CHAPTER - XI

SOCIAL SECTOR

CHAPTER XI

SOCIAL SECTOR[1]

11.1. The importance of Social sector, mainly health, education and welfare are undeniable and intricately linked to the developmental efforts in other sector and also becomes the push or pull factor in the process of development. Human potential cannot be expressed and achieved fully unless well being, capabilities and capacities are enhanced continuously.

11.2. Health :

11.2.1.Public Sector Health Infrastructure: The 3-tier health delivery system is as follows:

1) A Community Health Centre (CHC) for a population of approximately 80,000 serves as a referral centre for PHCs. It should be manned by four Medical Specialists; a surgeon, a physician, a gynaecologist and a paediatrician. It has 30 beds for indoor patients with an operation theatre, X-ray, labour room and laboratory facilities.
2) A Primary Health Centre (PHC) for population of 20,000 serves as the first contact point between the village community and a medical officer. It acts as a referral unit for 6 or so Sub-centers. It has 10 beds for indoor patients.
3) A Sub-Centre for a population of 3,000 is the most peripheral contact point between the Primary Health Care system and the community. It is manned by one Multi-Purpose Worker (Male) and one ANM.

Public sector health care infrastructure as it existed in 1972 and its growth since then is shown in Table 11.1. At present there are 7 Districts with 9 hospitals (beside one MIMHANS and 2 TB hospitals, and one 100 bedded institution), 28 CHCs, 104 PHCs, 405 Sub-Centres, 9 Dispensaries and 12 urban health centres. Besides, there are in-house hospitals for the police (2) and jails (1) with emergency bed facility. Further, development and improvement in health care services are seen not only in curative services but also in preventive and promotive health care services in the state.

Table 11.1: Status of Public Sector Health Institutions and Services (1972-2007)

Items	1972	1981	1991	2001	2007
Number of Hospitals	7	9	9	6	9
Number of Dispensaries	57	58	23	20	14
Number of CHCs				12-17	28
Number of PHCs	9	23	63	85-88	104
Number of sub-centres		93	272	401	405
Number of Beds	781	1264	1811	2735	3166
Number of indoor patients	3385	40260	342740	97000	158000
Number of outdoor patients	90788	2039973	1915790	1511000	1923000
No. of IUCD inserted	485	284	1789	2407	2646
No.of sterilizations	582	257	612	2294	2264

[1] For details on various aspects of Social Sector, please see the Meghalaya Human Development Report, 2008.

Doctors	113	189	335	389	568
Nurses	117	305	318	384	862
Health visitors	8	30	45	59	71
ANMs	82	227	450	594	687
Pharmacists			137	92	188
Lab. Technicians			45	100	172
Vaccinators			148		106
Birth rate				28.3	25.1
Death rate				9	7.5
IMR		58	53	56	49

Note: There is variation in the number of Hospitals, CHCs, PHCs and Sub-centres due to definitional problems, and sometimes due to the exclusion of non-functional entities and institutions such as the Institute of Mental Health and Neurological Sciences.
Source: Compiled from handbooks of statistics (Directorate of Economic and Statistics- http://www.megplanning.gov.in/handbook.htm)

Based on the current population of around 27.25 lakh vis-à-vis the norms indicated above, the State would require setting-up of SC/PHC/CHC as follows:

Table 11.2: Estimated Number of Sub-Centres, PHCs and CHCs required by Meghalaya by 2020

Institutions	Presently Required	Available	Shortfall	Availability by 11th Plan	Availability by 12th Plan	Requirement by 2020	Additional requirement
Sub Centres	817	405	412	551	801	1021	220
PHCs	122	104	18	119	144	153	9
CHCs	31	28	3	31	36	38	2

Source: MHDR, 2008

Urban Health Centres (UHCs) were introduced in 2005-06. At present, there are 9 UHCs in Shillong, 2 UHCs in Tura and 1 UHC in Jowai. There are also *first referral units (FRUs), to provide 24 - hour emergency referral services, particularly in maternal and child health care.* At present, 12 institutions have been identified to function as FRUs. Of these only 3 are functional, these are (1) Ganesh Das Hospital, Shillong (2) Civil Hospital Tura and (3) Civil Hospital, Jowai.

Out of the 28 *Community Health Centres (CHCs)* in the state, 12 are fully equipped, eight do not have OTs and 7 have OTs that are not fully equipped. 6 CHCs have non-functioning Labour Rooms. Almost all CHCs are without the required specialist doctors.

Out of the 104 *Primary Health Centres (PHCs)* in Meghalaya, 82 have no OTs. Of the remaining PHCs only eleven have fully equipped OTs. 22 PHCs do not have Labour Rooms. 12 of the PHCs do not have fully equipped Labour Rooms. 17 PHCs need repairs of the main buildings and quarters. Many PHCs are without vehicles.

There are 14 *Dispensaries* in the state out of which one is functioning from a rented house. All Dispensary buildings require repairs. In course of time these should be converted to PHCs.

Of the 405 Sub-Centres, 53 are non-functioning because ANMs are not staying in the place of work. 19 Sub-Centres need new buildings, and 133 need repairs. 75 Sub-Centres need water and power supply. 73 Sub-Centres need separate quarters for ANMs to stay. 13 Sub-Centres are located far away from the villages and need to be shifted within the villages for better accessibility to the people. 10 Sub-Centres are functioning from rented houses. Many health institutions lack adequate furniture, examinations tables, delivery tables, steps, and other items like stool, bench, almirrahs, tables and chairs.

At the district level, South Garo Hills district has no hospital, while West Khasi Hills district, East Garo Hills district and West Garo Hills district have no dispensaries. Table 3.3 gives the distribution of public sector health care institutions in the districts of Meghalaya and in Table 11.4 we report certain other indicators of availability of health infrastructu e in the districts of Meghalaya.

Table 11.3: District-wise Distribution of Public Health Care Institutions in Meghalaya, 2008

District	Hospitals	CHCs	PHCs	Dispensaries	Sub-Centres	UHCs
East Khasi Hills	4	5	22	9	65	9
West Khasi Hills	1	5	17	-	65	-
Jaintia Hills	1	5	16	1	72	1
Ri Bhoi	1	4	8	2	28	-
East Garo Hills	1	3	16	1	72	-
West Garo Hills	1	5	18	-	82	2
South Garo Hills	-	1	7	1	21	-
Total	**9**	**28**	**104**	**14**	**405**	**12**

Source: MHDR, 2008

Table 11.4: Some Other Indicators of Availability of Health Infrastructure in Meghalaya, 2007

Name of District	No. of PHCs/ CHCs with functioning microscope	No. of PHCs/ CHCs with LTs	No. of villages/ habitations	No. of villages with ASHA	No. of villages with trained ASHA	ABER in PHCs
East Khasi Hills	24	28	980	867	0	3.6
Ri Bhoi	10	12	597	517	250	23.1
West Khasi Hills	17	22	1024	946	891	4.1
East Garo Hills	14	20	922	952	919	9.2
Jaintia Hills	16	21	519	552	349	17.4
West Garo Hills	23	24	1507	1660	1660	29.3
South Garo Hills	8	8	701	515	952	23.4
Total	**112**	**135**	**6250**	**6009**	**5021**	**14.3**

Note: ABER – Annual Blood Examination Rate; Source: MHDR, 2008

11.2.2 Private Sector Health Infrastructure

Table 11.5 shows the names and bed-strength of the well known private hospitals in Meghalaya. In addition to the Private Hospitals listed in Table 3.5, there are also a few other private institutions, which provide only outdoor services or deal with specialized subjects only. The two of the better known are:

1) Ramakrishna Mission Dispensary, Shillong, for outdoor services only.
2) Sanker Nursing Home, Shillong, for Mental Health Care Services. It is having both Indoor and Outdoor facilities.

Besides, there are a number of dispensaries in the rural areas, mainly run by Christian missionaries.

NGOs in health care: There is no mother NGO working in the State. However, there are a few active NGOs like Bosco-Reach out, Impulse NGO Network, Lions Club, Rotary Club, Inner Wheel Club, VHAM (Voluntary Health Association of Meghalaya), World Vision, Ka Lympung ki Seng Kynthei, Ka Synjuk ki Rangbah Shnongs and YMCA, that are involved in health care in various ways. Besides, there is a Livelihood Improvement programme implemented by the MRDS (IFAD and GOI funded programme) which has a small health component.

Table 11.5: Bed Strength of Selected Private Hospitals in Meghalaya

Name of Private Hospitals	No of Beds	Name of Private Hospitals	No of Beds
K.J.P. Hospital, Shillong	600	K.J.P. Hospital, Jowai	100
Nazareth Hospital, Shillong	500	Mission Hospital, Tura	60
Bethesda Hospital, Shillong	40	Holy Cross Hospital, Tura	50
Woodland Hospital, Shillong	150	Holy Cross Hospital, Mairang	50
Indian Red Cross Society, Shillong	10	Bethany Hospital, Shillong	90
10 Hospitals-----1650 beds			

Source: MHDR, 2008

11.2.3 Central Government Health Institutions

The North East Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS), which is now commissioned and where the first batch of MBBS students have been enrolled, will have a 500 bedded Super-Speciality Hospital. However, there are a number of vacancies in the faculty in various departments. This Institute when fully functional can be utilized for giving 6 months training of Medical Officers on Obstetrics and Gynaecology, Paediatrics and Anaesthesiology. The Union Ministry of Health is likely to set up an Institute of AYUSH (Ayurveda Unani Siddha & Homeopathy) within the campus.

Military and Paramilitary Health Institutions:- There are a number of military and paramilitary hospitals and dispensaries around Shillong. Some of the main such institutions are: (1) Military

Hospital, Shillong (2) BSF Hospital, Shillong (3) Assam Rifle Hospital, Shillong and (4) Air Force Hospital, Shillong. These hospitals also coordinate with the state health authorities on preventive and promotive health care services such as immunization and other RCH services, besides organizing health camps for the community.

CGHS and ESI: Meghalaya also has Central Government Health Scheme (CGHS) and Employees' State Insurance (ESI) services at a very modest level.

Regional Directorate of Health Services, Ministry of Health, GOI, Shillong: This Regional Directorate also has an important role in health care services for Meghalaya particularly in connection with National Anti-Malaria Programme and RCH Programme. Some of the important and essential activities are the verification and confirmation of the correctness of positive and negative blood-slide smears in diagnosis of malaria parasites, the training of Microscopists for correct diagnosis of malaria parasites, and the quality control of some contraceptives.

11.2.4. Problems and constraints of health sector in Meghalaya

Current problems faced by the health care services in Meghalaya include:

1. Persistent gaps in manpower and infrastructure especially at the secondary and tertiary health care levels and poor referral services.
2. Sub-optimal /improper utilization of the infrastructure and resources including manpower resources.
3. Various health institutions (Government, voluntary and private) do not have appropriate manpower, diagnostic and therapeutic services and drugs.
4. Low absorption capacity for programme funds.
5. Massive intra state differences in performance as assessed by health and demographic indices; availability and utilisation of services being poorest in the most needy areas.
6. Sub-optimal inter-sectoral coordination; poor coordination among various services provided by directorates.
7. Lack of innovation and adaptation.
8. Poor capacity of personnel and poor exposure to technological advances.
9. Growing dual burden of communicable and non-communicable diseases because of demographic, lifestyle and environmental transitions.
10. Increasing awareness and expectations of the population regarding health care services.
11. Lopsided emphasis on short term, quick fix solutions; lack of long term planning and delivery of services.
12. Escalating costs of health care, ever widening gap between what is possible and what the individual or the state can afford.
13. Lack of an adequate management information system for planning, monitoring and evaluation.

11.2.5. Human Resources for Health Services

The selection by the World Health Organisation (WHO) of the theme *"Human Resource for Health"* for observation of the World Health Day, 2006 is particularly relevant for Meghalaya. Most of the CHCs in Meghalaya function without specialists. At the village level, the curative, preventive and promotive health care services are provided and looked after by Sub-Centres through the Female Health Workers (ANMs) and Male Health Workers, by working in close co-ordination with the community mainly through the help of the recognized workers like ASHAs, AWW, Trained Birth Attendants (Traditional Dais), FTDs (Fever Treatment Depots), DTCs (Disease Treatment Centres) and Village Health Committees.

Meghalaya has no Medical College. However, a welcome development is the setting up of NEIGRIHMS with under graduate and post graduate study facilities as noted in section 3.2.5 above. In Meghalaya there is an acute shortage of specialized manpower (Doctors) in Obstetrics & Gynaecology, Paediatrics, General Surgery and Anaesthesia. The Government of Meghalaya has requested the Government of India to allot more seats for MBBS Course and Post-Graduate Courses in various Medical Colleges in the Country. Under RCH - II, a proposal was incorporated in the State Programme Implementation Plan to undertake supplementary training of six months duration for selected Medical Officers of the state in urgently needed specialized subjects for proper functioning of CHCs and FRUs. These are yet to fructify.

For requirement of nursing staff, etc. there are 5 training centres in the public sector which include: 1 Regional Health and Family Welfare Training Centre, 2 GNM training centres, and 2 Nursing Training Schools and 1 ANM training school. The State Government had also submitted its requirement of 2 additional GNM Training Schools to be set up at Tura Civil Hospital and Jowai Civil Hospital. The proposal of setting up of a paramedical training institute and for strengthening of the existing Government Nursing Schools and ANM Training Centres should be given priority. In order to build capacity in the health sector the Government of Meghalaya has provided land for setting up of Indian Institute of Public Health. Emphasis is also being given to the development of trained manpower to cope with the increasing demand of increasing strength of manpower vis-à-vis the increasing bed strength in the State. The present Doctors: Patient ratio is 1: 5000 and the Nurse: Patient ratio is 1: 1700.

Table 11.6: Existing and Additional Requirement of Manpower in Health Sector of Meghalaya (2007)

Manpower	Existing	Additional Requirement
Specialist Doctors	78	200
General Duty Stream	471	200
Dental Surgeons	36	25
Nursing Professional (GNM and ANM)	1232	500
Allied Health Professional(Para-medical staff)	350	200

Source: MHDR, 2008

11.2.6. Public Expenditure on Health Sector in Meghalaya

Public investment has been recognized as an indicator of planning priorities. But investment in public health in the country as a whole – and in Meghalaya – does not show that health care has been given due importance. In Meghalaya, the Government funding and Plan expenditure had increased from Rs.16.65 crore in the Seventh Plan to Rs.54.72 crore during the Eighth Plan. Further in the Ninth Plan the expenditure was more than Rs 150 crore which again saw an increase of expenditure to the extent of Rs. 205 crore during the Tenth Plan. These figures do not include the annual expenditure of about Rs 50 crore under non- plan and expenditure in cash and kind under various Central and Centrally Sponsored health sector programmes including that of the NRHM which if absorbed well can exceed more than Rs 100 crore annually. The proposed state Plan outlay during the 11th plan is more than Rs 600 crore.

Table 3.7 shows at a glance, the year wise percentage of expenditures on Health & Family Welfare from the consolidated fund of the Government of Meghalaya. However, as mentioned above the table does not take into account the expenditure under various national health programmes, funds for which are directly received in various health programme societies, including the State Committee on Voluntary Action (SCOVA) and State Health Society implementing RCH and NRHM programmes. The assessment of such funds has not been done so far.

Table 11.7: Expenditure on Health & Family Welfare in Meghalaya

(Source: MHDR, 2008)

Year	State Total Revenue and Capital expenditure (Rs. lakh)	State Revenue and Capital expenditure for H & FW (Rs. lakh)	Expenditure for H & FW as percentage of total
1999-2000	85864.37	6368.00	7.4 percent
2000-2001	103697.08	7050.59	6.8 percent
2001-2002	102447.99	8206.93	8.0 percent
2002-2003	109579.18	8186.40	7.5 percent
2003-2004	182084.77	8256.43	4.5 percent

2004-2005	207234.21	9194.87	4.4 percent
2005-2006	200709.28	9602.81	4.8 percent
2006-2007	232010.25	9910.97	4.3 percent
2007-2008 (R.E.)	344846.82	12742.89	3.7 percent
2008-2009 (B.E.)	397322.38	15484.94	3.9 percent

Note: (a) Does not include direct programmatic fund and material flow from GOI.; (b) R.E. – Revised Estimates, B.E. – Budget Estimates;Source: Government of Meghalaya "Budget at a Glance", various issues.

As per estimates **during the 11th Plan following fund is likely to flow to the sector:** (a) State Plan - Rs. 450 - 500 crore; (b) Funding under NRHM and other Centrally Sponsored Schemes - Rs 450 crore (approx.); (c) from NEC, NLCPR and other agencies of GOI - Rs 150 crore. (d) Non-Plan fund - Rs. 500 crore. Thus, about Rs 1400-1500 crore may be available if programmes are managed well.

The central resources to the overall public health funding have been limited to about 15 percent only. There is also inherent problem of absorption of programmatic fund due to various factors. The current annual per capita public health expenditure is no more than Rs 200. But with the launching of NRHM by the Government of India, it is expected that things will greatly improve. This expectation is mainly because the NRHM also aims at commitment of the Government of India to increase public spending on health form 0.9 percent of GDP to 2 - 3 percent of GDP, during the Mission period from 2005 to 2012. It remains to be seen how well the entire health sector absorbs the fund and the managers in the state leverage and perform under NRHM. The initial years show somewhat tardy progress in the matter in the state which requires concerted and expeditious mode of action. It is a matter of record that the health sector failed to utilize a possible expenditure of Rs 22.0 crore, which was slashed down to Rs. 6 crore, which ultimately was utilised for a paltry sum of about Rs 50 lakh or so for similar mission mode programme under the European Commission Programme during 2000-2005.

11.2.7 Health Indicators in Meghalaya

With difficult hilly terrain and poor road connectivity in the rural areas, the shortage of proper health infrastructure, manpower, and the trend of financial investment/ absorptive capacity on health by the State Government etc. as discussed earlier, we cannot expect much about the improvement of health conditions of the people and about the accessibility of health care services to the people, particularly the remote vulnerable sections of the rural population of Meghalaya. Poor human-resources management and poor work culture of the service providers at different levels of the health systems, have further worsened the situation. This is evident from some of the recent available health indicators for Meghalaya that are mentioned below.

The health indicators given below are based on the following sources:

1) The National Family Health Surveys (NFHS-1, NFHS-2, NFHS-3)
2) The Sample Registration System Surveys (SRS, Monthly Surveys)
3) The Rapid Household Surveys for RCH Services (1998-99 & 2002-2004)
4) Monthly/ Quarterly reports of Health & Family Welfare Department (Management Information System Reports)
5) The Birth and Mortality Survey, 2007

The health indicators from the first three services of the independent agencies above are not for the whole State or for every part of the State of Meghalaya. They only show the status of health conditions and health services provided for a few selected villages and urban areas and a few households of Meghalaya. For example, the NFHS-2 covered only about 1250 households (out of about 3 lakh households of Meghalaya), and about 1000 couples (out of more than 2 lakh couples). Therefore, the figures may be taken to be indicative only.

The health indicators from the monthly reports of the Health and Family Welfare Department are often considered unreliable, because they are given and reported by the service providers themselves, though they cover more than 60 percent of the villages of the State. However, those reports are also important because it is also their objective to invite corrective measures by the higher level authorities of the health system.

11.2.8 Health Programmes: Like other states in India, the health department of the Government of Meghalaya, caters for implementation of different National Health Programmes of the Government of India. All the different vertical Health programmes of the Government of India are integrated under the Multipurpose Health programme at all levels in the State. The earlier Family Planning programme was renamed as Family Welfare programme and later modified as Reproductive and Child Health (RCH) programme. All the different National Health programmes are being implemented as per guidelines of the Government of India. At present, the welcome development is that the hitherto unreached rural population is attempted to be reached out through the National Rural Health Mission (NRHM), though it needs a focused and dedicated effort.

The Programmes of the Department aims at a rapid transition and transformation in which efficient health systems will improve quality of life well being of the people and reduce burden of diseases which in turn will increase economic productivity and growth. This is to be achieved through (i) various health programme and parameters under NRHM (ii) Strengthen Public health infrastructure (iii) Improve professionalisation of health service delivery (iv) Improve convergence of health related activities of various sectors of Government (v) Increase Public Private Partnership (vi) Improve monitoring, accountability and transparency of the system (vii) Popularization of alternative medicine systems like AYUSH and (viii) Ensuring access to essential drugs in public health system.

National Rural Health Mission (NRHM):-

The NRHM was launched in April 2005 in the State with a view to bring about marked improvement in the health System and health Status of the people. The Mission seeks to provide universal access to equitable, affordable and quality health care to the people and especially the poor and vulnerable section of community residing in the rural areas through out the country . The duration of the mission is 7 years (2005-2012). The state and the District Health Missions and Societies are constituted for effective implementation of the goals of the Mission.

Components of NRHM: The National Rural Health Mission seeks to adopt a sector wide approach and subsumes key national programme, such as RCH-II Programme, the National disease Control Programme and Intigrated Diseases Surveilance, Universal Immunization Programme (UIP) and The Intersectoral convergences are 5 important parts of the efforts

The current Health Status in the State is as follows:-IMR-49(SRS-2006); BR-25,1(SRS-2006); DR-7.5(SRS-2006); TFR-3.8(NFHS-3);MMR-450(State Records)
Physical targets under NRHM :In line with the goals of the Mission the State expects the outcome of NRHM by 2012 will be as follows :

a. **IMR** to be reduced to **30/1000** live births.
b. **MMR** to be reduced to **100/1000,000.**
c. **TFR** to be brought to **2.1.**
d. **Malaria mortality reduction rate – 50%** upto **2012.**
e. **Cataract Operation :** increasing to **1000** cases per year until **2012.**
f. **Leprosy prevalence rate :** to be brought to less than **1/10.000.**
g. **Tuberculosis DOTS Services :** from the current rate of **1.8/10,000,85%** cure rate to be maintained through the entire Mission period.
h. **34 Community Health Centres** to be upgraded to **Indian Public Health Standards.**
i. **Utilisation of First Referral Units** to be increased from **less than 20% to 75%.**
j. Link Workers **(ASHA)** will be engaged in all the Villages of the State (5438 ASHAs in place against a total of 6180 is required).

Activities And Performances Under NRHM upto 2008-09:-

JSY Beneficiaries–Total target (2006-07) – 4000 : Total achieved (Sept 2007) – 1500.Procurement of Drug, Kits under NRHM have already been supplied and distributed to all districts. 7 Nos. Mobile Medical Units, one for each district has been approved by Government of India; 2 Health Meals are being held annually.

Table 11.8 NRHM FINANCIAL STATEMENT FOR 2008-09

(Rs. in lakhs)

Sl. No	Name Of Scheme (Ongoing/ New)	Approved Outlay For the Scheme During 2007-2008	Actual Expenditure up to 31st March, 2008.	Approved Outlay for the Scheme During 2008-09	Cumulative Achievement up to Sept, 2008.	Percentage of Achievement %
1	2	3	4	5	6	7
1.	RCH -II	1174.86	407.14	1377.04	225.80	16.39
2.	NRHM	4849.25	3234.91	4332.73	529.36	12.21
3.	UIP	167.00	87.67	191.21	16.56	8.67
4.	IPPI	66.15	59.59	86.00	6.62	7.69
	TOTAL	6257.26	3789.31	5986.98	778.34	13.00 %

Progress of physical and financial achievement under NRHM.

Achievement for 2007-08 & 2008-09:

- The Approved **Outlay** for **2007-2008** was **Rs. 6257.26 lakhs** against which an amount of **Rs.3789.31 lakhs** has been utilized. The percentage of utilization is **60 %.**
- Of the Approved **Outlay** for **2008-2009** amounting **Rs. 5986.98 lakhs** an amount of **Rs. 778.34 lakhs** has been utilized **up to 30.9.08.** The percentage of utilization is **13 %.**

Cumulative Achievement till Sept 2008:

RCH- II – Maternal Health

- **30** Nos of **ANMs** have been recruited against the **Target of 50** Nos.
- **3** Nos of **Staff Nurse/PHN** for 24X7 PHCs have been recruited against the **Target of 42**
- **15 AYUSH doctors** have been recruited against the **Target of 15 Nos**.

Training:

- Training of on skill birth attendance(SBA) - **31** against the **target of 120** SNs/PHN.
- Multi skilling training of Mos from CHC - **2** Nos. against the **target of 20** Nos.
- Training on RTI/STI - **41** MOs. against the **target of 75** MOs.
- Training of MOs on mini laparoscope or conventional tubectomy - **2** MOs against the **target of 21 MOs**
- Training of MOs on ARSH - **41** MOs against the **target of 75.**
- Training of ASHA - **3197** Nos. of ASHA against the **target of 6180** Nos.

NRHM

- **7** CHCs have been Upgraded and **17** are near completion.
- **1** Store Keeper has been appointed.
- **2** Assistants have been appointed.
- **4** Helpers have been appointed.
- **7** Nos of MMU have been released to all Districts against the **target of 7** Nos MMUs.
- Outsourcing of **14** PHCs to NGOs is under progress.
- **15** AYUSH Doctors have been recruited in 10 PHCs & 5 CHCs against the **target of 15** Nos.
- **63** Nos. of PHC Accountant have been appointed of accountant against the target of **104** Nos.
- 1 Accounts Manager has been appointed
  1 Office assistant has been appointed

Development of Infrastructure:-

A. Medical Institutions :-

- At present, the Department has 9 Hospitals, 28 CHCs, 104 PHCs and 405 Sub-Centres. The strategy of the Department during the Plan period is to upgrade the existing Hospitals by providing more beds and facilities with a view to improve patient – to – bed ratio (1:730) drastically. It will also focus on upgradation of CHCs to Hospitals on case to case basis. Simultaneously, the Department will also set up new CHCs, PHCs and Sub-Centres to cover more population of the State as per the norms.
- The Department would achieve the goal to set up additional 10 CHCs, 20 PHCs and 200 Sub-Centres during the Plan period.
- Accident and Trauma Centres at Tura, Williamnagar and Jowai will be set up.
- Construction of Warehouses at all the District Head Quarters would be initiated.
- Training Centre for Male Health Workers will be set up for both in-service and newly recruited workers.
- Female Health Workers Training Institutes at Shillong and Rongkhon will be upgraded.
- The Department will also set up Training Institute on Para-Medical Workers.
- The Regional Family Welfare Training Institute at Shillong will also be upgraded to meet the requirement of in-service staff at various levels.
- Blood Bank Unit at all District Hospitals with 24 hours delivery services would be set up.

B. Equipments :-

- Pasteur Institute, Shillong would endeavour to set up the New Tissue Culture (NTCARV) for preparation of anti-rabbies vaccines.
- Major Hospitals and CHCs are required to maintain standards in terms of waste disposal systems. All Hospitals and CHCs would be equipped with Waste Disposal Units.
- District Hospitals would be provided with Laparoscopic and Endoscopic machines.
- 18 ECG machines would also be provided at all District Hospitals and CHCs located at the District and Sub-Divisional Headquarters.

- 18 X-Ray machines would also be provided at all major Hospitals/CHCs. 25 Portable X-Ray machines would also be provided and attached at all District Hospitals. Accidents and Trauma Centres and for the purpose of Post Mortem Operations.
- 25 Dental Chairs would be provided at all Hospitals and CHCs.
- Deficiency in critical equipments may also be ameliorated through Public-Private Partnership and outsourcing mode.

Material And Child Health & Family Welfare Programmes:-

MCH & FW Programme is taking a shift from normative to a need-based Client oriented programme with twin objectives of (i) Maternal and Child Health and (ii) Family Welfare Programme on the one hand to seek stabilization of population in the shortest time and on the other hand to seek improvement in the reproductive and child health status.To meet these objectives, a number if interventions are being attempted through various programmes including NRHM. Some of the main intervention under MCH & FW Programme are (i) Reproductive and Child Health Programme (under NRHM) (ii) Training activities taken by Health & Family Welfare Training Center, Shillong is an ongoing activity conducted in all the seven District of the State (iii) Civil Registration System of Births and Deaths and Vital Statistics (iv) Iodine deficiency Disorder (IDD) Control Programme (v) Universal Polio Immunization Programme (UPIP).

11.2.9. Looking Ahead: The plan document mentions following desirables for its future plans:

- Professionalisation of Health Service Delivery:-This include
- Further specialization of Doctors, Nurses, Para Medical Staff and Multipurpose
- Health Workers in Training Institutes both outside and inside the State.
- Extensive use of Computers in office management, hospital management, inventory control, monitoring, date collection and reporting of facilities.
- To provide with Telemedicine 3 Hospitals and to cover District and Sub Divisional Hospitals during the 11th Five Year Plan.
- Restructuring of location of health facilities as per need and functional utility by GIS mapping of all facilities.
- To counter distance factor and to bridge this time divide, a public policy would be worked out to establish Call Centers on Health Information and advice on minor ailments etc.

- **Convergence of Activities:** To achieve the goals of convergence, high level Co-Ordination Committee are set up at State and District levels involving all concerned sectors to ensure best possible result during the Plan period.
- **Monitoring, Accountability and Transparency:** Monitoring is done at various levels. Regular audit is done by Accountant General and by the Chartered Accountants. It is proposed to improve monitoring by use of Information Technology and increased performance based accountability by decentralization and improving monitoring through concurrent sample surveys, social audit and institutionalizing community management at all levels through the committee in the Sub-Centers, PHC, CHC and Hospital levels.

- **Public Private Partnership (PPP):**

  - PPP exists in the form of recognition of specially hospital both within and outside the State for treatment for certain category of persons. The Department proposes to extend such facility to more specialty hospitals during the Plan period.
  - Hospital Management Societies will be set up in all hospitals, CHCs and PHCs involving NGOs under NRHM during the Plan period.
  - The issue of handing over and manage some public infrastructure, like sub- centers, PHCs, CHCs and Hospitals for private joint management would be considered by the Department.
  - The implementation of a comprehensive Health Insurance Policy for the people of the State is a key area where PPP is envisaged under the Plan period.
  - Training on Professional course for all categories of Doctors and Staff is under consideration on a tie up with medical Institution of repute.

- **Popularisation of Alternative Medicine System like AYUSH:-**
  - AYUSH will be established as a institution in all District Hospitals and CHCs.
  - Medicines and treatment as a supporting base will be provided to supplement other treatment.
  - All CHCs and Hospitals will be provided with at least 1 (one) Ayurvedic /Homoeopathic Physician.

- **Access to Essential Drugs:-**
  - All District Hospitals, CHCs and PHCs will support the need of common ailments with essential drugs.
  - Essential drugs will be provided through these Medical Institutions free of cost. The budget provision will be doubled for this purpose.

- **Focussed and integrated approach to National programmes of disease control-**

  The National Programmes on control of Communicable Diseases will also be continued, where special attention will be given to control of Malaria and Tuberculosis diseases to reduce the menace of the diseases. An Integrated Disease Surveillance Programmes has already been initiated and will be carried on. The same will be followed with respect to Scheme such as Establishment of Ayurvedic / Homoeopathic Wing in all the Districts.

- **Integration Of NRHM with National Health Programmes:** All national and state health programmes would be integrated with NRHM in order to enhance delivery of Health Services. This will be attempted to be done in a seamless manner by integrating structures, institutions, establishments and plans and programmes. Ayush would also be mainstreamed. A focused effort would be made for convergence with Water Supply Sanitation, Nutrition, and Welfare Programmes such a mental health, drug abuse, persons with disabilities etc.

11.2.10. Observations and Recommendations of the State Planning Board:

- There is no document pertaining to the maternal mortality rate (MMR). There is need to gather correct information on the MMR in the State.
- Recognition of the traditional system of medicine was stressed upon.
- Physically challenged persons need to be given proper health care.
- Awareness programmes on sanitation and health need to be undertaken.
- Potability of water used in CHCs and PHCs needs to be addressed.
- As far as health is concerned data could be collected family wise.
- Greater sensitivity to be shown to women when addressing health issues.
- Increase the number of maternity beds in health centres.
- Health is to be identified as the primary concern.

11.3. Education:

11.3.1 General Education

A. Elementary Education: The vision of the State is for Universalisation of Elementary Education along with universal access to schools and constantly improving quality of teaching and learning process. The aims and objective is for attaining total enrolment and retention of children in schools by the year 2010.The level of enrolment at the end of the 10th Plan is 488000 in the Lower Primary and 212000 in the Upper Primary stage. During 2007-08, the enrolment had increased to 518000 in the Lower Primary and 232000 in the Upper Primary stage. The physical target fixed for 2009-10 is 550000 in the Lower Primary and 265000 in the Upper Primary stage. The Sarva Shiksha Abhiyan (SSA) is a Programme for universalization of Elementary Education for providing quality education to the primary students.With the launching of the SSA programme and its various interventions the Department is making an effort to provide education of satisfactory quality, bridge the existing gaps in access, provision of infrastructure including educational curricula and teachers Training.

- **Financial Status of SSA from 2000-01 to 2007-08 :** Allocation approved by the Project Approval Board according to the AWP&B was **Rs.262.08 crore. Fund received** against the allocation - **Rs. 261.32 crore; Expenditure** incurred - **Rs. 200.08 crore; Unspent** balance at the end of 2007-08 - **Rs. 61.24 crore.**
- **Financial Progress of Implementation during 2007-08:** Approved **Outlay = Rs. 14007.306 lakhs; Expenditures = Rs. 9735.19 lakhs; Percentage** of Achievement - **69.50 %.**

- **Physical Achievement during 2007-08:** The status is as shown below:

Sl. No	Achievements :-	Completed/ Achievement
1.	No. of EGS Centres	1197 Nos
2.	Nos. of New L.P. Schools opened (including upgradation of EGS)	1604 Nos. (including 267 upgraded EGS)
3.	Nos. of LPS upgraded to Upper Primary Schools	1223 Nos
4.	TLE provided for LPS	1604
5.	TLE provided for UPS	1223
6.	School Grant	Rs. 2000/- per School released to all existing LPS and UPS
7.	Teacher Grant	Rs. 500/- per Teacher released to all existing LPS and UPS Teacher
8.	Text Books & Exercise Books	Provided to all children
9.	Teachers' Training	**A**. 7495 Teachers – 20 days, In-service Training; **B**. 534 Teacher – 30 days, Induction Training; **C**.3612 Teachers- Deputed to CPE against Target of 4400
10.	No. of BRCs/CRCs functioning	A. 39 BRCs functioning B. 437 CRCs " "
11.	Nos. of School given access to Computer Aided Learning.	132 UPSs

LPS- Lower Primary School; UPS – Upper Primary School; TLE – Teaching Learning Equipment;BRC – Block Resource Centre; CRC – Cluster Resource Centre; **Dropouts** -The total number of dropouts during the period are 27028 children. Implementation in progress.

- **Progress of Implementation during 2008-09:** The Physical achievement up to September 2008 under the Scheme is shown below:

Sl. No	Items of Works/Programmes	Completed/ Achievement	Target
1.	No. of EGS Centres	33022 Nos.	33022 Nos.
2.	New Primary Schools	Nil	497 Nos.
3.	Appointment of Teachers	3208 Nos.	4202 Nos
4.	Interventions for Disabled Children (i) Total CWSN enrolled (ii)CSWN provided assistive devices (iii) Teacher's Training (iv) Barrier Free Access	 3408 Nos. 32 Nos. 347 Nos. 272 Nos	 3630 Nos 1300 Nos. 780 Nos. 272 Nos
5.	TLE provided for New Primary	Nil	497

6.	TLE provided for New Upper Primary	Nil	298
7.	School Grant (i) Lower Primary (LPs)) (ii) Upper Primary (Ups)	Being collected -- do --	6618 2259
8.	Teacher Grant (i) Lower Primary (ii) Upper Primary	Being collected -- do --	16273 10599
9.	Text Books & Exercise Books	Nil Nil	410520 LPS 175525 UPs
10.	Teachers' Training (UPs) Training for untrained Teachers	4716 Nos. 918 Nos.	7023 Nos 1500 Nos.
11.	Block Resource Centres (i) Appointment of Resource Persons (ii) Contingency Grant (iii) Meeting, T.A. (iv) TLN Grant	 234 Nos. 39 Nos 39 Nos. 39 Nos	 234 Nos. 39 Nos. 39 Nos. 39 Nos.
12.	Cluster Resource Centres (i) Appointment of Resource Persons (ii) Furniture Grant (iii) Contingency Grant (iv) Meeting, T.A. (v) TLN Grant	 438 Nos. 111 Nos. 438 Nos 438 Nos. 438 Nos.	 438 Nos. 111 Nos. 438 Nos 438 Nos. 438 Nos.
13.	Civil Works	Nil	85201 Nos.

LPS- Lower Primary School; UPS – Upper Primary School; TLE – Teaching Learning Equipment; BRC – Block Resource Centre; CRC – Cluster Resource Centre

- **Financial Achievement 2008-09 upto september:** Approved **Outlay** for SSA + NPEGL + KGVB during **2008-09 = Rs. 16613.492 lakhs ; Expenditure** up to 1st Quarter = **Rs. 1201.99 lakhs; Cumulative Expendi**ture up to the 2nd Quarter ending 30.9.08 for SSA+NPEGL+KGVB =**Rs. 4359.44 lakhs;** The percentage achievement was **26.24 %.**
- **Statement of Expenditure up to September, 2008**

(Rs. in lakhs)

Sl. No	Name of Scheme (On -Going/ New) (CSS/ State Plan)	Approved outlay for the scheme during 2008-09	Achievement up to September, 2008
1	2	3	4
1	New Primary School	2815.560	157005
2	New Upper Primary School		
3	Block Resource Centre	97.500	68.76
4	Cluster Resource Centre	191.068	70.15
5	Civil Works	8335.960	1505.10
6	Toilets, Drinking Water		

7	Interventions for Out of School Children	1337.549	138.84
8	Interventions for Girls Children		
9	Innovative Activities	347.000	134.73
10	Interventions for Disabled Children	70.736	18.06
11	Maintenance Grants	227.000	-
12	Managements & MIS	731.360	108.97
13	Research & Evaluation	79.893	1.86
14	School Grants	489.030	205.02
15	Teacher Grants	134.360	103.93
16	TLE	248.400	8.70
17	TLM		13.520
18	Teacher Training	219.376	33.16
19	Community Mobilisation	25.124	13.27
20	SIEMAT		-
21	Free Text Books	1054.593	327.22
22	State Component	131.508	23.79
23	Others		
Grand Total Under SSA		**16536.017**	**4345.11**
24	NPEGEL		1.20.
25	KGVB	77.475	13.13
GrandTotal (SSA+NPEGEL+KGVB)		**16613.492**	**4359.44**

NPEGEL=National Programme for Education of Girls at Elementary Level; KGVB = Kasturba Gandhi Balika Vidyalaya. ***Source: Education Department, Meghalaya***

Mid Day Meal (MDM): The National Programme for Nutritional Support to Primary Education (NPNSPE) known as Mid Day Meal Scheme is being implemented in the State for providing cooked meals for every child in Govt. and Govt. Aided Primary Schools & EGS Centres and Upper Primary Schools. The cost for conversion of foodgrains has to be met jointly by the Govt. of India @ Rs. 1.80 per child per day and the State Govt. @ Rs. 0.20p per child per day for Primary level and Rs. 2.30 per child per day and Rs. 0.20p by Govt. of India and State Govt. respectively at the Upper Primary level. Kitchen devices are being provided by the Govt. of India @ Rs. 2500/- per school and Rs. 2000/- per EGS Centre. Govt. of India has provided fund also for Monitoring, Management and Evaluation (MME) of the Scheme. Construction of Kitchen sheds @ Rs. 60,000/- per school for 2539 Govt. LP Schools has been provided by the Govt. of India. An amount of Rs. 500.00 is proposed for State Share for Mid Day Meal Schemes.

Status of implementation: The Mid Day Meal Scheme is a National Programme started in the year 2005. The scheme is related with free distribution of food grains by Govt. of India through FCI where the transportation cost incurred by the DRDAs of the respective districts is to be reimbursed by the Govt. of India. Meghalaya as one of the special category state receive the maximum transport subsidy of Rs. 125 per quintal. Initially the scheme was implemented by free distribution of food grains to the children @ 3 Kg per child per month as dry ration. However, as per Supreme Court order in 2001 all the State Governments are directed to provide cooked Mid Day Meal containing

450 calories and 8-12 grams of protein per child per day.In Meghalaya, Mid Day Meal is given for 210 days in a year to all Governments and Government Aided Primary Schools and EGS Centre. **In 2008-09 Upper Primary Schools are also included under the schemes both Government and Government Aided.**

- **Mid Day Meal Schemes during 2007-08:** Total fund **received -Rs. 3003.79 lakhs; Expenditure** incurred-**Rs. 2979.23 lakhs; Unspent** Balance- **Rs. 33.26 lakhs** .
- **Financial Achievement for Upper Primary Schools in Educationally Backward Blocks for Year 2007-08:** Amount received-Rs. 434 lakhs; Expenditure-Rs. 4,04 lakhs; Total unspent Balance is Rs 7 lakhs.
- **Progress of Implementation during 2008-09:** Approved Outlay -**Rs. 1907.65 lakhs; Expenditure up to the 2nd Quarter** ending 30.9.08 **= Rs. 1498.70 lakhs**.The **percentage** achievement was **78.56 %. Physical Achievement up to September, 2008:** LP Schools-6618; UP Schools-2259; EGS-1197; **Total-10074**, against the target of **10,074 Schools.**

Enrollment up to September, 2008: Total achievement= 675512 against the target of 637266 ; The achievement is based on the release made as per sanctioned of the Government of India for 2007-08.

In order to clear the backlog of untrained teachers 2 year diploma course are being conducted by the DIETs. Further, teachers are being deputed in two cycles within a year for the certificate course for Primary Education (CPE) being conducted by IGNOU. There are also various short term training being conducted by DERT, DIET and at the Block Resource Centres. Maintenance of Govt. Schools and Govt. Office buildings and also for replacement of dilapidated Govt. schools. Maintenance of Non Formal Education Centres now EGS Centres under SSA is also done.

Adult Education: Adult Education programmes are also undertaken by the department which includes maintenance of staff under DAEO/DSEO, meeting the contingency, strengthening the Total Literacy Campaign(TLC), Post Literacy Project (PLP) and Continuing Education Programme (CEP) to remove illiteracy in the adults.

B. Secondary & Higher Education: Salaries to Govt. Establishment and recurring maintenance grant to Non-Govt. Institutions are being given by the Govt. Other programmes include provision of basic facilities like school buildings, furniture, Science equipments and Co-curricular activities like Science Seminar and exhibition etc. Besides maintaining the existing 74 Higher Secondary Schools, (18 Govt. and 56 Non-Govt.) there is a need to set up more Govt. Higher Secondary Schools through out the State in order to cater to the need of transferring the Plus two stage from the college to the school level. There is also a need for assistance for building, equipments etc. enhancement to Non-Govt. Higher Secondary School teachers. These would require considerable investment. There is a need to rationalise the grant in aid systems and reduce the burden on Govt. mainly in urban centres and to such institutions which have received aid for considerable continued period.

Creation of essential infrastructure for Higher & Secondary Education : With the attainment of statehood in 1972 many of the existing educational institutions were inherited from the Govt. of Assam. At present there are 8 Government Secondary, 19 Government Higher Secondary Schools and 3 Government Colleges in the State. The Government has also planned to provincialise 3 Colleges in the State soon. While the status of existing institutions shall have to be maintained, it is the vision of the Government to improve the quality of infrastructure in the educational

institutions in the State. It may also be mentioned that many of the old existing institutions are badly in need of renovation. However, during the past few years the Govt. has not been able to strengthen infrastructure due to fund constraint. Since good infrastructure is the key to quality education, there is an urgent need to strengthen infrastructure in Secondary and Higher educational institutions by upgradation and modernization of existing facilities, provision of well lit and well maintained school rooms in schools with provision of basic facilities like clean toilet, drink clean water and have good play facilities, many of which are lacking in schools in the State. Hostels facilities for students coming from the villages are urgently required.

The medium-term goal is to ensure these schools have enough classrooms, basic necessities such as water and toilets and facilities such as sports equipments, libraries, laboratories, hostels etc. Schools are ideal nurturing ground for instilling in children clean and healthy habits, but this is possible only when water and facilities exist.

College & Higher Education : According to UGC norms there shall be 5(five) Lecturer per subject in Government and Deficit grant-in-aid colleges, at present many colleges under deficit grant-in-aid are having only 2(two) Lecturers per subject. The state proposes to increase the strength of lecturers to 3(three) nos. per subject, subject to fund availability.

Language Development: The recognition of Khasi and Garo languages by the Sahitya Academy will depend on the enrichment of these languages in various field likes science, classics, folktales, cultural heritage. The promotion of language will be done through assistance to authors, translation and publication.

Youth Welfare Programme For Students (NCC & NSS): This programme is partly operated by the DHTE and major share opted by Director of Sports & Youth Services. The National Service Scheme covers students of College and University level. At present there are approximately 3000 NCC cadets which are not even 10% of the College/University student population. Efforts to increase the NCC, Scouts & Guides & Jr. Red Cross activities in the State to cover all the Districts / Sub-Divisions within the next five year plan and target at least 20 % of the student population are necessary to inculcate disciplined and strong youth force.The Ministry of Culture, Youth & Sports Department has approved the establishment of a State level NSS cell to be financed by the Govt. of India in order to increase the activities under the National Service Scheme.

Vocational Education / Skill Development : It is necessary to implement Vocational Education in right earnest so as to divert at least 25% of students completing 10 years education to the vocational stream, reducing the pressure on the universities and also preparing students for gainful employment. This would enhance individual employability, reduce the mismatch between demand and supply of skilled manpower and provide an alternative for those pursuing higher education thus ultimately diversify educational opportunities and bring about a change in the structure of the working population from the present rate of 2%-3% who are engaged in the industrial sector. The Government is encouraging the Private organization to establish Vocational institutions for offering short term courses on vocational education. At least 2 vocational institutes will be established in each district and 3 Secondary/Higher Secondary institutions will be identified for running courses in vocational education. At present Govt. is giving grant for vocational education to Don Bosco Technical School, Shillong.

C. Training : The programmes under the sector are being administered by the Directorate of Educational Research & Training (DERT). These comprises improvement of the quality of education through training of teachers, research and innovation including the development of curricula etc.

The Directorate of Educational Research and Training (DERT) is primarily involved in the task of improving and promoting the standard and quality of School Education and Teacher Education in the State through provision of In-service Trainings, holding of Seminars and Conferences, Workshops and undertaking Research Studies, Surveys and Innovative Programmes.

Long –term training: To help clear the backlog of In-service untrained Teachers at the Elementary stage, Long-term In-service Trainings for primary teachers are being conducted at the Government Basic Training Centres (BTCs) located at Shillong, Thadlaskein, Resubelpara and Tura as well as at the Non-Govt. Cherra Teachers Training Centre, Sohra. The duration of the training programmme is two year. Long-term In-service Trainings for Upper Primary Teachers are being conducted at the Government Normal Training Schools (NTSs) located at Sohra and Tura as well as at the District Institutes of Education and Training (DIETs) located at Sohra, Thadlaskein, Resubelpara, Nongpoh, Nongstoin, Tura and Baghmara. Untrained Primary Teachers are also provided training at the above DIETs during 2008-2009. As per the direction of the National Council of Teacher Education (NCTE) the duration of the Training Course is two years.

Basic Computer Training for U.P. School Teachers: 140 Upper Primary Teachers were provided training in Computer Awareness at the Computer Cell of the DERT, Shillong. This scheme will continue.

Other Schemes: State Level Screening Test for National Talent Search Examinations & State Talent Search Examinations; Intelligence Test for Talented Children from Rural Areas for award of National Scholarships at the Secondary Stage; Evening Coaching Classes for Tribal Students in Science, Mathematics & English in 92 (ninety two) Coaching Centres located in different districts; Grants-in-Aid to Meghalaya Board of School Education (MBOSE) and Training of Lower Primary School Teachers on foundation course for children with disabilities in Distance mode are some of the other schemes of the department.

EDUSAT: The uplinking Hub of the Educational Satellite has been installed and construction of sound proof studio and air conditioning of rooms is being made.

D. Technical Education: The Shillong Polytechnic falls under Technical Education with four (4) Streams namely, Civil, Mechanical, Electrical and Electronics besides sponsoring students for various technical courses outside the State. Technical Education is being augmented through introduction of additional courses in Shillong Polytechnic, namely, 3years Diploma in Computer Science and Engineering and 2 years post Diploma in Information Technology. Under the World Bank Assisted Tech Ed-III Project, two new polytechnics in Jowai and Tura respectively have been set up and the matter of taking over the management of two Polytechnics by the Government or a Society is under consideration. The new courses introduced are (1) Tura Polytechnic – Food Processing and Preservation (b) Computer Application (c) Medical Electronics and (2) Jowai Polytechnic – (a) Architectural Assistantship (b) Costume Design and Garment Technology (c) Automobile Engineering. **Community Polytechnic Scheme** sponsored by Govt. of India for training of school drop out, women and other disadvantaged groups in technical skills for gainful employment and transfer of technology for improving the local production and for generally improving the quality of life of the rural population is being implemented through Shillong Polytechnic. The various trades are motor driving and auto mechanic, welding and fabrication, plumbing and sanitation,

cutting and tailoring, house wiring. The state is likely to upgrade the Shillong Polytechnic to a Degree level Institution/Engineering College either on its own or in PPP mode. Besides the state permitted technical institutes, and private universities to function and hope to make the state a place of learning and educational hub (details in the infrastructure chapter).The state is committed to exploring the possibility of setting up more Technical Professional and Vocational Institutions under PPP Mode.

I.T. Education : A strategic IT vision for the State titled "IT Vision 2020" has been drawn up by the State Government to cover various aspects of ICT development for the State as well as for promoting IT education. The overriding focus of the vision is the creation of jobs through ICT within the State. Human Resource and Skill Development besides facilitating placements to youth and student will be the prime focus. The Government envisages reaping the benefits of ICT revolution in terms of jobs for local youths which will eventually increase the State GDP, socio-economic upliftment and improvement of human development indices. As of now, youth from the State are forced to migrate to other parts of the country to find jobs in IT/ITeS industries and software companies.IT Department has envisaged the need to have a finishing school in IT Sector. The school will provide training, expertise to students and youth and also create a talent pool to make them employable in the rapidly growing ICT sector and local needs of NeGP. The Government intends to train 2000 students over a period of 2(two) years thereby making them IT professional ready for the job market. It may be mentioned that NASSCOM (An autonomous body under Ministry of Communication & Information Technology) are scouting for 2000 students during 2007-08 for employment in the IT Sector but has not been able to reach the target.

11.4. Sports & Youth Services: Development of sports and games and also to take up relevant, youth welfare activities is important aspect of development facet. Necessary infrastructure and facilities right from the village and block levels to the District and State Level to promote physical fitness , discipline, and excellence in sports and all round development are important. More tournaments in various disciplines, creation of various state Sports Associations, participation in the Regional, National and International sports events, regular coaching and training facilities are some of the aspects needing attention.

11.5. Arts & Culture: Intensive Arts & Culture Dev. Programme and Development of Traditional & Folk Music and maintenance of Heritage Conservation are some of the programmes undertaken under this sector. **Performing Arts:** Promotion of Arts & Culture, Fine Arts and Literature is a vital field of activity of the Department. The Department is regularly imparting lessons free of charge in folk songs and dances and also in Western Music such as guitar and piano playing. Apart from participation in all major national festival, the department regularly associated with and sponsored artistes to participate in the Cultural Programme organized by the North East Zone Cultural Centre, Dimapur at various places with a view to promote cultural exchange between Meghalaya and the rest of the Country. **Research and Documentation:** Publication of the State Gazetteers, financial assistance to the budding authors to develop and promote literary works, and for production of folk literature, promotion of Garo and Khasi Languages, Museum activities such as collection of exhibits and artifacts , promotion of Traditional musical instruments and art and craft galleries. **The Development of Traditional Folk Music and for Intensive Arts & Culture Development Programme** respectively are schemes implemented by the choice of MLAs. Hence the sector has

hardly adequate allocation for the NGOs and associations. **Archaeology:** The preservation and protection of ancient monuments and historical sites in the States also could not make much progress due to shortage of fund. There are ancient and mid age archaeological sites which has not been developed owing to lopsides approach in the matter. **Library Services:** The State Central Library, Shillong and four District Libraries at Jowai, Tura, Williamnagar and Nongstoin, at Nongpoh, Sohra and Baghmara have been set up. The library services should be made available in all the District Headquarters of the State. **Archives:** The State Archives is still in the nascent stage. Only limited numbers of public records, etc. are available at present. Collection of old and valuable manuscripts. Documents, files from different district headquarters of the State and also from various States in India could not be done for want of space and accommodation. Further the services of trained personnel and better infrastructure are also required for the purpose. **State Museum:** The State Museum is considered as one of the centre of studies into the history and culture.

11.6. Social Welfare:

A. Welfare Programmes: The Department have undertaken a number of major initiatives in the Social Welfare Sector, such achievements are vocational training programmes, rehabilitation services to the disabled, training and capacity building for self employment. Schemes are implemented according to the type of disability, environment and social life of the disabled persons. In pursuance with the Disability Act, 1995 several programmes were incorporated towards the welfare and rehabilitation of the Disabled and Handicapped persons according to availability of funds. NGOs and Voluntary Organisations play a vital role in the development of the society and most of the schemes are implemented through NGOs/Voluntary Organisations by providing training and financial assistance to the NGOs and Voluntary Organisations. Effort is being made to mobilize the Non- Governmental Organisations to take up schemes of Central as well as State Sector.

B. National Social Assistance Programme: i) National Old Age Pension Scheme:- The Programme envisages payment of financial assistance to old age persons of the age from 65 years and above residing in the villages and urban areas who live below the BPL who are destitutes. The state pay @ Rs 200 pm at present to eligible old persons. **(ii) National Family Benefit Scheme:-** The Programme provides lump sum assistance of Rs 10,000/- to the households living below poverty line on the death of a primary bread winner in the age of 18 to 64 years to help to the immediate need of the family.

C. WELFARE OF HANDICAPPED : i) Scholarship to Physically Handicapped Students : The rate of scholarship for the physically handicapped is too meagre. During 2008-09, 592 students were covered. Such benefits should cover all the handicapped persons. **ii) Grant in aid to Voluntary Organisations :**Financial assistance is given to Voluntary Organisations for maintenance of special school, vocational training etc for the physically challenged person. The allocation is quite meagre.

iii) Assistance to Physically Handicapped Persons for Vocational Training/ for Self Employment: One year Vocational training is imparted to physically handicapped persons in carpentry, handicraft, knitting, tailoring etc. During the training period they are given a stipend of Rs.500/- per month each and an honorarium of Rs.800/- per month is given to the instructors. Here also the allocation is paltry. **iv) Implementation of the Disability Act, 1995 :** In pursuance of the Disability Act, 1995 disabled students are given financial assistance in the form of uniform grant, book grant, conveyance allowance, and unemployment allowance to the disabled persons. During 2008-09, 600 disabled students is covered under the Scheme.**v) Rehabilitation Treatment for the Disabled :**The main objective of the scheme is to rehabilitate the persons with disability as normal citizen which also include treatment of all types of disabilities. Under the Scheme, financial assistance for a maximum amount of Rs.25000/- for treatment outside the State is provided to the family whose income does not exceed Rs.3000/- per month based on the recommendation of the Government Medical Officer. **vi) NPRPD – National Programme for Rehabilitation of Persons with Disabilities :** The NPRPD started as a Central Sector Scheme with the basic objective of providing comprehensive rehabilitation services to persons with disabilities, especially in rural areas closer to their doorstep through a four-tier delivery system established at Community, Block, District and State levels. There is a provision for two Community Based Rehabilitation Workers (CBRWs) at the Community and two Multipurpose Rehabilitation Workers (MRWs) in districts covered under the scheme. A District Resource Centre have been set up at Shillong and Tura and also State Resource Centre was established at Shillong during 2002-03. The scheme has been made a State Scheme under which provision to maintain the CBRW/ SRC Shillong, Tura etc are required. **vii) Implementation of PWD Act, 1995 – Appointment of Commissioner of Disabilities :** In pursuance of Section 60 of the Disability Act, 1995, the full fledged Commissioner for Persons with Disabilities have been appointed .

D. Field Survey of Social Problems: Conducting the survey on problems of sexual abuse and trafficking of women and children; conducting survey to ascertain the deprivation of children in need of care and protection and other such requirements are also made.

E. Contribution to Meghalaya State Social Welfare Advisory Board is also made by the government.

F. Welfare Of Aged, Infirm And Destitutes: i) National Plan Of Action For Women Grant In Aids For Voluntary Organisation For Care Of Destitute, Widows, Aged And Infirm Women: Financial assistance is given to Voluntary Organisations working for the welfare of destitutes, widows, aged and infirm women are given under the scheme. However, the allocation are paltry. **ii) Medical Treatment for the Aged:** Enhanced rate proposed of Rs 2000/- per beneficiary are given to more than 170 aged persons. **iii) National Plan of Action for Older Persons :** In pursuance of the National Policy for Older Persons and Plan of Action of the Government of India to strengthen the legitimate place of the elderly in the society, advocacy meet/ sensitization programme for strengthening the integration and bond between the young and the old are conducted. **iv) International Day for Older Persons are celebrated on** October 1st .

G. Construction of Probationary Hostel and Reformatory School: The three homes set up under the Juvenile Justice Act 2000, are being housed in rented building with insufficient facilities and space. It is therefore necessary to construct own buildings/homes.

H. Women and Child Development: Women and Children are the most important section in our society more so where the society is matrilineal. Programmes for their welfare. Orphans, destitutes, children and deserted women require Government intervention to overcome their problems. Educating and raising women's economic status means educating and improving the economic condition of a family are most important. Children being vulnerable and helpless require a greater social, governmental and NGOs support in order to bring about a healthy environment amongst women and children in the State. **i) Grant-in-aid to Voluntary Organisations Working in the Field of Child Welfare to** voluntary organisations working for the welfare and development of children in rural areas like creches, orphanages etc. are given by the state Government. Motivation of the non-governmental organisations to take up other schemes such as foster care, adoption services, welfare services for street children and working children (Child Labour) are also stressed. **ii) Only 1** (one) Creche is run for the benefit of the State Govt. Employee's Children at Shillong. **iii) Correctional Services: i) Implementation of Children Act. Establishment of Juvenile Guidance Centre:** The Juvenile Justice Care and Protection of Children Act, 2000 which replace the Juvenile Justice Act 1986, clearly define that 2 (two) separate home should be set up for the delinquent juvenile i.e. Observation and Special Home and a separate Home for the neglected children known as Childrens' Home which may be run by NGOs with financial assistance 50:50 basis between the Central and State Government. **ii) Children's Home** for the reception and rehabilitation of child in need of care and protection pending enquiry report if any and subsequently for their care, treatment, education, training development and rehabilitation separately for boys and girls with 25 inmates and also to set up one Shelter Home for the children in the urgent need of care and protection such as destitute, street children and runaway children, requiring immediate shelter such as victim of domestic violence and trafficking etc . **iii) Grant in aid to Voluntary Organisations for Protective Homes and Anti Drug Campaign** and support the NGOs working in the field of women's issues for setting up of temporary shelter/protective homes for women who are victim of domestic violence and to organise sensitization programme for the police, judiciary, health personnel and N.G.Os. are also being done, **iv) Celebration of Anti Drug Day:** June 26th is observed as an International Day for Drug Abuse. The Department in collaboration with NGOs observes the Day in all the seven District Headquarters to highlighting the problems faced by the Drug users and prevention on Drug Abuse. **v) Intervention Programmes for Drug Abuse:** The problem of drug addiction is one of the main issues in the present day context and firm and rational measures are essential to combat this menace in the State.

I. Women Welfare:

i) Training Centre for Self Employment for Women in Need of Care and Protection: At present, the State Govt. is running 3 (three) training centres for 105 destitutes women. The training centres

impart training in tailoring, knitting, embroidery and weaving for a period of one year. During the training period a stipend of Rs. 500/- per month per trainee is given. After successful completion of the training, they are given a token grant of Rs. 5000/-, Rs. 4000/- and Rs. 3500/- respectively according to the grade they secured to enable them to start their own self employment. At present the above 3 training centres are located at Shillong, Jowai and Tura only with a capacity of 40, 25 and 40 respectively. It is felt necessary to diversify and upgrade the training in few more trades such as leather works, toy making etc in the training centre at Shillong since these trades have more employment/ income avenues. **ii)** Assistance to Voluntary Organisations for Setting up Training Centres for women and care of their children : Financial assistance is given to voluntary organisations working for the welfare of women in different activities such as handicrafts, training centres. **iii) National Plan of Action on Women's Policy and Empowerment:** The Department had initiated preparation of the State Plan of Action on Women's Policy and Empowerment. The Plan of Action incorporated programme action oriented on women's component and other related women's activities of allied Department. Effort is also being made for convergence and networking of women's development programmes at different level with NGOs which have strong presence at the community level for the empowerment of women. **iv) Meghalaya State Commission for Women:** The State Commission for Women was set up in the State during 2004-05 on the line of the National Commission. **v) Setting Up Employment -cum-Income Generating Units For Women (NORAD) :** The scheme to train women folks in different income generating trades so as to enable them to earn their livelihood and improve their economic status in the Training Centres for Self Employment for Women in need of Care and Protection. The objective of the scheme is to train women, preferably in the non-traditional areas and to ensure their employment.

J) SWARADHAR: The Government of India has designed a scheme known as 'Swardhar' with a more flexible and innovative approach to cater to the requirement of various types of women in distress in diverse situations under different conditions. The objective of the scheme is to provide primary need of shelter, food clothing and care to the marginalized women/girls living in difficult circumstances who are without any social and economic support and to rehabilitate them socially and economically through education.

K. Centrally Sponsored Schemes: The following Centrally Sponsored Schemes are being implemented by the Department : **i) Integrated Child Development Services Scheme:** 1 (one) State ICDS Cell attached to the Directorate of Social Welfare; 5 (five) District ICDS Cells with Head Quarter at Shillong, Tura, Nongstoin, Jowai and Williamnagar. 39 (thirty nine) ICDS Projects offices at Block Level Head Quarter(s); 2 Urban ICDS Project in Shillong and Tura with 190 AWCs. 3388 Anganwadi Centres and 1234 Mini Anganwadi Centres. Government of India has sanctioned so far 1725 anganwadi buildings. Each building has one room attached with kitchen, store room, water tank and toilet facilities @ of Rs.1.25 lakhs/ Rs.1.75 lakhs. 700 anganwadi buildings have been completed and construction of 457 Anganwadi buildings is under progress during 2008-09. Status of the programme has been mentioned under Rural development (chapter-7) **ii) Training Programme of the Anganwadi Workers under the ICDS Scheme:** Meghalaya has 2 (two) AWTCs, one at Shillong which caters to the ICDS functionaries from Khasi and Jaintia Hills Districts, the other at Tura covering Garo Hills Districts. Government of India has also sanctioned one MLTC

located in the State Headquater Shillong which conducted all training programmes of middle level field functionaries, and the lady supervisors. The MLTC also conduct the innovative training programme to in collaboration with SIRD and allied Department.The MLTC has also brought out publications and pamphlets, posters and have translated the materials in local languages (Khasi and Garo) to disseminate information on Nutrition, Health and Education etc. **iii Nutrition Surveillance System (NSS) :**The project is implemented through National Institute of Nutrition (NIN) Hyderabad in collaborative exercise between Department of Women and Child Development, NIN and the State Govt. The project involves training/ reviewing/ monitoring on the implementation of ICDS Programme at the district level and project levels and also involving anganwadi workers. **iv) Balika Samridhi Yojana (BSY) :** Balika Samriddhi Yojana (BSY) was introduced during 1997-98 and was implemented in the State covering 12357 beneficiaries. The Scheme aims at giving prime importance to a girl child to ensure population stabilization with gender equity and sustain socio-economic development. The benefits under (BSY) is restricted to two girl child. The BSY is part of the long term strategy to change social attitude and behavioural practices towards the girl child. **v) Kishori Shakti Yojana – KSY (Adolescent Girls Scheme) :**The scheme Kishori Shakti Yojana, a component of ICDS scheme aims to improve the nutritional health of the adolescent girls, promote awareness of health, hygiene, nutritional and family care, link them for learning life skill and take steps to become productive member. The scheme is in operation in all the 39 ICDS Projects as per the guidelines of Govt. of India. **vi) Integrated Women's Empowerment Programme (IWEP):** The objectives of the Scheme is establishment of self reliant women Self Help Groups (SHGs), creation of confidence and awareness among members of Self Help Groups, social, economic and political issues. Integrated Women Empowerment Programme is implemented in the 5 (five) Community and Rural Development Blocks viz; Betasing in West Garo Hills, Mawshynrut in West Khasi Hills, Resubelpara in East Garo Hills, Umling in Ri Bhoi District and Mylliem in East Khasi Hills. The first phase is over in 2006-07 and it has been extended to 2007-08. The second phase is to start from 2008. During the 2nd Phase, 6 Community and Rural Development Blocks is likely to be recommended for implementation of the scheme. **vii) Integrated Child Protection Services:** Under the Juvenile Justice (care and protection of children's) Amendment Act, 2006 it is mandatory to set up the child protection units as provided under section 62 A. Child Protection Unit for State and such Units for every District consisting of such officers and other employees as may be appointed by the Government, to take up matters relating to children in need of care and protection and juveniles in conflict with a view to ensure the implementation of this Act including the establishment and maintenance of homes, notification of competent authorities in relation to these children and their rehabilitation and co-ordination with various official and non-official agencies concerned. In Writ Petition (civil) No.473 of 2005 Sampurna Behrua Vrs Union of India & others, the department have given some kind of commitment/assurance that the constitution of the Child Protection Units would be taken up.

L). Nutrition: Schemes implemented under nutrition are as follows: i) Supplementary Nutrition in Urban Areas : S.N.P. in Urban Areas is provided to malnourished children below 6 years of age, expectant and nursing mothers of low income group in all the Districts headquarters. The programme is run by the District Social Welfare Officers through the non-governmental organisations and communities in 63 centres covering 13200 beneficiaries i.e. East Khasi Hills - 12 centres, West Garo

Hills - 10 centres, Jaintia Hills - 9 centres, East Garo Hills, South Garo Hills, Ri Bhoi District and West Khasi Hills District - 8 centres each. The cost of foodstuff given to each beneficiaries is @ Rs.1.20/- for children and @ Rs.1.50/- for pregnant and nursing mothers for 300 days in a year i.e. 25 days in a month. Foodstuff such as bengal gram, groundnut, soyabean, suji, dried peas are provided to the beneficiaries at the rate mentioned above. **ii) National Nutrition Mission :** National Nutrition Mission was introduced by the Government of India during the year 2002-03 for implementing subsidized foodgrains to adolescent girls, expectant and nursing mothers belonging to Below Poverty Line families and undernourished. In Meghalaya, East Khasi Hills District has been selected for covering seven ICDS Projects. The programme is to be implemented in the lines of weighing and identification of undernourished, distribution of 6 kgs of foodgrains (wheat/ rice) based on local habitual through Public Distribution System. Training in weighing, health and nutrition education, health check up, referral services, to conduct IEC programme and purchase of weighing scales. The programme is to be implemented through a network with the Department of Food and Civil Supplies and Deputy Commissioner of the concerned district for necessary arrangement of foodgrains and distribution through Public Distribution System. **iii) Supplementary NutritionProgramme for ICDS Scheme :** The Social Welfare is the Nodal Department in the implementation of Supplementary Nutrition Programme in the State i.e. by providing supplementary nutrition to children below 6 years, pregnant and nursing mothers and adolescent girls to improve the health and nutritional status of women and children in rural areas. In the implementation of SNP Scheme food stuff i.e. Bengal gram, Ground nut, Soya bean, Dried peas, Suji, Rice flakes, Green peas, Sugar, Onion, Mustard oil, and Iodised salt are being distributed to the beneficiaries through AWCs in the 39 ICDS. The present unit cost under S.N.P. per beneficiary per day is @ Rs.2.00p for 0 - 6 years children, @ Rs.2.70p for severely malnourished children, @ Rs.2.30p for pregnant mother, nursing mother and adolescent girls. The number of feeding days in a year is 300 days i.e. 25 days in a month . During 2008-09 , 589975 beneficiaries were covered under the Scheme.

M) Welfare of Scheduled Castes/Scheduled Tribes/ Other Backward Classes: The All India pre-Examination Training Centre (AIPETC) is meant for meeting the need for imparting Coaching Classes to SC/ST candidates who intended to appear at the Civil Services Examination conducted by UPSC every year.

11.7. Labour & Employment: i) Strengthening of the machinery such as Directorate, District Labour Offices and opening of Sub-Divisional Labour Office,for proper implementation of Labour Laws such as (i) Minimum Wages (ii) Child Labour Act and Rules (iii) Contract Labour Act and Rules (iv) Shop and Establishment Act and Rules (v) Motor Transport Act and Rules (vi) Inter State Migrant Act and Rules etc. **ii)Establishment of Labour Welfare Centres :** Labour Welfare Centres at Mendipathar, Byrnihat, Umiam and Khliehriat for providing free training in sewing, knitting and embroidery to the workers and their family members are done in the state. **iii) The Inspectorate of Boilers and Factories:** It has only a Skeleton Staff's since the date of its inspection in 1973. With the present trend of development in the field of Technology and the expansion of Industrial sector, where many industries have been set up in the state especially in the Medium Scale Sector, registration

and inspection of these factories and boilers are numerous and cannot be taken up only with the existing manpower. **iv)Employment & Training: a)Employment Services :**The Employment Wing is responsible for administration, control and supervision of the Employment Exchanges in the State. The main activities of Employment Exchanges include placement of registered unemployed youth against vacancies notified by Employers, Employment Market Information(EMI), for collection of employment and unemployment data and conducting Vocational Guidance Programmes to educated unemployed youth. The present system does have some constraints to take up such task. **(b) Craftsmen Training :** The Training Wing is responsible for implementing the Craftsmen Training Schemes(CTS) and Apprenticeship Training Schemes(ATS) at the Certificate level. The Craftsmen Training Schemes being implemented through a network of ITIs/ ITCs is the core Scheme for Vocational Training. Its objectives are to inculcate and nurture a technical and industrial attitude in the minds of the younger generation and reduce unemployment among the educated youth by providing them employable training.

With globalization, liberalization and entry of multinational Companies, the industrial sector has taken a new shape. The employment growth in the organised sector is on the decline. Vocational Training thus needs re-orientation so as to meet the requirement of the changing scenario which is envisaged to be achieved. Running of **Short Term Employment Oriented Course outside National Council of Vocational Training (NCVT)** pattern and taking **the skill development and mini ITIs** and more ITIS in PPP mode or by govt. is essential. – At a time when our youths are facing un-employment problem it is desirable to include new training programmes in the existing ITIs by running Short Term Employment Oriented Course as per the local requirement.

11.8 The Human Development Index [2]:

This section provides a comparative analysis of the level of human development in terms of the Human Development Index (HDI) and Gender related Development Index (GDI) among the states in India and among the districts in Meghalaya.

Human development is the combination of people's entitlements and attainments relating to education, health and livelihood. These three areas, taken together, form the everyday experience of 'development' for the people as individuals and as members of a community, state or nation. The concept of human development is a people-centred approach to development where the primary concern is enhancement of human well-being. Human development therefore corresponds to a holistic approach in the process of development.

The term *human development* denotes both the process of widening people's choices and the *level* of their achieved well-being. It also helps to distinguish clearly between two sides of human development. One is the formation of human capabilities, such as improved health and knowledge. The other is the use that people make of their acquired human capabilities, for leisure, productive purposes or being active in cultural, social and political affairs. If the scales of human development do not finely balance the two sides, considerable human frustration may result.

[2] Meghalaya Human Development Report, 2008.

Beginning with the first HDR of 1990 the UNDP has developed a summary indicator for the level of achievement in human well-being, called the Human Development Index (HDI). It measures achievements in the basic dimensions of human development – health, education and income. It is normalized to a scale of 0 to 1 where 1 implies that maximum human development is achieved as per the pre-defined norms and 0 implies no achievement at all.

The MHDR, 2008 have constructed the HDI for each district with the following key components. For the first component – a long and healthy life –the Infant Mortality Rate (IMR) has been used. For the second component – knowledge –two indicators, the literacy rate with two-thirds weight and the combined gross enrolment ratio (primary to higher secondary level) with one-third weight have been used. For the third component – a decent standard of living – is measured with per capita income.

Meghalaya ranks poorly in level of Human Development. Meghalaya ranked 24th in HDI in 1991. Its position has deteriorated from a rank of 21 in 1981. The HDI value of 0.365 is also lower than the All-India average of 0.381. This is the case when we take the combined HDI of rural and urban sectors. It reflects the situation in the rural areas due to the population weightage of the rural sector.

The picture in the urban sector, however, is different. The HDI has improved from a value of 0.442 in 1981, which incidentally is exactly equal to the All India average, to 0.624 in 1991, which is higher than the All India average of 0.511. The rank of urban Meghalaya in HDI over the same period improved from 21st to 10th. Obviously, this is a big leap forward [3].

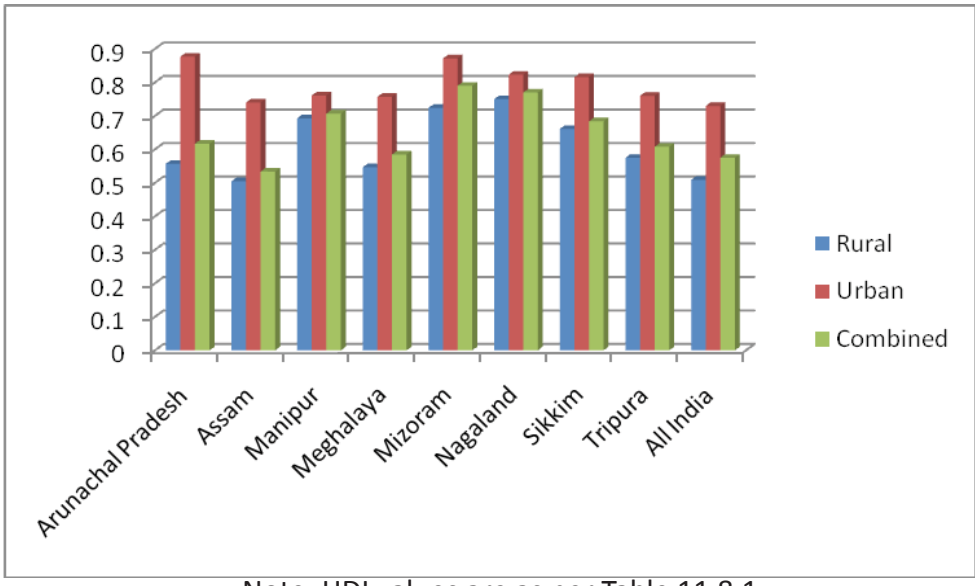
Among the North Eastern States, Meghalaya showed better performance than Assam and Arunachal Pradesh only. The other states of the region, namely, Manipur, Mizoram, Nagaland, Sikkim and Tripura showed higher achievements in human development in 1991.

The situation has further deteriorated in 2005. Although the HDI values are not directly comparable with those of the National Human Development Report, 2001; the ranking of the states may be compared. Out of the 35 states and Union Territories, Meghalaya ranks 26th in human development (Table 11.1) slipping two places down the ranking in 1991. The HDI rank for the rural areas of the state is 24^{t}h, same rank as in 1991; and for the urban areas, it is 22nd in 2005 down from a rank of 10th in 1991.

A closer look at some of the components of the HDI suggests that there has been stagnation or no development in Meghalaya in some areas. For instance, the IMR of Meghalaya has remained more or less constant in the recent years. In the spheres of education and income in Meghalaya, available data show that that there has been improvement and growth during the 25 year period of 1981 to 2005. However, the deterioration in the ranking of Meghalaya in HDI implies that the rate of development is slower than the rate in most of the states and hence many states have improved their ranking while Meghalaya has lagged behind.

[3] The HDI values of different States for 1981 are taken from the National Human Development Report, 2001.

Figure 11.8.1: Comparison of HDI Values among NE States in 2005



Note: HDI values are as per Table 11.8.1

Table 11.8.1: Human Development Index of States in India – 2005

State/UTs	Rural		Urban		Combined	
	Value	Rank	Value	Rank	Value	Rank
Andhra Pradesh	0.513	27	0.714	29	0.572	27
Arunachal Pradesh	0.557	23	0.877	1	0.617	22
Assam	0.505	28	0.740	25	0.534	29
Bihar	0.427	33	0.625	34	0.449	35
Chhatishgarh	0.470	30	0.690	31	0.516	30
Goa	0.753	3	0.818	9	0.779	6
Gujarat	0.534	25	0.758	21	0.621	20
Haryana	0.607	15	0.725	26	0.644	17
Himachal Pradesh	0.658	12	0.855	6	0.681	14
Jammu & Kashmir	0.569	20	0.716	28	0.601	24
Jharkhand	0.458	31	0.716	27	0.513	31
Karnataka	0.517	26	0.745	24	0.600	25
Kerala	0.799	1	0.856	5	0.814	2
Madhya Pradesh	0.427	34	0.663	32	0.488	33
Maharashtra	0.593	17	0.798	12	0.689	12
Manipur	0.693	10	0.761	17	0.707	11
Meghalaya	**0.547**	**24**	**0.757**	**22**	**0.585**	**26**
Mizoram	0.724	6	0.872	2	0.790	4
Nagaland	0.750	4	0.823	8	0.770	7
Orissa	0.417	35	0.639	33	0.452	34
Punjab	0.635	14	0.761	19	0.679	15

Rajasthan	0.485	29	0.691	30	0.537	28
Sikkim	0.661	11	0.816	10	0.684	13
Tamil Nadu	0.598	16	0.766	16	0.675	16
Tripura	0.575	19	0.760	20	0.608	23
Uttar Pradesh	0.454	32	0.618	35	0.490	32
Uttarakhand	0.585	18	0.761	18	0.628	18
West Bengal	0.567	21	0.757	23	0.625	19
Andaman & Nicobar Is.	0.707	9	0.864	4	0.766	8
Chandigarh	0.717	7	0.872	3	0.860	1
Dadra & Nagar Haveli	0.563	22	0.833	7	0.618	21
Daman & Diu	0.729	5	0.783	15	0.754	9
Delhi	0.712	8	0.796	13	0.789	5
Lakshadweep	0.783	2	0.805	11	0.796	3
Puducherry	0.654	13	0.791	14	0.748	10
All India	**0.509**		**0.730**		**0.575**	

Source: Special Calculations for the Meghalaya State Human Development Report by Veronica Pala.
For details of data and methodology used please see the Report(MHDR2008).

The district with the highest HDI is East Khasi Hills district followed by West Garo Hills district. The two major towns of the state namely, Shillong and Tura, are in these two districts and the relatively higher HDIs of these districts seem to suggest that human development in Meghalaya has been urban-centric. The other five districts exhibit HDIs that are lower than the state average.

Table 11.8.2: Human Development Indices of Districts of Meghalaya

District	Infant Mortality Rate	Literacy	Combined Gross Enrolment Ratio	NSDP Per Capita at current prices (Rs.)	HDI	HDI Rank
East Khasi Hills	34.51	76.98	63.10	24793	**0.676**	**1**
West Garo Hills	18.13	51.03	65.99	13782	**0.571**	**2**
Ri Bhoi	60.63	66.07	50.47	14752	**0.496**	**3**
South Garo Hills	102.01	55.82	85.52	23321	**0.484**	**4**
Jaintia Hills	77.34	53.00	43.31	20405	**0.469**	**5**
West Khasi Hills	86.17	65.64	79.13	9926	**0.405**	**6**
East Garo Hills	90.60	61.70	60.91	12047	**0.396**	**7**
Meghalaya	52.28	63.31	62.87	17595	**0.550**	

Notes and data sources:
(i) Infant Mortality Rates are as per the estimates obtained from the Birth & Mortality Survey, 2007
(ii) Literacy rates are as per the Census of India, 2001
(iii) The gross enrolment ratio is obtained by dividing the combined enrolment numbers by the population aged 5 - 19 years in 2001. The combined enrolment numbers are for Classes I - XII as per the All India Seventh Educational Survey, 2002.
(iv) Net State Domestic Product Per Capita at current prices are for the year 2004-05 provided by Directorate of Economics & Statistics, Government of Meghalaya.

The most backward district of the state as per our calculations is East Garo Hills. However, five districts out of seven have HDIs value that are lower than 0.5. The HDI scale is a 0 to 1 scale and if we take 0.5 as the half way mark of development, then all districts of Meghalaya except East Khasi Hills and West Garo Hills fall short of that mark. Put another way, they have not achieved even half of what is supposed to be done in the basic areas of human development. South Garo Hills has the highest IMR among all the districts, but because of highest enrolment ratio, it manages to claim position No. 4 in the HDI ranking.

Summing up it may be noted that the concept of human development is much broader and more complex than any summary measure can capture. The HDI is not a comprehensive measure. It does not include important aspects of human development, notably the ability to participate in the decisions that affect one's life and to enjoy the respect of others in the community. The indices give an overview of some basic dimensions of human development, but they must be complemented by looking at the underlying data and other indicators.

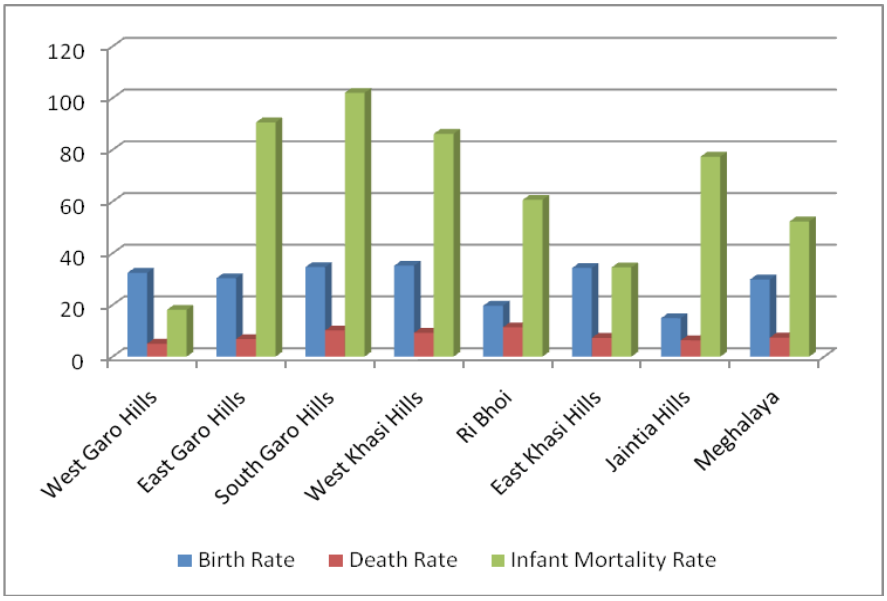
11.8.1. Health

The key indicators of the status of health of the people of Meghalaya do not show a happy picture. For instance, in 2002-04, full Immunisation Coverage for Children 12 - 35 months of age was only 14 percent, Coverage of Full Ante-Natal Care for Pregnant Mothers was only 12 percent and only 35 percent of deliveries are attended by skilled persons. The same indicators for the other North Eastern States are much better. Significant inter district variations are also observed. Full Immunisation Coverage for Children 12 - 35 months of age and Coverage of Full Ante-Natal Care for Pregnant Mothers are very low in the three districts of Garo Hills (Source: Rapid Household Surveys for RCH Services).

The IMR is one of the most important indicators of the health status because of its correlation with a number of health and economic characteristics like poverty, illiteracy, health and education of the mother, access to health care facilities and so on. The IMR in Meghalaya in 2007 is 52.28 per 1000 live births. South Garo Hills is observed to have the highest IMR (102) among all the districts. Other districts with IMR above the state average are East Garo Hills, West Khasi Hills, Ri Bhoi, and Jaintia Hills. In other words, the moderate IMR of the state is because of low IMR in East Khasi Hills and West Garo Hills only.

As per SRS survey, the IMR for Meghalaya in 2006 was 53. It is lower than the national average of 57. The rural IMR was 54 for Meghalaya, 62 for all India; urban IMR was 43 for Meghalaya and 39 for all India. Among the states in the North Eastern Region, Assam had the highest IMR of 67. The rest of the NE states showed IMRs that were lower than Meghalaya. Among the NE states, however, Meghalaya has the highest birth rate (24.7) and also the highest death rate (8.0) except Assam with death rate of 8.7 (SRS Bulletin, October 2007).

Figure 11.8.2: Birth Rate, Death Rate and Infant Mortality Rate in Districts of Meghalaya, 2007



Source: Birth and Mortality Survey, 2007

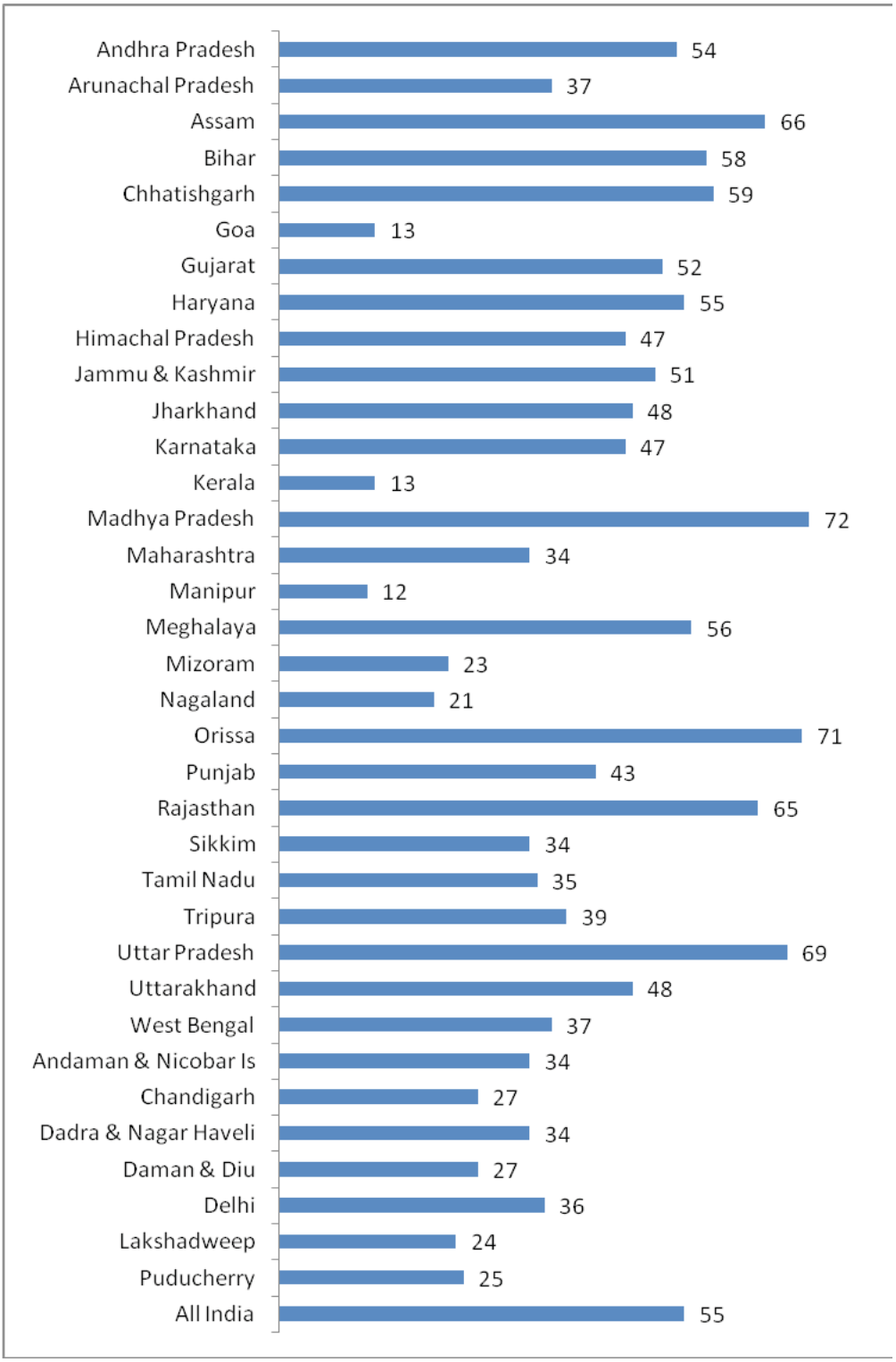
As per NFHS-3[4] (2005-06), the total fertility rate or number of children per woman in Meghalaya was 3.8. It has declined from 4.57 in 1998-99. However, this is much above the national average of 2.7. Other states with total fertility rate of 3 and above are Uttar Pradesh, Rajasthan, Madhya Pradesh, Jharkhand, Arunachal Pradesh and Nagaland. The contraceptive prevalence rate for currently married women is the lowest at 24 percent in Meghalaya among all the states in India. The national average is 56 percent. It is highest in Himachal Pradesh at 73 percent followed by West Bengal at 71 percent. A state closer to Meghalaya's performance in this regard is Nagaland at 30 percent.

Unmet need for family planning among currently married women is 13 percent for the country as a whole. Among the states, the lowest is 5 percent in Andhra Pradesh and the highest is Meghalaya with 35 percent. In addition to Meghalaya, more than 20 percent of women have an unmet need for contraception in Nagaland, Jharkhand, Bihar and Uttar Pradesh.

At the all India level, as per NFHS-3, 52 percent of mothers had three or more antenatal care (ANC) visits. Meghalaya's figure is slightly above the national average at 53.4 percent. However, other indicators are below the national level. The percentage of births assisted by doctors/ nurses/ LHV/ ANM or other health personnel is 31.7 percent in Meghalaya; 47 percent for all India. The percentage of institutional births is 29.7 percent in Meghalaya; 39 percent for all India. The percentage of mothers who receive post natal care from doctors/ nurses/ LHV/ ANM or other health personnel is 28.8 percent in Meghalaya; 42 percent for all India. Besides, Meghalaya is among the states where the provision of IFA (iron and folic acid) supplements was far below the national average.

[4] Available at http://www.nfhsindia.org

Figure 11.8.3: Infant Mortality Rates of the States/UTs of India, 2007



Source: IMRs for bigger states are for the year 2007; for smaller states and Union Territories they are based on three year period 2005-2007 (SRS Bulletin, Vol 43, No. 1, October 2008).

At the all India level 48 percent of children under 5 years of age are stunted and 43 percent are underweight. Wasting is quite as serious problem in India, affecting 20 percent of children. In Meghalaya, 42 percent are stunted, 46 percent are underweight and 28 percent are wasted. These figures point to a very sad state of Undernutrition.

Anaemia is a very common problem in India. 79 percent of children aged 6-35 months are anaemic in the country as a whole. In Meghalaya, the figure stands at 68.7 percent. NFHS-3 reports that although state differentials in the prevalence of anaemia are marked, a high prevalence of anaemia is found in every state.

Meghalaya, however, shows significantly lower levels of Undernutrition and Obesity among adult men and women. In Meghalaya 14 percent (36 percent in all India) of ever married women have BMI below normal. 8 percent (34 percent in all India) of ever married men have BMI below normal. In India, 15 percent of ever married women are overweight and obese. The figure is less than half of the all India average in Meghalaya at 7 percent.

Anaemia is a major health problem for adults as well as in children. It affects 55 percent of women and 24 percent of men in India. In Meghalaya too the problem is serious with significantly less gender differential. It affects 45.4 percent of ever married women aged 15-49 and 34.2 percent of ever married men aged 15-49 in Meghalaya. 56 percent of pregnant women in Meghalaya are anaemic. This leads to high prevalence of anaemia among children.

The key indicators of the status of health of the people of Meghalaya are worrisome, to say the least. Much more needs to be done to improve the health care services and health of the people of Meghalaya.

The state has acute shortage of specialized manpower and proper basic health care facilities especially in the rural areas. Most of the CHCs in Meghalaya function without specialists. For providing quality health care services and for making these services more accessible to the rural poor population of Meghalaya, the provision of quality manpower is equally important. Presently for Meghalaya, quality manpower especially in respect of responsibility and dedication is of more urgent need in addition to the number of medical and paramedical personnel. In this connection the focus on monitoring and supportive supervision is the need of the day to day activities. Further, there are concerns about the quality of service being provided to the people.

Meghalaya has no Medical College; the North East Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS), which is now commissioned and where the first batch of MBBS students have been enrolled, will have a 500 bedded Super-Speciality Hospital. However, there are a number of vacancies in the faculty in various departments.

For requirement of nursing staff, etc. there are 5 training centres in the public sector which include: 1 Regional Health and Family Welfare Training Centre, 2 GNM training centres, and 2 Nursing Training Schools and 1 ANM training school. The State Government had also submitted its requirement of 2 additional GNM Training Schools to be set up at Tura Civil Hospital and Jowai Civil Hospital.

Public investment has been recognized as an indicator of planning priorities. But investment in public health in the country as a whole – and in Meghalaya – does not show that health care has been given due importance.

The central resources to the overall public health funding have been limited to about 15 percent only. There is also inherent problem of absorption of programmatic fund due to various factors. The current annual per capita public health expenditure is no more than Rs 200. But with the launching of NRHM by the Government of India, it is expected that things will greatly improve. It remains to be seen how well the entire health sector absorbs the fund and the managers in the state leverage and perform under NRHM.

11.8.2. Education

The literacy rate of Meghalaya in 2001 is slightly lower than the national literacy rate. Rural literacy rates continue to be low. The total literacy rate in Meghalaya mainly is a reflection of the situation prevailing in the rural sector. The urban literacy rate in Meghalaya is in fact about 7 percentage points higher than the national literacy rate.

Table 11.8.3: District Wise Literacy Rates in Meghalaya by Place of Residence

Districts	1981			1991			2001		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Jaintia Hills	20.77	66.01	24.51	30.35	81.37	35.32	48.97	91.14	52.79
East Khasi Hills	31.95	65.25	43.73	46.36	83.68	60.04	63.72	88.65	74.74
West Khasi Hills	31.47	52.35	31.97	49.06	71.82	50.52	63.13	83.83	65.50
East Garo Hills	33.05	47.41	33.51	46.99	68.79	48.38	57.97	82.15	61.57
West Garo Hills	21.69	61.25	25.91	34.34	78.29	39.32	46.09	85.17	50.78
South Garo Hills	NA	NA	NA	NA	NA	NA	62.66	77.10	63.67
Ri Bhoi	NA	NA	NA	NA	NA	NA	52.28	83.96	55.21
Meghalaya	27.45	64.12	34.08	41.05	81.74	49.10	57.00	87.12	63.31
All India	29.65	57.40	36.23	44.70	73.10	52.20	59.40	80.30	65.38

Source: Census of India, 1981, 1991, 2001

There are wide intra state variations in educational achievement. West Garo Hills has the lowest literacy rate followed by Jaintia Hills District. In the state as a whole, we note that the female literacy rate is lower than male literacy rates in all the three years. This is more like what can be seen at the all India level except that the quantum of gender gap is much smaller (about 7 percentage points) in Meghalaya than all India (more than 20 percentage points). We observe a similar gender gap in the literacy between males and females among the districts in Meghalaya except for the Jaintia Hills District where the female literacy rate is higher than their male counterparts.

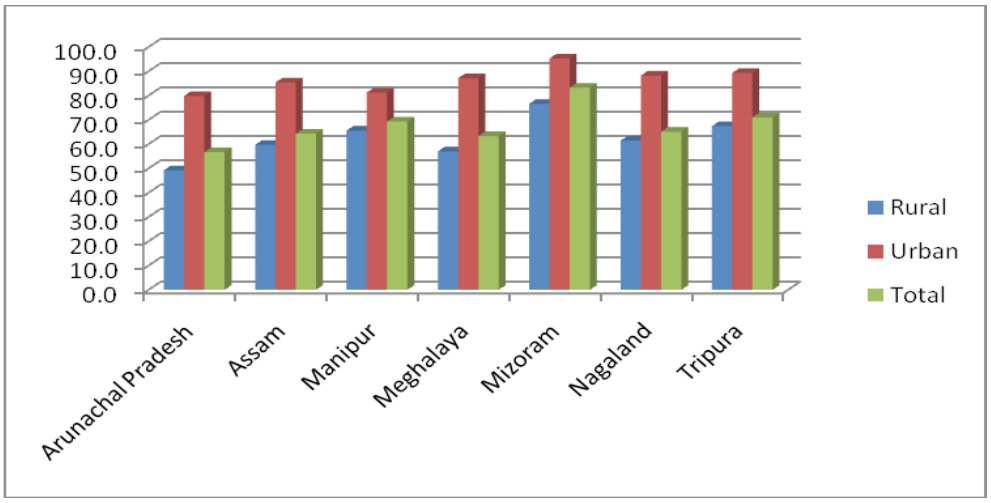
Table 11.8.4: District Wise Literacy Rates in Meghalaya by Sex

Districts	1981			1991			2001		
	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
Jaintia Hills	24.63	24.38	24.51	34.37	36.31	35.32	50.52	55.54	53.00
East Khasi Hills	46.96	40.30	43.73	62.86	57.04	60.04	78.12	75.82	76.98
West Khasi Hills	34.08	29.75	31.97	52.98	47.94	50.52	67.02	64.21	65.64
East Garo Hills	39.01	27.66	33.51	54.70	41.70	48.38	67.39	55.74	61.70
West Garo Hills	32.04	19.55	25.91	46.93	31.32	39.32	57.51	44.51	51.03
South Garo Hills	NA	NA	NA	NA	NA	NA	62.60	48.61	55.82
Ri Bhoi	NA	NA	NA	NA	NA	NA	69.22	62.67	66.07
Meghalaya	37.89	30.08	34.08	53.12	44.88	49.10	66.14	60.41	63.31
All India	46.89	24.82	36.23	64.13	39.29	52.21	75.85	54.16	65.38

Source: Census of India, 1981, 1991 and 2001.

Meghalaya is located in the northeastern region in arguably the most backward region of India. Here we have compared the literacy rates in other six states, namely, Arunachal Pradesh, Assam, Manipur, Mizoram, Nagaland and Tripura with that of Meghalaya. Meghalaya ranks second from the bottom after Arunachal Pradesh as per 2001 Census, though the literacy rate has increased considerably over the years. However, the situation in the rural sector of the state appears to be worse compared to the other states in the Northeastern Region. In 1981 about 28 percent of the rural population of Meghalaya was literate. This is the second lowest literacy rate in the region after Arunachal Pradesh (19 percent). Rural Meghalaya continued to be second ranked from bottom in 1991 as well as in 2001. The Urban sector of the state has done relatively better than the rural sector within the state though in terms of ranking, Meghalaya ranks fourth out of seven states in the region.

Figure 11.8.4: Literacy Rate in NE State (2001 Census)

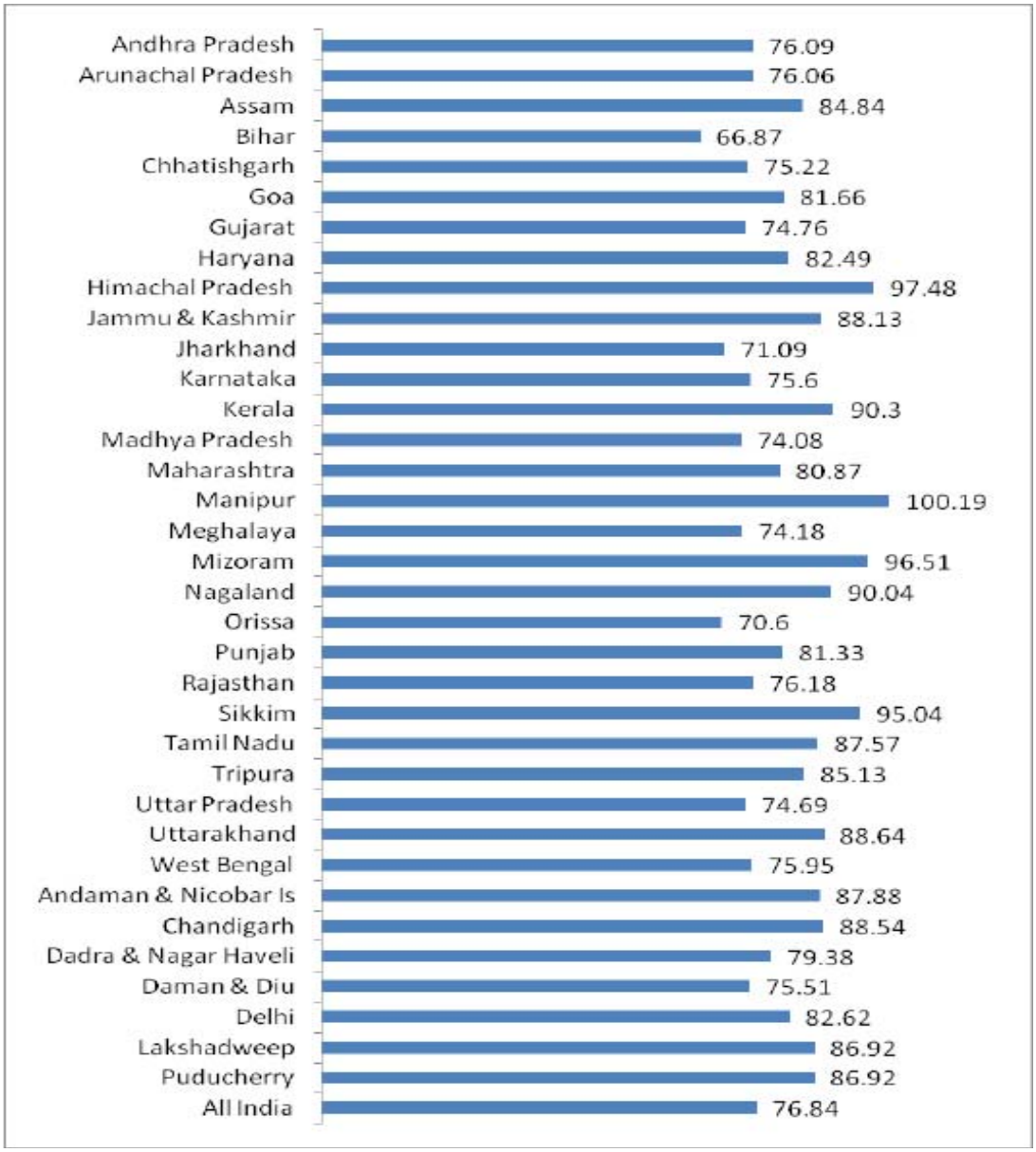


The combined enrolment ratios of Meghalaya indicate that the state is at a low level of achievement in this respect. A combined GER of 74.18 percent in 2004-05 as per NSSO estimates (see Figure 11.5) is lower than the all India average of 76.84 percent. The state ranks fifth from the bottom in enrolment among the 35 states and Union Territories in the country. Meghalaya is ahead of only Bihar (66.87 percent), Orissa (70.60 percent), Jharkhand (71.09 percent) and Madhya Pradesh (74.08 percent) in the combined gross enrolment of Classes I – XII in 2004-05.

There are significant intra state variations in enrolment as seen in Figure 11.6. Highest enrolment rate is observed in South Garo Hills with 85.5 percent and the lowest in Jaintia Hills with 43.31 percent. Female enrolment rates are higher in East Khasi Hills, Ri Bhoi, Jaintia Hills and West Khasi Hills. It appears that the notion that education for boys is not considered important since they will leave their parental homes for their wives' homes is still prevalent to some extent in the matrilineal societies of Khasi-Jaintia Hills. The gender gap in enrolment in the three districts of Garo Hills is negligible.

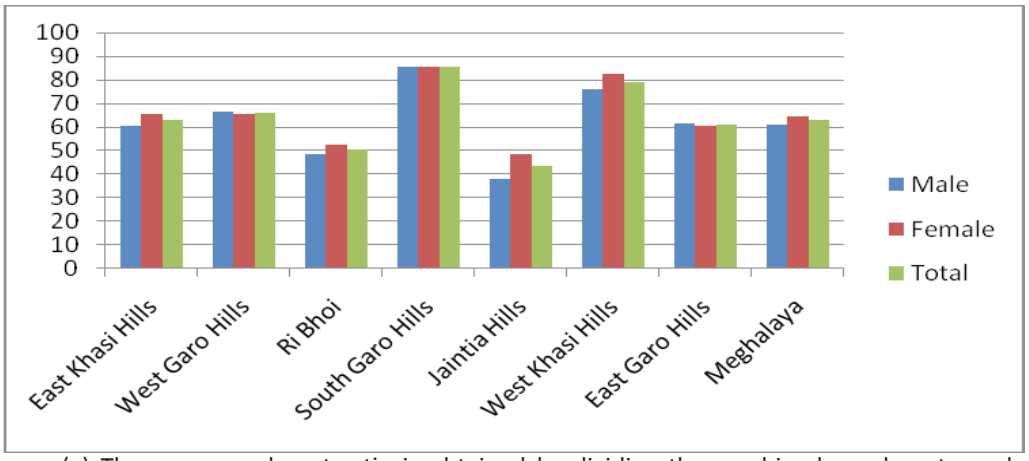
The GDI for Meghalaya is higher than most states in India. The reverse or negligible gender gap in enrolment in the mentioned districts is one of the main factors that lead to higher GDI.

Figure 11.8.5: Combined Gross Enrolment Ratios of the States/UTs in 2004-05



Note: Gross Enrolment in Classes I – XII in the age group of 6 - 18 years is taken into consideration.
Source: Special tabulation by Veronica Pala using unit record data of the National Sample Survey on Employment and Unemployment, 61st round.

Figure 11.8.6: Gross Enrolment Rates in Districts of Meghalaya by Sex in 2002



Note & Source: (a) The gross enrolment ratio is obtained by dividing the combined enrolment numbers by the population aged 5 - 19 years in 2001. The combined enrolment numbers are for Classes I - XII as per the All India Seventh Educational Survey, 2002.

Table 11.8.5: Gross Enrolment Ratio by Place of Residence and Sex (2004-05) (in %)

Standard	Rural			Urban		
	Boys	Girls	All	Boys	Girls	All
Meghalaya						
Primary	117.22	118.12	117.63	105.97	96.62	101.58
Middle	51.96	66.69	58.87	110.17	72.42	88.52
Secondary/Higher Secondary	44.29	48.46	46.28	91.47	93.76	92.66
Graduate and Above	1.29	3.32	2.36	16.91	12.67	14.53
All India						
Primary	112.05	106.86	109.63	105.92	100.10	103.09
Middle	80.96	69.44	75.57	85.35	82.71	84.07
Secondary/Higher Secondary	57.30	41.52	50.05	72.19	72.54	72.35
Graduate and Above	7.73	4.49	6.08	18.42	15.99	17.29

Source: Special Tabulation by Veronica Pala using NSS 61st round Employment and Unemployment Data.

The educational infrastructure leaves much to be desired especially in the rural areas. Indicator of 'quality school' is much more than just construction of **pucca** building. Other infrastructural facilities like drinking water facilities, proper toilet facilities including the provisioning of separate toilets for girls, etc. are very important to assess the quality of educational infrastructure.

Table 11.8.6 reveals that 18.3 percent of Lower Primary (LP) schools and 24 percent of Upper Primary (UP) schools do not have buildings of their own. 25 percent of LP schools and 20 percent of UP schools are in dilapidated condition. 60 percent of LP schools and 91 percent of UP

schools need additional classrooms. Only 22 percent of LP schools have drinking water facility. 57 percent of LP schools and 73 percent of UP schools are without toilet facilities and only 5 percent and 11 percent of LP and UP schools respectively have separate toilet for girls. Only about a quarter of the schools have playgrounds and 99 percent do not have kitchens for midday meals.

Table 11.8.6: Educational Infrastructure Gaps in Primary Schools of Meghalaya, 2005-06

Stage	Total Schools	Schools without Own Building	Schools in dilapi-dated Condition	Schools requiring Additional Classrooms	Schools without drinking water facility	Schools without Toilet facilities	Schools with Girls' Toilet	Schools with play-ground	Schools without kitchen for midday meals
Number									
LP	5851	1070	1488	3532	1336	3363	298	1354	5820
UP	1759	423	347	1599	NA	1286	190	492	1742
Total	7610	1493	1835	5131	1336	4649	488	1846	7562
Percentage									
LP	100.00	18.29	25.43	60.37	22.83	57.48	5.09	23.14	99.47
UP	100.00	24.05	19.73	90.90	NA	73.11	10.80	27.97	99.03
Total	100.00	19.62	24.11	67.42	NA	61.09	6.41	24.26	99.37

Source: Directorate of Elementary and Mass Education, Government of Meghalaya, Shillong.

Thus educational infrastructure gaps in Meghalaya gravely indicate the sorry state in which many of the schools are provision, extension and maintenance of the school buildings along with the basic facilities like drinking water and toilets should be given utmost importance and priority.

Over the years Meghalaya has made considerable progress as far as literacy and education is concerned. Besides, literates in Meghalaya are more evenly distributed across households in both rural and urban sector than all India. Further, though there are some indications of gender gap and rural-urban gap prevailing in the state it is much lower than that for the country as a whole. However, there exists intra-state disparity in literacy rates and distribution of schooling facilities in Meghalaya. There is also a lack of access to schools beyond primary level and higher educational institutions especially in the rural areas that adversely affects school participation and literacy in the state.

A lot needs to be done to improve the access to basic infrastructure including increasing the number of teachers especially trained teachers thereby improving the quality of teaching. In addition, there is a need to construct more schools and higher educational institutions, evenly distributed across the state. This will contribute positively towards school attendance and enrolment.

11.8.3 Poverty

The official poverty ratios (as reported by the Planning Commission) are reported separately only for Assam from among the states in the NER. For remaining seven states in the region, i.e. including Meghalaya, the poverty ratios of Assam have been assigned. Since the poverty ratios

used by the Planning Commission, GOI for Meghalaya are those of Assam, we have no reliable data on the incidence of poverty in Meghalaya.

The Ministry of Rural Development, GOI advised all the States and Union Territories to conduct the BPL Census for identifying the households living below the poverty line at the beginning of every Five Year Plan. The Government of Meghalaya conducted the BPL Census in 1997 and 2002.

Table 11.8.7: Poverty Incidence in C&RD Blocks of Meghalaya as per BPL Census, 2002

C&RD Block/ District/State	Total Households	BPL Households	Percentage of BPL Households
Jirang	5078	3551	69.93
Umling	11065	4390	39.67
Umsning	16447	8335	50.68
Ri Bhoi District	**32590**	**16276**	**49.94**
Amlarem	7185	3735	51.98
Khliehriat	10759	3390	31.51
Laskein	10931	3364	30.77
Saipung	5155	2780	53.93
Thadlaskein	15741	6394	40.62
Jaintia Hills District	**49771**	**19663**	**39.51**
Mairang	15533	7089	45.64
Mawkyrwat	10203	5046	49.46
Mawshynrut	9623	4968	51.63
Mawthadraishan	8532	3698	43.34
Nongstoin	10279	4672	45.45
Ranikor	9781	5007	51.19
West Khasi Hills District	**63951**	**30480**	**47.66**
Khadarshnong Laitkroh	6307	3355	53.19
Mawkynrew	8594	3976	46.26
Mawphlang	14492	9594	66.20
Mawryngkneng	10960	5236	47.77
Mawsynram	11941	6615	55.40
Mylliem	35540	10936	30.77
Pynursla	12278	6986	56.90
Shella Bholaganj	9003	4299	47.75
East Khasi Hills District	**109115**	**50997**	**46.74**
Betasing	13094	7391	56.45
Dadenggre	7893	4354	55.16
Dalu	8827	4417	50.04

C&RD Block/ District/State	Total Households	BPL Households	Percentage of BPL Households
Gambegre	7469	4208	56.34
Rongram	9628	5370	55.77
Selsella	23355	12252	52.46
Tikrikilla	10544	5790	54.91
Zikzak	14889	7618	51.17
West Garo Hills District	**95699**	**51400**	**53.71**
Dambo Rongjeng	8830	4208	47.66
Kharkutta	9229	5201	56.35
Resubelpara	15400	10582	68.71
Samanda	6151	3566	57.97
Songsak	10788	4635	42.96
East Garo Hills District	**50398**	**28192**	**55.94**
Baghmara	5428	1931	35.57
Chokpot	5286	2778	52.55
Gasuapara	4136	2481	59.99
Ronggara	3298	1036	31.41
South Garo Hills District	**18148**	**8226**	**45.33**
Total State	*419672*	*205234*	*48.90*

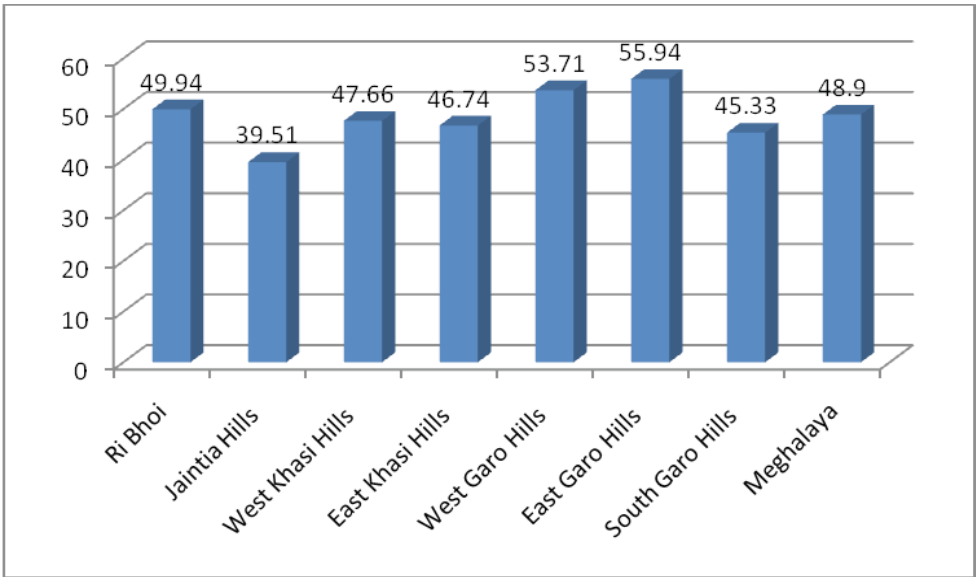
Source: Community & Rural Development Department, Government of Meghalaya.

Table 11.8.7 shows that the proportion of households living below the poverty line is a staggeringly huge figure at 48.9 percent. East Garo Hills district has the highest incidence of poverty at 56 percent followed by West Garo Hills district at 54 percent. Jaintia Hills district has the lowest proportion of households below the poverty line at a little less than 40 percent. The incidence of poverty in the other districts is in the range of 45 – 50 percent.

However, the use of different score limits for different Blocks makes comparison impossible across the Blocks and districts except in cases where the poverty line (score limits) are the same. That is, two households which have more or less the same standard of living may be classified as poor in case of one household and non poor in case of another if they happen to be in two different Blocks with different score limits.

Estimation of the incidence of poverty as measured by the proportion of people living below the poverty line hinges crucially on the poverty line and how it is defined. There are several problems associated with the concept of poverty line, especially in Meghalaya and the other NE states as highlighted in this chapter. Nevertheless, poverty is pervasive and is evident to anyone who takes a look at the living conditions of the people of Meghalaya, especially those who reside in the remote rural areas of the state.

Figure 11.8.7: Proportion of Households Living Below the Poverty Line in Districts of Meghalaya in 2002



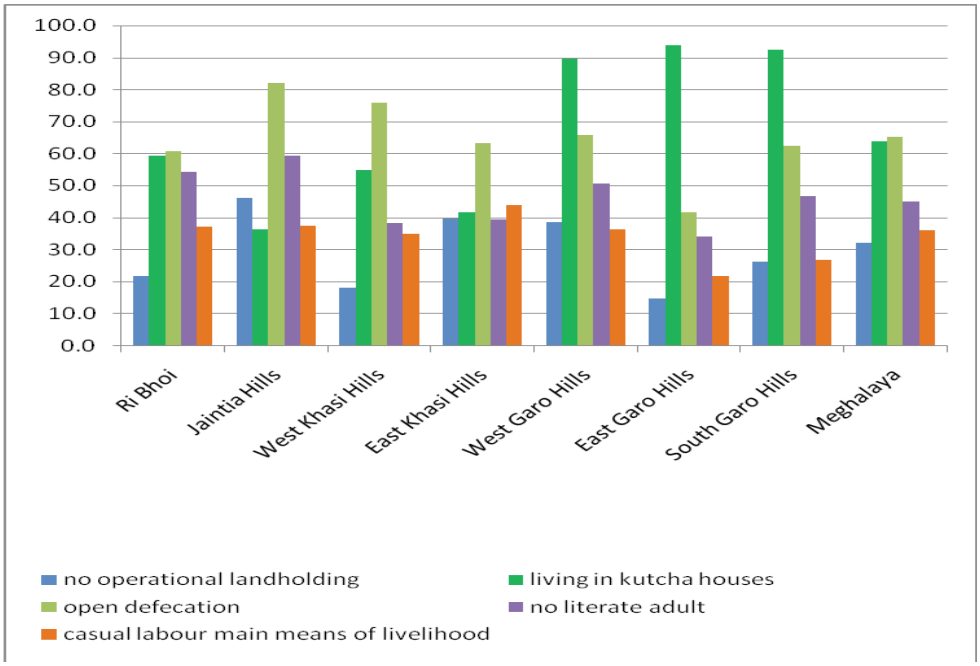
Source: BPL Census, 2002

The BPL Census, by using the score based ranking method, provides us with very important insights into the living conditions of the people of Meghalaya. The 13 indicators shed light, among others, on the adequacy of food, clothing and shelter; educational status and the assets that the people possess; the important means of livelihood and the type of assistance that the people prefer.

In the entire state of Meghalaya, 31.9 percent of households score 0 in indicator 1. In effect, this gives the percentage of households with no operational size of landholding, while 44.3 percent have less than 1 hectare of un-irrigated land or less than half a hectare of irrigated land. 63.7 percent live in kutcha houses and 22 percent live in semi-pucca houses. More than half, i.e. 58.2 percent have only 2-3 pieces of clothing per person. In respect of food, we note that 50 percent of households have two square meals a day with occasional shortage (score 3) and 18 percent of households have adequate food throughout the year. 5 percent of households suffer from acute hunger getting less than one square meal a day for major part of the year. 65 percent score 0 in sanitation. In other words, 65 percent of households resort to open defecation. 45 percent of households score 0 in literacy status of the highest literate adult. This means that 45 percent of households had no literate adult in 2002. A large proportion of households (39.4 percent) reported that their highest literate adult studied upto primary level only.

Rural indebtedness is a problem for many households of Meghalaya. 35.7 percent reported that they borrowed for daily consumption purposes from informal sources, i.e. friends, relatives and moneylenders. 16 percent borrowed for production purposes but from informal sources. We note that institutional credit is not significant at all in the rural areas. Only 2.5 percent of households borrowed from institutional sources. 32 percent of households reported no indebtedness.

Figure 11.8.8: Selected Indicators of Poverty, 2002



Note: The figure shows percentages of households in each category out of the total households in each district.

Source: BPL Census, 2002.

Coming to the status of households in labour force, we observe that 54.4 percent reported that only adult males work, while 11.7 percent reported that only adult females work and there is no child labour. 8 percent of households had to send their females and children to work. Most of the households derive their livelihood from vulnerable sources. We observe that 41.9 percent reported subsistence cultivation as their means of livelihood while 36 percent of households get their livelihood from casual labour. 3.5 percent of households were artisan households. Child labour is common in Meghalaya. 26.8 percent of households have at least one child who works and does not go to school at all. 25 percent of households have at least one child who goes to school and works at the same time. Only 27.6 percent of households send all their children to school.

Most of the rural households (63.6 percent) were non-migrant households. 14.3 percent migrated for casual work, 10.9 percent migrated for seasonal employment and 6.1 percent migrated for other forms of livelihood. Coming to preference for assistance from the Government, 44 percent of households would like to get help in starting their own enterprises. 20.4 percent would like to get wage employment or Targeted Public Distribution system and 20.1 percent would like assistance for housing. Only 4.1 percent wished to have training or skill upgradation assistance. Ownership of consumer durables is another important indicator of the standard of living. 77.6 percent of households did not own any consumer durables like TV, radio or modern kitchen appliances.

Measurement of poverty critically depends on the poverty line definitions which should be current or access to goods and services besides assets on the score card or other socio-economic parameters that captures real situation and proper survey. The chapter suggests appointing a panel

of experts to assess and devise a proper methodology and course of action to define and determine the people below poverty line at current level for Meghalaya. To address the multifaceted face and challenge of poverty and deprivation we require a multifaceted approach involving policy and action.

Stagnant agriculture, low productivity, and lack of backward and forward linkages need to be addressed upfront. Helping small farmers and to increase productivity through investment, subsidy and appropriate linkages should be our focus. Stress on non-farm activity that bolster traditional and private sector activities, with special attention to micro enterprises would also be needed in the rural areas.

Many well-conceived poverty alleviation programmes seeking to empower rural poor through group efforts supplemented by agriculture and allied activities and social services like education, health and social welfare, water and sanitation, and labour welfare measures already exist. All that is required is effective delivery mechanisms and instruments so that these reach the intended beneficiaries.

11.8.4 Gender Related Issues

Gender issues assume special significance since the major tribes of Meghalaya follow a unique system of matriliny. As far as the Gender-related Development Index (GDI) is concerned, Meghalaya is in a better position compared to most of the states in India. The GDI rank of Meghalaya was 12th in 1981 and improved to 7th in 1991 [5]. However, the GDI could not be calculated in 2005 due to lack of data.

Table 11.8.8: Gender Related Development Index of Districts of Meghalaya

District	Sex	Population	IMR	Literacy	Combined gross enrolment ratio	Share in economically active population	Ratio of female to male rural labour wage	NSDP at current prices (Rs in lakh)	GDI	GDI Rank
East Khasi Hills	M	333187	27.26	78.12	60.67	63.03	0.679	171616	0.640	1
	F	327807	41.43	75.82	65.55	36.95				
West Garo Hills	M	259440	18.96	57.51	66.42	59.82	0.825	74764	0.550	2
	F	256373	17.32	44.51	65.54	39.99				
Ri Bhoi	M	99315	53.09	69.22	48.64	57.52	0.729	29769	0.478	3
	F	93480	68.28	62.67	52.39	42.47				
South Garo Hills	M	51051	88.08	62.60	85.74	55.38	0.813	24796	0.477	4
	F	48054	114.99	48.61	85.30	44.63				
Jaintia Hills	M	149376	97.64	50.52	37.94	57.10	0.683	63756	0.437	5
	F	146316	55.80	55.54	48.71	43.00				
East Garo Hills	M	126312	96.75	67.39	61.46	54.77	0.846	31630	0.392	6
	F	121243	84.83	55.74	60.36	45.26				

[5] Please refer the National Human Development Report, 2001

West Khasi Hills	M	149159	91.51	67.02	75.91	53.91	0.544	30692	0.321	7
	F	144956	81.14	64.21	82.53	46.06				
Meghalaya	M	1167840	51.55	66.14	61.12	58.51	0.742	427024	0.534	
	F	1138229	52.99	60.41	64.67	41.47				

Notes and data sources: As in Table 11.2

The gender-related development index (GDI), measures achievements in the same dimensions using the same indicators as the HDI but captures inequalities in achievement between women and men. It is simply the HDI adjusted downward for gender inequality. The ranking of the districts by GDI is exactly the same as the ranking by HDI with one exception. West Khasi Hills replaces East Garo Hills at the bottom of the GDI ranking.

The GDI values show the existence of gender inequality in all districts. However, it may be said that in the spheres of health (as captured by the Infant Mortality rate), education (as captured by the literacy rate and enrolment rate) and income, gender imbalance in Meghalaya is prevalent at a lower degree compared with most other states in India. This is because of lower gender gap in literacy and enrolment as well as higher female labour force participation. In four districts of East and West Khasi Hills, Ri Bhoi and Jaintia Hills, we observe a reverse gender gap in enrolment, i.e. female enrolment rates are higher than male enrolment rates. In the three districts of Garo Hills, on the other hand, the gender gap in enrolment is negligible.

West Khasi Hills has the lowest GDI among all the districts. The reason lies in the disparity of wages between men and women. As per the data on Rural Labour Wages collected by the Directorate of Economics and Statistics, Government of Meghalaya in 2005, the ratio of female to male wages is 54 percent in West Khasi Hills. The ratio is 68 percent in East Khasi Hills and Jaintia Hills, 81 percent in South Garo Hills, 83 percent in West Garo Hills, 85 percent in East Garo Hills and 73 percent in Ri Bhoi.

The GDI of Meghalaya, as discussed earlier, is higher than most of the states in India. This is because of high workforce participation of women and negligible gender gap in school enrolment. Female literacy rates in Meghalaya are lower compared to males, although with a significantly lower gender gap. However, the indicators of women's health show that there are serious inadequacies in maternal health care, use of family planning methods and nutrition.

It may be noted here that higher participation of women in the labour force may be looked at from two aspects and the work participation rate itself will not convey whether women's welfare is improved or not with high participation. For poor and uneducated women, working or not working is not a choice. They have to work to support their families and their burden is actually more, since generally they have to attend to domestic chores as well. With high level of fertility, this burden is compounded along with the psychological burden of seeing their children work and not attending schools. On the other hand, being a worker increases the independence and decision making power of the women within their respective households. For educated women who can command higher wages in the labour market, higher participation in the labour force definitely increases their welfare and has a direct relation with women empowerment.

Women in Meghalaya have a higher status compared to their counterparts in the patrilineal societies. Women inherit the parents' property - acquired and ancestral. Women get the better share as the custodian of the property and the keeper of the home and hearth. For women coming from poor or landless families these property rights are meaningless. However, their responsibilities are no less than their landed counterparts.

When it comes to public life, the mindset and long-held views and attitude against women still pose a major obstacle for women to enter electoral politics. Authority in its real sense is the exclusive preserves of men. Local administration is completely under the domain of men.

Women in Meghalaya suffer from problems of illiteracy, poverty and malnutrition, male drunkenness and family discord. Cases of domestic violence and sexual crimes also are not unheard of. These problems are universal and the prevalence of matrilineal system does not guarantee gender equality and absence of gender related discrimination.

Chapter 8 of the Meghalaya State Human Development Report also outlines some of the programmes undertaken to promote women's empowerment in the state. The achievement of these programmes has been minimal in terms of the number of beneficiaries. Much more needs to be done for upliftment of women, especially women belonging to the poor and vulnerable sections of the society.

11.9 Conclusion

Meghalaya may be considered to be a case of unfulfilled potential in many ways. The rich natural resource base of the state has been sub-optimally utilised. Therefore, the challenge ahead is to harness the resources to the full potential and more importantly, to bring the fruits of development to the people, especially the poor and the powerless.

Achievements in the sphere of human development have been mainly urban centric. The rural and remote areas remain under developed and large numbers of people in these areas still do not have access to basic health care facilities and proper schools. Lack of rural infrastructure development limits the opportunities for better livelihood. Further the existing system of governance needs reforms to improve the delivery mechanism.

In the struggle for enhancement of human welfare the challenges ahead are many. Provision of social services like education, health, water supply and nutrition should be given topmost priority. The state should strive for enhancement of the level of human well being through creation of essential infrastructures, provision of educational avenues including diversified training for skill development, generation of employment opportunities, extensive health care, adequate attention for women and children welfare, improvement of environment, and provision of safe drinking water supply and sanitation.

Generation of employment, particularly in the rural areas should be one of the state's top priorities. For Meghalaya, we see great potential for creation of jobs in the rural areas in the field of post harvest management, agro processing and tourism. There is a need to increase

employment in non-agricultural sector and rural non-farm sector with development of clusters around towns/market centres. Learning from experiences gained from the implementation of the Self Help Groups (SHGs) and watershed based approach on livelihoods under North Eastern Region Community Resource Management Programme and Livelihoods Improvement Programme assisted by International Fund for Agriculture Development (IFAD), it is important to cover all areas of the State under livelihood improvement programme with adequate investment and appropriate institutional mechanisms. Reforms of planning and development structure by converging programmes may see better outcomes. There is an urgent need to upgrade skills of our youth to enable them to stand on their own feet. A skill development mission for the rural areas may be evolved and supported.

Participation of the people at the grassroot level in planning process has made a beginning through the implementation of the National Rural Employment Guarantee Act (NREGA) in the state. The government of Meghalaya has evolved a system of village employment councils consisting of both elected representatives at the village level and the traditional heads of village and tribal institutions in these councils. This will ensure the participation of village people in the formulation, execution and monitoring of plans locally, in a democratic manner. The government may plan to expand the concept for people's participation in planning and development as envisaged in this Report. Both for addressing the issue of poverty and for addressing the demand side of agriculture, all districts of Meghalaya have been now covered under National Rural Employment Guarantee Act (NREGA).

The augmentation of the standards of public services like education, healthcare, water supply, sanitation, housing, etc. requires significant commitment of additional resources by the government. Branches of good quality schools should spread to our blocks and villages. Good quality model schools need to be established in each Block of Meghalaya. One Central school/ Navodaya Vidyalaya or equivalent with hostel facilities should be set up in each Block for tapping and promoting available rural talent in Meghalaya. Further, we need more specialized seats for our in-service doctors who will provide better health service.

Summing up, improvement of health care services; increasing the number of quality schools and skill development centres; developing alternative and sustainable models and means of livelihood; and participatory development strategy are major areas that should be given top priority and utmost importance for promoting human development in Meghalaya. The real challenge, however, is to bring the benefits of development to the backward and poor sections of the society, especially in the remote rural areas. Reforms in governance are a must to enable and ensure the participation of the poor to enhance quality of life and to derive the fruits of development in the State.