MILLENNIUM DEVELOPMENT GOALS: OUR SUCCESSES AND SLIP-UPS – AN EVIDENCE-BASED REVIEW

P. K. Visvesvaran
Faculty Member (Retd.), Madras School of Social Work, Chennai

K. Madhavi
Assistant Professor, Department of Social Work,
Stella Maris College, Chennai

ABSTRACT

Impediments are concrete and objective factors that slow down our march toward success. Imponderables are also impediments, but are often shrouded in mystery and puzzlement. They are harder to explain or explain away. An example of an impediment is the popular resistance to polio vaccination that surfaced in Nigeria in 2003. Closer home, quite recently, something happened in West Bengal that could have shaken people's faith in the safety of vaccination. A mix up of vaccines resulted in the children receiving them being hospitalized (The Hindu, 2013). An imponderable is why the Government of India chose to devote just a few lines to the Millennium Development Goals (MDGs) in its 3-volume Eleventh Plan Document.

Disparities and Divides: Within the country, the SCs/STs are lagging behind others in terms of income, access to health facilities, Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR), literacy, school education and related issues. Also, some states lag behind others. These are impediments that must be tackled.

Organizational Issues: Not everything is all right with our health system. In the Government's own words, there are disparities and inequities that must be set right.

Allocation of Funds: At the moment, our budget allocations seem to be skewed and not designed to serve the interests of the poor and needy. A great deal of economic and fiscal acumen, political cooperation and political will seem necessary to set these anomalies right.

Soundness of Database: A sound, coherent and reliable database is necessary for the planning and successful achievement of the MDGs.

Inter-relatedness of Issues: The provision of sanitary facilities is absolutely essential for girls' education, and for the reduction of MMR and IMR, to name just a few. In a nation where half the

people still use open spaces as water closet, the MDGs are sure to remain a far cry.

Conclusion: The sooner we come to grips with the organizational, planning, allocation of funds, interrelatedness and sound database issues, the faster will be our progress towards MDGs.

Millennium Development Goals: Our Successes and Slip-ups: An Evidence-based Review

This write-up is divided into four sections: Section A is the introduction, listing of the MDGs and a summary of our achievements and slip-ups in this regard. Section B is an elaboration on the successes and setbacks. Section C consists of an evidence-based investigation into the causes for the setbacks and slip-ups. Section D consists of the lessons learnt and suggestions for ensuring greater success in our future efforts.

Certain observations made in the article are elaborated upon in a couple of appendices to the main write-up.

It should be mentioned here that these themes, inevitably, overlap. For example, poverty levels find a place in Section B. The same factor is featured in C also as a variable that affects other factors.

Section A

Introduction:

The developing nations have undertaken a solemn pledge to accomplish the following tasks by the year 2015. These are known as the Millennium Development Goals (MDGs). They are:

1. **Eradicate extreme poverty and hunger.**
2. **Achieve universal primary education.**

3. **Promote gender equality and empower women.**
4. **Reduce child mortality rates.**
5. **Improve maternal health.**
6. **Combat HIV/AIDS, malaria & other diseases.**
7. **Ensure environmental sustainability.**
8. **Develop a global partnership for development.**

How close we are to the above goals can be seen from the following chart. (Main source: The 11th Plan Document, Government of India)

	MDG	Present Status (Selected Information)
1.	Eradication of Extreme Poverty	India's HDI Rank is 122.Food Security Bill passed. Rural Employment Guarantee Programme being implemented.
2.	Universal Primary Education	Boys 96.9% Girls 89.9%
3.	Gender Equality and Empowerment	Reservation of seats for women in parliament - pending.
4.	Reduce Child Mortality	i.10th Plan target 45 per 1000 live births Achievement: 58/1000 ii.India fails to cut infant mortality rate. Only Tamil Nadu and Kerala are likely to achieve the National Goal. (The Times of India, 2012). Eleventh Plan Target (IMR)28/1000 by 2012. Achievement: 42/1000 (UNICEF)
5.	Improve Maternal Health	MMR: 10th Plan target 2 per 1000 live births Achievement: 3/1000.
6.	Combat **HIV**/ AIDS, malaria etc.	i.Malaria: 3 million cases in1996; in 2005. ii.Early oral ART effective in reducing transmission of HIV. Only 1.5% of the children who need this get it (OPD).
7.	Ensure Environmental Sustainability	50% of people in India still defecate in the open. Almost 50% of households have no toilets (Census 2011, The Hindu, 2012).
8.	Global Partnership	E.g. The Bill and Melinda Gates Foundation help in tackling HIV and in the construction of toilets.

The Tamil Nadu Scenario: UNICEF Report:

1. 45% of children in Tamil Nadu are underweight.
2. Diarrhoea, pneumonia and malaria are the main causes for child deaths.
3. Mothers' undernourishment during pregnancy and children's own malnourishment are to blame.
4. ICDS is not as effective today as it used to be. (Source: Deccan Chronicle 26.09.2012 p.5)

Many ICDS centres do not have toilets (The Hindu, 2013). What's more, children's stunted growth is directly related not only to malnutrition but also to people defecating in the open. It is probable that the air and water pollution resulting from the same adversely affects the child's health and well-being (The Hindu, 2013).

The main focus of this paper will be upon education, poverty, sanitation, IMR and MMR.

'Impediments' refer to concrete, visible factors that stand in the way of achieving the Millennium Development Goals (MDGs) – such as, for example, non-acceptance by some groups of polio vaccination owing to apprehensions, real or contrived, spontaneous or engineered by vested interests - as happened in certain African countries. Quite recently, in our own country, children fell ill because of the wrong vaccine being administered to them (The Hindu, 17.9.13, p.13). And 'imponderables' are factors and their causes, not quite visible to the naked eye, to which this paper will return in due course.

The present write-up seeks to throw light on factors that impede the achievement of the above objectives. It is based on information gathered from secondary sources, chief among them, the Government of India's Eleventh Plan, the Official Plan Document (OPD).

Also, items of information relevant to the topics have been selected from the four major English dailies of Chennai. These are indeed numerous, but there is no reason to doubt their accuracy or authenticity, since all are based on data supplied by the Government of

India and its agencies, international organizations and reputed NGOs. Some of these are listed below:

1. The Registrar General of India
2. National Sample Survey
3. The Planning Commission of India
4. Government Officials such as the Health and Family Welfare Secretary
5. Indian Council of Medical Research
6. WHO and UNICEF
7. Centre for Global Health Research, Toronto, Canada
8. The Lancet (UK), and
9. National Family Health Survey

The very fact that governmental authorities have not challenged or refuted any of these data published by the newspapers indicates that they pass muster.

Section B

Details of our Successes and Setbacks:

Supply of Drinking Water: As per the Govt. of India's own assessment, as of 2004, a large proportion of our urban population does have access to water supply. Its adequacy and equitability in terms of distribution are, however, questionable. The per capita availability ranges from 58 per cent to 73 per cent of the norm in the bigger towns, but slums and squatter settlements suffer from deprivation of a more severe and serious kind.

Access to Sanitation: As per 2001 data, just a little over one-third of our entire population has access to a hygienic toilet, or any toilet at all. In rural areas, usage drops drastically to as little as one-fifth of the population. Another impediment is that a fifth of all newly- constructed toilets are not being used (Eleventh Plan, 2008). (Incidentally, the authors of this article, during the course of their study, came across a public toilet constructed in a low-income community (within the city of Chennai) that had been converted into a virtual shrine for worship

with images and icons of Hindu gods and goddesses placed inside it, replete with the customary flowers and scented sticks thrown in with the general purpose of discouraging the public from putting this place to the use for which it was originally meant.)

Facilities in Rural Homes: No drinking water, electricity or sanitation in 20 per cent of rural homes (India Rural Development Report 2012-13, as reported in TOI, 27.9.13). (More in Section C.)

Sanitation and Education – the Link: Girl-friendly toilets, with guaranteed privacy and a never-failing water supply, are essential if female students are to stay on at school and complete their education without let or hindrance. Therefore, when the Union Rural Development Minister announced that three States and a Union Territory had almost achieved the goal of providing toilets to all of their schools, it was heart-warming news. Ten more states, he said, would achieve this target "shortly." However, the total coverage would be to the tune of 54 per cent only, it was learnt. The Minister gave a lengthy list of other states and Union Territories where progress was not up to the mark. This is unfortunate because, without access to a decent toilet at the school, girl students would feel ill-at-ease, to say the least, and might even be inclined to discontinue their studies prematurely (The Hindu, 2008). Nearly half all schools in Tamil Nadu do not have toilets (The Times of India, 2012). Indeed, it has been estimated that 443 million school days are lost every year due to poor hygiene and sanitation – that is, due to morbidity from water-borne diseases, girls absenting themselves because of menses and the like. Sixty per cent of all girls withdraw prematurely from school before completing their education, owing to a lack of adequate toilet facilities at the school (The Hindu, 2009). As far as individual dwellings are concerned, the Government gives a subsidy of Rs.2200/- to each household for the construction of a latrine. Despite this, as already mentioned, there is resistance from the public to the construction of hygienic toilet facilities, with some even going to court to obtain stay orders (The Hindu, 2008). In one particular case, the learned judge found it necessary to make an elaborate reference to the importance given by our ancient civilization to hygienic toilets and the sewage system - which made them models and objects of envy to others -, and refused to

issue an order to stay the construction of a public toilet in a dalit colony (The Times of India, 2010). The Government subsidy in this regard is in the shape of reimbursement of the cost incurred. The initial investment has to be made by the household concerned, which it is unable to do (The Times of India, 2010). Is a one hundred per cent subsidy possible? Yes, it is – but only if we reconsidered our priorities and put first things first. Kalpana Sharma says that one half of India defecates in the open. The Government wants to get these 600 million people to start using toilets by 2012. That means construction of millions of toilets on a war footing - not to mention the change of heart and of cultural practices that such a revolution will necessitate (The Hindu, 2008).

Intriguing Variations: More cases of, and more deaths from, diarrhoeal disease are reported in Andhra Pradesh, Karnataka and West Bengal than elsewhere. The incidence of typhoid presents a curious scenario: Jammu and Kashmir reported 42,000 cases in 2006, but no deaths; Karnataka had nearly 1 lakh cases with just 5 deaths. But Jharkand had only 5000 cases, although nearly 400 had died. Tamil Nadu reported 37,000 cases, but no fatalities. The reasons for these intriguing variations within the nation have yet to be investigated.

More examples of troublesome variations are cited below:

Kerala's life expectancy is 10 years more than that of Madhya Pradesh and Assam. IMR in Madhya Pradesh and Uttar Pradesh is more than 4 times that of Kerala. Crude death rates in some states are only half the rate reported by other states. These facts represent a great variation in access to, and availability of, healthcare, says the OPD.

The Scheduled Castes and Scheduled Tribes are found to be lagging behind the rest of the population, which fact may retard our progress in regard to the MDGs. For example, the school dropout rates are higher for this group, especially among girls, the difference being 6 to 7 percentage points from class 1 to class 10 (Eleventh Plan, 2008). A similar variation is seen in regard to population below the poverty line, once again the difference ranging from 9 (rural) to 14 (urban) percentage points (Eleventh Plan, 2008). The Scheduled Tribes group is still worse off, with their literacy rate lagging behind the general

population by 16 to 19 percentage points. The dropout rate is higher by 17 percentage points (Eleventh Plan, 2008).

Infant mortality rate (rural) among SCs and STs is 8 to 16 points higher than among others. The under-five mortality rate is 20 to 31 percentage points higher. School dropout rates among STs is 11 (boys) to 17 (girls) per cent higher. Thus the impediment here seems to be the community factor, and it points to the very real need to redouble our efforts to bring these groups in line with the rest of society.

Poverty Reduction: The percentage of population below the poverty line had come down from 36% in 1993-94 to 28% in 2004-05. However, the decline is not proportionate to the growth in GDP, while the Scheduled Tribes, going from 320 to 302 million – a drop of 6% only – had shown no change.

Further, there has been no upward revision of poverty line criteria since 1973-74. Therefore, it is all the more disappointing that the proportion of poor people has not declined appreciably since.

Using one other indicator of deprivation, the National Family Health Survey reveals that nearly half the children (in the 0-3 years age group or 46%, to be precise) suffered from malnutrition in 2005-06 – almost no drop from the 1998 estimate of 47%, which is, without doubt, a distressing trend (OPD, Volume I, p.i).

The Poverty situation – the Latest

In 2012, the Planning Commission had determined that an income less than Rs.22.43 in the rural areas and Rs.28.65 in the urban areas was Below Poverty Line (BPL) and, as per this criterion, poverty had declined from 7.3 per cent in 2009-10 to 29.8 per cent, compared to 2004-05 (The Times of India, 2012).

In the following year, namely 2013, adopting the criterion that anyone earning Rs.27.20 or less is BPL, it is estimated by the Planning Commission that 1 in 5 Indians (20 per cent) falls into this category. Compared to 2004-05, the poverty situation has considerably improved in the following 5 states: Goa, Kerala, Himachal Pradesh, Punjab and Pondicherry, but had improved only marginally in the following 5:

Chattisgarh, Jharkhand, Manipur, Andhra Pradesh and Bihar (The Times of India, 2013).

As recently as in 2012, the Planning Commission reported that poverty increased in 4 states (Nagaland, Manipur, Assam and Meghalaya), and there was an increase in the absolute number of the poor in Bihar, Uttar Pradesh and Chattisgarh (The Times of India, 2012). Thus, any growth that we have achieved is uneven.

Infant and Child Deaths:

The Registrar General of India reports that 14 lakh infants died in India in 2005 from avoidable causes like pneumonia, diarrhoea, premature birth, low birth weight, delivery infections, trauma and suffocation during the delivery. Altogether, 23 lakh children below 5 years of age died that year.

The situation was no better in 2008, when the Planning Commission reported that 2.5 million children die in India *every year,* the boys to girls ratio being 2:3. India has the highest number of neonatal deaths in the world. India has the largest percentage of Vitamin A- deficient children. Only 42 per cent of Indian households have access to piped water (NFHS). Childhood anaemia has risen to 79 per cent. In Bihar it has gone up by 7 per cent, due to food insecurity, poor breastfeeding practices and lack of complementary feeding (according to the Planning Commission.) In India, the great divide between the rich and the poor is ever-widening, says Ramya Kannan. A recent international survey shows that India's position is a lowly 135 among 176 countries in terms of child health. India's neighbours – namely, Sri Lanka, Nepal and Bangladesh - have fared much better in this regard (The Hindu, 2013).

Children and HIV/AIDS:

A recent International Labour Organization (ILO) study revealed that children of HIV-infected parents face severe discrimination and acute economic hardships. Children orphaned by AIDS, especially girls, tend to take up shady and disreputable occupations. In India, 70,000 children are in urgent need of anti-retro-viral treatment, but only 1.5 per cent or 1048 are receiving this life-saving therapy (Eleventh Plan, 2008).

The Grimmest Picture: Maternal Deaths

Out of the 5 lakh women who die in the world every year due to pregnancy-related reasons, 1.25 lakh deaths (25 per cent of the world's maternal mortality) took place in this country (The Hindu, 2008).

The maternal mortality situation in the country should be a cause for worry to the MDG planners, especially in view of the healthcare system that has "collapsed." As of now, more than half of all child births take place outside the hospital, without professional assistance. This is a serious threat to the lives both of the mother and child, not the least because the major causes for maternal deaths are anaemia and haemorrhage, grave medical conditions that can be handled only by trained personnel available in a clinical setup (Basavanthappa, 2008).

The disturbing news is that female anaemia has reached new highs in recent periods, affecting children as well. This is a reflection of poor nourishment, which is the lot of many women in this country. Add to this the denial of access to medical facilities, and the picture becomes complete in all its grimness. No wonder, then, that the MMR rate has hit the ceiling in Assam (409), MP (498), Uttaranchal (517), and UP, which takes the cake with a whopping 707.

Human Development Index: India's position among the world's nations, in terms of its Human Development Index (HDI), gives us food for thought. For the year 2010, HDI had three dimensions and four indicators. The former were: health, education and living standards. And the latter were: life expectancy, per capita income, and years of schooling so far and expected years of schooling (Deccan Chronicle, 2010). If gender inequality is accepted as a criterion, India slips to the 122nd position. Bangladesh and Pakistan are better off in regard to life expectancy. India's position on income has looked up, but it still lags behind Bangladesh and Pakistan in the education and health sectors.

India's development has not been rated by UNDP as "very high" or "high," but only as "medium." Still, it is a mystery why it lags behind Bangladesh, which is placed in the "low development" category. Is it that we have not utilized our resources properly and efficiently, while poorer nations have scored over us handsomely in this regard? The

mean years of schooling is only 4.4, compared to the global figure of 7.4 (a whopping 41% shortfall). Expected years of schooling, on the other hand, is 10.3, which is substantially lower than the global average of 12.3 – the shortfall amounting to over 16 per cent (The Hindu, Editorial, 2010). The Right to Education Act has to be implemented in a vigorous fashion. The resistance to the Act that has risen from some quarters is an impediment that has to be overcome (The Times of India, 2011).

Hanging Fire: Many programmes intended to tackle child malnutrition have been planned, but there is considerable delay in launching them. Health and nutrition education for mothers will play a pivotal role in this programme, which will benefit 8 states. It was meant to be launched in July 2010, but delayed due to apprehensions about approval for the budget, which is to the tune of Rs.90 crores. It will be implemented in the fourth phase of the Integrated Child Development Scheme (New Indian Express, 2011). The delay should cause concern to MDG enthusiasts.

Having thrown light on the set-backs, slip-ups and shortfalls we will, in the next section, look into the probable reasons for the same.

Section C

Evidence-based Investigation into the Causes of MDGs – Setbacks

After perusing the official 11th Plan document, and especially after going through the information supplied regarding the health and disease situation in the country, one is bewildered and befuddled by the understatements found therein.

TB is often called the number one killer in this country while lung infection takes the number two place (Source: Ministry of Health). But as per the official 11th Plan document, there were hardly 3,500 deaths in the year 2006 from Acute Respiratory Infection (ARI).

Interestingly, the OPD comes out with the startling finding that accidents and injuries claim no less than 8,50,000 lives every year in this country – almost two deaths every minute. The Govt. of India says that state-run hospitals are ill-equipped to deal with such emergencies,

besides being poorly managed and overworked (OPD, Vol II, p.102). This is one more piece of evidence that suggests that our hospitals are in a sorry state and cannot be relied upon to save lives – a setback to our MDG aspirations.

1. **Inadequate Budget Allocation:** This is not the author's own allegation or conclusion, but is something that is stated with astounding candour in the official plan document. (Eleventh Plan, Volume II, p.203). Speaking of BFC (budget for children), it states that meeting the MDGs with respect to children has been stymied by inadequate funds – just 3.10 per cent of the total budget has been allocated towards this end, and the actual expenditure incurred has been only 2.42 per cent – and this for one-third of our population! For health, the allocation has been a paltry 0.41 per cent. Therefore it is not quite surprising that almost 4 lakh children succumb to diarrhoea every year, with the rota virus claiming the most lives in this regard (WHO-UNICEF, 2009). In India, we are yet to introduce vaccination against the rota virus, the cost of which could be as high as Rs.1000/-. On 14th May 2013, the Government of India announced that a low-cost rota virus vaccine had been produced and would be pressed into service soon at a cost of $1 (Rs.65 or so) per shot. This is good news, since it could save the lives of at least 1 lakh newly born every year. (The Internet – see under Ref).

2. **Unmet Basic Needs:** A major impediment to national health and hygiene is non-availability of adequate and safe water supply. The shortfall has been made public, ironically, by none other than the Government of India itself. This is an MDG goal that has to be met by arrangements made on a war footing. The current shortfall is to the tune of 25 per cent (rural). The urban situation too is "far from satisfactory," as per the Government's own admission. The second major hurdle experienced by our population is a lack of access to hygienic toilets.

   Drinking water and toilets, it goes without saying, are basic requirements for a healthy life. Without them, the assurance of a balanced diet for everyone will mean little. In other words, among

the MDGs there are a few that will have to be targeted on a priority basis, since the fulfilment of the others depends squarely on these.

Mega Impediment: Information on the mother of all impediments comes from the most unexpected quarters. It goes like this:

The public health care system in rural areas…is in a shambles. Extreme inequalities and disparities persist. This (situation) places the burden on the poor, particularly women, scheduled castes and tribes. Iniquitous disparities among states is a glaring reality. (paraphrased) (Eleventh Plan, 2008).

This statement has been made by none other than the Govt. of India itself in its OPD (Official Plan Document). With stunning candour, it has admitted that the rural health setup in India is in ruins – at least, it was upto 2005 and, possibly, 2008. Now the cat is out of the bag. We know now why the achievement of the MDGs is a distant dream. It may be added here that, as early as in 2006, the World Health Organization had pointed out that the ratio of primary health care workers to the population was the lowest in our country, just 3 for every 10,000 of the general populace (Hindu, 2006).

Echoing the above fact, Jairam Ramesh, Union Rural Development Minister, has gone on record as saying that the public healthcare system in the country has "collapsed." Further, 70 per cent of the expenditure on health is met from private sources, thus increasing the rural citizens' debt burden. It is the single most important reason for indebtedness in rural areas, the minister revealed (The Times of India, 2012).

This is one more instance of the link between health and the economy: lacuna in one leads to manifold problems in the other.

3. **Disparities and Divides:** By *disparities* we mean the differential rates of poverty, IMR, MMR and such other problems in different states of the Indian Union, pointed out in the previous section. By *divides* we mean the differing rates of these phenomena among various groups such as the SCs/STs *within* the same states. For one thing, these differential rates tend to lower the national averages of

these phenomena. For another, they point to the absence of inclusive growth.

The Central Rural Development Ministry's Survey (2012-13): There are wide disparities among different states in regard to the availability of power, water and toilets in rural homes. For example, Tamil Nadu ranks the lowest when it comes to the availability of all three facilities together in the same unit.

As far as poverty is concerned, among the SCs and STs respectively, 42 per cent and 47 per cent are poor, compared to only 28 per cent among the rest.

Another 28 per cent of rural people could not avail medical treatment, owing to poverty. The proportion goes up to more than one-third among the SCs/STs (The Times of India, 2013).

4. **The Inter-relatedness of Crucial Variables:** It was pointed out earlier how school sanitation and attendance of girl students are interlinked. Without the former, the latter would suffer. It was also mentioned, in an earlier section, how the absence of a sound healthcare system drives villagers to seek private treatment, resulting in their becoming paupers. And it goes without saying that in the absence of adequate and safe water supply people's health, especially children's, is imperilled. In other words, there is no alternative to all-round growth.

5. **Some Nagging Doubts about the Database:** In a country in which nearly 4 lakh children die every year from diarrhoea, as reported by the WHO-UNICEF, it is incongruous to note that the Planning Commission declares that only about 3000 persons died due to that cause in 2006. The Planning Commission has no explanation to offer, however (p.182, Volume II Eleventh Plan). Similarly, when 2 persons succumb to Tuberculosis (TB) every 3 minutes (The Times of India, 2005), the Planning Commission reports that only about 7000 died from TB in the same year. (Ibid).

   An official and weighty document like the OPD can hardly afford to dispense what appear to be gross underestimates, without a word of explanation or clarification.

Woe unto the MDGs, if they are going to be implemented on the basis of such shaky groundwork!

Section D

Conclusions and Suggestions:

1. MDGs-wise, much has been achieved: for example, poverty is declining, food security and employment guarantees have entered the scene. All these bode well for people's health, education and general well-being. But much remains to be done.

2. Inadequate fund allocation is a worrisome theme. One wonders why it is that when one has sufficient funds - actually an astronomical sum - for regular DA hikes for the better-off sections who constitute a tiny percentage of our population (see Appendix Tables I and II), we are tight-fisted when it comes to health and education for 30 per cent of our population, namely children below 14 years of age! What is being set aside for them is a pittance. Unless this anomaly is set right, progress in terms of realization of the MDGs will be painfully slow.

3. A sound healthcare system is the mainstay of the MDG's health objectives. So, when the Government of India itself has thrown up its hands in despair and said that it is all but dead, there is little hope indeed. Let the planners concerned identify the lacunae and weak points that exist – is it the lack of committed staff? Supplies like medicines not reaching the clinics in time? Or are the staff overworked and underpaid? What really ails the system? Government ministers and planners should tell us what is being done to breathe life back into the system.

4. Health, sanitation, education, poverty and many other phenomena are closely linked together. Therefore, unless all of them are tackled simultaneously and satisfactorily, the MDGs cannot be reached in the near future.

5. Wanted - A Sound Database: The Planning Commission should have a separate cell, if there isn't one already, to ensure

statistical accuracy and consistency of the data that they use and dispense to others. The nation looks to the Planning Commission for reliable data. The Planning Commission, with all the resources at its command – an army of trained personnel and an arsenal of state-of-the-art, sophisticated equipment - should cross-verify and supply internally consistent data, especially those pertaining to the nature and volume of problems afflicting people. Lapses in this regard are sure to cast a shadow over MDG – related efforts.

In sum, no piece-meal approach but a multi-pronged one would seem imperative.

The failure to achieve the Millennium Development Goals within the stipulated time could be laid at the doors of organizational impasse, skewed allocation of funds and uneven socio-economic development. By addressing these issues fair and square, we can indeed hope to achieve the set goals at least by the end of the 12th Five Year Plan. Also, it will be helpful if trained social workers are involved at all stages of official and private efforts at achieving the MDGs – the planning, execution and evaluation phases, as the professional training that these workers undergo equips them for the effective performance of all these tasks.

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Appendix I

MDGs and the OPD

One would expect the MDGs to be incorporated into the national planning process, and its progress explained fully and coherently in the Official Plan Document, which is published in three volumes and constitutes 1000-odd pages. Unfortunately, that is not the case. The information on the MDGs is scanty and, further, not to be found all in one place. It is found on five different pages (173, 184, 203, 205 of volume II and 136 of volume III) that one can locate only after a laborious page-by-page search. The MDGs are mentioned under "glossaries" in volume two, but without an index or page number. Certainly the OPD is not user-friendly, as far as the low-down on the MDGs is concerned.

Appendix II

Wanted: A Second Look at DA

More funds should be allocated for child welfare schemes like the ICDS, since many of its centres lack infrastructural facilities like toilets and storage space. Huge sums are being doled out to government servants, who form a miniscule proportion of the general population, as DA, No less a person than the then Prime Minister of India, P.V. Narasimha Rao, finding that a sum of Rs.40,000 crores was being allocated only for DA during the 8th Plan, threw up his hands in despair and exclaimed, "Gosh, no planning will prosper at this rate!" (GOI, 1993).

Hence it is suggested that a cap be laid on DA payments, and the funds thus salvaged directed towards the accomplishment of the MDG tasks. Of course, there may be other ways of getting additional funds too.

Appendix Tables:

Among other things, the following three tables illustrate the skewed allocation of resources that shocked a former Prime Minister of India. Tables A 1 and A 2 deal with DA and Salaries – the lion's share - respectively. Table A 3 shows that what is left for the poor children of our country is little better than chicken feed.

Appendix Table 1: D.A. and Salaries for Central Government Employees and Pensioners

Sl. No.	Head	Crores (Rupees)	% of Population Covered
1.*	Dearness Allowance (8th Plan)	40,000	Less than 1
2.*	Rural Development (8th Plan)	30,000	50%
3.**	Total Salary + Pension (2010-11)	55,000	p.a.Less than 1

*Source: For the Success of the 8th Plan, Government of India

** Source: The Times of India, 16.09.2010, p.8

Appendix Table 2 : Tamil Nadu Budget Allocation 2010 – 2011: Salaries*

Sl. No.	Details	Salaries and Pensions for Govt. Staff Rs./Crores	% of TamilNadu Population Covered
1.	Amount	34,000	2%
2.	% in Total Budget	50%	

*Source: The Times of India, 25.09.2010, p.7

3 : Tamil Nadu State Budget Allocation for Nutritious Meal Programme 2010 – 2011*

No. of children covered	69,000,00 (69 lakhs)
Budget allocation	Rs.377 crores
Available funds, per capita (Derived)	Rs.500 to 600 p.a. ($8 to $9)

*Source: The Times of India, 25.09.2010, p.7