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8

Understanding the Role of Social Exclusion in Progress towards MDGs for the Excluded Groups

Nidhi S Sabharwal

UNDERSTANDING THE ROLE OF SOCIAL EXCLUSION IN PROGRESS TOWARDS MDGs FOR THE EXCLUDED GROUPS

Southern Voice Occasional Paper 8

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Preface

The *Southern Voice on Post-MDG International Development Goals* was born in the spirit of collaboration, participation and broad academic inquiry. It is a network of 48 think tanks from Africa, Latin America and South Asia which has identified a unique space to contribute to the post-2015 dialogue. By providing quality data, evidence and analyses derived from research in the countries of the global South, these think tanks seek to inform the discussion on the post-2015 framework, goals and targets, and to help to shape the debate itself.

With these goals in mind, *Southern Voice* launched a call for papers among its members to inform the global debate based on the research they have already carried out, to strengthen national or regional policy discussions. The objective of the call was to maximise the impact of the knowledge that already exists in the global South, but which may have not reached the international arena.

In response to the call, we received numerous proposals which were reviewed by *Southern Voice* members. The research papers were also peer reviewed, and the revised drafts were later validated by the reviewer.

The resulting collection of ten papers highlights some of the most pressing concerns for the countries of the global South. In doing so, they explore a variety of topics including social, governance, economic and environmental concerns. Each paper demonstrates the challenges of building an international agenda which responds to the specificities of each country, while also being internationally relevant. It is by acknowledging and analysing these challenges that the research from the global South supports the objective of a meaningful post-2015 agenda.

In connection with the ongoing debates on post-2015 international development goals, **Understanding the Role of Social Exclusion in Hunger: Analysis of MDGs for the Excluded Groups in India** by *Dr Nidhi Sadana Sabharwal* (Executive Director) at Indian Institute of Dalit Studies, focuses on discrimination, inequality and poverty. It proposes to look deeper into the reasons for the gap between discriminated groups and 'the rest' to get some recommendations.

I would like to gratefully acknowledge the contributions of *Ms Andrea Ordóñez* (Research Coordinator of the initiative) and *Ms Mahenaw Ummul Wara* (Research Associate, Centre for Policy Dialogue (CPD) and Focal Point at the *Southern Voice* Secretariat) in managing and organising the smooth implementation of the research programme.

I would also like to thank *Professor Rounaq Jahan* (Distinguished Fellow, CPD) for peer reviewing, and *Dr Oliver Turner* for copy editing the paper.

I would like to take this opportunity to recognise the support of Think Tank Initiative (TTI) towards *Southern Voice*, particularly that of *Dr Peter Taylor*, Programme Leader, TTI.

I hope the engaged readership will find the document stimulating.

Dhaka, Bangladesh
May 2014

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Abstract

The poor are not uniformly disadvantaged. Across most Millennium Development Goals (MDGs), the situation of the excluded groups is significantly worse than the others. While, much of the poverty, hunger and deprivation of indigenous and excluded groups are the results of factors which are common to all poor, including the excluded groups, however, there are additional 'group-specific factors' that affect the scenario and make them more vulnerable to poverty and malnutrition than their counterparts from the general population. These factors that are known to affect excluded groups relate to social exclusion in the past and its continuation in the present in different forms, resulting in denial of equal rights and entitlements in economic, social, political and civil spheres. 'Social exclusion' makes it harder to meet the MDGs for excluded groups. To achieve the UN High Level Panel's commitment to deal with inequality and ensure that "no one is left behind", we must recognise that social exclusion is based on social and cultural identities; make non-discriminatory access and participation a 'right'; and combine universal policies with affirmative action to address poverty and reduce disparities.

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Acronyms

BMI	Body Mass Index
CED	Chronic Energy Deficiency
DNT	De-Notified Tribe
EPI	Expanded Programme of Immunisation
HCR	Head Count Ratio
HLPR	High Level Panel Report
IMR	Infant Mortality Rate
MDG	Millennium Development Goal
NFHS	National Family Health Survey
NT	Nomadic Tribe
OBC	Other Backward Classes
PDS	Public Distribution System
SC	Scheduled Caste
ST	Scheduled Tribe
UPI	Universal Programme of Immunisation

Understanding the Role of Social Exclusion in Progress towards MDGs for the Excluded Groups

Nidhi S Sabharwal

1. Introduction

The South Asian experience with respect to changes in poverty and hunger in the Millennium Development Goals (MDGs) is positive. Notably, it is forecasted that extreme poverty and hunger will halve by 2015 (GMR 2011, World Bank). The goals and principles embodied in the MDGs have been reflected in India's development priorities, which are inculcated in the 11th and 12th Five Year Plans. The 11th Five Year Plan (2006-11) and the 12th Five Year Plan (2012-17) have adopted several monitorable targets as key features of an inclusive growth strategy. These targets are designed to capture the economic and social objectives of an inclusive approach to growth. In all, 25 targets have been identified at the national level which have been placed in six major categories: (1) income and poverty; (2) education; (3) health; (4) women and children; (5) infrastructure; and (6) environment.

Now, as we approach 2015 and come closer to the committed year of meeting the MDGs' targets, the experiences of numerous countries including India indicate that achieving the target for the indigenous and excluded groups remains an urgent challenge. Indigenous, ethnic and other excluded groups tend to suffer from high poverty, malnutrition, illiteracy and poor health outcomes compared to the general population. Large disparities in poverty and nutritional levels exist across gender, economic, social, ethnic and religious groups. Within indigenous and ethnic groups poverty is often persistent and chronic in nature and is passed on to consecutive generations. In some growing economies, such as India and China, these groups have experienced reductions in poverty and improvements in indicators of human development. However the pace of poverty reduction and malnutrition is invariably lower than the non-excluded groups, and therefore they continue to lag behind the remainder of the population.

Much of the poverty, hunger and deprivation of indigenous and excluded groups is a result of factors common to all poor, including those of excluded groups. These factors include slow increases in income, poor access to assets (e.g. agricultural land and non-agricultural enterprises), gainful employment, education and skills training, health facilities, housing and a lack of participation in governance. Ultimately these factors combine to cause poverty among the poor, including those from discriminated groups.

However, in case of discriminated groups – and while similar factors are the ultimate cause of low income and poverty – the 'channel of causation' is often different. Particular 'group-specific factors' are faced by excluded groups, who become more vulnerable to poverty and malnutrition than their counterpart from the general population. These factors have been known to relate to social exclusion in the past, and its continuation in the present in different forms which result in the denial of equal rights and entitlement. This, in turn, acts as a barrier to the features of poverty outlined above, such as the ownership of assets, access to education and health facilities, and participation in governance. 'Social exclusion' makes it harder to achieve the MDGs for the benefit of excluded groups. Thus, 'exclusion-induced deprivation' is faced by people from discriminated groups, causing high and persistent poverty.

The United Nation's (UN) High Level Panel Report (HLPR) contains a commitment to dealing with inequality with the clear intent of putting the needs of marginalised groups at the heart of the policy guidance which will emerge from the process of defining the next set of global goals for poverty reduction and sustainable development in 2015. The Report states: "Targets should only be considered achieved if they are met for all relevant and social groups." It is important to recognise that the group characteristics of exclusion are based on social and cultural identity, which results in the denial of equal rights and entitlements, and are irrespective of individual attributes. Hence, we can ensure that "no one is left behind" by:

a) Making non-discriminatory access and participation a 'right'; and
b) Combining universal policies with targeted or affirmative action to address human poverty and reduce disparities.

Objectives

The paper examines some of the issues relevant to excluded groups in India with regards the performance of the MGDs related to human development. First, it discusses the changes and disparities in those MGDs among both excluded groups and the general population since the early 1990s. Then, it discusses the reasons for relatively slower progress in the MGDs for excluded groups and persistent disparities between them and the 'rest' of the population. Finally, it proposes a way to bridge the gap and addresses the issues of 'exclusion-induced poverty and deprivation' with regard to human development of excluded groups in India.

2. Progress towards MDGs in India

In India, social exclusion is generated by institutions that exclude, discriminate, isolate and deprive some groups on the basis of their identities defined, for example, by caste, ethnicity, and religion. Excluded groups include the Scheduled Castes (SCs), Other Backward Classes (OBCs), Scheduled Tribes (STs), nomadic and de-notified tribes (NTs and DNTs), and religious minorities such as Muslims. The SCs, STs and OBCs account for around half of India's population. If we add minorities like Muslims, the proportion goes up to 64 per cent. So, almost three-fifths of India's population suffers from one or the other form of social exclusion and isolation.

The groups that suffer from social exclusion and discrimination associated with the institution of caste include former untouchables (SCs), and socially and educationally backward sections of OBCs. The groups that suffer from exclusion and isolation associated with ethnic background include STs, notified and de-notified tribes. The de-notified tribes also suffer from the stigma of criminality. The groups that suffer exclusion and discrimination as a result of religious identity are mainly Muslims. Women from all religious backgrounds face discrimination in various forms, although the nature of discrimination differs depending on their caste, ethnicity and religious background. The nature of social exclusion and discrimination of each of these groups differs in term of spheres and forms.

The Indian government has recognised the unique problems of these groups and developed group-specific policies as early as 1930. The government has developed Affirmative Action policies for SCs, STs and OBCs. The policies for these three groups are legal in nature. However, in the case of religious minorities (the Muslims) it takes the form of informal Affirmative Action policy. Besides, the government has also developed policies along the lines of Affirmative Action for women.

In this section we assess the progress of the MDGs-related to poverty, malnutrition, health, education and sanitation in India at the aggregate level and by social groups, namely the SCs and the STs in comparison to the rest of the population. We limit our exercise to the SCs and the STs due to the paucity of official data available for other excluded groups. Together, SCs and STs constitute around a quarter of India's population. In order to gain a comparative picture we take the 'rest' of the population as others or non-excluded groups (the non-SC/ST population). The changes in the MDGs are studied for the relevant years depending on the availability of the data. However, the focus is on the 1990s and 2000s. In the case of income and poverty, the paper covers the period between

1993-94 and 2009-10 (the latest period for which the data are available). In the case of the other indicators, two main sources are used which mainly include National Family and Health Survey and National Sample Survey. Changes in income of the poor, poverty, malnutrition, health indicators, literacy, by gender, caste and ethnic groups of SCs, STs and the 'rest' are based on the data for the 1990s and 2000s from these two official sources.

The specific variables are as follows:

A. Proportion of poor below the poverty line in India: poverty ratio
B. Prevalence of underweight children under 5-years of age
C. Anaemic rates for adult men, women and children
D. Infant Mortality Rates (IMR)
E. Full immunisation
F. Literacy rates of 7-years and above
G. Access to safe drinking water and sanitation

Changes in Poverty

In this section we examine the changes in the incidence of poverty, the Head Count Ratio (HCR) at the national level in India by caste and ethnic groups in the rural and urban sectors. The change in the incidence of poverty (measured as HCR) is reported in Table 1.

Poverty by Caste and Ethnic Groups in Rural Sector

Table 1 shows that the HCR is 30 per cent for SCs and 33 per cent for STs, while the total poverty incidence is close to 22 per cent in 2009-10. Between 1993-94 and 2009-10, rural poverty declined at a per annum rate of 2.5 per cent which is equivalent to a 15 percentage points decline (Table 1). Across social groups, the rate of decline in poverty for the 'others' (i.e. non-SCs/STs), has been 2.7 per cent, followed by 2.4 per cent among SCs and 2.1 per cent among STs.

Table 1: Incidence, Change and Rate of Change (Annual) in HCR for Socio-Religious Groups

Socio-Religious Group	**Poverty Incidence (HCR) (%)**					
	1993-94			**2009-10**		
	Rural	**Urban**	**Total**	**Rural**	**Urban**	**Total**
All	36.9	32.8	35.9	21.9	20.8	21.6
ST	50.2	42.9	49.6	33.0	28.6	32.5
SC	48.3	49.7	48.6	29.6	32.8	30.3
Others	31.2	29.6	30.7	17.5	18.2	17.7
Socio-Religious Groups	**Net Change in HCR (Percentage Point) (1993-94 to 2009-10)**			**Rate of Change (Annual %) 1993-94 to 2009-10**		
	Rural	**Urban**	**Total**	**Rural**	**Urban**	**Total**
All	-15.0	-12.0	-14.3	-2.5	-2.3	-2.5
STs	-17.2	-14.3	-17.0	-2.1	-2.1	-2.1
SCs	-18.7	-16.9	-18.3	-2.4	-2.1	-2.4
Others	-13.7	-11.4	-13.0	-2.7	-2.4	-2.6

Source: Thorat, Sukhadeo and Amaresh Dubey (2012). 'Has Growth Been Socially Inclusive during 1993- 94/2009-10?' *Economic and Political Weekly*, March 10.

Changes in Urban Poverty

The urban poverty level was 20.8 per cent in 2009-10 which is only marginally lower than that in the rural sector discussed above (Table 1). During the 16 years between 1993-94 and 2009-10, urban poverty declined by around 2.3 per cent per annum – only marginally slower than that in the rural sector (2.5 per cent, Table 1).

The incidence of poverty in urban India was highest among the SCs in 2009-10, followed by STs and 'others'. It is the change in the incidence of poverty across social groups that presents an interesting picture (Table 1). Between 1993-94 and 2009-10 the rate of decline has been highest among 'others' at 2.4 per cent annually, while for SCs and STs it has been uniformly at 2.1 per cent.

Underweight Children

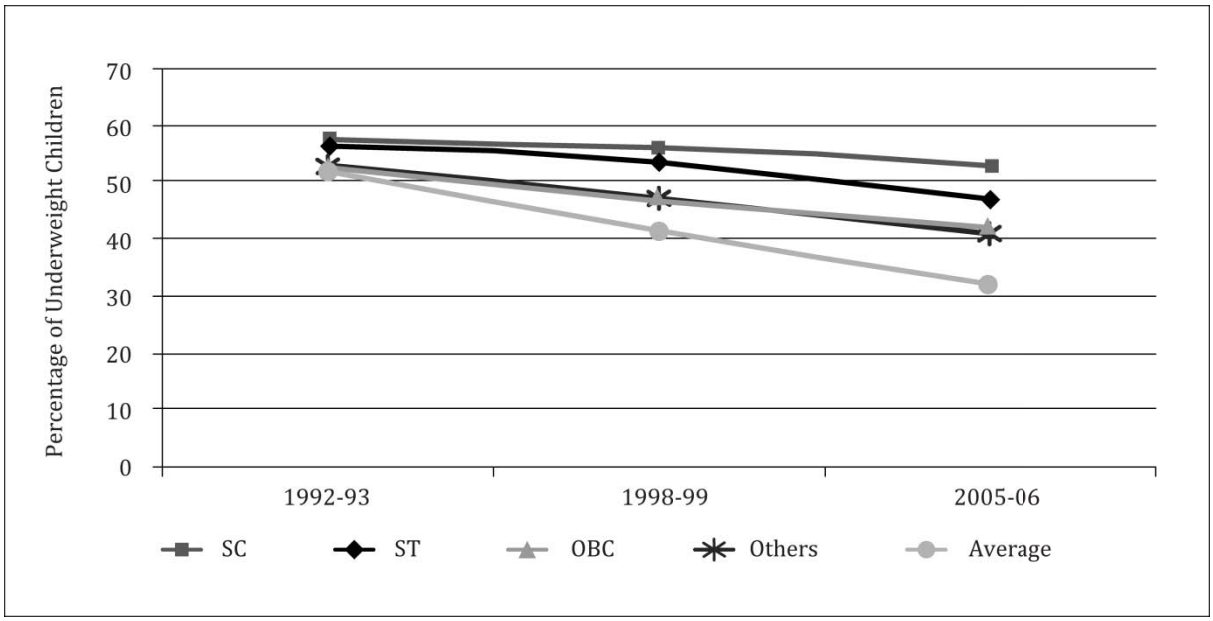
According to National Family Health Survey (NFHS), during 2005-06 (the latest years for which the data are available), nearly 45 per cent of India's children were underweight. The proportion of underweight children declined over the years, from 47.1 per cent in 1999-2000 to 45 per cent in 2004-05 at an annual rate of change of (-) 0.9 at the aggregate level.

Further, we also find that the percentage of underweight children varies across various social groups like SCs, STs, OBCs and 'others' which denotes higher castes or 'others' category.

Among children less than 5-years of age, 56 per cent in STs, 51 per cent in SCs, and 45 per cent in OBCs were underweight. For 'others' children (non-SCs/STs/OBCs), the prevalence was 36 per cent, still disturbingly high, but significantly better than rates among children in SCs, STs and OBCs (Figure 1).

Moreover, the decline of child malnutrition levels in SCs and ST over the three rounds of NFHS (1992 to 2006) has been slower than that is seen in the case of the GC category (Figure 1). The rate of decline in malnourishment was slower among children in SCs (0.9 per cent) and STs (0.8 per cent) compared to children from the 'others' category (2.3 per cent).

Figure 1: Malnutrition Levels by Social Groups: National Family Health Surveys (1992-93, 1998-99 and 2005-06)



Source: Thorat and Sabharwal: Addressing Unequal Burden of Malnutrition, India Health Beats and World Bank NFHS-1: 1992-93, NFHS-2: 1998-99 and NFHS-3: 2005-06.

Anaemia Rates among Children

Anaemia also negatively affects the weight of children, hence we also see the status of anaemic rates across social groups. The prevalence of anaemia among all caste categories was high: The proportion of underweight children under 5-years old was nearly 78 per cent in STs, 74 per cent in SCs, and 72 per cent in OBCs children compared to 67 per cent in the 'others' category.

Anaemia Rates amongst Adults

We also examine the prevalence of Chronic Energy Deficiency (CED) (Body Mass Index (BMI) <18.5 kg/m^2) among adult men and women across social groups. For adults, we find significant gender differences as well as social group differences. Around 41 per cent of women have CED compared to 38 per cent of men in rural India. The proportions of women suffering malnutrition with a BMI below 18.5 kg/m^2 is particularly high in STs (almost 49 per cent), SCs (45 per cent) and OBCs (40 per cent). This compares to 36 per cent of non-SC/ST/OBC women. Moreover, around 69 per cent of ST and 58 per cent of SC women suffered from anaemia, compared to only 51 per cent 'others' category (non-SC/ST/OBC) women. The trend is similar for men. Here, 43.3 per cent of those in STs, 42.3 per cent in SCs, and 38 per cent in OBCs suffer from CED, compared to 33 per cent of 'others' category (non-SC/ST/OBC) men.

To conclude, the incidence of poverty at the national level is 21.6 per cent (for the years 2009-10), and is higher in rural than urban India. Across the social groups, it is higher among SCs and STs compared to 'others' and the rate of decline in poverty has been faster among the non-excluded 'others' compared to the excluded SCs and STs. Similarly, the percentage of underweight children was at 45 per cent in India in 2004-05. The proportion of underweight children has declined over the years (1999-2000 to 2004-05) at an annual rate of 0.9 at the aggregate level in India. Further, we also find that the percentage of underweight children varies across various social groups, and is higher for SCs and STs compared to in OBCs and 'others'. Moreover, the decline in proportion of underweight SC and ST children has been slower than that is seen in the case of the 'others'.

Infant Mortality Rate (IMR)

At the national level in India, the infant mortality was 57 per 100,000 in 2005-06, a decline from 73 per 100,000 in 1999-2000. The annual rate of change was negative at 3.7 indicating a decline in IMR. Among the social groups, IMR was highest among SCs (66.4) followed by STs (62.1), OBCs (56.6) and 'others' (48.9). The IMR declined between 1999-2000 to 2004-05 across social groups, with the corresponding figures being for 1999-2000 being SC (-) 83, ST (-) 84.2, OBC (-) 76, and 'others' (-) 61.8. The annual rate of change was highest in STs at (-) 4.4, followed by OBCs (-4.3), 'others' (-3.5) and SCs (-3.3). The disparity ratio between SC and 'others' increased from 1.34 in 1999-2000 to 1.36 in 2005-06 although the disparity gap was negative at (-) 0.01 points indicating negative change.

Literacy Rate of 7-Years and Above

In 2009-10, at the aggregate level, 73 per cent of India's population were literate. The proportion of literate increased over the years (2004-05 to 2009-10), from 66.9 per cent to 73.2 per cent at an annual rate of 1.9 per cent at the aggregate level in India. Across social groups, the rate of increase was the highest among STs (3.8 per cent), followed by SCs (2.7 per cent), OBCs (2.1 per cent) and 'others' (1.0 per cent).

Literacy rates were lower among SCs and STs (65 per cent for both) compared to OBCs and 'others' (72 per cent and 82 per cent respectively).

Further, the proportions of school drop-out rates (measured as those leaving before the completion of five years schooling) are much higher among SCs and STs than in the general population. The drop-out rates in 2004-05 at primary levels for SCs was 34.2 per cent and for STs was 42.3 per cent, compared to a national average of 29 per cent (Table 2).

Table 2: Drop-Out Rates by Social Composition: 2004-05

Categories	Primary (I-V)			Elementary (I-VIII)		
	Boys	Girls	Total	Boys	Girls	Total
SCs	32.7	36.1	34.2	55.2	60.0	57.3
STs	42.6	42.0	42.3	65.0	67.1	65.9
All	31.8	25.4	29.0	50.5	51.3	50.8

Source: Selected Educational Statistics, 2004-05.

Full Immunisation

"The vaccination of children against six serious but preventable diseases (tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, and measles) has been a cornerstone of child healthcare system in India. As part of the National Health Policy, the National Immunisation Programme has been implemented on a priority basis. The Expanded Programme on Immunisation (EPI) was initiated by the Government of India in 1978 with the objective of reducing morbidity, mortality and disabilities from six diseases by making free vaccination services easily available to all eligible children. The Universal Programme of Immunisation (UPI) was introduced in 1985-86 with the objective to cover at least 85 per cent of all infants against the six vaccine-preventable diseases by 1990" (International Institute of Population Studies: NFHS-2 (1998-99): 203). According to the data collected in both the rounds NFHS-2 (1998-99) and NFHS-3 (2004-05), these targets have lagged behind in India at the overall level across social groups, with children from the SCs and STs fairing the worst.

At the national level, the percentage of children with full immunisation was 43.5 per cent in 2005-06, representing a slight increase from 42 per cent in 1999-2000. The annual rate of change did show positive signs and the percentage of children immunised increased annually by 0.6 per cent.

Among the social groups, children with full immunisation were the highest among 'others' (53.8 per cent), followed by those in OBCs (40.7 per cent), SCs (39.7 per cent) and STs (31.3 per cent) in 2005-06. Across social groups, the percentage of children with full immunisation increased from 1999-2000 when it was highest among 'others' at 46.8 per cent, followed by OBCs (43 per cent), SCs (40.2 per cent) and STs (26.3 per cent). The disparity gap between SCs and 'others' increased. It was 0.86 in 1999-2000 and 0.74 in 2005-06, indicating a lower achievement in full immunisation for the SC group. Thus, the disparity gap was 0.12 which indicates a negative change and lower improvement for the SC group as compared to others.

To sum up, in 2005-06 India recorded 57 (IMR). Mortality was also higher among SC and ST children, compared to children from other caste groups. The mortality rates for OBCs, though lower than in SCs and STs, were still high compared to 'others' castes. With respect to changes, mortality declined in all groups but at a slower rate for SCs and STs compared to OBCs and others. The percentage of children who had full immunisation was generally low in India, with SC and ST groups fairing worst than OBCs and 'others'. Between 1999-2000 and 2004-05, full immunisation rates grew by 0.6 per cent per annum. Across social groups, SCs showed lower progress compared to others. The disparity gap between SCs and 'others increased. It was 0.86 in 1999-2000 while it was 0.74 in 2005-06, indicating lower achievements towards full immunisation for the SC group.

Access to Safe Drinking Water and Sanitation

Proportion of Houses in Rural Areas without Drinking Water Facilities

At the national level in India, the proportion of houses in rural areas which lack drinking water facilities was 56.82 per cent in 2009. This level declined steadily between 1993 and 2009, from 73.25 per cent 65.57 per cent. The rate of change from 1993 to 2008-09 was (-) 1.60, indicating a positive change.

Among social groups, the proportion of houses in rural areas without drinking water facilities was found to be highest among STs (77.2 per cent), followed by those among SCs (67.8 per cent), and then 'others' (49.6 per cent). Across social groups, the proportion of houses in rural areas which lack drinking water facilities has declined gradually over the years, and was higher in 1993 at 84.6 per cent for STs, 77.8 per cent for SCs and 69.8 per cent for 'others'. The rate of change from 1993 to 2008-09 was (-) 0.58 for STs, (-) 0.87 for SCs, and (-) 2.15 for 'others'. This indicates a positive change as a proportion of houses in rural areas with no drinking water facilities has gone down over the years. However, the improvement has been slower for the SC and ST groups compared to others.

Proportion of Houses in Rural Areas having no Latrine Facility

At the national level in India, the proportion of houses in rural areas with no latrine facilities was 66.41 per cent, 2008-09. The figure gradually declined from 87.24 per cent in 1993 to 78.34 per cent in 2002. The rate of change from 1993 to 2008-09 was (-) 1.72, indicating a positive change.

Among social groups, the proportion of houses in rural areas without latrine facilities was highest among SCs (77.43 per cent), followed by STs (76.52 per cent) compared to 'others' (60.92) in 2008-09. Across social groups, the proportion of houses with no latrine facilities has declined since 1993, when it was 91.09 per cent for SCs, followed by 90.83 per cent for STs and 85.37 per cent for 'others'. The rate of change from 1993 to 2008-09 was (-) 1.08 for STs, (-) 1.03 for SCs, and (-) 2.12 for 'others'. This further indicates a positive change as the proportion of houses in rural areas without latrine facilities has gone down over the years.

3. MDGs: Positive Improvement for All, but at Lower Rate for Excluded Groups

Analysis of progress towards the MDGs from the 1990s to 2010 produces three specific findings. First, there has been an improvement in the MDGs for all, including those in the excluded groups of SCs and STs. Second, the rate of improvement in most (if not all) of the MDGs for SCs and STs has been lower compared to the 'rest' of the population, which also means that SCs and STs have benefited less than others. Third, since progress towards the MDGs for SCs and STs has been slower, disparities continue to persist between the SC/ST groups and the 'rest' of the population. This has been the feature in the past, as the reduction in social group disparities would require a higher rate of improvement among these two excluded groups than the 'rest' of population. Below we present a summary of these features.

Poverty

In rural areas between 1993 and 2010 poverty declined by 2.5 per cent per annum. However those in the 'others' category experienced the highest declines, followed by SCs and finally STs which experiences the lowest decline. In urban areas during the same period, poverty declined by 2.3 per cent per annum, again at a slightly at higher rate for the 'others' compared to SCs and STs.

Hunger (Underweight Children)

During the period 2004-05 the percentage of underweight children was 45 per cent, at the national level and the incidence was high among SCs and STs. Between 1999-2000 and 2004-05 the proportion of underweight children declined, although at a lower rate, but the rate of decline was lower for SCs and STs compared to 'others'.

Mortality

At the national level, IMR was higher for the children of SCs and STs compared to those from other castes. Mortality rates declined for all groups but at a slower rate among SCs and STs compared to OBCs and others. The percentage of children who had full immunisation was generally low in SCs and STs, which faired worse than OBCs and 'others'. Between 1999-2000 and 2004-05, full immunisation rates also increased at a lower rate for SCs leading to an increase in disparities between them and 'others'.

Literacy

Literacy rates were lower among the SCs and STs (65 per cent for both) compared to OBCs and 'others' (72 per cent and 82 per cent respectively). However educational drop-out rates, before completion of five years of schooling, are much higher in SCs and STs than in the general population.

Housing, Drinking Water and Sanitation

Access to safe drinking water increased between 1993-94 and 2008-09 at the national level and for social groups. However, it has improved at a lower rate for SCs and STs. In 2010, the proportion of houses in rural areas having no drinking water facility has been high among them. The availability of sanitation facilities has also improved, but with 66 per cent not having toilet in 2009-10, problems still persist. The SC and ST groups performed much worse than others. The improvement in access to toilets over the years is also slower for among SCs and STs.

4. Causes of Slow Progress towards MDGs among the Excluded Groups

While summarising the trends in the MDGs since the early 1990s, we pointed out that there has been an improvement in the indicators of human development for all including the excluded groups of SCs and STs, but the rate of improvement in their case has been lower compared to the 'rest' of the population. As a result the disparities between them and the rest of the population continued to persist.

We have also submitted that while there are common factors that caused low income and high poverty for all including the excluded groups, the channels of causation in the case of excluded groups is different which makes them more vulnerable to poverty and deprivation than their counterparts from the general population. Using logistic regression analysis for in 2005-06, Sabharwal (2011) captures the key factors impacting child malnutrition in rural areas. Income levels; educational attainment of the mother; access to antenatal care (as an indicator for access to health services), and social belonging have all emerged as important determinants of nutrition levels in this analysis (Table 3). In the case of SCs and STs, even after controlling for factors such as income, educational level of the mother, and access to health services, the malnutrition rates turn out be high indicating that there are constraints associated with their social belongings. The logistic regression exercise indicates that the likelihood of children in SCs and STs being malnourished is around 1.4 times higher than among children from the 'others' category. Hence, the logistic regression indirectly captures the influence of caste and ethnic background on the incidence of malnutrition and estimates the likelihood of children from these groups being malnourished compared to the rest, when the wealth index, education, access to health services and other factors are held constant.

Table 3: Logistic Regression Results of Factors Affecting Child Malnutrition

Explanatory variables	**Exp (B)**	
Wealth Index	Poorest	1.000
	Poorer	.856*
	Middle	.681*
	Richer	.538*
	Richest	.342*
Education of Mother	No education	1.000
	Primary	0.828*
	Secondary	0.799*
	Higher	0.463*
Mother's Antenatal care	No antenatal care	1.000
	Taken antenatal care	.669*
Social Group	Others	1.000
	SC	1.350*
	ST	1.418*
	OBC	1.218*
Religious Group	Others	1.000
	Hindu	1.092
	Muslims	1.065

Source: Computed from NFHS-3, Unit-Level Data.
Note: *denotes significant at 1% level; Exp (B) is the Odds ratio.

Similarly, an analysis by Borooah *et al.* (2012) on mortality in women among different social groups in India brings out two important features. It shows that the average age at death for Dalit women (39.5 years) is 14.6 years less than the average age at death for higher caste women (54.1 years). The analysis establishes that Dalit women's life expectancy is lower as a result of higher exposure to mortality-inducing factors. In the case of age at death, mortality-related factors such as poor sanitation and water supply had more impact on Dalit women than on higher caste women. However, even in cases where the higher caste and Dalit women experience similar mortality-related factors, Dalit women have lower life expectancies. Even after accounting for social status differences, a gap of 5.48 years remains between the average ages of death of higher caste women and Dalit women. Further, we applied the levels of mortality-related factors catalogued for higher caste women and found that there is still a gap between the life expectancy for higher caste women and Dalit women. A difference of 11.07 years remains even after attributing the Dalit social status coefficient to higher caste women. This means that life expectancy among Dalit women is 11 years lower than that of the higher caste women despite experiencing identical social status conditions like sanitation and drinking water.

Thus, the findings indicate that even after controlling for factors such as income, education level, access to health services, mortality and malnutrition rates turn out to be comparatively high among women and children from SCs and STs. The findings demonstrate that there are constraints associated with their social belongings. A lack of data means it is not possible to include such constraints in the regression equation. However, some field-based studies indicate group-specific factors for high malnutrition levels. These factors generally relate to the discrimination these communities face in accessing income earning assets, education and government schemes providing services like food and health. There is some evidence for the SCs. The SCs face discrimination in accessing food from the Public Distribution System (PDS) for food. The scheduled caste children also face discrimination in accessing mid-day meals in schools and state kindergarten centres (anganwadi centres), which adversely affects their food intake, and thereby their level of nutrition (Thorat and Lee 2005; Jansahas 2009), Indian Institute of Dalit Studies (2010, 2013) provide evidence on the discriminatory access faced by SC women and children to primary health services, leading to lower utilisation of the health services. Indeed, the NFHS data for 2005-06 reveals that SC mothers and children have relatively poorer access to public health services than others. For example, the immunisation rates for SC children are about 20 per cent lower than the others (Table 4). Access to health services at the time of delivery is also lower for SC mothers compared with others. Thus, discrimination resulting in limited access appears to be an additional pervasive factor contributing to lower levels of progress towards MDGs among SCs compared to others. The issue of discrimination-induced deprivation has been neglected in the literature, and more research is needed.

Table 4: Access to Health Services in Rural India: 2005-06

Access to Essential Health Services	SCs	STs	OBCs	Others
% of children vaccinated	39.7	31.3	40.7	53.8
% distribution of children 0-59 months covered by AWC by frequency of weighing	78.1	64.2	83.3	82.7
Place of delivery at home (%)	67.1	82.3	62.5	49.0
Assistance during delivery (%)				
From Dai (TBA)	*37.7*	*50.2*	*37.1*	*30.4*
By friends/relative	*20.7*	*23.0*	*15.5*	*11.3*
By skilled provider	*40.6*	*25.4*	*46.7*	*57.8*
Postnatal check-up: <4 hrs (%)	23.7	16.3	26.4	34.5

Source: Calculated from NFHS-3 (2005-06) data file.

In sum, lower levels of human development are directly affected not only by factors such as income levels, education, public health and other services, but also indirectly by discriminatory access to income opportunities and publicly supplied goods. Thus income level, education and access to public services in health and sanitation are important factors in reducing human poverty and increasing

levels of human development for all, including in the SCs and the STs. But in the case of the excluded groups additionally, affirmative action measures and safeguards against discriminatory access to education, public services, food security schemes and livelihood opportunities are necessary.

5. Policy Implications

The trend analysis of MDG progress in India between the 1990s and 2010 indicates that:

- There has been an improvement across the MDGs for all social groups, including for the most-excluded groups of Scheduled Castes (SCs) and Scheduled Tribes (STs). Poverty, which is an aggregate indicator of well-being, has declined in both rural and urban areas. Similarly, the incidence of underweight children, IMR, maternal mortality, literacy rates, and the proportion of those without housing, drinking water and sanitation facilities have also declined at the national level. To that extent, there was progress towards the MDGs in India between the early 1990s and 2010 (the latest years for which the data are available).
- However, the rate of improvement among SCs and STs has been lower than that in the 'others' category. The gains of development seem to have been shared unequally across groups. With isolated exceptions, the rate of improvement in SCs and STs has been lower compared to the rest of the population ('others'), which means that others have benefited more than the excluded groups. and
- The disparities between the SCs and STs and the rest of the population – which have been a feature in the past – continue to persist, since a reduction in disparities across social groups would require a relatively higher rate of improvement among the backward groups, which did not occur in this instance.

The approach by Indian policymakers to overcoming the problems suffered by SCs and STs includes two types of measures:

1. **Measures against discrimination,** including legal safeguards such as an anti-untouchability law; fair access policy in the form of reservation in *government-managed* institutions, such as politics, employment in *public sector* enterprises, education and other spheres; legal mandates for corporate spending on social welfare; affirmative action policies for the private sector focussed on the capacity enhancement and promotion.
2. **General measures** for economic and social empowerment, which are part of anti-poverty and other welfare programmes, including focused government interventions in food, nutrition, health and education.

These policies have brought about positive changes, but the gap in deprivation levels between SCs, STs and non-SC/STs remains wide. General economic and educational empowerment, although a necessary pre-condition for human development, is not enough. Like other economically and educationally backward sections from the non-excluded groups, the excluded groups require income earning opportunities, education and skill development to raise employability and improve access to capital assets. But unlike others, they face discrimination in economic and social spheres, and hence require affirmative action policies to ensure non-discriminatory access to market institutions and services supplied by non-market institutions engaged in the implementation of government programmes in food, nutrition, health and education. The discrimination faced by the excluded groups of SCs and STs is one of the reasons for slower improvement in the indicators of human development compared with their counterparts from non-excluded groups and the persistence disparities between them.

A reduction in disparities across social groups would require a relatively higher rate of improvement among the excluded groups through a combination of universal and targeted or affirmative action policies, and making non-discriminatory access a 'right'. Exceptions exist, such as Malaysia which has developed comprehensive affirmative action policy covering multiple economic spheres. For example, it has developed policies to enable the minorities to have greater shares of the capital in private companies. In other countries the affirmative action policy is

narrow and selective in nature and excludes many sectors where excluded groups face discrimination. The absence of broad-based affirmative action policies in multiple market and non-market transactions including a focus on non-discriminatory access to the excluded groups is an important missing element towards reducing inter-group inequalities. The absence of such complementary policies results in slower improvement in the human development indicators and persistent disparities between excluded and non-excluded groups.

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