"Actions express priorities"
M.K. Gandhi, 1869-1948

Serve the Essentials

What Governments and Donors must do to improve South Asia's Essential Services

Foreword by Jean Drèze

Oxfam International

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Child using a water tap at standpoint built near campsites built after the earthquake at Gahridupatta Muzaffarabad
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School students studying in the open air in Badakshan province
Basira Mojaddidi/Oxfam GB/Afghanistan/2006

Health service provider administering an injection to a child at a dispensary/sub center in Bharatpur district, Rajasthan, India
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Back cover image:
Government dispensary/sub-centre in Bharatpur district, Rajasthan where a delivery had taken place the previous night
Oxfam GB/India/2006

Serve the Essentials

What Governments and Donors Must Do to Improve South Asia's Essential Services

Foreword

One of the central insights of development economics is the importance of human capabilities, both as an end and as a means of development. At early stages of development, capabilities related to nutrition, health and elementary education are of special importance. For instance, literacy and education (especially female education) make wide-ranging contributions not only to economic growth but also to demographic change, social equality, political democracy, and many other aspects of development. Similarly, good health is a fundamental basis of the quality of life as well as of social progress.

Further, both theory and evidence point to the importance of public services in these fields. Economic theory draws attention to pervasive "market failures" in the private provision (especially unregulated provision) of essential services such as health care and elementary education. Empirical evidence suggests that rapid reductions in undernutrition, illiteracy, ill health and related deprivations are typically based on extensive public action. This pattern can be seen in South Asia itself, whether we look (say) at Sri Lanka's lead vis-à-vis other South Asian countries, or at Kerala's outstanding achievements vis-à-vis other Indian states.

This report presents an insightful assessment of essential services in South Asia, with special focus on health and education. In this as in many other fields of social enquiry, the comparative perspective is of great value, and the report makes excellent use of this perspective by scrutinizing regional contrasts in South Asia – between as well as within countries. Somehow, this comparative South Asian perspective has been overlooked in development studies. For instance, an Indian economist or sociologist is much more likely to compare India with, say, China or the United States than with Bangladesh or Sri Lanka. Yet there is a great deal to learn from looking around us within South Asia. For instance, I am sure that many development experts in India would be surprised and interested to learn that private schools have been banned in Sri Lanka since the 1960s, or that in Sri Lanka "few people live more than 1.4 km away from the nearest health centre".

On the prescriptive side, this report argues that the state has an "inalienable responsibility to provide universally accessible and robust public delivery systems for essential services". In this respect it is a useful antidote to the current passion for targeting, user fees and other means of "rationalizing" (read downsizing) public services in developing countries. One can argue about the precise range of services that should be provided through "free and universal" public facilities. But when it comes to basic entitlements such as primary education and health care, I believe that this is indeed the best approach. And it is certainly important to reaffirm the notion that ensuring universal access to essential services is a social responsibility. This is, indeed, the central principle of the welfare state.

There is an important complementarity between this emphasis on free and universal public services and the "rights approach" to social policy. In this approach, essential services such primary education and health care are seen as fundamental rights of all citizens, rather than as a form of state largesse. The rights approach can be of great value in shaping public perceptions of the social responsibilities of the state. It also draws attention to the possibility of legislative action to ensure that some essential services become enforceable legal entitlements.

Recent experience in India provides rich illustrations of the value of a rights approach to social policy and essential services. Wider acknowledgement of elementary education as a fundamental right of every child (recently expressed in the 86th constitutional amendment) has contributed to the rapid expansion of school education in the nineties. The Right to Information Act 2005 has lifted the veil of secrecy from government documents, a major step towards restoring accountability in public life. Supreme Court orders on the right to food have forced the Central and State Governments to take major initiatives in this field, such as the provision of cooked mid-day meals in primary schools. Last but not least, the National Rural Employment Guarantee Act 2005 has empowered rural labourers to demand work as a matter of right and reversed the long-standing neglect of rural employment in public policy. In the light of these experiences, there is a strong case for extending the rights approach to many other domains.

India often becomes the centre of attention in South Asia, and some readers may feel that this Foreword also fell into that trap. Let me admit it – I have never been to Bangladesh or Sri Lanka, let alone Afghanistan. This report, however, has motivated me to take more interest in other South Asian countries. Indeed, it shows that India has much to learn from its neighbours – just like every other country in the region.

Jean Drèze
Delhi School of Economics

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Acronyms and Abbreviations

ADB	Asian Development Bank
ANMs	Auxiliary Nurse-Midwives
APL	Above Poverty Line
ARDWSP	Accelerated Rural Drinking Water Supply Programme (India)
ASER	Annual Status of Education Report (India)
ASHA	Accredited Social Health Activist (India)
BHUs	Basic Health-Care Units (Pakistan)
BPHS	Basic Package of Health Services (Afghanistan)
BPL	Below Poverty Line
CABE	Central Advisory Board of Education (India)
CAGR	Compounded Annual Growth Rate
CAMPE	Campaign for Popular Education (Bangladesh)
CCT	Conditional Cash Transfer
CEDAW	The Convention on the Elimination of All Forms of Discrimination Against Women
CERD	The International Convention on Elimination of all forms of Racial Discrimination
CHV	Community Health Volunteer (India)
CLTS	Community Led Total Sanitation (Bangladesh)
CMP	Common Minimum Programme (India)
CRC	Convention on the Rights of the Child
DOTS	Directly Observed Treatment Short Course
DPHE	Department of Public Health Engineering (Pakistan)
DWSSA	Dhaka Water Supply and Sewerage Authority (Bangladesh)
EFA	Education for All
EPI	Expanded Programme on Immunisation
FFE	Food for Education (Bangladesh)
FSSP	Female Secondary Stipend Programme (Bangladesh)
GATS	General Agreement on Trade in Services
MDG	Millennium Development Goal
GCE	Global Campaign for Education
GNI	Gross National Income
ICCPR	The International Covenant on Civil and Political Rights
ICDS	Integrated Child Development Services (India)
ICESCR	International Convention on Economic Social and Cultural Rights
IIT	Indian Institute of Technology
LGRDD	Local Government and Rural Development Department (Pakistan)
LHW	Lady Health Worker (Pakistan)

LTTE	Liberation Tigers of Tamil Ealam
MKSS	Mazdoor Kisan Shakti Sangathan
MMR	Maternal Mortality Ratio
MOPH	Ministry of Public Health (Afghanistan)
NGO	Non Governmental Organisation
NGOCCEFA	Collective Consultation of NGOs on Education for All
NGRPS	Non-Government Registered Primary Schools
NHRM	National Rural Health Mission (India)
NRSP	National Rural Support Programme (Pakistan)
NSS	National Sample Survey (India)
NWPF	North West Frontier Province (Pakistan)
NWSC	Nepal Water Supply Cooperation
OBC	Other Backward Caste (India)
ODA	Overseas Development Assistance
PEPP	Primary Education Planning Project (Sri Lanka)
PHC	Primary Health Care Centre (India)
PHED	Public Health Engineering Department (Pakistan)
PIO	Public Information Officer
PMA	Pakistan Medicial Association
PNA	Pakistan Nursing Association
PTA	Parent Teacher Association
RHC	Rural Health Centre
RNGPS	Registered Non-Government Primary Schools (Bangladesh)
SAARC	South Asian Association for Regional Cooperation
SMCs	School Management Committees
TB	Tuberculosis
TBA	Traditional Birth Assistant
TWAD	Tamil Nadu Water Supply and Drainage Board (India)
UMBVS	Urmul Marusthali Bunkar Vikas Samiti (UMBVS)
UPA	United Progressive Alliance (India)
UPPSS	Uttar Pradesh Primary School Teachers Association
VECs	Village Education Committees
YSWO	Young Sheedi Welfare Organisation (Pakistan)
WFP	World Food Programme
WSSD	World Summit on Social Development

Executive Summary

The boatman stands to declare
That the ship is in the midst of a storm

Shah Hussain,
17th Century Punjabi Sufi Poet (Translation)

The Good, The Bad and the Ugly

South Asia is a melting pot of contrasts. Three hundred and forty children die every single day in Bangladesh due to untreated diarrhoea, but an average person in Sri Lanka can expect to live for 74 years. Thirty million children across South Asia who stay at home, work on farms, or beg at traffic lights are out of school, while thousands of government-subsidised highly educated doctors and engineers work in foreign countries. Nepal, Pakistan, and Afghanistan have a horrific record of deaths of pregnant women and infants, while India's private hospitals are a favoured destination for medical tourism, attracting 150,000 foreign patients every year. These tragic inequalities resonate across South Asia.

While South Asia is witnessing unprecedented prosperity and growth, basic human development for the vast majority is not happening. The region is expected to miss many of the Millennium Development Goal (MDG) targets, and governments need to uphold the basic rights to essential services. Well-planned actions need to be implemented on a mammoth scale to improve the delivery of education, health, water, and sanitation. There are some examples of good practice within the region itself that provide hope and demonstrate beyond a doubt that a mixture of the right policies and sincere political commitment can indeed change the daily tragedies of impoverished communities.

Table 1: A Balance Sheet for Human Development and Access to Essential Services

	What Has Progressed	What Remains Deprived
India	In 2004, universal education 'cess' (tax on all taxes) started to fund education initiatives, including cooked midday meals in every government school Increased successful treatment of tuberculosis cases from 3 out of 10 cases to 8 out of 10 between 1993 and 2001 Water coverage in rural habitations increased from 56% to 95% between 1995 and 2004	In 2002, 14 million school-age children were out of primary school and the drop out rate in primary education was 38% 80% of total health financing is from out-of-pocket expenses of end-users and the poorest 20% have double the mortality rate of the richest quintile Even if the MDG targets are achieved in 2015, 500 million people will lack access to sanitation and 334 million access to safe water
Pakistan	The literacy rate increased from 33% in 1990 to 46% in 1999 38% of children are malnourished, which is marginally better than most of the other countries under study from South Asia, except Sri Lanka In 2002, 90% of the population had access to improved drinking water	More than one-third of children are out of school Half the population do not have access to health care and there is only one nurse for every eight doctors 46% are without access to adequate sanitation

	What Has Progressed	What Remains Deprived
Bangladesh	Increased primary school enrolment from 73% to almost 100% from 1990 to 2004, and achieved gender parity in primary and secondary education by 2005 In Bangladesh, the infant mortality rate dropped dramatically: from 145 to 46 per 1000 live births between 1970 and 2003 Population with sustainable access to improved sanitation increased from 23% to 48% between 1990 and 2002	In 2001-2002, the drop-out rate from primary education was 45% There is a 40% vacancy rate in doctor postings in poor areas, with a concentration of health workers in urban centres Arsenic in shallow tube-wells found in 59 out of the 64 districts has exposed an estimated 25 million people to toxins
Sri Lanka	Tuition fees from kindergarten to university were eliminated in 1945, free textbooks have been available since 1980 and free school uniforms from 1993 90% of child deliveries take place in a public health facility by a skilled birth attendant, health services are free and few people live more than 1.4 km from their nearest health centre High mortality rates in urban areas and estate plantations were partially addressed through concerted efforts to build water and sanitation facilities	The midday meal programme, restarted in May 2006, is not universally applicable, and it is targeted only to grade one and two of 7,384 schools in the 'poorest' districts Recent escalation in conflict in August 2006 has resulted in schools across the country being closed for two weeks In Jaffna in the last two decades of conflict, maternal mortality rates have increased ten-fold and are 10 times that in Colombo In 2002, 22% of the population was without access to improved drinking water
Afghanistan	Since the fall of the Taliban in 2001, there has been a 400% increase in school enrolments (up to 2005) Measles claimed an estimated 30,000 lives a year, but a campaign in 2002 vaccinated 11 million children, which has stopped the epidemic transmission	More than half the schools are in need of major repair while 2 million students study in tents or in the open air Afghanistan currently has just over 800 Basic Health Units (BHCs) in total, but it is estimated to need almost 6000 87% of the population are without access to safe drinking water and 92% without access to adequate sanitation
Nepal	In 2002, community management of schools by parents and local citizens has been restarted, including their right to fire government teachers and to index teacher salaries to school performance Community consultation in the $500 million Melamchi project has reduced average connection cost and introduced low cost tariff for the first ten cubic metre with incremental increases by volume With the recent end of monarchy, the new draft constitution intends to guarantee free universal access up to secondary education and primary health care	More than one-third of children stay out of school Only 20% of rural medical posts are filled as compared to 96% in urban areas 73% of the population are without access to adequate sanitation

The 'Wows!' and the Hows...

In a mere seven years (1946–53), life expectancy in Sri Lanka increased by an incredible 12 years. In a matter of decades, the Indian state of Himachal Pradesh not only ensured that every child is enroled in school but also that they remain in school, by reducing the drop-out rate to 1 per cent, as compared with the national average of 35 per cent. Similarly concerted government action has ensured that in Bangladesh in the last few decades the infant mortality rate has fallen by two-thirds.

What are some of the key lessons from these remarkable success stories of the delivery of essential services in South Asia?

States with a strong focus on action and accountability are high-achievers. A comparison between Bangladesh and Pakistan illustrates this fact. While both countries have similar incomes, in the last three decades Bangladesh has managed to reduce its infant mortality rates by two-thirds, while Pakistan continues to have rates 60 per cent higher than the average for low-income countries. Similarly a huge contrast is evident in the quality of governance between the Indian states of Kerala and Bihar, with the former doing much better than the latter in basic human development indicators. Political commitment and policy space for public pressure are crucial. High-achieving regions also consistently devote substantive financial outlays as a higher percentage of GDP to essential services in comparison with the rest of South Asia.

Equitable and efficient resource use ensures that a strategic deployment of resources generates the maximum yield on the investments in essential services. Sri Lanka serves as an excellent illustration of the range of farsighted measures undertaken by the state for the equitable development of its population. The country has consistently prioritised a primary level of services. In its social development expenditures it also ensures that a substantial chunk of its recurrent expenditure gets allotted to non-salary items and to building a critical pool of trained service providers. Schools and health clinics with free and universal services have gone a long way to satisfy the human development needs of the population.

Synergising social sector development also proves to be a prudent investment strategy. As 30– 50 per cent of infant deaths in South Asia are due to water-borne diseases it makes little sense to look at health care without ensuring that the population has access to adequate water and sanitation. Education of mothers has also been found to play a very important role in reducing child mortality. Experience from Sri Lanka, Kerala, and Himachal Pradesh shows that it is necessary to have multi-pronged measures when delivering essential services.

Bringing women forward as change agents is a challenge that some states are addressing head-on in South Asia. This is a high priority, given the ugly reality that infant mortality is 30–50 per cent higher for girls than boys in this region. It is in this context that Bangladesh achieved the remarkable feat of increasing girls' enrolment in primary education from 73 per cent to almost 100 per cent between 1990 and 2004. Empowered and educated women also provide substantial value to the critical human resources of a country. Women from traditional conservative societies are training to be mechanics and masons, voluntarily becoming community inspectors of essential services, and silently transforming their role into that of change agents.

And the 'Why Nots?'

What are the retarding factors in the provision of essential services in the rest of South Asia? Why is privatisation mushrooming almost 'by default'? What are the key loopholes to be plugged in the

public delivery system, in order to ensure that governments in South Asia fulfil the basic rights of their peoples to essential services?

Sheer incapacity of infrastructure is a stark reality across South Asia. While one-fifth of children in India remain out of school, in war-ravaged Afghanistan an estimated 2 million children study in inadequate tents or open spaces. In India and Pakistan the existing health facilities barely meet the needs of half the population. About 170 million people in India do not have access to safe drinking water. It is not just the public infrastructure which is grossly overstretched. The picture is equally grim when it comes to human resources. Bangladeshi classrooms are packed with as many as 75 students per teacher. The entire region also suffers from a skewed distribution of health workers – an excess of doctors in urban areas, a massive shortage in rural areas, and an acute shortage of nurses across the board.

Inefficiencies in the public delivery systems are mutually destructive. Across South Asia teacher and health-worker absenteeism is rampant. An important contributory factor is that the existing infrastructure in health care and education is in a state of crumbling disrepair. Thirty-five per cent of classrooms in India have no blackboard, 62 per cent in Pakistan have no electricity, 40 per cent in Bangladesh have no functioning toilets and 52 per cent in Afghanistan are without drinking water. Primary health centres paint a similar dismal picture. Most do not have essential medicines, running water, electricity, sanitation facilities, or adequate staff. It is perhaps of no surprise that all of these countries are widely noted to be among the most corrupt in the world. Vertical programmes promoted by donors are another cause of inefficiencies as they create unsustainable parallel structures.

Inequalities of gender, caste, income, and class also inevitably worsen the situation. Gender discrimination in the patriarchal societies of the region is shocking – in India a girl is up to 50 per cent more likely to die before her fifth birthday than her brother. In Nepal *dalit* children have a literacy rate of only 10 per cent and only 42 per cent of them are immunised, as compared with a national immunisation average of 60 per cent. There is also a pro-rich bias in the delivery of services, with most subsidies accruing to the rich despite the probability of the poor falling sick being 2.3 times that of the rich. Existence of end user costs – both direct and indirect – further marginalises the poor. Forced to approach private health-care systems, increasing numbers of people are being pauperised due to both simple and catastrophic ailments. Indisputably the steep user costs involved in accessing essential services is one of the important reasons for the trend of increasing inequalities both within and between countries in the region.

The Doctor's Prescription

The people of South Asia are living in interesting times. While some countries are still struggling to emerge from the ravages of ethnic bloodshed, others are coming to terms with the democratic model of governance, while still others are learning to live with their newfound global superstardom of political and economic power. Common to all these countries' futures, however, is the reality of huge populations deprived of the basic needs of existence. The state must ensure that it lives up to the expectations of impoverished peoples and communities (homeless street children, destitute pregnant women in the rural heartland, slum dwellers living in sub-human conditions – all waiting in long queues at water standpoints, health clinics, and schools) to fulfil the most essential of human needs. The vocal and powerful sections of the population need to ensure that the state is remorselessly held accountable for the performance of its inalienable responsibility to provide universally accessible and robust public delivery systems for essential services. Only then will this mercurial subcontinent succeed in making the present rival its glorious past, and claim its rightful place in the new global order.

A way forward for governments and donors in South Asia lies in suitable implementation of the following actions:

- ❑ 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 legislati
  - ⇒ 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

1 Essentials of Essential Services in South Asia

One ordinary morning, at the age of twenty-nine when Prince Siddhartha Gautama stepped out for the first time from the walled enclosure of his opulent palace and walked aimlessly in the bylanes of his father's kingdom, the sight of a decrepit old man, another suffering from chronic ill health and a corpse troubled him so deeply that he sought to renounce the world and seek enlightenment (moksha).

Chronicle of the life of Gautum Buddha, 6 century B.C

We too need to open our eyes to the stark inequities that exist in our world. To this day in South Asia, islands of prosperity and islands of impoverishment continue to coexist. A girl child born to a poor Indian family is thrice as likely to die before her fifth birthday than if her family was rich. She would have been able to increase her chances of survival twofold if her mother had a secondary education rather than being illiterate. These realities of poor access to essential services resonate across South Asia as 30 million children never see the inside of a classroom,[1] and every 30 minutes an Afghan woman and six Indian women die in childbirth.[2]

These untimely deaths can easily be prevented, as has been demonstrated time and again in South Asia itself. Sri Lanka, the Indian states of Kerala and Himachal Pradesh, and more recently Bangladesh, have made impressive strides towards providing good quality essential services – education, health, water, and sanitation – to their populations.

In the last decade, South Asia has emerged as the hub of economic[3] and political[4] activity. It is therefore appalling that governments here have failed to uphold the basic rights to essential services of the overwhelming numbers of their populations who lag behind in terms of basic human development. To improve their position on the world stage, the governments of South Asia need to rapidly upgrade the scale and quality of delivery of essential services in tandem with the booming economic growth. It is simply unacceptable that nearly 340 children die every single day in Bangladesh due to simple untreated ailments like diarrhoea.[5]

This report[6] reviews the potential role of South Asian governments and bilateral and multi-lateral donors in fulfilling the aspirations of the people of this vast subcontinent to quality human development. While provision of employment, food security and childhood care are important determinants of human development this report concentrates on evaluating the delivery of education, health, water and sanitation as key components of essential services.

This section provides a bird's-eye view of the inequities in South Asia's human development. Section 2 probes the key lessons from successful regions which have accelerated human development processes. Against this backdrop, section 3 analyses the root causes of inequality of social and human development in the region. The final section brings together practical recommendations to governments and donors to improve the delivery of essential services. The aim is not only to avert millions of avoidable deaths due to disease, lack of hygiene, and ignorance, but also to unleash the potential for growth and equitable development in South Asia.

A. Divergent Paths Since Freedom at Midnight

The service of India means the service of the millions who suffer. It means the ending of poverty and ignorance and disease and inequality of opportunity.

Jawaharlal Nehru
Constituent Assembly on 14 August 1947

On gaining independence,[7] the new nation-states in South Asia were comparable in most population human development indicators. But despite the commitments of their founding fathers, progress since then has diverged widely.

Increased Spatial Inequality[8]

In the last few decades South Asia has witnessed a marked increase in inequality (Gini coefficients) especially within urban areas. While hindering poverty alleviation,[9] this has meant the remarkable progress of some areas along with the visible stagnation of others.[10]

Figure 1[11] exposes the cross-boundary contiguous stretches of deprivation and prosperity which exist both between and within all countries. In India the poverty in the BIMARU states[12] across the Gangetic plain contrasts with the high-growth information-technology metropolises in the south. Similarly, while Nepal has reduced child mortality in some pockets, it continues to battle extreme poverty aggravated by long years of civilian conflict. Bangladesh is making historic strides in human development nationally but in its Sylhet district 88 per cent of children are stunted due to malnutrition. Pakistan's concerns are concentrated on the widespread poverty of the north-western regions. Afghanistan after 23 years of conflict suffers from a damaged social infrastructure[13] especially in the rural areas. While Sri Lanka is hailed for its long commitment to social development, the estate plantations and conflict-affected north continue to remain disadvantaged in access to education, health, water, and sanitation. The challenge for South Asia lies in spreading its prosperity more uniformly across its geography.

Figure 1: Comparison of poverty across South Asia's national boundaries

Source: Dixit Kunda (2005) 'A future out of grasp, we've seen poverty, and it is us', Analysis, *Himal Magazine,* November

South Asia Will Make or Break the MDGs

South Asia holds the 'swing vote' whether the Millennium Development Goals can be reached by 2015... South Asia has 40 per cent of the problem,which it means it has 40 per cent of the solution.....So this region is most going to drive whether we reach the targets or not.

Mark Malloch Brown
UNDP Administrator, 2003[14]

There is little doubt that South Asia's progress is crucial to the global fulfilment of the Millennium Development Goals (MDG)[15] by 2015, as the region currently stands at the halfway mark. But at South Asia's current pace, several goals are expected to be comprehensively missed. Goals 1, 4, and 5, related to poverty and health (marked in red and pink in Table 2) are of particular concern.

Table 2: South Asia expected to miss many MDG goals

POVERTY			EDUCATION and GENDER PARITY						HEALTH						ENVIRONMENT, WATER AND SANITATION								
1			2			3			4		5	6			7								MDG Goal
Poverty $ 1	Poverty Nat Line	Malnutrition	Primary Enrolment	Reaching Grade 5	Primary Completion	Gender Primary	Gender Secondary	Gender Tertiary	Under-5 Mortality	Infant Mortality	Maternal Mortality	HIV Prevalence	TB Prevalence	TB Death Rate	Forest Cover	Protected Area	C O_2 Emissions	OPD CFC Cons	Water urban	Water rural	Sanitation urban	Sanitation rural	Indicators
–	–	–	–	–	–		–	–				–						–	–	–	–		Afghanistan
												–											Bangladesh
																							India
–	–																						Nepal
				–	–			–															Pakistan
				–	–		–	–															Sri Lanka

Key: Early Achiever; On-Track; Slow; Regressing

Source: ADB, UN, ESCAP (2005) *A Future Within Reach: Reshaping Institutions Within a Region of Disparities to meet the MDGs in Asia and Pacific,* Table I.1 Tracking the Millennium Development Goals in Asia and Pacific

The MDGs are within reach. In the last decade alone South Asia has also witnessed remarkable progress. From 1990–2004, Bangladesh increased girls' enrolment in primary education from 73 to almost 100 per cent while rural India has increased access to safe water from 41 to 95 per cent of the population. These substantive achievements now need to be replicated more equitably across the region.

B. Education: Time to Go Back to the Basics

It is the duty of every civilized government to educate the masses, and if you have to face unpopularity, if you have to face a certain amount of danger, face it boldly in the name of duty…. You will have the whole educated public with you in the struggle on the battlefield.

Mohammad Ali Jinnah, First President of Pakistan
Imperial Legislative Council in April 1912
in support of Gopal Krishna Gokhale's Elementary Education Bill

Most countries in South Asia verbally expressed their commitment for basic education as one of the founding principles of independence. The Universal Declaration of Human Rights, formulated in 1948, was an added inspiration. Article 26 of the charter unambiguously states that 'Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory'. But more than half a century later, and despite repeated reiteration of this commitment to basic education by South Asian countries (as signatories in the International Convention on Economic Social and Cultural Rights [ICESCR], 1966 and Convention on the Rights of the Child [CRC]), this dream remains unfulfilled.

Higher Education at the Cost of Basic Education?

There are more Indian doctors per capita in the US than in India.[16] South Asia produces the world's largest number of skilled doctors[17] and engineers[18] but many of them migrate abroad.[19] While advances in tertiary education are commendable, every Monday morning, 30 million children of primary school age and half of the secondary age children in South Asia do not go to school! With the exception of Sri Lanka, most South Asian countries have prioritised tertiary[20] education over the last five decades even though for the cost of educating one university student, it would be possible to educate 39 pupils in primary education.[21] This skewed prioritisation needs to be reversed.

Gender Disparity

Acute gender disparities in education have plagued the patriarchal societies of South Asia. Three-fifths of the primary age children who do not go to school are girls. The 2005 MDG deadline which aimed at the very least to achieve gender parity – equal number of girls and boys – in every primary and secondary classroom was predictably missed in many countries of South Asia. The region is unlikely to achieve this goal even in 2015 (Figure 2) despite substantive increases in girls' enrolments in the last five years in Afghanistan, India, and Nepal. A lot more needs to be done especially to increase girls' access to secondary education. Bangladesh and Sri Lanka have achieved not only parity but also universal enrolment and such concerted state action is an important source of inspiration.

Figure 2: Global likelihood of achieving MDG 3- eliminating gender inequities in primary and secondary enrolments

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

C. Health: Hastening the Revolution

We recognise health as an inalienable human right that every individual can justly claim. So long as wide health inequalities exist in our country and access to essential health care is not universally assured, we would fall short in both economic planning and in our moral obligation to all citizens.

Dr. Manmohan Singh, Prime Minister of India, September 2005

State commitment to health care has often been repeated. Article 12 of the International Convention on Economic Social and Cultural Rights (1966) states that 'the state is obliged to attain the highest attainable standard of health' for its populations. States are required to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures towards the full realisation of this right.[22] But inequality in health care is pervasive across South Asia. With the growing threat of HIV/ AIDS (India has the world's largest number of people infected with the disease) access and availability of health care provision has assumed even greater significance.

Highest Vulnerability: Maternal and Child Deaths

India has the largest privatised health system and is attracting 150,000 patients from all over the world to its state-of-the-art medical facilities[23] . But ironically India accounts for 20 per cent of global maternal and child deaths. In Nepal and Pakistan the situation is equally grim[24]. In Afghanistan, on average every single day as many as 600 infants and 50 mothers die[25]. Badakhshan province (Figure 3) records the worst maternal death rate[26].

Figure 3: Male relatives wait anxiously outside one of the few health clinics in Badakshan

Source: Nasrullah Ahmadzai / Oxfam GB / Afghanistan / 2005

Almost all these deaths could be avoided if mothers had routine primary health care and access to emergency obstetric care. In rural India only half the community health centres have the required delivery room and only a quarter have hygienic delivery kits[27]. The situation is similar in Pakistan[28]. Worse still, gender discrimination is evident at its starkest as infant mortality rates in South Asia are 30 to 50 per cent higher for girls than for boys – as parents are slower to seek medical care for girls when they fall sick[29].

Medical Revolution Easily Within Reach

The health challenges for South Asia are several. But the spectacular success of Sri Lanka, which has some of the best health indicators in the world, instils hope that sound policies can herald a medical revolution even in a low-income country. In just seven years (1946–53) Sri Lanka increased average life expectancy by an incredible 12 years. Sustainable change can be achieved even in short time spans of less than a generation.

D. Water: Safety and Sanitation

When the Government cannot provide arsenic-free drinking water for its countrymen, or support thousands of hungry children, provide shelter and food for the disabled old people, would it not be a huge waste of money to spend taka one thousand crore for holding such a conference by a poor country like us.

Begum Khaleda Zia, 2004
Prime Minister of Bangladesh in her address to the nation
on the issue of cancellation of the Non-Aligned Movement conference
in Dhaka while maintaining Bangladesh's commitment to the movement

In 2002, the United Nations Committee on Economic, Cultural and Social Rights issued a General Comment declaring that 'The human right to water entitles everyone to sufficient, affordable, physically accessible, safe and acceptable water for personal and domestic uses'. It also indicated that governments have a duty to respect, protect, and work to achieve this right progressively and that the right extends to providing the underlying preconditions of health including access to safe and potable water and hygienic sanitation. South Asian governments have a mixed record of progress on this count.

Water Water Everywhere

South Asia has made great progress in increasing access to safe water from 71 to 84 per cent between 1990 and 2002 (Figure 4) and is well on track to achieve the MDG target of reducing by half the the proportion of people without sustainable access to safe drinking water by 2015. Water is by no means scarce in South Asia. In fact, during the monsoons South Asia is often predictably in the news because of cloudbursts, cyclones, landslides, downpours, and floods.

Figure 4: Percentage of population using improved sources of drinking water, 1990 and 2002

Source: Secretary-general (2005). The Millennium Development Goals-meeting Human Needs, in Larger Freedom: Towards Development, Security and Human Rights for All new York: United Nations General Assembly,March 21

Paradoxes of H_2O

Two problems however persist. First, access to water sources is affected by regional differences in supply, wastage of resources, and caste discrimination. Second, the supply of polluted water for consumption,[30] improper disposal of wastewater, and poor water management create serious health hazards. The indirect costs of poor water quality are very high and in Bangladesh 65 per cent of the disease burden is water- and sanitation-related[31]. Poor water supply increases the risk of diseases like malaria, cholera, and typhoid and fosters ill heath especially during humanitarian crises and natural disasters (Figure 5).

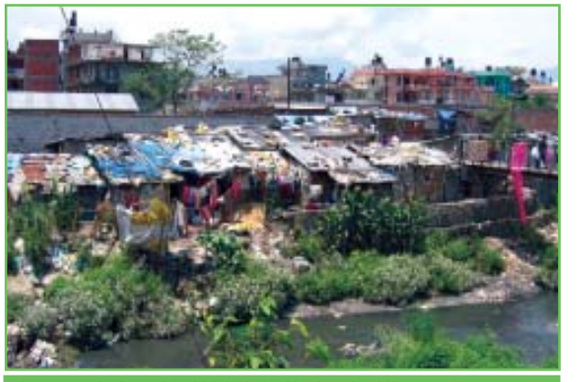
Figure 5: Flood-affected population in Bihar during the floods in 2003 without access to safe drinking Water

Source: OXFAM GB / India

Sanitation Woes

Unlike water supply, access to hygienic sanitation continues to be a challenge. In South Asia only 37 per cent of the population has access to adequate sanitation and 1.4 million people continue to either defecate in open areas or use unsanitary bucket latrines[32]. With the trend of increased urban migration, the situation in the slums of Mumbai, Colombo, Dhaka, Karachi, Kabul, and Khatmandu (Figure 6) is particularly dismal.

Figure 6: A squatter area next to a heavily polluted river, Kathmandu, Nepal



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

Reflection: Development Challenges for South Asia

The picture of South Asia is often painted in different hues. The fast pace of economic growth in the nineties – the expansion of service-sector professions like information technology, call centres, and medical tourism – often steal the limelight in international media. But equally glaring is the life on the other side of the spectrum. The fact that more and more people are being left behind in a region which is experiencing skewed economic growth needs to be highlighted in mainstream debates. The increasing levels of inequality are clearly unhealthy and unsustainable.

While South Asian governments have made a number of international commitments (Table 3) to uphold the basic rights of their citizens by guaranteeing access to essential services, ensuring availability of these services is crucially important. Unless governments fulfil these responsibilities the daily tragedies of millions of poor and marginalised children, women, and men will continue to unfold.

Table 3: Ratification of human rights treaties by South Asian countries

South Asian Countries	International Convention on Economic Social and Cultural Rights, ICESCR	The International Covenant on Civil and Political Rights, ICCPR	The International Convention on the Elimination of all Forms of Racial Discrimination, CERD	The Convention on the Elimination of all Forms of Discrimination against Women, CEDAW	The Convention on the Rights of the Child, CRC
Afghanistan	1983	1983	1983	2003	1994
Bangladesh	1998	2000	1979	1984	1990
India	1979	1979	1968	1993	1992
Nepal	1991	1991	1971	1991	1990
Pakistan	Nil	Nil	1966	1966	1990
Sri Lanka	1980	1980	1982	1981	1991

Various Sources

Reversing the trend is clearly possible and within reach. The greatest inspiration closest to home is Sri Lanka, which through sheer political will and sound developmental policies has made historic progress in the provision of universal education, health care, water and sanitation comparable with high-income countries. While Sri Lanka must strive to continue its good work, the rest of South Asia simply needs to follow suit – soon.

2 What Works?
The Case for Universal Public Provision

Some developing countries have made great strides forward in health, education, water, and sanitation in only a matter of decades. This kind of development took nearly 200 years in the industrialised world. Sri Lanka, a middle-income country, today has a life expectancy of 74 years, which is comparable with the United States, Switzerland, and Malaysia. Bangladesh, which in the 1970s had an infant mortality rate higher than Pakistan, had by 2003 reduced the infant mortality rate to half the rate in Pakistan. Bangladesh also increased primary school enrolment from 79 per cent to almost 100 per cent between 1990 and 1998.

What brings about these sustainable achievements in such short timeframes? This section analyses the experience of high achievers[1] from South Asia itself which shows that the keys to success are: the role of the state in essential social services; giving high priority to equitable and efficient resource use; exploiting synergies in social sector investment; and gender-sensitive policies which enable women to function as active agents of change.

A. The State in Action

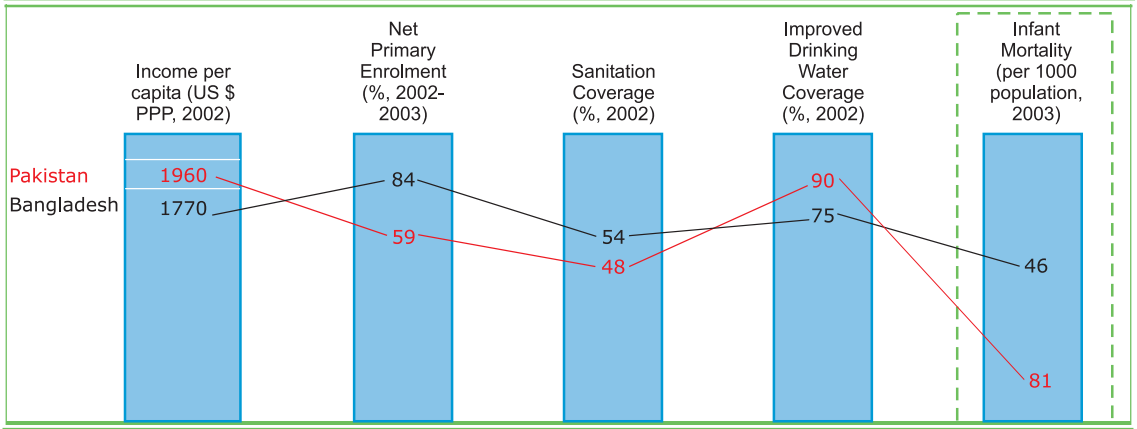
Commitment to Public Action

> *Finance is merely a matter of the heart being in the right place.*
>
> Sidney Buchman, 1902–75[2]

Government actions matter more than national income. Countries with low per capita income can transform scarce resources into quality essential services. The comparison between Bangladesh and Pakistan is illustrative (Figure 7). While their income per capita is similar, a Bangladeshi child is 30 per cent more likely to survive to age five and almost twice as likely to go to school and use a clean latrine more frequently.

High human development achievers either rely entirely on publicly-led systems, or inject substantial public finances into essential service delivery in order to uphold the basic human rights of their citizens. The common feature is financial commitment and investment of governments in essential services.

Figure 7: Income and social development indicators: Pakistan and Bangladesh



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

Sri Lanka, which has fundamentally relied on public systems of delivery, is one of the few countries in the world which has banned private schools from grades 1–9 since the 1960s.[3] Similarly, due to investment in public health infrastructure, 90 per cent of child deliveries take place in a public health facility, 96 per cent by a skilled birth attendant. Services are provided free of charge and few people live more than 1.4 km away from their nearest health centre,[4] and maternal and child mortality have declined dramatically.[5]In India, the state of Himachal Pradesh in the last few decades has consistently constructed government schools, recruited permanent teachers, and increased the per-pupil expenditure which has resulted in the reduction of the number of single-teacher schools from 28 per cent in 1986 to 2 per cent in 1995, enabling the achievement of the dream of gender parity and universal enrolment.[6]

On the other hand, in Bangladesh while 97 per cent of all secondary schools are managed by non-governmental organisations (NGOs) and local school management committees (SMCs), they receive substantial subventions from the government. Non-government registered primary schools (NGRPS – approximately 15 per cent of all schools) also receive 90 per cent of the base salaries of teachers from the government. Free textbooks are provided to all schools – public, NGO, community, and *madrasa*.[7] NGOs also receive government grants for repair of school buildings.[8] Similarly in the Indian state of Kerala with near universal enrolment, 60 per cent of primary and 53 per cent of secondary schools are private 'aided' (i.e. the state government aids these private schools by paying the full salaries of their teachers; and regulates, inspects, and monitors them to ensure conformity to quality standards).[9]

Safe drinking water with multiple externalities for good health when served as a public good can also provide substantive benefits. In the last decade there has been an impetus for public–private partnerships in water provision in urban areas which has had mixed results. Some positive changes include - a change management process in the Tamil Nadu Water Supply and Drainage Board (TWAD), India which has created a water revolution by sensitising an erstwhile bureaucratic government body to support and uphold decentralised community water management.[10] In Dhaka and Chittagong cities in Bangladesh also, the local municipal bodies have worked in direct partnership with local NGOs to ensure the expansion of utility connections to the poorest slum areas in the cities, at a cost affordable to these areas.[11]

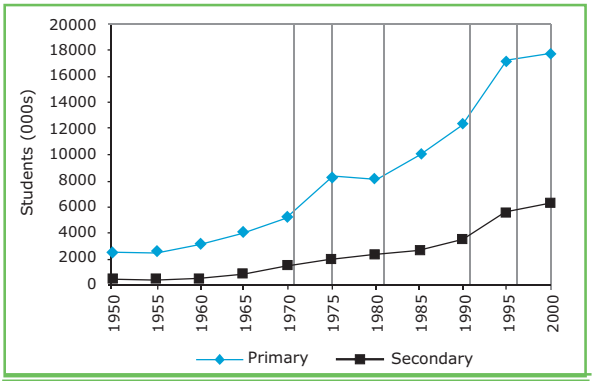
Political Will to Make a Difference

History shows that political will is an indispensable lever for sustainable change. A classic illustration of the huge difference that political will can make is a comparison of Bangladesh with Pakistan. The two

countries used to share similar human development indicators when they were still one country. But in the past three decades, Bangladesh has surged ahead of Pakistan in several human development indicators. It has managed the arduous task of reducing fertility rates by more than half and infant mortality rates by two-thirds. Pakistan however continues to have an infant mortality rate 60 per cent higher than the average for low-income countries.

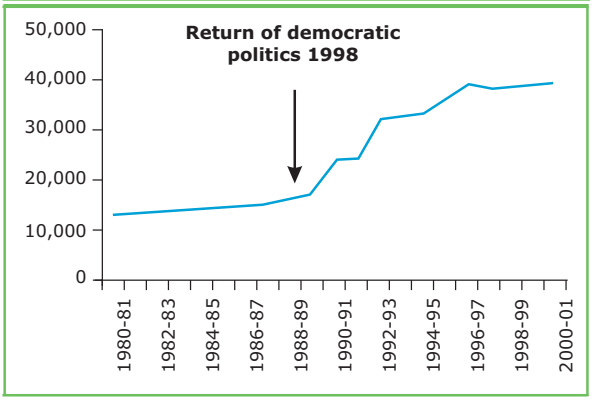
At the heart of this transformation in Bangladesh has been a rapid increase in school enrolment (Figure 8) especially for girls, through consistent political commitment across successive governments. The phase of the highest growth in enrolments was in the period 1991–97 when democratic political competition may have created a source of pressure on the government in power to prioritise education.[12] In contrast, in the Sindh province of Pakistan there was ironically a marked decline of net enrolments[13] after the return of democratic governance in 1988, despite a significant increase in the number of schools (Figure 9) and teachers. These expansions were heavily influenced by political patronage and did not improve the quality of education.

Figure 8: Total enrolments in primary and secondary education under successive governments in Bangladesh, 1950-2000



Note: 'Primary' excludes unregistered non-formal non-government schools.
Source: N. Hossain and N. Kabeer (2004) 'Achieving Universal Primary Education and Eliminating Gender Disparity', *Economic and Political Weekly*, Sept 4

Figure 9: Number of primary schools in Sindh province of Pakistan, 1980-2000



Source: Z. Hasnain (2005) *The Politics of Service Delivery in Pakistan: Political Parties and the Incentives for Patronage 1988-1999*, Washington DC: The World Bank, May

In India the contrast between Kerala and Bihar is insightful. Kerala has almost 96 per cent literacy while Bihar lags behind with less than 50 per cent. The former has reduced poverty to less than 15 per cent while the later struggles with more than 40 per cent. The stark differences in the quality of governance in the two states provide some analytical answers. Bihar has had elections for decades, but unlike Kerala, elected leaders have simply (due to lack of accountability) diverted precious developmental expenditure.

Policy Space for Public Pressure

While civil society organisations (CSOs) perform a variety of roles from service delivery and innovation to working as policy partners and advocates, in the face of the instable character of some states/governments, their role in building political momentum and instilling a culture of accountability and support for civil-society voices are crucial steps, in prioritising essential services and reducing the ability of politicians to act on pressures for patronage. In India the social mobilisation in the nineties which preceded the constitutional amendment to guarantee education as a fundamental right and the public interest litigation which resulted in the Supreme Court order to implement universal midday meals, have respectively ensured successful implementation of these programmes.

In contrast, health care as a fundamental right in India suffers from a relative neglect and abdication of state responsibility in recent years due its lack of social recognition as a fundamental right. Similarly while the Supreme Court has issued an order for the universalisaton of Integrated Child Development

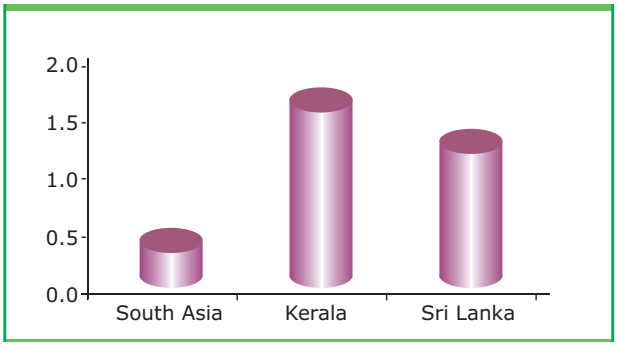
Services (ICDS) through the provision of functional *anganwadis* (child care centres) in "every habitation" it has suffered from slower implementation due to the diminished public pressure[14].

Several NGOs and civil society groups including CAMPE in Bangladesh, Parivartan and Pratham in India have popularized the use of citizen report cards, expenditure tracking surveys, corruption audits etc to increase public awareness of government actions and ensure significant impact on increasing public pressure for improving services. The roles of the state vested with primary responsibility and civil society as a key player in holding governments accountable are complementary in ensuring delivery of essential services.

Commitment Translates into M.O.N.E.Y

Public expenditure is the most crucial indicator for analysing government commitment. Kerala and Sri Lanka as high achievers have consistently devoted a higher percentage of GDP to health in comparison with the rest of South Asia (Figure 10). In Sri Lanka, while initial high investments were required in building long-term sustainable primary services, once critical goals in education and health were met, the focus shifted to secondary and tertiary services.

Figure 10: Health expenditure as a percentage of GDP 1978-1993



Source: 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.

Sustaining essential services becomes cheaper once the initial scale-up has been completed. Even though Sri Lanka currently spends only 3 per cent of GDP on education,[15] its legacy of educational infrastructure built in the 1950s and 1960s with an average expenditure of 5 per cent of GDP and 15 per cent of the government budget, explains its continued ability to provide free education for all children up to university.[16] Similarly in Kerala between 1956 and the early 1980s, priority for health care distinctly translated into financial expenditure for expansion of the government health services at an annual compound growth rate of 13.04 per cent, outstripping both total government expenditure at 12.45 per cent and state domestic product at 9.81 per cent.[17] In Himachal Pradesh the commitment to education is reflected in the fact that per capita expenditure on education is double the average for Indian states.[18] In India an increase in water coverage in rural areas from 56 per cent in 1995 to 95 per cent in 2004 is largely attributable to a 900 per cent increase in funds for the Accelerated Rural Drinking Water Supply Programme (ARDWSP).[19]

B. Equity and Efficiency

The emphasis of high achievers has not only been on raising new monies but also on increasing the cost effectiveness, 'allocative efficiency', and equity of public resources. These can be attained through a number of strategies, which need to be simultaneously implemented for maximum efficacy.

Prioritise Primary Services

Prevention is better and often cheaper than cure. Tertiary health care is curative while primary is preventive. It may therefore be more cost effective to allocate sufficient resources to primary levels of care in order to prevent potential cases reaching hospitals. Similarly, the social returns of primary

education are known to be high. Therefore prioritisation of resources for primary health care and schools, especially in rural areas, should potentially improve allocative efficiency and equity of government expenditure as a whole for the benefit of poor people.

In South Korea in the 1950s, 70 per cent of public education investment was in elementary education and only after its universalisation was attention shifted to secondary education. To this day tertiary education largely remains in private hands, based on the premise that its high private returns will enable students to easily repay education loans through potential future earning. Wide availability of primary schooling has ensured that South Korea's pattern of growth has been largely equitable and most of the population can benefit from it.[20] In Himachal Pradesh priority has been given to primary schools and most incentive schemes - scholarships and free textbooks - are concentrated at the primary level of education.[21]

In Sri Lanka policy makers have always prioritised primary health care but have allocated at least 50–65 per cent of total government health expenditure to hospital services since the 1960s as they acknowledge that often even tertiary hospitals predominantly provide primary care.[22]

Non-Salary Recurrent Expenditure

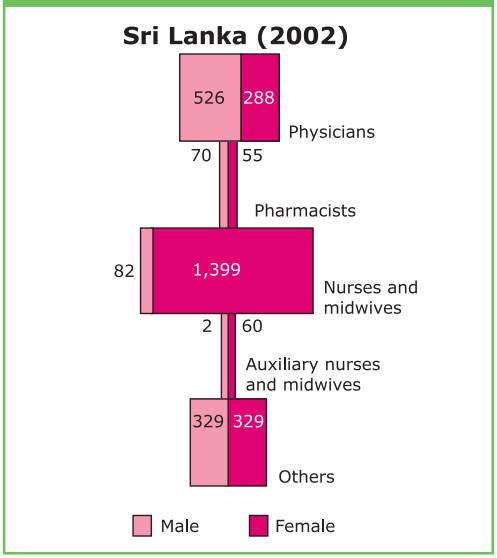
Apart from salary expenditure, high performing countries also invest recurrent spends on non-salary components. Sri Lanka allocates at least 27 per cent of education expenditure annually to non-salary recurrent items, which go a long way towards ensuring education quality. Textbooks and school uniforms are provided free to all students especially at primary education level, and these items receive 3 per cent and 2 per cent of total education expenditure respectively. The balance operation and maintenance funds are mainly used for electricity, communications, water and so on[23] to maintain high quality standards in schools such as ensuring availability of drinking water, functional toilets, and teaching materials.[24]

Popular and successful policies, such as the norm-based unit cost resource allocation mechanism in Sri Lanka to distribute public resources to schools, have also greatly enhanced the equity of resource distribution among schools. In India public health facilities in four southern states – Andhra Pradesh, Kerala, Karnataka, and Tamil Nadu – function better because drugs distributed through the primary health-care network give patients a reason to visit the facilities.[25]

Investing in Quality Service Providers

Efficient spends require investment in critical human resources. Many outreach and preventive care activities require more para-medical staff and nurses rather than physicians. In Sri Lanka, the bulk of maternal health care is provided by a large cadre of well-trained and low-cost professional female nurses and midwives, closely supervised by a few auxiliary nurse-midwives (ANMs) and a small number of medical doctors (Figure 11). This workforce deployment pattern has enabled the large force of nurses and midwives to bridge financial, geographic, and cultural barriers to medical access through their wide availability in rural areas, with a steady supply of appropriate medicines and linkages to back-up services.[26]

Figure 11: Indicative workforce distribution patterns in Sri Lanka's health care system based on representative samples



Source: Joint Monitoring Initiative (2005) Chapter 2, *Human Resources for Health: Overcoming the Crisis*, Harvard University

Similarly well-trained teachers have been the heart of the education system in Himachal Pradesh. The average primary school has more than three teachers, with a pupil:teacher ratio of 27:1, and approximately 40 per cent of teachers are female. Their responsible work ethos and positive rapport with parents and the community is clearly visible.[27] Similarly in Bangladesh the motivation of teachers especially those working in several NGO schools have contributed considerably to dramatic increase in educational attainments indicating the centrality of quality teachers at the heart of the education system.

Free Services for All

Essential services need to be provided free of charge to ensure greatest equity and access for poor communities. The experience of elimination of direct user fees is not new to South Asia. Sri Lanka eliminated tuition fees from kindergarten to university in 1945. User fees in health were abolished in 1951. Bangladesh has introduced a law for free and compulsory primary education, and provides girls with free education up to secondary school. India has even made a constitutional amendment to guarantee free and compulsory education, but in practice user fees are pervasive.[28] Political will is key to eliminating user fees. Abolishing user fees is important as once eliminated, people begin to expect public services to be provided free of charge, and subsequent governments will find it politically difficult to reintroduce end-user costs.

To maximise benefits it is also important that capacities of services which have been pronounced free are enhanced, in order to maintain their quality standards and ensure that free service does not equal 'poor' service. Free universal services guaranteed by right-based legislation are meaningless without sufficient good quality infrastructure to avail of the services. After the introduction of the free health-care policy, the workload of health workers in South Africa increased without any additional support to deliver suitable health care. Increased financial investment in infrastructure, staffing capacity, and availability of medicines can maximise benefits from the elimination of user fees. Tanzania's broad-based co-ordination with donors for closing the funding gap, and South Africa's increase in health budgets, offer important lessons for ensuring the success and long-term sustainability of the initiative (Box 1)

Indirect end-user costs are an even greater obstacle to access essential services than fees.

Box 1: African Wave of Scrapping User Fees

In 2003, when President Mawai Kibaki of Kenya scrapped tuition fees for primary education in keeping with his election promise, a million new students surged into classrooms, indicating the pent-up demand for education. Bold moves towards free primary education have been seen in varying degrees in Malawi (1994), Uganda (1997), Cameroon (1999), Tanzania (2001), and Zambia (2002). Enrolments increased by 51 per cent in Malawi, 70 per cent in Uganda, 49 per cent in Tanzania and in Kenya 1.2 million new children entered schools. Similarly in 1994, with the introduction of the Free Care Policy by South Africa's new government, there was a 20–60 per cent increase in the use of public health facilities. It is evident that end-user costs are a major deterrent for parents to send their children to school or seek medical care.

To increase potential benefits of user fee elimination, it is also important to build the capacity of public services to deliver and maintain quality. In Malawi, the education infrastructure was temporarily overstretched when there was a surge in demand – pupils:permanent classroom ratio was 119:1; pupils:textbook ratio was 24:1; and pupils:teacher ratio was 62:1. In Uganda total net primary enrolment increased from 53 per cent to reach 84 per cent immediately after the user fee elimination, fell to 76 per cent by 2000 due to decline in quality standards, and has again risen to 84 per cent with quality improvements in 2002. Tanzania's elimination of user fees resulted in a less severe decline in quality at the onset due to a strong government commitment, assured external funding to close the financing gap, and development grants to fund quality inputs such as non-salary recurrent costs and per-classroom capital expenditures, including teacher houses, sanitation, and the provision of clean water. Similarly in South Africa the free heath-care policy was accompanied by an increased health budget especially for primary care and for child and maternal health.

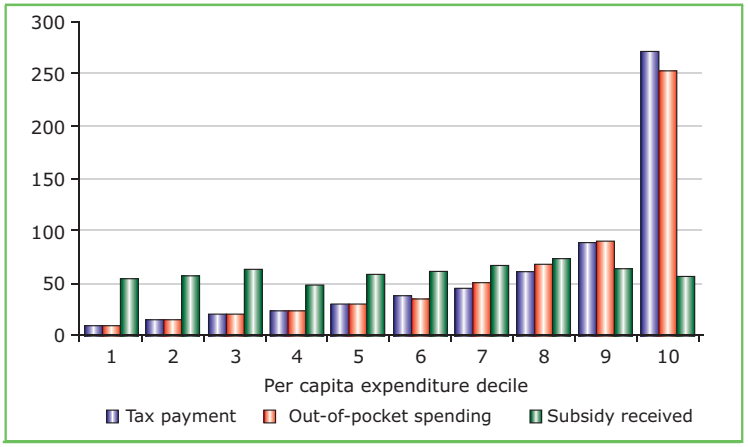
Source: R.B. Kattan and N. Burnett, *User Fees in Primary Education*, Education Sector, Human Development Network, The World Bank July 2004; Gilson *et.al.* 1999 and South Africa Health Review 2001.

Transport, curricula textbooks, school uniforms, ambulance services, costs of medicines, medical tests and so on balloon the actual costs of access. In eight states of India together containing two-thirds of its out-of-school children, uniforms are one of the largest out-of-pocket expenses.[29] To reduce the effect of indirect costs Sri Lanka began providing free school lunches in the 1950s,[30] free textbooks in 1980, and free school uniforms in 1993. The Sri Lankan government policy in 1935 recognised that the economic costs of illness include not only the cost of medical treatment, but also the care and feeding of the patient, and the loss of income of household members.[31] In the 1990s, Bangladesh introduced free textbooks for all children in primary school as a key measure to improve the quality of education.

Pro-Poor Policies

Country-specific equity-enhancing strategies – education in children's mother tongue, more female teachers, compulsory rural services for personnel trained with public funds and so on – can also be useful. Sri Lanka does not permit the registration of doctors with the General Medical Council without requiring them to work for the government health service in rural areas[32].

Figure 12: Distribution of health payments and subsidies by income decile, Sri Lanka, 1995/96



Source: Sri Lanka National Health Accounts database, Dorabawila *et.al.*, (2001) quoted in 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

In Sri Lanka, health-care subsidies funded through taxation are progressive and pro-poor – the rich pay for out-of-pocket health-care expenditure and general taxes far more than the poor, while the health subsidy they receive is less compared to the poor (Figure 12). Universally accessible free public health care is rationed through differences in consumer aspects of quality (for example television sets in private-sector hospital rooms encourage the rich with demanding tastes to voluntarily use private services) and time costs (for example long queuing time in a public health centre convinced Mala to choose a private clinic for the birth of her child (Box 2)) between public and private sectors[34].

Box 2: 'If not for this government school, I would have never gone to school'

Thirty-four years ago, in Hakmana village in Sri Lanka's Matara district, Mala Ratnaweera was born in a regional government hospital. Throughout her life she has been able to take advantage of Sri Lanka's publicly-provided essential services and she now works as a Programme Officer for Oxfam GB. Mala attended the only government school for girls in the village and admits that 'if not for this government school, I would have never gone to school'. Later she gained admission and a full scholarship to the government-funded Ruhunu University. Mala again relied on government services when her mother was diagnosed with throat cancer, 'the service and care given was wonderful and we did not have to spend anything'.

However once Mala's income increased for the birth of her child, she did break the tradition and use a private hospital. 'I had no time to go to the government clinic which has long queues as they see only a limited number of patients for four hours a day'.

For the schooling of her child, Mala wants to choose a government school, as she believes that they not only provide a good quality of education but also respect her ideals of identity and religion. Mala however is struggling to get her child admitted into a 'good' government school in Colombo as the quality is variable[33].

Source: Oxfam GB staff in Sri Lanka

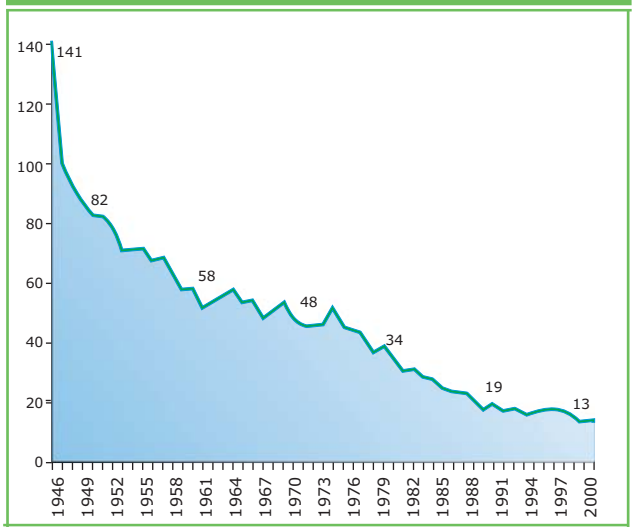
C. Capture Natural Synergies

You cannot talk in isolation about healthcare. It is linked with roads, sanitation and drinking water.

Aswini Kumar Nanda,
Researcher, India[35]

MDG targets like reducing infant and maternal mortality cannot be effectively tackled unless root causes like chronic incidence of anaemia, lack of emergency obstetrician care, access to hygienic water and sanitation, mothers' education and so on are addressed. High educational levels ensure strong demand for and utilisation of health services while critical investments in children's health, nutrition, access to safe water and sanitation help to lower the level of absenteeism and improve educational attainments. Synergies across social sector investment are crucial both for cost effectiveness and in order to ensure scale and efficiency.

Figure 13: Sri Lanka infant mortality rate per 1,000 live births 1946–2000



Source: World Bank (2005) *Attaining The Millennium Development Goals in Sri Lanka: How Likely and What Will It Take To Reduce Poverty, Child Mortality and Malnutrition, and to Increase School Enrolment and Completion?* Human Development Unit, South Asia Region, The World Bank

In Sri Lanka, there has been a consistent annual reduction in the infant mortality rate by 4.2 per cent, maintained over more than 50 years (Figure 13). This has been achieved through a multi-pronged approach of investment in social infrastructure. High mortality rates in urban areas and estate plantations were partially addressed by municipal authorities through concerted efforts to build water and sanitation facilities.[36] Not only did universal education (especially of mothers) in both urban and rural areas result in decline in infant mortality; it also expanded the long-term supply of potential nurses and other health-care personnel with a secondary education at lower costs in the long run.[37]

Himachal Pradesh had a literacy rate of only 19 per cent in the 1960s. But in the last three decades it has accelerated progress to reach near universal primary enrolment.[38] This is a reflection of the state government's commitment to prioritise multi-faceted social sector expenditure. Improvements in rural infrastructure, roads, bridges and transport have increased the accessibility of schools in a difficult terrain. High levels of parental education have helped not only to create a conducive learning environment at home, but also to monitor the quality of schools, make public services a common concern and demand better facilities from political leaders[39]. Despite the difficult mountainous terrain, 98 per cent of villages have safe drinking water.[40] A health centre is available to 84 per cent of the population within a radius of 5 km, which is particularly beneficial to women who suffer from reduced mobility and function as primary care givers. By addressing the multi-dimensionality of equity and social sector investment, high achievers have made exponential gains in increasing human development.

D. Women as Change Agents

Promoting women's education and health as a precursor to improving their participation in public life is crucial. In Sri Lanka and Kerala, where rural women have been educated, it is easier to hire and train

them as nurses and mid-wives. Conversely in many parts of north India, Nepal, and Pakistan the shortage of local recruits has meant the perennial under-supply of female health workers. Gender-sensitive strategies need to be adopted across the delivery of essential services.

Figure 14: Growth of secondary school enrolment in Bangladesh, 1970–2003

Source: J. Raynor (2005) *Educating Girls' in Bangladesh: Watering a Neighbour's Tree?* in S. Aikman and E. Unterhalter (eds.), *Beyond Access: Transforming Policy and Practice for Gender Equality in Education*, Oxford: Oxfam GB

Bangladesh has paved the way in South Asia to attain gender parity in education through concerted political commitment in a short timespan. The compulsory education and curriculum reform in the 1990s laid the foundation for a massive expansion in education enrolments particularly for girls (Figure 14). Gender disparities have been virtually eliminated at the primary and secondary levels.[41] Incentives introduced in the 1990s to expand access especially for girls and poor children has ensured that gender issues are integrated in the heart of policy making. Recognising social and cultural barriers resulting in unequal educational opportunities for boys and girls, the Female Secondary Stipend Programme (Box 3) in particular has succeeded in tackling demand- and supply-side constraints. Increased recruitment of female teachers through the 60 per cent of reservation in government primary schools has also gone a long way to improving girls' enrolment and retention.[42] These interventions not only draw girls into education but also prepare them as future change agents.

Education NGOs like CYSD in Orissa and Pratham across India are encouraging parents and community members especially women to voluntarily assist in assessing schools. Health NGOs are encouraging

Box 3: Pull Girls into Primary Schools by Providing Incentives in Secondary Education

The Female Secondary Stipend Programme (FSSP) in Bangladesh, initiated in 1982, is a conditional cash transfer scheme (CCT) for girls education, which aims to increase girls' enrolment in secondary school as an incentive to encourage their transition from and retention in primary education. To be eligible for an FSSP stipend a girl must have 75 per cent attendance, achieve at least 45 per cent examination marks and remain unmarried. FSSP stipends reinforce the strategic goals of increasing access and improving quality of education by increasing pressure for good performance and delaying girls' marriage, which often serves as a barrier to secondary education. A unique feature of the FSSP is that it not only supports demand-side incentives but also supply-side incentives. Schools, which educate girls, are provided with subventions for teacher salaries in order to cater for the projected increase in enrolment, with an emphasis on recruiting female teachers. In fact, it is reported that many *madrassas* opened their doors for girl students as the FSSP teacher subventions provided a sizeable incentive.

Currently in Bangladesh not only is there free tuition for girls up to class 10 but this serves as an additional incentive for 2 million girls to complete primary education. There is a significant difference in overall drop-out rates between stipend awardee girls (1.3 per cent) and non-awardee girls (50.3 per cent). Most importantly, as this is a universal programme with no selection of stipend awardees and the money is directly transferred to the girls' bank accounts, the intervention minimises leakages and has few hidden management costs. The main weakness of the programme however is the exclusion of the poorest girls, because the stipend is too low to cover all the user/parental costs of sending a girl to school. Further, in the absence of improvements to the quality of schooling, the declining performance of girl students in examinations also needs to be addressed.

Source: Mahmud 2003, UNESCO Global Monitoring Report, 2002, Chapter 4. Lessons from Good Practice, JBIC 2002, Bangladesh Education Sector Overview, JBIC Sector Study, March 2002, Japan Bank for International Cooperation.

governments to alter the top-down approach to health planning to engage villagers as 'active' and primary stakeholders in decision-making through participatory methodologies. In India, projects led by WaterAid and Gramonati Sansthan in villages around Mahoba in Uttar Pradesh have trained women as mechanics, not only to ensure quality maintenance of the water resources of the villages but also to crusade for allied health and sanitation issues to ensure larger benefits for the communities they serve. Similarly in Rajasthan women from traditional communities are working as informal inspectors of essential services (Box 4). The central rationale for the inclusion of women is to transform their low position and engage them in the process of change – not just as beneficiaries but as agents of change. In the process they are also silently bringing about definite changes in the gender equations in their communities.

Reflection: Formula for Success

Change is within reach. The formulas and key ingredients of success in providing universal good quality education, health, water, and sanitation in South Asia vary across countries and local contexts. But the common thread among high achievers is that governments systematically prioritise and provide critical investments in order to create sustainable long-term, cost-effective essential service delivery mechanisms. Experience of high achievers also indicates that the level of income of a country is not a deterrent and in fact it is feasible to embark on this journey of transforming the human development status of populations. The critical point is that well-planned investments need to be made in essential services, which ensure their allocative efficiency, utlisation of synergies across social-sector investment, and the active participation of women as change agents.

Figure 15: Raku Devi, Samda Devi, and Champa informally visit health centres to inspect the delivery of essential services in rural Rajasthan

Source: Jo Zaremba/Oxfam GB/India/2006

Box 4: Informal Community 'Inspectors' Monitor Their Rights to Essential Services

Walking across the sands of Rajasthan an unlikely group of inspectors is ensuring that government services are delivered. Three women, Raku Devi, Samda Devi, and Champa (Figure 10), from Goyalon ki dhani, Chheela, and Shivsagar villages respectively work as 'fellows' for NGO Urmul Marusthali Bunkar Vikas Samiti (UMBVS), an Oxfam partner. They visit local schools to check that the midday meals are being provided, and local health centres to verify that pregnant mothers are receiving adequate care. Just by turning up and asking questions they have been able to ensure that government officials fulfil their responsibilities, and long overdue cases are followed up. This process of 'social auditing' has challenged some in authority but the women are committed to monitoring the well-being of their community and upholding its basic rights to essential services. It is difficult and unusual for women from oppressed castes of rural Rajasthan to take on leadership roles, but their impact has helped them to win over skeptics from the local community.

Source: Oxfam GB staff in India.