



# Southern Voice

2015 On Post-MDG International Development Goals



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**IMPLEMENTATION OF SOCIAL  
PROTECTION PROGRAMMES IN INDIA**  
*Gaps and Challenges*

*Southern Voice Occasional Paper 40*

*Sanghmitra S Acharya*  
*Gobinda C Pal*

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# Preface

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*Southern Voice on Post-MDG International Development Goals* is a network of 49 think tanks from Africa, Asia and Latin America. Since its inception in 2012, it has served as an open platform to provide structured inputs from the global South into the negotiations on the post-2015 development agenda, with a view to addressing the 'knowledge asymmetry' and 'participation deficit' that usually afflict such global discussions.

After a substantial negotiation process, the *2030 Agenda for Sustainable Development* was finally adopted at the Seventieth Session of the UN General Assembly on 25 September 2015 by the member states. With the 17 new Sustainable Development Goals (SDGs) placed as oncoming development priorities, *Southern Voice* is currently working to examine national experiences in meeting the early challenges of delivering the 2030 Agenda.

The research programme titled *National Level Implication of Implementing SDGs* is based on call for proposals among its network members, and through a peer process, eleven country studies were commissioned for nine countries across Africa, Asia and Latin America. The broad areas of concern of the country papers are the following: (i) investigate the means of mainstreaming the SDGs into national planning process, within the context of its national priorities; (ii) explore the adequacy of coordination, management and leadership of the SDG implementation process, including the monitoring and evaluation mechanism; (iii) examine the adequacy of financing and other specific means of implementing the SDGs; (iv) investigate the extent of partnerships and stakeholder participation, including institutional arrangements for implementing the SDGs; and (v) evaluate the capacity of the national statistical agencies and other data-related issues.

This country paper on India titled **Implementation of Social Protection Programmes in India: Gaps and Challenges** is the seventh of the eleven country studies to be published under the Southern Voice Occasional Paper Series. The study has been authored by *Dr Sanghmitra S Acharya*, Director, Indian Institute of Dalit Studies (IIDS) and Professor, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi and *Dr Gobinda C Pal*, Associate Professor, Indian Institute of Dalit Studies (IIDS).

The study focuses on two social protection intervention, i.e. Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) and the National Rural Health Mission (NRHM) linked to the economic and social aspects of the SDGs in India. The findings of the study show that these programmes are facing three major challenges, in terms of strategy, engagement and evaluation. Thus, the study proposes to strengthen the means of implementations through increased partnership among stakeholders in planning, convergence and coordination of different interventions, diversify resources and share knowledge on the SDGs in this regard.

I would like to take this opportunity to recognise the support of The William and Flora Hewlett Foundation towards *Southern Voice*, particularly of *Dr Ruth Levine*, Programme Director and *Ms Sarah Lucas*, Programme Officer of the Global Development and Population Programme, at the Hewlett Foundation.

In connection to the publication of this paper, contribution of *Ms Umme Shefa Rezbana*, Senior Research Associate, Centre for Policy Dialogue (CPD) and the focal point at the Southern Voice Secretariat for overseeing the programme is highly appreciated. *Ms Tarannum Jinan*, Administrative Associate, CPD is acknowledged for

providing useful contribution in following-up of the country papers. *Ms Farah Nusrat*, Publication Associate, CPD provided assistance in processing of the publication. I would also like to thank *Mr Ben Hudson* for his editorial inputs and feedback.

Hoping that the paper will be a useful addition to the ongoing discussion on challenges of implementing SDGs in developing countries.

Dhaka, Bangladesh  
January 2017

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This country report is prepared under the Southern Voice research programme titled 'National Level Implications of Implementation of SDGs'. For the purposes of this study, the research team collected data from key stakeholders associated with two national social protection programmes. Many individuals contributed directly or indirectly towards the preparation of this report, so much so that it would not be possible to mention all by name here. However, we would like to acknowledge that this report would not have been possible without the support of Southern Voice at the Centre for Policy Dialogue (CPD) in Dhaka, Bangladesh. We would like to express our particular gratitude to Professor Debapriya Bhattacharya and Professor Mustafizur Rahman for providing the opportunity to undertake this research and also for providing guidance during the course of the project. Our special thanks also go to their colleagues at the Southern Voice Secretariat, Maeesa Ayesha, Shefa Rezbana, Tanzen Rahman and Uttam Kumar Paul, for their kind cooperation and support.

We are thankful to Professor Sonalde Desai for inviting us, on behalf of the Ministry of Rural Development, the United Nations Development Programme and the National Council of Applied Economic Research, to the discussion session held just prior to the release of two reports on MGNREGA. This session in fact enabled us to informally meet many social actors and policy makers associated with the social protection programmes, consequently broadening our thoughts and ideas. In addition, we would like to express our special thanks to the National Campaign for Dalit Human Rights (NCDHR) in New Delhi for inviting us to the one-day national conference on 'Discrimination and Exclusion in MGNREGS' in October 2015. This event gave us the opportunity to interact with representatives from grassroots level organisations from all over the country. While expressing our sincere appreciation to the many conference participants who shed light on MGNREGS implementation issues, we would like to specifically acknowledge the valuable input provided by Ramesh Nathan, Gopal K Iyer, Jagsir Singh, P L Mimroth, Laxmi Devi, G Mani, Rahul Singh and Kamal Chand Kispotta, with whom we were able to engage in comprehensive discussions on the issue of MGNREGS. Our special thanks also go to K B Saxena, the Chairperson to the Expert Committee on MGNREGS, for sharing with us his insights from the field.

We would also like to extend our thanks to Anand Kumar for sharing with us valuable case studies on the problems associated with the implementation of MGNREGS and health programmes, as well as CSO initiatives under the 'Poorest Areas Civil Society' (PACS) Programme in seven states. We also acknowledge those experts working on health-related topics whose knowledge and ideas have influenced this study. Some of these individuals are Ravi K Verma, Ravi Duggal, Amar Jesani, T Sundari Ravindran, Laxmi Lingam, Sayeed Unisa, V K Tiwari, Usha Ram, Suresh Sharma and Hemkothang Lhungdim. We would also like to express our gratitude to Sudama Devi (Jan Kalyan Samiti, Jaunpur), Dhurandhar Gautam, (Uday Sewa Kalyan Samiti, Mahrajanj), and Dharmbra Kumar (Need Trust Gorakhpur).

Lastly, we must emphasise our heartfelt appreciation to some of our colleagues, including Dr Chandrani Dutta, Dr Dilip Diwakar, and Dr Mala Mukherjee for their research support. Our special thanks go to Ms Ojasvini R Baral for providing data collection and research support. Thanks also to all IIDS staff for their dedicated support during this project.



In the context of the post-2015 development, every country is expected to work towards achieving the SDGs through various programmes. It is significant to understand the ‘means of implementation’ and ‘implementation gaps and challenges’ with regard to these programmes. This paper examines two social protection interventions in India linked to the economic and social pillars of the Sustainable Development Goals (SDGs), those of poverty alleviation through the Employment Guarantee Scheme and universal healthcare through selected programmes. The paper examines issues including the integration and mainstreaming of the programmes into the SDGs implementation process; coordination, management, leadership, stakeholders’ participation, accountability, monitoring and financing; and implementation-related gaps and challenges. Evidence suggests that the implementation of the programmes faces strategic-, engagement- and evaluation-related challenges. It remains a challenge to equitably meet the needs of different sections of population with common strategies. The lack of participatory planning, accountability and monitoring at local level remain critical. Evaluation challenges also exist in understanding the reality of implementation in a more evidence-based manner. The means of implementation, thus, need to be strengthened through increased partnership between stakeholders in planning, convergence and coordination of different interventions, diversification of resources, and greater sharing of knowledge on the SDGs.



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# Acronyms

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AABY	Aam Aadmi Bima Yojna
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CBHI	Central Bureau of Health Intelligence
CCT	Conditional Cash Transfer
CMR	Child Mortality Rate
CSO	Civil Society Organisation
CSSM	Child Survival and Safe Motherhood
DGHS	Directorate General of Health Services
DLHS	District Level Household Survey
GDP	Gross Domestic Product
GP	Gram Panchayat
GS	Gram Sabha
HMIS	Health Information Management System
IGNOAPS	Indira Gandhi National Old Age Pension Scheme
IMR	Infant Mortality Rate
JSY	Janaji Surakshya Yojna
MDG	Millennium Development Goal
MGNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme
MIS	Management Information System
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
MoRD	Ministry of Rural Development
MPCE	Monthly per Capita Expenditure
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
NSSO	National Sample Survey Office
OBC	Other Backward Classes
ORS	Oral Rehydration Salt
OWG	Open Working Group
PPP	Public-Private Partnership
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RGI	Registrar General of India
RSBY	Rashtriya Swasthya Bima Yojna
RTI	Reproductive Tract Infection
SC	Scheduled Caste
SDG	Sustainable Development Goal
SHG	Self-Help Group

SRS	Sample Registration System
ST	Scheduled Tribe
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
U5MR	Under-Five Mortality Rate
UN	United Nations
UNCSD	United Nations Conference on Sustainable Development
UNICEF	United Nations Children's Fund
USD	United States Dollar

# **Implementation of Social Protection Programmes in India**

## *Gaps and Challenges*

*Sanghmitra S Acharya*

*Gobinda C Pal*

### **1. Introduction**

#### **1.1 Background**

The 2000 United Nations (UN) Millennium Declaration outlined a commitment to a new global partnership that would set out a series of time-bound goals, known as the Millennium Development Goals (MDGs). The MDGs provided a focal point for UN Member States, a framework around which they could develop and evolve national development policies. However, the MDGs' focus on national and global averages resulted in the masking of much slower rates of progress in a number of specific indicators. Recognising these shortcomings experienced in the implementation of the MDGs, in 2012, the UN Conference on Sustainable Development (UNCSD) proposed the establishment of a process to develop a new set of so-called Sustainable Development Goals (SDGs), the core focus of which will emphasise the importance of national diversity for development. The UNCSD Outcome Document (2012) stated that, "the SDGs are expected to contribute to change through rights-based, equitable, inclusive and universal processes that enhance sustainability at the global, regional, national, and local levels." The Post-2015 Development Agenda highlights the need to build on the lessons learned from the MDG implementation process and advance the international development framework through the design, implementation and monitoring of the SDGs (Bhattacharya and Ali, 2014). In this connection, the Open Working Group (OWG), established in early 2013 by the UN General Assembly to elaborate a series of the SDGs, has identified the 'means of implementation' to be particularly important in achieving the SDGs.

India made notable progress towards achieving the MDGs. However, there remained many challenges in how development programmes worked towards achieving the MDG targets. It has been well recognised that certain 'implementation gaps' have hindered overall progress. In particular, the MDGs overlooked the way in which overlapping inequalities constrain the life chances of some excluded groups (Kabeer, 2010). Indeed, one of the missing elements in the MDGs was the strengthening of schemes that aim to increase access of the socially-excluded groups (Thorat, 2015). The Twelfth Five Year Plan (2012-17) of India calls for greater attention to be given to the issue of sustainability, and emphasises the need for the concerns of marginalised groups to be addressed in the development discourse. Considering the cross-cutting nature of many sustainable development challenges, the Twelfth Five Year Plan also envisions simultaneous achievement of the SDG goals. It states, "development must be guided by a vision of India moving forward in a way that would ensure a broad-based improvement in living standards of all sections of the society through a growth process which is faster than in the past, more inclusive, and also more environmentally sustainable" (Planning Commission, 2013). Further, a variety of economic and social development-oriented programmes and measures, which are aligned with the Twelfth Five Year Plan goals, have recently been revisited in order to accelerate the process of equitable and sustainable development.

#### **1.2 Focus of the Study**

The Indian Government is committed to sustainable development through greater investment in social protection programmes. Success in such programmes is key to achieving the SDGs. Of the large

number of development indicators contained within the SDG framework, the eradication of poverty is key as an underpinning goal. Great emphasis has also been placed on healthy living as crucial for overall well-being.

This study focuses on two social protection interventions linked to the economic and social aspects of the SDGs. These include the poverty alleviation intervention through the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) and the universal health intervention through the National Rural Health Mission (NRHM). The MGNREGS provides a social safety net for poor rural households through the provision of secured employment, and simultaneously transforming rural livelihoods through the creation of productivity-enhancing infrastructure. The NRHM covers a wide range of essential quality healthcare services with the goal of ensuring healthy lives and promoting well-being. When these two interventions are considered in the light of the SDG framework, critical questions arise that this study aims to address. Such questions include:

- How are these social protection programmes working towards the SDG objectives?
- To what extent are the programmes universal in nature?
- What are the common implementation gaps? and
- What should be the implementation priorities for the development agenda?

### ***1.3 Objectives of the Study***

The specific research objectives of this study are to:

- Examine the integration and mainstreaming of the national social protection programmes into the implementation of the SDGs at the national level;
- Understand the implementation of the social protection programmes, with a particular focus on coordination, management, leadership, monitoring and accountability;
- Evaluate financing and other means of implementation;
- Examine the participation of multi-stakeholders and institutional arrangements;
- Identify data-related challenges and capacity of national statistical agencies; and
- Reveal possible implementation gaps and SDG challenges.

### ***1.4 Methodology***

In order to understand development processes and their implementations, both quantitative data and qualitative insights are crucial. As such, this study will consider the latest official data sources available on the status of the two national social protection programmes as well as current literature based on empirical and evaluative research. In addition, experiential accounts by various stakeholders involved in the implementation and monitoring of the two social protection programmes will be considered. Given that the sustainable development actions are guided by local considerations, and that it is at the grassroots level where implementation challenges are most fully experienced, insights from members of civil society organisations (CSOs) will be particularly drawn upon. Information will be collected from different sources so as to allow for triangulation. This information will ultimately be used to better understand the extent to which the Indian Government has fulfilled its programmatic responsibilities, and identify implementation gaps and challenges relevant to achieving national targets in the context of the SDGs.

### ***1.5 Report Structure***

The report is structured into two main parts. Implementation of the MGNREGS scheme will be considered first; then implementation of the NRHM programme and other healthcare service provisions will be focused. Within each of these sections, the content will be structured broadly around the specific research objectives as outlined above. The findings of these two parts will then be brought together in a set of concluding remarks and policy recommendations.

## 2. Implementation of the Employment Guarantee Programme and the SDGs

### 2.1 Integration and Mainstreaming of the SDGs in the National Context

In 2006, the Indian Government implemented the MGNREGS as a social safety net programme for the vulnerable sections of the society, with the ultimate goal of providing livelihood support and eradicating poverty. By 2008-09, all districts in India were brought under the programme. The MGNREGS is the largest employment guarantee programme in the world. It works towards the achievement of two national constitutional provisions, those of the “right to an adequate means of livelihood” (Article 39) and the “right to work” (Article 41). Unlike many other social protection schemes, the MGNREGS introduces a rights-based framework that provides a legal guarantee and mandate, with time-bound actions aimed at fulfilling the employment guarantee at a stipulated minimum wage. It also incorporates several other entitlements, such as an employment allowance, work site facilities, social audit, etc. Beneficiaries of the programme have the right to take legal action against the violation of any of their entitlements. If the Indian State is unable to provide work, it has a liability to pay unemployment allowances. Moreover, under the MGNREGS, every individual, willing to work, is to be provided with a minimum wage as prescribed under the Minimum Wages Act for agricultural labourers in the State. As per the rules, the MGNREGS provides short-term public employment to unskilled workers from poor households when they suffer from an absence of employment opportunities, thereby preventing poverty levels to get worsened. Specifically, it strengthens social security for the rural poor by guaranteeing 100 days of wage employment to adults in a rural household who volunteer to undertake unskilled, manual work.

The MGNREGS has several social implications. It is not just an employment guarantee scheme, rather a tool for economic and social change in rural areas that realises sustainable livelihoods. It provides a legal guarantee of wage employment, and ensures equal work and equal pay for men and women for manual work. Emphasis on building productivity-enhancing infrastructure in rural areas intends to facilitate sustainable development. The Twelfth Five Year Plan recognises that the MGNREGS takes a holistic approach to achieving inclusive growth in rural areas by offering social protection alongside livelihood security.

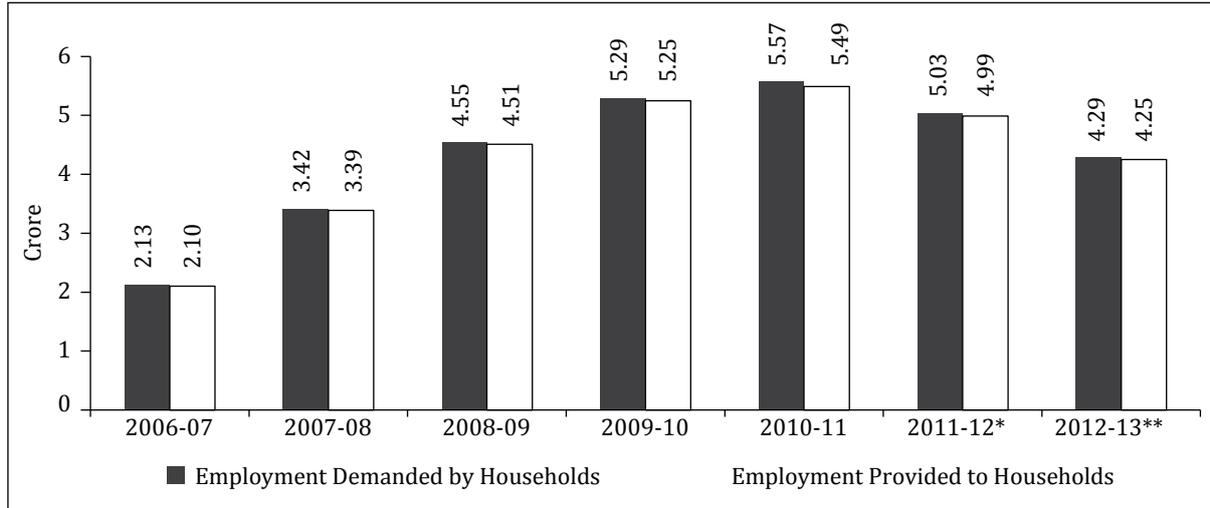
How does the MGNREGS promote and advance livelihood security? Data provided by the Ministry of Rural Development (MoRD) indicates that, in 2013-14, 65 per cent of total expenditure and 65 per cent of employment generated under the MGNREGS has targeted 330 of the country’s most vulnerable areas. Data provided by the 68th National Sample Survey office (NSSO) (2011-12) on the MGNREGS indicate that 38 per cent of rural households possessed job cards, with an average of 120 job cards per 100 households. However, concerns remain regarding discrepancies between the level of demand for employment and actual employment provided (see Figure 1).

Data also indicate that the provision of 100 days of wage employment, to all those rural households, has not been fulfilled. In fact, the number of households that have completed 100 days of employment has decreased considerably over recent years (see Figure 2).

There has also been a sharp decline in the total number of days of work per person generated under the MGNREGS, falling from 230 crore days of work per person in 2012-13 to 220 crore in 2013-14, and then 132 crore in 2014-15. In addition, the average number of days of work per person provided to each household has been low. In contrast to the supposedly guaranteed 100 days of unskilled waged employment, the annual average between 2006-07 and 2014-15 has been around 45 days of work per person per household (see Figure 3).

As are all know, the SDGs pledge to ‘leave no one behind’. In accordance with this motto, the MGNREGS aims to aid the development of particularly socially vulnerable communities. However, there has, in

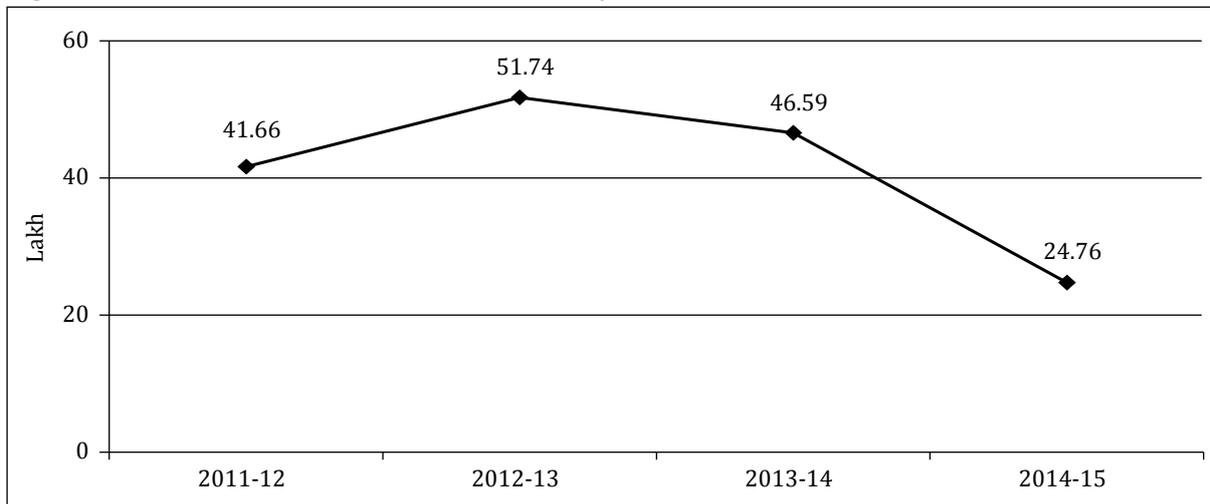
**Figure 1: Employment Demand and Provision**



Source: MoRD (2012-13).

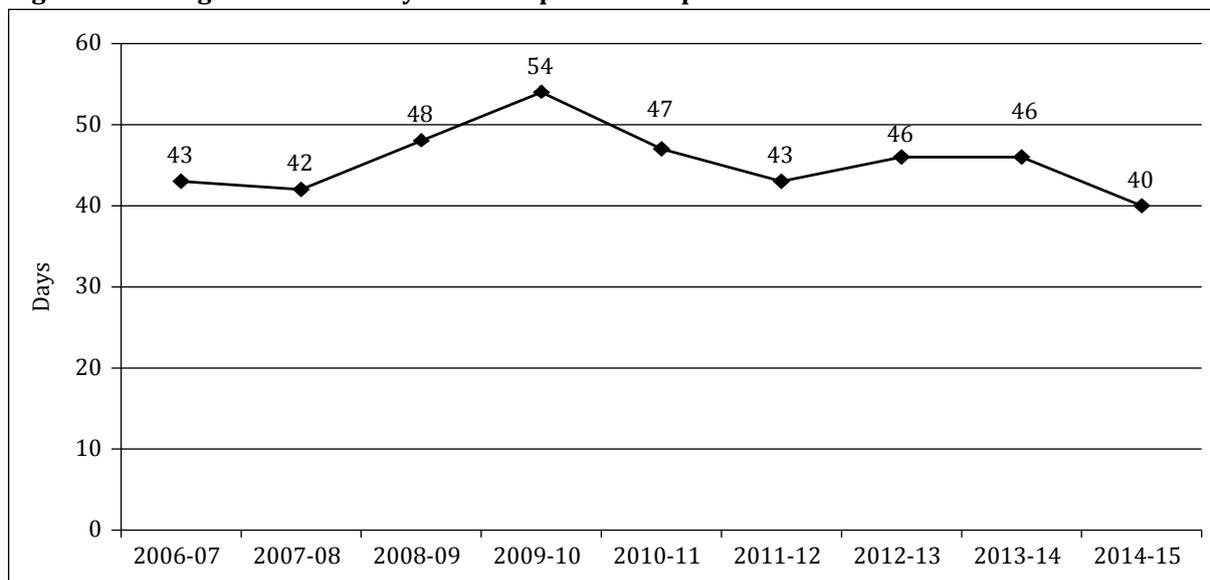
Note: \* Provisional; \*\* as of 31 January 2013.

**Figure 2: Total Number of Households at 100 Day Work Limit**



Source: UNDP (2015).

**Figure 3: Average Number of Days of Work per Person per Household**



Source: MoRD (2012-13); The Indian Express (2015a).

**Table 1: MGNREGS Performance as regards Work Days per Person by Group**

Year	Schedule Castes (Crore)	Scheduled Tribes (Crore)	Persons with Disabilities (Number)
2008-09	63.35	55.01	204,772
2009-10	86.44	58.74	297,215
2010-11	78.75	53.61	294,490
2011-12	48.47	40.91	395,200
2012-13	51.21	41.00	455,307
2013-14	50.09	38.39	484,264
2014-15	37.06	28.20	410,692

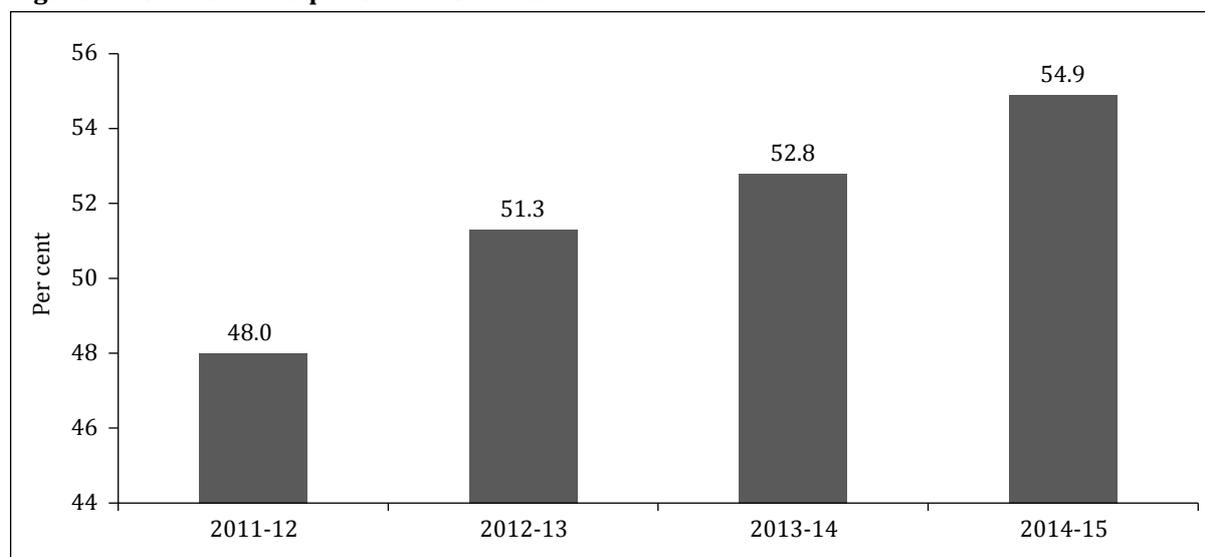
Sources: UNDP (2015) [for the year from 2011-12 to 2014-15]; MoRD (2012-13) [for the year from 2008-09 to 2010-11].

fact, been a significant decline in the total number of days of work per person among marginalised groups, such as the scheduled castes (SCs) and scheduled tribes (STs) (see Table 1).

According to Chandrashekar and Ghosh (2014), in the case of SC workers, the share of work days increased from 25 per cent in 2006-07 to 31 per cent in 2010-11, but has since fallen to only 22 per cent in both 2011-12 and 2012-13. In the case of ST workers, the share of work days has steadily decreased from 36 per cent to 17 per cent. However, performance, in terms of work days for persons with disabilities, has experienced an increasing trend in general. Nevertheless, it is clear that a large portion of the socially most vulnerable communities remains excluded to a significant extent from the MGNREGS.

Unlike SC and ST participation, there has been increased participation of women in the MGNREGS (see Figure 4). Since 2012-13, more than half of women participated in the programme, which is much higher than the statutory minimum level of one-third of beneficiaries. The programme has therefore been successful in providing more work opportunities to women.

Notwithstanding the total overall low participation in the MGNREGS, there is significant evidence to suggest that the programme has helped not only the poor, but also the entire rural community as a whole. An increased female participation rate contributes to an improvement in household economy, and has helped women to participate in the planning of household matters. The programme has also helped to narrow the wage gap between rates for male and female workers (Shah and Makwana,

**Figure 4: Female Participation in MGNREGS**

Source: The Indian Express (2015a).

2011). Further, it has also had implications for the health and education of children (Desai, Vashistha, and Joshi, 2015), thereby reducing levels of child labour (Islam and Sivasankaran, 2014).

Recent literature on the impact of the MGNREGS has shown how the programme has enabled poor households to improve their livelihoods. In this regard, there has been two crucial outcomes: firstly, poverty levels have reduced by 32 per cent at the aggregate level; and secondly, informal borrowing has also reduced (Desai, Vashistha and Joshi, 2015). This has also had a positive impact on households' potential for savings (Ravi and Engler, 2014), and the availability of an alternative form of employment has also helped to reduce short-term migration (Imbert and Papp, 2011; Shah and Makwana, 2011). Poor, unskilled labourers with low levels of education, and households that are either landless or have only very small farms, have also been benefitted hugely from the programme (Desai, Vashistha and Joshi, 2015; Narayanan *et al.*, 2014), as well as those who have a very low asset base and fewer life opportunities (Joshi *et al.*, 2015). The extension of the MGNREGS to private farms has also increased the farm income of small and medium farmers (Mohanakumar, 2015; Ranaware *et al.*, 2015).

The MGNREGS has also had a number of positive environmental impacts. MGNREGS initiatives have resulted in sustained or improved groundwater levels, water availability for irrigation, irrigated area, cropping intensity, and improved availability of drinking water (Esteaves *et al.*, 2013). Individuals, working on their own lands under the programme, have significantly improved the quality of those lands, which has further generated extra income through creating alternative sources of livelihood for those households (Sambodhi, 2012-13). One of the most important outcomes under the MGNREGS has been the creation of sustainable assets, such as wells, and their importance in improving agricultural productivity, increasing incomes and bettering livelihoods (Aggarwal, Gupta and Kumar, 2012; Bhaskar and Yadav, 2015). As such, it can be concluded that the MGNREGS, as a rural development programme, has contributed to sustainable economic gains and the reduction of poverty.

## **2.2 Implementation Process: Coordination, Management, Leadership, Monitoring and Accountability**

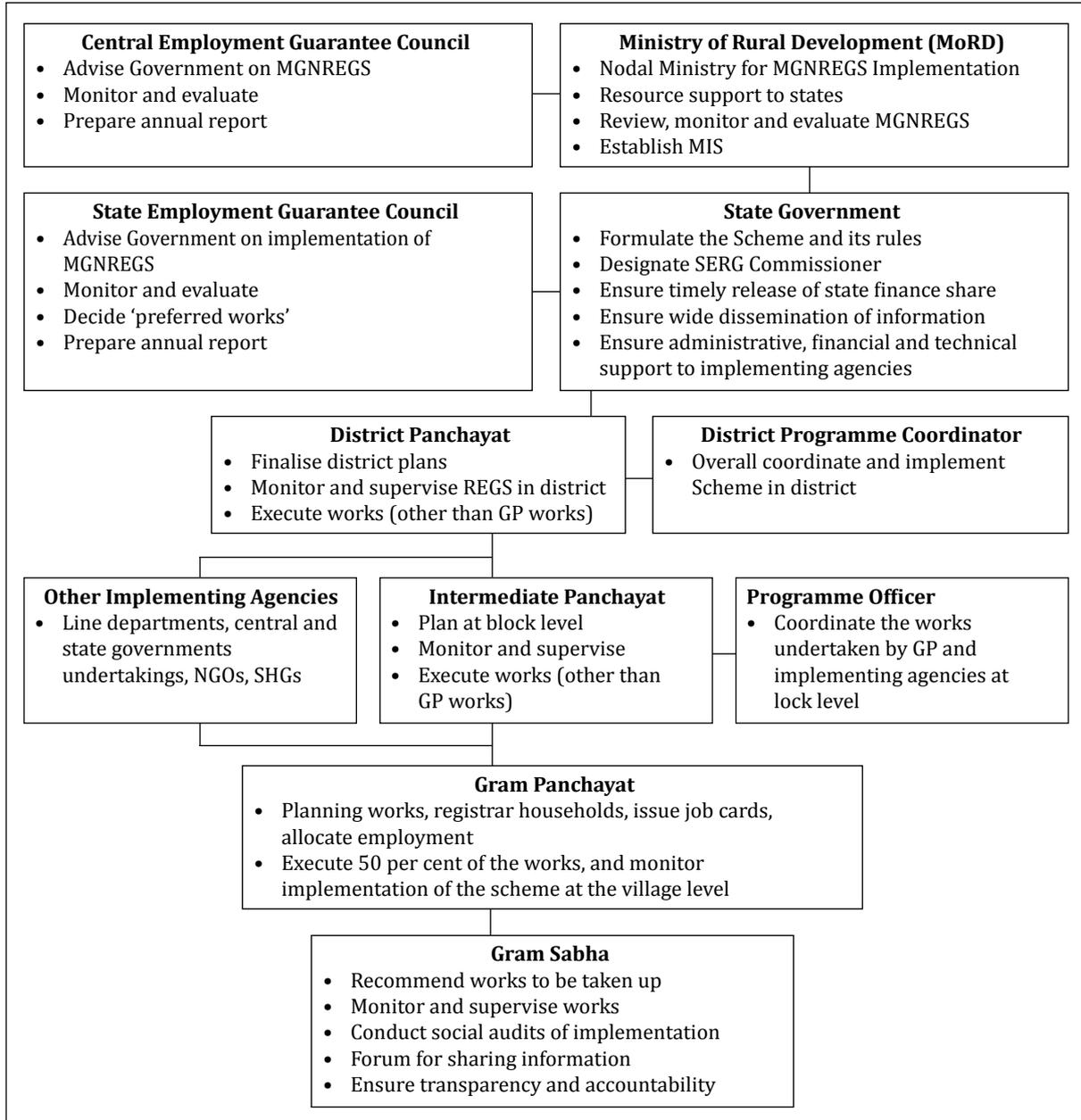
The MGNREGS, as a national flagship programme, is executed under the authority of the MoRD. However, it is implemented by the state governments. *Panchayat raj institutions* (PRIs) (local governing bodies) play a pivotal role in the planning of undertaken projects and overseeing the implementation through district planning committees constituted by the Ministry of Panchayat Raj. On occasion, an integrated development approach has been followed whereby the MGNREGS is implemented through convergence with other programmes that have the specific objective of enhancing security of rural livelihood. Normally, there is convergence of the MGNREGS with programmes on agriculture and water resources. The Department of Rural Development therefore has to forge linkages with departments concerned with agriculture and water resources during implementation. The MoRD also coordinates with the Ministry of Environment and Forest whenever local officials face difficulties in undertaking works in forest areas. Further, the MoRD, in association with the Ministry of Tribal Affairs, implements the Forest Right Act in order to address the indifference of officials as regards the productive utilisation of land occupied by tribal people.

The MGNREGS has a decentralised implementation structure (Diagram 1). The PRIs, such as the *gram panchayat* (GP)<sup>1</sup>, are involved in the planning and monitoring of the scheme, which includes responsibilities for registration, the issuing of job cards to beneficiaries, and allocating employment. For the purposes of the MGNREGS, individual demand emanates through the *gram sabha* (GS).<sup>2</sup> Adult members of a rural household apply for work via the GS, which then recommends the individual to the GP. Each employment seeker is registered by the GP and the household is issued a job card. Once in possession of a job card, a household may then submit an application for employment. As a rule,

<sup>1</sup>*Gram panchayat* is the primary unit of the three-tier structure of local self-governance in rural India, the *Panchayat raj* system. Each GP consists of one or more villages.

<sup>2</sup>A *gram sabha* is a body of all persons entered as electors in the electoral roll for a GP. All the meetings of the GS are convened by the GP.

**Diagram 1: Organisational Structure: Implementation of MGNREGS**



Source: Natesan and Marathe (2014, p.353).

Note: MIS: Management information system; NGO: Non-government organisation; SHG: Self-help group.

the GP has to guarantee work within 15 days of application. The programme officer at the block level then coordinates implementation processes, ensuring that employment-seekers receive their due entitlements.

A panel of national level monitors, deployed by the MoRD, is involved in monitoring so as to ensure effective implementation of development programmes. The monitors are involved in ‘regular monitoring’ through periodic visits to districts, and ‘special monitoring’ of individual programmes, as well as monitoring serious enquiries and complaints on the implementation of the programmes. In addition, at the local level, the GS is required to conduct regular social audits (at least once every six months) of all the MGNREGS initiatives undertaken within the GP. Social audits are independent of any process undertaken by the scheme’s implementing agency. A social audit unit is established by the state government for the purposes of GS capacity-building as regards conducting social audits. The social audit unit identifies suitable persons at village, block, district and state levels, drawing

from key stakeholders and other CSOs. The state government also includes the Ombudsperson's office in each district, which receives complaints from the MGNREGS workers and others on any matter related to the scheme, and facilitates the resolution of such complaints in accordance with the law. State governments also determine the appropriate grievance redressal mechanism at the block and district levels for dealing with any complaint by any person in respect of MGNREGS implementation.

A critical factor built into the MGNREGS framework is that of accountability of the public delivery system. An annual report on the outcomes of the programme is presented by the central government to Parliament, and by the state government to the Legislature. The constitution of Vigilance and Monitoring Committees at the state and district levels oversees the implementation of the rural development programmes, and ensures transparency and accountability during MGNREGS implementation.

As regards leadership of MGNREGS implementation, the MoRD is the primary ministry, with state governments taking major responsibility in planning and implementation. The MoRD annually acknowledges the leadership shown by state governments, recognising excellent administration and outstanding contribution. It awards the 'National Award for Leadership' to a state government for new productivity-enhancing innovations in implementing the MGNREGS. However, despite the importance of these institutions, the GP undertakes the most crucial function of planning and implementing the MGNREGS at the local level. 'Needs analyses' are also conducted by the GP in partnership with the GS. The latter also exercises control in the work selection process. The programme officer at the block level coordinates and monitors overall initiatives and consolidates development activities annually, submitting these to the district panchayat. As such, leadership in practice rests at different levels of governance, including the state, district, block and panchayat levels – this is a critical feature for the successful implementation of the programme.

### ***2.3 Financing and Other Means of Implementation***

India, currently, has only 5 per cent of the funds required to implement the SDGs (The Hindu, 2015). Moreover, Rs. 15,000-20,000 crore is estimated to be required for implementing the SDGs, if raised from corporate social responsibility (CSR) funds. Data indicates that social security programmes for the poor in India are not being implemented on the ground because of lack of government funds. The cost of the MGNREGS is presently shared between the central and state levels at the ratio of 90:10. Data shows that while the total available funds for the MGNREGS increased during 2009-10 and 2010-11, this declined in later years. In 2014, despite an estimated requirement of Rs. 66,000 crore, the budget allocation for the MGNREGS was only Rs. 34,000 crore. In 2015, it increased slightly to Rs. 34,699 crore. Despite government's commitment to continuous support to the MGNREGS, it is widely recognised that the recently declining budgetary allocation for the programme is a major deterrent for its effective implementation. Minutes from an MoRD internal review of the programme states that, "states expressed their inability to continue the uninterrupted implementation of the MGNREGS, given the situation of an overall fund shortage" (The Indian Express, 2014). In the recent national budget, the permissible administrative expenditure limit has been increased in order to strengthen the management and administrative support-structures for the purposes of maintaining data that enables more rapid monitoring of MGNREGS implementation.

### ***2.4 Stakeholder Participation in Planning and Implementation***

In accordance with the MGNREGS rules, state governments are mandated to take steps to organise workers into formal groups, either through its own machinery or through coordination with CSOs, so as to improve their participation in implementation. PRI representatives and self-help groups (SHGs) are also expected to facilitate the participation of eligible beneficiaries. However, the selection of schemes appears to have been completely determined by block-level officials. Further, decision making processes at the village level have also been bureaucracy-driven. Although the panchayat is

constitutionally empowered, elected representatives at the GP and the GS act as officials expect them to do. The GS therefore maintains but a façade of formalised participation. Despite the fact that the MGNREGS is a demand-driven programme, meaning that people in villages should have a significant say in its schemes, public participation in implementation has been limited. As such, despite a decentralised implementation structure, the programme lacks participatory planning, with the entire process remaining 'top-down'.

Although there has been an increase in female participation in the MGNREGS, in many cases, such participation has been a result of poor implementation coupled with social compulsions. Indeed, female participation has increased in the absence of demand for work from male members due to a decrease in the number of work days, a lack of regular work, and lower wages (Chandrashekhar and Ghosh, 2014). Further, there has been no increase in the participation of women in the GS so as to plan specific schemes that would be of benefit to them. As such, those women, who do participate in the MGNREGS, do not get benefitted from this as an instrument of empowerment (Sexnea, 2015). In addition, the participation of socially-vulnerable communities, such as SCs and STs, has also declined despite the MGNREGS programme being highly relevant to them.

### ***2.5 Data-related Challenges and the Capacity of National Agencies***

There exists a specific MGNREGS portal that aims to promote transparency, facilitate monitoring, and ensure accountability in the overall implementation process. It is a requirement that the progress of all initiatives related to the programme is updated so that these details can then be sent to the MGNREGS directorate on a regular basis. The extensive data generated by the panchayat management information system (MIS) has provided useful evidence to identify fault-lines or bottlenecks in implementation and make timely corrective interventions. However, as a result of lack of coordination among various officials at the block and panchayat levels, the flow of record-keeping and information is not properly managed. The MGNREGS portal is an important source of data on beneficiaries, of access to basic entitlement, and of other implementation details. So, anomalies in record-keeping at the field level sometimes misleads planning at the national level. This, therefore, calls for improved technical supervision in implementing the programme, as well as regular monitoring of the quality of record maintenance. It also underlines the need for capacity-building on how to make use of MIS data to improve the performance of the programme. Social audits have also been an important tool in ensuring accountability of implementing officials and increasing understanding of the anomalies and possible actions.

It is notable that there are a number of different data sources, such as the MoRD, the NSSO, census, and CSO social audits, all of which provide information on the MGNREGS. However, there are discrepancies between the 'big data' provided by the MoRD and household survey data collected through other agencies. While datasets from a diverse range of sources do provide information on different dimensions of the programme, it is difficult to assess the actual progress made and to perceive the impact of the programme. Moreover, the data sources do not provide much in the way of disaggregated data to assist in micro-level planning.

### ***2.6 The MGNREGS and the SDGs: Implementation Gaps and Challenges***

Although there is substantial evidence which shows that the MGNREGS is having a positive impact on the condition of rural livelihood, current monitoring at grassroots level does indicate several problem areas as regards implementation. The 42nd Standing Committee on Rural Development (MoRD, 2012-13), while highlighting several achievements of the MGNREGS in ensuring livelihood development for people in rural areas and facilitating sustainable development, identified several implementation challenges. These challenges included the fabrication of job cards, delays in wage payments, a significant amount of incomplete work, non-payment of unemployment allowances, poor quality of assets created, lack of PRI involvement, and other institutional failures.

In concurrence with these observations, consultations with several stakeholders working at the grassroots level indicate violations of various provisions prescribed under the programme. In addition to issues with the scale of work generated and the participation of certain stakeholder groups, other important implementation gaps and challenges were identified related to planning processes, coordination and management, accountability, transparency, monitoring, the MIS, and the financing and quality of assets created in realising sustainable livelihoods. One significant weakness in the design of the programme is that it does not grant due importance to long-term goals, meaning it lacks direction. This has consequences for planning. There is no mention of how to plan for initiatives to be undertaken in a multilevel framework, or how to bring about the convergence between the MGNREGS and other ongoing rural development programmes, or how to ensure the durability of assets. Therefore, without a strong planning component, there is a tendency to take up work that lacks strong linkages with the local economy.

The MGNREGS ensures a legal guarantee of work in a time-bound manner at a stipulated minimum wage. The administration, therefore, has specific accountability. However, much complexity exists in the course of implementation. As the programme is demand-driven, it does not have any fixed targets, plus demand may increase at any time. The administration is therefore always challenged by the needs of its beneficiaries. As a result, administration tends to go slowly to avoid any legal problem.

As mentioned above, the panchayat is assigned with the most crucial function of MGNREGS planning and implementation, with the aim of ensuring that people's needs are adequately addressed. However, in many states, GP heads do not carry out their duties in accordance with the wishes of the people, meaning that participatory planning is largely absent. As a result, initiatives do not sufficiently respond to the needs of the specific village context. This deficit in planning fails to realise efficiency in expenditure, effectiveness of area development, or optimum utilisation of available resources. The failure of the panchayat, to spend the budgeted amount, clearly demonstrates the indifference and insensitivity of officials.

Planning for 100 days' work throughout the year is the most critical aspect of programme implementation that is currently missing. Further, the level of demand and the availability of work often do not match. As a result, those who seek work under the programme, are not always given work; for instance, the poor are less likely to participate in the MGNREGS as work is not easily available when needed (Desai, Vashishta and Joshi, 2015; Himanshu, Mukhopadhyay and Sharan, 2015). Moreover, in many cases, the poor do not seek work as they do not receive their wages on time. As a result of this widespread resentment, others are then discouraged. 'Work-rationing' also occurs (Das, 2015; Dutta *et al.*, 2012; Liu and Barret, 2013), which may prevent many from receiving the full 100 days' work, and in many cases, late approval of work means that 100 days' work cannot in fact be provided.

Due to a lack of regular monitoring by district-level officials, there are instances of, *inter alia*, fake job cards, fictitious names, and non-existence of assigned work. The district-level administration also has limited coordination with grassroots-level organisations and other elected bodies involved in regular monitoring, meaning it can provide only minimal feedback on various aspects of the programme. Grievance redressal mechanisms do not exist in most cases, and in those states where they have existed, this has been at the district level rather than the village level. Further, social audits have not been particularly prolific.

Equity in the implementation of the MGNREGS is another important issue. There has been a large-scale omission of excluded communities, such as SCs and STs. There is considerable discrimination based on caste in the implementation of the programme, meaning that inequities can be seen in the distribution of works, allocation of resources, generation of employment, number of days' work, level of expenditure, and so on.<sup>3</sup> In many cases, panchayats are largely represented by the dominant caste

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<sup>3</sup>The keynote address of K B Sexena at the National Conference on Discrimination and Exclusion in MGNREGS, held on 7 October 2015, in Chandigarh. K B Sexena was the Chairperson of the Expert Committee, a body constituted by the Government of India for three years to nominate the best performing districts for the national-level award based on visits to districts for verification.

groups despite a one-third reservation for SC and ST representation in local governance. Under the MGNREGS rules, there is a specific provision for funding to develop assets of these excluded groups. However, any benefit from this provision in reality is minimal. Further, these excluded groups have been unable to raise their voices against the problems they face in accessing their MGNREGS entitlements.<sup>4</sup>

Notwithstanding the greater level of female participation, women do face challenges that can prevent their full participation. Besides a lower wage rate and delay in wage payments, there are lack of gender-sensitive provisions, for instance the non-availability of proper childcare facilities, a lack of sanitation and safe drinking water, and a lack of appropriate first aid (Chandrashekhar and Ghosh, 2014; Holmes, Sabharwal and Rath, 2011). These conditions make workplaces unfriendly to women and can hinder their full participation. Another issue related to gender equity is the type of work women are engaged in. There are cases of gendered labour divisions, wherein 'soft work' is allocated to women (Holmes, Sabharwal and Rath 2011). This kind of practice leads to fewer days' employment and wages based on male productivity norms and preference. As Dutta *et al.*, (2012) argues, the programme's design has not been uniformly inclusive of women and their needs.

A final issue related to planning and implementation is the massive underutilisation of funds, especially in districts with a larger population of poor/SC/ST individuals. On average, approximately 24 per cent of the total available funds for work remained unspent during the period from 2006-07 to 2011-12 (MoRD, 2012-13). There has also been large-scale pilfering of programme funds at the state level, which has implications for the level of work completed. Acknowledging the problems associated with the unnecessary holding back of funds and the complaints regarding wage payment delays, the Government of India recently decided to release wages directly to workers using a fund transfer order to be generated by the state's implementing agencies (The Indian Express, 2015b). This decision is essentially aimed at empowering state governments and grassroots implementation agencies to deliver entitlements in accordance with the objectives of the programme.

### **3. Health Planning and the SDGs**

India's commitment to health and development began in 1946 with the Bhole Committee's guidelines and recommendations. The 1978 Alma Ata Declaration was especially geared towards maternal and child health. Major health activities shifted from family planning to overall family welfare, with a separate ministry being set up for this purpose. The main objective was to increase rates of child survival and ensure safe motherhood, as with the Child Survival and Safe Motherhood (CSSM) Programme, which was joint-funded by the World Bank and the United Nations Children's Fund (UNICEF), and implemented from 1992-93 to 1997-98. This programme was then boosted through its inclusion in the Reproductive and Child Health (RCH) Programme in 1997-98, integrating it with other RCH services (Nayar, 2011; Paul *et al.*, 2011). In addition, a new component for the management of reproductive tract infections (RTIs) and sexually transmitted infections (STIs) was also incorporated. The RCH programme, which was partially funded by a number of international donor agencies, is especially concerned with the needs of underserved areas and the poor, coupled with improving implementation capacity (MoHFW, 2013).

#### ***3.1 Integration and Mainstreaming of the SDGs in National Health Planning***

In India, the MDGs shaped national health policy and the RCH programme and then the NRHM. The MDGs continue to influence health today, as well as themselves being influenced by health needs. However, the eight MDGs did not consider the root causes of poverty and inequality, especially in the sphere of health. Indeed, the goals were bereft of human rights and ways to address economic development. As the MDG implementation period came to an end, women found themselves continuing

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<sup>4</sup>According to Jai Singh, an SC union leader in a state who shared his experiences at the National Conference on Discrimination and Exclusion in MGNREGS.

to have to fight hard for their rights, and millions of women still died in childbirth (WHO, 2013). Unlike the MDGs, all countries will be expected to work towards achieving the SDGs over the next 15 years, being guided by its specific goals, targets, and indicators, including as regards health. It is noteworthy that, long before the SDGs, the National Health Policy, which was aimed at improving the performance of health systems, was formulated in an attempt to move towards universal health coverage as part of the MDGs.

The established aim of the National Health Policy was to address the needs of maternal and child health in line with the MDGs. India's target maternal mortality ratio (MMR) is 140 per 100,000 live births. In 2004-05, the MMR was 254 per 100,000 live births. By 2010-12, this had reduced to 178 per 100,000 births, and by 2015, had declined further to 141 per 1,000 births (see Table 2). In the case of the child (under-5) mortality rate (U5MR), the MDG target was set as 42 per 1,000 births. From a baseline figure of 126 in 1990, this then reduced to 56 in 2012, and then reached 42 in 2015. These improvements are particularly commendable given that, in 1990, India's MMR and U5MR were 47 per cent and 40 per cent above the international average respectively. India still ranks 49th in U5MR. In addition, the infant (under-1) mortality rate (IMR) reduced by half in between 1990 and 2012, from 88 to 44 per 1,000 births, and neonatal mortality rate (NMR) reduced to 31. Antenatal care (ANC) and skilled delivery care, however, remained low, with approximately 60 per cent of women receiving no post-natal check-up.

**Table 2: Selected Socio-Demographic Indicators of Development**

Indicator	Unit
Total population (thousands), 2012	1,236,686.7
Annual number of births (thousands), 2012	25,642.2
Annual number of under-5 deaths (thousands), 2012	1,414
U5MR (per 1,000 births), 1990	126
U5MR (per 1,000 births), 2012	56
Male U5MR (per 1,000 births), 2012	54
Female U5MR (per 1,000 births), 2012	59
IMR (per 1,000 births), 1990	88
IMR (per 1,000 births), 2012	44
NMR (per 1,000 births), 2012	31
Life expectancy at birth (years), 2012	66.2
MMR (per 1,000 births), 1990	560
MMR (per 1,000 births), 2010-12	178
MMR (per 1,000 births), 2015	141

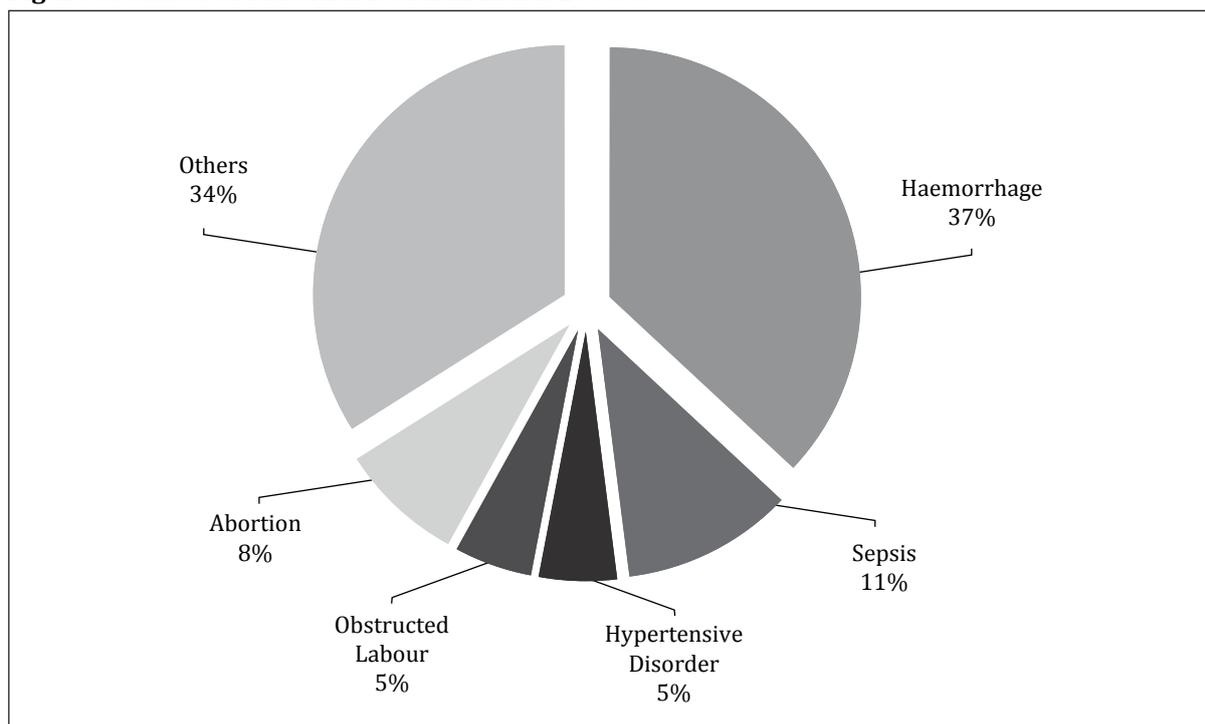
Source: UNICEF (2015).

Maternal deaths are determined by a range of factors that can lead to pre-term birth and neonatal deaths (see Figure 5), for instance, hemorrhaging contributes to more than one-third of maternal deaths.

As regards nutrition, nearly 30 per cent of children did not consume iodised salt. Less than half of children were exclusively breastfed (46.4 per cent), and 40.5 per cent were initiated into breastfeeding early. While approximately 60 per cent of children were given full vitamin A supplementation, around 2 per cent were overweight, and 16 per cent were severely underweight (see Figure 6).

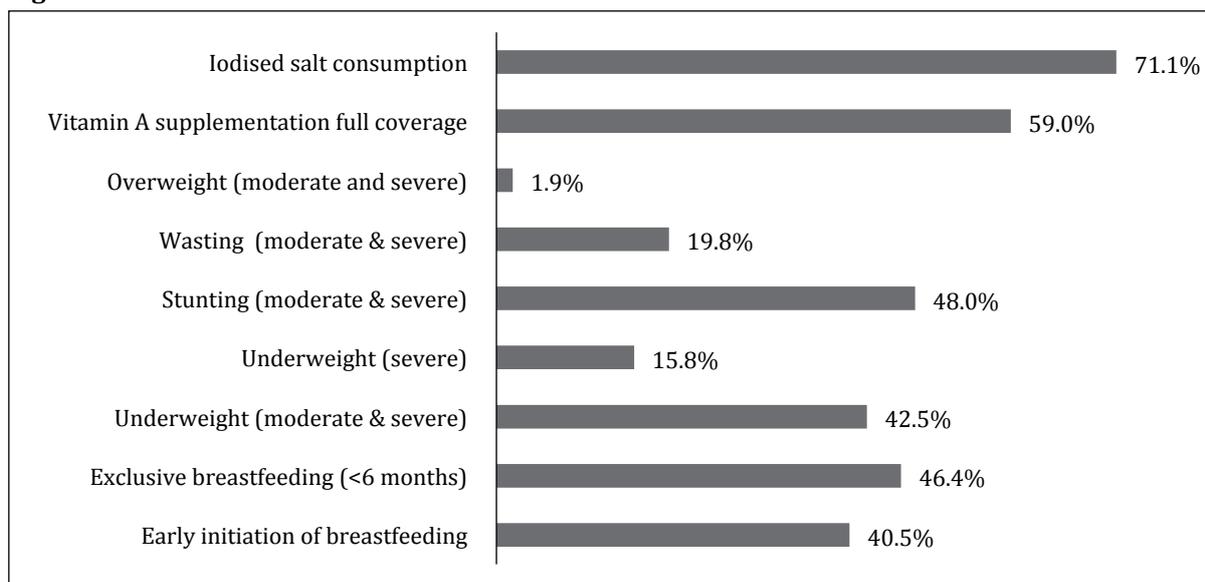
India has shown improvement in population stabilisation, with a decrease in decadal growth rates. The national total fertility rate (TFR) has declined from 3.1 in 1999 to 2.4 in 2012. The rural TFR has reduced from 2.4 to 2.1, and urban from 2.3 to 1.8. The IMR also showed a declining trend to almost half from 84 to 42 during the same period (Table 3).

**Figure 5: Causes of Maternal Death in India: 2008-09**



Source: MoHFW (2013).

**Figure 6: Nutritional Status of Children in India: 2008-2012**



Source: UNICEF (2013).

**Table 3: Disparities in Health Outcomes**

Variables	1999-2000	2006-07	2012-13*
<i>TFR*</i>			
Total	3.1	2.7	2.4
Rural	2.4	3.0	2.1
Urban	2.3	2.0	1.8

(Table 3 contd.)

(Table 3 contd.)

Variables	1999-2000	2006-07	2012-13*
<i>IMR**</i>			
Total	84.2	62.1	42
Rural	86.9	63.9	46
Urban	57.6	43.8	28

**Source:** \*Estimates of fertility indicators, 2011 Census of India, available at: [www.censusindia.gov.in/vital\\_statistics/SRS\\_report\\_2012/10\\_chap3](http://www.censusindia.gov.in/vital_statistics/SRS_report_2012/10_chap3)

\*\* MoHFW (2013)

The rural-urban differential in the case of basic availability of improved drinking water sources and sanitation facilities has a negative impact on child health, and often negates the effect of medication, and even vaccination. While use of improved drinking water sources reached almost 90 per cent in rural areas in 2011, there was only 23.9 per cent use of improved sanitation facilities in rural areas (see Table 4). This is reflected in incidences of diarrhea, which while frequent, received insufficient treatment, with only around a quarter of cases being known to be treated with oral rehydration salt (ORS). As regards immunisations, coverage ranges from 70 per cent for Polio3 to 98 per cent for DPT1.

**Table 4: Selected Health Indicators**

Indicator	Per cent
Use of improved drinking water sources (total), 2011	91.6
Use of improved drinking water sources (urban), 2011	96.3
Use of improved drinking water sources (rural), 2011	89.5
Use of improved sanitation facilities (total), 2011	35.1
Use of improved sanitation facilities (urban), 2011	59.7
Use of improved sanitation facilities (rural), 2011	23.9
Routine EPI vaccines financed by the government, 2012	100.0
Immunisation coverage (BCG), 2012	87.0
Immunisation coverage (DPT 1), 2012	88.0
Immunisation coverage (Polio 3), 2012	70.0
Diarrhoea incidences treated with ORS, 2008-2012*	26.0

**Source:** UNICEF (2015).

**Note:** \*Refers to the most recent year available during the period specified.

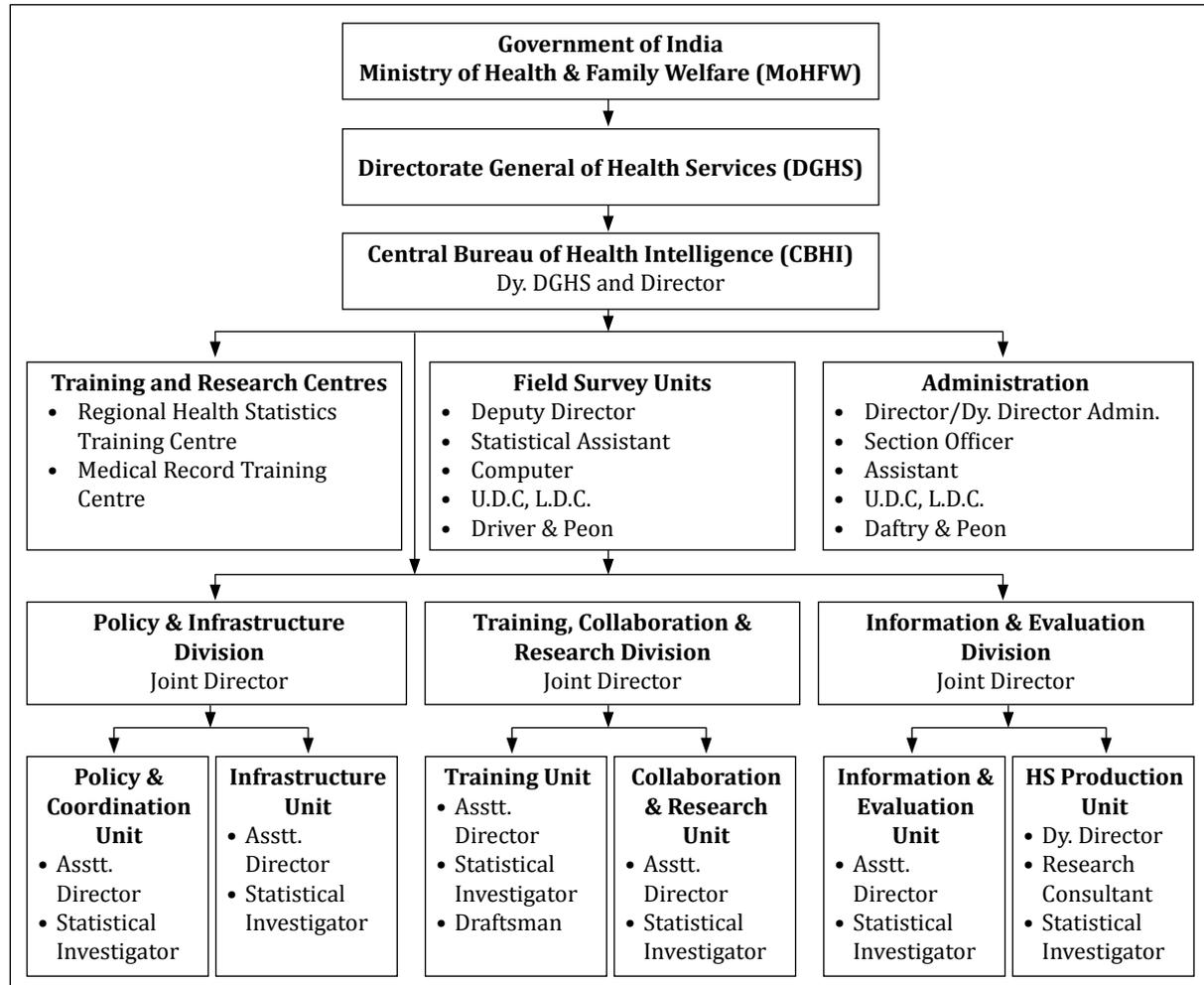
### 3.2 Implementation of Health Programmes: Coordination and Management

India's health system is organised into three tiers: primary, secondary and tertiary; and three broad sectors: public, private and trust or 'NGO-like' organisations (see Diagram 2).

The facilities at the primary tier include the primary health centre and the sub-centre; the main facility at the secondary tier is the community health centre; and the facilities at the tertiary level include the district and civil hospitals in the public sector. In the private sector, which varies in size, facilities range from numerous single unit clinics to large specialty hospitals. These facilities are functioned by a team of medical and para-medical professionals. Although located within the Ministry of Health and Family Welfare (MoHFW), this structure intersects with other ministries and their departments, such as those for women and child development, water and sanitation, and labour. The MoHFW functions through the Directorate General of Health Services (DGHS), working through the Central Bureau of Health Intelligence (CBHI) and the departments which take care of administration, training, research, coordination, implementation and evaluation of programmes and infrastructure.

Programmes are implemented with the help of health workers, predominantly located at the grassroots level, who connect users to services and local facilities. Two important health workers at this level

**Diagram 2: Organisational Structure: Implementation of Health Programmes**



Source: MoHFW (2013).

are the auxiliary nurse midwife (ANM) and the accredited social health activist (ASHA). While the ANMs have existed in the system for some time, ASHAs were introduced as part of the NRHM in 2005. Their responsibilities include coordination and dispensing in accordance with the functions of the primary health centre. Overall quality of care reflects serious compromises that have been made in the effectiveness, and therefore the coordination and management, of the programme.

### 3.3 Health Service Provision: Financing and Other Means of Implementation

The NRHM has strengthened public health systems in many ways. For instance, a workforce totalling approximately 9 lakh community health volunteers, named ASHA, has been introduced as a link between the community and public services. Over 18,000 ambulances provide free services to over a million patients per month. More than 178,000 health workers have been employed under the NRHM. Conditional cash transfer (CCT) enhances the implementation of quality care services. In 2005, a cash assistance scheme was introduced for the purposes of decreasing maternal and neonatal mortality. However, while institutional deliveries increased from 41 per cent in 2005-06 to 46 per cent in 2007-08, the quality of maternal care is still lacking in many ways (IIPS and Macro International, 2007).

Over one crore pregnant women were provided with cash transfers annually, empowering and facilitating their access to free institutional care. Across states, there was a major increase in the levels of outpatient attendance, bed occupancy, and institutional delivery. However, these developments were uneven. More than 80 per cent of the increase in services is likely to have been contributed by less than 20 per cent of the public health facilities. Further, while states with better baseline capacity

were able to take advantage of NRHM financing sooner, high focus states had to revive first or expand their nursing and medical schools and revitalise their management systems before being able to take advantage of the scheme. Inefficiencies in fund-utilisation, poor governance, and leakages have been additional problems in some of the weaker states.

The health system in India has remained under-funded for the last 40 years. The Indian Government spends around only 0.9 per cent of gross domestic product (GDP) on health services, which is one of the lowest levels in the world. The CSSM and RCH programmes contributed an additional USD 600 million, with approximately USD 300 million going to maternal health, over a 12-year period. However, during these 12 years, there were about 300 million new births in India, meaning on average an additional USD 1 per birth. This small increase has been insufficient for providing maternal care to pregnant women, with donor support also remaining inadequate. In accordance with the Indian Constitution, Indian states are responsible for providing health services and must increase their funding substantially (Mavalankar and Rosenfield, 2005). In addition to low levels of funding, financial systems in India are both bureaucratic and slow, resulting in the non-availability of funds at peripheral locations. Funds, which are mostly centrally available, often remain unused and lapse at the end of each financial year. Further, financial and audit rules demand significant amounts of paperwork and lengthy procedures to use the money budgeted. Under the NRHM, efforts were made, however, to streamline this process (Vora *et al.*, 2009).

The private sector provides nearly 80 per cent of outpatient care and around 60 per cent of inpatient care. According to NSSO estimates, as much as 40 per cent of private care is likely to be provided by informal, unqualified providers. About 72 per cent of all private healthcare enterprises are own-account-enterprises-household run businesses, providing health services without hiring workers on a regular basis. In terms of comparative efficiency, the public sector provides value for money as it accounts for less than 30 per cent of total expenditure, yet provides about 20 per cent of outpatient care and 40 per cent of inpatient care (NSSO 60th Round, 2006). The same expenditure also funds 60 per cent of end-of-life care (based on estimates of the Registrar General of India (RGI) on hospital mortality), almost 100 per cent of preventive and promotive care, and a substantial part of medical and nursing education (Vora *et al.*, 2009).

Data on health expenditure support (NSSO, 2015) reveals that, in India, 86 per cent of the rural population and 82 per cent of the urban population were not covered under any health expenditure support scheme (Sangwan, 2015). The health survey also found that health expenditure schemes covered only 19 per cent of households in the top monthly per capita expenditure (MPCE) quintile. In the lower MPCE quintile (i.e. 20 per cent and below), only 11 per cent of households were covered. Approximately two-third of households in the bottom MPCE quintile had to meet medical expenses from their own savings. When their health is affected, working class families face acute challenges in meeting medical expenses in addition to day-to-day household expenses.

Recognising the need for health protection for the poor, the Rashtriya Swasthya Bima Yojna (RSBY) was launched in 2008 by the Ministry of Labour and Employment. Of the 69 million households to be targeted through RSBY by the end of 2017, by mid-2014, about 54 per cent were enrolled, with wide variations existing across regions. In accordance with 2015 RSBY guidelines, two other schemes, namely, Aam Aadmi Bima Yojna (AABY) and the Indira Gandhi National Old Age Pension Scheme (IGNOAPS), were aligned with RSBY so as to provide facilities available under different schemes through a single 'smart health card'. To tackle the slow progress made to date in maternal health, India has committed to spending USD 3.5 billion per year to strengthen maternal and child healthcare services in 225 districts, as part of the 2010 UN Global Strategy for Women and Children's Health.

### **3.4 Stakeholder Participation: Access to Health Services across Social Groups**

Inclusive development is one of the main principles embedded in the 17 SDGs adopted by UN Member States. However, descent (caste), which is a critical axis of exclusion in South Asia, is not specifically

**Table 5: Child and Infant Mortality Rates across Social Groups**

Health Indicators	SC	ST	OBC	Others	Total
Infant Mortality Rate (IMR)	66.4	62.1	61.1	55.7	57.0
Neonatal Mortality Rate (NMR)	46.3	39.9	42.1	38.1	39.0
Child Mortality Rate (CMR)	23.2	35.8	18.7	13.3	18.4
Under Five Mortality Rate (U5MR)	88.1	95.7	78.7	68.2	74.3

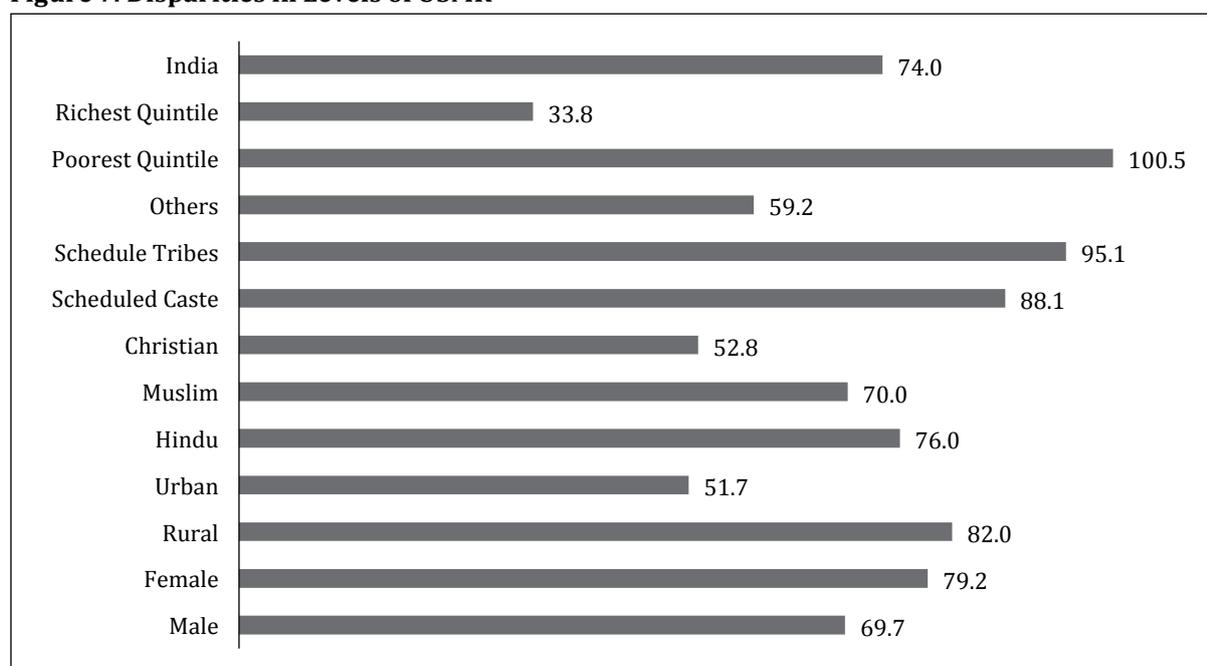
Source: Ministry of Tribal Affairs, (2010).

Note: OBC: Other Backward Classes.

recognised in the SDGs. Various Dalit rights groups gathered in New York at the time of the UN Summit to draw attention to this fact and to demand that this 'critical lapse' be rectified. Arguably, the pledge to 'leave no one behind' will remain handicapped as a result of no specific mention to caste as a major cause of poverty and deprivation of opportunity. Discrimination based on work and caste is an important and prolific cause of exclusion. It is therefore curious why no explicit recognition is given to the discrimination incurred by 260 million Dalits, when age, sex, race, ethnicity, and origin are all explicitly mentioned.<sup>5</sup> Indeed, socially-marginalised communities, such as SC and ST, record higher levels of IMR, NMR, CMR and U5MR than their upper caste counterparts (see Table 5).

Inequalities in the levels of child mortality (U5MR) highlight the fact that a child born into an ST household is 1.5 times more likely to die before reaching their fifth birthday, when compared to a child born into a non-ST household. A child born into the poorest household is three times more likely to die before their fifth birthday, when compared to a child born into the richest household. Similar disparities are also reflected among children from different religious groups, as well as among children from rural rather than urban areas (see Figure 7).

Disaggregation by social group reveals that 70.9 per cent of ST women and more than 50 per cent of SC women give birth in their homes, whereas only 40.5 per cent of non-SC/ST women choose to have a home delivery. Among SC/ST women, of those who do opt for institutional delivery, most of

**Figure 7: Disparities in Levels of U5MR**

Source: UNICEF India (2011).

<sup>5</sup>[https://www.unngls.org/index.php/un-ngls\\_news\\_archives/un-ngls\\_news\\_2014/30-un-ngls-interviews-paul-divakar-convenor-of-wada-na-todo-abhiyan](https://www.unngls.org/index.php/un-ngls_news_archives/un-ngls_news_2014/30-un-ngls-interviews-paul-divakar-convenor-of-wada-na-todo-abhiyan) (accessed on 13 January 2016).

them go to government centres, whereas non-SC/ST women and OBC women prefer private centres over government centres. The disparities evident in the coverage of safe deliveries suggest that rural, Muslim, ST and poor women remain disadvantaged. About 10 per cent more SC women are able to access safe delivery services than ST women, and the ratio of rich women to poor women who can access safe delivery services is approximately 3:1 (IIPS and Macro International, 2007).

It is clear that discrimination continues to hamper health development goals. Observations from the field reveal that unequal opportunities in accessing health services among social groups are perpetuated by caste-based discriminatory practices, which work against marginalised groups in the course of healthcare delivery. SC women have the least access to institutional services, with most of them relying on community *dai* or relatives, and having home deliveries (UNICEF-IIDS, 2014). The same study reveals the existence of caste-based discrimination in government hospitals. As two SC women respondents reported:

“I do not go to the hospitals, but call the dai; because dai knows us very well and behave passionately. From my neighbours, I came to know that people face rude behaviour in the hospitals; so, I preferred having my last three deliveries at home.”

“During my last delivery, I was in the government hospital and crying in pain when the nurse slapped me ...twice” and in another case as reported, “...when I was in the government hospital for my delivery, the nurse put some weight on my stomach which instead of reducing, increased my pain... and I lost my child too” (UNICEF-IIDS, 2014).

Financial constraints often prevent access by SC/ST women to hospitals. While the *Janaji Surakshya Yojna (JSY)* scheme provides cash incentives for institutional delivery, most SC women report that the low level of funds and delays in payment have discouraged them from participating in the scheme, approximately 70 per cent of women received a JSY card, and 68 per cent received a cash benefit. In summary, both macro and micro-level data on maternal and child healthcare indicate that SC and ST women have less access to healthcare facilities compared to their non-SC/ST counterparts (UNICEF-IIDS, 2014).

### **3.5 Data-related Challenges**

Data sources for health indicators range from Sample Registration System (SRS) to census, National Sample Survey Organisation Rounds, Health Statistics of India, National Family Health Survey (NFHS) and District Level Household Survey (DLHS) rounds and micro studies. The nature of data includes vital statistics, mortality, morbidity, nutrition, and data on specific diseases, health infrastructure, and manpower. Availability of facilities and utilisation of services, quality of facilities and services are also reported in data sources like NFHS, DLHS and NSSO. If these sources can provide high-quality data covering the time and space, reporting on levels and trends of various indicators, it would help in generating estimates. Demographic surveillance sites and hospital data are also important, although they are rarely representative.

The biggest data challenge is the identification and recording of beneficiaries. Infant and child death can often go unreported if the information is not sought sensitively. Information about girls and women is often laced with bias and remains under-reported. Indeed, it is important to track the numbers of prospective eligible women considering home childbirth (as per cultural norms) in order to ensure the delivery of effective healthcare services.

Health management information system (HMIS) collates the data needed by policymakers, health service providers and users to improve and protect population health. Although India is still striving to put in place effective and comprehensive information systems in place for this purpose, the need for statistical health information has been on the rise in recent times.

The efforts to meet the targets set by the MDGs in terms of healthcare are directed towards prevention and treatment of diseases such as HIV/AIDS, tuberculosis and malaria. Out of pocket expenditure, for illness, is increasing. Data challenges, therefore, also need to address the surveillance and monitoring of illness, capacity to provide care for ill, training of personnel at various levels, and infrastructure for healthcare. The support staff for rendering care, facilities in private sector, share of services being rendered by private, public or both sectors – these need a robust data recording.

### **3.6 Implementation Gaps and Challenges in Healthcare Provision and Access**

In order to appreciate the major challenges fully that contribute towards lower access to health services, both in general and among marginalised groups in particular, it is important to understand the multiplicity of barriers to implementation. There is a lack of awareness of healthcare programmes and a lack of awareness of government policies and schemes, meaning there is a need for improved mechanisms for the proper dissemination of information on JSY registration and other maternal and child healthcare services. The quality of health services is another concern, with clear deficiencies in health infrastructure and ill-equipped health centres at the community levels that are staffed by untrained personnel. This reveals not only the poor quality of the facilities, but also the negligent attitude of service providers. Further, in remote villages, patients, especially pregnant women, do not have easy access to health centres due to a lack of transportation and poor road conditions. Besides these common challenges, there exist several group-specific problems for SC beneficiaries, for instance, non-receipt of JSY monetary benefits and discrimination by service providers based on caste and religious identity.

Another relevant issue is the absence of independent maternal health advocates in civil society (Vora *et al.*, 2009). Maternal death has not been a subject of social, political or legal debate in India. Although some medical organisations have promoted maternal health, there has been limited collaboration between the government and other agencies on this topic. International agencies, while focusing on family planning and child survival, have neglected maternal health (Mavalankar and Rosenfield, 2005). Women's NGOs, by disapproving of injectable and implanted contraceptives in the interest of women, have in fact inadvertently affected maternal mortality levels. In addition, the National Human Rights Commission and the National Women's Commission have paid too little attention to the high number of maternal deaths in India.

## **4. Conclusions and Recommendations**

The latest Five Year Plan in India has taken steps to integrate the SDGs into national development frameworks. Indeed, India's social protection programmes consider all dimensions of sustainable development, meaning that their successful execution is key to achieving the SDGs. Implementation of any social protection programme is a holistic process, and the Indian Government is responsible for mobilising the resources needed for the proper implementation of these programmes. Aside from financing, many challenges exist at the national level those need to be addressed. The analysis presented in this study, concerning national employment guarantees and healthcare programmes, provides many insights and associated recommendations as regards implementation gaps and challenges.

Implementation of SDG-focused social protection programmes appears to be facing three major challenges: strategic, engagement and evaluation. The strategic challenges concern how the needs of different groups can be met within common strategies, the engagement challenges revolve around local governance, and the evaluation challenges deal with how to convey evidence-based messages concerning the effectiveness of government programmes (a task that is especially difficult given that there is no one single reality). In the least, challenges in monitoring and evaluating the SDGs remain critical to understanding of the lessons learnt from strategies and programme implementation. Given the challenges, in order to reach sustainable development in the long-term, the government needs to develop partnerships with other stakeholders and institutions as regards the planning and implementation of social protection programmes.

Implementation of social protection programmes through local governments has several advantages. However, due to a lack of commitment by local administration and service providers, these programmes are not implemented according to their true spirit. This raises questions about the viability of such programmes. This is not helped by the lack of a strong participatory planning process, which results in some groups of persons experiencing restrictions to access to the benefits available from the programmes. The negligent and/or discriminatory attitude of local service providers also remains a major problem. SDG implementation should rather be strongly rooted in the principles of human rights and social justice. Moreover, it is important to recognise the central role of participatory processes in realising socio-economic development. In this context, the role of CSOs is crucial as is their mainstreaming in the planning process.

Considering the shared responsibility of national and state governments in SDG implementation, it is imperative to strengthen federal structures and institutions. In India, although the federal system is well placed to implement the sustainable development agenda, its various tiers and actors need to be strengthened and sensitised in terms of human and financial capacity so as to improve service delivery and governance. A strong monitoring process also needs to be in place to meet the goals. Along with the commitment of public institutions at the highest level, the involvement of other stakeholders, including civil society, is crucial in monitoring the SDG progress. Moreover, to ensure better monitoring (including continuous sustainability assessments) and accountability of key stakeholders, collection of highly disaggregated data will be required using new techniques.

Identifying data gaps, training of data collectors and data recording for policy formulation and implementation emerge as major challenges. Data collected through large-scale surveys enables quantification of attributes, but the processes of the attributes can better be recorded through the experiential data from qualitative micro-studies. Training of the data collectors needs to be specifically geared towards the sensitisation of the differentials embedded in the society.

Diversification of funding resources is important for achieving sustainability. At the national level, public-private partnerships (PPPs) can play a key role in financing sustainable development. Concurrently, efforts should be made towards increasing financial and technical support from developed countries. The Indian Government works with several international agencies. The services of these international agencies could be sought so as to help service provider develop capacity and assist in the planning and implementation of the SDG-focused government programmes.

Lastly, the sharing of the SDG knowledge and experience could better be exploited through increased networking across countries. In addition, when SDG-focused programmes are established at the national level, it is necessary to have clear means of implementation. As a result of different programmes operating under the aegis of different governments (including both at the central and state levels), ministries and departments, at the ground level, there exists a lack of convergence and proper coordination. Each ministry needs to ensure that efforts are made to explore areas of possible convergence among its own programmes, as well as working towards convergence among programmes run by different ministries, at the level of planning, process and implementation.

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