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Promoting Social Inclusiveness for Effective Citizenship

Social inclusiveness is an end in itself and a powerful tool for effective citizenship. Inclusiveness can be fostered through several routes.

First, health, nutrition, and education are important ingredients of "human capital", a critical input in the production process and long-term growth acceleration. Health and nutrition are also important risk mitigating measures. However, their social significance goes beyond their economic relevance. In a society divided by caste, religion, and ethnicity, equal opportunity of access to "primary goods"⁹⁶ such as health, nutrition, and education can create the basis for social mobility and social cohesion.

Second, expanding the reach of social protection schemes engenders security, and establishes the legitimacy of the new state, because it cares about the poorest and this goes beyond its importance as a vulnerability reducing measure.

Third, social inclusiveness has additional importance in Jharkhand where tribals constitute a significant minority (28 percent of the total population). For the sustenance of democracy, effective citizenship must be ensured for the tribal population, which has been historically left out of the development process and remains the most disadvantaged. This cannot be done through economic and social service delivery programs alone as these continue the perception that the tribals merely receive handouts,

and are not empowered citizens realizing their rights.

Mainstreaming the tribal population requires their civic and political empowerment (recognizing their civic as well as traditional rights), integral to economic growth projects and social service delivery programs. There is no single "best way" to attain these rights. These can be addressed through bonding that is forging horizontal links among themselves through social movements; bridging or promoting linkages between them and pro-tribal local elites; and advocacy and lobbying at the local, block, district, state, and national level.

Reach of Priority Health Services

Adverse Initial Health Conditions

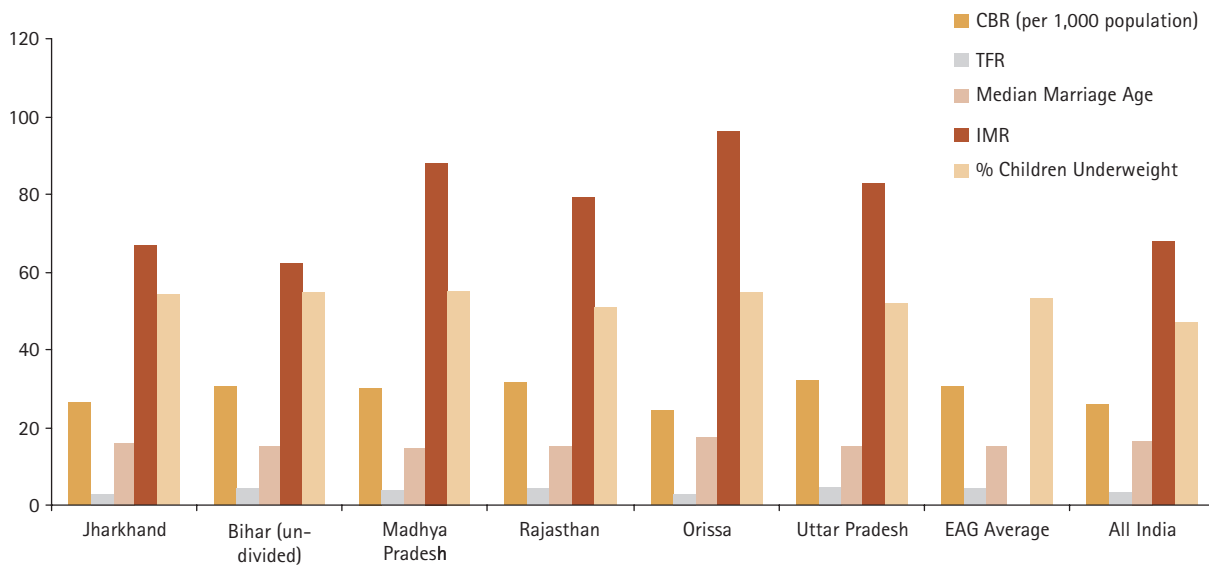
Jharkhand's initial health status indicators are unfavorable as compared with the all-India average and the major Indian states. This can be measured by both health outcome and health service indicators.

The limited sample size of Jharkhand in the National Family Health Survey (NFHS)-II data poses serious problem in estimating some of the health outcome indicators.

Two examples illustrate this. Total Fertility Rate (TFR), a measure of reproductive health, appears to be lower than the all-India average (2.8 versus 3.2), and much lower than that observed for Bihar, Orissa, MP, UP and Rajasthan (Figure 5.1). The pattern of TFR is consistent with the relatively low Infant Mortality Rate (IMR) in Jharkhand (67 as against 96 in Orissa, 88 in MP,

⁹⁶ Rawls (1971).

Figure 5. 1: Initial Comparison of Key Health Outcome 1998/99



Source: Estimated from NFHS-II, 1998/99.

83 in UP and 79 in Rajasthan).⁹⁷ However, the level of TFR and IMR may be underestimated, given the small size of bifurcated NFHS-II sample of undivided Bihar. Input-based indicators may provide a more realistic assessment. In fact, the prevalence rate of contraception among married women in Jharkhand is about half the all-India average (25 percent vs. 48 percent), which contradicts the reverse trend for TFR noted above. Similarly, the proportion of children with full vaccination is assessed at an abysmal 9 percent compared with the all-India average of 42 percent—suggesting a pattern that is inconsistent with the relative prevalence of IMR. As in other states in the country with a similar level of infant mortality, neo-natal deaths comprise a large proportion of total infant deaths. In Jharkhand it is estimated that about 60 percent of all infant deaths occur in the first week after birth.

For most health service indicators relating to maternal and child health care, Jharkhand has adverse initial

figures vis-à-vis the all-India average and other states.

The proportion of institutional deliveries was a low 14 percent, presence of skilled birth attendants 17 percent, and proportion of women who received at least one ANC contact just 42 percent. These are close to coverage levels in undivided Bihar, but much lower than the all-India average (Figure 5.2).

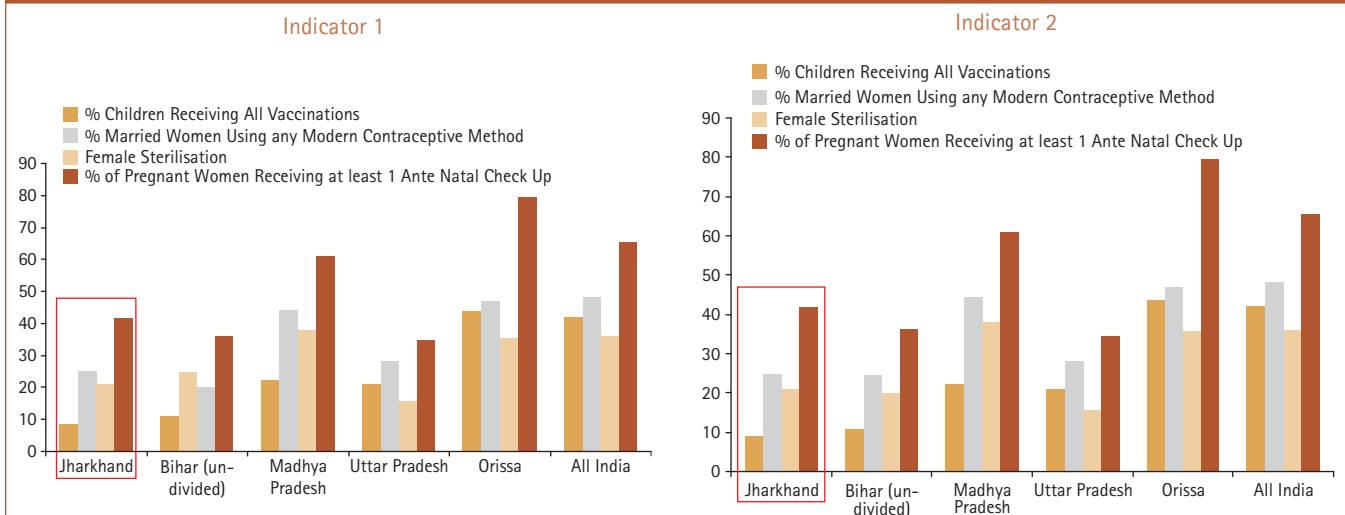
With respect to child malnutrition, the state was relatively disadvantaged, possibly due to the higher incidence of income-poverty.

Thus, the proportion of underweight children (under three years) is assessed at 54 percent in Jharkhand compared to 47 percent for all India and almost identical to that for undivided Bihar, Orissa, and MP, and slightly higher than in UP and Rajasthan.⁹⁸ As is known, child nutritional outcomes are determined both by food and health access indicators. The higher incidence of income-poverty (food-poverty) in Jharkhand vis-à-vis the rest of India appears to drive its relative disadvantage in child malnutrition.

⁹⁷ Various studies on cross-country, cross-state, and cross-district data for developing countries indicate the statistically significant negative relationship between the level of TFR and IMR (for instance, Murthi et al, 1995 for evidence on India).

⁹⁸ The NFHS-III round for 2005/06 shows that the matched figure for child malnutrition has actually deteriorated to 59% in recent years.

Figure 5. 2: Initial Comparison of Health Service Indicators



Source: Estimated from NFHS-II, 1998/99.

Poor child nutritional status is further confirmed by high levels of anemia among children as well as women of reproductive age. Approximately 56 percent of children (aged 6–35 months) and 28 percent of women (aged 15–49 years) suffer from moderate to severe anemia. This compares with 17 percent of women in India as a whole. While there are no reliable measures of the Maternal Mortality Rate (MMR), it is estimated to be roughly in the region of 504 per 100,000 live births.⁹⁹ This is well above the all-India figure of 407 per 100,000 live births.

Jharkhand had a very high initial burden of communicable diseases. This relates to TB, malaria and other vector-borne diseases. At the time of formation of the new state, TB afflicted nearly 57,000 persons every year, of which almost one-fourth died. Frequent outbreaks of malaria were common in most rural districts of the state.

Recent Progress in Priority Health Service
Notwithstanding the adverse beginning, Jharkhand has made steady progress in nearly all priority health service indicators. Coverage of reproductive and child health (RCH)

related services improved during the period 1999–2003 (Figure 5.3). The proportion of safe deliveries increased by 9.7 percent, proportion of institutional deliveries by 7.2 percent, and proportion of pregnant women receiving at least one ANC check-up by 14.4 percent.

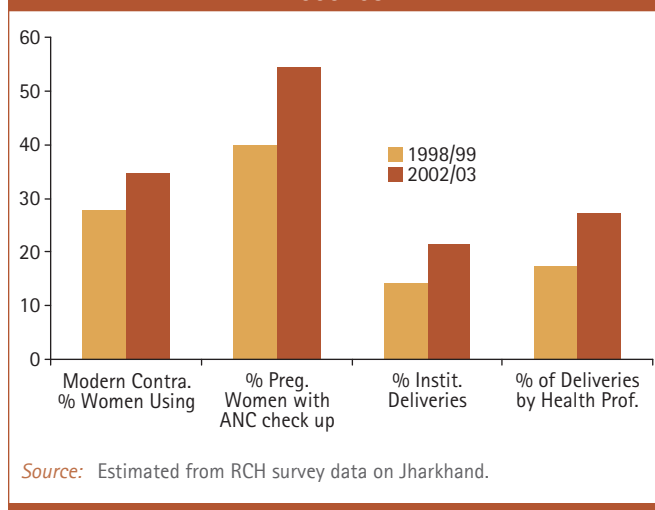
Impressive progress has been made in child vaccination. The newly instituted “catch up rounds” (since 2002/03) has led to a dramatic improvement in child immunization, and vitamin A and iron supplementation. The UNICEF has recently verified that immunization coverage is now almost 50 percent compared to 9 percent in 1998/99. This is the most rapid rise in coverage recorded in India for a five-year period.¹⁰⁰

Considerable progress has also been made in expansion of services related to communicable diseases such as TB and, to a lesser extent, malaria. The Revised National TB Control Program (RNTCP) was introduced in 2000 with support from the Global Fund for AIDS, TB and Malaria (GFATM) in three districts. By end 2004 it

⁹⁹ Health Policy, GoJ.

¹⁰⁰ The NFHS-III round for 2005/06 also shows considerable improvement in full immunization, though less dramatic than the above claim, the matched figure being 35%.

Figure 5. 3: Changes in Key RCH Service Indicators 1999–03



had expanded to all 22 districts. In the third quarter of 2004/05, Jharkhand achieved an impressive treatment success rate of close to 90 percent, compared to the national average of 85 percent. Case detection rate, however, is still only 52 percent, well below the national average of 70 percent. Even today malaria is still endemic with frequent outbreaks. More than half of the reported malaria cases are due to Plasmodium Falciparum and are often fatal. Confirmed and suspected deaths from malaria totaled 61 in 2004.¹⁰¹

The state has made remarkable progress in reducing the prevalence of leprosy. In 2001, leprosy prevalence was three times the national average at 10.9 per 10,000. By 2005, it had dropped to 2.69 per 10,000. Multi-drug treatment was introduced in undivided Bihar in 1994/95, and special leprosy campaigns undertaken in 1998, 2000, 2001, 2002, and 2004 to detect new leprosy cases. Another effective strategy was the integration of the vertical leprosy program into the routine health delivery system.¹⁰²

¹⁰¹ GoI, RNTCP Quarterly Performance Report.

¹⁰² The proportion of blood slides collected in the state relative to population increased from 3.6 percent in 2000 to 4.78 percent in 2004. However, it still remains below the nationally recommended minimum Annual Blood Slides Examined (ABER) of 6 percent. The Slide Positive Rate (SPR) fluctuated over the four-year period between 11–17 percent.

Factors Influencing Progress in Priority Health Service

Progress in expanding the reach of priority health services has been brought about by both supply and demand factors. Among the supply-side factors, increased budgetary allocations for health, reorientation within the health budget towards priority services, tapping synergies among different health and anti-poverty programs, and partnership with NGOs in implementing the programs are some of the important steps. Among the demand-side factors are the development of region and culture-specific behavior change communication strategy, enhanced access to media, and favorable effects through greater health awareness in recent years by expanding basic education across gender and social groups. However, not all these factors have been fully tapped for expanding the reach of health services in Jharkhand. However, even partial implementation of these initiatives is likely to result in significant improvements against the backdrop of highly adverse initial health conditions.

Jharkhand has one of the highest budgeted shares for health expenditures in the country. Over the period 2001/02–2003/04 public health expenditure fluctuated from Rs.377 to Rs.440 crore per year, translating to an average per capita spend of Rs.150 in nominal terms. This was slightly more than Orissa's level during the same period (Rs.134) but less than the average per capita spend in 15 major Indian states (Rs.174).¹⁰³ The situation has changed considerably since 2003/04 with the public health budget (plan plus non-plan) increasing from Rs.377 crore to Rs.666 crore in 2004/05, and projected to increase further to Rs.839 crore. As a result of these increases, public health allocations in 2005/06 accounted for 6.25 percent of the revenue budget in Jharkhand, compared to an average 4.71 percent of revenue budget on health in 15 other major states, as estimated for 2004/05 (Figure 5.4). This indicates the high budgetary priority being accorded to health. Much of the increased spending went

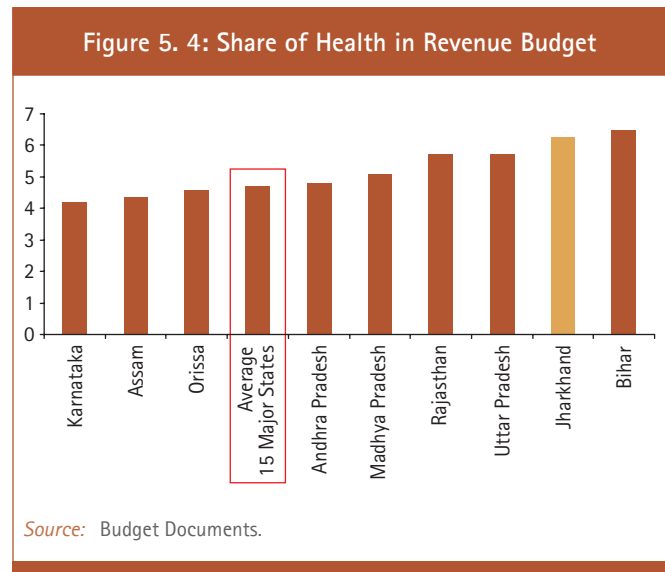
¹⁰³ See, Dave Sen and Berman (2005).

on paying salaries of the newly contracted 1,500 doctors (80 percent) and on drugs (5 percent).¹⁰⁴

However, lack of institutional capacity impedes implementation. The shortfall in "realized" as against the "budgeted" amount is an important indicator of the governance capacity of the state (Chapter 1). Much of the increase in health budget allocations are "on paper" with little implications for explaining the outcomes. In the preceding year, the Jharkhand health department could spend only 68 percent of the funds allotted. This was due largely to delays caused by an over centralized financial system, lack of willingness to take responsibility for spending and issuance of utilization certificates, and finally, inability of the health system to take on new activities. Unless these constraints are addressed and there is an improvement in the capacity to access and utilize budgeted funds in a timely manner, the full benefits of the recent increase in the health budget will not be realized. Moreover, increased allocation of budgetary resources for health is only one precondition for improved health outcomes.

One of the most important factors underlying the recent improvements in priority health service indicators is related to the adoption of a campaign style approach, termed "the catch-up round". Initiated in December 2004, this approach was quite effective in rapidly improving immunization and nutritional outcomes. Comprising a two-month long activity, it galvanizes support and involvement of all district-level personnel (including anganwadi workers, Auxiliary Nurse Midwives (ANMs), doctors etc), local NGOs, international donors, and the community to provide a core package of priority health services. To begin with, the package included routine immunization, micro-nutrient supplementation (including vitamin A and iron folate

¹⁰⁴ Fund flows through the budget represent only a part of total health spending. Much of the funding under the national programs (e.g. RCH, TB, malaria and HIV/AIDS) flows through the Jharkhand Health Society. Once these off-budget funds are included, resources available for health in 2005/06 rise by 25 percent. In 2004/05, total health spending represented 1.15 percent of the Net State Domestic Product.



tablets) and de-worming. The package of interventions was expanded during the last "catch-up round" to also include TB and malaria screening, and ANC. This approach has been successful in dramatically improving select key service indicators over a very short period. Another key strategy has been to increase availability of doctors and paramedical workers.

Public-private partnerships, especially with NGOs, have been one of the key ingredients of recent improvement. The state government has several ongoing partnerships with private providers including: (i) contracting NGOs under RCH and the HIV/AIDS program largely for social mobilization efforts and delivering targeted interventions to high-risk groups; (ii) social marketing for family planning and other commodities for the delivery of subsidized family planning through private sector channels such as shops and retail pharmacists; (iii) contracting of health staff; and (iv) providing equipment and supplies to private facilities.

Better planning and coordination among different actors also contributed to improved institutional performance in the health sector. A new institution called the Jharkhand Health Society, registered in 2003, currently plays a vital role in supporting the department in policy development and planning, coordinating donor support to the sector, forging partnerships with NGOs

and faith-based groups, design of innovative schemes, monitoring and evaluation and channeling funds.

Neglected Concerns for Social and Spatial Equity

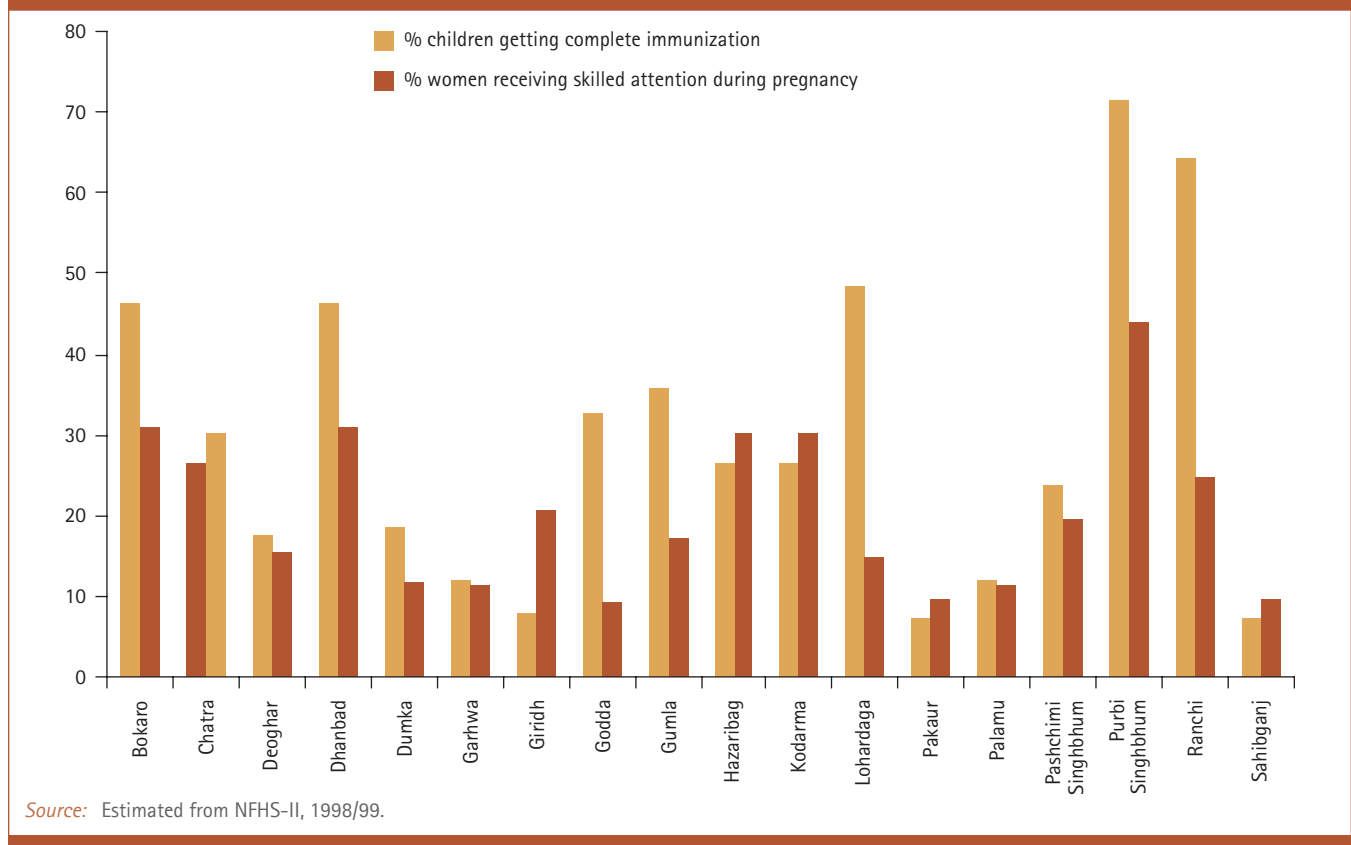
The average progress discussed above masks the stark inequalities in health status that exist across districts, between different ethnic and social groups, and the poor and non-poor. Hence, NFHS-II found the crude birth rate (CBR) varying from a high 36 per 1000 in Hazaribagh district to a low of 20 per 1000 in East Singhbhum. Such disparities are noticeable with respect to other indicators as well (Figure 5.5).

One of the reasons behind the stark disparities in health outcomes is that the reach of most health service providers is limited to a few districts, excluding the remote areas where most of the socially disadvantaged groups reside. This is true for the NGOs as well. A recent

USAID study mapped the location of NGOs, their size and the type of health work that they undertake. Out of the 143 NGOs engaged in health care provision in the state, 80 percent are located in just 10 districts out of a total of 22 new districts. This is also confirmed by the second round of RCH data. The proportion of pregnant women receiving at least one ANC check-up is highest in Lohardaga (77 percent) and East Singhbhum (75 percent), compared with only 35 percent in Godda and Deoghar. Even more striking differences are seen in the case of child vaccination. The proportion of children with full vaccination varies from as high as 44–47 percent in Ranchi and Lohardaga to as low as 6 percent in Godda, 10 percent in Deoghar, 14 percent in Dumka, and 18 percent in Sahibganj.

Social disparity in health and nutritional indicators is equally striking. The nutritional status of children from Scheduled Caste and Scheduled Tribe (SC/ST) groups was found to be much worse as compared to socially

Figure 5. 5: Health Indicators



advantaged, groups (Figure 5.6). Sixty-one percent of children from ST groups were underweight, compared with 38 percent from non-SC/ST/backward groups.¹⁰⁵

A recent econometric study carried out in the three newly created states, Jharkhand, Chhattisgarh and Uttaranchal, indicates the relevance of socio-economic characteristics in health care access.¹⁰⁶ The positive association between education of women and delivery illustrates the importance of social development through education for achieving 100 percent institutional deliveries. More importantly, the state-specific logistic models for Jharkhand showed that women belonging to SC, ST or lower economic strata tend to utilize lesser delivery care. Hence, the RCH program should address the needs of these women and create a conducive environment for them to utilize delivery care.

Concerns over the Quality of Health Care

The quality of rural primary health care services seems to be inadequate. The results of the Jharkhand User Satisfaction Survey, although restricted to primary health facilities, show the magnitude of the problem. Over 65 percent of respondents reported that they visit Primary

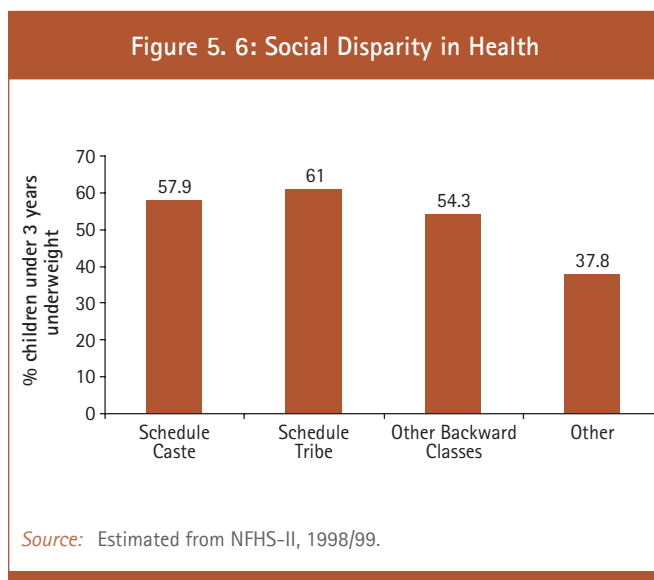
Health Centers (PHCs) in the case of ailments; about half reported the availability of doctors at the PHC; and over 75 percent of the households prefer to get prenatal check-ups outside of the PHC, with private providers being the main alternative source. Though ANMs visited households in 56 percent of the cases surveyed, 52 percent of respondents who had been visited by ANMs felt the visits were infrequent and 42 percent felt that ANMs did not impart proper health care. Respondents who did not visit PHCs cited reasons such as distance, preference for private doctors or traditional healers, improper medical care, or non-availability of doctors.¹⁰⁷ Clearly, if the quality of PHC services is any indicator, it is likely to be even worse in the case of secondary and tertiary health care.

Achieving Health MDGs

The GoJ has identified and prioritized interventions that address health MDGs within the health sector strategy. These include services related to maternal and reproductive health care, child health, TB, malaria and other communicable diseases, and HIV/AIDS. The strategy of continuing with the “catch up” approach as an interim measure for scaling up provision of priority services, and at the same time building a sustainable routine health delivery system, is a sensible one. However, the manner in which the routine system is built up will determine how effectively priority interventions are scaled up.¹⁰⁸

Despite the recent progress towards health MDGs, the overall health sector performance is far from satisfactory. If Jharkhand maintains the current pace of improvement in health outcomes and coverage of

Figure 5. 6: Social Disparity in Health



¹⁰⁵ NFHS-II noted disparities on basis of living standards (as defined by household ownership of various assets): 78.6 percent of women with a low standard of living suffered iron-deficiency anemia compared to 57 percent of women with a high standard of living.

¹⁰⁶ Pandey et al (2005).

¹⁰⁷ The average distance of the respondent's resident from the PHC was about 3.8 km.

¹⁰⁸ Three new policies have been developed – a Health Policy, a Population and Reproductive and Child Health Policy, and a Drug Policy. In addition to these, a detailed Program Implementation Plan (PIP) for the second Reproductive and Child Health (RCH II) program has also been developed. Collectively, these documents provide strategic policy direction to the sector, map out priority health outcomes and outputs to be achieved, and outline specific interventions to achieve them, including institutional requirements.

priority services, it will not reach the health MDG targets.¹⁰⁹ There are many impediments to attaining the health MDGs, with the key ones being poorly functioning and under-developed health systems, lack of public-private partnerships in the delivery of priority interventions, poor accountability of public health services, and the problem of overcoming the barriers of social exclusion for improved access to priority services.¹¹⁰

The state needs to address the problem of poorly developed health systems. Building new institutions remains the biggest challenge. While a new health directorate has recently been created, it still remains on paper. Staff is yet to be recruited. The directorate is to have one director-in-chief, and seven directors (one each for health, family welfare, medical education, training and research, planning and administration, AYUSH and vector-borne and infectious diseases). Once the directorate is up and running, the Jharkhand Health Society can function more effectively as a strategic policy and planning unit, as well as a forum for coordinating donor inputs and public private partnerships. The village health committee (VHC) is another new institution, which can potentially play an important role. Participation in local planning, supervision of Sahiyya activities and generating awareness of and demand for priority services will be among the responsibilities of the VHC.

Other elements of the health system that need strengthening include: the drugs management system; the Health Management Information System (HMIS); and Human Resource Development and Management (HRD). The RCH Program Implementation Plan (PIP) recognizes the need for an integrated and more useful health MIS that provides a complete picture of all activities at the PHC level. Planned HRD-related activities

include development of job descriptions and introduction of performance-based management systems.

Health services cannot be delivered by the public sector alone as the "public sector model of health delivery" faces significant challenges on two major counts. *First*, due to under-funding, the network of public facilities has not been developed to fulfill Gol population-based norms in any Indian state. Where they do exist, their performance is sub-optimal because staff is unavailable, drugs are insufficient, equipment is not in place or not working, or facilities are poorly maintained. *Second*, in the absence of effective accountability mechanisms at the local level, there is a high incidence of absence of doctors in many states in India, with Jharkhand ranking third after Bihar and Tamil Nadu.¹¹¹

Poor accountability of public health services is reflected in the high rate of absenteeism among service providers and poor client satisfaction, indicating a serious failure in service delivery in the state that affects the quality of curative health services. Such service delivery failures can be linked to a breakdown in the chain of accountability between the providers and clients, as well as the policy makers and providers.¹¹² As priority services are scaled up in Jharkhand, the government will need to address these accountability failures. In strengthening the chains of accountability, examples of other Asian countries may be instructive. These include greater use of performance-based incentives, decentralization and local supervision of health services, provision of vouchers and the use of contracts.

Addressing the demand-side constraints is crucial for the success of health policy in Jharkhand. These include costs (related to transportation, opportunity costs

¹⁰⁹ The child immunization target would be reached if the current pace of expansion was maintained; however the mode of delivery through "catch up rounds" is not a sustainable one.

¹¹⁰ There are other barriers such as inadequate financial insurance to unanticipated health shocks, maximizing inter-sectoral impact on health, but arguably they can only be addressed effectively once these bottlenecks are removed.

¹¹¹ The fact that doctors' absence has little correlation with per capita income of the state shows that the problem with the public sector model of health delivery is much more deep rooted.

¹¹² Unlike the private market transaction when the seller or provider is directly responsible to the customer or client, in government the accountability between the client and provider is an indirect one intermediated by the government (World Bank, 2003).

of lost work when seeking health care, unofficial fees etc), lack of knowledge and awareness of health needs and availability, and socio-cultural beliefs and practices. As noted earlier, there are wide disparities in health status and service coverage across districts and population groups in the state. The exclusion of particular groups such as STs is particularly striking. The health department has no systematic strategy for improving performance of lagging districts and population groups, such as SCs and STs. Some recognition is given to a special approach in tribal areas; however, this is not backed up by the concept of resources being allocated on the basis of need. There is a need for greater use of incentives for providers to serve target populations, as well as greater use of demand-side approaches, such as provision of vouchers for overcoming social exclusion.

Health Sector: The Way Forward

Recent health sector development in Jharkhand can benefit from the experience of other states and developing countries and international best practice. The GoJ seeks to develop public health infrastructure as per Gol population norms. The population-driven approach to planning infrastructure and staffing has not worked well over much of India. Other equally important criteria that need to be considered while planning infrastructure and staffing for Jharkhand relate to terrain, population density, presence of roads, availability of transportation, and doctors and health staff. The GoJ is also aggressively forging partnerships with private providers. This could result in a health system that comprises public finance and plural provision; in the present context, such a system would best meet the state's health needs. The GoJ may consider implementing the following five-point approach, which will speed up the development of such a system and deliver health outcomes for the poor:

- **Prioritizing the use of new resources:** Even the recently doubled health budget falls far short of that required for universal provision of health care. Available resources would be best used on: (i)

priority health services (PHS); (ii) focusing PHS on the poor; and (iii) extending financial protection to the poor against major illnesses.

- **Scaling up of the PHS delivery by public and private providers.** While priority interventions need to be financed from the public budget, they can be delivered either by public providers or by private providers or by a judicious mix of both. The main approach for promoting access to basic as well as specialist care in Jharkhand, as in the rest of India, has been to develop a network of government owned and staffed health facilities on the basis of Gol norms. So far there has been limited use of partnerships with the private sector as a strategy for enhancing access. For example, some NGOs have been contacted to provide care under several of the national health programs, such as RCH, TB and HIV/AIDS. Going forward, GoJ will need to: (i) agree on the contents of the PHS; (ii) review infrastructure, staff and drug norms most suited for delivering PHS; (iii) decide on comparative advantage of public and private provision for different priority services; (iv) conduct a survey to map out existing public and private providers; (v) contract private providers or develop public health services depending on comparative advantage; and (vi) undertake local planning for integrated provision of priority services. Social marketing of health goods (contraceptives, impregnated bed nets for malaria, etc.), social franchising and demand-side vouchers that can be redeemed at accredited private providers, are other attractive approaches for scaling up service delivery.
- **Developing and strengthening organizations and systems:** The GoJ has just begun the process of forming new institutions, such as the health directorate, Jharkhand Health Society, and the department for health and family welfare. Organizational structures and staffing should reflect the required roles and functions under a system of public financing and

rural service provision. Human resources, planning and budgeting, financial management, quality assurance, monitoring, procurement and, finally, regulation and accreditation would all need strengthening.

- **Making greater use of demand-side approaches:** In addition to behavior change communication to overcome demand-side barriers, demand-side approaches, such as demand-side financing (DSF) should be used. DSF is defined as a means of transferring purchasing power to specified groups for the purchase of defined good and services. Purchasing power can be in the form of vouchers, stipends, grants or loans, and scholarships. Certain health services, such as maternal care, STI treatments are particularly suitable for DSF support. Additionally, strategies that give voice to and strengthen participation of excluded groups in health care planning and management would promote use of services by the poor.
- **Promoting local oversight of public health services:** Mechanisms to strengthen the chain of accountability between government providers and clients should be developed. Representation of the poor on village health committees is one way. While Panchayati Raj has yet to develop in Jharkhand, supervision and responsibility for public service delivery by local elected bodies should be a long-term strategy for increasing accountability.

Once the medium-term strategic objectives of priority and basic health services are met, it would be easier to tackle the challenges of secondary and tertiary curative health care, especially hospitalized and specialized services. The state of the latter is extremely precarious with limited coverage of the rural poor by both public and private institutional health facilities. In particular, the high incidence of health shocks, including emergency and catastrophic diseases, is a major barrier to upward mobility of the rural poor. The public health system needs

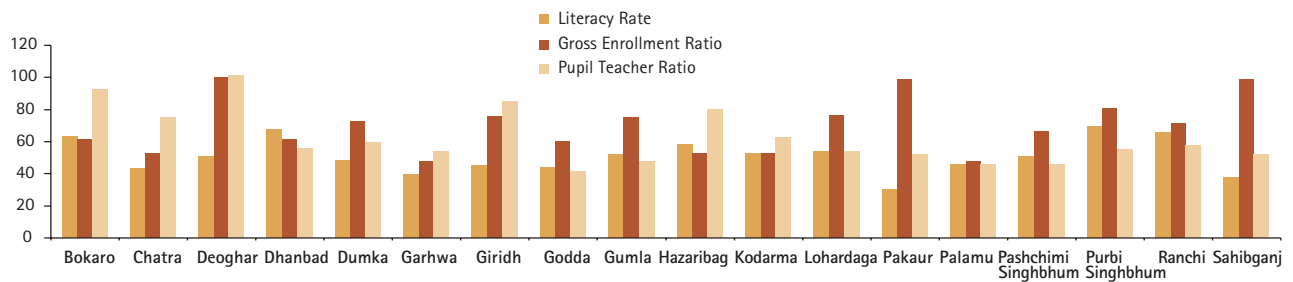
a threshold level of basic health infrastructure, human resources, management capacity, skill, and the experience to effectively administer activities across districts and blocks in both rural and urban areas, with greater or lesser accessibility. Only then will it become easier to design effective delivery mechanisms for the hospital-based and specialized curative services. Public-private partnership will enlarge further in that context, with greater attention to innovative health insurance products. Greater attention needs to be paid to the inter-sectoral impact on health status as well.

Expanding Access to Primary and Secondary Education

As with health, the education scenario in Jharkhand was in an adversely affected condition at the time of bifurcation. As per the census (2001) figures, the literacy rate of the state is the second lowest in the country (after Bihar) at 54.1 percent against the national average of 65.4 percent. With the male literacy rate at 67.9 percent and female literacy rate at 39.3 percent, the state has the second highest gender disparity rate in the country after Rajasthan. In rural areas, one-third of the men and two-thirds of the women cannot read or write. The literacy rates of the SC and ST population are as low as 37.6 percent and 40.7 percent respectively.

Another important feature in the education sector was the high initial spatial disparity. Literacy rates also varied across districts – with a low of 30 percent in Pakur district to a high of 69 percent in East Singhbhum (Figure 5.7). The task of improving educational outcomes was thus complicated by the fact that most children were first-time learners from households with illiterate parents. Given the low literacy rates, the average duration of schooling of an adult (aged above 14 years) as per the NSS 55th round stood at 4.25 years. The latter, although somewhat close to the all-India average of 4.5 years showed high differences across districts.

Figure 5. 7: Education Indicators



Source: Population census 2001.

Recent Trends in Primary Education

There has been an impressive increase in enrolment in the 6–14 year age-group. The age-specific enrolment rates for the 6–11 year age-group improved from 56 percent in 1993/94 to 58 percent in 1999/2000 (as per the NSS data) and further to 95 percent in 2005 (as per the SSA Household census). Around 87.6 percent of the 11–14 year age-group children are also currently enrolled in schools. Around 18 percent of all children in the 6–14 year age-group are enrolled through the Education Guarantee Scheme (EGS)/AIE/ Bridge course or in some residential camps.¹¹³

Impressive increase in enrolment has been accompanied by greater gender and social equity. The GPI for primary grades in the state is 0.98 and for upper primary, 0.97. Similarly, as far as the social equity in enrolment is concerned, SC/ST enrolment shares were close to their shares in respective age-group population. However, there is considerable variation in the GPI across different districts.

Notwithstanding progress in enrolment in primary education, a few concerns such as large numbers of

out-of-school children, poor student attendance, low internal efficiency, and poor learning achievement stand out. The number of out-of-school children in the state has declined slightly from 1.9–1.8 million in the 6–10 year age-group, and from 0.64–0.2 million in the 11–13 year age group between the 2001 census and the 2005 SSA census. Of all out-of-school children in the 6–11 year age-group, 54 percent were girls, 28 percent belonged to SC category (as against their population share of 12 percent) and the rest belonged to the ST category. Districts with some of the lowest literacy figures, like Pakaur, Palamu, Godda, Giridih and Hazaribag, accounted for the maximum number of out-of-school children in the state.

Student attendance is a key concern, as the attendance rate appears to have changed little over the recent years. A few years ago only 43 percent of students in government schools and 68 percent in private schools attended classes regularly in primary schools.¹¹⁴ Recent data shows that, on an average, only 58.4 percent of the children enrolled in Grades I–V and 58.5 percent of the children enrolled in Grade VI–VIII attend schools regularly.¹¹⁵ Around 30 percent of the primary schools and 32 percent of the upper primary schools registered an average student attendance of less than 50 percent.

¹¹³ These are, however, gross enrolment rates as distinguished from age-specific enrolment rates. Though most of the 6–14 year age-group children are enrolled in schools now, the enrolment rates in the primary stage is highly “grossed” given that many of these children are late entrants to the education system. On the other hand, those enrolled at the upper primary stage also included children who are above 14 years, due to the same reason or due to repetition.

¹¹⁴ World Bank (2003).

¹¹⁵ Annual Status of Education Report (ASER) 2005 by Pratham.

With a very low completion rate, internal efficiency of schooling is a major issue in the state. The primary completion rate was around 56 percent as per the NSS 55th round estimates. The transition rate from the primary to the upper primary stage was 78 percent for boys and 74 percent for girls. Overall, these figures varied from 50 percent for girls in Pakaur to 95 percent for boys in West Singhbhum and Chatra, highlighting wide spatial variations (Figure 5.8).

The state has one of the poorest learning scores in the country. As the District Information System for Education (DISE) data for 2003/04 reveals, less than one-fourth of the children in primary and less than one-fifth of the children in upper primary grades in the state pass their grades with more than 60 percent scores. However, the SSA Baseline Assessment Study shows that the average achievement level in Class II is 62 percent for language and 65 percent in arithmetic while in Class VII, it is 41 percent and 33 percent respectively for language and mathematics. The ASER 2005 by Pratham looks at learning achievements from a different point of view. It reveals that only 58 percent of children in the 7–14 year age-group could read a small paragraph with short sentences of standard I difficulty

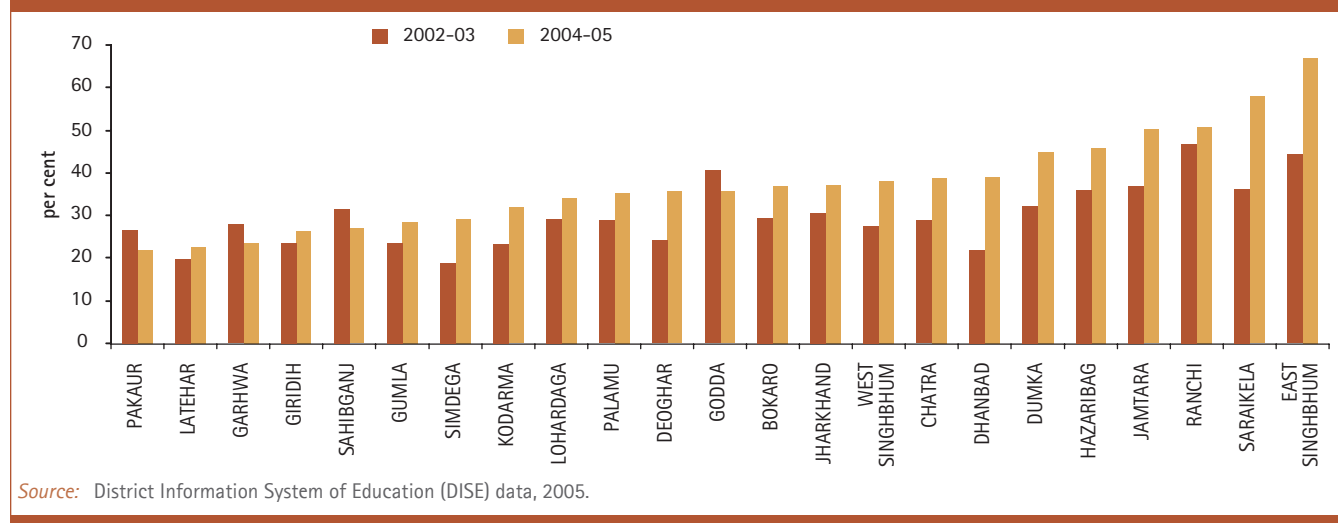
levels; and only 42 percent could read a story text. The arithmetic ability of Jharkhand's children is worse with 70 percent of children in the 7–14 age-group, and half of the children in the 11–14 age-group are unable to divide.

Factors Affecting Progress in Primary Education

Both the supply and demand-side factors have affected progress in primary education. Among the supply-side factors, the three key constraints are accessibility, quality of facility, and availability of teachers.

While access is improving, there is a need to expand it further to meet the growing demands of the states' diverse and dispersed child population. As per the Seventh All India Education Survey (AIES), 61 percent of the habitations in the state did not have primary schools within them (as against 47 percent for all India).¹¹⁶ However, 77 percent of the habitations had access to schools within the prescribed norm of one km (compared to 87 percent for all India). Similarly, 61 percent of the habitations had an upper primary school facility within 3 km in the state in 2002 as against 78 percent for all India.¹¹⁷ The latest survey conducted by the Jharkhand

Figure 5. 8: Class I to Exit Class of Primary



¹¹⁶ NCERT, September 2002.

¹¹⁷ Within the state, habitations in East Singhbhum district have better access and coverage of both primary and upper primary schools.

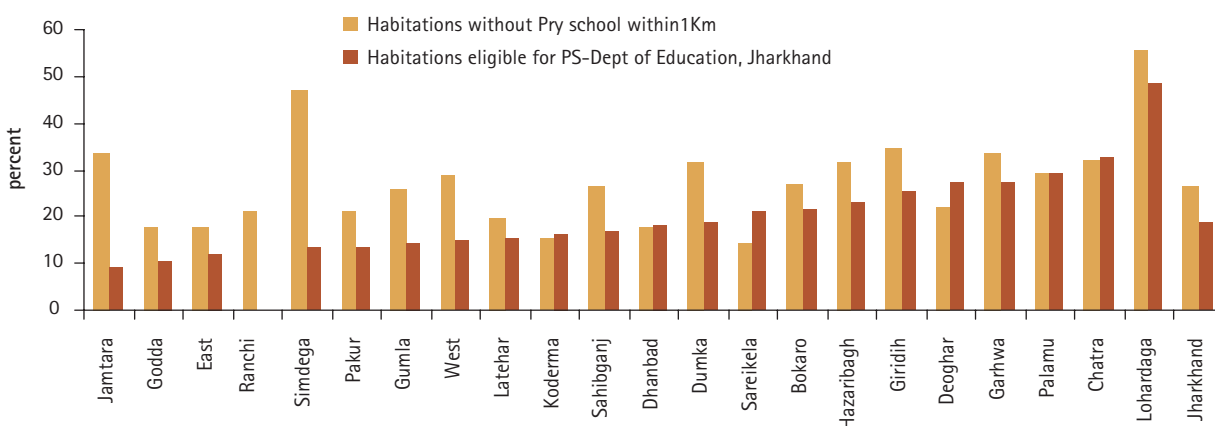
Education Project Council (JEPC) under the SSA program in 2005 suggests that the state still has around 8,000 habitations that are eligible for primary schools but do not have one (Figure 5.9). However, there are around 14,000 EGS and 9,500 Alternative Learning Centers (ALCs) and bridge courses in the state, which provide access to education facilities in those habitations that do not have primary schools. However, EGS and ALCs are basically transitional arrangements and, hence, unless converted to regular schools, are not sustainable substitutes for schools in the long run.

A key factor constraining primary education is the lack of minimum school-level facilities such as classrooms, blackboards, and teaching learning materials (TLMs). Addressing the lack of facilities could ensure some enabling conditions for students to attend schools regularly. Statistics from DISE show that around 45 percent of the schools have less than three rooms to conduct classes for five grades, 48 percent of the schools do not have toilets, and 72 percent of the schools do not have girls' toilets. The Annual Survey of Education Report (ASER) 2005 by Pratham looked at the facilities available in the government schools in the state and reported that a little less than 40 percent of the primary schools in the state

do not have water facilities and approximately 10–12 percent have the facility, but not in usable condition. Similarly, around 70 percent of the primary schools have no toilet facilities while around one-tenth of the schools have the facility, but not in usable condition. The Pratham study shows that the share of schools where most (75 percent) children in standard V have textbooks is only around 40 percent.¹¹⁸ However, more than 60 percent of primary schools and around 80 percent of upper primary schools have midday meal provision.

Despite teacher shortages, most of the running costs were still on account of teachers, and hence both the numbers and training of teachers is a huge task. Moreover, the quality and availability of teachers together help build an efficient education system. According to the DISE data, the average Pupil Teacher Ratio (PTR) was 52:1 in 2002/03 and worsened to 57:1 in 2003/04 as the pace of teacher recruitment remained below the growing rate of enrolments, and far below the required rate to achieve the target PTR of 40:1. Around one-tenth of the primary government schools in Jharkhand are single-teacher schools, which makes multi-grade classrooms and teaching an inevitable necessity. However, in March 2005, only 68 percent of

Figure 5. 9: Habitations without Primary School and Eligible to get Primary School



Source: District Information System of Education (DISE) data, 2005

118 ASER 2005.

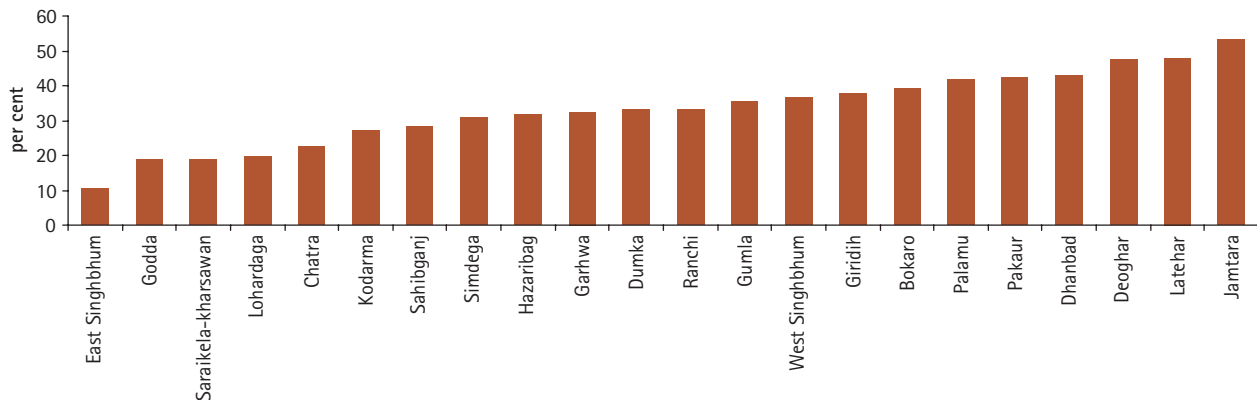
regular teacher vacancies could be filled due to lack of adequate funds.¹¹⁹ Under these circumstances the state has resorted to the appointment of para-teachers to bridge the gap between teacher needs and availability. Approximately 15 percent of total estimated teacher vacancies consistent with the PTR norm have been filled through the hiring of para-teachers, but far more needs to be done.¹²⁰

In many states, including Jharkhand, not only is the availability of teachers, but their regular attendance and actual teaching, which is a problem. One of the major issues related to teacher management in the state is the teacher absentee rates, which were as high as 39

percent of primary schools and a shocking 27.8 percent of upper primary schools had all teachers present.

While absenteeism is a governance issue, not all issues of quality interactions are related to accountability failure alone. This can be illustrated by the amount of time that a teacher spends on teaching and learning activities, especially given the multi-grade situations in both regular schools and EGS and ALCs. The average number of teachers per primary schools with five grades range from 1 to 2.3. In many districts, the share of single-teacher schools is as high as 40–50 percent (Figure 5.10). An important aspect that influences the schooling outcome of girls is the presence of female teachers. In

Figure 5. 10: Primary Schools with Single Teacher (percent)



Source: District Information System of Education (DISE) data, 2005.

percent.¹²¹ There has been some improvement in recent years. The Pratham study points out that on average the share of primary school teachers attending schools was 76 percent while that of upper primary teachers was 75 percent. However, on average on a single day, only 50

percent of primary schools and a shocking 27.8 percent of upper primary schools had all teachers present. most districts of Jharkhand, the share of female teachers in the total teacher workforce is less than 30 percent (Figure 5.11). Clearly, there is a need to appoint more teachers, but there is also a need to use teacher deployment as a tool to favor appointments in those districts where the average number of teachers is low as well as in schools with single teacher.

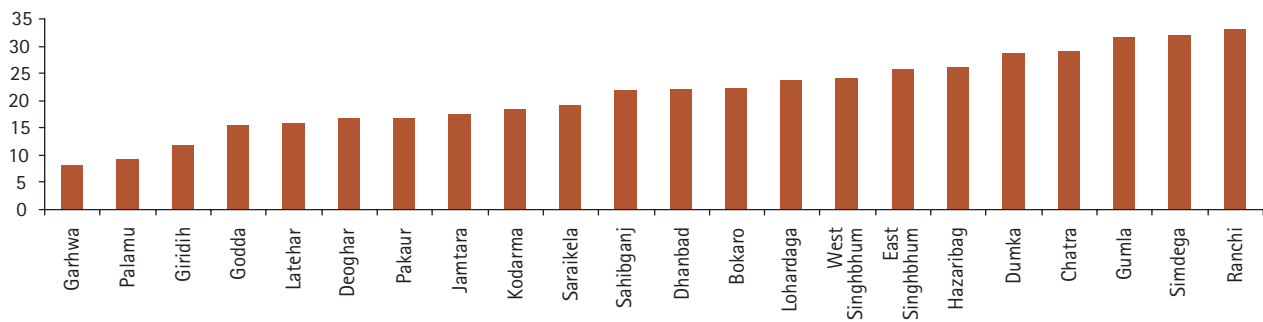
¹¹⁹ The fiscal crunches faced by the state, where teachers' salaries constitute more than 95 percent of non-plan expenditure, do not facilitate expansion of the regular teachers' cadre.

¹²⁰ While the proportion of graduates and above is higher in the regular teacher cadre, para-teachers mostly consist of secondary school graduates. However, there is no evidence to show that there is any significant difference in the effectiveness of regular and para-teachers in terms of outcomes measured as learning achievements of students.

¹²¹ World Bank (2003).

Demand-side factors are equally responsible for poor educational output and outcome indicators. For instance, while there are many reasons for being out-of-school, poverty appears to be the most compelling

Figure 5. 11: District-wise Female Teachers (percent)



Source: District Information System of Education (DISE) data, 2005.

factor as shown by: (i) household work (25 percent); (ii) earning compulsions (23 percent); (iii) lack of interest (14 percent); (iv) migration (9 percent); and (v) lack of access (8 percent).¹²² The Pratham study (ASER, 2005) estimated that out-of-school children amount to 9.8 percent of the total population in the 6–14 age-group, 7.7 percent in the 6–10 year age-group and 13.7 percent in the 11–14 year age-group.

Access to Secondary Education

The importance of secondary education can be judged by two parameters. *First*, the income effects of education are considerable with the completion of secondary education. *Second*, given the current emphasis on the expansion of primary education there will be a huge demand for secondary education in the next 5–10 years for which the state needs to be prepared.

Since the state was struggling with the issues in the elementary education sector, the cascading effect in terms of development of secondary education is yet to show its results. This can be judged by the enrolment data. The Gross Enrolment Ratio (GER) for secondary education is very modest. In 2002/03 it varied from 13.5 percent (as per the Ministry of Human Resource

Development statistics) to 18.3 percent (as per the 7th All India Education Survey). Gender inequity is sharper in the case of secondary education, with the GER for boys at 22 percent as against 14 percent for girls. The accessibility to secondary school, especially in rural areas, is a major constraint to the expansion of secondary education. According to the NSS survey of village facilities, only 36 percent of the villages in the state had access to secondary education facility within five km.¹²³

For a predominantly rural state, secondary education seems to be an urban phenomenon. Currently, for every 11 primary schools and every three upper primary schools, there is one high or higher secondary school in the state. The Seventh All India Education Survey (AIES) shows that between 1993 and 2002, the secondary education facilities increased by 13 percent in rural Jharkhand and by 17 percent in urban Jharkhand. Moreover, secondary GER is as low as 9 percent in rural Jharkhand, compared with an estimated 18 percent for the state as a whole. Thus there is a need to focus on the development of secondary education facilities in the rural areas.

Vocational education as judged by the number of Vocational Higher Secondary Education (VHSE)

¹²² SSA Household census 2005.

¹²³ NSS 58th round, 2002.

institutions is in a dismal state. VHSE has never been a major part of the strategy for higher secondary education in the state. It is alarming that Jharkhand has only 20 VHSE institutes compared to 622 in Maharashtra, 560 in AP, or 469 in Kerala. Half of them are in the government sector and the other half in the private sector. Eight of these are located in Ranchi itself. It is imperative the quantity of vocational institutions in Jharkhand be increased and spread more towards the backward districts where the youth can be trained to meet the needs of the industrial sector.

Medium-Term Sector Strategy in Education

While impressive progress has been made in the state in expanding the net of primary education, strategic initiatives are required in several areas, particularly with regard to quality and broad-based access. Clearly, to reach universal primary completion rates by 2015, Jharkhand needs: (i) a much faster growth rate in enrolment as compared to its historical trends; and (ii) better internal efficiency of the education system by reducing drop-outs and repetition rates and by improving transition and primary completion rates. The state is close to achieving gender parity in primary education. In the SSA program, Jharkhand is moving in the right direction, but needs further rigor and speed. Secondary education needs attention and general education at the secondary level needs to be modified to suit the labor market requirements. Other areas of concern include quality and learning levels. Overall policy, sectoral management and governance must be strengthened in order to achieve goals in the education sector. Some of the key areas relate to: (i) strengthening existing provisions and improving access; (ii) addressing the demand-side issues and formulating policies to ensure equity and social protection safety nets; (iii) teacher management and accountability for improvement in service delivery; (iv) management, support structure, capacity building and monitoring at the district and sub-district levels; (v) improvement in the efficiency of resource use both in elementary and secondary education; and (vi) partnership with the private sector at the post-elementary

and secondary levels and in vocational training. Each of these issues is discussed below.

Strengthening existing provisions and improving access: The state needs to address issues related the status of EGS and AIEs, especially since they were originally conceptualized as transitory arrangements which should not be treated as substitutes for regular schools. The upgrading of EGSs into primary schools in a phased manner is a major challenge, which the state should undertake with utmost care. Secondary education is clearly an area that needs attention as it prepares children to either enter the workforce or proceed for higher education. However, the expansion of secondary sector education needs careful planning aimed at expansion in the rural areas to balance the current urban concentration. There is an urgent need to expand the vocational education sector; especially given the existing and upcoming industrial clusters in the state. All these recommendations point towards strengthening the implementation of the existing schemes in elementary education and the need for increased attention to other areas of education.

Addressing demand-side issues and formulating policies to ensure equity: Jharkhand is predominantly a tribal state and the expansion of the education sector needs to address the requirements of the tribal population. While there is a need for systemic reforms within the education sector, some issues can only be addressed from the demand side, by providing incentives to households to send their children to school. For instance, conditional cash transfers and residential schools schemes could be effectively used to target the children and retain them in school. On the supply side, provision for care of younger siblings through ICDS and pre-schools may help in releasing the elder siblings from duties involving the care of the younger ones. There is also a need to strengthen community involvement in planning and monitoring these issues.

Teacher management and accountability for improvement in service delivery: Addressing teacher-related issues in the state requires well thought out strategies. The state needs

to fill vacant positions and ensure that teachers without formal teacher's training receive the minimum pre-service and regular in-service training. Moreover, there is a need to ensure adequacy of teachers with subject-specific knowledge in upper primary and secondary sectors. It is also important to ensure that all single-teacher schools receive additional teachers at least to ease the burden of handling multi-grade teaching and learning. It is also important to ensure that adequate female teachers and those who understand the local tribal language and are sensitive to the contextual culture are selected. As in the case of EGS and AIE, the tenure, qualification requirements, standardization, selection and appointment by the local committees and pre-service and in-service training of the state's large group of para-teachers needs to be thoroughly analyzed.

Management, support structure, capacity building and monitoring at district and sub-district levels: Setting up of the State Institute of Education Management and Training (SIERT) and strengthening the links between all these support systems are important for effective sector management. The BRC and CRC structures should be made effective by periodic evaluation of the impact of their training and support. These institutions should be molded to play important roles in providing technical support: SIERT and State Institute of Educational Management and Training (SIEMAT) in curriculum revision, textbook development, and training of trainers at the district levels, research and evaluation. The state depends on the National Council for Education Research and Training (NCERT) textbooks because of which children are deprived of learning local-level issues.

Improving the efficiency of resource use in elementary and secondary education: Both the amount of resources and the efficiency with which resources are spent determine the quantity and quality of service delivery. The state should seriously address the issue of under-spending of SSA allocations. Since the money under innovative activities in SSA is aimed at introducing state-specific interventions, the state should identify activities that it could carry out in each of the districts using the innovative grants. It is important to step up the spending

under community mobilization since the community could be used for better monitoring of the education process.

Partnership with the private sector at the post-elementary and secondary levels and in vocational training: Since the state has around 10 percent of its total schools under grants-in-aid, it could think of public-private partnerships in providing education, especially at the secondary level. One possibility is to increase the private institutions under grants-in-aid. The other could be to get NGO support to supplement the interventions in the education sector, especially among vulnerable groups. However, the options regarding grants-in-aid support to private schools in the present forms need to be re-examined to plug the loopholes in the system. The private unrecognized sector cannot be allowed to function without ensuring quality. For this purpose, legislation for regulating unrecognized schools in terms of quality, teacher management and other issues needs to be examined in a broader reform framework.

Access to Anti-Poverty Programs

An attempt is made here to answer three broad questions relating to the GoJ's programs specially targeted for the poor: (i) the main elements of the social protection strategy for the estimated 24 lakh families living below the poverty line (BPL); (ii) the reach and effectiveness of these programs from an administrative and beneficiary perspective; and (iii) based on the above, the adjustments needed in the current strategy to improve the impact of public policy. The state's programs¹²⁴ cover the traditional mix of social protection interventions that promote livelihoods (income generation) or provide safety nets

¹²⁴ Social protection programs in Jharkhand can be broadly classified as follows: self-employment programs (formerly IRDP and now SGSY); wage-employment programs (formerly JGSY and EAS, and now SGRY and which is NREG from February 2006); food security programs (TPDS, Antyodaya Anna Yojana, Annapurna Yojana, Midday Meal, ICDS); housing programs (formerly PMGY, now IAY); pensions and income transfer programs (National Social Assistance Programs including NOAPS, NFBS and NMBS); and area development programs that include several of the above strategies (DPAP, IWDP, PMGSY, RSVY, Zila Yojana, MLA and MPLADS).

and transfers, and focus either on the chronically poor or those who fall temporarily into poverty due to shocks.

Budget Allocation and Execution

Jharkhand's investment in social protection programs has gradually increased to about 4 percent of GSDP in 2004/05. As a share of revenue expenditures, these programs¹²⁵ have accounted for 18–24 percent in recent years (Table 5.1). Both as a share of GSDP and of revenue expenditures, Jharkhand appears to be an above-average spender on social protection programs among Indian states.¹²⁶ The expenditure per BPL family is quite considerable at about Rs. 5,025 (2004/05).

Wage employment programs and food security interventions, (mainly the PDS) traditionally accounted for two-thirds of the social protection budget. However in 2004/05, Area Development Programs, including both central and state-funded schemes, the Rashtriya (RSVY) and Zila Yojana respectively, as well as the Member of Parliament (MP) and Member of Legislative Assembly (MLA) managed welfare programs¹²⁷ accounted for the largest share of the expenditure (44 percent). Housing

programs are significant, accounting on average for more than 10 percent of the investment. The share of self-employment programs has fallen and is now less than 5 percent of total expenditures, while pensions are insignificant at 0.05 percent of GSDP.¹²⁸

While the majority of the programs are mandated and funded by the center, the state's share of expenditures is growing. Centrally funded programs typically involve co-financing by the state of approximately 25 percent. Moreover, the state's increasing investment on state initiated and funded programs such as the MLA welfare programs and the Zila Yojana has resulted in a growing state share of the investment, currently more than one-third of the total.

The district-wise allocation for several major programs has varied widely and does not appear to have a correlation with backwardness in recent years. The average per capita allocation per district over a three-year period (2001–2004) varied from a low of Rs.173 to a high of Rs.616. When compared with the district poverty index, the per capita allocation showed little correlation with poverty (Figure 5.12).

Table 5. 1: Social Protection Expenditures by Program Type

(Rs. crore)

	2001/02	2002/03	2003/04	2004/05
A. Food Security Programs	272.75	348.39	396.37	281.83
B. Wage-Employment Programs	285.93	325.55	402.81	423.73
C. Self-Employment Programs	48.92	39.37	47.12	55.87
D. Housing Programs	78.12	120.89	132.53	159.43
E. Area Development Programs	296.49	320.89	323.91	536.56
F. National Social Assistance Programs	15.59	21.75	n.a.	46.13
Total Expenditures	997.8	1176.84	1302.74	1503.55
Total as Share of Revenue Expenditures (%)	20.7	21.3	24.0	18.1
Total as Share of GSDP (%)	3.2	3.5	3.7	4.1

Source: Government of Jharkhand administrative data.

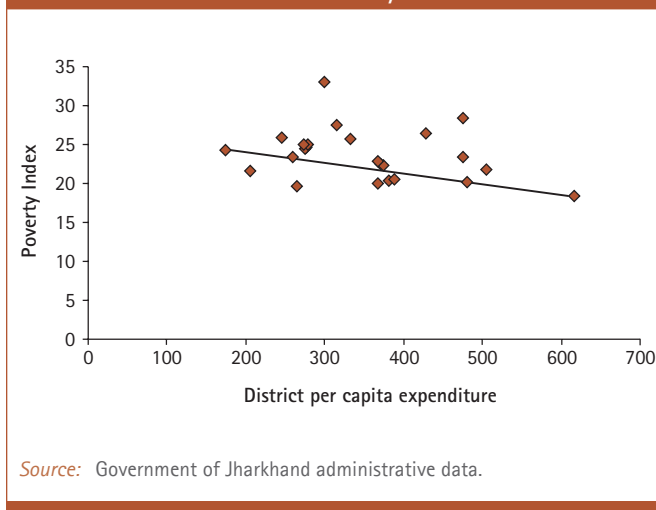
¹²⁵ This analysis only reviews the major programs listed in the previous footnote. A plethora of other programs exist, mostly Centrally Sponsored Schemes, but they account for a very small share of the budget. The only exception is the Tribal Welfare Sub-Plan, which is significant in Jharkhand.

¹²⁶ Central spending on safety net programs was estimated to be 1.7 percent and 9.8 percent of GDP and revenue expenditures respectively in 2001 (Srivastava, 2004).

¹²⁷ All these programs are implemented through the district administration.

¹²⁸ It appears that the state has been allocated a far lower share of pensions than warranted if the formula adopted by the center is correctly applied (2.92 lakhs rather than the current 1.5 lakhs).

Figure 5. 12: Correlation between District Expenditure and Poverty



Program Awareness, Coverage and Targeting

There is a clear divide in the level of awareness between public works programs, i.e. Annapoorna and Swarnjayanti Gram Swarozgar Yojana (SGSY) on the one hand – where less than half the population is aware of the programs – and PDS, Indira Aawas Yojna (IAY) and social pensions on the other hand, where awareness is generally high. While the high knowledge of PDS is not surprising, the differentials between social pensions and Annapoorna for example (which have substantial overlap in target groups), and between IAY and other programs operated by the rural development

department are noticeable. The relatively low awareness of public works is a particular cause for concern, given the intention of scaling-up of spending under the National Rural Employment Guarantee (NREG) scheme (Table 5.2).

All sources indicate that, despite significant investment, only a small percentage of BPL families benefit from these programs. First, using administrative data (Table 5.3), even in the best case scenario, program coverage is low, at around 3 percent for the self-employment and housing programs, 11 percent for wage employment, and 27 percent for old-age pensions for the elderly living below the poverty line. These estimates are very optimistic, as they assume that only BPL families benefited from the programs and that there was only one beneficiary per family per program. Survey-based data allows for a clearer picture. For example, according to a recent PEO evaluation of TPDS, only 57 percent of BPL families were able to avail of TPDS benefits and a similar evaluation commissioned by the Department of Food and Public Distribution¹²⁹ found that those who received benefits still depend on market sources for more than half their rice requirements.

Program coverage is even lower if estimated from the results of two government surveys – the National Sample Survey (NSS rounds 43, 50 and 55) and a Planning Commission Evaluation¹³⁰ (2000). The NSS data (1999/2000) shows that only about 5.5 percent of families in Jharkhand were covered by a wage employment program, although this is likely to be an underestimate since it only covers those families which received more than 60 days of work in the preceding year. However, coverage appears to be decreasing over the successive NSS rounds despite an increase in the number of man-days reported in the administrative data. For self-employment programs (SGSY), NSS data also shows that about 6 percent of the population was covered (that is, lived in a household which

Table 5.2: Familiarity with Social Protection Programs by Program Type (2005)

Program	Share of HH Familiar with Program (%)
Wage Employment Schemes	45.1
Food-for-Work Schemes	44.5
Annapoorna	36.6
SGSY	40.6
PDS Foodgrains from FPS	97.0
IAY/Rural Housing	89.3
Social Pensions for Destitute Elderly, Widows and Disabled	85.5

Source: Rural Jharkhand Baseline Survey, 2005.

¹²⁹ ORG Centre for Social Research: Evaluation Study of the Targeted Public Distribution System and Antodaya Anna Yojana, September 2005.

¹³⁰ Planning Commission: Survey of Poverty Alleviation Programs, Bihar-Jharkhand. 2000.

Table 5.3: Estimated Coverage by Program, Administrative and NSS data (Rs. crore)			
Program	Average Benefit Rs./Year	Maximum Share of Eligible BPL Households Covered ^a (Admn data) %	Estimated Coverage (NSS data 99/00)%
SGRY	7300	11.4	5.5
SGSY	8000	3.6	6.0 ^b
IAY	20,000	3.4	Na
TPDS	780	70	64.3
NOAPS	1200	27	Na

Source: Government of Jharkhand administrative data; NSS 55th round.

^a Optimistic estimate assuming entire expenditure was received by BPL households, and using 1997 estimates of number of BPL households.

^b Number of families reporting an IRDP benefit in the past 5 years.

received Integrated Rural Development Program (IRDP) or SGSY assistance in the five years preceding the survey). Coverage under PDS is relatively high (63 percent), but about 27 percent of eligible families reported not having a ration card, and 38 percent reported that they could not avail of PDS commodities due to non-availability of the items in the ration shop. The NSS data showed 0.4 percent coverage under the midday meal program against a national average of 3.2 percent.

While the NSS data is useful, the 2005 RJBS provides a more updated picture of coverage for a wider range of programs, indicating a very high degree of leakage once again. It also provides precise estimates of benefits actually received by households, which the NSS does not allow except for PDS. The survey asked about the share of the population that had benefited from or participated in the scheme in the past three years. This is a generous estimate of program coverage and the results are presented in Table 5.4, with beneficiary coverage estimated across the whole respondent population. With the exception of PDS, no program covers more than 10 percent cent of all households. However, this needs to be interpreted with some caution, as the potential target share of households is much less than all households.¹³¹

¹³¹The official number of BPL households in Jharkhand is just under 24 lakh.

Nonetheless, the figures indicate the relatively low coverage of the major anti-poverty programs across the entire population.

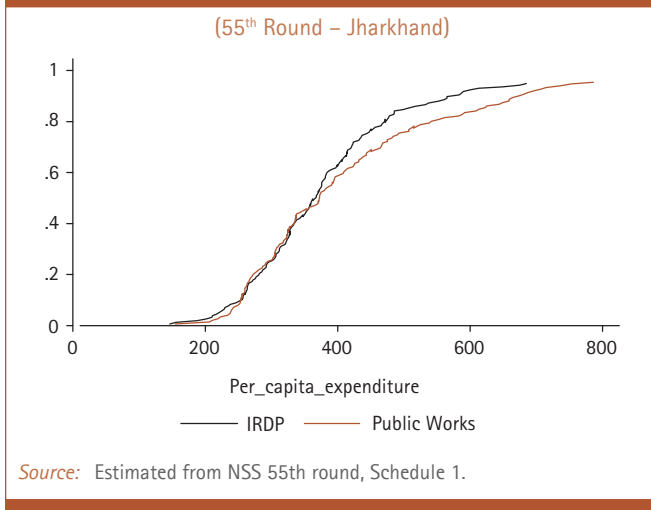
The NSS and Planning Commission sources indicate that public works programs are relatively well targeted, but all the programs had some leakages. The concurrent evaluation for SGRY confirmed that more than 80 percent of the wage employment program beneficiaries in Jharkhand belonged to BPL households, more than 90 percent lived in kutchha houses and that 70 percent of beneficiaries had been through primary education or less. Early rounds of the NSS also confirm that the poor benefit significantly more than the non-poor in wage employment programs.

However, in the most recent (55th round), this difference was more muted in Jharkhand probably due to the fact that the SGRY wages (which cannot be lower than the statutorily fixed minimum wage) are higher in many areas than the market wage rates. Approximately half the IRDP beneficiaries were estimated to be non-poor from the NSS data, while the Planning Commission evaluation put the non-poor at 39 percent of the IRDP beneficiaries in Jharkhand. This is also visible in the cumulative density functions of beneficiaries in both programs in 1999/00, as shown in Figure 5.13. A surprisingly high percentage of old-age pensioners (36 percent) were reported to be

Table 5.4: Share of Households Benefiting from Schemes in the Past Three Years	
Program	Share of HH Benefiting in Past Three Years (%)
Wage Employment Schemes	9.7
Food-for-Work Schemes	4.4
Annapoorna	1.0
SGSY	1.55
PDS Foodgrains from FPS	73.0
IAY/Rural Housing	9.3
Social Pensions for Destitute Elderly, Widows and Disabled	4.1

Source: Rural Jharkhand Baseline Survey, 2005.

Figure 5. 13: Cumulative Benefit to Households for IRDP and Public Works



ineligible to receive the benefit while 23 percent of the housing program beneficiaries (IAY) were also estimated to belong to households above the poverty line.¹³²

Initial results from RJBS also indicate mildly progressive targeting of social protection programs, with the apparent exception of SGSY. The analysis is ongoing, but some initial results are presented below.¹³³ Table 5.5 presents monthly per capita expenditure between beneficiary and non-beneficiary households of major programs.¹³⁴ Two points emerge:

- Beneficiary households are notably poorer than non-beneficiary households for nearly all programs, with the exception of SGSY. The average per capita expenditure of beneficiary households is between 12 percent and 21 percent lower than for non-beneficiaries, though for SGSY, beneficiary households are actually 5 percent better off than

¹³² Planning Commission (2000).

¹³³ Further analysis will allow a more disaggregated profile of beneficiaries relative to the non-beneficiary population, as averages among the two groups are not useful for getting a sense of distribution among both groups, for example, how many non-beneficiary households are in the lower bounds of the expenditure distribution, and what share of beneficiaries have above average expenditure levels.

¹³⁴ Expenditure is generally considered a more robust indicator of household welfare than income as it tends to be less subject to short-term fluctuations, and also tends to be reported more reliably. See Deaton (1997).

non-beneficiaries. This may indicate selection bias among more entrepreneurial households (though this should in principle be more than offset by the requirement of BPL status for most *swarozgaris*).

- Self-targeted workfare programs perform best in terms of largest expenditure shortfall of beneficiary households, though BPL-based IAY also does relatively well. In contrast, both SGSY in particular and PDS to a lesser extent have relatively lower (negative in the case of SGSY) expenditure shortfall among beneficiary households.

Another key dimension in assessing impact is the level of benefit received by those households who participate in different anti-poverty programs. The survey asked about benefits received over the past 12 months among households who reported participation at any time in the previous years. The results are presented by program in Table 5.6 (for PDS items in Table 5.7), with median and mean benefits. The following points are noteworthy:

- The benefit reported from IAY is around Rs.5, 000 less than the official amount per household, which

Table 5.5: Average Per Capita Expenditure of Beneficiary and Non-Beneficiary Households by Program 2005

	Beneficiary Household (Rs. per month)	Non-Beneficiary Household (Rs. per month)	Per capita Expenditure of Beneficiary/ Non-beneficiary Households (a)
Wage Employment	221.6	280.8	78.9
Food-for-Work	220.3	280.9	78.4
Annapoorna	223.5	285.7	78.2
SGSY	296.9	282.3	105.2
PDS Foodgrains	248.1	283.9	87.4
IAY	211.9	265.3	79.9
Social Pensions	230.5	264.5	87.1

Source: Rural Jharkhand Baseline Survey, 2005.

Note (a): percentage of less than 100 percent indicates that beneficiary households are poorer than non-beneficiaries and vice versa.

Program	Median Benefit	Mean Benefit
Wage Employment Schemes	10 days work Rs. 600	20.3 days work Rs. 1,390.8
Food-for-Work Schemes	14 days work Rs. 535 equivalent	19.2 days work Rs. 762.6 equivalent
Annapoorna	76 kg rice 0 kg wheat	66.1 kg rice 6.1 kg wheat
SGSY	Rs. 10,000 credit	Rs. 13,400 credit
IAY/Rural Housing	Rs. 20,000	Rs. 18,200.2
Social Pensions for Destitute Elderly, Widows and Disabled	Rs. 1,200	Rs. 1,260.7

Source: Rural Jharkhand Baseline Survey, 2005.

Item	Median Amount Received	Mean Amount Received	Amount Received by 75 th Percentile
Rice	0 kg	38.8 kg	24 kg
Wheat	0 kg	35.3 kg	45 kg
Cooking Oil	0 litre	1.1 litre	0 litre
Kerosene	36 litre	32.2 litre	36 litre

Source: Rural Jharkhand Baseline Survey, 2005.

is consistent with field reports of a required bribe of Rs. 4,000–5,000 for a household to secure an IAY benefit.

- Social pension receipts in contrast appear to have minimal leakage, given that the monthly average benefit in 2005 was Rs.100.
- The total number of workdays received from public works was considerably less than the stated target in both SGRY and National Food for Work (NFFW) of 100 days per rural poor household. Even assuming that the same households access both food-for-work and wage employment schemes, the median number of workdays per household was only 25, and the mean less than 40 days. In terms of wage rates, the average daily wage rate received in wage employment schemes appears to be quite

close to the state's official agricultural minimum wage at the time, which was just under Rs. 65 per day. However, the average wage rate in NFFW beneficiaries was considerably lower than those in other wage employment schemes, closer to Rs. 40 per day. However, there are larger measurement issues here due to the need to value food received, and the result needs to be interpreted with caution.

- Grains received under Annapoorna appear to be significantly below the quota allocation, which was 10 kg of rice or wheat per beneficiary per month. The survey results indicate that grains received were just over 60 percent of the official allocation per beneficiary.

Given that several different items are available in principle from the fair price shops, which distribute PDS items, results on benefits received from PDS are presented in Table 5.7. The results for the general population are somewhat difficult to interpret (with the exception of kerosene), due to the low offtake by Above Poverty Line (APL) households, and those without ration cards. The amount received by the 75th percentile households has also therefore been added. Nonetheless, several points emerge:

- The median household in Jharkhand was only using FPS for purchasing kerosene and not foodgrains or cooking oil in 2005. This figure itself is a cause for concern, given that around half the Jharkhand household population is considered to be BPL.
- Focusing only on the 75th percentile (ranked according to amounts received from PDS), the annual amount of total grains received comes to only 69 kg of rice and wheat combined. This compares to an allocation for BPL households of 35 kg per month or 420 kg per year, indicating a major shortfall in grains actually delivered to the poor.
- Even for kerosene, the average allocations appear to be well below the official norm. Annual official

allocation is 276 liters per year in rural areas. A median actual amount of 36 liters is therefore well below the quota for the large majority.

Seasonal targeting of anti-poverty programs seems to be quite inadequate. An additional aspect of implementation, which is important for some schemes, is regularity or seasonal concentration of benefits. For example, in principle, public works should be more important to beneficiaries in the lean rather than the peak agricultural season (though evidence from states such as Orissa and Maharashtra have indicated that the concentration of public works employment is counter-cyclical), while for programs such as PDS or social pensions, regularity of benefit may be more important. The results on seasonal concentration of selected benefits are presented in Table 5.8. A few observations can be made:

- For the two employment programs, there appears not to be any concentration of employment in the lean season. This is of some concern given the low average numbers of days of employment per beneficiary.
- PDS in contrast is more regular for the bulk of beneficiaries, though as noted, the bigger question is what and how much of it they receive on a regular basis. However, even for PDS, over one-third of beneficiaries report less than regular benefits.
- Surprisingly, social pensions have less than 40 percent of beneficiaries receiving regular payments

Table 5. 8: Regularity of Benefits by Program (2005)
(in percent)

Program	All Year	Lean Season Only	Non-lean Only	Irregular/ No Fixed Timing
Wage Employment	8.5	10	4.5	76.9
Food for Work	2.2	14.3	5.5	78.0
PDS	64.7	2.8	1.6	30.9
Social Pensions	38.9	9.4	1.2	50.6

Source: Rural Jharkhand Baseline Survey, 2005.

(though the benefit is in principle monthly), indicating bunching of payments.

The rural Jharkhand baseline survey also reveals the problem of the BPL approach to program implementation. While the approach of a summary identification process and the provision of identification cards to BPL families seem attractive in theory, there are a number of problems in the implementation of this approach. In 1997 and again in 2002, the GoI Ministry of Rural Development directed the states to carry out a BPL census. This methodology has come in for serious criticism¹³⁵ on the grounds that: (i) the indicators are widely disparate but have the same weight (for example, hunger and preferred form of assistance); (ii) the list includes contingent indicators (households that have migrant workers or school-age children) that would skew the ranking; (iii) lack of rationale in assigning values to some indicators (for example, artisans are presumed to be better off than subsistence farmers and self-employed service providers better than both); and (iv) lack of transparency in the selection of the cut-off scores. In addition, the problem of a list that remains static till the next census was not addressed.¹³⁶

Several exercises, comparing the results from independent income and expenditure surveys to the BPL survey have shown little correspondence in the BPL and survey-based lists. Table 5.9, which tabulates the ORG-MARG data to capture the false-positives (not poor, but classified as AAY/BPL) and false negatives (poor, but classified as APL), shows that only 54 percent of the households had been properly classified, that 40 percent of households declared to be AAY or BPL were actually middle or high income and that 6 percent of households that were poor were wrongly classified as APL.

High overhead costs and outright leakages severely limit the cost effectiveness of the programs. The

¹³⁵ For a full discussion see Sundaram (2003).
¹³⁶ See also Jalan and Murgai (2006) for detailed empirical analysis of the BPL 2002 census methodology and its weaknesses using NSS data.

2005 Programme Evaluation Organization (PEO) evaluation of Targeted Public Distribution System (TPDS) estimated the average leakage due to corruption to be about 36 percent nationally, but listed Bihar¹³⁷ as a state with "abnormal levels of leakage" (75 percent) as well as the state with the *second* highest share of "ghost cards" (14 percent). Bunching of the off-take in March (only about 10 percent of the 2005 allotment had been drawn up to end-February 2005), lends credence to the suspicion that stocks not drawn through the FPS are diverted to private traders who pocket the subsidy.

Similarly, a PEO evaluation of SGRY reports rampant corruption including widespread use of contractors and fudging of muster rolls. About nine percent¹³⁸ of beneficiaries in Jharkhand reported difficulties in finding work under SGRY because of the involvement of contractors. The Planning Commission evaluation of IRDP¹³⁹ also showed that 25 percent of beneficiaries existed only on paper. The CAG evaluation of Swarnjayanti Grameen Swarozgar Yojna (SGSY) assessed that only 38 percent of overhead expenses in Jharkhand were legitimate project expenses. Overall, multiple assessments and occasional public scandals (for example Sholapur, Maharashtra in 2004) support the widely held view that corruption is one of the most significant challenges of government-implemented programs.

Significant shortfalls in program allocation vis-à-vis need or eligibility, and delays in implementation increase the likelihood of demand for bribes. The average number of days of employment provided under SGRY was only 30 (against the targeted 100 days) in 2002/03, according to the SGRY concurrent evaluation. The delivery of the grain component under SGRY was seriously delayed, so much so that it is not clear whether all the participants eventually received their due share in kind. Beneficiaries interviewed in the Planning Commission's evaluation of poverty alleviation programs in Jharkhand reported long delays between the time an application was made and when payment was received under SGSY, IAY and programs under the National Social Assistance Scheme. More than 80 percent reported paying "speed money" for the first two programs, while two-thirds paid for inclusion in the pensioners' list.

The state government (district administrations in particular) lacks the capacity to implement many of these supervision-intensive programs and has failed to maximize the use of possible supervisory agencies. Lack of technical support was a significant issue in failures in IRDP and SGSY projects and for the quality of works in SGRY. Districts reported a serious shortage of qualified engineers and supervisors to monitor public works programs, as a result of widespread vacancies and without the sanction of additional positions to meet an increasing volume of work. This situation will require even more urgent attention for implementation of the recently approved NREG¹⁴⁰. The PRIs, which could play an important role in supervision, are currently not operational in Jharkhand. Approximately 40 percent of the panchayats had identified local leaders or facilitators for the works in the state, according to the concurrent evaluation, and less than half were assigned duties such as maintenance of the muster roll or distribution of wages. Only about half the beneficiaries said they were aware of a supervisory role by the implementing agency.

Table 5. 9: Comparing List of Poor Families from the ORG-MARG and BPL Surveys

Status of Household as per ORG-MARG Survey	Status of Household as per Family Ration Card			
	AAY/BPL		APL	
Very Poor/ Poor	8398	37%	1357	6%
Middle/High Income	9098	40%	3949	17%

Source: ORG Center for Social Research: Evaluation Study of TPDS and AAY.

¹³⁷ The Bihar State Food Corporation handles the lifting and transportation of foodgrains for Jharkhand. Only nine of the 22 districts in the state have FCI godowns.

¹³⁸ The national average was 2.5 percent.

¹³⁹ Planning Commission (2000).

¹⁴⁰ The scheme, however, makes provision for financing of additional personnel.

Similarly, greater NGO involvement could improve the performance of SGSY, as it has in Lohardaga district, with the involvement of Pradan, an NGO that is providing necessary technical support for poultry development and other animal husbandry activities.

The overall monitoring of programs is weak. At the state level, the department of rural development should be commended for establishing a computerized monitoring system that provides up-to-date information on all the major programs implemented by it. Similar information was not readily available from other departments. Only about half the districts had been visited by state-level officials according to the concurrent evaluation for SGRY. At the district level, although regular monitoring by the deputy commissioners and SSS heads of the different departments is supposed to take place, the TPDS evaluation similarly reported poor monitoring by taluk and block officials. PRIs, user groups and gram sabhas have not been widely established and do not play a significant role in regular field-level monitoring. The concurrent evaluation of SGRY revealed that no beneficiary committees had been appointed for 40 percent of the works in Jharkhand. Only half the beneficiaries were aware of the price fixed for food grains under the non-cash wage component of SGRY. Area development programs lacked details and appeared to be least monitored of all the programs. This is an important lacuna that must be addressed, given the rapidly increasing investment in these programs, particularly the state-funded Zila Yojana and MLA welfare schemes.

Beneficiaries lack the necessary information about programs which constrains their ability to participate in them fully, demand their fair share of benefits and monitor program implementation. According to the findings of the ORG-MARG survey, only 15 percent of the population in rural areas nationwide was aware of the process of selection for AAY. About two-thirds of the AAY beneficiaries in the country were themselves unaware of the criteria for selection. Similarly 80 percent of the people surveyed were unaware of the selection process for being

included in the BPL list. Concurrent evaluation of SGRY found that only 55 percent of beneficiaries in Jharkhand were aware of the agency that implemented works under that program, that half the works did not display signboards providing details of the work, and that 30 percent of village monitoring committees met irregularly.

Tribal Inclusion through Civic Empowerment

Among adivasis in Jharkhand, land and the surrounding natural environment constitute the basis of their socio-political institutions, serving as a template for social organization and political thought besides being a mode of subsistence. The reinforcement of social boundaries, the protection of the environment and the enforcement of community rights over natural resources (land, forest, and water) constitute the foundation and the *raison d'etre* of tribal institutions in Jharkhand.

Tribal institutions in Jharkhand are an expression of direct democracy. Traditional leaders derive their legitimacy from being *primus inter pares* and communities have the power to recall and replace traditional leaders in case of misconduct. The application of customary law is based on consensual decision-making, made possible by the fact that adivasi communities in Jharkhand are generally small in scale and based on kinship ties. Traditional leaders apply customary law in regulating sustainable access to land and forest by different social groups (be it tribes, castes, clans or lineages) as well as in regulating marriages and ensuring the favor of supernatural forces for the physical and social reproduction of the group.

The weakening of socio-political institutions in charge of the social reproduction of the group and the protection of natural resources represents a threat both to tribal society and to the environment. The weakening of traditional institutions also threatens the environment and National Resource Management (NRM)-based livelihoods. Institutions are not frozen but change through time, as a response to external

factors or as an inherent process of adaptation to new demands and challenges. However, institutional change can also be imposed from outside. When this happens, it is perceived as a threat to the survival of the social group and its habitat. In Jharkhand, many ethnographic accounts have captured the process of transformation and weakening of adivasi traditional institutions, either under the pressure of religious and social movements or as a consequence of assimilation and mainstreaming efforts by the state.

Constitutional provisions aimed at protecting adivasi culture and interests have been mostly ineffective as seen from:

- Part X (Article 244) – This deals with the administration of scheduled areas and tribal areas, which covers the operation of the 5th Schedule. In practice, experience with the 5th Schedule has been disappointing. Tribal Advisory Councils hardly have any teeth, laws applicable to the rest of the state are routinely extended to scheduled areas, the governor rarely exercises the powers vested in him or her, and the overall result manifests in the miserable human development indicators for adivasis.
- Part IX (Panchayats) – Article 243B makes it mandatory for every state to constitute panchayats at the village, intermediate and district levels. However, an exception is made for scheduled areas in Article 243M, which notes that parliament can modify or pass new laws on panchayats for scheduled areas.

Parliament passed the Provisions of the Panchayats (Extension to the Scheduled Areas) Act (PESA) on December 24, 1996 (Box 5.1). However, the amendment has mainly remained on paper.

Similarly, national policies have been aimed mostly at the achievement of a single national identity rather than emphasizing the specific identity of adivasis as groups in need of protection. The new Draft Tribal Policy reiterates the same approach as it seeks to bring them into the mainstream of society and assimilate, while not integrating, them through opportunities to interact with outside cultures.

The decentralization process also needs to be carried out by recognizing the special status of tribal community institutions, as envisaged in PESA. Statutory panchayats based on representative democracy are extended to scheduled areas regardless of the different constituent elements of already-existing adivasi institutions, contradicting the spirit of PESA. Panchayat leaders are elected for a term of five years and cannot be recalled by the community. Their decision-making process is not based on consensus-building process. Their administrative jurisdictions do not overlap with tribal kinship-based jurisdictions. Moreover, the very size of the statutory gram panchayat (5,000 residents) suggests its incompatibility with decentralized self-governance.

North-East India provides an example where traditional headmen were replaced by elected leaders leading to extensive elite capture, land alienation

Box 5. 1: Panchayat Extension to Scheduled Areas Act (PESA) 1996

PESA is the first law that empowers adivasis to redefine their own administrative boundaries, with the traditional village council (gram sabha) becoming their core institution. The formal recognition of the tribal traditional system as the basic unit of self-governance is the most significant aspect of PESA and the implications of this in terms of empowerment are far wider than it is generally acknowledged. The basic assumptions are that: (i) tribal customary norms and practices are somehow more democratic than those imposed by colonial and post-colonial states; and (ii) the basic unit of governance in tribal areas is the hamlet or the "natural" village rather than the revenue village (clause 4.b). However, the Act is in itself contradictory, when it provides for upholding custom, which would involve non-elected headmen at the village and pargana level, while at the same time providing for elections of the village panchayats (clauses 4c&tg).

Box 5. 2: Recognition of Customary Land Tenure Systems through Traditional Institutions

The expression "customary tenure" is used here to define property arrangements characterized by the following elements: ritual and cosmological relations with ancestral lands; community "rights" of control over land disposal; kinship or territory-based criteria for land access; and principles of reversion of unused land to community control. One has to understand the causes of tenure insecurity to influence the legal policy response. In the case of Jharkhand, tenure insecurity derives primarily from encroachment by outsiders and interaction with the state rather than from conflicts internal to the customary groups. Indeed, the denial of rights has led to a situation where ancestral lands are still used by the adivasi community yet without any tenurial security.

Global experience shows that the recognition of customary tenure increases tenure security on both accounts. On the one hand, it increases adivasi negotiating power with the government. On the other, it reduces alienation of land by outsiders. In the case of failure of protective laws and regulations points to the fact that a paradigm shift may be required. Ensuring community control over land transfers has been shown to effectively reduce land alienation whereby all have a stake in the land. Wherever land is owned individually, the legal owner and the community, through the gram sabha and other traditional mechanisms, would jointly exercise control rights over land transfers.

and consolidation and social inequalities. Despite the legal recognition of collective land ownership, communities were dis-empowered from their traditional function to control access to and disposal of land, while the traditional institutional mechanisms that ensured downward accountability of the leaders got weakened. In Meghalaya, a demand has been expressed for constitutional recognition of tribal customary leaders, like Syiems, Nokmas and Dollois vis-à-vis elected leaders due to the failure of the electoral system to achieve true democracy and accountability.¹⁴¹

Civil society in Jharkhand is demanding a reform of traditional structures from within, along the lines identified by PESA. In point of fact, PESA dismisses the possibility of autocratic leaders, albeit non-elected, by providing for gram sabha control. This control is meant to cover different economic spheres, including land protection and restoration, by legitimizing customary norms, which

the same headmen are subject to, and by empowering communities to replace those leaders that misbehave.

Care must be taken to look after the needs of voiceless groups, particularly women, youth, landless and migrants, and to involve them in decision-making and the everyday affairs of the gram sabhas. The seasonal migration from Santhal Parganas and elsewhere could result in usurpation of control over gram sabha or gram panchayat decisions by those who can afford to stay in the village. The state government should also grant rights to local people in natural resource management. Customary land tenure should be recognized (Box 5.2). People should be consulted on their vision of development, their land should not be acquired without their prior and informed consent (instead of mere consultation), they should have shares in any project that comes up on their land with their land ownership remaining intact, and they must be asked to move only if rehabilitation has been satisfactorily completed.

¹⁴¹ See, Hussain (2004).

