
UNIT 11 SOCIAL ISSUES IN DEVELOPMENT

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11.0 INTRODUCTION

We have discussed the basic issues in development in Unit-9 and the sectoral issues in development in Unit-10. This unit, i.e. Unit 11, presents a contemporary discourse on social issues in development. It briefly elucidates the processes and trends that have influenced understanding of social issues in development in contemporary times. It also focuses on various dimensions of social development by examining some of the social issues in development, such as education, health, nutrition, gender, marginalization and exclusion, and culture.

11.1 OBJECTIVES

After going through this Unit, it is expected that you will be able to:

- Explain the rationale of understanding social issues in development; and
- Analyse various social issues in development such as education, health, nutrition, gender, marginalization and exclusion, and culture.

11.2 UNDERSTANDING SOCIAL ISSUES IN DEVELOPMENT

The development discourse initially focused on economic growth in terms of sustained increase in average incomes. The underlying assumption was that economic growth by increasing a nation's total wealth would also enhance its potential for reducing poverty and solving other social issues. But, as evidences have indicated many regions, communities, and sections of population remained marginalized, and even excluded from the benefits of economic growth. They are increasingly becoming vulnerable to: i) poverty, ii) social injustices, iii) human rights abuses, and iv) violence; which often surpass the actions to tackle them. Clearly increments in economic growth both in developed economies as well as in developing and less developed economies do not necessarily lead to added well-being.

The discourse was expanded further in 1990's to include the concept of human development as a complement to existing income-based approaches to development. Rooted in the capabilities, literature of Amartya Sen and adopted by the Human Development Reports of the United Nations Development Programme (UNDP), the human development paradigm focused on enhancement of people's freedoms, capabilities, and wellbeing (Foa, 2011).

Though the theory of human development refined the objectives of development intervention, there were gaps between its conceptualization and its measurement. For instance, as a measurement, human development using Human Development Index (HDI) typically monitored the levels of income, health and education — the capability and well-being dimensions of development. Health and nutrition, education, and skills affect people's perceived and/or actual well-being and their capacity to gain control of their lives. When individuals possess knowledge, they are physically able, well-informed and more likely to stand a better chance of achieving their personal objectives and wellbeing. The other essential dimensions such as equity and empowerment, however, were not emphasized. Equity can best be understood in terms of access to social services, economic opportunities, and outcomes. Empowerment refers to expanded opportunities through norms, networks, and civic commitments that enable collective action, inclusion and social accountability. The dimensions such as absence of poverty, undernourishment and capacity at one end, and at the 'higher' end dimensions such as rights, entitlements, freedoms and choices of opportunities, non-discrimination based on caste, ethnicity or gender, engagement in a community, and social cohesion are the 'elementary' prerequisites for human security and survival.

Social issues in development are thus the components within the broader paradigm of human development. They affect a person, a group of persons or the whole society in general, either directly or indirectly, due to development processes. They are related to the intrinsic characteristics of people (age, gender, health and nutrition, education and marginality conditions) as well as to the environmental circumstances (at the social, economic, cultural and institutional levels).

In the sections that follow we shall examine social issues related to the provisioning of basic services as education, health, and nutrition (the social aspects) in order to improve the quality of life; socio-cultural and institutional conditions in the context of development, for instance, gender, marginalization and exclusion that affect policy outcomes.

11.3 EDUCATIONAL ISSUES IN DEVELOPMENT

Education is fundamental to growth and development. It plays an important role in improvement of the equity. As stated in the preceding section equity can be understood in terms of access to social services, economic opportunities and outcomes. Equity in education implies the following specific aspects.

- i) *Gender Equity* refers to the opportunities of the traditionally disadvantaged gender group, i.e. females, in their access to various levels of education, in their opportunities for success in education, and in their opportunities to employment and to make use of education as an asset for enhancing their life chances. It has a key role in promoting the interests of women and increasing their diversified impact and contribution to national development goals.
- ii) *Income Equity* refers to the opportunities for financially disadvantaged groups, i.e. in terms of their income and access to various levels of education;
- iii) *Region Equity* refers to the opportunities for people living in disadvantaged regions. In most cases, the disadvantaged regions are rural, but they can also be economically backward regions within an economy, and also the poor income areas within urban areas.
- iv) *Socio-cultural Equity* refers to the educational opportunities of socio-culturally disadvantaged groups. In most cases, they are marginalized groups within the economy, but sometimes women are also regarded as “marginalized” in certain respects as their educational opportunities are limited by sociocultural perceptions of women also that are unfavorable for them to receive education. It has a direct role in poverty reduction by enhancing the marketable skills of the economically disadvantaged and vulnerable groups, and by expanding their ability to take advantage of income generation possibilities and available social services (Lee, 2002).

The right to basic education has been expressed in the Universal Declaration of Human Rights (1948). This declaration has served as a foundation upon which the substance of the right has been translated into numerous international legal and political commitments that followed. Article 4 of the Convention against Discrimination in Education (1960) contains the normative framework for the right to basic education. Provisions for education rights are also upheld in the International Covenant on Economic, Social and Cultural Rights (1966) and the

Convention on the Rights of the Child (CRC) (1989). Similar to the 1960 Convention, Article 28 of the CRC requires the State Parties to recognize the right of the child to education and to realize the right on the basis of equal opportunity, including through free and compulsory primary education and “available and accessible” secondary education for every child. The political commitment in reaffirming education as a basic human right was also made through the World Education Forum, setting out six goals of Education for All in 1990. The Millennium Declaration (2000) marked similar political commitment for the right to development, including six commitments for promotion of the human rights. Millennium Development Goal #2 (MDG) of UNDP aims to ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. Through its impact on employment opportunities and earning potential, education alters the value placed on children and the willingness of parents to invest more in each child’s development (ADB-UNICEF, 2010).

11.3.1 Education in India

Education is one of the priorities of the Indian government. India’s commitment to provide for and ensure Universal Elementary Education for all children up to the age of 14 has been reiterated time and again. The Kothari Commission (1964-1966), the Acharya Ramamurthy Committee (1990), the Prof. Yash Pal Committee (1993), the Saikia Committee (1997) have all emphasized the need for free and compulsory universal elementary education (UEE) and quality education. The Right of Children to Free and Compulsory Education Act, 2009 guarantees to all children within the age-group of 6-14 years the right to education in proper schools with trained teachers.

Box 11.1: Some Noteworthy Government Initiatives

Sarva Shiksha Abhiyan (SSA): In order to promote EFA goals in effective manner SSA was started in 2001. It aimed to: a) provide education to children between 6–14 years by 2010 — 5 years of primary education by 2005 and 8 years of schooling by 2010; b) bridge all gender and social gaps at primary level by 2007 and elementary level by 2010; and c) achieve universal retention by 2010.

The program also seeks to open new schools in those habitations which do not have schooling facilities and strengthen existing school infrastructure through provision of additional classrooms, toilets, drinking water, maintenance grant and school improvement grants. Existing schools with inadequate teacher strength are provided with additional teachers, while the capacity of existing teachers is being strengthened by extensive training, grants for developing teaching-learning materials and strengthening of the academic support structure at a cluster, block and district level. SSA seeks to provide quality elementary education including life skills. SSA has a special focus on girl’s education and children with special needs. SSA also seeks to provide computer education to bridge the digital divide.

Mid-day meals: With a view to enhancing enrollment, retention and attendance and simultaneously improving nutritional levels among children, the National Programme of Nutritional Support to Primary Education (NP-NSPE) was launched. The objectives of the mid-day meal scheme are:

- Improving the nutritional status of children in classes I-V in Government, Local Body and Government-aided schools, and EGS and AIE centers.
- Encouraging poor children, belonging to disadvantaged sections, to attend school more regularly and help them concentrate on classroom activities.
- Providing nutritional support to children of primary stage in drought affected areas during summer vacation.

Mahila Samakhya: The Mahila Samakhya Scheme was started in 1989 to translate the goals enshrined in the NPE into a concrete programme for the education and empowerment of women in rural areas particularly those from socially and economically marginalized groups. This scheme recognizes the centrality of education in empowering women to achieve equality. The *Mahila Sanghas* or women's collectives at the village level provide the women a space to meet, reflect, ask questions and articulate their thoughts and needs and make informed choices.

Saakshar Bharat was launched on 8 September 2009. It aims to recast India's National Literacy Mission to create a literate society through a variety of teaching-learning programmes for non-literates and neo-literates of 15 years and above. It strives to increase the literate population by 70 million adults, including 60 million women. Women being the prime predominant participants, the entire programme will be given gender treatment. The gender, social and cultural barriers that women face will be taken into consideration while designing teaching-learning programmes. *Lok Shiksha Kendra* (Adult Education Centre) established in Panchayats will act as a centre for registration of learners for all teaching-learning activities in their jurisdiction.

Rashtriya Madhyamic Shiksha Abhiyan (RMSA) launched in March 2009 seeks to enhance access to secondary education and improve its quality as well. The objective is to achieve an enrollment ratio of 75 percent for classes IX-X within 5 years by providing a secondary school within a reasonable distance of every habitation, to improve quality of education imparted at secondary level through making all secondary schools conform to prescribed norms, to remove gender, socio-economic and disability barriers, to universalize access to secondary level education by 2017, i.e. by the end of 12th Five Year Plan and universal retention by 2020.

11.3.2 Issues of Concern

Despite the noteworthy initiatives, educational issues continue to persist as an impediment to development. Under the EFA (Education for All) Global Monitoring Report, India has been placed among one of 30 countries that are likely to miss all or some of the 2015 EFA targets. India still accounts for 30 per cent of the world's population that has no access to literacy, with 70 per cent of them being women. It means, India is unlikely to achieve the Dakar target of reducing illiteracy by 50 per cent by 2015. A study entitled 'A Civil Society Report on Monitoring Right to Education in India' has drawn attention to issues such as lack of access and poor state of educational infrastructure hindering the process of universalization of primary education.

Box 11.2: A Civil Society Report on Monitoring Right to Education in India in the States of Andhra Pradesh, Bihar and Orissa

- Around 23.5 per cent of children in Bihar and 18 per cent in AP have to cover more than 1 km to reach primary school.
- Situation of accessibility for upper primary level students is even worse with access of 27 per cent and 42 per cent in Orissa and Bihar respectively.
- More than half of the total girls enrolled are in schools with no provision for separate toilets; Orissa faring worst with 74 per cent of such girls' enrollment.
- Majority of the students, despite availability of furniture, are forced to sit on floors.
- Of the total sample, around 24 per cent students enrolled in elementary stream are excluded from the Mid-Day Meal facility.
- Poverty and economic backwardness were the most commonly cited reasons for the children who remain out-of-school; the condition being especially worse in case of SC/ST across all the states and Muslims in Bihar.
- Lack of participation among parents in the decision-making at the village and school level is a major reason for inefficacy of government programmes in education. Around 34 percent parents of the students surveyed have never visited the school where their children are studying. The situation is particularly worse for STs and Muslims. This is not to say that the parents are not interested but numerous focused group discussions held during the study revealed that participation of parents in school management is not welcome by the school authorities.
- The lack of access is also manifested in terms of out-of-pocket expenditure incurred by the parents for their child's education. The figures are especially high in Orissa, major chunk being incurred on school uniform, books and stationery. This is a stark evidence of non-adherence to the very principle of the 'Right to Education' which entitles every child to free education. The state of affairs demands immediate action given the poor economic condition of the sample households. Even the recently published audit report on SSA by the CAG of India emphasizes 'lack of affordability' as the primary reason for non-enrollment and dropout at the elementary level.

Source: Mishra Yamini. 2007. 'Education for All' Not Necessarily!. New Delhi: Centre for Budget and Governance Accountability (CBGA). Also See www.cbgaindia.org/press_releases.php?id=6.

Teacher absenteeism is another serious area of concern. Various studies have shown that at any given time, 30 percent of teachers at government schools were absent from their classrooms. While the RTE mandates the number of teaching hours per year, it does not address the lack of accountability on the part of the teacher or the system if the mandated number of hours is not actually provided. The absence rate of students was also high. The incentives for going to school were not apparent. Despite the government's decree on compulsory education

and the child labour ban, an estimated 30 million children were out of school to go to work. Other problems include discrimination on caste basis, violence and abuse of children, and discrimination against girls. The latter is not often overt but a result of certain existing situations. For example, findings of a study revealed that 27 percent of schools did not have even one female teacher, resulting in a lack of confidence on the part of parents, especially of older girls. Fifty per cent of schools did not have separate toilets for girls. Given the dismal situation, the study estimated that for every 100 girls who enrolled in school in rural India, 40 would reach Class IV, 18 would reach Class VIII, nine would reach Class IX, and only one would make it to Class XII. The dropout ratio among schoolchildren reflects inequalities between social groups as well a strong gender bias against girls. In India, girls and women within the age group of 15 to 24 years are twice as likely to be illiterate as men in that group. The gender gap is an important issue in the literacy landscape of India (Institute for Human Development, 2010).

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions."

1) Explain MDG # 2.

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2) What are the objectives of mid-day meal scheme?

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3) What do you understand by gender bias in education?

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11.4 HEALTH ISSUES IN DEVELOPMENT

Health, as World Health Organization (WHO, 2006) defines it, is more than just the absence of disease. It is a state of complete physical, mental and social well-being. There is both direct and indirect relationship between health and development. The state of health contributes to the realization of other developmental objectives such as economic development, labour productivity, growth, responsiveness to innovation, and future-orientedness. Economic development tends to improve health status, while better health contributes to economic development. Health has a direct association with labour productivity. Illness and malnutrition lead to loss of strength and energy and productive capacity which ultimately has a negative effect on labour income.

Box 11.3: Goals agreed upon at the United Nations Conferences for selected Basic Social Services for All (BSSA) indicators

Access to health services

- All countries should seek to make primary health care, including reproductive health care, available universally.
- Governments should promote full access to preventive and curative health care to improve the quality of life, especially by the vulnerable and disadvantaged groups, and in particular women and children.
- Governments should provide more accessible, available and affordable primary health-care services of high quality, including sexual and reproductive health care.

Family planning

- All countries should seek to provide universal access to a full range of safe and reliable family-planning methods.

Underweight prevalence among preschool children

- By the year 2000, a reduction of severe and moderate malnutrition among children under five years of age by half of the 1990 level should be achieved.

Maternal mortality ratio

- Countries should strive to effect significant reductions in maternal mortality by 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015.

Infant mortality rate

- By the year 2000, reduction of mortality rates of infants by one third of 1990 level should be attained. By 2015, an infant mortality rate below 35 per 1,000 births should be achieved.

Under-5 mortality rate

- Countries should strive to reduce their under-5 mortality rates by one third or to 70 per 1,000 live births, whichever is less, by the year 2000. By 2015, all countries should aim to achieve an under-5 mortality rate below 45 per 1,000.

Life expectancy at birth

- By the year 2000, life expectancy of not less than 60 years should be achieved in every country.
- Countries should aim to achieve by 2005 a life expectancy at birth greater than 70 years by 2015 a life expectancy at birth greater than 75 years.

Source: United Nations. 1997. *United Nations Basic Social Services for All*. United Nations: New York. <http://www.un.org/esa/population/pubsarchive/bss/bssgoal.htm>.

The Millennium Declaration by the United Nations in September 2000 has accepted health in general and health care of women and children in particular as important component of development. Among the eight Millennium development goals, three goals are related to health. These are: reduction in child mortality, improvement in maternal health, and combating HIV/AIDS, malaria and other diseases (IGNOU, 2010).

11.4.1 Health Programmes in India

The first National Health Policy in 1983 aimed at achieving the goal of 'Health for All' by 2000 AD, through the provision of comprehensive primary healthcare services. It stressed the creation of an infrastructure for primary healthcare; close co-ordination with health-related services and activities (like nutrition, drinking water supply and sanitation); the active involvement and participation of voluntary organisations; the provision of essential drugs and vaccines; qualitative improvement in health and family planning services; the provision of adequate training; and medical research aimed at the common health problems of the people. The revised National Health Policy, 2002 aimed to achieve an acceptable standard of good health among the general population of the country, reduce inequities and allow the disadvantaged sections of society a fairer access to public health services. The National Rural Health Mission (NRHM) initiated in 2005 promises to provide universal access to equitable, affordable and quality healthcare, which is accountable and at the same time responsive to the needs of the people, especially of those who are marginalized and live in rural areas. The key objectives of the Mission are reduction in child and maternal deaths, population stabilization and gender and demographic balance. The processes set to achieve the objectives of the Mission will help accomplish goals under the National Health Policy (NHP) and the Millennium Development Goals (MDGs). The National Urban Health Mission (NUHM) focuses on the healthcare needs of the urban poor, particularly the slum dwellers in urban areas.

Box 11.5: Important Health Programmes in India

- *Reproductive and Child Health Programme (RCH)* to improve mother and child health was initiated to address major factors contributing to high IMR, under-five mortality and maternal mortality.
- *Universal Immunization Programme (UIP)* to immunize infants against tuberculosis, diphtheria, pertussis, poliomyelitis, measles and tetanus.
- *National Polio Surveillance Programme (NPSP)* to prevent paralytic illness due to polioviruses.
- *The Oral Rehydration Therapy Programme (ORT)* to prevent deaths due to dehydration caused by diarrhoeal diseases among children under 5 years of age due to dehydration.
- *National AIDS Control Programme (NACP)* is a centrally sponsored scheme implemented through State AIDS Control Societies.
- *National Anti-Malaria Programme (NAMP)* for Early Case Detection and Prompt Treatment (EDPT) to provide relief to the patient, and reduce reservoir of the infection, Selective Vector Control and Promotion of personal prophylactic measures.
- *National Tuberculosis Control Programme (NTCP)* for case detection among patients spontaneously attending health facilities and ensuring adequate drug supply.

Source: http://www.searo.who.int/en/Section313/Section1519_10857.htm.

11.4.2 Health Scenario: Status and Trends

The health scenario, particularly the status and trends presented below will inform us of the health issues that impinge upon the development in general.

11.4.2.1 Health Care Services

In India, public sector has a critical role in ensuring healthcare delivery to all the sections of the society. According to our Constitution, it is the primary duty of the government to ensure the welfare of the people and provide health care facilities to all. The government must safeguard the Right to Life of every person. It provides public health services through chain of health centers and hospitals run by the government. They cover both rural and urban areas and provide treatment to all kinds of problems – from common illnesses to special services. The health service is called ‘public’ for many reasons. In order to fulfill its commitment of providing healthcare to all citizens, the government has established these hospitals and health centers. Also, the resources needed to run these services are obtained from the money that we, the public, pay to the government as taxes. Hence, such facilities are meant for everyone. One of the most important aspects of the public health system is that it is meant to provide quality healthcare services either free or at a low cost, so that even the poor can seek treatment. Another important function of public health is to take action to prevent the spread of diseases such as TB, malaria, jaundice, cholera, diarrhoea, chikungunya, etc.

At the village level there are health centers where there are usually a nurse and a village health worker. They are trained in dealing with common illnesses and work under the supervision of doctors at the Primary Health Centre (PHC). Such a centre covers many villages in a rural area. At the district level is the District Hospital that also supervises all the health centers. Large cities have many government hospitals.

India rates poorly on the basic healthcare indicators — when benchmarked against developed economies but also against other BRIC nations. This can be attributed to the poor healthcare and rural disparity infrastructure reflected in the low bed-density ratio, low doctor-density ratio, and poor healthcare spending.

Table 11.1: Basic Healthcare Indicators

Indicator	Year	India	US	UK	Japan	Brazil	Russia	China
Life expectancy at birth (years)	2008	64	78	80	83	73	68	74
Infant mortality rate (probability of dying by age 1 per 1000 live births)	2008	52	7	5	3	18	9	18
Maternal mortality rate (per 100000 births)	2000-09	254	13	7	3	77	24	34
Hospital bed-density (per 10000 population)	2000-09	9	31	39	139	24	97	30
Doctor-density (per 10000 population)	2000-09	6	27	21	21	17	43	14

Source: KPMG. 2010. *Healthcare: Reaching out to the Masses*. kpmg.com/in

Healthcare penetration has for a long been concentrated in urban areas such as Mumbai, Delhi, Chennai and Kolkata and other Tier-I cities. While 70 percent of the Indian population lives in semi-urban and rural areas, 80 percent of the healthcare infrastructure is built in urban areas.

Some alarming facts about status of healthcare infrastructure in rural areas vis-à-vis urban areas are:

- Rural doctors to population ratio is lower by six times.
- Rural beds to population ratio is lower by 15 times.
- Seven out of ten medicines in rural areas are substandard / counterfeit.
- Sixty six percent of the rural population lack access to critical medicine
- Thirty one percent of the rural population travels for over 30 kilometers for medical treatment.

The primary reasons for under-developed infrastructure in the semi-urban cities and rural areas are poor healthcare expenditure by the government, lack of investment incentives for private sector investment, inefficiencies in the public human resource pool and supply and distribution infrastructure.

The primary healthcare infrastructure has a three-tier system with Sub-Centers, Primary Health Centers (PHCs) and Community Health Centers (CHCs) spread across rural and semi-urban areas. The Sub-Center is the most peripheral contact point between the Primary Healthcare System and the community. Hence, manpower is an important prerequisite for the efficient functioning of this set-up. The tertiary care comprising multi-specialty hospitals and medical colleges are located in almost exclusively in urban regions (KPMG, 2010).

Table 11.2: Primary Healthcare Infrastructure

Facilities: Number of health centres	Available data	Year
Sub-Centres	137371	2001
Primary Health Centres	22842	2001
Community Health Centres	3043	2001

Source: http://www.searo.who.int/en/Section313/Section1519_10857.htm

11.4.2.2 Mortality

Mortality rates are largely used as indicators of health development by different nations, and by agencies involved in assessing and promoting health care. The definition and calculation of maternal mortality rate and infant mortality rate is given in the keyword at the end of the unit.

There have been considerable efforts to reduce *under-five mortality* rates in the country. UNICEF estimated that in India, in 2009, children under 5 mortality rate was 66 per thousand. In 1990, Indian children under 5 mortality rate was 118 per thousand (The Hindu, 2010). *Infant Mortality* in India has declined significantly from 57 per thousand live births in 2006 to 53 per thousand live births in 2008 (India Current Affairs, 2011). The target for MDG 2015 is 27 per 1000 live births. Indian *maternal mortality ratio (MMR)* fell from 570 per

1,00,000 births in 1990 to 230 in 2008. The target for MDG 2015 is 109 maternal deaths per 100,000 live births (Economic Times, 2010).

11.4.2.3 Morbidity

The number of people suffering from various diseases is also used as indicators of health. The WHO has devised a new parameter to assess the global burden of diseases called Disability Adjusted Life Year (DALY). DALY is a time-based measure that combines the year of life (YLL) due to premature mortality and years of life with disability (YLD) or years of life lost due to time lived in states of less than full health.

India is burdened with a larger HIV/AIDS epidemic than any other country in the world. It accounts for almost 13 percent of the 40 million people living with HIV/AIDS globally and over 69 percent of the 7.4 million people living with HIV/AIDS in the Asia and the Pacific region in 2003. Malaria was almost eradicated by mid-sixties but has staged a comeback thereafter. About 6.47 million malaria cases were reported in 1976, the highest since resurgence. The country has been able to contain malaria incidence of 2 to 3 million cases annually since 1984 in spite of increased population at the rate of 2.1 percent annually. India accounts for one-third of global TB and has more TB cases than any other country in the world. About 40 percent of the Indian population is infected with TB bacillus. Every year about 2.2 million persons are added to the existing load of about fifteen million active TB cases; of these, about 800,000 are smear positive (infectious), and about 450,000 die. Since TB is one of the important opportunistic infections of HIV, it is feared that deaths due to TB can go up to four million in the next decade if not controlled. According to WHO (2001) in recent years, morbidity which is receiving more attention is mental disorders (IGNOU, 2010a).

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions."

4) Name 3 MDGs that are related to health.

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5) Describe primary health care infrastructure.

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6) What is DALY?

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11.5 NUTRITIONAL ISSUES IN DEVELOPMENT

The development policies since 1990s have explicitly emphasized three-fold principles. *First*, economic growth, that deliberately involves participation of the poor, is the long-term solution to poverty. *Second*, social security is required to maintain a basic level of living (“safety net”) for the poor; sustained access to adequate food (“food security”) is a central feature of this. *Third*, development of human resources is an essential underpinning of the first two (United Nations, 1991).

Nutrition is an *outcome*, a result of access to food, dietary intake, health and care of the individual. It is also a precondition to the development of human resources; fulfilling most human aspirations as individual development, good health, and self-fulfillment. For societies and nations, adequate nutrition is required for their function and success. The concerns range from day-to-day meeting of basic needs, including survival especially in infants and children, through lagged effects on performance of individuals and societies, to inter-generational influences notably through women’s nutrition.

Poor nutritional status of the individual results usually from a combination of inadequate dietary intake and infectious diseases. Malnutrition is extensive in the world. It implies both under-nutrition including micronutrient deficiencies, and over-nutrition. There is (by definition) no single measure. However, from some widely quoted indicators, we can derive a usable picture. For example, some 150 million children are *underweight*; around 500 million women *anaemic* due to iron deficiency; over 20 million *low birth weight* infants born each year; some 40 million children are estimated to be *vitamin A deficient*, and over 1,000 million people either suffering or at risk of *iodine deficiency*. Such trends are particularly relevant to understand the magnitude of malnutrition. The MDGs, goals proposed by WHO/UNICEF at the World Summit for Children and in a number of international contexts reiterate such aims: to eradicate severe malnutrition, and to reduce mild/moderate malnutrition by half. Such goals can be met only with a great deal of deliberate action.

Box 11.6: Nutrition and the Millennium Development Goals

Goal - 1 Eradicate extreme poverty and hunger: Under-nutrition contributes to dysfunctional societies with individuals too weak, too vulnerable to disease, and too lacking in physical energy to carry out the extraordinarily laborious tasks of escaping the poverty trap. Malnutrition and hunger feed directly into ill-health and poverty.

Goal - 2 Achieve universal primary education: The effectiveness of universal primary education is in part dependent on avoiding the cognitive damage associated with iodine deficiency in pregnancy, iron deficiency in infancy and protein-calorie malnutrition in preschool children.

Goal - 3 Promote gender equality and empower women: Chronic under-nutrition of women and the strong gender bias robs them of control of their lives. There is a link between the empowerment of women and the achievement of MDGs.

Goal - 4 Reduce child mortality, and Goal-5: Improve Maternal Health: Goals 4 and 5 can be achieved only with the elimination of micronutrient deficiencies, such as iodine, vitamin A, folic acid, iron and zinc. Continuing to promote early exclusive breastfeeding and supporting better prenatal care will also help.

Goal - 6 Combat HIV/AIDS, malaria and other diseases: Infectious diseases and malnutrition are synergistic. Nutrition plays an important role in the severity and outcome of infectious diseases and on the effect of infections in precipitating nutritional deficiencies and stunting.

Goal - 7 Ensure environmental sustainability: Nutrition is dependent on food, but food security requires environmentally sustainable food production in terms of sound cropping practices.

Goal - 8 Develop a global partnership for development: Because of the link between malnutrition and poverty there is a need to promote global partnerships for development.

Source: Nevin S Scrimshaw. 2004. 'The SCN and the Millennium Development Goals' in *SCN News #28 July 2004* <http://www.unsystem.org/scn/Publications/SCNNews/scnnews28.pdf>.

11.5.1 Nutrition Programmes in India

Article 47 of the Constitution of India clearly mentions that state shall regard raising of the nutrition and the standard of living of its people and the improvement of public health as its primary duties. Consequently, several programmes, missions and acts including a National Nutrition Policy (1993), National Nutrition Plan of Action (1995) and National Nutrition Mission (2001) have been formulated with scientific and technological underpinning. Coalition for Sustainable Nutrition Security was initiated in the year 2008 by Professor M. S. Swaminathan. The coalition includes politicians, administrators, scientists, NGOs, international agencies and industries as partners. The nutrition safety net programmes for increasing availability and access to food and nutrition, and improving assimilation (absorption) are elucidated in the box below.

Box 11.7: Nutrition Safety Net Programmes

Increasing Availability of Food

- 1) Rashtriya Krishi Vikas Yojana – Increased investment in agriculture to increase growth.
- 2) National horticulture mission — Horticulture production has doubled. However, focus is on income and export, rather than nutrition.
- 3) National food security mission — Focus is on rice, wheat and pulses.

Improving Access

- 1) National Rural Employment Guarantee Act (NREGA).
- 2) Integrated Child Development Service (ICDS) — targeted at preschool children and pregnant and lactating mothers. Supplementary feeding is an important component of ICDS.
- 3) School Mid-Day-Meal programme (MDM).
- 4) Annapoorna scheme – 10 Kg food grains to elderly above 65 years.
- 5) Food Security Act (proposed) — National Food Security Act now being debated in the parliament promises 25 Kg rice or wheat at Rs.3/Kg for families below the poverty line (BPL).
- 6) Public distribution system — Currently targets BPL population, leaving out a vast segment of undernourished people above the poverty line. The issue of BPL and targeted PDS needs to be revisited from the point of view of nutrition security for all.
- 7) Micronutrient supplementation programmes like a) anaemia prophylaxis programme (distribution of iron folic acid tablets to pregnant and lactating women, children, and adolescent girls), b) massive dose of vitamin-A programme (administration of 100,000 iu of oral vitamin-A to 1-6 years old children). Linking it with measles immunization and thus netting younger children is being tried.
- 8) Universal iodization of salt to combat iodine deficiency disease.

Improving Absorption of Nutrients

- 1) Rajiv Gandhi drinking water mission.
- 2) Total sanitation programme.
- 3) National rural health mission (2005). Emphasis is only on disease prevention and mortality. Surprisingly, it does not mention about *nutrition*, without which diseases cannot be prevented.

Source: Indian National Science Academy. 2009. *Nutrition Security for India – Issues and Way Forward. A Position Paper.* Indian National Science Academy, New Delhi.
www.insaindia.org/Nutrituion%20security%20position%20paper.pdf

11.5.2 Nutrition Scenario: Status and Trends

The initiatives as mentioned above have yet to achieve nutrition goals. India's nutritional ranking globally vis-à-vis other countries is also very gloomy. The box below explains clearly the dismal status.

Box 11.8: India's Nutritional Ranking

- India's infant and maternal mortality rates, 80 and 517 respectively, are higher than even the neighbouring countries like Sri Lanka (12, and 60) and Bangladesh (54 and 350).
- Sex ratio including juvenile sex ratio has shown alarming reduction over the years- (964 in 1971, 927 in 2001). This cannot be explained on education or income, because lowest sex ratios are seen in educated and wealthy communities. It shows deep-rooted gender bias.
- India's ranking in Human Development Index (2009) which incorporates life expectancy, adult literacy, and school enrollment and per capita income is 134 out of 182 countries.
- India's ranking in Global Hunger Index is 66 out of the total 88 nations surveyed. The survey is based on child malnutrition, child death rate and less calorie intake. India's position is lesser than Bangladesh and many Sub-Sahara nations.
- India's ranking in Global Gender Gap Index is 113 out of 130 countries. It takes into consideration, Political empowerment (rank 25), Education attainment (rank 116), Health and survival (rank 128).

Source: Indian National Science Academy. 2009. *Nutrition Security for India—Issues and Way Forward. A Position Paper*. New Delhi: INSA. See www.insaindia.org/Nutrition%20security%20position%20paper.pdf.

Malnutrition is seriously and adversely impacting the country's development and health care expenditure. Almost 60% of deaths due to major infectious diseases are caused by coexistence of under nutrition. In India, 36% deaths and 42% DALYs lost are due to communicable diseases, perinatal and maternal conditions and nutritional deficiencies. Lifestyle and environment-related diseases like obesity, diabetes, hypertension, cardio-vascular disease, and cancers are also increasing. The magnitude of double burden of under-nutrition and over-nutrition is elucidated in the box below.

Box 11.9: Magnitude of the Double Burden of under-nutrition and over-nutrition

According to the findings of a National Family Health Survey (2005-06):

- The prevalence of low birth weight (LBW) is nearly 30%.
- About 55% of preschool children are under-weight (weight for age), and 50% stunted (weight for height).
- Micronutrient deficiencies, mainly iron deficiency anemia (70% in women and children), iodine deficiency disorders, and vitamin-A deficiency continue to be public health problems, though prevalence of goitre has declined and blindness due to vitamin-A deficiency has been

eliminated. B-vitamins deficiencies (riboflavin, folic acid and B12) are common. Despite tropical sunlight, reports of vitamin-D deficiency in adults and children are appearing. Osteoporosis in women, perhaps due to calcium and vitamin D deficiencies has become a public health problem.

- There are marked interstate variations with some of the southern states mainly Kerala and Tamil Nadu, which were traditionally better, are continuing to be better than states like Bihar, Madhya Pradesh, Uttar Pradesh, Rajasthan and Orissa.

Surveys of the National Nutrition Monitoring Bureau reveal that:

- Overweight and obesity are increasing; 7.8% men and 10.9% women are overweight.
- A fourth of Indian adults have hypertension.
- 5-6% has impaired glucose tolerance or diabetes.
- Cereal-pulse based Indian diets are qualitatively deficient in micronutrients, particularly iron, vitamin-A and riboflavin (hidden hunger). There has been substantial erosion of millets production and consumption over time.
- More than 70% of preschool children consume less than 50% Recommended Dietary Allowance (RDA) of iron, vitamin-A and riboflavin.
- The rising trend in obesity can be attributed to shift from traditional diets which were bulky, had low energy density, were slowly digested and had high protein, low fat, unsaturated fats, and complex carbohydrates-fiber.
- Burden of infectious diseases is very high in India due to poor environmental sanitation, water scarcity, particularly potable water, and poor personal hygiene.
- Life-style related factors contribute substantially to malnutrition (often over nutrition) and chronic diseases. Migration, urban-rural living, work environment, loss of sleep, abuse of alcohol, tobacco, recreational drugs, etc which lead to stress.

Source: Indian National Science Academy. 2009. *Nutrition Security for India—Issues and Way Forward. A Position Paper.* New Delhi. INSA. See www.insaindia.org/Nutritiuion%20security%20position%20paper.pdf.

The reasons for poor nutritional status are as follows (Indian National Science Academy, 2009):

- 1) Nutrition is a poor cousin even in health and agriculture planning and execution;
- 2) Nutrition improvement is not a stated goal with measurable parameters for monitoring in missions like National Food Security Mission, National Horticulture Mission and National Rural Health Mission, except those aimed at income, sanitation and drinking water in particular;

- 3) Top-down approach without sensitizing the community and making them partners in planning and execution;
- 4) Poor targeting, accountability and governance;
- 5) Inadequate importance to nutrition in school, college and even professional (health, agriculture, social science) education;
- 6) Neglect of women and children's health and education.
- 7) Vertical programmes with poor convergence and synergy between functioning of ministries and departments.

Nutrition Security implies physical, economic and social access to balanced diet, clean drinking water, safe environment, and health care (preventive and curative) for every individual. Without nutrition, neither communicable nor non-communicable diseases can be prevented and hence it should have an important status as an independent entity.

Access at affordable cost to balanced diet at household and individual level, knowledge of right feeding practices, clean environment and safe drinking water, and health care outreach — primary and curative — should be made available to all, particularly those below poverty line. Education and awareness are needed to utilize these services. Education, particularly of women is important for optimum utilization of the available services and creating demand. All planning and execution should be done with community participation and involvement of trained nutrition leaders from the community. There should be more scientific dialogue and interaction between and among nutrition scientists, scientists belonging to agriculture, medicine, public health, and basic sciences and social scientists.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions."

- 7) Name nutrition safety net programmes related to improving access to food.

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8) Explain micronutrient deficiency.

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9) What do you understand by the term Nutrition Security?

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11.6 GENDER ISSUES IN DEVELOPMENT

Like race, ethnicity and class, gender as a social category shapes and establishes one's life chances in society and development. The term *gender* refers to a set of roles, attributes behaviours expected from women and men by their societies. *Gender relations* represent the ways in which the *socially constructed* categories of women and men relate over a wide range of social interactions within family, community as well as in all economic and political relations in a given society. Gender relations are institutionally constructed. It creates and reproduces systemic differences in the positioning of women and men in the society. Rules, norms and practices of gender relations have a strong ideological content as it reflects the normative or prescriptive version of female and male roles. As gender relations are constituted in terms of relations of power and dominance; therefore, the nature of gender relations is one of opposition and conflict and often takes the form of male dominance and female subordination (Pant and Farrell, 2007).

Gender is a salient factor in participation and representation in development processes; both women and men need to actively participate. The nation-states world over guarantee all its citizens the right to equality. The criteria of equality between sexes afford women the right to participate and represent without any discrimination. But, do women really participate equally with men? Women and men do not have equal social, economic and legal rights. Women still lack

independent rights to own land, manage property, conduct business or even travel without the husband's consent. Women continue to have poor command over a range of productive resources including education, land, information and financial resources. Limited access to resources and weaker capabilities constrain women's power to influence resource-allocation and investment decisions at home, in their community and at national level. Women remain vastly underrepresented in national and local government (Pant and Farrell, 2007). A close look at the recent gender development indicators in India reveals disadvantaged positions of women (See Box 11.10).

Box 11.10: Gender Development Indicators in India

Sex Ratio

- The sex ratio is 933 women per 1000 men according to the 1991 Census. (The world average is 990 women per 1000 men).
- The sex ratio of the 0-6 age group has declined sharply from 945 in 1991 to 927 in 2001.

Health and Nutrition

- In rural India almost 60 per cent of girls are married before they are 18. Nearly 60 per cent of married girls bear children before they are 19. Almost one-third of all babies are born with low birth weight. 80 per cent of women are anaemic.
- Maternal mortality is estimated to be 385-487 per 100,000 live births. Close to 125,000 women die from pregnancy and pregnancy-related causes each year.
- Social restrictions on women's mobility also contribute to lesser healthcare for women and children. For example, 90 per cent of married women in Uttar Pradesh and Jammu and Kashmir and about 80 per cent in Bihar, Madhya Pradesh, Rajasthan, Haryana, West Bengal, Andhra Pradesh and Assam need permission to visit even friends and relatives.
- Women's health tends to be viewed narrowly as reproductive health, whereas many factors need to be considered. For instance, communicable diseases are more of a threat to women than pregnancy. Tuberculosis and not pregnancy is the leading cause of death of women in the reproductive age group followed by burns and suicides.

Water and Sanitation

- Only 62.3 per cent of Indian households have access to safe water — 81.4 per cent urban and 55.5 per cent rural households. This means that women spend a considerable amount of time carrying water from distant wells and other sources, adding to women's burden.
- Access to sanitation facilities is a special problem for women and girls, given the social emphasis on privacy and seclusion. Having to go out exposes them to harassment. Women and girls living in urban slums are particularly affected. Public toilets for females are few. Even many schools do not have toilets for girls and women teachers.

Education

- 53.67 percent of women are literate as compared to 75.26 per cent of men.
- Fewer girls go to school. Fewer girls are in school for more than ten years. Dropout rate amongst girls is high. More than 50 per cent girls dropout by the time they are in middle school.

Employment

- Work participation rate of women is 25.6 percent as compared to 57.9 percent men. Only 4.83 percent of them, compared to 23.20 percent men, are in organized sector. Women generally work in unorganized informal sector, in piece-rate and subcontracting work. They earn a far lower wage than men doing the same work.

Political Participation

- They are underrepresented in governance and decision-making positions. For instance, there are about 72 women in Parliament as against 712 men. There are 725 women compared to 1997 men in Panchayati Raj Institutions.

Social Status

- Violence, both outside and within the household, is a grim reality of women's lives. Between 1990 and 1996 crimes against women grew by 56 per cent. Cruelty to wives comprised 28 per cent of all crimes in 1996.
- The extent of trafficking in women is unknown. However, one official study admits to 100,000 prostitutes in six metro cities. Of these, 15 per cent are girls below the age of 15. Cross-border trafficking is common.
- According to the National Sample Survey Organization figures, one out of ten households is headed by a woman. Women-headed households include widows, deserted and divorced wives and single women. They tend to be among the poorest households in the country.

Source: Madhok Sujata. 2008. 'Women: Background & Perspective' in *InfoChange women, News and Analysis on Social Justice and Development Issues in India*. Pune. See <http://infochangeindia.org/women/backgrounder/> — Accessed in July 2011.

11.6.1 Factors Constraining Participation of Women in Development Processes

A noteworthy factor responsible for non-participation of women is *unequal gender relations*. Gender relations and power distribution between the sexes in both the private (personal) and public spheres create gender inequalities. Unequal gender relations, reproduced across the range of inter-related institutions such as household, community, market and state, mediate the construction of gender identities and synergistically determine the capacities to exercise independent agency. Such relationships determine and influence the ways the resources, roles and responsibilities are allocated; values are assigned and power is mobilized. Without any sense of power, whatsoever, their participation in decision-making is generally minimal not only in political sphere but also at home and within the community.

Private-public divide associated with women and men have always hindered women to negotiate in the public domain. The private domain is associated with household, reproductive work and femininity, whereas, the public domain is associated with political authority, public decision-making, productive work and masculinity. Women are either being criticized for their inadequacies or patronized by men.

Autonomy of women in family/household also influences their status and ability to participate in governance. Development policies often conceptualize altruist, conflict-free, harmonious households where production, income and consumption are equally shared. Empirical studies, on the contrary, have shown that far from being a unit where all resources and benefits are pooled and shared equitably, the use of resources and labour, distribution and output, have to be constantly negotiated within the households. Intra-household relations are often conflictive. The bargaining power is derived from options available to household members, the perceptions of contributions by members to the household prosperity and the degree to which members identify their self-interests within their personal well-being. Although, the private domain of household is typically associated with women, men are held responsible for the welfare and safety of all members. Women's bargaining power at the household is restricted typically due to lack of access and control over resources, no autonomy in decision-making, low self-esteem, low skills and education, restricted physical mobility and eventually less power as compared to men.

Other intersecting hierarchies such as *class, caste, ethnicity, religion, and rural/urban locations* further complicate gender inequality. In India, for example, women face hurdles posed by patriarchy, caste and class when they enter political domain. Women from low caste groups, despite reservations, seldom wielded any real political power due to the strongly entrenched notions of caste and gender hierarchy. Studies have also shown that women elected representatives with no economic entitlements were often under the control of those who owned and controlled resources (usually males). Consequently, dependency curbed their independent decision-making powers.

The existence of persistent discrimination against women and inequality between women and men requires that engendering governance strategies by and large complemented with targeted interventions on women's empowerment. Definition of empowerment ranges from increasing choices available to and capacities of women to transforming the power structures of society. It is assumed that by increasing women's choices, capacities, decision-making power, women's right and gender equality can be realized at all levels of decision-making (Pant and Farrell, 2007).

11.6.2 Gender Mainstreaming in India

The concept of bringing gender issues into the mainstream of society has been clearly established as a global strategy for promoting gender equality in the development agenda. Mainstreaming is not just about adding a "women's" component into an existing activity. Mainstreaming brings together the experience, knowledge and interests of both men and women to build upon the development agenda. Gender mainstreaming requires that all policy, planning, implementation and resource allocation reflect the interests and the views of both women as well as men.

Before the Decade for Women, development essentially had a *welfare* approach, addressing the practical needs of women surrounding their reproductive role through delivery of food, family planning, health care, etc. The *Women in Development (WID) approach*, ushered in during the Decade for Women, was initially conceived as an *equity* approach. This approach recognized women's active role in the development process as reproductive, productive and community workers, and emphasized the fulfillment of their strategic needs through direct state intervention. However, due to its political nature, this approach was not very acceptable to governments, and was soon replaced by an *anti-poverty approach*. The *efficiency approach* sought to enhance women's contribution to the development process in order to ensure the efficiency and effectiveness of project interventions, albeit it tended to assume that women's time and energy are elastic. The *empowerment approach* considered women's improved condition and position to be the ends in themselves. It focused on meeting women's strategic needs focusing on a bottom-up, self-reliant approach. The equity and empowerment approaches together labelled as *Gender and Development (GAD) approaches* because of their emphasis on strategic needs. *GAD* changed the focus and interventions from women as a target group to gender analysis of women and men's roles and relations as part of all development interventions, and to gender equality as a goal of development. More recently, a *rights-based approach* sets the achievement of human rights and the creation of an enabling environment in which human rights can be enjoyed as the main objectives of people-centered sustainable development, as well as the means to achieve it. In this way, a *rights-based approach transcends sectoral concerns, and encompasses the concepts of welfare, anti-poverty, equity and empowerment as facets of the rights of all people.*

The UN summits on the environment, social development, human rights and population brought issues of women's rights to the forefront of international development debates. A major breakthrough was in getting women's rights on to the mainstream human rights agenda. Women's movements across the world mobilised and organised in the build-up to the Vienna Human Rights Conference in 1993. The recommendations made by women's rights groups were included in the Vienna declaration and Programme of Action. The mobilization on rights continued in Cairo's conference on Population and Development in 1994. The Beijing conference saw major advances in pursuing women's rights commitment. It took forward the Cairo agenda and crystallised the core rights issues: equal rights in law, entitlement to productive resources, right to education and health, equal right to representation in decision-making, security and freedom from violence. The Beijing Platform for Action, 1995 (BPFA) provides the comprehensive mandate for governments to ensure that gender equality and women's empowerment are actively addressed as core development concerns. It clearly mentions that without the active participation of women and incorporation of the perspectives of women in all levels of decision-making, the goals of equality and development cannot be achieved. The BPFA became the basis for civil society advocacy. Many NGOs and civil society groups used the policy recommendations and agreements to lobby with their own governments.

Complementing the BPFA is the Convention on the Elimination of Discrimination against Women (CEDAW). It is one of the most important international human rights instruments having a legal binding. These two mandates have informed the most recently proposed Millennium Development Goal (MDGs) that resolves to promote gender equality and women's empowerment to combat poverty, hunger, and disease and to stimulate sustainable development.

Achieving equal participation in decision-making and governance is a high priority according to the recommendations of World Summit on Social Development. Addressing gender issues in governance requires states to create space for women to participate at all levels. Its recommendations are consistent with other International agreements such as Agenda 21. Agenda 21 is a comprehensive plan of action to be taken globally, nationally and locally by organizations of the United Nations System, Governments, and Major Groups in every area in which human impacts on the environment. It represents a *global consensus and political commitment at the highest level* on socio-economic development and environmental cooperation. One of its commitments is allowing people to participate in decision-making at all levels; particularly empowering women and increasing their participation in decision-making (Commonwealth Foundation, 2004).

Gender mainstreaming in India emerged in the early 1980s as a concern of the women's movement to move women's issues from the periphery to the centre of development decision-making. The Eighth Plan (1992-97) spoke of the need to ensure a definite flow of funds from the general development sectors to women. The Ninth Plan introduced the Women's Component Plan to ensure that 30% of funds/benefits under various welfare and developmental schemes were to be earmarked for women. The Tenth Plan reaffirmed the major strategy of mainstreaming gender perspectives in all sectoral policies, programmes and plans of action. Women specific interventions are undertaken to bridge existing gaps.

India's commitment to gender equality is further evidenced by the fact that it is a signatory to Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which was ratified on 25-6-1993. The aim of the National Policy for the Empowerment of Women (2001) and the Tenth Plan has been to bring about social change — changes in attitudes towards women and women's empowerment. The effort is to bring gender justice and make *de jure* equality into *de facto* equality. Among the most significant achievements of the decade has been the reservation of one-third of the seats for women elected as representatives in Panchayats and urban local bodies through the 73rd and 74th Constitutional Amendments. This has brought about a million women into positions of decision-making and has contributed significantly to the political empowerment of women (Pant and Farrell, 2007).

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions."

10) What do you understand by the term 'gender relations'?

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11) How does private-public divide affect women's access to development processes?

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12) What is gender mainstreaming?

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11.7 ISSUES OF MARGINALIZATION AND EXCLUSION IN DEVELOPMENT

Marginalization refers to the process of becoming or being made marginal (especially as a group within the larger society). Individuals and groups are often ignored or relegated to the sidelines of political debate, social negotiation, and economic bargaining and are kept there. Marginalization combines discrimination and social exclusion.

Exclusion is a process through which certain segments of the population are wholly or partially kept out of social interaction; or cast-out from full participation in the society within which they live. Caste, class, gender, sexual orientation, disability, age, language, employment status, migrant status, HIV status, educational status, skill, race, and religion are some of the criteria that marginalize and exclude people. Discrimination occurs in public institutions, such as the legal system or education and health services as well as social institutions like the household (Department for International Development, 2005).

Box 11.11: The Most Vulnerable Marginalized and Excluded Groups

The marginalized and excluded groups share a sense of collective identity and common burdens. These groups include the following.

- **Women** are, in general, always marginalized relative to men, in every country and culture. They don't present a homogeneous category in terms of common interests, abilities, or practices. Women belonging to lower classes, lower castes, illiterate, and the poorest regions have different levels of marginalization than their better-off counterparts.
- **People with disabilities** battle against biased assumptions, stereotypes, and irrational fears. The stigmatization results in the social and economic marginalization.
- **Minority** include any group that is considered subnormal with respect to a dominant group, in terms of social status, education, employment, wealth, political power and religion. It is not necessarily a numerical minority. It suffers from discrimination and subordination.
- **Caste** system is a strict hierarchical social system based on underlying notions of purity and pollution. Brahmins are on the top of the hierarchy and Shudras or *Dalits* constitute the bottom of the hierarchy. The marginalization of *Dalits* influences all spheres of their life, violating basic human rights such as civil, political, social, economic and cultural rights.
- **Tribes** are marginalized across nations, whether it is advanced countries like the USA, Australia or the developing and underdeveloped countries in Asia and Africa. In India, the Scheduled Tribes are socially and economically disadvantaged. They are mainly landless with little control over resources such as land, forest and water. They constitute a large proportion of agricultural labourers, casual labourers, plantation labourers, industrial labourers, etc. This has resulted in poverty, low levels of education and poor access to health care services among them.
- **Elderly** are the most neglected group of population. Children of elderly in many families consider expenditure on care for elderly such as on their health and nutrition as wastrel investment. The stereotypes, that the old age people are usually subject to such kind of illness, add further to their neglect.

Source: IGNOU. 2010. "Unit 3 Marginalization" in *Block 4 Development Imperatives*. MEDS-002 Dynamics of Extension and Development. See <http://www.egyankosh.ac.in/bitstream/123456789/34923/1/Unit3.pdf>.

11.7.1 Types of Marginalization and Exclusion

There are various types of marginalization and exclusion. As we have mentioned elsewhere above, marginalization subsumes both discrimination and social exclusion. We will discuss the types of marginalization below.

11.7.1.1 Social Marginalization

Marginality is both ascribed and acquired in a social setting. The experience of marginality arises in a number of ways. People who are severely impaired from

birth, or are born into marginal groupings (e.g., lower castes in India, members of ethnic groups, nomads), experience life-long marginality. For others, marginality is acquired by later disablement or by changes in the social and economic system. For instance, communities are dispossessed of lands, livelihoods, or systems of social support due to development policies.

Socially marginalized people are by and large deprived of social opportunities. They become stigmatised and are often at the receiving end of negative public attitudes. Their opportunities to make social contributions may be limited, and they may develop low self-confidence and self-esteem. They have relatively limited access to valued social resources such as education and health services, housing, income, leisure activities and work.

Another problem is that people born in a marginalized community lack the required social and cultural capital to participate in mainstream development processes. Their social networks are weak and vulnerable. Lack of social capital deprives an individual of access to resources such as economic, educational, cultural and other support systems. This creates social isolation and limits their participation in the development process (IGNOU, 2010).

Box 11.12: Nomads in India

Nomads in India such as *Gadiya Luhar*, *Banjara*, *Nat*, *Bhopa*, and *Bawariya* move from one place to other providing specialised services to settled communities. The *Banjaras*, for instance, are trading nomads dealing in salt, *multani mitti* (fuller's earth) and cattle. The *Gadiya luhars* are blacksmiths. They fabricate and repair iron tools and utensils, moving shop from village to village. They get their names from their *Gadiya* (bullock driven carriages) and *luhars* (blacksmiths). The *Bawariya* hunt wild animals. The *Nat* are itinerant entertainers. They are acrobats, performing at village fairs. *Bhopa* are sacred specialists, sing ballads and recite poetry, often extempore. Because movements of nomads are unpredictable, their dwellings keep shifting and they do not follow the norms of sedentary societies; settled communities in the villages treat them suspiciously. They are stigmatized, ostracized, and marginalized. They generally live beyond the village limits in isolated clusters of huts.

Their traditional means of livelihood, formerly supported by their nomadic nature, have of late become outdated. Changing economic scenario is forcing many nomadic communities to opt for settling down for alternative livelihoods. There has been, however, much social resistance to this. Adverse social stereotype perceptions about nomads and their lifestyles have worsened the situation. They are struggling to meet their basic requirements of shelter, security and livelihood and, most of all, of acceptance in the societies they have chosen to settle down with. Their dwellings are unauthorized. Consequently, they lack basic civic amenities such as safe drinking water, electricity, etc. Besides compounding their poverty, this also leads to their suffering social indignities and harassment. For example, the settlements have no water source of their own; they suffer humiliation whenever they approach village for water. Some settlements are not even linked to roads.

Nomads variously find inclusion as one of the underprivileged groups such as SCs, STs, and OBCs and are, therefore, also entitled to benefit from constitutionally mandated affirmative action and safeguards. Access to state entitlements require formal state recognition in the form of identity cards such as ration card, voter identity card, BPL identity card, and other documents as proof of residence. Many nomadic groups have not found coverage in development benefit schemes available to the below poverty line (BPL) citizens, or even as SCs, STs, OBCs just because they did not have such authorized documents. Consequently they are deprived of benefits of development schemes meant for poor, marginalized communities. Lack of recognition by the state agencies of the rights and entitlements of nomads further reinforce their marginalization. Some politicians, opinion leaders, and state officials have bias against nomads. Many of them believe that they are and would remain wanderers and, therefore, there is not much point in helping them settle down.

Source: Pant Mandakini. 2006. 'Marginalized Citizenship of Nomads' in Ranjita Mohanty and Rajesh Tandon (Ed.) *Participatory Citizenship: Identity, Exclusion and Inclusion*. New Delhi: Sage Publications.

11.7.1.2 Economic Marginalization

Economic marginalization as a process relates to economic structures, in particular, to the structure of markets and their integration. To the extent in the markets that some individuals or groups engage in are segmented from the others in general, these individuals or groups can be said to be marginalized from the rest of the economy.

Segmentation and exclusion may, however, have non-economic and non-financial origins, for example, in discrimination by gender, caste or ethnicity. People who are experiencing marginalization are likely to have tenuous involvement in the economy. The sources of their income will vary. These experiences affect men and women differently and vary with age. Poverty and economic marginalization have both direct and indirect impacts on people's health and wellbeing.

The forced population displacement is caused by development programmes implemented by the governments of various nation states. The government of India itself admitted that there are 15.5 million displaced persons when it drafted the National Rehabilitation Policy in 1994. The increasing construction of development projects consistently displaced a massive number of tribal, poor, and weaker sections. The ultimate gainers are the contractors, businessmen, industrialists, politically and economically well-ups, and the real poor are the underdog. As a consequence, we find social unrest, resistance, and disharmony in many parts of the globe (IGNOU, 2010).

Box 11.13: Economic Growth and Impact on Tribals

The post-liberalization phase of Indian economy has opened the floodgates for extractive industrialization by the corporations both Indian and multinationals. Most of the regions in India, endowed with mineral and natural resources are, by and large, in the tribal areas. The states of Andhra Pradesh, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh and Orissa comprise of the mining corridor in India. This corridor is inhabited by a large tribal

population since times immemorial. It is also a region with a huge and dense forest cover, hills, and with a large variety of flora and fauna.

The mining and industrial policies of these states clearly specify that the government would facilitate development of mineral-based industries by providing necessary infrastructure for investment, reducing the cost of production for the investor, and ensuring an 'investor- friendly' administration. Consequently, the state governments have signed MOUs with the private industries to establish mining, steel, sponge, iron and power plants.

The tribals are the real victims of the acquisition of their lands. The law prohibits the sale of tribal lands. The amended Land Acquisition Act, 2009 emphasizes consultations with the people likely to be affected, and provides for Social Impact Assessment and Ombudsman for the grievance redressal. The Forest Right Act, 2006 also makes approval of gram sabha mandatory for any diversion of forestland for any form of land acquisition. Yet, land acquisitions have taken place on unrecorded basis through fraudulent and coercive means without often even mentioning the amount of compensation, in a non-transparent manner. Size of the average operational land holding in the tribal lands in the cited States has become progressively smaller over the years on account of accelerated land acquisition for industrialization facilitated by the Government. The marginalized tribals lack power to oppose the acquisitions or to even bargain a suitable cost / livelihood deal for themselves.

Source: Pant Mandakini. 2010. *Claiming Rights in the Era of Rapid Economic Growth: Issues in Multi-party Accountability towards Environmentally Sustainable Inclusive Development in Chhattisgarh & Jharkhand*. Unpublished paper.

11.7.1.3 Political Marginalization

Political marginalization does not allow the group to participate democratically in decision-making, and, hence, they lose their right to every social, economic and political benefit. Political empowerment is one of the most important tools for accessing other social and economic privileges. In every society, lack of political empowerment affects large sections of people including women, ethnic minorities, migrants, disabled persons, elderly, etc. So far as gender is concerned, we find that participation by women is minimized across the globe. It is men who hold power and lead politics around the world. This is true at all levels of power in politics, whether it is party leadership, elected offices, appointed offices, or at policy-making levels. This is a particularly acute problem in the third world countries, where women's participation in political affairs is mostly linked with the dominant, male-oriented social, cultural and religious environment (IGNOU, 2010).

Box 11.14: Women Leaders in Panchayati Raj

The 73rd Constitutional Amendment Act of 1992 enabled 33 percent representation of women in Panchayats. Since Indian rural women by and large experience marginalization, deprivation and oppression, it is assumed that affirmative action will build a critical mass of local leadership who will be active participants in the strategic decision-making process. The political representation will give them the voice and a solidarity base to

change initial gender-biased preferences and help in formulating democratic policies. The constitutionally mandated Panchayats and constitutionally mandated participation of women therein will change the power concentration. The opportunity for women to participate in local self-governance, however, has not actually transformed the prevailing institutional practices (relations), which still emphasize male dominance. A study finding on women leadership in Panchayats, elucidated below, corroborate this statement.

- Majority contested from the reserved seats.
- Elected women representatives (EWRs) contested elections primarily to fulfill family's wish. Husband and other family members such as father-in-law, brother-in-law by and large decided the candidature of women elected representatives. Political parties, previous elected representatives and NGOs also determined the candidature of WERs.
- The local body meetings were overwhelmingly male-dominated events. Sheer presence of men intimidated EWRs. They participated only to sign registers. Often their spouse or male relatives attended the meetings on their behalf. A significant section of them remained a mute spectator by proposing nothing in the meeting.
- The household work, working in the field or engaging in income-generating activities influenced the extent of their political engagements. Daily pressures of occupation as well as household often prevented them to undertake additional governance related responsibilities. They did not mind their husbands or adult family members taking interest in their activities and even acting on their behalf. They depended on them for day-to-day advice and support on governance related matters. Domestication and seclusion ethics undermined their potential for holding public office.
- Every day practices of elected male representatives (EMRs) and Government officials construe men as the only real political actors. EMRs and government officials had reservations about the potentials of EWRs to govern. They felt that illiteracy, lack of communication skills and dependency inhibited their participation in the local politics. The masculinity of political processes, the adversarial proceedings, subtle forms of coercion to conform to the central interests of EMRs, the timing of meetings and sessions, the pervasiveness of patronage, etc., curb and control women leaders' self-determining behaviour. The patriarchal nature of local administration reinforces a sense of worthlessness among these women.
- Internalisation of dominating ideologies and stereotypes about gender roles, values and behaviour deterred women to take on active leadership roles. Many EWRs described themselves as housewives with no sense of independent identity. Low self-esteem has made them passive, dependent on men in matters relating to governance.

Source: Pant and Farrell. 2007. 'Gender & Governance: Empowering Women's Leadership', in Rajesh Tandon (Ed) *Citizen Participation and Democratic Governance: In Our Hands*. New Delhi: PRIA.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under
“Answers to ‘Check Your Progress’ Questions.”

13) Define Exclusion.

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14) Explain the consequences of social marginalization.

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15) What is political marginalization?

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11.8 CULTURAL ISSUES IN DEVELOPMENT

Culture refers to full range of learned human behavior patterns which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society (Tylor, 1871).

We can think of culture as comprising *three layers or levels* that are part of learned behavior patterns and perceptions. *Cultural pattern* is the *first layer*, which distinguishes one society from the other. It is a behaviour pattern common among the members of a given community or group. When people speak of Indian, Italian, British, Japanese, etc, cultures, they are referring to the shared language, traditions, and beliefs that each of these peoples share apart from others. Cultural patterns are of two types: *ideal cultural patterns* and *actual behaviour patterns*. Ideal cultural patterns define how the people of a society should behave in particular situations. But, people do not always behave according to the ideal patterns as defined by their society, they sometimes deviate from them. Actual behaviour patterns refer to the manner in which people actually behave in particular situations. A cultural pattern generally combines two or more elements in a given culture. The tradition of untouchability, which has been abolished way back in India at the time of framing of our Constitution in India, comprised the following elements: the notion of inequality among human beings, the ranking of individuals and groups in terms of high and low, the association of ritual purity and pollution, birth and occupation, food and touch.

Subculture is the *second layer*. In complex diverse societies comprising of people from different parts of the world, people often retain much of their original cultural traditions. As a result, they are likely to be part of an identifiable subculture in their new society. The shared cultural traits of subcultures set them apart from the rest of their society. Examples of easily identifiable subcultures in the United States include ethnic groups such as Vietnamese Americans, African Americans, and Mexican Americans. Members of each of these subcultures share a common identity, food tradition, dialect or language, and other cultural traits that come from their common ancestral background and experience. As the cultural differences between members of a subculture and the dominant national culture blur and eventually disappear, the subculture ceases to exist except as a group of people who claim a common ancestry. That is generally the case with German Americans and Irish Americans in the United States today. Most of them identify themselves as Americans first. They also see themselves as being part of the cultural mainstream of the nation.

The *third layer* of culture is *cultural universals*. These are learned behavior patterns that are shared by all of humanity collectively. No matter where people live in the world, they share these universals. Examples of such “cultural universals” include:

- 1) *Cultural trait*, which is the smallest identifiable unit of a culture, such as bow and arrow. The system of primogeniture, which is prevalent in most parts of India and other countries and according to which the eldest son succeeds his father after his death, is an example of a cultural trait. The aggregate of cultural traits is referred to as a *cultural complex*. The jajmani system, which was prevalent in many parts of rural India provides an illustration of a cultural complex. The *jajmani system* refers to a complex

network of economic, social and cultural relationship between a food producing family and an artisan family. A farming family, for example, gets its agricultural tools and implements made and repaired by the former a part of the crop at harvest-time.

- 2) *Cultural Symbols*, with special meaning and significance are attributed to certain objects and things by members of a given culture. A flag, for example, is the symbol of a nation. The sacred thread worn by Hindu men in India is a symbolic index of the same. It is a symbolic pointer to their *dwija* or twice-born status.
- 3) *Cultural ethos* is the world-view of people, their conception of the world and of man's relationship with the world. The ethos of Indian culture is expressed in terms of the concept of dharma which refers to moral duty or right conduct. The concept of Hindu dharma finds expression in the *four life-stages (varnashrama dharma)*: student, house-holder, forest dweller and ascetic. Each of these stages is associated with a distinct set of duties and obligations.

The universal components of culture can be analytically separated into the following units (http://anthro.palomar.edu/culture/culture_1.htm):

- *Technology* refers to the system of tools, implements and artifacts, made and used by a group of people to meet their basic needs.
- *Economic organisation* includes the techniques which are employed by a group of people in organising the production and distribution of goods and services.
- *Social organisation* refers to the framework of social and inter-personal relations — Using age and gender to classify people, e.g. teenager, senior citizen, woman, man; classifying people based on marriage and descent relationships and having kinship terms to refer to them, e.g. wife, mother, uncle, cousin; having a sexual division of labor, e.g. men's work versus women's work.
- *Political organisation* refers to the ways and methods of controlling conflict, and deals with the maintenance of the social order. e.g. leadership roles for the implementation of community decisions.
- *Ideology* includes a guiding set of beliefs, values and ideals. e.g. distinguishing between good and bad behavior.
- *Arts* refer to the forms which ensure the fulfilment of human beings' aesthetic urges. e.g. some sort of body ornamentation.
- *Language* the communicating medium. e.g. a verbal language consisting of a limited set of sounds and grammatical rules for constructing sentences. People in deaf subcultures frequently use their hands to communicate with sign language instead of verbal language. However, sign languages have grammatical rules just as verbal ones do.

11.8.1 Culture in Contemporary Development Discourse

In the earlier development discourse, development was conceptualised either in terms of the spread of western modernity and rationality or in terms of economic growth - the GNP growth. Culture was perceived as one of the elements of 'traditional' societies that needed to be changed. Development meant modernization and westernization of indigenous societies and culture.

Contemporary development discourse focuses on the external world, i.e. the social, political, economic, cultural and natural environment and its impact on human wellbeing. The focus is primarily on outer changes that need to be effected to improve the quality of human life. The underlying premise is that development can be sustainable if there is harmony and alignment between the objectives of cultural diversity and that of social equity, environmental responsibility and economic viability.

There are two primary ways in which culture is incorporated into development; *culture as institution* and *culture as resource*. Poverty, in its many forms, is linked with issues of access to opportunities, and knowledge invariably has a particular impact on social, ethnic and religious groups. For these reasons, the inclusion of minorities and disadvantaged groups in social, political and cultural life remains an ongoing development priority. *Culture as institution* aims to work with local social networks and indigenous forms of organization. By invoking familiar organizational structures, it is envisaged that stakeholders will be encouraged to participate in, take ownership of and lead development. Local cultural values deepen commitment. The community commitment, ownership and participation will enhance the accountability of government, strengthen the demand for appropriate services and involve the members effectively. Multilateral donor organizations such as the ADB and the World Bank endorse the inclusion of the developing nation's culture into their aid projects.

Culture as an economic resource means both tangible and intangible property which can be brought to market. Culture can clearly facilitate economic growth through job creation, tourism and the cultural industries (i. e. culture as an economic sector for production, consumption, and access). Cultural and creative industries are understood in this context as those which comprise the formation, production, commercialization and distribution of cultural goods and services resulting from human inspiration and imagination. They include, among others, printing and publishing, visual and performing arts, cultural tourism and related heritage industries, cinema, music, radio, television and online industries, arts, and design and crafts. Creative industries are one of the fastest growing sectors in the global economy (Beatty and Gibson, 2009).

11.8.2 Culture's Critique of Development

The contemporary development discourse looks upon culture as a good, like health or education, or as an evil, like corruption or child labour. It also seems to appraise culture, as one with the state of the economy, to see whether or not it can be 'improved' to facilitate development. Accordingly, one could then consider strategies to suppress or strengthen aspects of the cultural environment, depending on whether they hinder or promote development goals. Meaning thereby, this discourse does not assume culture to have its own inner dynamics that might have a bearing on development thinking or strategy. Rather, culture is viewed

from outside, as a relatively fixed domain to be confronted, evaluated and acted upon from within a developmental frame of reference:

Culture as an object finds a place on the developmental agenda in two ways. *Firstly*, it is acknowledged to have instrumental value. For example, cultural expression is used by development agencies to spread literacy or to communicate health or environment programmes. As a medium of communication, it is accepted as having a role in contributing to social change, building constituencies, raising consciousness, and even helping to overcome cultural resistance to development ideas. *Secondly*, development agencies use culture as an offshoot of their interest in sustainable livelihoods. Under this rubric, support mostly goes out for projects that enhance the income-generating potential of crafted or performed forms of cultural expression in local communities. The main thrust of such projects is to give these forms access to wider markets. These 'development' programmes sidestep vital issues of culture. The first sees no harm in altering the content of traditional cultural forms to reflect development messages, the second one in treating these merely as products to be bought and sold. Both ignore the fact that local communities attach specific meanings to their forms of expression — meanings that derive from the local context in which, and purpose for which they are presented or produced. In the case of the crafts, for instance, it is not just the materials, colours or motifs that are used, even the very process of creation might have ritual or symbolic significance. As market dictates the nature of the craft product as well as the mode of its production, cultural agents are being reduced to contract labourers. Folk and tribal festivals are being systematically appropriated and commodified, packaged and marketed through electronic media, plucked out of context and cut off from their roots (Panikkar, 1995). They are being alienated from their act of creation and its results, which are emptied of cultural meaning to serve a milieu entirely unrelated to their own. Such projects — rooted in the development concern with sustaining or altering external conditions for the sake of human wellbeing — disregard the intimate and symbiotic relationship between culture and meaning. Because seen as part of an inhibiting or facilitating environment, culture plays no role in determining the nature of development strategies or initiatives.

Empowerment implies 'democratizing the ownership of productive assets, capacities and opportunities' and sharing decision-making powers with the dispossessed or marginalized in matters that directly impinge on their lives. It is assumed that empowerment in this sense would give the disadvantaged a greater *say* in matters affecting their lives and enable them to take control of their lives. But, would shared decision-making powers necessarily be enabling for weaker groups? Given the entrenched caste-based, feudal or patriarchal values and prejudices it is not surprising that the well-intentioned development projects often end up imposing the vision of modernity and development of elitists upon the diversity of culture (Vellani, 2009).

Development affects components of culture. For instance, in India we find that commercial activities have brought the tribals into contact with a cash economy and exploitative relationships. As forest regulations curtailed their earlier access to the forest and its products; their culture, which was based on settled cultivation in relative isolation became increasingly controlled by outsiders (contractors) and the dictates of a wage-labor economy. The development schemes uprooted them from their traditional homelands. Their removal from a forest habitat to the

drought-prone plains is destroying the delicate interplay between culture and environment. Their removal from an economy, where class relations and class structures are least developed, to a semi-feudal economy with a well-defined network of class relations and a rigid caste hierarchy has disrupted the values of communal social life. Faced with the threat to their livelihoods and their culture, tribals across India have begun to organize themselves against development schemes, and the government and private agencies directing them.

Check Your Progress

- Notes:** a) Space given below the question is for writing your answer.
b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions."

16) What is culture?

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17) What is cultural pattern?

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18) Explain culture as an economic resource.

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11.9 LET US SUM UP

In this unit, we learnt about the processes and trends that have influenced understanding of social issues in development in contemporary times. Social issues in development form part of the broader paradigm of human development. They are related to non-monetary factors such as, education, health, nutrition, gender, marginality conditions and culture. Such factors influence people's perceived and/or actual well-being and build their capacity to gain control of their lives.

11.10 ANSWERS TO "CHECK YOUR PROGRESS" QUESTIONS

- 1) *Millennium Development Goal #2* (MDG) of UNDP aims to ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.
- 2) *The objectives of mid-day meal scheme are to:*
 - Improve the nutritional status of children in classes I-V in Government, Local Body and Government-aided schools, and EGS and AIE centers;
 - Encourage poor children, belonging to disadvantaged sections, to attend school more regularly and help them concentrate on classroom activities; and
 - Provide nutritional support to children of primary stage in drought affected areas during summer vacation.
- 3) Gender bias in education refers to gender-based discrimination related to girls' education. Girls and women are likely to be more illiterate than men. Many schools do not have female teachers; do not have separate toilets for girls. Given such dismal situation parents especially of older girls do not feel comfortable to send them to school. The dropout rate among girls, therefore, tends to be very high.
- 4) Three MDGs related to health are as follows: Reduction in child mortality, improvement in maternal health, and combating HIV/AIDS, malaria and other diseases.
- 5) The primary healthcare infrastructure has a three-tier system with Sub-Centers, Primary Health Centers (PHCs) and Community Health Centers (CHCs) spread across rural and semi-urban areas. The Sub-Center is the most peripheral contact point between the Primary Healthcare System and the community.
- 6) The Disability-Adjusted-Life Year (DALY) is a summary measure of population health, integrating mortality with morbidity and disability information in a single unit. It is a time-based measure that combines the year of life (YLL) due to premature mortality and years of life with disability (YLD) or years of life lost due to time lived in states of less than full health.

- 7) Nutrition safety net programmes related to improving access to food are:
 - i) National Rural Employment Guarantee Act (NREGA).
 - ii) Integrated Child Development Service (ICDS).
 - iii) School Mid-Day-Meal programme (MDM).
 - iv) Annapoorna scheme.
 - v) Food Security Act (proposed).
 - vi) Micro-nutrient supplementation programmes like anaemia prophylaxis programme, massive dose vitamin-A programme.
 - vii) Universal iodization of salt.
- 8) Micronutrient deficiencies include iron deficiency anemia, iodine deficiency disorders, vitamins A, B (riboflavin, folic acid and B12), D and calcium deficiencies.
- 9) Nutrition security implies physical, economic and social access to balanced diet, clean drinking water, safe environment and health care (preventive and curative) for every individual.
- 10) *Gender relations* represent the ways in which the *socially constructed* categories of women and men relate over a wide range of social interactions within family, community as well as in all economic and political relations in a given society. Gender relations are institutionally constructed. It creates and reproduces systemic differences in the positioning of women and men in the society.
- 11) The private domain is associated with household, reproductive work and femininity, whereas, the public domain is associated with political authority, public decision-making, productive work and masculinity. *Private-public divide* associated with women and men roles hinder women to negotiate in the public domain. They are either being criticized for their inadequacies or patronized by men.
- 12) Gender mainstreaming refers to bringing gender issues into the mainstream development agenda. It requires that all policy, planning, implementation and resource allocation reflect the interests and the views of both women as well as men.
- 13) Exclusion is a process through which some segments of the population are wholly or partially kept out of social interaction; or cast out from full participation in the society within which they live.
- 14) Socially marginalized people are by and large deprived of social opportunities. They become stigmatised and are often at the receiving end of negative public attitudes. Their opportunities to make social contributions may be limited, and they may develop low self-confidence and self-esteem. They have relatively limited access to valued social resources such as education and health services, housing, income, leisure activities and work.
- 15) Political marginalization does not allow the group to participate democratically in decision-making. Consequently, they lose their right to every social, economic and political benefit.

- 16) Culture refers to full range of learned human behavior patterns which include knowledge, belief, art, law, morals, custom and any other capabilities and habits acquired by man as a member of society.
- 17) Culture pattern refers to common behavioural patterns among the members of a given community or group. Shared language, traditions and beliefs set each of community or group apart from others.
- 18) *Culture as an economic resource* means both tangible and intangible property which can be brought to market. Culture can facilitate economic growth through job creation, tourism and the cultural industries.

11.11 ABBREVIATIONS AND GLOSSARY

ADB: Asian Development Bank.

BPFA: Beijing Platform for Action.

BRIC: Brazil, Russia, India and China.

MDG: Millennium Development Goals.

UNDP: United Nations Development Programme.

UNICEF: United Nations International Children's Emergency Fund. (United Nations Children's Fund).

Maternal Mortality Rate = Number of deaths due to puerperal causes in women x 100,000 / Number of live births.

Infant Mortality Rate = Number of deaths under 1 year of age in a year x 1000 / Number of live births in that year.

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