3 What's Holding Others Back?

The root cause of South Asia's weak aggregate record of human development is inequity. While significant progress has been made on the delivery of education, health, water, and sanitation, large areas need attention. Strapped for cash – both domestic resources and foreign aid – many governments are unable to uphold the basic rights of their citizens to essential services. In the last few decades, privatisation is occurring 'by default' as governments fail either to fund or to reform essential public services. In analysing the causes – physical, human, financial and social – of this deficiency, three overarching issues can be detected: incapacity, inefficiency and underlying inequities in the provision of essential services

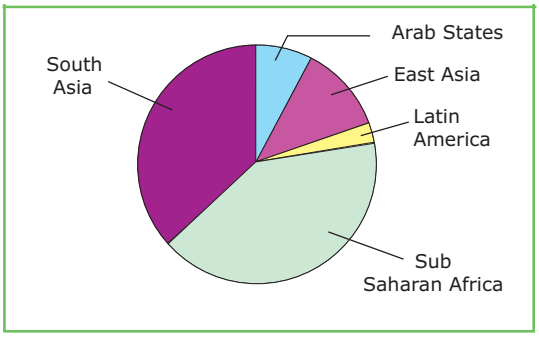
A. Incapacity

When the well's dry, we know the worth of water

Benjamin Franklin, 1746

The basic feature of incapacity is that the supply of services is unable to keep up with the burgeoning demand. Not only are 30 million children out of school (Figure 16), but 11.3 million are not immunised.[1] South Asia also contains 65 per cent of the world's population without safe water and 80 per cent of those without sanitation. Several states have proved to be unable to fulfill the basic rights of their people to essential services.

Figure 16: Where do the 100 million out-of School children live



Source: UNESCO (2004), EFA Global Monitoring Report 2005, Education for All-The Quality Imperative, Paris: UNESCO

Public Delivery Systems: Need to Make Them Extra Large

India has one of the world's largest public primary education system[2] for 115 million students, but one-fifth (equivalent to the population of Australia) of the school age population remains out of school. In Pakistan and Nepal more than one-third of the children suffer the same fate. Millions of Afghan children are effectively denied access to education due to the lack of schools or teachers[3] to cater for

the huge influx of students in the post-conflict era[4]. More than half the schools are in need of major repair while 2 million children study in tents (Figure 17) or in the open air.[5] Across these countries, it is students in rural areas who suffer the most from the lack of infrastructure, as most schools are concentrated in urban centres.

Health infrastructure is also inadequate across South Asia. Despite its massive size,[6] the infrastructure barely covers half of India's population[7] – primary health-care centres (PHCs) serve only 21 per cent of villages and medicines are not available in 74 per cent of villages[8]. HIV/AIDS poses an additional challenge to the health infrastructure and a recent UN report estimates that economic growth could decline by 0.86 percentage points in India over the next 10-15 years unless measures are immediately taken to address its mushrooming spread.[9] More than half of all Pakistanis also do not have access to health facilities.[10] Since independence in India and Pakistan, due to the failure of the public health infrastructure to keep pace with the exploding demand, the private sector has flourished.[11] After 23 years of conflict and political instability, the Afghan health system too is unable to cater for a significant proportion of the population, mainly in rural areas.[12] In Afghanistan lack of security plays a role, as health personnel are in constant fear for their lives. In Nepal, during periods of conflict, essential medicines often cannot be transported to remote rural areas.

Figure 17: A temporary shelter / tent used as a girls' school in Afghanistan's Badakshan Province

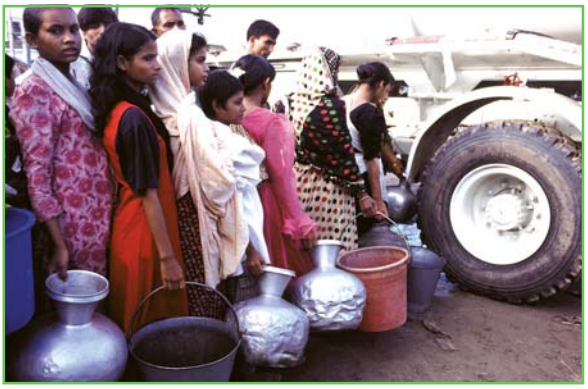
Source: Basira Mojaddidi / Oxfam GB / 2006

Table 4: Population without access to improved water and sanitation

Country	Drinking Water (%)	Sanitation (%)
Bangladesh	25	52
Pakistan	10	46
Nepal	16	73
India	14	70
Sri Lanka	22	9
Afghanistan	87	92

Source: UNDP 2005, Human Development Report 2005, *International Cooperation at the Crossroads: Aid, trade and security in an unequal world, New York:* Oxford University Press

Figure 18: Dhaka residents queue to collect clean water from a private water tanker



Source: Shafiqul Alam / Oxfam

Eight hundred and eighty million people in South Asia are deprived of proper sanitation facilities (Table 4). In Bangladesh, diseases are common during floods, due to contaminated drinking water sources and low sanitation levels. On the other hand in Pakistan due to persistent droughts, water scarcity is a significant issue, especially in the rural areas of the north. In a country as large as India, over 170 million people do not have access to safe water and 70 per cent of the population (11 times the population of the UK) lack adequate sanitation. Women in urban slums suffer the most due to lack of privacy, harassment, and reproductive health ailments. The unregulated spread of bore wells has in some areas depleted groundwater reserves built up over the last 300 years. Water shortages in many areas have resulted in the emergence of 'water lords' and 'private tanker supply' (Figure 18). In India, as primary responsibility for collection of water for the household rests with women, it is estimated that they have to devote as much as 150 million working days per year for the chore equivalent to the loss of $200 million.[13]

The Missing Millions – Many More Teachers and Nurses Wanted

The school should have six teachers, but there are only three regular teachers available now. I teach five classes a day with an average of 276 students.

Md. Mizanur Rahman Moolah, 2006
Assistant Teacher, Primary School
Bhedorganj, Shariatpur, Bangladesh

In India, one-third of all primary schools have only a single teacher, who is forced to manage hundreds of students in multi-grade classrooms, as enormous numbers of teacher posts routinely remain vacant (Figure 19).[14] In Bangladesh in public schools the teacher:pupil ratio can be as high as 1:76. While officially there is no shortage of qualified teachers in Pakistan, the national teacher:student ratio has increased from 1:37 to 1:44 between 1990 and 2001.[15] Multi-grade classrooms and high teacher:student ratios reflect the lack of school teachers. India has resorted to the hiring of contract teachers (Box 5) to overcome this deficiency.

Figure 19: A multi-grade classroom in Uttar Pradesh, India where the teacher is attempting to teach students of different grades simultaneously on two different sides of the blackboard

Source: OXFAM partner/ AAK/India/2005

South Asia has a curious mix of too many doctors in urban areas, too few doctors in rural areas and an across-the-board shortage of nurses.[17] India has an excess of urban physicians and an acute shortage of nurses.[18] Worse still, only 40 per cent of registered nurses are active, due to low recruitment, migration abroad, and job attrition. Similarly, Pakistan has only one nurse for every eight doctors.[19] Bangladesh has a 40 per cent vacancy rate of doctor postings in poor areas,[20] with a concentration of health workers in urban centres.[21] In Nepal many of the health posts, sub-health posts and district hospitals lack human resources.[22] Afghanistan struggles with being able to convince expatriate doctors to return, because of security problems and low wages – many of those who do return prefer to be employed as guards and drivers.[23]

In particular there is an important need to employ women as teachers, health workers and water technicians. Women are particularly effective in encouraging increase in enrolment in school and use of health

Box 5: Hierarchies of Access - Contract Teachers in India

In the last two decades, India has been witnessing a new phenomenon of employment of 'contract teachers' or para-teachers in large numbers. This phenomenon is influenced by extreme budget shortages faced by national and provincial governments. The contract teachers come under the auspices of externally-assisted programmes. In theory para-teachers are hired on short-term contracts as shiksha karmis (education workers), shiksha mitrs (friends of education), lok shikshak (peoples' teachers), or guruji (leaders). But they are paid much lower wages than their counterparts in mainstream government schools, and barely trained. This experiment has institutionalised a cheaper, inferior, parallel schooling system for the poorest children. In some states, the para-teachers have only passed class VII examinations. They are expected to teach children in classes I-V all subjects, with meagre instructional materials, typically with all students huddled in a multi-grade classroom, for a wage less than that of a clerk! This strategy of hiring low-qualified para-teachers is particularly absurd given that the economy is reeling under the strain of jobless growth and has a vast army of educated unemployed.[16]

Note: The term Hierarchies of Access was used in Ramchandran (2004), *Gender and Social Equity in Primary Education: Hierarchies of Access,* New Delhi: Sage.

Source: S Wadhwa (2004) *Pencil Erasure*, Education, Outlook, 1 March and R Atma (2002) *Teachers by Contract,* The Statesman, 6 June

services. This is because women working as teachers are often role models for young girls. Female nurses make it easier for local women especially from traditional societies to have the confidence to access health services.[24].

B. Inefficiency: Need Quality Improvements

The cost of inefficiency in essential services delivery in several pockets of South Asia is very high. In Nepal 24.7 per cent of students in primary education are repeating years, compared with a low of 0.8 per cent in Sri Lanka. But even in Sri Lanka only 37 per cent of students pass the higher secondary education examinations. The drop-out rate in primary education in India, Bangladesh, and Pakistan is a shocking 35 per cent, and the majority of those who drop out are girls. In India at any given time, 15 per cent of waterpoints are unusable or dysfunctional.

Teachers, Doctors, and Nurses Absent: Schools and Hospitals Not Fit to Work in?

Absenteeism among teachers is widespread across South Asia. In India, according to surveys, one in four teachers is absent and only 45 per cent actively engaged in teaching at the time of an unannounced inspection.[25] The rate of absence is estimated at 16 per cent in Bangladesh.[26] In a sample of public and private schools in the North West Frontier Province of Pakistan, the rate of teacher absence averaged 20 per cent while the official absence rate according to school records was only 5 per cent.[27] Even Sri Lanka has reported an increase in teacher absenteeism due to imposition of various official duties on teachers.

Teacher absenteeism may be linked to bad quality school infrastructure – teachers are de-motivated about working in under-equipped, under-funded, under-staffed, and overcrowded schools. In India, half the schools have a leaking roof and no water supply, 35 per cent have no blackboard or furniture, and close to 90 per cent have no functioning toilets. Some school buildings are misused as cattle sheds, police camps, teacher residences, or for drying cow-dung cakes.[28] Similarly in Pakistan, 49 per cent of schools have no toilets, 39 per cent no drinking water, 17 per cent no shelter and 62 per cent no electricity.[29] While in Bangladesh, 40 per cent of schools do not have adequate toilet and water facilities,[30] in Afghanistan, 52 per cent have no safe drinking water and 75 per cent inadequate sanitation facilities.[31]

Among health workers the rate of absence is reported to be even higher than that of teachers. In India and Bangladesh, absence rates are recorded at 40 and 35 per cent respectively.[32] In the Indian states of West Bengal and Jharkhand[33] not only is absenteeism high, the frequency of health workers recommending that patients see them in their capacity as private practitioners is widespread.

Doctor absenteeism is reported to be closely related to difficulty of access, lack of electricity, poor latrine facilities, and lack of piped water at the health centre.[34] In India, most rural primary health-care centres (PHCs) do not have essential drugs,[35] running water, electricity, or medicines for even the common cold, let alone telephones or vehicles. Many PHCs lack hygienic facilities for deliveries (Figure 20). In Pakistan similarly the majority of basic health-care units (BHUs) are dysfunctional.[36]

Figure 20: The equipment used in a government dispensary in Bharatpur district in India for a delivery conducted the previous night

Source: Oxfam GB/India/2006

In Afghanistan, most health clinics do not have electricity and clean water, and sanitation remains a major concern.[37] In Bangladesh, 63 per cent have inadequate facilities, 60 per cent inadequate personnel, and 80 per cent face a shortage of vaccines and medicines.[38] Doctors simply cannot cure patients without adequate equipment and supplies.

The Vicious Tentacles of Corruption

Corruption is an important hidden cost of access to services. Often those who are least able to afford bribes are the worst victims. According to a survey by Transparency International, Bangladesh for the fifth year running has topped the list of most corrupt countries (Table 5). The cost of corruption goes beyond the billions of rupees, takas, and afghani lost to bribery and extortion. It leads to prescription of life-threatening treatments, helps trigger drug-resistant strains of diseases, denies poor communities access to schools, erodes the sanctity of examinations, and compromises the health and education of communities, especially women in urban slums, by denying them access to water and sanitation. The effect of corruption doesn't end with the act; its impact continues for generations.

Table 5: Most corrupt countries according to Transparency International

Country	World Rank
Bangladesh	1
Pakistan	5
Nepal	9
India	13
Sri Lanka	16

Source: Transparency International 2005

Corruption permeates the delivery of essential services in South Asia, both in public and private sectors. In India corruption in education is reported to be rampant (Box 6). In Bangladesh, it was found that 40 per cent of students at the primary level had to pay admission fees (the service is supposed to be free), 22 per cent engaged private tutors from the same school where they were enroled, and 32 per cent of girls entitled to the government stipend had to pay to receive their entitlement.[39] Corruption in classroom construction provoked outrage in Pakistan after the 2005 earthquake, which resulted in an unnaturally large collapse of school buildings and child deaths.[40]

In the case of health services, corruption is mostly related to non-availability of medicines, getting admission into hospitals, consultation with doctors and use of diagnostic services. In Bangladesh it is reported that 26.4 per cent of out-patients and 20 per cent of in-patients had to pay bribes to doctors for receiving medical treatment at the public hospital.[41] Access to essential medicines is the primary source of corruption in the country's public health facilities, with the poor paying the greatest price.[42] Apart from that, in India and Bangladesh the X-ray

Box 6: Corruption Highest in Schools: Rs. 4,137 crore ($ 920 million) Paid in Bribes

Transparency International's report on corruption in India indicates that the amount of corruption in education (contributed to by 18 per cent of households) is equal to what the government is trying to raise through the 2 per cent education cess tax! Every year, parents are asked for money to pay for improving educational programmes, maintaining school buildings, and buying equipment and supplies. The study found that 33 per cent of bribes involved additional school fees, 28 per cent related to obtaining certificates and 26 per cent was admission related. Those who don't have access to and cannot afford private education are the ones who suffer the most as bribe-givers. But the bribe-takers are also poor; 70 per cent of those who asked for bribes had an average monthly household income of less than Rs 10,000 ($ 223). Bribe giving is more widespread in rural areas and in states with low educational development.

Source: *The Indian Express*, July 14, 2005 quoted in http://www.infochangeindia.org/features287.jsp Rashme Sehgal, 'If the politicians are corrupt, so too will be the people', InfoChange News & Features, July 2005 based on Transparency International's 2005, India Corruption Study to Improve Governance, June 30, 2005, Centre for Media Studies.

machines and pathological tests (Figure 21) seem to elicit the greatest incidence of corruption.[43]

Figure 21: Ill-maintained x-ray facilities in a district hospital in Nepal

Source: Oxfam GB (2005) *Suffering in Silence: Terror on the Terraces in Nepal*, Public Health Assessment, June

Vertical Programmes

Since the 1960s, donors have traditionally preferred large-scale interventions in health care, where the successes are easily measurable and visible – as with disease-specific immunisation,[44] for example. These programmes can be successful in combating large-scale mortality. Some examples include Bangladesh's Expanded Programme on Immunisation,[45] India's Directly Observed Treatment Short Course (DOTS) against tuberculosis (TB)[5] and Afghanistan's measles vaccination.[46]

Stand-alone programmes however are often not cost-effective if delivered through vertical organisational structures – for example in India currently there are district TB officers, district leprosy officers, district polio officers, and so on. The recent National Rural Health Mission (NRHM) in India purportedly intends to support inter-sectoral convergence across diseases but health analysts are sceptical of the approach[47] as it does not dramatically improve the underlying primary health infrastructure. Underlying root causes of ill health are therefore often neglected. The Pulse Polio campaign aims to target lameness in children but the majority of cases are due to unknown neurological causes or water-borne viruses other than the polio.[48] Ad-hoc prescriptions are sometimes fatal.[49]

While NGOs and even the private sector offer interventions that are timely, innovative, and fill the gap left by insufficient state capacity, there are dilemmas in non-governmental service delivery. The main difference between state and non-state provision is the model of accountability, which is pertinent for the end-user. In Bangladesh, management of NGRPS is decentralised to the school level to such an extent that the Ministry does not even keep records of NGO education service providers, and large NGOs have even begun to sub-contract services to smaller NGOs.[50] In Afghanistan, while in the face of government incapacity most donors and NGOs are performing an exemplary role in health-care provision for the nationally co-ordinated Basic Package of Health Services programme (BPHS) (Figure 22), some bilateral donors have by-passed it, which undermines the functioning of the government.

Figure 22: A noticeboard outside a health centre in Wardak managed by the NGO Swedish Committee for Afghanistan

Source: Swati Narayan/OXFAM/Afghanistan/2006

The most important question is – who is answerable to end-users for upholding their rights to essential services? Donors, NGOs, the private sector, and civil society do not share a mandate for accountability to citizens; democratic governments do. A planned strategy to upgrade government capacities and services to provide essential services to ALL needs to be prioritized (Box 7). Pratham as an NGO in India has been therefore been working dedicatedly for the last 10 years to upgrade teaching practices within government classrooms and provide extra support to academically weak students. On the other hand, it is also crucial to alter the dependency syndrome created by some non-governmental providers. Very often, once a non-government provider leaves a country there is rapid decline in quality of high-cost services due to lack of large budgets and local capacity for maintenance.[51] The model set by BRAC offers an important solution as it has progressed gradually over the years from an almost entirely donor funded small-scale project towards a large-scale provider with alternative self-financing income streams; e.g. handicrafts, banking, business ventures etc; to support sustainable essential service delivery without burdening end-users with heavy costs.

Without ensuring self-sufficiency in the long-run, the danger is the prolonged entrenchment of a two-tier service delivery system. Citizens in areas dependent on non-government service delivery (who are themselves often dependent on the vagaries of donor funds) may have more unpredictable and limited

Box 7: Securing Basic Services for Sand Bank Dwellers of Bangladesh

Ten million of the poorest people in Bangladesh live on sandbanks called *Chars*, which are vulnerable to flooding and erosion. The geographical terrain makes it difficult to provide essential services. Decisions on location of schools and health centres are often made with reference to the density of population. Since each *Char* settlement has less than a thousand people they are often by-passed altogether.

Oxfam has been working with local partner organisations to lobby government officials and politicians to provide essential services for *Char* settlements. It has also built a small number of non-formal primary schools to demonstrate that it is possible despite the difficult terrain. Programme Co-ordinator Farid Hasan Ahmed explains, 'Our role is not to replace the government but to help make it effective and accountable. Ultimately it is only through the government that access to quality basic services for all can be secured. It is the governments' responsibility to provide basic services and ensure people's rights. The money is there – both the Government of Bangladesh and international donors have the funds to ensure that everyone in *Char* areas can have access to health care and send their children to school. All we are asking for is fulfilment of the rights enshrined in the 1972 Constitution of Bangladesh.'

Source: OXFAM GB Bangladesh

Figure 23: Government sub-district health complex, Rowmary, Kurigram

Source: Oxfam / Bangladesh / 2006

Figure 24: Free primary school, Rowmary, Kurigram

Source: Oxfam / Bangladesh / 2006

access to essential services than those with direct government provision. Therefore to ensure parity in NGO-run schools CAMPE successfully lobbied with the Bangladeshi Prime Minister in 2005 to extend the free textbook policy to NGO-run non-formal classrooms to ensure the existence of universal syllabi and free access to all.

There is also the danger of abdication of responsibility by the government in the face of excessive donor involvement, which proves to be self-defeating. For example in Bangladesh a trend towards 100 per cent funding of urban water projects by donors led to a lack of ownership by the government which in turn led to delays in required staff allocations, ultimate withdrawal of most donors, and dramatic decline in their funding. To combat this in the water sector in recent decades donors are increasingly funding NGOs to increase the capacity of citizens to demand that their political representatives uphold their rights to basic services.[52]

With increased emphasis on decentralisation, most projects, especially those implemented by external donors, have created community associations such as *pani panchayats* (water users association), village education committees (VECs), and parent teacher associations (PTAs) as an integral component of the project implementation.[53] While emphasis on community participation is admirable, it is imperative that these groups are not nurtured mechanically. One concern is that these 'consumer groups' or 'end-user groups' as parallel entities by-pass existing legal institutions of decentralised governance such as *panchayats* at the lowest tiers in India.

Proliferation of single-issue committees in each village also dilutes their efficacy. Dominance of upper caste[54] groups, poor record-keeping, insufficient training and so on also hamper their effectiveness. Social mobilisation of water and sanitation end-users, in Pakistan, indicates that programmes which enter the community through local notables yield lower participation of poor people in decision-making.[55] Artificially created social groups therefore may not necessarily represent the interests of the community at large. Community ownership is often simply a euphemism to insist on the levy of a user charge to be borne by the community – see Zero Point water project in Pakistan (Box 8). In India, the Swajadhara programme, which expects village *panchayats* to contribute to 10–20 per cent of capital costs and the entire operations and maintenance costs at waterpoints, has not been as successful in mobilising community resources as envisaged.[56]

Box 8: Community Contribution for Water Supply Affects Women

Zero Point settlement, a village of 350 *Mohanas* (fisher folk) households situated in the coastal belt of Badin District of Sindh Province, suffered from acute drinking water shortage due to lack of infrastructure repairs. During the three months of fish breeding in particular, the local contractor refused to provide the village with drinking water through tankers. Women with primary household responsibility for fetching water had to walk on foot for nearly four or five hours and carry containers from water sources 5–8 kms from the village.

In 2004 the Pakistani government declared that repairs would be initiated only if local communities contributed at least 25 per cent of the total cost of the water supply scheme, but this was beyond the existing financial capacity of the Zero Point community. Oxfam, with the help of its local partner Young Sheedi Welfare Organization (YSWO), not only supported the creation of water tanks in Zero Point but also encouraged the local community to talk with and lobby local and provisional governments to ensure that their voice is heard by policy makers. The community demands focused on

C. Inequality

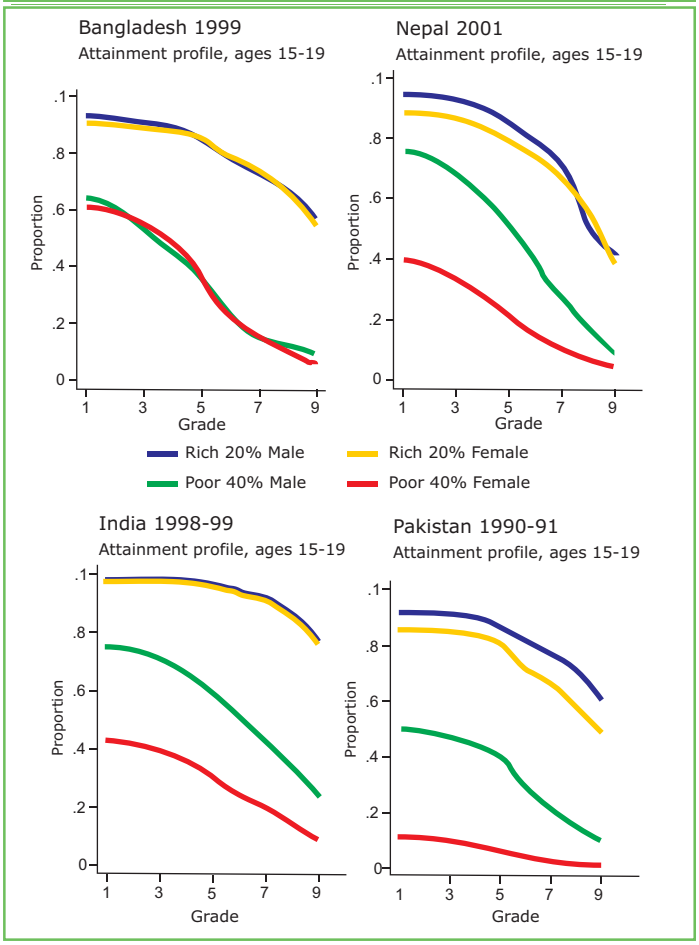
Across South Asia prevalent social inequities – of income, class, caste, and gender – contribute to lack of access to essential services for the socially marginalised. Women suffer the most from lack of services. Conflict-affected areas are also vulnerable to dramatic increases in inequality. Jaffna had the

best infant mortality rate and child nutrition status in Sri Lanka but in the last two decades skeletal remains of shelled hospitals reflect the continued deprivation of basic health care.[57] In South Asia caste, class, and poverty continue to remain the predominant factors in inequity.

The Human Face: Poverty, Caste, Class, and Gender

Poverty exacerbates educational deprivation. Figure 25 portrays the disparity in completion of education between the richest 20 per cent versus the poorest 40 per cent of students from grade 1 to grade 9 (X Axis) in four countries. The red curve in each graph indicates the inequities faced by girls from the poorest households in access to education. Social factors like harassment in schools, preference for male child, responsibility for sibling care especially for eldest girls and child labour constrain educational attainment of girls especially from poor households. In India almost 40 per cent of children from poor agricultural households are out of school.[58] Caste is another major reason for discrimination. In the prosperous Indian state of Punjab, government schools are often referred to as '*dalit* [59] schools'. In Nepal, *dalit* children have a literacy rate of only 10 per cent and adult women only 3.2 per cent.[60]

Figure 25: Difference in the educational attainment on the basis of wealth and gender in South Asian societies



Source: Filmer and Pritchett (1999) 'The Effect of Household Wealth on Educational Attainment: Evidence from 35 Countries', *Population and Development Review* 25 (1)

Diseases of the poor' are similarly worsened through neglect.[61] In India, the poorest 20 per cent of people have more than double the mortality and malnutrition rates of the richest quintile.[62] Amongst poor people, scheduled castes and scheduled tribes suffer the most. In Nepal, only 42 per cent of *dalit* children are immunised, compared with the national average of 60 per cent.[63] In Sri Lanka extreme inequities exist in health provision in the low-income plantation sector.[64] The reasons for this systematic disparity are inherent deprivations in livelihoods, nutritional security, safe water, sanitation, and health services across different strata of society and discrimination within households.

Access to drinking water across South Asia has a clear caste and class geography. The *dalit basti* in India and Nepal is always at the outskirts of the village, where there is least access to water. One hundred and eighteen million households in India do not have drinking water at home,[65] and as across South Asia the primary responsibility for water collection rests with women, they are unduly burdened.[66]

Women have shorter lives than men due to acute lack of access to essential services and widespread gender discrimination across South Asia.[67] A girl in India is also 1.5 times less likely to be hospitalised

than a boy and up to 0.5 times more likely to die between her first and fifth birthdays.[68] With the clear trend of feminisation of HIV/AIDS in the last decade, women also suffer from a greater increase in rate of infection.[69] Gender division of labour in a majority of the patriarchal households in South Asia consigns women to be the primary users of essential services - to wait in long queues at health centres with sick relatives as the primary care givers for the family, to walk long distance to fulfill the responsibility to collect water for the household, to make children ready for school daily and make additional use of health centres for their own reproductive needs.

Several strategies to target women specifically have not worked in isolation. In Pakistan, Lady Health Workers (LHW), despite covering one-fifth of the population, are largely ineffective due to lack of medicines and referral support.[70] In India, the National Rural Health Mission (NRHM) proposes to appoint 250,000 ASHAs (Accredited Social Health Activist), similar to the previous appointment of women community health volunteers (CHVs), which ran into serious problems due to misuse of the selection process for political patronage; caste, class, and gender prejudices; and limited training. The concept of Traditional Birth Attendants (TBA) has also proved to be a practical failure.[71]

Why Subsidise the Rich?

In Nepal, the wealthiest 20 per cent of the population receive about 40 per cent of the total public

> *The role of the state is to provide basic education to all, not higher education to a privileged few*
>
> Mahbub Ul Haq, 1997

subsidy on education while the poorest quintile receives less than 12 per cent.[72] In India, where 25 million children are out of school, higher education receives 20 per cent of the public expenditure on education. At the tertiary education level the pattern of public education spending is invariably regressive, with benefits accruing disproportionately to the higher economic class. The recent reservation policy in India in higher education for Other Backward Castes (OBCs) intends to reverse this trend.

The probability of the poor falling sick is 2.3 times more than the rich. Nevertheless, in India while five-star hospitals and medical tourism receive government incentives,[73] Primary health care centres (PHCs) suffer from lack of government patronage.[74] The poorest 20 per cent of the population captured only 10 per cent of the total net subsidy from publicly-provided clinical services while the richest quintile received more than the three times that.[75] Unlike Sri Lanka where the top quintile pays more than 50 per cent, tax financing of health care is moderately regressive in Bangladesh with the top quintile contributing to only 39 per cent of overall payments to the health care system.[76]

The social benefits of water supply and sanitation, in terms of fewer illnesses, far exceed its costs. But the poor continue to suffer from unequal access. In India only 38 per cent of the population have piped household water but they continue to pay below cost and receive the greatest subsidies. In Delhi city, inequity in supply results in the cornering of most of the available water for the elite residential areas.[77] The poor households and slum dwellers however are forced to pay exorbitant prices to water vendors. In Pakistan too, poor people have to pay private water vendors as much as 10 times the cost of piped water supplies for water of dubious quality.[78] Bottled water companies, which are very high-growth profit[79] enterprises, also receive subsidised water.[80] The General Agreement on Trade in Services (GATS) has so far only focused on privatising water supply and opening markets to foreign investors, but in future, requests for sanitation and sewage services may be included when WTO negotiations are resumed. But private service providers are not too keen to provide water and sanitation facilities in rural areas because they are generally considered unprofitable.

Killer Fees

End-user costs such as school tuitions, doctor consultation fees, cost of essential medicines and so on are common across the provision of essential services in South Asia. Schools in Pakistan and Nepal charge tuition fees for primary education.[81] While Bangladesh officially provides free education, household spending on education constitutes over 60 per cent of the per student public expenditure in primary education.[82] Official policy on user fees for public health clinics varies across countries in South Asia[83] but the unofficial practice of user fees, indirect costs, and expenditure for private care is sizeable. In Pakistan since the 1980s hospitals no longer provide medication, meals, clinical care, beds, or clothing for patients, which has adversely affected poor people.[84] Even in Sri Lanka there is an increasing tendency to charge indirect user fees for blood tests and other medical tests. In India over 80 per cent of total health financing is from end-users in out-of-pocket payments (see Table 6).

Table 6: Out of pocket expenditure as user fees for health

Country	Out of Pocket Spending/Total Health Expenditure %
Afghanistan	47
Bangladesh	52
Nepal	58
India	82
Pakistan	77
Sri Lanka	50

Source: P. Musgrove, R. Zeramdini, and G. Carrin (2002) 'Basic Patterns in National Health Expenditure', *Bulletin of the World Health Organization* 80(2): 134–42.

User fees often result in reduced use of services (Box 9), especially by those with the greatest need –poor and vulnerable people. In India, the number of users who reported not being able to access health care due to the financial constraints imposed by increased user fees has risen from 13 to 23 per cent from 1986 to 1996. For the poorest expenditure deciles, the rate of untreated ailments increased by 40 per cent.[85] It is estimated that almost 43 per cent of households affected by HIV had either borrowed money (double that of non-HIV households) or liquidated assets for consumption.[86] Asian Development Bank (ADB) water and sanitation projects in India, Bangladesh, and Nepal have resulted in poor people being excluded from benefits due to lack of affordability of the connection charge (equal to as much as 10 months' income of a poor household) and increased tariffs.[87]

People are often forced to resort to dubious low-cost providers due to user fees. In Pakistan only 21 per cent of poor households use government health care and 54 per cent go to private medical practitioners including amateur private 'doctors' and faith healers. It is estimated that there are 1.25 million quacks in India,[88] 600,000 in Pakistan[89] and 40,000 in Colombo alone.[90] The risk of neo-natal mortality was found to be six times higher when mothers consulted self-styled health workers with no recognised qualifications.[91]

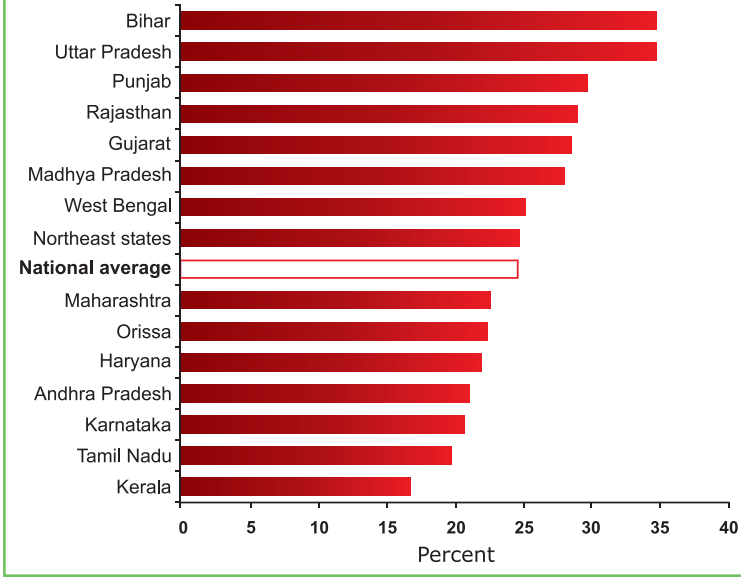
Box 9: Poor People Reduce Their Visits to Government Health Clinics when User Fees are Charged

User fees were introduced in secondary hospitals in the Indian state of Maharastra as part of the reform process supported by the World Bank. As user costs rose sharply in the period 1999–2001 there was a simultaneous fall in overall utilisation for outpatient visits and inpatient care especially amongst the poor which may be attributed to the following reasons: First, revenues from user fees in Maharastra have largely remained unutilised and, therefore, have not contributed to quality improvements. Second, the exemption (targeting) scheme for the poor may not have worked as envisaged. There is evidence from the comparable state of Punjab that the process for obtaining exemption cards was time-consuming and bureaucratic, making it virtually impossible for a poor person to obtain the benefits associated with such cards. Without quality improvements and without exemptions, it follows that utilisation by the poor must have declined and they must have shifted either to self-care, or worse still to lower quality providers.

Source: National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Government of India, 2005

End-user costs are also a frequent reason for people falling below the poverty line due to catastrophic medical expenses.[92] One-quarter of hospitalised Indians fall below the poverty line as a result of their hospital stay (Figure 26). More than 40 per cent of hospitalised people take loans or sell assets to pay for their treatment.[93] Across eight Indian states the indirect cost of education in the form of uniforms is the primary reason for children dropping out of school.[94] User fees and lack of public health-care infrastructure collectively are pushing poor people into a vicious cycle of poverty, illiteracy, and ill health.

Figure 26: Percent of hospitalized Indians falling into poverty from medical costs, 1995-96



Note: Northeast states consist of Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland and Tripura.
Source: National Sample Survey Organisation (1998)

Reflection: Need to Rebuild Public Delivery Systems

Over the last two decades, South Asian governments have systematically reneged on their social contract to deliver public services, adopting overarching skewed governmental priorities resulting in rapid privatisation of public utilities and erosion of the public service ethos. Privatisation of water supply has not only largely failed to deliver, but international private investment in water services has also declined after peaking in 1996–99 apparently because returns were too low. With pressure from widespread public protest, private water projects in Colombo, Karachi, and New Delhi have been put on hold and the future of the Melachmi[95] project in Kathmandu valley remains uncertain.

The analysis is unequivocal. The public delivery of essential services is deficient across large pockets of South Asia. However, this should not translate into an absolute loss of faith in the public delivery system. Rather it presents a strong and compelling case for the rebuilding of public infrastructure and the service delivery ethos. In fact the incapacity, inefficiency, and inequity of the delivery mechanism are a direct product of its neglect, which has eroded its efficacy.

4 How to Make a Big Dent

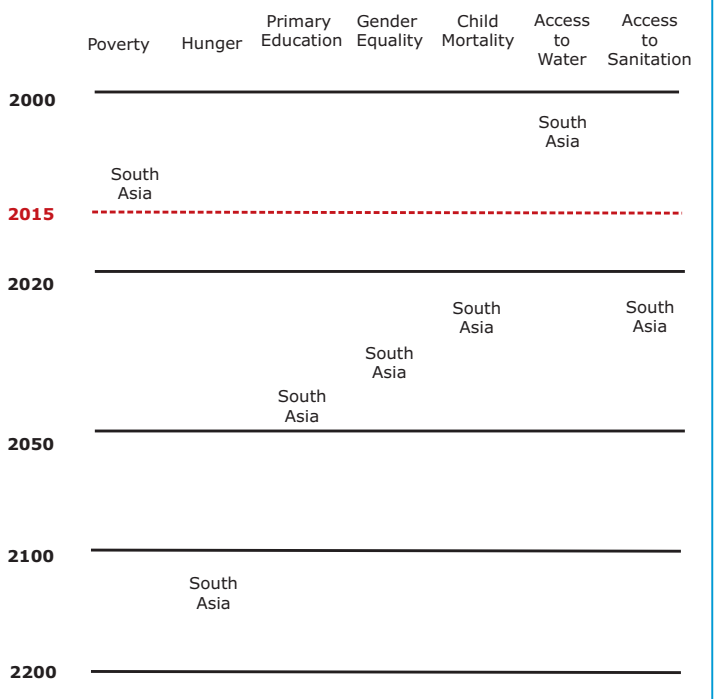
There is a tide in the affairs of men
Which, taken at the flood, leads on to fortune;
Omitted, all voyage of their life
Is bound in shallows and in miseries
On such a full sea are we now afloat,
And we must take the current when it serves
Or lose our ventures

William Shakespeare (1564–1616)[1]

Despite South Asia's emergence as an important global political and economic force, if the current state of slow progress of delivery of essential services is maintained (Figure 27), the region is unlikely to reach the MDG goal of reducing child mortality until after 2020, and is not expected to reach the goal of universal primary education until 2040.

Business-as-usual is clearly not a viable option. Three important commitments need to be demonstrated by the region's governments and donors: institutionalising political commitment; building capacity in public systems; and working with all stakeholders for the delivery of essential services. This concluding analysis, based on insights from previous sections, clearly sets out the specific action points that will

Figure 27: How long will South Asia take to achieve the Millennium Development Goals?



Source: UNDP (2003), *Human Development Report 2003, Millennium Development Goals: A compact among nations to end human poverty*, New York: Oxford University Press

enable the achievement of the dream of universal, good quality education, health, water and sanitation for all – the most basic of civilisational goals.

A. Get the Politics Right

> *No, no we are not satisfied, and we will not be satisfied until justice pours down like water, and righteousness like a mighty stream.*
>
> Martin Luther King Jr., 1963[2]

Political will is one of the most crucial ingredients needed to build a high level of human development. Governments need to fulfil their responsibility to uphold the basic rights of their citizens for essential services. For this commitment to be sustainable, it needs to be integrated in the political system as the bulwark of legitimacy. The necessary political change goals are: elimination of user costs; fighting entrenched corruption; and making services work for women.

i. Abolish killer fees: Eliminate both direct and indirect end-user costs

> *All I can say is this, Find money! Find money!! Find money!!! I appeal to the president, not as president but as the finance minister. I say, find money. If you say you have not got enough money, discover and tap new sources...*
>
> Mohammad Ali Jinnah, 1912
> at the Imperial Legislative Council in support of the Gokhale's Elementary Education Bill[3]

Free doctor consultation, no school fees, a bucket of clean water, free medicines, and a hygienic toilet can potentially save millions of lives in South Asia. End-user costs to access essential services often exclude poor people, who are forced to resort to unregulated private services. Worse still, end-user costs are a frequent reason for children dropping out of school or people falling below the poverty line due to catastrophic ailments. In addition, user fees raise little money and are most often insufficient to cover the cost of service delivery. The case for abolishing user fees is strong (see Section 3C: Killer Fees).

Bangladesh and Sri Lanka already provide free education and health care apart from support to a host of indirect end-user fees for textbooks and uniforms, for example. India needs to act soon. The 1992 constitutional amendment to guarantee education as a fundamental right can only take effect after the government passes and fulfils the financial commitments of the Free and Compulsory Education Bill 2005, including provision of free books and uniforms.[4] In Nepal, fees for in-patient care, including maternity care, need to be eliminated. User fees in Afghanistan, which are common for patients seeking treatment, also need to be eliminated. In Pakistan there is a need for elimination of direct user fees across the board, as even PHC schemes run by NGOs do charge – and achieve significant levels of cost recovery.

In the case of water, a precious natural resource, while some form of cost recovery is desirable to avoid excessive usage; a minimum ration of free water (for example in India the norm is approximately 40 litres per capita per day - lpcd in urban and 135 lpcd in rural areas) along with a slab-based water tariff that cross-subsidises lower consumption levels is desirable. Construction, operation, and maintenance charges should also not unduly burden the community and their contribution can be encouraged only in terms of physical labour to build a sense of ownership for the public good.

The World Bank in recent years has after a rethink endorsed this call for the elimination of user fees, at least in primary education.[5] The time is now ripe for countries in South Asia to implement well-planned and sustainable mechanisms for scrapping user fees for health and education and ensuring affordability and cross-subsidisation of water and sanitation facilities in order to make significant improvements in access to essential services.

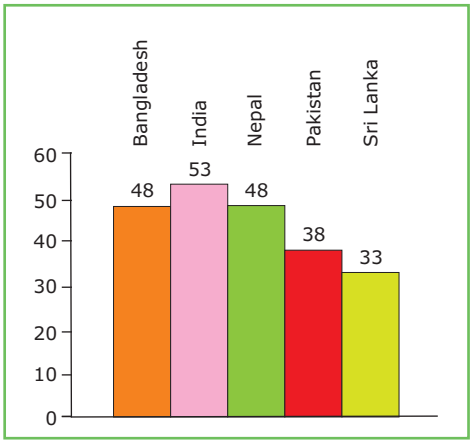
ii. Universal access rather than poor targeting

Why should essential services, especially in health and education, be free for ALL? The reasons are multi-faceted.

Identifying who is poor is often difficult. The accuracy of data is often questionable and the process of identification breeds corruption. India has had a long history of gross deficiencies in poverty identification.[6] In Bangladesh, unlike the stipends offered for secondary education, the poverty-targeted Female Primary Education Stipend Programme (PESP) has been unsuccessful with two-thirds of the eligible girls from the poorest households not receiving their entitlement. In fact, 27 per cent of those from affluent households usurped the benefit.[7]

Selection of beneficiaries is not cost-effective if poverty is widespread. In South Asia child malnutrition is in the range of 30–55 per cent (Figure 28).[8] Ironically it is not limited to poor people – in India a quarter of the children in the richest fifth of the population are also underweight and nearly two-thirds are anaemic.[9] Universal nutrition programmes like the midday school meals in India[10] are expected to improve child nutrition, health, and education as well as address the malaise of high drop-out rates and repetition in schools.[11] In the Indian state of Rajasthan, for instance, girl enrolment in Class 1 jumped by nearly 20 per cent in a single year after midday meals were introduced.[12] While targeted school meal programmes exist in Bangladesh,[13] Afghanistan,[14] and Sri Lanka[15] there is a real advantage in converting them to universal programmes. Such programmes could also go a long way towards addressing chronic malnutrition, which afflicts millions of children in Nepal and Pakistan.

Figure 28: Prevalence of child malnutrition in South Asia



Source: World Development Indicators, 2004 graphically depicted in Suresh Babu, 2006, *Food Security in South Asia*, South Asian Journal

Targeting also excludes elites from access to, and monitoring of, public goods. For example, a politician who sends her son to a government school would take a greater interest in its quality of education. With targeting there is also a danger that poor people will be further marginalised due to their diminished political voice to demand their rights.[16]

The movements for Education for All (EFA)[17] and Health for All[18] have therefore emphasised universal access at least to basic levels of services for entire populations. Targeting problems in healthcare for example arise due to a lack of comprehensive approach to both preventive and curative aspects. The keys to success in Sri Lanka have been strong political commitment to universalism, good infrastructural coverage of health clinics and schools, no user charges, no explicit targeting of services, and reliance on progressive taxes.[19]

Legal safeguards to universal free delivery of essential services are also extremely important. In India the passage of the legislation guaranteeing the fundamental right to education has played an important role in the recent expansion of schooling though the fundamental problems of financial commitments remain. Similarly financial commitment and legal safeguards for universal education and healthcare need to be robustly implemented across South Asia.

iii. Fight corruption

The most effectual method to keep men honest is to enable them to live so… An augmentation of salary sufficient to enable them to live honestly and competently would produce more good effect than all the laws of the land can enforce.

Thomas Paine, 1772[20]

Corruption can be combated at various levels. For each specific essential service a number of steps can be taken, including increasing salaries and improving working conditions. Codes of conduct[21] and accountability mechanisms also need to be strengthened. At the two extremes, banning[22] and legalising[23] private tuition[24] and medical practice after working hours can both be effective. Simple practices like displaying noticeboards of free and official charges for essential services (like Oxfam's best practice depicted in Figure 29), regulation of quality standards and inspections need to be instituted together with political commitment, to weed out entrenched corruption.

Public action in democracies is a sustainable measure to fight corruption. India's Right to Information movement (Box 10) is a case in point – as the popular movement has not only created substantive social momentum to pass the Right to Information laws in India but also enable citizens to use these laws and foster a culture of public vigilance. At a political level, the existence of multi-party democracies, the emergence of civil society, and a free press are key building blocks in this fight against corruption. Effective practical solutions include simplification of rules and procedures, empowering the public, increasing transparency, and effective punishment.[25]

Figure 29: A sign displaying the seeds given to a village affected by Bangladesh floods to sow crops by Oxfam's partner SKS and technical assistance by Padakhep Manabik Unayan Kendra

Source: Gail Williams/Oxfam/2005/0563 – 84

Uprooting corruption at political and societal level is the most effective. In Pakistan while a dozen anti-corruption

Box 10: Right to Information

On 15 June 2005, the Government of India passed the historic Right to Information Act inspired by a long-standing grassroots movement *Mazdoor Kisan Shakti Sangathan* (MKSS) in Rajasthan, which has repeatedly exposed corruption in rural development schemes. The MKSS has also popularised an empowering strategy of *Jan Sunwai* or 'public hearing'. In these gatherings, official documents related to school buildings, health centres, water standpoints, dams, bridges, and other local structures are read out to local villagers. When the records were read out it was sometimes immediately obvious that they contained false information – construction of non-existent structures, remuneration for 'ghost' teachers, overbilling for transporting materials, or people listed on the muster rolls that were long dead.

These successful 'social audits' at the village level brought to the fore the question of accountability at the macro policy level and led to the conceptualisation of the Right to Information Act enforced in 2005. Every government office in India must now have a 'public information officer' (PIO) and any citizen can, for a modest fee, demand information on any government responsibility and action – the absence of teachers in government schools, insufficient medicines in hospitals, decisions on water provision, and so on. This movement provides a model for other countries in South Asia and beyond on society-wide initiatives for tackling the malaise of corruption.

Various Sources

commissions already exist, donors are investing heavily in ensuring their effectiveness.[26] On the other hand, while Bangladesh set up an anti-corruption commission in 2004,[27] it has yet to appoint an Ombudsman[28] after 25 years of enactment of the Act. Political commitment at the highest level is essential for uprooting corruption.

iv. Make services gender-sensitive

Women and girls as primary users need to be placed at the centre of all decisions – from the design and planning to operations and maintenance of essential services. Changing laws[29] to institutionalise the voice of women is important. India's 1992 constitutional amendment to reserve one-third of *panchayat* seats for women has proved to be effective. There has been a clear increase in spending on public water and latrines for low caste communities when women are in a majority in *panchayats*.[30] Employment of women as teachers, nurses, and doctors (as in Sri Lanka) is advantageous as they serve as role models and improve the comfort levels of women and girls from traditional societies like Afghanistan (Figure 30) when they access essential services.

Figure 30: Women queuing in the waiting room of a primary heath clinic in Wardak, Afghanistan

Source: Swati Narayan / Oxfam / Afghanistan / 2006

However, both these strategies need to be sensitive to the country context (for example in Pakistan there is an acute need for nurses to be protected from sexual harassment).[31] Lessons need to be drawn from the failure of CHVs in India and LHWs in Pakistan (Section 3C: Inequality: The Human Face – Poverty, Caste, Class, Gender).

Changing prevalent beliefs is equally important. In rural Gujarat, *Anandi*, a grassroots NGO, has encouraged women from traditional households who suffered excruciatingly from the lack of privacy and had to wait till dark to defecate in the open, to be trained as masons and construct toilets as symbols of their empowerment in the community.

In classrooms across South Asia increasing the number of functioning latrines for girl students is also an important need with potential synergies across the essential services of education, health, and sanitation. Innovative demand- and supply-side incentives such as Bangladesh's FSSP (Box 4), can be implemented to empower women to increase their expressed demand for and access to essential services.

B. Build Capacity in Public Systems

Government exists to defend the weak and the poor and the injured party; the rich and the strong can better take care of themselves

Ralph Waldo Emerson, 1844

Free education and health care is meaningless without adequate classrooms, teachers, nurses, and medicines to support the surge in latent demand. Maintaining quality standards is important. Access to poor quality services is often tantamount to no access at all.[32] Once a pupil drops out of school or a

patient has a bad experience at a heath centre, convincing them to use the service again becomes even more difficult. Due to sustained neglect, in most South Asian countries public service delivery infrastructure remains in disrepair. While privatisation has spread, its quality and affordability need to be strictly regulated. The governments of South Asia need to honour their social contract by upholding the basic rights to essential services.

i. Financial priorities

More money!

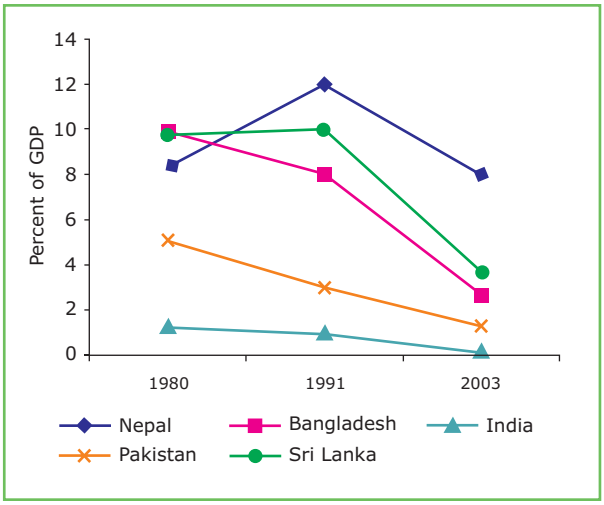
With rapid growth in South Asia, it should be easier for governments not only to allocate greater monies in absolute terms for essential services but also a greater proportion of Gross National Income (GNI) from the enlarged pie.[33] South Asian governments need to honour their commitments made at the Copenhagen summit in 1995 to spend at least 20 per cent of their current expenditure on basic services.[34]

Donor countries also need to ensure that they provide at least 0.7 per cent of their GNI in foreign aid and allocate at least 20 per cent of this to basic services to ensure predictable aid especially for budget support as committed in the Paris conference on aid effectiveness in 2005[35]. South Asia has been systematically receiving less aid (Figure 31) in the form of overseas development assistance. This trend needs to be reversed. Based on a conservative estimate South Asia would need an additional $495 million per year to make any advance in universal primary education.[36] To provide access to clean water for 200 million people without safe drinking water and 800 million people without proper sanitation in South Asia by 2015 another $4 billion per annum (i.e. a 10-fold increase)[37] is required.

In Afghanistan in particular, donor aid needs to increase considerably in tandem with stated pledges and commitments (Figure 32). Donors need to invest in building the capacity of government systems to absorb funds, rather than by-passing them.[38]

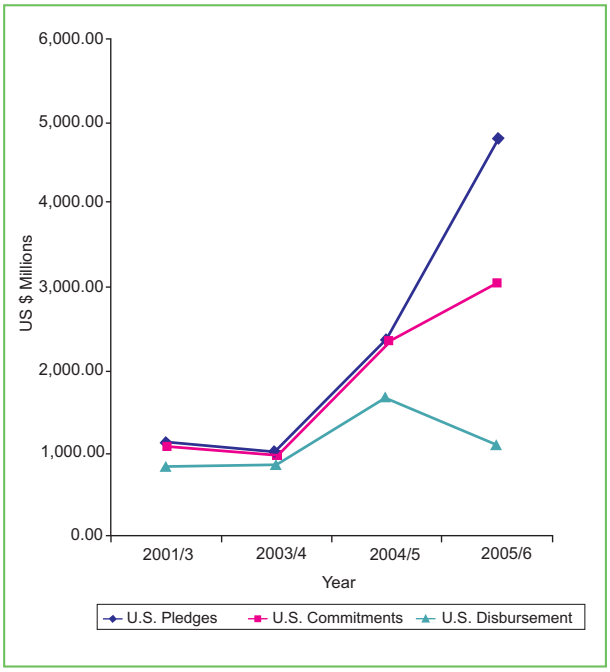
In addition, national governments need to function more effectively and take action. In India, the United Progressive Alliance (UPA) in its National Common Minimum Programme (CMP) has promised to allocate 6 per cent of GDP to

Figure 31: Overseas Development Assistance (ODA) received as a percentage of GDP



Source: SAAPE (2003) *Poverty in South Asia 2003, Civil Society Perspectives*, South Asia Alliance for Poverty Eradication: Nepal

Figure 32: United States assistance to Afghanistan



Source: Afghan Ministry of Finance quoted in B. Rubin (2006) *Afghanistan's Uncertain Transition from Turmoil to Normalcy*, Center for Preventive Action, Council on Foreign Relations, CSR No.12, March

primary education but its current allocation continues to hover around 4 per cent. On the other hand, while there seems to be an excess of funds allocated to rural water supplies in India, the Total Sanitation Campaign suffers from neglect and unless it is dramatically scaled up to cover 20 million people each year, the MDG target is unlikely to be met.

As allocations of annual expenditure are subject to the vagaries of political negotiation, sustainable mechanisms like the innovative education cess in India (Box 11) need to be instituted.

Box 11: Innovative Tax on Every Bar of Soap and Haircut Feeds Children in Indian Schools

In May 2004, the United Progressive Alliance (UPA) government in India imposed a well-planned and executed 2 per cent universal cess (tax on tax) on all central taxes to help raise funds for primary education. Most of the funds have been used to provide midday meals for school students. Due to the burgeoning fiscal deficit of the state governments to the tune of 5 per cent of their net domestic product, the central government has sought to generate additional monies. This cess (which imposes a universal tax of 2 per cent on every transaction in the economy i.e. from the purchase of a bar of soap to a haircut) for education is expected to accumulate $ 1.5 billion per year and assures the sustainability of the midday meal scheme and its detachment from annual political budget-making imperatives.

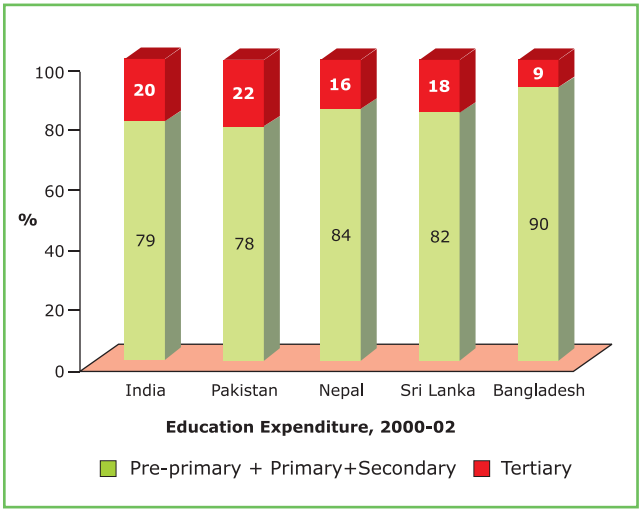
Various Sources

Prioritise non-recurrent salary spends and primary services

Teachers without blackboards, chalk, and textbooks simply cannot teach. In South Asia, an extremely high proportion (over 95 per cent) of recurrent education budgets is spent on salaries of teaching staff, with negligible proportions (i.e. below 5 per cent) remaining for educational material and maintenance.[39] Even African countries devote at least 5-10 per cent of the education budget to non-salary recurrent expenditure.[40] In South Asia, donors have also traditionally been unwilling to finance recurrent costs and prefer infrastructure costs (such as schools and hospitals). This needs to change.

Nurses and doctors are unable to do their jobs without medicines and supplies. In India, 65 per cent of the population is without access to essential medicines.[41] Sri Lanka, on the other hand, ensures that medicines and supplies account for one-third of recurrent expenditure. The Sri Lankan government also generates savings by procuring generic drugs at low cost.[42] South Asian Association for Regional Cooperation (SAARC) countries similarly can explore a system of pooled procurement of generic medicines so that the public health system can save almost 30–40 per cent on costs.[43] The price of all medicines (not just essential ones[44]) needs to be controlled.[45]

Figure 33: Intrasectoral Public Expenditure on Education across South Asia



Primary spends need to be prioritised. By 1900 most of the developed countries had almost achieved universal basic education with 90 per cent literacy rates, but they continued to allocate 90 per cent of education spends to basic education.[46] Especially given that a majority of the tertiary spends accrue to the rich (Section 3C: Why Subsidise the Rich?) and that countries like India already produce an excess of urban doctors, focus needs to shift to primary education to promote social equality.[47] South Asia too needs to increase expenditure on basic education to 90 per cent (Figure 33) to ensure equal opportunities for the population at large to partake in economic growth.

ii. Invest in public systems: There are no quick fixes or 'magic bullets'!

Horizontal and vertical programmes

Donors have typically emphasised vertical, disease-specific programmes for developing countries with limited income streams. But Sri Lanka has succeeded not only in building a comprehensive horizontal primary health care system with linkages of vertical disease-specific inputs but also spending less than 50 per cent of the World Bank's stipulated 'minimum cost-effective package' and without resorting to user fees, community financing or third-party insurance. Its key to success has been consistent efficiency gains of 2–5 per cent per annum[48] through investment in primary health facilities, which can be used as an infrastructure base for delivery of immunisation and other preventive services.

In the rest of South Asia there is an important need to integrate vertical programmes with the existing infrastructure of general health systems in order to derive the greatest cost efficiencies and sustainability. It is also crucial that in the process of replication and scaling up quality of essential service delivery should not deteriorate or be compromised. The spread of HIV/AIDS in particular increases the urgency of the challenges of ensuring quality healthcare. The region has particularly high levels of communicable diseases and greater susceptibility of pregnant women to infectious and parasitic diseases than is the case globally, and therefore holistic primary health care would have greater impact on preventing avoidable deaths than disease-specific interventions.[49]

The Bangladesh NGO BRAC's[50] *shashta shabikas* (village-level community workers for primary care) provide a useful model. These people are trained to deliver primary care, vertical programmes, or a combination of both.[51] The DOTS programme against tuberculosis was implemented as a partially integrated programme with dedicated laboratory services, linked to generalist *shasta shabikas* in villages. Innovative incentives were also introduced. Patients are required to pay a fee up-front, part of which is returned upon successful completion of treatment and part retained by the *shasta shabikas* as an incentive for patient compliance. Similar models of comprehensive primary health care need to be restored in policy debates and practice across South Asia.

Regulate the non-government and private players

While governments need to play a leading role in financing and co-ordinating universal access to essential services, given the trend of privatisation in South Asia, it is necessary to devise effective strategies for collaboration. The state and non-state actors should function as symbiotic partners. Governments need to co-ordinate the integration and regulation of the mushrooming private sector at the primary level of education and health care. This can be best achieved by guaranteeing a legal framework for essential services from a rights perspective and by monitoring and evaluation through active engagement with both private sector and civil society as non-state actors.

That apart, suitable supply-side incentives such as large subventions of teacher salary based on free enrolment of students (as successfully experimented with in the FSSP in Bangladesh) may be used as a guide to register, inspect, and monitor the quality of private schools. In health care given the large number of quacks and unregulated drugs on the market, a regulatory system with rigid quality standards is essential to ensure that qualified retailers sell quality medicines only to recognised practitioners and genuine patients.

Cost effectiveness and appropriateness of technology used for delivery of essential services are equally important. Three-quarters of the aid to the water sector has been devoted to large systems of piped water and sewerage connections. Instead, low-cost technologies[52] like standpipes, hand pumps, gravity-

fed systems, rainwater collection, and latrines need to be promoted as not only are they more sensitive to local needs but also have proven to be greatly cost-effective in terms of each incident of diarrhoea death averted.[53]

iii. Rebuild the public service ethos

Their (relatives of patients) anger is spilling over in assaults on doctors, unheard of till now in a country where the medical profession is worshipped next to God

Dr Armida Fernandes, 2005
Former dean of a state government hospital in Mumbai city 99[54]

Teachers, nurses, and doctors hold the key to the solution, not the problem. Given the sustained neglect of most South Asian public services, they are generally unwilling to attend schools and health centres, which are largely under-equipped, under-funded, understaffed, and overcrowded. Increasing their work ethic and efficiency is crucial to make any visible progress in the delivery of essential services.

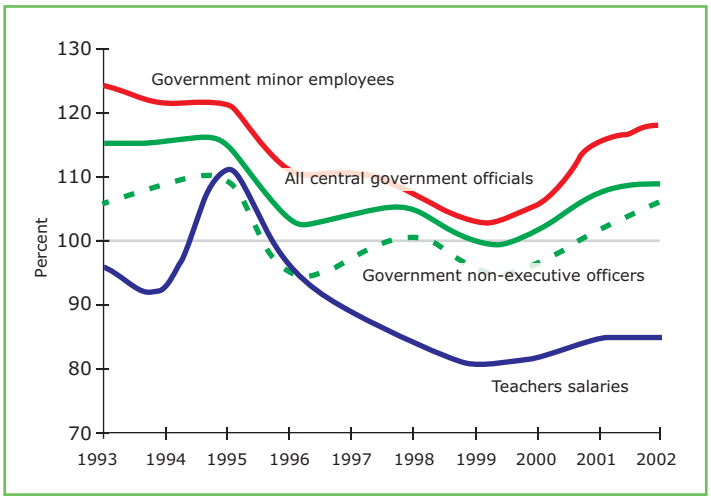
Pay suitable salaries, fill vacancies, and improve working conditions

In order to supplement my salary of Tk 7200 per month, I cultivate land on holidays and vacations to enable my family to meet its needs due to the high price of essential goods. I am not involved in private tutoring. On an average I take 5 classes a day and the average size of the class is around 80 students.

Swapan Mitra, 2006
Headmaster, Khalilnagar Government Primary School, Bangladesh[55]

In none of the South Asia countries is the salary of teachers greater than the World Bank norm of 3.5 times of per capita GDP.[56] In Sri Lanka, teachers earned only about 85 per cent of their incomes in 1978 in real terms, resulting in poor teacher motivation (Figure 34).[57] Salaries eroded by inflation affect teacher and health worker morale, forcing them to take second jobs and indulge in corruption.[58]

Figure 34: Real value of salaries of teachers in Sri Lanka in relation to other government employees (1978 = 100)



Source: World Bank (2005) *Treasures of Education System in Sri Lanka, Executive Summary, Overview, Principle Findings and Options for the Future, World Bank, Sri Lanka*

Ensuring suitable salaries of education and health workers could go a long way towards rebuilding their morale and efficiency. When the Dhaka Water Supply and Sewerage Authority (DWSSA) employees' trade union was given one zone to self-manage, it improved water supply, customer services, and revenue collection simply by doubling employee salaries and utilising their experience through participative decision-making.[59]

A large number of teacher and health worker posts which routinely remain vacant across South Asia need to be filled. In India, one-third of all primary schools are single teacher units with multi-grade classrooms.[60] In Bangladesh there enough trained schoolteachers for only half of the 18 million primary

school age children, at the recommended ratio of 1:40. Health workers too need to take on multiple responsibilities. In rural India about 49 per cent of doctor posts in primary health centres remain vacant.[61] Despite the vast pool of educated unemployed,[62] India, Pakistan and Bangladesh rank as the top three countries worldwide in terms of the shortage of teachers and health workers (Table 7).

Table 7: Current shortage of public sector workers

	Primary Teacher Shortage	Health Worker Shortage
India	276,441	1,346,861
Pakistan	234,940	285,986
Bangladesh	246,883	200,399
Nepal	20,638	52,691
Sri Lanka	0	23,802
Afghanistan	52,722	46,374
Total	**831,624**	**1,956,113**

Source: Calculations by Oxfam based on consultation with UNESCO, WHO, and GCE

Teachers and health workers are less likely to be absent from those schools and clinics which have been inspected recently, have better infrastructure, and are closer to a paved road. Improving working and living conditions is crucially important to rebuild public sector ethos.

Create rural bias and invest in nurses and midwives

The skewed deployment structure of health and education workers needs to change.

> *Because of inefficient placing and monitoring systems, many of our poorer schools are understaffed.*
>
> Angela Wijesinghe, 2006
> All Ceylon Teachers Union in Sri Lanka[63]

Rural areas across South Asia suffer from an acute shortage of education and health personnel. Doctors and teachers do not normally want to stay there. In Nepal only 20 per cent of rural physician posts are filled, compared with 96 per cent in urban areas.[64] In India, Pakistan, Bangladesh, and Afghanistan 70–80 per cent of the population live in rural areas but 90 per cent of the doctors are located in urban areas. This situation needs to be reversed. Service contracts such as those used in Malaysia, the Philippines, and Sri Lanka can be implemented to ensure that medical personnel spend a few years in public service in rural areas.[65] The existing ineffective 'transfer system' for teachers in Sri Lanka and India also needs to be reformed.[66]

Nurses and midwives are essential to ensure the fulfilment of the MDG heath goals in South Asia. India would require an additional 325000 nurses by 2015, and for national needs alone an additional 225 nursing colleges need to be constructed.[67] International migration of nurses also needs to be rationalised.[68] In Bangladesh, the engineering staff for water and sanitation in the Department of Public Health Engineering (DPHE) need training in socio-economic disciplines, including communication and awareness-raising, critical to sanitation and hygiene.

C. Work with Others

Civil Society Actors as Symbiotic Partners

South Asia has one of the world's most buoyant civil societies, including over 100,000 non-government organisations.[69] In the last few decades, civil society actors have played multi-faceted roles such as alternative service providers, innovators, critical thinkers, advisers, watchdogs, advocates, and policy partners.[70] The fundamental responsibility for the planning, co-ordination, regulation and provision of essential services lies with the state. Civil society has proven to be an able partner when there is limited state capacity to build systems which can potentially be transferred to the government for long-term sustainability. The roles of the state and civil society are largely complementary in this regard.

In Bangladesh, a large proportion of those enrolled in Registered Non-Government Primary Schools (RNGPS) compared to government schools are from households below the national poverty line.[71] In Afghanistan due to low state capacity the interim government has contracted external agencies, primarily NGOs, in the Basic Package of Health Services (BPHS) to avoid duplication of a multitude of donors. Donors are also crucial partners in supporting long-term investment and in Sri Lanka foreign assistance for education covered 25 per cent of capital expenditure over the period 1994–1998.[72] NGOs/CSOs are important allies in the delivery and monitoring of essential services.

Figure 35: Oxfam laying pipes for water connections to hand over to the Batticloa Water Board

Source: Oxfam GB/Sri Lanka/2006

The role of civil society working with the private sector has led to encouraging innovations. For example Oxfam Novib, through a collaboration with a Dutch multinational and its NGO partner Proshika in Bangladesh, has devised an innovative solution to tackle the problem of arsenic contamination on a large scale.[73] This can potentially save between 35 and 60 million people at risk. The best practice emphasis needs to be on upgrading and supporting government systems rather than replacing them (Box 12).

Since the start of the new millennium there has been a trend among NGOs to shift their focus from delivering services to being policy partners and advocates.[74] For starters, they are being consulted more and more in the policy-making process.[75] As advocates, NGOs worldwide are increasingly forming coalitions from the macro to the micro level (for example the Global Call for Action Against Poverty and India's *Wada Na Todo* coalition [Don't Break your Promises]) in order to perform their role as

Box 12: Upgrade and Support Rather than Replace Government Services

Pratham, an NGO that began in Mumbai's slums in 1994 with the aim of helping the government in its quest to universalise primary education, has today spread to 13 Indian states. Pratham has employed a variety of strategies to improve the formal school delivery system. The accelerated learning method teaches an illiterate child reading and basic mathematics in a mere three weeks to prepare out-of-school children to re-enter formal school. Pratham also provides *balwadi* (crèche) programmes for pre-school children and *balsakhi* (tuition support) programmes to support academically weak students. Pratham receives assistance from Oxfam Novib as well as other donors. It is based on a unique triangular partnership: government, the corporate sector, and citizens. The model is easy to replicate as no immovable assets are acquired. The unique feature of Pratham is that it does not create any parallel structures. It utilises government schools to conduct after-school classes, improves quality within formal classrooms, and supports home-based pre-school centres.

In Sri Lanka, Oxfam has supported the National Water Supply and Drainage Board to renovate and rehabilitate the water supply system of Batticoloa Municipal Council and Kathankudy urban area. This is expected to benefit more than 10,000 people. The project mainly covers repairs, operations, and maintenance of existing water supply infrastructure (Figure 35). Similar initiatives are planned in Thiruperumthurai areas to improve the distribution system in the tsunami-affected areas. Oxfam intends not only to upgrade the facilities but also to train the local municipal staff in maintenance of equipment and then hand over the renovated systems to the municipality to ensure the sustainability of the project.

Source: Oxfam NOVIB, Pratham and Oxfam GB in Sri Lanka

'watchdogs' of governments and donors. Similarly, the Peoples Health Movement (PHM) with a strong presence in Bangladesh as a global coalition of varied civil society actors including people's organizations, civil society organizations, NGOs, social activists, health professionals, academics and researchers from 80 countries upholds the vision of a truly comprehensive Health for All agenda. In South Asia, the experience of Pratham's ASER Report and CAMPE's Education Watch (Box 13) also indicates that civil society voices have begun to function as credible policy advocates. This trends needs to be bolstered with state commitment for inclusive stakeholder participation.

Box 13: NGO 'Eyes' Monitors Government Systems

Education Watch is an independent citizens' report currently in its eighth year of publication in Bangladesh. As the name suggests it 'watches' and monitors different aspects of the 'education for all' agenda. Under the auspices of CAMPE – a coalition of around 700 NGOs – Education Watch has emerged as a leading civil society voice in advocating for educational improvements. These insights of an independent 'eye' are particularly important as Bangladesh has achieved massive increases in enrolments in primary education in less than a decade. Education Watch's research methodology and inclusive civil society participation, which has been acclaimed by Columbia University assessments, holds a mirror to the government to guide and steer it towards the dream of quality 'Education for All'.

Pratham's Annual Status of Education Report (ASER), on the other hand, monitors only one aspect of education quality – do children learn in school? The first edition, based on an exhaustive nationwide survey in 2006, depicted startling results: 35 per cent of primary school children were unable to read a simple paragraph and 41 per cent unable to solve a two-digit subtraction or division problem. Pratham aims to conduct ASER surveys annually until 2010 (the government's deadline to achieve universal elementary education) in order to keep the issue alive in the public eye and help planners devise strategies for improvement of education quality, especially in regions with the greatest deficit.

Source: Oxfam NOVIB, CAMPE, Pratham

Community Involvement and Ownership

As primary stakeholders, community members hold the key to the monitoring of essential services. Nepal[76] has recently embarked on an ambitious effort to devolve public school management responsibilities to parents and influential local citizens. It is the only country where the community has been granted the right to fire government teachers who do not perform their duties and to index teacher salaries to school performance. The verdict on the suitability of this devolution of power is yet to be given, but it offers an important model of inclusive community participation.

In contrast, the Total Sanitation Campaign in India suffers from lack of community ownership especially when construction activities are contracted out by the *panchayats* [77]. Community-managed urban toilet complexes can be more desirable than contractor-managed toilets in urban slums. WaterAid has demonstrated in more than 400 villages in Bangladesh that open defecation can be completely stopped through participatory public outreach programmes like Community Led Total Sanitation (CLTS), which increase community awareness of the risks of open defecation.[78] Similarly, communities have been encouraged to join citizen action groups to monitor water service delivery (Box 14).

Figure 36: Community working together for installation of sanitary latrine, Kurigram, Bangladesh

Source: River Basin Programme/Oxfam GB/ Bangladesh/ 2005

Box 14: Citizen Action to Build Accountability

WaterAid has pioneered the concept of Citizen Action, which enables communities to engage with service providers and governments in order to improve water and sanitation services. To bridge the accountability gap, WaterAid facilitates citizens to collect information about services, entitlements, and responsibilities. Local communities use a range of methods for collecting and analysing information – report cards, community scorecards, mapping access, and control of water and sanitation facilities. This leads to a process of constructive dialogue with providers on entitlements and practical solutions.

In Nepal this process has resulted in the production of a report card on governance in Thimi Municipality and the creation of water and sanitation user groups across rural areas. Community consultation in the disputed ADB $ 500 million Melamchi project in Kathmandu Valley has resulted in several positive steps including a reduction in average connection cost from $156 to $26 per household, installment-based payment systems for the poor, and low-cost tariff for the first ten cubic metres with incremental increases by volume. However, some concerns, especially those of poor households, remain unresolved.

Source: WaterAid, 2006, Bridging the Gap: Citizens' Action for Accountability in Water and Sanitation, New Delhi

Pro-poor community participation however need not only be at the decentralised level, which may suffer from undue biases of caste, class, gender, and other entrenched societal forms of discrimination. In Sri Lanka basic decisions about the health system are not taken at the local level, but nationally, where poor people have a more powerful voice in macro issues, which can be resolved through central government action; for example the redistribution of resources from the wealthiest parts of the country to the poorest.[79]

Public perceptions and social consensus are important in ensuring effective implementation of the legislation to guarantee universal rights to essential services. In Himachal Pradesh a large measure of the success of the 'education revolution' can be attributed to the social effectiveness and policy space provided to parents to demand fulfilment of the right to education. The active participation of Gram Panchayats, Mahila Mandals (women's groups), Yuva Mandals (youth groups), Parent-Teacher Associations (PTAs) and Village Education Committees (VECs) have played an important role in improving educational provision[80]. Multi-stakeholder participation in essential service provision across South Asia needs to be encouraged in letter and spirit.

Voices of local communities as primary stakeholders of essential services have also been effectively integrated at varied levels from the global to the local. The Global Campaign for Education (GCE)[81] co-ordinates decentralised policy calls by national civil society coalitions within an umbrella of global advocacy on education (for example campaign actions include 'send your politician to school', creation of local 'missing-out-maps' etc.). Trade unions of teachers and health workers can also play a crucial supportive role in campaigning. In the Indian state of Uttar Pradesh, the Primary School Teachers Association (UPPSS) with a membership of 300,000 teachers has been working closely with UNICEF for the last eight years to improve girls' education through a School Chalo Abhiyan ('Go to School' enrolment campaign).[82] These powerful multi-stakeholder campaign initiatives can potentially transform the delivery of essential services in South Asia.

Reflection: Recommendations to Policy Makers

This report analyses the state of essential services in South Asia and the impact on the basic human development needs of its inhabitants. While much progress has been made since independence, there is widespread inequity of access to and variable quality of essential services due to sustained deterioration of the public delivery mechanism. However, pockets of success indicate that change is within reach – the most crucial ingredient is political commitment to uphold the rights of the population and deliver

what they need. This commitment needs to be translated into the following mutually reinforcing policy actions by both donors and governments across South Asia:

- ❑ Create a robust political commitment to the delivery of essential services
  - ⇒ Eliminate user fees in education and heath
    - – Eliminate both direct and indirect costs for all end-users of health and education services and cross-subsidise water for poor people
  - ⇒ Support universal rather than targeted programmes for the delivery of essential service
    - – Ensure legal safeguards for universal access by adopting universal legislation
  - ⇒ Adopt a multi-pronged strategy to fight corruption
    - – Implement society-wide 'right to information' laws
    - – Weed out corruption in essential services delivery
  - ⇒ Ensure that essential services are truly sensitive to the needs of women
    - – Increase women's role in community decision-making
    - – Hire more female teachers and health workers
- ❑ Rebuild capacities in public delivery systems
  - ⇒ Make financial commitments and priorities
    - – Governments need to allocate at least 20 per cent of their annual expenditure to basic services, based on their commitment at the Copenhagen summit in 1995
    - – Donors need to reverse the trend of declining overseas development assistance in South Asia and likewise invest at least 20 per cent of their aid to support basic services. This aid must be co-ordinated, predictable, long-term and comply with the Paris commitment in 2006 on aid effectiveness.
    - – Prioritise primary levels of service
    - – Need to ensure that at the very least 15–20 per cent of total government annual recurrent expenditure is devoted to non-salary quality-enhancing inputs
    - – Governments should regulate private service providers to ensure quality standards and affordability
  - ⇒ Build the public sector work ethos
    - – Ensure teacher salaries are at least 3.5 times the national per capita GDP
    - – Hire 800,000 teachers and 1.9 million health workers in South Asia
    - – Improve infrastructural conditions in schools and health clinics
    - – Create rural bias in service delivery through service contracts
    - – Employ and train more nurses rather than doctors
- ❑ Work with other stakeholders
  - ⇒ Promote partnerships with civil society especially as policy partners and advocates
  - ⇒ Foster social consensus and community ownership to value essential services from a rights perspective

The lives of millions of poor people in South Asia crucially depend on these basic actions. South Asia, with the largest concentration of poor people in the world, needs to make a huge step forward in this battle against impoverishment. Concerted action to provide universal education, health care, water supply, and sanitation of good quality have enabled dramatic strides in human development within some pockets of South Asia. The time has now come for the entire region to emerge as an influential global voice on the strength of its overall development – both economic and human. The annals of history eagerly await the erasure of poverty and inequality. The efficient delivery of free and good quality essential services will be key.

Endnotes

1. Essentials of Essential Services in South Asia

[1] UNESCO (2006) EFA Global Monitoring Report 2006, Education for All: Literacy for Life, Paris: UNESCO.

[2] Associated Press (2006) Mortality Rates climb in Afghanistan, Health, 20 April 2006; R. Bakshi (2006) Maternal Mortality: A woman dies every 5 minutes in childbirth in India, Health, 2 March 2006, UNICEF.

[3] With the exception of East Asia, South Asia has recorded the highest worldwide average real GDP growth rates for the 10-year period 1998–2007. For the period 2001–2005, South Asian countries under study grew at exceptional average growth rates: India 6.7 per cent, Pakistan 4.9 per cent, Sri Lanka 3.9 per cent, Bangladesh 5.3 per cent. Nepal, due to its brewing political turmoil, has been an exception with only 2.6 per cent. Even Afghanistan's 12.5 per cent since 2003, after the fall of the Taliban, is substantive despite the low base. The growth rates of CIS and East Asia are projected to taper off, while during the ten year period 1998–2007 the advanced countries are projected to have grown only at 2.6 per cent and Africa at 4.3 per cent. The International Monetary Fund (2006) World Economic Outlook 2006: Globalisation and Inflation, World Economic and Financial Surveys, Washington: IMF.

[4] South Asia has emerged as an important political voice in recent years. India has recently increased the pressure for its claim for a seat in the UN Security Council based on its newfound economic and nuclear prowess. Pakistan and Afghanistan have emerged as important allies of the United States in the 'war on terror'. As Nepal grapples with the recent transition to democracy and cessation of conflict, its success could provide precedents for the rest of the world polity. Sri Lanka's ability as a middle income country to achieve high standards of human development provides important lessons in development. Bangladesh is also rapidly making inroads onto the world economic stage.

[5] In Bangladesh the deaths of 125,000 small children every year due to diarrhoea would be avoidable if half the country's population had access to clean drinking water and hygienic toilets. A. Lawson (2003) Dhaka tackles diarrhoea deaths, BBC News, South Asia, 27 May, 2003. In Nepal 50 per cent and in Pakistan 30 per cent of the deaths of children under five years of age are due to diarrhoea. IRIN Asia (2004) National campaign to treat acute diarrhoea launched, Pakistan: IRIN Asia.

[6] Of the six countries in South Asia under study in this report – India, Pakistan, Nepal, Bangladesh, Sri Lanka and Afghanistan - due to general paucity of research data from Afghanistan and Nepal this report has found it difficult to source more accurate information from these areas

[7] India, Pakistan (its eastern part would become Bangladesh in 1971), and Sri Lanka all gained independence from the British Empire between 14 August 1947 and 4 February 1948. Nepal and Afghanistan had a slight head start in their historical journey towards independence. Britain recognised the absolute independence of Nepal in 1923 while Afghanistan gained full control of her foreign affairs after the third Anglo–Afghan war in 1921.

[8] This sub-section mainly draws from D. Kunda (2005) A Future out of Grasp, we've seen Poverty, and It is Us, Analysis, Himal Magazine, November 2005: Kathmandu.

[9] Across South Asia, while there has been decline in levels of poverty, inequality has increased at different spatial levels especially in urban areas. In India the Gini coefficient has increased from 0.315 in 1994 to 0.378 in 1997. If this change in inequality had not occurred, the head count rate of poverty in 1999–2000 is estimated to have been 1.2 per cent lower. In Bangladesh similarly if inequality had not worsened from 0.259 to 0.306 between 1991 and 2000, poverty would have declined at twice the rate it actually did. S. Jayasuriya (2002) 'Globalisation, Equity and Poverty: The South Asian Experience', paper presented at the 4th Annual Global Development Conference of the Global Development Network on 'Globalization and Equity' held in Cairo, Egypt, January 19–21.

[10] Ibid. In recent decades, the sectoral and geographical pattern of growth seems to favour states with better initial conditions, while those with low levels of initial human development have not been well suited to reduce poverty in response to economic growth. Similarly in Sri Lanka the estate plantations, which have poor human capital, have experienced a widening of the Gini coefficient from 0.27 to 0.44 between 1980 and 1995, while the national average during this period has remained constant.

[11] Afghanistan as a South Asian country has not been depicted on this map.

[12] BIMARU (Hindi translation: sick) is an acronym to refer to the Indian states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. In terms of human development Orissa is also often grouped with these states due to its chronic pervasive poverty and pathetic human development indicators.

[13] The statistics and data on Afghanistan presented in this report therefore need to be viewed in the historical context and are not strictly comparable with other South Asian countries analysed.

[14] Inter Press Service News Agency (2003) Development: South Asia Holds The Key To Millennium Goals, 8 July. London: IPS quoted in M. Kulshreshta and A.K. Mittal (2005) 'Water and Sanitation in South Asia in the context of the Millennium Development Goals', South Asia Economic Journal 6:1.

[15] In September 2000, 189 UN Member States adopted the Millennium Development Goals (MDGs), setting clear, time-bound targets for halving world poverty by 2015.

[16] S. Mehrotra (2004) 'Reforming Public Spending on Education and Mobilising Resources: Lessons from International Experience', Economic and Political Weekly, 28 February.

[17] Ibid. This phenomenon can be attributed to the emphasis on higher education through government educational institutions and subsidies as high as 70 times the per capita GDP to train each doctor.

[18] Approximately 10 per cent of all start-ups in Silicon Valley between 1995 and 1998 were by Indians, most of whom had come from an Indian Institute of Technology (IIT). IITs have, perhaps, produced more millionaires per capita than any other undergraduate academic institution in the world. M. Kanta (2003) The IIT Story: Issues and Concerns, Frontline Essay, Volume 20, Issue 3, February 1–14.

[19] The migration of health professionals from India, Sri Lanka, and Pakistan began in the 1950s–70s and later extended to Bangladesh and Nepal. Nursing professionals moved mostly to the Middle East, but have recently shifted attention (like the doctors) to the UK, US, and Australia. This worldwide phenomenon has been described as a 'global conveyor belt of health personnel moving from bottom to top'. B. V. Adkoli (2006) 'Migration of Health Workers: Perspectives from Bangladesh, India, Nepal, Pakistan and Sri Lanka', Regional Health Forum 10(1). Similarly, almost half the annual output of the seven IITs goes abroad every year. The US alone has 25,000 IIT alumni. Kanta, op.cit.

[20] While it is acknowledged that tertiary (especially vocational) education can play an important role in technology transfer and rapid national economic growth, as witnessed in East Asia, it must be noted that even in South Korea tertiary education is completely privatised. As the private-sector returns on tertiary education are high the individual is expected to earn sufficiently after his or her higher education to repay the cost of the education incurred through easily available loans etc. S. Mehrotra (2005) 'Only Tiger Cubs become Tigers', Columns, The Indian Express, November 10.

[21] K. Watkins (2001) The Oxfam Education Report, Oxford: Oxfam.

[22] ICESCR (2000) Twenty-second session, 25 April–12 May 2000, New York: United Nations.

[23] R. Chinai and R. Goswami (2005) 'Are We Ready for Medical Tourism?', The Hindu, 17 April. Over the next 10 years health care is expected to grow to be US$1 to 2 billion, contributing 6.2 to 7.5 per cent of India's GDP.

[24] More than 500 women die during pregnancy for every 100,000 live births. Z. Bhutta, S. Nundy, and K. Abbasi (2004) 'Replicating Kerala and Sri Lanka', Elsewhere, Himal Magazine, May.

[25] This is based on a UNICEF estimate quoted in Associated Press (2006) op.cit. and P. Garwood (2006) 'Life Ending Before it's Begun', e-Ariana, The Star, South Africa, 27 April.

[26] Badakhshan has a maternal mortality ratio (MMR) of 6,500 maternal deaths for every 100,000 live births. More than 60 per cent of all childhood deaths in Afghanistan are due to preventable respiratory infections, diarrhoea, and measles.

[27] GoI (2003) RCH Facility survey quoted in A. Das (2006) A New Plan for Safe Motherhood, Maternal Mortality, 7 March, http://www.indiatogether.com/2006/feb/hlt-deliver.htm.

[28] In Pakistan, more than 80 per cent of women give birth with the help of traditional birth attendants (TBAs) but pregnancy complications are on the rise due to lack of health-care facilities. G. Waqar (2004) 'PMA report roasts health policy, practice', Daily Times, January 20, based on evidence from the Pakistan Medical Association Annual Report 2003.

[29] In India a girl is 1.5 times less likely to be hospitalised than a boy. Zinc Study Group (2005) 'The effect of maternal education on gender bias in care-seeking for common childhood illnesses', Social Science and Medicine, 60:715–24. In Pakistan, there exists the curious phenomenon of sons having better access to health care but not necessarily being better fed than daughters. G. Hazarika (2000) 'Gender Differences in Children's Nutrition and Access to Health Care in Pakistan', The Journal of Development Studies, 37(1): 73–92. It is argued that intra-household gender discrimination has primary origins in higher returns to parents from investment in sons. In Bangladesh, utilisation of health-care services even at a free treatment unit showed marked male preferences. L. Chen, E. Huq, and S. D'Souza (1981) 'Sex Bias in Family Allocation of Food and Health Care in Rural Bangladesh', Population and Development Review, 7(1): 55–70.

[30] In Bangladesh, arsenic in shallow tube wells found in 59 out of the 64 districts has exposed an estimated 25 million people to toxins. In Nepal, arsenic has been identified in 31 per cent of all tube wells.

[31] West Baseline Livelihoods Monitoring Project reported in K. Kar (2003) Subsidy or self-respect? Participatory total community sanitation in Bangladesh, IDS Working Paper 184, Institute of Development Studies.

[32] UNDP (2003) Human Development Report 2003, Millennium Development Goals: A compact among nations to end human poverty, New York: Oxford University Press.

2. What Works? The Case for Universal Public Provision

[1] This section draws heavily on the analysis of Mehrotra, Vandemoortele and Delamonica (2000) *Basic Services for All?* UNICEF Innocenti Research Centre, Florence, Italy and Mehrotra (2000) *Integrating Economic and Social Policy: Good Practices from High-Achieving Countries*, Working Paper No. 80, UNICEF Innocenti Research Centre, Florence, Italy. These sources include Sri Lanka, the Indian State of Kerala, Malaysia, and the Republic of Korea as high achievers from Asia.

[2] Sidney Buchman was an American writer and producer and President of the Writers Guild of America.

[3] World Bank (2005) *Treasures of Education System in Sri Lanka*, Executive Summary, Overview, Principle Findings and Options for the Future, World Bank, Sri Lanka. It is interesting to note that education has been a burning emotive rallying point and one of several factors, which led to the Sri Lankan civilian crisis. The standardisation policy in higher education in the 1970s, which meant that Tamil students would have to secure more marks than their Sinhalese counterparts for parity, was heavily contested. To this day, the separatist group, the Liberation Tigers of Tamil Eelam (LTTE) claims that there is a surplus of nearly 14,000 Sinhalese teachers and a deficit of around 10,000 Tamil teachers and that the contentious standardisation system has even trickled down to the primary level. Language of education has also been a serious bone of contention and the LTTE has taken an initiative to translate textbooks into Tamil, prepare notes for teachers, buy textbooks from publishing houses and appoint teachers with salaries in the conflict-ridden North-East. The Government of Sri Lanka however has accused the LTTE of using schools as platforms for propaganda. V.S. Sambandan (2003) *On Tiger Turf*, Cover Story, Frontline, 5 December.

[4] The exception has been that in the early 1980s Sri Lanka did rely heavily on UNICEF and other NGO- sponsored programmes to deliver primary health care – nutrition supplements, recruitment and training of primary health-care workers and so on – in the plantation areas.

[5] World Bank (2003) *Investing in Maternal Health: Learning from Malaysia and Sri Lanka*. Washington, DC; World Bank (2003) Human Development Network, Health, Nutrition and Population Series, Washington, DC; and Mehrotra (2000) *op.cit.*

[6] Literacy levels witnessed a quantum increase from 32 per cent in 1971 to 77 per cent in 2001 with female literacy trebling from 20 per cent to 68 per cent in the same period. Almost every child in the 6–14 age group, regardless of sex or caste, is now enrolled in school. D. Sanan (2004) 'Delivering Basic Public Services in Himachal Pradesh: Is the Success Sustainable?' *Economic and Political Weekly*, February 28.

[7] A. Mansoor and R. Chowdhury (2005) *Beyond Access: Partnership for Quality with Equity*, Beyond Access, Regional Seminar, Dhaka, 31 January–1 February 2005.

[8] Centre for Policy Dialogue (2003) *Policy Brief on Education*, Dhaka: National Policy Review Forum Task Force Report.

[9] Mehrotra and Jolly (eds.) (1997) *Development with a human face: Experiences in social achievement and economic growth*, Clarendon Press: Oxford.

[10] V. Suresh and Vibhu Nayar (2006) *Democratisation of water management: Establishing a paradigm shift in the water sector: The Tamil Nadu experiment with governance reform,* WaterAid and World Development Movement.

[11] B. Calaguas and V. Cann (2006) 'Reforming public utilities to meet the Water and Sanitation MDGs', paper presented at a conference at the UK DFID, 4 July 2006, organised by the World Development Movement and WaterAid.

[12] N. Hossain and N. Kabeer (2004) 'Achieving Universal Primary Education and Eliminating Gender Disparity', *Economic and Political Weekly*, September 4. They argue that political support for educational expansion

in Bangladesh in the post-democratic period appears to derive from inter-party competition for ideological influence in the form of teachers (or village-level bureaucrats) not only to ensure a political presence at the heart of rural society but also to control the curricula as a medium of national identity formation. The active role of the student movement in political struggle for independence in the 1970s and the subsequent surge in educational expansion during Ershad's time (1982–91), as a measure to garner popular support for a military dictatorship, have also contributed to the importance of education.

[13] Z. Hasnain (2005) *The Politics of Service Delivery in Pakistan: Political Parties and the Incentives for Patronage 1988–1999*, Washington DC: The World Bank. With the arrival of democracy in Pakistan 1985, there was a surge in school construction and teacher recruitment. From 1985 to 1999–2000, the number of public primary schools increased nationally by 70 per cent and the teachers almost doubled. In the Sindh province primary schools increased by 180 per cent and teachers by 125 per cent! But ironically this was marked by a decline in net enrolments. One reason could be that teachers were recruited primarily on patronage grounds, and schools were built of poor quality because of the commissions given to the contractors. Since non-salary recurrent spends for operations and maintenance were neglected, the quality of education was adversely affected. A political economy explanation could be that to get elected, politicians must credibly communicate to voters that they are personally responsible for certain improvements which tend to favour 'targeted' benefits or patronage, rather than universal public goods. For example even though patronage-based recruitment of teachers benefits only the teachers selected, these 'clients' will be well-informed about who was responsible for hiring them. But if meritorious teachers are routinely recruited then while education will clearly improve, it will be difficult for voters to assign credit to a particular politician. This reiterates the fact that often there is no systematic relationship between development expenditures and human development outcomes.

[14] J. Drèze (2004), 'Democracy and the Right To Food', *Economic and Political Weekly*, 24 April.

[15] There are a range of factors which contribute to Sri Lanka's low spending on education as a percentage of GDP in recent years. Sri Lanka built up its capital stock of schools during the 1950s–1970s, so that there is now no need for major investment in the construction of classrooms and new school buildings. The education capital budget has therefore sharply declined in recent years with a high proportion of investment expenditure financed through donor-funded projects (approximately 68 per cent of the capital budget) and comparatively low teacher salaries (Sri Lankan teachers receiving salaries about half or less, as a proportion of national income per capita, than teachers in countries such as India, Bangladesh, Malaysia, Thailand, and South Korea).

[16] While education up to university level is free and enrolments near universal, Sri Lanka has not yet achieved universal secondary completion, with about 18 per cent of children failing to complete grade 9.

[17] S. Mehrotra (2000) 'Integrating Economic and Social Policy: Good Practices from High-Achieving Countries', Working Paper No. 80, UNICEF Innocenti Research Centre, Florence.

[18] R. Cassen, G. Kingdon, K. McNay and L. Visaria (2005) 'Education and Literacy', Chapter 7, *Twenty First Century India: Population, Economy, Human Development, and the Environment,* New Delhi: Oxford University Press

[19] WaterAid (2005) *Drinking Water and Sanitation Status in India: Coverage, Financing and Emerging Concerns*, New Delhi: WaterAid.

[20] S. Mehrotra (2005) 'Only tiger cubs become tigers', Columns, *The Indian Express*, November 10.

[21] K. Bhatty (2006), Social Equality and Development: Himachal Pradesh and its Wider Significance, Doctoral Thesis (unpublished) submitted to the University of London, London School of Economics

[22] R. Rannan-Eliya (2001) 'Strategies For Improving The Health Of The Poor: The Sri Lankan Experience', Health Policy Programme, Institute of Policy Studies of Sri Lanka.

[23] World Bank (2005) 'Treasures of Education System in Sri Lanka', Executive Summary, Overview, Principle Findings and Options for the Future, World Bank, Sri Lanka.

[24] S. Mehrotra (1998) 'Education for All: Lessons from High-Achieving Countries', *International Review of Education* 44 (5/6): 461–84, quoted in UNDP (2003) *Human Development Report 2003, Millennium Development Goals: A compact among nations to end human poverty*, New York: Oxford University Press.

[25] National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Government of India, 2005.

[26] Joint Learning Initiative (2004) 'Communities at the Frontlines', Chapter 2, *Human Resources for Health: Overcoming the Crisis*, Global Equity Initiative, Harvard University.

[27] PROBE (1999) *Public Report on Basic Education in India*, New Delhi: Oxford University Press.

[28] In 2002, India passed the 93rd Constitutional Amendment to make primary education free and compulsory for all. Nevertheless only 14 States and Union Territories have laws which aim to achieve free and compulsory primary education through local bodies.

[29] Mehrotra and Delamonica (forthcoming), *Public Spending for the Poor: Basic Services to Enhance Capabilities and Promote Growth*, Oxford: Oxford University Press, quoted in UNDP (2003) *op. cit.*

[30] In Sri Lanka, the midday meal scheme was withdrawn in the 1970s for a short period but restarted in all schools in the 1990s – both government and private. It was very successful, with all schools reporting a much higher attendance rate, but discontinued in 1992. It has now been restarted in May 2006. It is only applicable to grade one and grade two of the poorest 7384 schools in the poorest districts. 'Projects to Improve Nutritional Status of Children', *Sunday Observer*, Daily News Online Edition, 21 May 2006. The definitions of 'poorest' however have not been clearly defined.

[31] R. Rannan-Eliya (2001) *Strategies For Improving The Health Of The Poor: The Sri Lankan Experience*, Health Policy Programme, Institute of Policy Studies of Sri Lanka.

[32] In Sri Lanka doctors need to serve in rural areas for 5–6 years, but if they are specialising in areas which rural hospitals do not have the capacity for, then they can seek exceptions.

[33] There has been sharp increase in demand for popular, prestigious urban schools and decreasing demand for rural and less prestigious semi-urban schools. This shift in demand has led to the existence of a large number of very small schools. About 60 per cent of schools have less than 300 students and 14 per cent schools have less than 50 students. This network of small schools is expensive to maintain and operate. Sixty per cent have student:teacher ratios of 15:1 or less. These small schools typically have unit recurrent costs about 100 per cent greater than large schools with student:teacher ratios of about 25:1. World Bank (2005) *Treasures of Education System in Sri Lanka*, Executive Summary, Overview, Principle Findings and Options for the Future, World Bank, Sri Lanka. Therefore the government has shut down a number of schools in an attempt to rationalise education expenditure. In tandem, supportive measures have been initiated, such as providing subsidised transport for school children in recognition of the fact that some need to travel longer distances.

[34] R. Rannan-Eliya (2001) op.cit.

[35] Centre for Research in Rural and Industrial Development, Chandigarh quoted in A. Zaidi (2006) *Ailing System*, Public Health, Frontline, 21 April.

[36] R. Rannan-Eliya (2001) *op.cit.*

[37] *Ibid.*

[38] The drop-out rate in primary schools is less than 1 per cent, single teacher schools 7–10 per cent, and gender parity 100 per cent. S.

Akshay (2003) 'Himachal Pradesh: Critical Issues in Primary Education', Commentary, *Economic and Political Weekly*, June 21.

[39] K. Bhatty (2006), *op.cit.*

[40] P. Tripathi (2006) *A role model for development*, Interview with Virbhadra Singh, Chief Minister, Himachal Pradesh, Focus: Himachal Pradesh, Frontline 23(2), Jan. 28–Feb. 10.

[41] The achievement of gender parity is reflected not only in national aggregates but has truly percolated across the social structure of schooling in Bangladesh. A household survey in the catchment areas of selected primary schools in 10 Upazilas shows broad-based gender parity across the board among catchment areas, upazilas, school types, and socio-economic groups. CAMPE, *Education Watch 2003/4: Quality with Equity: The Primary Education Agenda*, Education Watch School Catchment Area Household Survey, 2004.

[42] A. Mansoor and R. Chowdhury (2005) *Beyond Access: Partnership for Quality with Equity* 'Beyond Access' Regional Seminar, Dhaka, 31 January–1 February.

3. What's Holding Others Back?

[1] UNICEF (2005) *Children unimmunized against measles in South Asia in 2003*, A Report Card On Immunization: Number 3, September.

[2] The government is the largest provider of education in India with only about 15 per cent of children enroled in private institutions. UNESCO (2004) *EFA Global Monitoring Report 2005, Education for All: The Quality Imperative*, Paris: UNESCO.

[3] The security situation has worsened, with schools having emerged as the latest soft targets of arsonists. Especially in the south, schools have been burnt, teachers threatened and some even killed. (D. Walsh, *Fears of a lost generation of Afghan pupils as Taliban targets schools*, Special report Afghanistan, March 16, 2006.)

[4] The rate of growth of the enrolments in Afghanistan presents an unprecedented challenge. According to the Ministry of Education (personal communication with Mr. Hameeda Karbolai, Head of Basic Education Dept, 4th April 2006), enrolment in the formal primary school system was approximately 5–5.5 million in 2006, an increase of 50 per cent from 3.1 million students in 2003. This is in addition to the 350 per cent increase in enrolments since the fall of the Taliban in 2001.

[5] These figures are for the year 2003. A. Strand and Olesen (Eds.) (2005) *Afghanistan: Findings on Education, Environment, Gender, Health, Livelihood and Water and Sanitation From Multidonor Evaluation of Emergency and Reconstruction Assistance from Denmark, Ireland, the Netherlands, Sweden and the United Kingdom*, CMI Report, Chr. Michelsen Institute, R 2005: 15.

[6] The Indian public health infrastructure consists of 17,000 public hospitals, 23,000 PHCs, 1,37,000 sub-centres and 3,000 community health centres, serving the semi-urban and rural areas. A. Krishnakumar (2004) 'An Unhealthy Trend', *Public Health*, 21(24) *The Hindu*, December.

[7] K.R. Nayar (2004) 'Rural Health: Absence of Mission or Vision?', Commentary, *Economic and Political Weekly*, November 6, and Banerji Debabar (2005), 'Politics of Rural Health in India', EPW Perspectives, *Economic and Political Weekly*, July 23.

[8] Wada Na Todo (2005) *Securing Rights: Citizens' Report on MDGs, People Speak The Truth about MDGs*, Chap 5: Securing Rights: Citizens Report on MDGs, p.26.

[9] Ojha V and P Basanta (2006), *The Macro-Economic and Sectoral Impacts of HIV and AIDS in India*: A CGE Study, United Nations Development Programme

[10] In Pakistan, there are only 455 rural health centres expected to serve two-thirds of the population with a patient:hospital bed ratio of only 1500:1. M. Shafqat (2003) 'Pakistan's budget 2003-04: The economics of hypocrisy', Report, *Himal Magazine*.

[11] In India at the time it gained independence only 8 per cent of all medical institutions were operated by private agencies, and 5 per cent by the non-government sector which received government grants, but by 1995 private hospitals represented more than two-thirds of all hospitals and nearly 40 per cent of the hospital beds. R. Baru (2003) 'Privatisation in Health Services: A South Asia Perspective', EPW Commentary, *Economic and Political Weekly*, October 18.

[12] Afghanistan currently has just over 800 BHCs in total, but health experts have estimated that it needs almost 6,000, given its population size. A. Frumin, M. Courtney and R. Linder (2004) *The Road Ahead: Issues for Consideration at the Berlin Donor Conference for Afghanistan*, A CSIS Special report, Post-Conflict Reconstruction Project, Center for Strategic and International Studies, Washington DC, March 31–April 1.

[13] UNESCAP (2005) *A future within reach: reshaping institutions in a region of disparities to meet the Millennium Development Goals in Asia and the Pacific*, Programme Management Division, United Nations Economic and Social Commission for Asia and Pacific.: A Future Within Reach

[14] In Orissa at one time there were as many as 14,000 vacant posts in primary schools, while 89,864 additional posts were needed. A. Ram (2002) 'Teachers by Contract: Quality Education Calls for Dedicated and Competent Faculties', *The Statesman*, New Delhi, Thursday 6 June.

[15] P. Nilsson (2003) *Education For All: Teacher Demand and Supply*, Education International Working Paper No.13, Brussels.

[16] In India, in the post liberalisation period, unemployment on a Current Daily Status basis rose from 6 per cent in 1993–94 to 7.3 per cent in 1999–2000 resulting in an additional 27 million job seekers. Of these, 74 per cent are in rural areas and 60 per cent of them are educated. Planning Commission (2000), 'Special Group on Targeting Ten Million Employment Opportunities per Year', New Delhi: Government of India

[17] The World Bank benchmark for low-income countries is physicians:population ratio of 0.1:1000. S.Mehrotra (2004) 'Reforming Public Spending on Education and Mobilising Resources: Lessons from International Experience', *Economic and Political Weekly*, 28 February. High-achieving countries – those where life expectancy is high and under-five mortality is low – tend to have more nurses per doctor. Mehrotra and Delamonica, forthcoming, *op.cit*.

[18] D.H. Peters, A. S. Yazbeck, R.R. Sharma, G.N.V. Ramana, L.H. Pritchett, and A. Wagstaff (2002) *Better Health Systems for India's Poor: Findings Analysis and Options*, Human Development Network, Health, Nutrition, and Population Series, Washington DC: World Bank. India has only 0.79 nurses per 1000 people. The rule of thumb is that there should be between 2 to 4 graduate nurses per physician. India has a nurse:doctor ratio of only 1:1.

[19] There are 0.5 doctors per 1000 people in Pakistan. M. Shafqat (2003) *op.cit.* There are a mere 46,331 registered nurses for a population of 150 million people, stated the Pakistan Economic Survey, (2005) quoted in A. Yusufzai (2005), *Nurses Get Little Training or Respect*, Inter Press Service News Agency, 4 June.

[20] N. Chaudhury, J. Hammer, M. Kremer, K. Mularidharan, and F. H. Rogers (2004) *Roll Call: Teacher Absence in Bangladesh*, June, World Bank.

[21] In Bangladesh, metropolitan centres have only 15 per cent of the country's population, but have a concentration of 35 per cent of doctors and 30 per cent of nurses in government positions. Unlike India there are almost no doctors or nurses in the private sector in rural areas. Joint Learning Initiative (2004) *The Power of the Health Worker*, Chapter 1, Human Resources for Health: Overcoming the Crisis, Global Equity Initiative, Harvard University. In Bangladesh the doctor:nurse ratio is 3:1 when ideally it should be 1:3.

[22] In Nepal, training of Auxiliary Nurse Midwives (ANMs) is also an acute need as they are often missed out of in-service training. Oxfam GB Nepal (2005) *op.cit.*

[23] UNICEF is cooperating with UNHCR in order to identify professionals among the returnees who fled the country during the conflict years and are reluctant to leave jobs in other countries. According to Dr. Nayeem Azim, chairman of Afghan Medical Association, "There are estimated to be about a thousand Afghan doctors and a few thousand nurses in Pakistan alone and thousands more in Europe and North America". The challenge lies in attracting them back to Afghanistan. The British Medical Association has suggested that as an incentive donor countries may be able to contribute by not withdrawing the status of asylum in the host country for health professionals willing to go back to Afghanistan. M. Taksdal (2005) *op.cit.*

[24] WaterAid (2005) Bangladesh, Water Sector: National Water Sector Assessment, New Delhi: WaterAid.

[25] N. Chaudhury, J. Hammer, M. Kremer, K. Muralidharan, and H. Rogers (2004a) 'Teacher Absence in India: A Snapshot', *Journal of the European Economic Association*. 9 (2): 85-110

[26] N. Chaudhury, J. Hammer, M. Kremer, K. Muralidharan, and H. Rogers (2004b) *Roll Call: Teacher Absence in Bangladesh*. World Bank, Washington, D.C.

[27] E. M. King, P. F. Orazem, and E. M. Paterno (1999) *Promotion with and without Learning: Effects on Student Dropout*, World Bank: Washington, DC, quoted in Chaudhury et al. (2004a) *op.cit.*

[28] The Sixth All-India Educational Survey, National Council of Education Research and Training cited in PROBE Team (1999) *op.cit*. Primary school teachers at Bihar's government schools spend less than two months a year in the classroom. The shortfall of 199,014 classrooms indicates that the teacher:pupil ratio is 1:122. Teachers are routinely employed for non-classroom duties and the state has failed to get the second instalment of the central grant for education due to non-utilisation of funds.

[29] Pakistan Development Forum (2004) *Challenge of Education and Economic Growth*, Government of Pakistan, Ministry of Education, March 17–19.

[30] Government of the People's Republic of Bangladesh (2003), *Education for All: National Plan of Action II 2003–2015*, Fourth Draft, Ministry of Primary and Mass Education, May.

[31] Bruns, Minger, and Rakotomalala (2003) *Achieving Universal Primary Education by 2015: A Chance for Every Child*, Washington DC: World Bank.

[32] N. Chaudhury, J. Hammer, M. Kremer, K. Muralidharan, and H. Rogers (2005) 'Provider Absence in Schools and Health Clinics', *Journal of Economic Perspectives*. 9 (2)

[33] Pratichi (India) Trust (2005), *Pratichi Health Report*, TLM Books, New Delhi

[34] N. Chaudhury and J. Hammer (2003) *Ghost doctors: absenteeism in Bangladeshi health facilities*, Washington, DC, The World Bank, Policy Research Working Paper No. 3065.

[35] Data on availability of essential drugs show that between 1982–83 the gap in availability was only 2.7 per cent but by 1991–92 it had risen to 22.3 per cent when the drug price control went out of the window. A. Phadke (1998) *Drug Supply and Use: Towards a rational policy in India*, Sage, New Delhi cited in Wada Na Too (2005) *op.cit.*

[36] State Bank of Pakistan (2004) The State of Pakistan's Economy First Quarter FY 2004, Special Section 1, *Making Health Services Work for the Poor in Pakistan: Rahim Yar Khan Primary Healthcare Pilot Project*.

[37] A. Frumin, M. Courtney and R. Linder (2004) *op.cit.*

[38] R. Baru (2003) *op.cit.*

[39] Transparency International Bangladesh (2005) *Corruption in Bangladesh: A Household Survey*.

[40] D. Montero (2005) 'The Pakistan quake: Why 10,000 schools collapsed', World: Asia: South & Central, *Christian Science Monitor*, 8 November.

[41] Transparency International Bangladesh (2005) *op.cit.*

[42] T. Begum *et al.*(1999) 'Unofficial Fees in Bangladesh: Price, Equity and Institutional Issues', *Health Policy and Planning* 14(2): 152–63. All patients are supposed to be provided with required medicines for free at public hospitals. But medicines constitute 85 per cent of unofficial payments in the hospitals surveyed. Findings suggest that middle-income and to some extent poor patients pay relatively greater proportions of unofficial fees than the comparatively wealthy.

[43] Transparency International Bangladesh (2005) *op.cit.*

[44] Bangladesh's Expanded Programme on Immunisation (EPI) is often cited as a 'success story' not only of NGO–Government collaboration (B. Afrose (2001) 'Government: NGO Collaboration in Health and Population Management in Bangladesh: Experiences from the Field', *IASSI Quarterly* 20(1) July–September) but also of combating mortality – it saves an estimated 4 million children each year. The EPI helped increase coverage against six preventable childhood diseases – diphtheria, tetanus, tuberculosis, whooping cough, polio, and measles by 70 per cent in three decades from 1973. The identity-blind approach of EPI and the high visibility of vaccinations also helped the programme receive substantial foreign aid. L. Russell (2006) 'A Quick Jab: Bangladesh's renowned vaccination programme turns its focus on measles, and provides an example for the rest of South Asia', Report, *Himal Southasian*, March–April.

[45] India, which initiated the DOTS programme to fight tuberculosis (TB), has increased successful treatment of TB cases from three out of ten cases in 1993 to eight out of ten in 2001. This is an important achievement as India accounts for a quarter of the world's TB cases – 421,000 deaths per year.

[46] In Afghanistan under the Taliban, measles claimed an estimated 30,000 lives a year. A campaign led by the Ministry of Health with donor technical support and funding visited mosques in 2002 and vaccinated 11 million children between the ages of 6 months and 12 years. Ninety-four per cent coverage was achieved nationally and epidemic transmission has stopped. 'Afghanistan's Health Challenge', Editorial, *The Lancet* 362(9387), 2004.

[47] The NRHM proposes to appoint 250,000 women for medical care jobs, chosen by and accountable to the women in the community, titled ASHA (Accredited Social Health Activist). However this experiment has been tried in the past with the large-scale employment of community health volunteers (CHVs) and serious problems arose

in the misuse of selection processes for political patronage. Caste and class social prejudices restricted the utility of the CHVs and with their extremely limited training most of them became quacks. K.R. Nayar (2004) 'Rural Health: Absence of Mission or Vision?', Commentary, *Economic and Political Weekly*, November 6.

[48] The first initiatives of the NRHM apart from the Pulse Polio campaign also include the Hepatitis-B vaccination drive which targets chronic liver disease in adults. However, major causes of cirrhosis of the liver are alcoholism and malnutrition. Vaccination drives tend to create false promises, divert attention from basic underlying causes and 'create demand' for medical technology that may have only marginal benefit. P. Ritu, A. Sagar, R. Dasgupta, and S. Acharya (2004) 'CMP on Health: Making India World Class', Perspectives, *Economic and Political Weekly*, 3 July.

[49] The World Bank's Booster Program to combat malaria, launched in April 2005 in India, has come in for sharp criticism because the publicised statistics of the decline in disease-incidence are inaccurate and the Bank sanctioned purchases of $1.8 million, i.e. more than 100 million tablets of *chloroquine* even though this violates WHO guidelines that *chloroquine* should explicitly not be used in conditions such as those in India where highly resistant strains of the virus exist. Attaran *et.al.* (2006) *The World Bank: false financial and statistical accounts and medical malpractice in malaria treatment*, Viewpoint, Published online April 25.

[50] Chowdhury *et. al.* (2005) *Bangladesh: Study of Non-State Providers of Basic Services*, Technical and Policy Research, DFID.

[51] An international NGO in healthcare pulled out of Afghanistan in July 2004, following the murder of five of their staff in Badghis province. At the time they provided assistance in 13 provinces with 80 international and 1,400 Afghan staff members. Clinics were rapidly handed over to other NGOs and the Ministry of Public Health (MOPH), but not with sufficient budgets, resulting in rapid decline of quality of services. Ewen MacAskill (2004) *Aid Agency Quits Afghanistan Over Security Fears,* Special Report, The Guardian, July 29

[52] WaterAid (2005) 'Bangladesh: National Water Sector Assessment', WaterAid Bangladesh.

[53] J. Isham and S. Kähkönen (2002) 'The Institutional Determinants of the Impact of Community-Based Water Services: Evidence from Sri Lanka and India', *Economic and Cultural Change*, 50(3) April, University of Chicago Press. This was based on a study of three community-based rural water projects in Sri Lanka and the Indian states of Karnataka and Maharashtra started in the early nineties. It suggests that communities with a high level of social capital – community groups and associations – are more likely to have better monitoring mechanisms in place so greater investment needs to be made in social mobilisation efforts (e.g. strengthening of local organisations) and more direct supervision by project personnel working in these communities.

[54] In the Indian state of Andhra Pradesh, the biggest landlords and contractors of the region headed the Water Users Association. P. Sainath (2006) *Thirst for Profit,* Cover Story, Frontline, 21 April.

[55] The study compared the progressive National Rural Support Programme (NRSP) to those run by the Local Government and Rural Development Department (LGRDD) and Public Health Engineering Department (PHED). Atiq-ur-Rehman (2000) Book Review of Shahrukh Rafi Khan, 1999, 'Government, Communities, and Non-Governmental Organisations in Social Sector Delivery: Collective Action in Rural Drinking Water Supply', *The Pakistan Development Review*, 39(2) summer, Islamabad.

[56] WaterAid (2005) *op.cit.*

[57] In Sri Lanka, health-care facilities are minimal in the conflict-affected north. In Colombo, in 2001, the maternal mortality ratio (MMR) was just 0.2 per 10,000 live births, while rebel-held Kilinochchi registered an MMR of 14.3, the highest for any district. Across all northern and eastern districts, the MMR has deteriorated in comparison to pre-conflict times. In Jaffna the MMR has increased from 0.3 in 1981 to 2.8, from 2.7 to 9.7 in Mannar, in Batticaloa from 1.0 to 5.1, in Ampara from 0.6 to 9.7 and in Trincomalee from 0.4 to 4.1. The availability of health personnel is the lowest in Kilinochchi at 0.036 per million persons in comparison to the national average of 0.45. V.S. Sambandan (2003) *A war-ravaged economy, Sri Lanka*, Frontline, August 15, 2003, p. 128-130. In 1993 in Jaffna 18.9 per cent of children under 3 years were wasted (acutely malnourished), 31.4 per cent were stunted (chronically malnourished) and 40 per cent were below the expected weight for their age. Wickramage Kolitha, no date, *World Health Organization, Sri Lanka and University of NSW*, School of Public Health and Community Medicine, Sydney, Australia.

[58] J. Praveen (2005) 'Withering Commitment and Weakening Progress: State and Education in the Period of Neo Liberal Reforms', *Economic and Political Weekly*, 13 August.

[59] '*Dalit*' refers to lower castes in Hindu societies who were referred to as 'untouchable'.

[60] Oxfam GB Nepal (2005) *Suffering in Silence: Terror on the terraces in Nepal*, Public Health Assessment, May–June.

[61] 'Diseases of the poor' refer to the repeated outbreak of communicable diseases like malaria, gastroenteritis, kala azar, Japanese encephalitis and so on, which show a distinct regional and social variation. In India, these outbreaks have been largely confined to the poorer states like Bihar, Madhya Pradesh, Orissa, Andhra Pradesh, and Rajasthan and tribal and *dalit* populations disproportionately bear the burden of mortality. R. Baru (2004) *Abdicating Responsibility*, Seminar. Volume 537.

[62] D.H. Peters *et.al.* (2002) *op.cit.*

[63] Oxfam GB Nepal (2005) *op.cit.*

[64] Until the early 1990s, each plantation had primary health-care officers (Estate Medical Assistants - EMAs) who were paid for by the estate funds. Estate health care was perceived as better than rural health care. After the privatisation of estates however, the private companies refused to fulfil health care responsibilities and the government stepped in. EMAs were axed and doctors were appointed to the estates but due to the difficult terrain and language issues most doctors do not take up their posts. Workers find it difficult to leave the estates to attend to their medical needs because of the expense (due to long distances) and difficult terrain.

[65] P. Sainath (2006) *op.cit.*

[66] N. Ilahi and N. Grimard (2000) 'Pubic Infrastructure and Private Costs: Water Supply and Time Allocation of Women in Rural Pakistan', *Economic Development and Cultural Change*, 49(1) October, The University of Chicago Press.

[67] Despite the fact that women have a biological tendency to outlive men (in all developed countries and most undeveloped ones, women outlive men, sometimes by a margin of 10 years), in Pakistan and Nepal women actually have shorter lives than men and in Afghanistan, Bangladesh, and India their advantage is less than one year. UNESCAP (2005) *op.cit.*

[68] WHO (2005) *Making Every Mother and Child Count*, Switzerland: World Health Organisation.

[69] In broad terms, Asia-Pacific is where Africa was 12 or 13 years ago. The *physiological* fact is that women are more than twice as vulnerable to HIV/AIDS infection as men. The *sociological* fact is that in South Asia women's subordinate status, in marriage and society at large, makes them even more vulnerable. Bloom *et.al.* (2004) *Asia's Economies and the Challenge of AIDS*, Manila: Asian Development

Bank. In India more than 90 per cent of HIV-positive women are married and monogamous (statement by Dr. Nafis Sadik, Special Adviser to the United Nations Secretary-General and Special Envoy for HIV/AIDS in Asia and the Pacific at the Asia-Pacific Women, Girls and HIV/AIDS Best Practices Conference, Islamabad, Pakistan, 29 November 2004).

[70] Pakistan's National Programme for Family Planning and Primary Health Care, created in 1994 to improve access to health care in rural communities and urban slums, has relied heavily on the performance of its 80,000 Lady Health Workers. Serious institutional weaknesses - and governance deficiencies have adversely affected the programme - shortage of equipment and staff in district health offices, Basic Health Units (BHUs) and Rural Health Centres (RHCs), especially of female doctors, nurses, lady health workers, laboratory equipment, and drugs continue to pose serious constraints as the referral services of the LHWs prove ineffective. Pakistan: evaluation of the Prime Minister's programme for Family Planning and Primary Health Care. Interim report. Oxford, Oxford Policy Management, 2000 quoted in WHO (2005) *Making Every Mother and Child Count*, Switzerland: World Health Organisation. Government of Pakistan (2004) *Pakistan Millennium Development Goals Report 2004*, United Nations and Centre for Research on Poverty Reduction.

[71] In the 1970s, training of traditional birth attendants (TBAs) in modern methods of delivery became widespread in regions with a lack of professional health personnel or infrastructure for maternity care. While WHO encouraged this strategy until the mid-1980s, evidence emerged that it had little impact on maternal mortality. While TBAs were expected to persuade women with complications to go to hospitals, they tended instead to delay or discourage women from doing so as it affected their income. It will have taken more than 20 years to realise the failure of this strategy and there is a growing realisation of the need to train professional midwives. World Health Organisation (2005) *op.cit.*

[72] World Bank (2001) *Nepal: Priorities and Strategies for Education Reform*, Human Development Unit, South Asia Region.

[73] Negative experience of incentives given to private hospitals, such as excise duty exemptions, free land, etc. in lieu of treating 10 per cent of inpatients and 40 per cent of outpatients free have been a dismal failure. R. Baru, I. Qadeer and R. Priya (2000) 'Medical Industry: Illusion of Quality at What Cost', EPW Commentary, *Economic and Political Weekly*, July 15-21.

[74] Observations of Jean Dreze, economist from Delhi School of Economics; R. Chinai and R. Goswami (2005) 'Are we Ready for Medical Tourism?', *The Hindu*, 17 April.

[75] D. H. Peters *et.al.* (2002) *op.cit.*

[76] Triequity (2001) *Equity in Financing and Delivery of Health Services in Bangladesh, Nepal and Sri Lanka: Results of the Tri-country Study*, Data International Limited, Nepal Health Economics Association, Institute of Policy Studies.

[77] WaterAid (2005) 'Profiling "Informal City" of Delhi: Policies, Norms, Institutions and Scope of Intervention', New Delhi: WaterAid India.

[78] H. Mumtazah (2003) *Water for People, Water for Life, For the Right Price*, Pakistan Water Gateway, 28 February.

[79] India is the tenth largest bottled water-consuming nation in the world and is one of the fastest growing industrial sectors with a compounded annual growth rate (CAGR) of 25 per cent and gross profit of 25 to 50 per cent. B. Chandra (2006) *Bottled Loot: The structure and economics of the Indian Bottled Water Industry*, Cover Story, Frontline, 21 April.

[80] In the Indian city of Jaipur, Coca-Cola which produces the bottled water brand 'Kinley' is reported to extract millions of litres of water per day – at the cost of 14 paise per 1000 litres (it takes 2-3 litres of groundwater to make one litre of bottled water). B. Chandra (2006) *op.cit.*

[81] R. B. Kattan and N. Burnett (2004) *User Fees in Primary Education*, Education Sector, Human Development Network, World Bank Publications, Washington DC.

[82] JBIC 2002, Bangladesh Education Sector Overview, JBIC Sector Study, March 2002, Japan Bank for International Cooperation.

[83] In Nepal while some services are free, all out-patient care requires a nominal registration fee. In India while practices differ by state, there are no formal fees for primary care. In Bangladesh there are no 'official' user fees at the primary health-care level.

[84] Now, a patient entering any hospital in Pakistan, private or public, has to provide their own medication, food and so on. User fees have particularly increased after the passing of the Punjab Health Ordinance in January 2002. Sind and Baluchistan governments have refused to impose them. I. Humeira (2003) *Health Care Privatization In Pakistan, Corporate*, Globalisation, Znet, February 7.

[85] Cited in R. Priya, A. Sagar, R. Dasgupta and S. Acharya (2004) 'CMP on Health: Making India World Class', Perspectives, *Economic and Political Weekly*, 3 July. Also 33 per cent of the poorest income quintile reported cost as the reason for not seeking care. *Morbidity and Treatment of Ailments: NSS Fifty-Second Round*, July 1995-June 1996, Calcutta.

[86] R Pradhan, R Sundar and S Singh (2006) *The Socio-Economic Impact of HIV/AIDS in India*, United Nations Development Programme

[87] Connection charges range from between less than one to more than ten months' income for a poor family. Tariffs were found to be as high as 6 per cent of a poor family's monthly income and set to increase based on project conditions. No examples were found of different tariffs for the poor. WaterAid (2006) *Water for All? A study on the effectiveness of Asian Development Bank funded water and sanitation projects in ensuring sustainable services for the poor*: A synthesis report, WaterAid.

[88] In India, quacks routinely administer intravenous fluids, antibiotics, steroids, give dental treatment, treat infants, set fractures, and treat arthritis, tuberculosis, and sexually transmitted diseases. Pharmaceutical companies woo these practitioners with free product samples since they are a large source of prescriptions, nursing homes give them a fee to refer any complications to them. The fake drug manufacturing industry accounts for a whopping 30 per cent of total production.

[89] W. Gillani (2004) 'PMA report roasts health policy, practice', *Daily Times,* Tuesday, January 20.

[90] R. Lakshmini (2006) 'More than 40,000 quack doctors practising in Colombo', *Daily News*, Friday 12 May.

[91] World Health Organisation (2006) *Working Together for Better Health: World Health Report 2006*, World Health Organisation, Geneva.

[92] R. Rannan-Eliya and A. Somanathan (2005) *Access of the Very Poor to Health Services in Asia*: Evidence on the role of health systems from Equitap, Meeting The Health-Related Needs Of The Very Poor DFID Workshop, Workshop Paper 10, Sri Lanka 14th and 15th February.

[93] Hospitalised Indians, on an average, spend 58 per cent of their total annual income on medical expenses; over 40 per cent borrow heavily or sell their assets to cover medical expenses and over 25 per cent fall below the poverty line because of hospital expenses. P. Ritu *et.al.* (2005) *op.cit.*

[94] Mehrotra and Delamonica (forthcoming) *op.cit.*

[95] The $500 million Melamchi project includes a proposal to build a 27km tunnel to bring water to the water-scarce Kathmandu Valley. The initial World Bank conditions attached to the construction loans included that Nepal Water Supply Corporation (NWSC) be privatised. The Bank pulled out of the project and was replaced by ADB, which proposed private sector participation under the management contract. However, due to political upheaval in Nepal the project is clouded in uncertainty.

4. How to Make a Big Dent

[1] From William Shakespeare's play *Julius Caesar*, Act IV, Scene 3.

[2] Excerpts from Martin Luther King's 'I Have a Dream' speech delivered on the steps at the Lincoln Memorial in Washington D.C. on August 28, 1963.

[3] A. Cowasjee (2003) *Pakistan First*, Opinion, Dawn, June 15.

[4] Report of the CABE Committee (2005), *Universaliation of Secondary Education*, Ministry of Human Resource Development, Department of Secondary & Higher Education, Government of India.

[5] Coalition for Health and Education Rights (2002) *User Fees: The right to education and health denied*, A policy brief for the UN Special session on children, CHER, New York, May.

[6] In India, several cases have been reported of poor people being excluded and rich people usurping the privileges of a Below Poverty Line (BPL) card due to local class and caste politics. A. Sethi (2006) 'Life Above Poverty Line', The States, *Frontline*, 23(2) Jan. 28–Feb. 10. At the macro level the 55th National Sample Survey (NSS) Consumer Expenditure poverty estimation methodology has been disputed as it simultaneously uses a 7- and 30-day recall from the same sample households.

[7] The PESP relies on School Management Committees and head teachers to identify pupils in grades 1-5 from the poorest households. The student must attain 40 per cent marks in examinations and have 85 per cent attendance. However, two-thirds of the children from the poorest category were not selected to receive the stipend while 27 per cent from affluent households received it. Forty-six per cent of the stipend holders did not receive the full eligible amount, with girls and students from the poorer families receiving less on average. R. Choudhury and A. Mansoor (2005), 'Beyond Access: Partnership for Quality with Equity', paper presented at the 'Beyond Access' Regional Seminar, Dhaka, 31 January– 1 February.

[8] Forty-eight per cent of children in Nepal, Afghanistan, Bangladesh, and India are undernourished. In Sri Lanka while only 29 per cent are malnourished in aggregate terms, the figure is as high as 46 per cent among disadvantaged populations especially in the North-East, North, Central, and Uva provinces.

[9] World Bank (2006) *Repositioning Nutrition as Central to Development: A Strategy for Large Scale Action*, Directions in Development, Washington DC: The World Bank.

[10] In response to public interest litigation by the People's Union for Civil Liberties (Rajasthan) in April 2001, a Supreme Court order has directed all state governments in India to provide cooked midday meals for all children in government schools. The production of food has been decentralised to NGOs, self-help groups, corporate houses, or assistants within schools.

[11] The midday meal is expected to reduce the drop-out rate by 5 per cent per annum and result in retention of an additional 1.5 million children every year. Planning Commission (2005) *Mid-Term Appraisal of the Tenth Five Year Plan (2002–2007)*, Government of India, Box 2.1.1 and Para 2.1.29.

[12] Cited in J. Drèze (2004), *op.cit.*

[13] In Bangladesh the PESP has replaced the earlier Food for Education (FFE) programme, which provided 2.2. million children from selected poor families with 15–20 kg of uncooked wheat per month for regular school attendance. N. Hossain (2004) 'Access to Education for the Poor and Girls: Educational Achievements in Bangladesh', paper presented at a conference on Case Studies in Scaling Up Poverty Reduction - What Works, What Doesn't, and Why', A Global Exchange for Scaling Up Success, Scaling Up Poverty Reduction: A Global Learning Process, Shanghai, May 25–27.

[14] In Afghanistan, the World Food Programme (WFP) provided take-home food rations to 1.2 million students in support of the government's '*Back to School*' campaign in 2002, to alleviate hunger and to encourage enrolment, attendance, and school performance especially among female students. They were supplied with 50 kg bags of wheat and 4 kg of cooking oil. But the sustainability of this programme remains in question. E. Ebadi (2005) *Sarghailan Girls Search High and Low for Educated Husbands*, In Depth, 5 May, Badakshan, Afghanistan, World Food Programme.

[15] In Sri Lanka, the midday meal scheme has been re-started in 2006 but it is confined to the poorest schools in the poorest districts. The definition of 'poorest' is ad hoc, with only a few schools receiving this assistance.

[16] In India, since the government classifies the population into Above Poverty Line (APL) and Below Poverty Line (BPL) families based on regular surveys and no one has a right to a BPL card and its benefits of subsidised food rations, it weakens the ability of BPL households to demand their rights, and destroys solidarity between the two categories of households. J. Dr ze (2004) *op.cit.*

[17] Education for All (EFA) refers to the international commitment first made in Jomtien, Thailand during the 1990 World Conference on Education for All. Having failed to meet the original 2000 target, this was reaffirmed during the World Education Forum, 26–28 April 2000, Dakar, Senegal. The Dakar Framework for Action commits governments to achieving quality basic education for all by 2015, with emphasis on girls and a pledge from donor countries and institutions that 'no country seriously committed to basic education will be thwarted in the achievement of this goal by lack of resources'.

[18] In 1978, WHO member nations took a pledge at Alma-Ata to ensure not only universal access to primary health care, but 'health for all' by the year 2000. The vision was to create universal, vertically integrated, publicly provided health-care systems which could potentially capture synergies by linking preventive activities with ambulatory and in-patient clinical care; to improve quality and generate cost savings from an integrated referral chain; and to provide universal and equal coverage for all.

[19] R. Rannan-Eliya and A. Somanathan (2005) 'Access of the Very Poor to Health Services in Asia: Evidence on the role of health systems from Equitap', Meeting The Health-Related Needs of The Very Poor, DFID Workshop, Workshop Paper 10, Sri Lanka 14–15 February.

[20] Thomas Paine (the author of 'Common Sense', 'The Age of Reason', and 'The Rights of Man') before his rise to fame and involvement in the American War of Independence 1776, worked as a local collector of excise (indirect) taxes in England in 1761-65. When he wrote in support of a petition by tax collectors for a pay rise, he was sacked from the government. D. Hall (2003) *Public Services Work! Information, insights and ideas for our future*, Paris: Public Services International.

[21] In Bangladesh and the Uttar Pradesh, teacher codes of conduct have been in existence since the 1920s and 30s and were revised in the 1970s. In Nepal, formal codes have been adopted since 1940. However, there has been no systematic capacity building and most stakeholders are not very familiar with the procedures for lodging complaints against erring teachers. Khandewal and Biswal (no date), *Ethics and corruption in education*, Section Two. Teacher codes of practice in Bangladesh, India (Uttar Pradesh) and Nepal: a comparative study, UNESCO, International Institute for Educational Planning (IIEP).

[22] The excessive incidence of private tuitions (A. Sen (2002), Introduction, *The Pratichi Education Report*, Number 1, Pratichi (India) Trust) hides

the inefficiency of the school system and increases the inequity of education outcomes across income groups. In India, the *Free and Compulsory Education Bill 2005* (draft 14.11.2005), which intends to impose a blanket ban, states that, 'No teacher shall engage in any teaching activity for economic gain, other than that assigned by his employer or supervisor'.

[23] Some states in India have implemented pragmatic solutions such as legalised private health practice by government doctors as long as they pay 25 per cent of their private earnings for the maintenance and upgrading of facilities in government hospitals. Verma Amita (2001) 'UP to allow private practice by Doctors', *The Asian Age*, Mumbai, 6 March; 'Govt. Allows private practice by doctors: Kerala/ Code of Conduct Announced, Thiruvananthapuram', *The Hindu*, 12 January. Even in Sri Lanka, in 1977 public medical officers were permitted to practise privately outside their working hours without compromising on their public sector work ethos.

[24] In Bangladesh 43 per cent of primary school students engage private tutors, often the same teachers as they have in school (R. Choudhury and A. Mansoor *op.cit.*), which constitutes 39 per cent of household expenditure on education (Japan Bank of International Cooperation, 2002, Bangladesh: Education Sector Overview, JBIC Sector Study, March). India, Pakistan, Sri Lanka, and Nepal also witness this conflict of interest. Shunaid (2003), 'Tuitions and the Educational Racecourse', *Daily Times,* May 9.

[25] N. Vithal (2000) *Combating Corruption*, India 1999: A Symposium on The Year That Was, Issue 485, Seminar, January.

[26] To combat corruption in Pakistan, the ADB supports a $350 million *Access to Justice Program Loan*, $150,000 Technical Assistance to the *National Accountability Bureau* and $300 million *Decentralization Support Program*. The UN, World Bank, and CIDA also support programmes for public sector management, good governance and transparency in tune with the 2002 cabinet approved National Anti-Corruption Strategy.

[27] S. Khan (2004) *Bangladesh to Set up Anti-Corruption Commission*, OneWorld South Asia, 20 February; (2006) 'World Bank terms Anti-Corruption Commission in Bangladesh a "joke"', *Asian Tribune*, Dhaka, 18 May.

[28] The Ombudsman Act, 1980, and the Minister for Finance and Planning, Mr. M. Saifur Rahman had declared that, 'the Office of the Ombudsman will be operational soon' (Speech on The State of the Economy and the Economic Stabilisation Programme at Bangladesh Development Forum Meeting held in Paris, 2002); this has not been implemented even in 2006 (M. A. Halim (2006), 'Office of ombudsman: Why the delay?, Law and Our Rights', *The Daily Star*, Issue No: 223 January 21). The word Ombudsman is Swedish in origin and literally translated means 'grievance person'. One of the principal functions is to oversee the activity of executive and other state authorities by considering citizens' complaints against the actions of authorities or their officials who violate citizens' rights and freedoms.

[29] The Convention on the Elimination of all forms of Discrimination against Women (CEDAW), 1979, established the principle of non-discrimination as a binding agreement and provided the basis for equality between women and men by ensuring women's equal access to and opportunities in, political and public life including the right to vote as well as education, health, and employment.

[30] Basu (2005), Women, Political Parties and Social Movements in South Asia, United Nations Research Institute for Social Development

[31] The sexual abuse and general image of nurses as professionals has deteriorated so gravely that enrolments at Peshawar's biggest undergraduate nursing school, Hayatabad, fell by 10 per cent this year. A. Yusufzai (2006) *Nurses Get Little Training or Respect*, Inter Press Service News Agency, 4 June.

[32] UNICEF (2003) *Accelerating Strategies for Girls' Education*, Education Division, Programme Division, United Nations Children's Fund, New Delhi.

[33] The combined expenditure of Indian states in the 1990s on medical, health, sanitation, water supply and family welfare declined from 8.4 per cent of total expenditure to 7.2 per cent in 2001. Public investment in public goods and primary and secondary services alone will require 2.2 per cent of GDP at current government prices. When added to the current level of 0.9 per cent, the total public health spending (i.e. expenditures incurred by the health departments at central and state level) in proportion to GDP will be about 3 percent. Such spending will bring down the household expenditures by over 50 per cent and entail substantial health gains. This expenditure includes capital investment required for building up the battered health infrastructure; subsidisation of the Universal Health Insurance Scheme (UHIS) programme for the entire country over the next 10-15 years; and recurring costs towards, salaries, drugs, training, research and so on. GOI (2005) *Financing the Way Forward: Issues and challenges*, Section IV, National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Government of India.

[34] An important commitment is the 20-20 initiative made at the World Summit for Social Development (WSSD) in Copenhagen, 1995. The commitment seeks to establish a mutual contract between donor and recipient countries in which 20 per cent of the donor country's commitment to Official Development Assistance (ODA) and 20 per cent of the recipient country's public expenditure will be used on basic social services such as primary health care with clean water supply, sanitation, basic education and so on, as well as the institutional capacity for delivering those services.

[35] The Paris Declaration, endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators.

[36] B. Bruns, A. Mingat, and R. Rakotomalala (2003) *Achieving Universal Primary Education by 2015: A Chance for Every Child*, Washington DC: World Bank, p. 101.

[37] M. Kulshreshta and A.K. Mittal (2005) 'Water and Sanitation in South Asia in the Context of the Millennium Development Goals', *South Asia Economic Journal*, 6(1). These estimates assume that $75 per capita would be required apart from existing current domestic investments and that additional domestic investments will be made in the same proportion as the present.

[38] Currently three quarters of the funds channelled by international donors to private projects by-pass the government. The World Bank has declared that a basic package of health services contracted outside the government system can be 50 times more expensive. For example, the Louis Berger Group, which was contracted to construct 23 schools, has an average cost-per-classroom of $22813, double the government average. F. Nawa (2006) *Afghanistan Inc: A CorpWatch Investigative Report*, April.

[39] In India, non-salary expenditures increased only modestly from 1.2 per cent of total expenditures in education in 1992 to 4.7 per cent by 1998 and from 18.5 per cent of total expenditure in health in 1992 to 29.5 per cent by 1998–99. In Pakistan the greatest deficit of non-salary expenditure is in Punjab and Sindh provinces, which allocated only 4 per cent of total expenditure to education in 1989–99. In North West Frontier Province and Baluchistan approximately 10 and 8 per cent respectively are dedicated to education. The health care situation is comparatively better across Pakistan, with Punjab and Sindh allocating 40 per cent to non-recurring expenditure. Z. Hasnain (2005) *op.cit.*

[40] During 1975–97 developing regions exhibited different patterns of public enrolments and recurrent spending on primary education. In South Asia, West Asia, and sub-Saharan Africa the number of students enroled almost doubled, while recurrent spending increased modestly. But in East Asia and Latin America and the Caribbean enrolments remained stable, while recurrent spending increased rapidly. Thus some regions invested in quantity (enrolments) and some in quality (higher spending per pupil). UNDP (2002) *Human Development Report 2002: Millennium Development Goals: A compact among nations to end poverty*, New York: Oxford University Press.

[41] UNDP (2001) *Human Development Report 2001: Making Technologies Work for Human Development*, New York: Oxford University Press.

[42] Mehrotra, Vandemoortele, and Delamonica (2000) 'Basic Services for All?', UNICEF Innocenti Research Centre, Florence, Italy; Mehrotra (2000) 'Integrating Economic and Social Policy: Good Practices from High-Achieving Countries', Working Paper No. 80, UNICEF Innocenti Research Centre, Florence.

[43] GOI (2005) *op.cit.*

[44] Price control should not be limited to essential drugs as the industry can then simply switch its production to the non-controlled categories, depriving people of access to essential drugs. Price control in Canada is justified on the basis of the drug prices outstripping wholesale price index. It will also address 50–90 per cent of the national health needs and reduce household spending. *Ibid*.

[45] Rao (2005) *Role of private Healthcare provider*, Rural India, One India One People, August.

[46] Mehrotra (2004) 'Reforming Public Spending on Education and Mobilising Resources, Lessons from International Experience', *Economic and Political Weekly*, February 28.

[47] In India in the midst of the recent upheaval of the reservation of seats in tertiary education for Other Backward Castes (OBC), the Prime Minister has announced plans to create four more Indian Institutes of Technology (IITs) and dramatically increase the number of medical seats at the cost of 8,000 crores to the exchequer, even though India produces an excess of doctors.

[48] R. Rannan-Eliya (2001) *Strategies for Improving the Health of the Poor: Sri Lanka Case Study*, Health Policy Programme, Institute of Policy Studies of Sri Lanka.

[49] T. Mathew (2003) *Matters of Life and Death*, Essay, Himal South Asia, April.

[50] BRAC is the largest NGO in the world employing 97,192 people, with the objectives of poverty alleviation and supports livelihoods of around 100 million people in Bangladesh. From the time of its inception in 1972, BRAC recognised women as the primary caregivers who would ensure the education of their children and the subsequent inter-generational sustainability of their families and households. Its comprehensive approach combines micro-finance with health, education and other social development programmes, linking all the programmes strategically to counter poverty.

[51] Joint Learning Initiative (2004) *op.cit.*

[52] OECD (2003) *Improving Water Management: Recent OECD Experience*, Paris. Cited in UNDP (2003) *Millennium Development Goals: A Compact among Nations to End Poverty*, New York: Oxford University Press.

[53] UN (2006) *Water a Shared Responsibility*, The United Nations World Water Development Report 2, Executive Summary, New York: United Nations, UN-WATER/WWAP/2006/3.

[54] Quoted in R. Chinai and R. Goswami (2005) 'Are We Ready for Medical Tourism?' Magazine, *The Hindu*, April 17.

[55] Interview by Oxfam partner Uttaran in Upazila Tala in Satkhira District Bangladesh in January 2006.

[56] In the early 1990s, primary teacher salaries were 2.7 in Bangladesh, 3.4 in India, 2 in Nepal, and 3.6 in Pakistan in terms of GDP per capita. Bruns *et.al.* (2003) *op.cit.*

[57] While low teacher salaries have enabled the Sri Lankan education system to deliver basic education services at a fairly low cost to the government budget, this has hurt teacher morale and performance. World Bank (2005) *Treasures of Education System in Sri Lanka*, Executive Summary, Overview, Principle Findings and Options for the Future, World Bank, Sri Lanka.

[58] The starting government monthly salary for a medical doctor is BTK 7,400 (US$113), while for a nurse or a medical technologist it is BTK 2,550 (US$39). As a result of low salaries, it is estimated that about 30 per cent of those who work in the government sector are also engaged in the private sector after government hours. World Health Organisation (2006) *Heroes for Health in Bangladesh: World Health Day 2006,* Working Together for Health, 20 April.

[59] Similarly when Henry Ford in 1914 doubled autoworkers' wages from $2.50 to $5 per day, staff turnover and absenteeism fell and there was a 5 per cent increase in labour productivity. D. Hall (2003) *op.cit.*

[60] PROBE (1999) *Public Report on Basic Education in India*, New Delhi: Oxford University Press.

[61] GOI (2005) *op.cit.*

[62] In 2003 there were more than 10,200 unemployed qualified MBBS doctors in India. More than 5,000 doctors in the Punjab, 3,000 in Sindh, 1,200 in Balochistan, and 1,000 in the North West Frontier Province were jobless and most of the health units in the country were without doctors. This was because provincial governments had a policy to recruit doctors on contract only if they pass the Public Service Commission examination which in Punjab has not been held for the last ten years! G. Waqar (2004) 'PMA Report Roasts Health Policy', Practice, *Daily Times*, January 20. H. Iqtidar (2003) 'Health Care Privatization In Pakistan', February 7, Corporate Globalisation, Znet.

[63] Telephone interview conducted by Oxfam GB staff in Sri Lanka in May 2006.

[64] WHO (2000) *World Health Report 2000: Health Systems Improving Performance*, Geneva.

[65] Service contracts, which require medical personnel to spend a certain number of years in public service, are common in Latin America and have also been implemented in the Philippines and Tanzania. In the 1970s Malaysia, another high performer, required all holders of medical degrees to work three years for the government health service enabling the government to post doctors to rural areas they had previously avoided. UNDP (2003) *op.cit.* In India given the high level of subsidies ($ 2000 per medical graduate) provided to public medical students and the fact that more than 50 per cent of these graduates each year migrate abroad, it is suggested that permanent licenses and right to pursue postgraduate degrees be made dependent on fulfilment of compulsory public service for at least five years, of which three years must be at PHCs and rural hospitals. R. Duggal (2000) *Where are We Today, Unhealthy Trends: A Symposium on the State of our Public Health System*, Issue 489, Seminar.

[66] In Sri Lanka, each teacher is transferred out to serve a minimum of 5 years in 'difficult districts' even if their place of birth is classified as a 'difficult district'. This has led to high teacher absenteeism. In India, the proposed *Free and Compulsory Education Bill 2005* intends to do away with the transfer system entirely and assign each teacher to an individual school.

[67] The demand from the United States alone is estimated to be 100000 nurses over the next decade. GOI (2005) *op.cit.* According to established staffing norms for existing sub-centres, primary health centres, and community health centres, the shortfalls range from 17 per cent for auxiliary nurse midwives, to 28 per cent for doctors, to 47 per cent for male multipurpose workers and nurse midwives. Mehrotra (2004) *op.cit.* In India, the newly created Public Health Foundation is mobilising resources to establish five schools of public health spread through a public–private partnership with the Ministry of Health. While this initiative is commendable, it needs to be replicated multifold to make a sizeable impact on the nursing shortage. According to Pakistan Nursing Association (PNA) chief Nazir Abdur Rehman, in Peshawar in the capital of the North West Frontier Province (NWFP), more than 100 nursing schools are without syllabus or proper teaching staff and the stipend offered is unattractive.

[68] WHO (2005) 'Efforts under way to stem 'brain drain' of doctors and nurses', news, *In Focus*, News, Bulletin of the World Health organisation, February', 83(2).

[69] Of these, 25,000 are in India, 22,000 in Bangladesh, 10,000 in Pakistan, and about 18,000 in Nepal. S. Shah (2002) 'Development critique, From evil state to civil society', Essay, *Himal Magazine*, November. Some 30,000 are in Sri Lanka and 500 in Afghanistan.

[70] UNESCO (2001) *Report on the Special Session on Civil Society Involvement in EFA at the International Conference on Education*, UNESCO.

[71] NGO provision caters for around 1.3 million children, comprising around 7 per cent of total enrolment. Of these, 60 per cent are enroled in the BRAC primary education programme.

[72] M. Ranaweera (2000) 'Donors and Primary Education' in A. Little (ed.) *Primary Education Reform in Sri Lanka*, Primary Education Planning Project (PEPP), Educational Publications Department, Ministry of Education and Higher Education, Colombo.

[73] Oxfam Novib (2005) *Clean Water for Bangladesh: 'DSM Dream Team' makes the dream a reality*, Oxfam International website.

[74] S. Schnuttgen and M. Khan (2004) 'Civil society engagement in EFA in the post-Dakar period: A self-reflective review', Working Document for the Fifth EFA Working Group Meeting (20-21 July 2004), UNESCO NGOCCEFA (Collective Consultation of NGOs on Education for All).

[75] In Bangladesh the Health and Population Sector Programme (HPSP) in 1998 showed initial success in achieving radical structural reforms (integration of health and family planning cadres under a single management) and funding and official recognition of community consultations in the design phase. But as this process was abandoned in the implementation phase the new government was easily able to reverse the unification process despite donor protests due to lack of supportive civil society constituents. WHO (2005) *Making Every Mother and Child Count: World Health Report 2005, Geneva*: World Health Organisation, Box 7.6 Civil Society involvement requires support.

[76] Nepal has had a history of community-managed schools prior to nationalisation in 1972 when the government took over. N. Choudhury and S. Devarajan (2006) 'Human Development and Service Delivery in Asia', background paper for the conference on 'Asia 2015: Promoting Growth, Ending Poverty', London, March 6-7.

[77] Twenty-five to 30 per cent of assets are out of function at any given time. WaterAid India Annual Report 2005-2006.

[78] K. Kar (2003) 'Subsidy or self-respect? Participatory total community sanitation in Bangladesh', IDS Working Paper 184, Institute of Development Studies.

[79] R. Rannan-Eliya (2001) *Strategies For Improving The Health Of The Poor: The Sri Lankan Experience*, Health Policy Programme, Institute of Policy Studies of Sri Lanka.

[80] K. Bhatty (2006), *op.cit.*

[81] The Global Campaign for Education was created in 1999 by four international civil-society organisations: Oxfam International, ActionAid, Education International, and the Global March Against Child Labour. The breadth of the GCE and its breadth of membership has given its messages a greater legitimacy than campaigns of individual coalitions.

[82] Information from UNICEF Programme officer in Lucknow.

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Serve the Essentials

South Asia is a study in contrasts. While in Sri Lanka and Bangladesh school fees and textbooks are officially free, in the rest of South Asia 30 million children never see the inside of a primary school classroom. Similarly, while thousands of foreign tourists are visiting the region each year for advanced medical treatment in speciality private hospitals, every 30 minutes-six Indian women and one Afghan woman die in childbirth while seven Bangladeshi children die of untreated diarrhoea!

These untimely deaths can and must be prevented. With the advantage of booming economic growth in recent decades governments in South Asia need to uphold the basic rights of its people to universal and good quality essential services - education, health, water and sanitation.

This report analyses the potential role of governments and donors in this endeavour. The aim is not only to avert millions of avoidable deaths but also to improve South Asia's position on the world stage by unleashing the potential for growth and equitable development.

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