Executive Summary

Serve the Essentials

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

Oxfam International

G Shantakumari/Oxfam GB/ India/2006

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.

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.

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
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 did 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

Contd...

	What Has Progressed	What Remains Deprived
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 metres with incremental increases by volume With the recent end of monarchy, the new draft constitution intends to guarantee free universal access upto 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

Oxfam GB/Sri Lanka/2006

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.

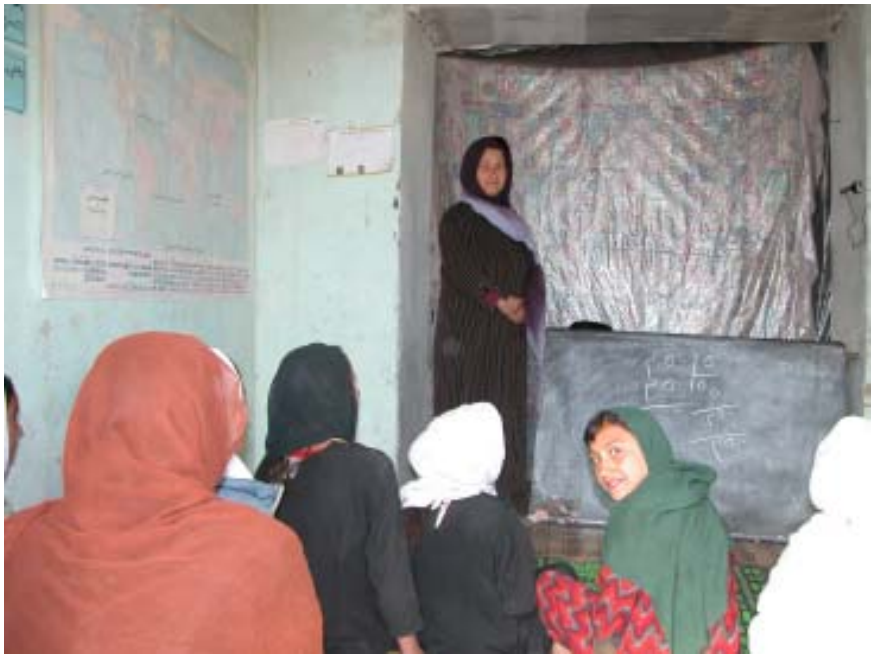
Bringing women forward as change agents is a challenge that some states are addressing head-on in South Asia. This is a high priority, given the ugly reality that infant mortality is 30–50 per cent higher for girls than boys in this region. It is in this context that Bangladesh achieved the remarkable 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



Swati Narayan/OxfamGB/Afghanistan/2006

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 health
    - – Eliminate both direct and indirect costs for all end-users of health and education services and cross-subsidise water for poor people
  - ⇒ Support universal rather than targeted programmes for the delivery of essential service
    - – Ensure legal safeguards for universal access by adopting universal legislation
  - ⇒ Adopt a multi-pronged strategy to fight corruption
    - – Implement society-wide 'right to information' laws
    - – Weed out corruption in essential services delivery
  - ⇒ Ensure that essential services are truly sensitive to the needs of women
    - – Increase women's role in community decision-making
    - – Hire more female teachers and health workers

❑ Rebuild capacities in public delivery systems

⇒ Make financial commitments and priorities

- Governments need to allocate at least 20 per cent of their annual expenditure to basic services, based on their commitment at the Copenhagen summit in 1995
- Donors need to reverse the trend of declining overseas development assistance in South Asia and likewise invest at least 20 per cent of their aid to support basic services. This aid must be co-ordinated, predictable, long-term and comply with the Paris commitment in 2006 on aid effectiveness.
- Prioritise primary levels of service
- Need to ensure that at the very least 15–20 per cent of total government annual recurrent expenditure is devoted to non-salary quality- enhancing inputs
- Governments should regulate private service providers to ensure quality standards and affordability

⇒ Build the public sector work ethos

- Ensure teacher salaries are at least 3.5 times the national per capita GDP
- Hire 800,000 teachers and 1.9 million health workers in South Asia
- Improve infrastructural conditions in schools and health clinics
- Create rural bias in service delivery through service contracts
- Employ and train more nurses rather than doctors

❑ Work with other stakeholders

⇒ Promote partnerships with civil society especially as policy partners and advocates

⇒ Foster social consensus and community ownership to value essential services from a rights perspective

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This publication is published, distributed in print and available from
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Oxfam GB/India/2006

Serve the Essentials

South Asia is a study in contrasts. While in Sri Lanka and Bangladesh school fees and textbooks are officially free, in the rest of South Asia 35 million children never see the inside of a primary school classroom. Similarly, while thousands of foreign tourists are visiting the region each year for advanced medical treatment in speciality private hospitals, every 30 minutes- six Indian women and one Afghan woman die in childbirth while seven Bangladeshi children of untreated diarrhoea!

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

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

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