

India's Struggle Toward Mainstreaming Gender in the MDGs

Since their creation in 2000, India has been striving to achieve the targets and standards set by the Millennium Development Goals. Of most focus of the gender-related MDGs within India are a reduction of infant/child mortality, reduction in child malnutrition, universal enrollment and retention in grades 1 to 5, increased access to higher education for women, and empowerment of women through government policies and raising access to income and political positions. The struggle towards the targets set by the MDGs has been a long and arduous one, and India is making progress in some more than others. However, I feel there is a lot of momentum in the nation to bring the underrepresented and repressed out of the shadows and into the light of better equality and living conditions. In terms of gender equality, India has made great strides, at least for some. One of the biggest challenges that India faces is bringing positive, consistent change throughout all of its sub-regions. Some of the poorest states that are the most populous in India struggle to alleviate hardships and to reach the targets set by the MDGs and the rest of the country.

Infant/Child Mortality

In the children is our future. Within India they are dying at an alarming rate. It is estimated that within India 1.72 million children die before the age of one (Deolalikar

21). In respect to this INTL class, the question unanswered here is what percentage of this figure are girls. The target for the goal of reducing child mortality until the age of 5 is a reduction on mortality by two-thirds by 2015 (UN 2000). Specifically for India, the next targets they are striving to reach is to reduce the number of infant fatalities per 1,000 children to 28 by 2012, and to lower the under 5years old mortality rate to 41 by 2015 (Country Report 2005). Although there has been an annual rate of decline, the rates have not dropped as rapidly or as significantly as in other countries implementing the MDGs (Deolalikar 22). In addition, although rural communities are experiencing a decline in child/infant mortality, there is still a significant IMR between rural and urban populations. This suggests variations between the states within India on how successful death is being reduced. It has been reported that “Uttar Pradesh alone contributes to one-quarter of all infant deaths in the country” (Deolalikar 24). The MDG targets must be met, in my opinion, within all the various states of a country. To deem a goal successfully reached within a country; we need to look and the different regions and their varying successes and positive improvements. The MDGs need to be focused at decreasing mortality in all states, and cannot just collect a national average and call it good. The most effect way would be to target populous states with high mortality and high fertility rates.

However, that is not enough. Gender needs to be brought into the discussion. India is one of a few countries that has a ‘missing population’ of females that causes demographic distortions, and it is estimated that 23 million are missing (Seager 42). These discrepancies within India are arguably caused by social, cultural, and economic factor, rather than biological, especially since “Demographic and Health Surveys show

that in virtually all countries, baby-boys experience higher levels of infant mortality than baby-girls” (Vandemoortele 6). In India, where males are accorded higher status and worth, the missing millions could be victims of sex-selected abortions or discriminatory nutritional and health care practices.

India has begun to address these issues. Not only has the government implemented programs to reduce overall child mortality in the states, but efforts have been made to make sure that girls benefit from this as well. The NGO Bayalu Seeme Rural Development Society is an example of an organization working within India to address gender-based constraints. This program trains women to be birth attendants and pressures local authorities to provide gynecological services for expectant mothers (Yinger 3). Another promising program is the Reproduction and Child Health Program. Established in 1997 and funded by the World Bank and UNICEF, this program incorporates different aspects to prevent child mortality. These facets include immunizations, diarrhea disease control, acute respiratory infections, and education (Child Health Programme). Most importantly and relevantly to this paper, is that “the girl child is given special attention under the RCH programme” (Country Report 2005).

From summation of reports, it appears that India is not on target statewide for this Goal, and has fallen behind compared to other countries within the region. We can only hope for the continued implementation of programs and government expenditures to help India rise above current mortality levels in all states. I have hope that even though the country may be behind, steps are being taken. I believe serious efforts must be made in the poorer states, and the country also needs gender specific targeted programs to help raise the ratio of female deaths. The major tasks for India, which have been started but

need to continue, are implementing and monitoring of large programs at the local level, fostering of grass roots efforts, and state-by-state mortality reduction through pre-and-post natal support policies.

Child Malnutrition

Closely linked to child mortality, and also behind in reaching set targets, is the issue of child malnutrition under Goal #1. The MDG for all countries ratified to its program in this sector is to reduce by 50% underweight children by 2015. For India, this target means a reduction in underweight children from 54.8% in 1990 to a goal of 27.4% by 2015. It is estimated that there are approximately 37 million malnourished children in India, and although numbers have been decreasing, the rate of annual decline is rather slow, only 1.9%, which is also low compared to neighboring countries (Deolalikar 51). Some of the causes of malnutrition in India are infant feeding practices such as early breast-feeding termination, the poor nutrition of the mother, and low weights of infants at birth, all of which make children prone to illnesses and infection, and they have to struggle from the beginning. One foundational approach to combat child malnutrition, as well as infant mortality, is improving India's infrastructure. This includes access to safe drinking water, sanitation, and electricity (Deolalikar 60). A lot of government spending has also gone into the Integrated Child Development Services programs. This program sets up programs of support in all villages that facilitates and fosters the health of children and pregnant and new mothers. Each center provides growth monitoring, food supplementation, and education. However, the amount of support varies between states, a problem that we have seen before. Often in the poorer countries, supplies are meager and

irregular. There is also gender disparity within these programs, where male children are brought to and receive the benefits most frequently (Deolalikar 53-4).

I believe that if the government increased its expenditure, particularly in these poorer areas, resources would become more abundant, and as a result, perhaps parents would not be so hesitant to bring their girl children. However, I also believe that these programs need components that specifically aim at women and children. Some beacons of light in this respect are India's national Nutrition Policy of 1993 and the National Plan of Action for Nutrition of 1995. Particularly hopeful is the Plan of Action, which places a "special emphasis on improving the nutritional status of mothers, adolescent girls, control of anemia and micro-nutrient deficiencies, as well as nutritional health education of women," (Country Report 2005).

Schooling

In this arena, India has made rapid strides. The MDGs set Goal #2, and consequently, Goal #3, to have 100% universal primary school enrollment and retention through grades 1 to 5. Currently, the net enrollment for primary school education in India is 94.2% (MDGMonitor). Although a promising figure for the country, it masks any disparities between states. For example, in 2000, Uttar Pradesh, a notoriously poor state, had an enrollment rate of only 65%, whereas Sikkim could proudly say that there was a 139% enrollment rate (Deolalikar 70). Undoubtedly, to ensure widespread primary education, especially for girls, should be a top priority for the government of India. One major problem, particularly in poorer states, is the rate of teacher absenteeism. This lack of accountability or incentives correlate to higher dropout rates in schools, a move away

towards progress towards the MDGs. What are needed are institutional reforms, empowerment of the community to be able to want and demand insurance of performance by the state, and interest and mobilization of parents of both genders in schools.

The beneficiaries of this movement must include girls. A report by UNICEF brightly claims, “Girls in India are demanding greater, sustained support for equal access to a good education... in the Indian capital New Delhi on 7 April a group of around fifty girls from seven Indian states came together to discuss and share their experiences of schooling” (UNICEF 2005). As a result of the increased demand and need, India has taken steps to provide education for all. One experimental measure is the Learning Guarantee Program. This program fosters a competition between government schools for quality of education. This program provides incentives to teach and to learn via a standard assessment of the children attending the different schools, with rewards in the form of grant money and materials for the schools that have the highest achievement levels. In the first year, 2005, 1,000 schools enrolled in the program, and a marked increase in the quality of teaching as well as teacher and student retention was noted (Deolalikar 87). Another model for increasing education opportunities is the Education Guarantee Scheme of Madhya Pradesh. This was a drastic government program aimed to increase enrollment of all children in the poorest states. Under this program the state was guaranteed a school facility within one kilometer of any habitation/community. It is undeniable that one of the barriers for education is lack of school availability and poor infrastructure in some areas, such as lack of suitable roads. Within this program, once a community demands a facility, the government had to provide one within 90 days. Grant

money was given to the training of a selected community member to become a teacher, as well as money for materials and resources. This program was astonishingly successful. Within a year, a primary school was created within every community of Madhya Pradesh. It is also hopeful to note that many of the demands made for schools were made by women and girls (Deolalikar 86). I believe that this is a hopeful model for other states, and an indicator that India is taking the MDGs seriously. Drastic measure like this one must be made. However, I also believe there should be an increase and innovative way of accessing quality. Through the combined efforts of NGOs, the government, and international organizations and funding, India can make positive steps towards universal enrollment and retention.

Empowerment for All

India must look beyond enrollment and retention of girls in grades 1 – 5. This segways into the Third MGD, of the empowerment of women through increased access to higher education. With higher education, a woman can hopefully be more viable in the work force, and help alleviate any deficiencies in resources. Unfortunately, those women who are in the best position to receive higher education probably already have decent living standards and are economically well off. It seems to be a struggle to get women in rural areas any education, much less to get them into higher institutions. Although state schools are free, the cost of materials such as books and uniforms are often way beyond the scope of what a rural family can afford, especially in sending their daughters to school (UNICEF 2005). What is hopeful to note is that “school based administrative data suggest that India has made impressive gains in reducing the male-female gap in the

gross primary enrollment rate in the last fifty years” (Deolalikar 93). What is most notable of such studies is the probability that a girl will attend school will increase if the adult female of the household is educated. Girls are more positively affected than boys in school enrolment rates when their parents have received an education (Deolalikar 98). This underscores the importance of adult education, particularly women. Since gender disparities in school are the outcomes of deeper gender discriminations of the society, public policies and institutional changes that increase parental incentive to invest in education for girls are needed. These could be tuition waivers, female stipends and scholarships, as well as continued creation of women’s grass roots movements as well as support from NGOs and INGOs.

Once these women and children have more access to higher education, the challenge then becomes to raise their status among the workforce, politics, and in the eyes of the entire country. The empowerment and equality of women largely depends on collective efforts. Rhetoric and ‘new thinking’ on gender issues do not mean anything if they are not implemented in the institutions. IN 2004, India declared budgeting for gender equality as a goal, and the total government expenditure on gender development has increased from 3.8% to 5%, while the National Policy for Empowerment of Women in 2001 further envisions further introduction of gender perspectives (WomenWatch). For example, as a result of policy changes such as quotas for women, over one million Indian women at the grass roots level have been brought into the political arena, greatly enhancing women’s say and participation in decision-making processes (WomenWatch 2008). This I feel is an important step in elevating women’s worth, especially in a country with the pervasive idea that men are superior to women. However, women will

not take political seats of power if they are hungry. Many rural areas are severely impoverished, with women taking the brunt of the blows to support themselves and their families. It has become apparent that “the groups that have the most ill health from underdevelopment are in general women and children, because they bear a disproportionate burden of disease in poor countries” (Smith 2005). One memorable measure is the National Rural Employment Guarantee established in 2006. This program goes into the most impoverished areas, mostly agricultural lands, and provides 100 days of wage employment annually to every household. What this program incorporates is an effort to bring women into its sphere; one-third of the beneficiaries are to be women (WomenWatch 2008). Another area of women mobilization is the creation of women’s self-help groups. The World Bank reports that in Andhra Pradesh, one of the poorest states, has seen the movement of almost 8 million women in rural areas join over 600,000 self help groups with the support of the International Development Association, government encouragement, and initiatives of women (IDA 2007). The freedom and support that women have to create such groups indicates a changing of the tides for women. With more power and confidence, these women, especially in self -help groups and political arenas, can demand better equality for women throughout the country.

Conclusion

India as a country has made great strides towards achieving the MDGs. However, after the synthesis of data and research, it is apparent that the plight of women needs to be more strongly addressed in the MDGs, especially in the poorer states. With the goals, the problem is that “in assuming that ‘people’ are homogenous these approaches gloss over

the fact that there are different categories of people who will inevitably affected by, and participate in, democratic changes in different way... An institutional approach that does not look at people makes it much more difficult to attend to gender analysis or women” (Hirschmann 79). Specific measures made for the empowerment of women need to be included to make sure that a country is addressing the most underprivileged, We need to increase the ‘gender health’ of the country as a whole, not merely elevate further those that are already privileged. There need to be “incentives, arrangements, and procedures to ensure that the intended beneficiaries profit” (Hirschmann 78). What I found throughout the country was heartening, but there is definitely room for improving, especially in the area of alleviating poverty and women’s health. This was a very eye opening study, and although I am sure there are still gaps in my knowledge, I feel a lot more aware of the plight of women around the world.

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