had a very effective and extensive network of such water harvesting structures. An estimate suggests that the eight districts had close to 50, 000 traditional tanks during the late 1940s, which could irrigate close to 35% of the land in the area. In 1946, Kalahandi's 5, 497 traditional structures irrigated 38, 684 ha of land. By 1970, it reduced to 8, 007 ha - a drop of 80 per cent. It is estimated that now only 4, 451 ha are irrigated through tanks. Upland of 2.9 million ha, belonging mostly to tribal and very poor farmers, is degraded and barren precisely due to this.

During the Ninth Plan period (1997-2002), the State has continuously suffered from severe calamities. On the eve of the Tenth Plan i.e., 2002-03, the entire State of Orissa was under the grip of a severe drought. The total loss of livelihood and damage of capital stock of the state due to the calamities from 1998-99 to 2001-02 is Rs.13, 230.47 crore, according to the Tenth Plan Document, Government of Orissa. This is close to 60 percent of the state's total plan lay out of Rs 19, 000 crore for the 10th five-year plan.

Natural calamities have devastated the major livelihood sectors of the state and the income level of the households. The serious fall out of this unprecedented situation has been the serious setback suffered by the capital formation process in the economy. Consequently, Gross Domestic Product (GDP) of the State has been substantially depressed in the process, reports the State Human Development Report of 2003.

The impact of the series of disasters on the state's economy is evident. Orissa's per capita income has declined fast in the second half of the 1990s, disaster-wise the worst phase. It is now half of the national average. Due to calamities, an average 9, 00, 000 ha of agricultural lands lose crops every year in the state. Similarly, during 1980-2000, agriculture's contribution to the state's GDP has come down by 16 percent. Disasters have resulted in a type of poverty known as 'conjectural poverty'.

To attain the MDGs, it is imperative to identify the source of deprivation. And the source is environment. Making environment the axis of development or to term it differently to engineer environmental sustainability for overall sustainable development is the only way out.

Richard Mohapatra, Coordinator, Natural Resource Management & Livilihood Unit

'Katha Rakhibaa Sarakar' (Let US Keep Promises) Campaign is a State level collective initiative in Orissa, working towards creating an enabling environment towards realization and effective implementation of the Millennium Development Goals (MDGs) and other related commitments made by our Governments in form of National Development Goals (Five year plan), National Common Minimum Programme (of UPA Govt.), Sankalpa-2004 (election manifesto of rulling coalition in Orissa) etc. The KRS Campaign initiated by a group of NGOs and INGOs working in Orissa including Regional Centre for Development Cooperation (RCDC), Centre for Youth & Social Development (CYSD), Ekta Parishad-Orissa, Institute of Social Sciences (ISS) & Concern Wordwide India. It aspires to go for a broad based campaign on MDGs in general and Poverty Aleviation, Land Rights, Safe Drinking Water and basic Sanitation and HIV/AIDS related issues in particular. The KRS Campaign appreciates that achieving the MDGs is quite a challenge for any Govt. In fact, all players such as Govt, CSOs, private players and the grass root organizations in Orissa can achieve the MDGs only with the concerted efforts.

'Let Us Keep Promises' Campaign

Katha Rakhibaa Sarakar Campaign

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