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Progress towards
Millennium Development
Goals in Gujarat

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I. INTRODUCTION

India is a signatory of the United Nations Millennium Declaration (United Nations, 2000) which called for a new global partnership to reduce extreme poverty. The Declaration was the result of the collective commitment of 189 countries to overcome the poverty and the realization that business as usual would not be enough to combat poverty. The Declaration has set out a seven-point agenda for achieving human dignity, equality and equity at the global level and is based on six values – freedom, equity, solidarity, tolerance, respect for nature and shared responsibility.

The Millennium Agenda

1. Peace, security and disarmament
2. Development and poverty eradication
3. Protecting our common environment
4. Human rights, democracy, good governance
5. Protecting the vulnerable
6. Meeting special needs of Africa
7. Strengthening United Nations

The framework for measuring the progress of the Millennium Development Agenda comprises eight Millennium Development Goals (MDGs) which are to be achieved by the year 2015. To monitor these goals, 18 targets have been set and 48 monitoring indicators identified. The list of monitoring indicators has since been expanded to 53. These goals, targets and monitoring indicators have now been globally accepted as a yardstick for measuring and monitoring nations’

progress and analyzing the impact of social and economic development processes in terms of improvements made in the quality of life of people across and within countries and environmental sustainability.

In India, the progress towards MDGs has been mixed (Government of India, 2010). The country has made significant progress towards reducing poverty and universalization of primary education but progress has been slower than expected in reducing child mortality, improving maternal health and promoting gender equality. The analysis also reveals that within the country, region or across states, disparity in progress towards achieving MDGs has been quite substantial and appears to have persisted over time. It is argued that reducing inter-state disparity in achieving progress may go a long way in accelerating India’s progress towards MDGs. There is therefore a need to analyze regional or state-specific progress.

Therefore, the need to carry out a sub-national analysis of the progress towards achievement of MDGs is all the more important and relevant in India both because of social, cultural, economic and environmental diversity that is so pervasive in the country and also because India is a Federal Republic in which state governments are primarily responsible for meeting the development and welfare needs of the people and are therefore responsible for realizing the Millennium Development Agenda. The diversity in the development discourse in India requires that progress towards MDGs is analyzed at the sub-national level preferably across social groups so that results of the analysis leads to development planning and programming which has maximum impact on the quality of life of the people.

Millennium Development Goals

Goal	Targets	Indicators
1: Eradicate extreme poverty and hunger	1. Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below \$1 per day (PPP-values) 2. Poverty gap ratio [incidence x depth of poverty] 3. Share of poorest quintile in national consumption
	2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children (under five years of age) 5. Proportion of population below minimum level of dietary energy consumption
2: Achieve universal primary education	3. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	6. Net enrolment ratio in primary education 7. Proportion of pupils starting grade 1 who reach grade 5 8. Literacy rate of 15-24 years old
3: Promote gender equity and empower women	4. Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	9. Ratio of girls to boys in primary, secondary and tertiary education 10. Ratio of literate females to males of 15-24 years old 11. Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliament
4: Reduce child mortality	5. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of 1 year old children immunized against measles
5: Improve maternal health	6. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
6: Combat HIV/AIDS, Malaria and other diseases	7. Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	18. HIV prevalence among 15-24 years old pregnant women 19. Contraceptive prevalence rate 20. Number of children orphaned by HIV/AIDS
	8. Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective

Millennium Development Goals

Goal	Targets	Indicators
		malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)
7: Ensure environmental sustainability	9. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	25. Proportion of land area covered by forest 26. Land area protected to maintain biological diversity 27. GDP per unit of energy use (as proxy for energy efficiency) 28. Carbon dioxide emissions (per capita) [Plus two figures of global atmospheric pollution: ozone depletion and the accumulation of global warming gases]
	10. Halve, by 2015, the proportion of people without sustainable access to safe drinking water	29. Proportion of population with sustainable access to an improved water source
	11. By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	30. Proportion of people with access to improved sanitation 31. Proportion of people with access to secure tenure
8: Develop global partnership for development	12. Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system. Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally	32. Net ODA as percentage of DAC donors' GNI. [targets of 0.7% in total and 0.15% for LDCs] 33. Proportion of ODA to basic social services. (basic education, primary health care, nutrition, safe water and sanitation). 34. Proportion of ODA that is untied 35. Proportion of ODA for environment in small island developing states

Millennium Development Goals		
Goal	Targets	Indicators
	13. Address the Special Needs of the Least Developed Countries	36. Proportion of ODA for transport sector in land-locked countries
	14. Address the Special Needs of landlocked countries and small island developing states	37. Proportion of exports (by value and excluding arms) admitted free of duties and quotas
	15. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	38. Average tariffs and quotas on agricultural products and textiles and clothing
		39. Domestic and export agricultural subsidies in OECD countries
		40. Proportion of ODA provided to help build trade capacity
		41. Proportion of official bilateral HIPC debt cancelled
		42. Debt service as a percentage of exports of goods and services
	16. In co-operation with developing countries, develop and implement strategies for decent and productive work for youth	43. Proportion of ODA provided as debt relief
44. Number of countries reaching HIPC decision and completion points		
17. In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	45. Unemployment rate of 15-24 year olds	
18. In co-operation with the private sector, make available the benefits of new technologies, especially information and communications	46. Proportion of population with access to affordable essential drugs on a sustainable basis	
	47. Telephone lines per 1000 people 48. Personal computers per 1000 people	

Source: United Nations (2003)

This report is an attempt to analyze the progress and prospects of MDGs in Gujarat, one of the constituent States of India. The report is divided into two parts. The first part of the report analyses the prospects of achieving MDGs in the State on the basis of available data while the second part analyses social class and urban-rural differentials in selected indicators related to MDGs. A district-level analysis has not been attempted here and is planned for a later date.

A major challenge in analyzing progress and prospects of MDGs at the State and sub-state levels is the availability of appropriate data. The availability of relevant data decreases as one goes down the administrative hierarchy. In the absence of appropriate development data system at the state and district levels, the only option available is to use the data generated through the nationally organized census and surveys such as the National Sample Survey (NSS), National Family Health Survey (NFHS) and District Level Household and Facility Survey (DLHS) and Census 2011.

Use of data available from different sources, however, raises the issue of data compatibility as definitions used in different surveys are generally not uniform. Moreover, combining the data and information available from different sources may still not ensure the availability of time series data for different indicators to facilitate analysis. As such, the present analysis is restricted to only those MDGs indicators for which information is available from different existing sources for at least three points of time during the period 1990 through 2012.

II. METHODOLOGY

The methodology adopted for the present analysis of the MDGs in Gujarat comprises the following steps:

1. The first and the perhaps the most important step is to prepare annual time series of selected MDGs indicators for which information is available for at least three points in time during the period 1990-2012. This requires substantive interpolation and extrapolation which has been carried out using the average annual exponential rate of change between two points of time for which information is available.
2. The second step in the analysis is projecting the trend up to the year 2015 on the basis of annual time series for the period 1990-2012. This projection exercise is carried out using time series analysis technique. The SPSS software package has been used for the purpose. The 'model builder' option of the 'Forecasting' module was applied to estimate projected values for the period 2013 through 2015.
3. The third step in the analysis is to estimate the target level of a MDGs indicator on the basis of the level that prevailed in 1990. For example, one of the MDGs is to reduce child mortality by two-thirds from the level that prevailed in 1990. This means that the target level of child mortality for the year 2015 is one-third of the level that prevailed in the year 1990. Once the target for the year 2015 is estimated in the above manner, targets for different years of the period from 1990 through 2015 are estimated assuming the exponential rate of change between 1990 and 2015.

4. Comparing the projected value of an indicator to its target value to ascertain whether an MDG would be achieved or is likely to be achieved or will not be achieved by the stipulated date (year 2015). A Goal is considered to have been achieved if an indicator related to the Goal has reached a certain pre-defined absolute value called the cut-off value. If the projected value of an indicator is either equal to or is better than the target value in the year 2015, then the conclusion is that the MDG will be achieved and the progress towards the Goal is termed as satisfactory. On the other hand, if the projected value differs from the target by a maximum of 10 per cent of the target value in the year 2015, it may be concluded that the Goal is likely to be achieved. In this case, the progress towards the Goal is termed as satisfactory. Finally, if the projected value of the indicator falls short of the target value by more than 10 per cent, it may be concluded that the Goal in question will not be achieved with the current level of efforts. In this case, it is inferred that the progress towards the Goal is unsatisfactory.
5. The above exercise has been carried out for all the indicators included in the present analysis but not for all the 48 original and 5 extended indicators simply because the information related to all the 53 indicators is not available for the State of Gujarat. Moreover, some of the MDG indicators are not relevant for State-level analysis.

The list of MDGs indicators that has been used in the present analysis is given below. As already discussed, the main criteria for selecting the indicator for the present analysis has been the availability of the information necessary to estimate the indicator through a population-based census or survey. Moreover, some of the indicators used in the analysis are proxy to MDGs indicators as they reflect the situation in the State better than the MDGs indicator.

MDGs	Indicator	Source
Goal 1	1. Proportion of the population below the poverty line	National Sample Survey
	2. Proportion of children aged 0-3 years low weight for age	National Family Health Survey
Goal 2	3. Net enrolment ratio in primary education	DISE
	4. Literacy rate of persons aged 15-24 years	National Family Health Survey
Goal 3	5. Ratio of girls to boys in primary school enrolment	DISE
	6. Ratio of female literates to male literates in the age group 15-24 years	National Family Health Survey
Goal 4	7. Under-five mortality rate	National Family Health Survey
	8. Infant mortality rate	Sample Registration System
	9. Proportion of children 1 year old immunized against measles	National Family Health Survey
Goal 5	10. Maternal mortality ratio	Sample Registration System

	11. Proportion of births attended by skilled health personnel	National Family Health Survey
Goal 6	12. Contraceptive prevalence rate	National Family Health Survey
	13. HIV prevalence among females attending antenatal clinics	National AIDS control organization
Goal 7	14. Proportion of area covered with forests	Department of Forests
	15. Proportion of population with access to safe drinking water	National Family Health Survey
	16. Proportion of people with access to improved sanitation	
Goal 8	17. Unemployment rate among 15-24 years old	
	18. Telephone density	
	19. Personal computers	

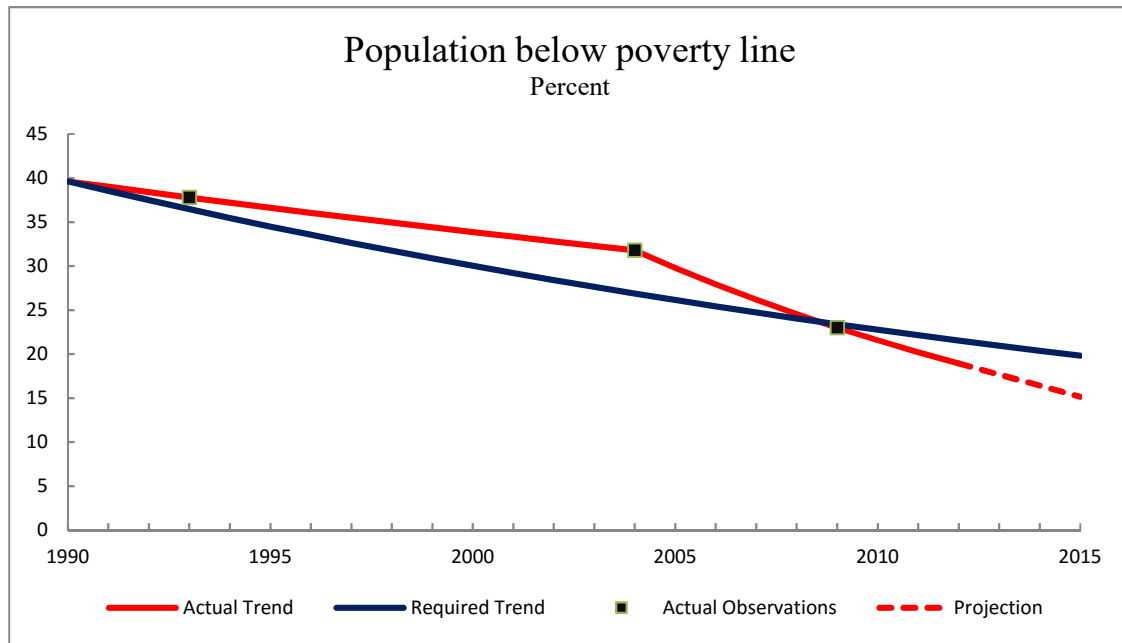
MILLENNIUM DEVELOPMENT GOAL 1

Eradicate extreme poverty and hunger

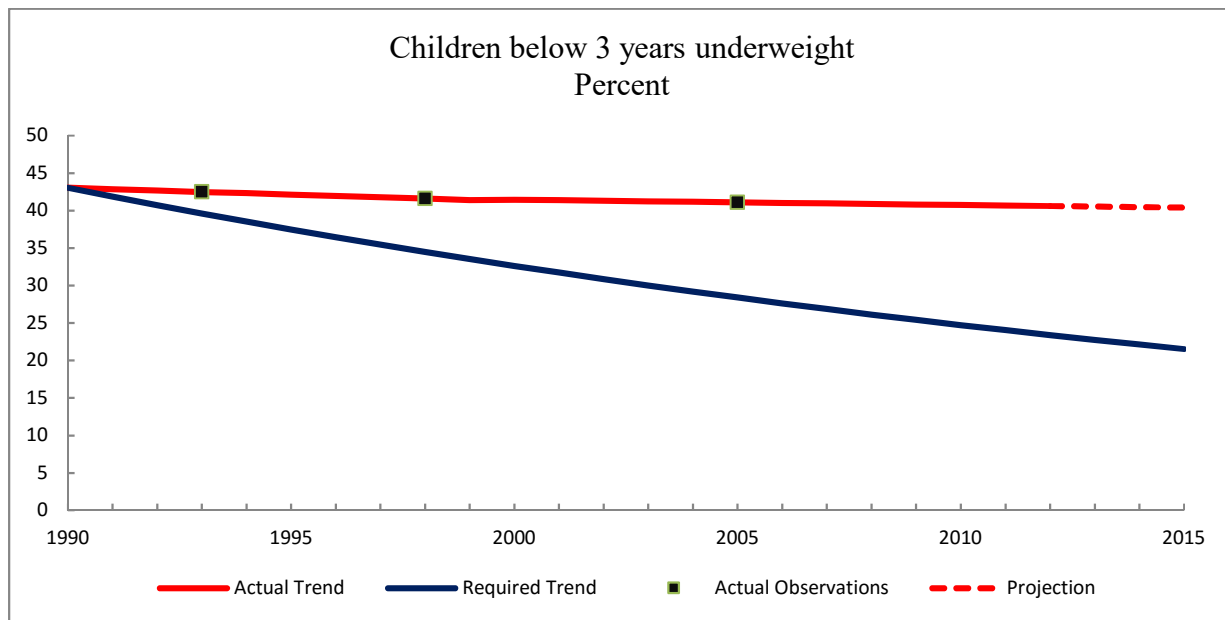
*Halve, between 1990 and 2015,
proportion of people whose income is less than one dollar a day*

Year	Monitoring indicators	
Trend and projection	Proportion of population below the poverty line (Percent)	Proportion of children (0-3 years) low for weight (Percent)
1990	39.62	43.05
1995	36.63	42.14
2000	33.86	41.46
2005	29.80	41.10
2010	21.56	40.75
2015	15.14	40.40
Target for the year 2015	19.81	21.52
Prospect for 2015	The target is already achieved	The target is unlikely to be achieved
<i>Progress</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>

Estimates of the proportion of the people having income of less than one dollar a day are not available for Gujarat. However, the State has done exceptionally well in reducing the proportion of population living below the official poverty line. As a result, the target to be achieved by the year 2015 appears to have already been achieved. It is projected that by the year 2015, only around 15 per cent of the population of the State will be living below the official poverty line. This proportion is substantially lower than the target of 20 per cent. It can therefore be concluded that the State's progress in achieving this MDG indicator is satisfactory.



However, progress in terms of the proportion of children aged 0-3 years who are low weight for age remains a serious cause for concern and is a major development challenge for the State. The decrease in the proportion of children below 3 years of age who are low weight for age has at best been marginal since 1990 and by the year 2015, the State will be falling significantly short of the target.



The State needs to make significant additional efforts to accelerate the reduction in the prevalence of undernourished children. Current efforts to tackle the problem of child under nutrition in the

State are organized under the centrally sponsored Integrated Child Development Scheme. These efforts do not appear to be sufficient. The State government should go beyond the Integrated Child Development Scheme to tackle the challenge of under nutrition. Rapid reduction in poverty provides a unique opportunity to the State to take up this challenge. State innovations in this direction may become a trend-setter in other States of the country.

MILLENNIUM DEVELOPMENT GOAL 2

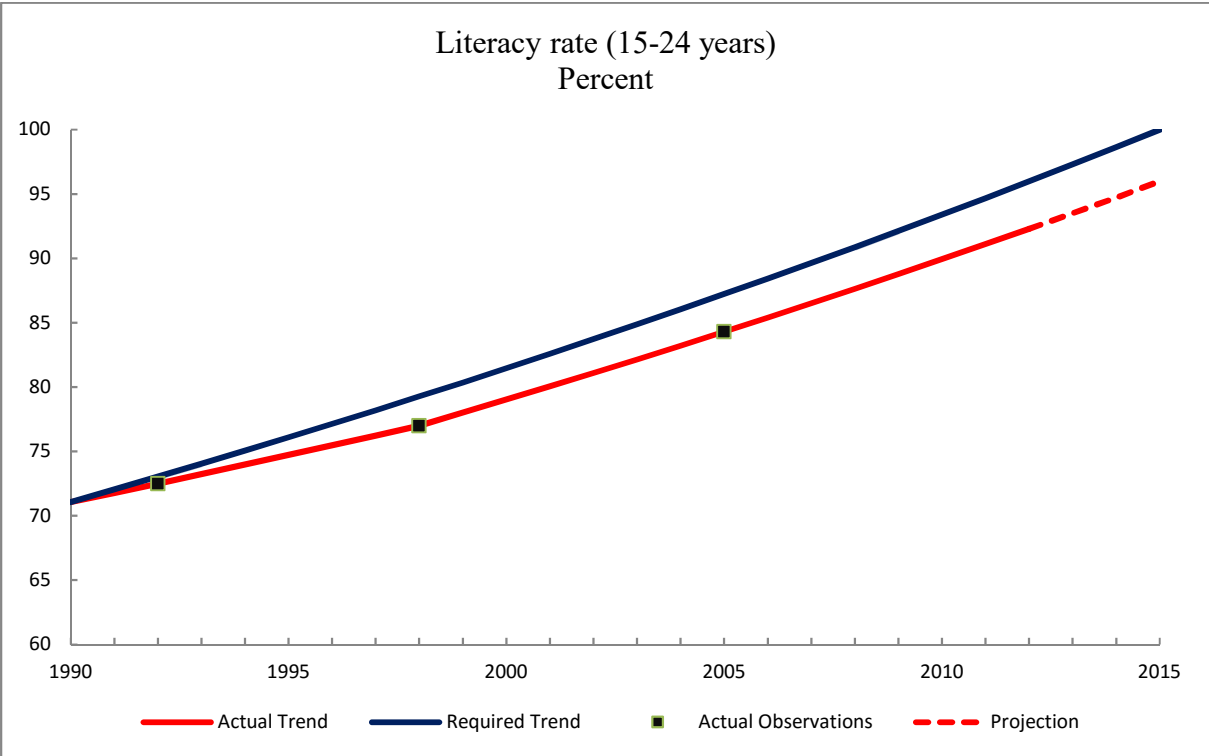
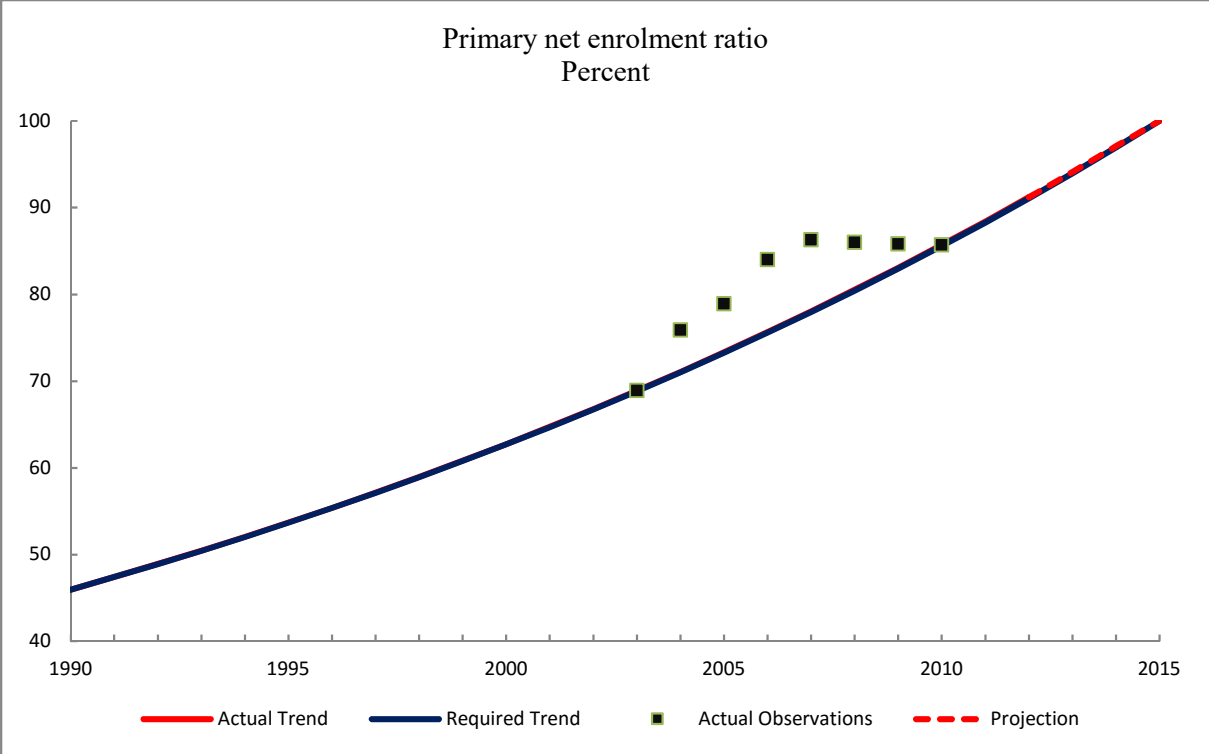
Achieve universal primary education

Ensure that, by 2015, children everywhere, boys and girls alike, are able to complete a full course of primary schooling

Year	Monitoring indicators	
Trend and projection	Net enrolment ratio in primary education (Percent)	Literacy rate of persons aged 15-24 years (Percent)
1990	45.94	71.06
1995	53.69	74.72
2000	62.75	79.02
2005	73.33	84.30
2010	85.70	89.93
2015	100.00	96.00
Target for the year 2015	100.00	100.00
Prospect for 2015	The target will be achieved	The target is likely to be achieved
<i>Progress</i>	<i>Satisfactory</i>	<i>Satisfactory</i>

In the context of universalization of primary education, the progress of the State appears to be satisfactory and there is all likelihood that the target in terms of net enrolment ratio in the primary grades (I-V) will be achieved by the year 2015. There is also a possibility that with some additional efforts, the State will also be able to achieve universal literacy among population aged 15-24 years.

The satisfactory progress of the State in universalizing primary education may be traced in State innovations in directed towards improving the school enrolment and school attendance.



MILLENNIUM DEVELOPMENT GOAL 3

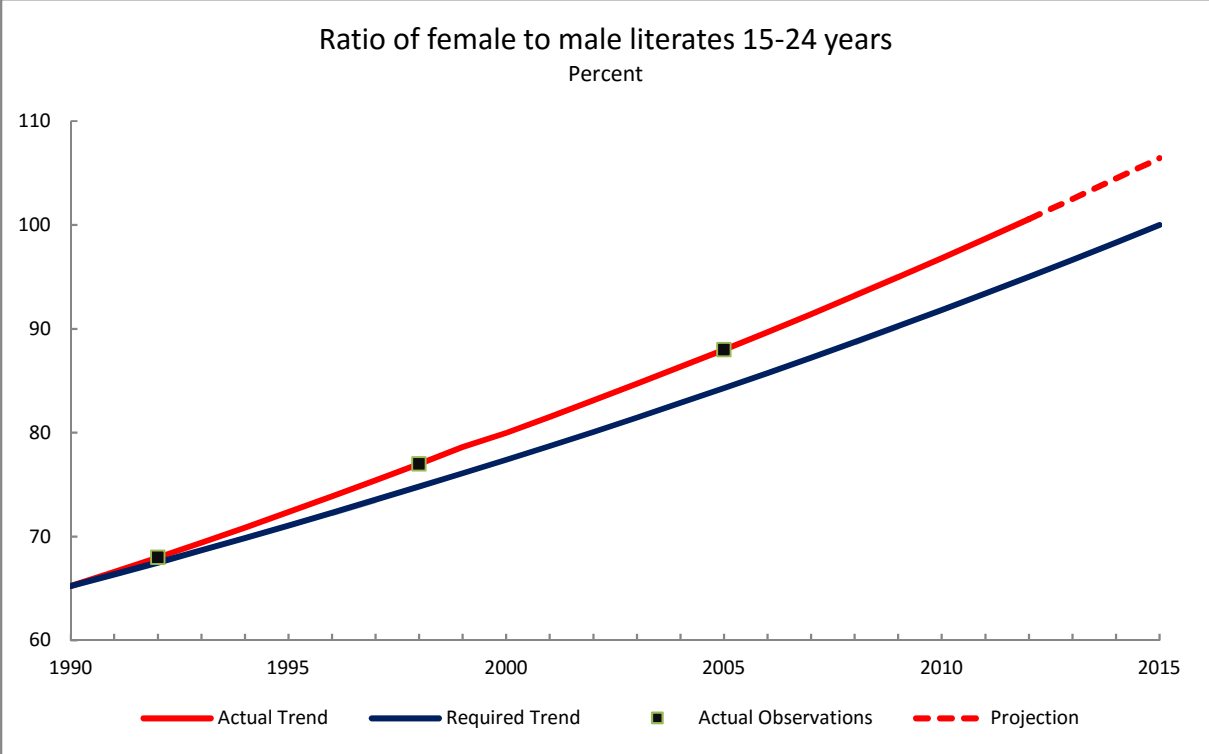
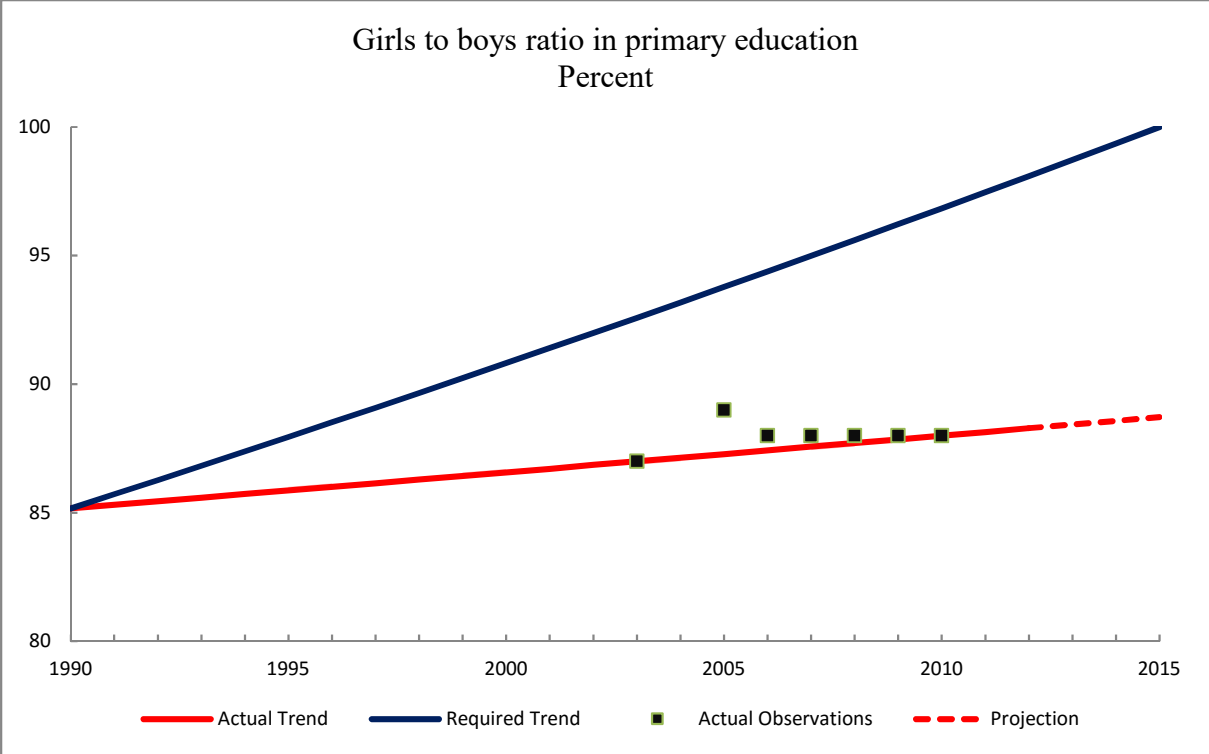
Promote gender equality and empower women

Eliminate gender disparity in primary and secondary education preferably by 2005 and at all levels of education no later than 2015

Year	Monitoring indicators	
Trend and projection	Ratio of girls to boys in primary school enrolment	Ratio of literate females to literate males in the age group 15-24 years
	(Percent)	(Percent)
1990	85.17	65.24
1995	85.87	72.37
2000	86.57	79.99
2005	87.28	88.00
2010	88.00	96.81
2015	88.72	106.42
Target for the year 2015	100.00	100.00
Prospect for 2015	The target will not be achieved	The target will be Achieved
Progress	Unsatisfactory	Satisfactory

In the context of promoting gender equality and empowering women, the State progress appears to be mixed. Current trends suggest that the State will have to make additional efforts to eliminate the gender gap in primary school enrolment by the year 2015 as progress towards achieving this has at best been marginal since 1990. If the past trend continues till the year 2015, there is every probability that the State will not be able to eliminate gender disparity in primary school enrolment by 2015. This means that State needs to make extra efforts in improving female enrolment in primary education so as to achieve gender equality in primary school enrolment by the year 2015.

On the other hand, the progress of the State in terms of literacy sex ratio – female literates for every 100 male literates - in the population aged 15-24 years – appears to be satisfactory and there is every possibility that the literacy sex ratio will turn favourable for females by 2015. Projection of the past trend in literacy sex ratio in the population aged 15-24 years up to the year 2015 suggests that by that time there will be more literate females in the State than literate males in the age group 15-24 years. This will be a unique achievement of the State in terms of the progress towards achieving MDGs.



MILLENNIUM DEVELOPMENT GOAL 4

Reduce child mortality

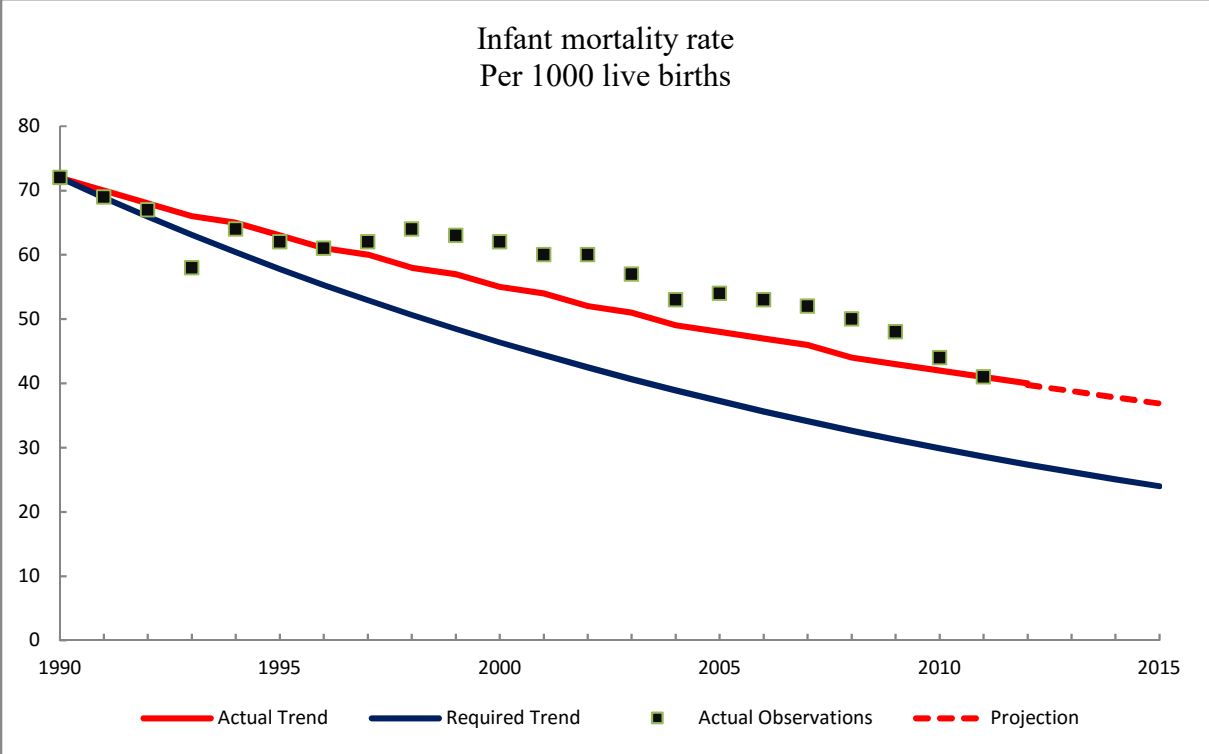
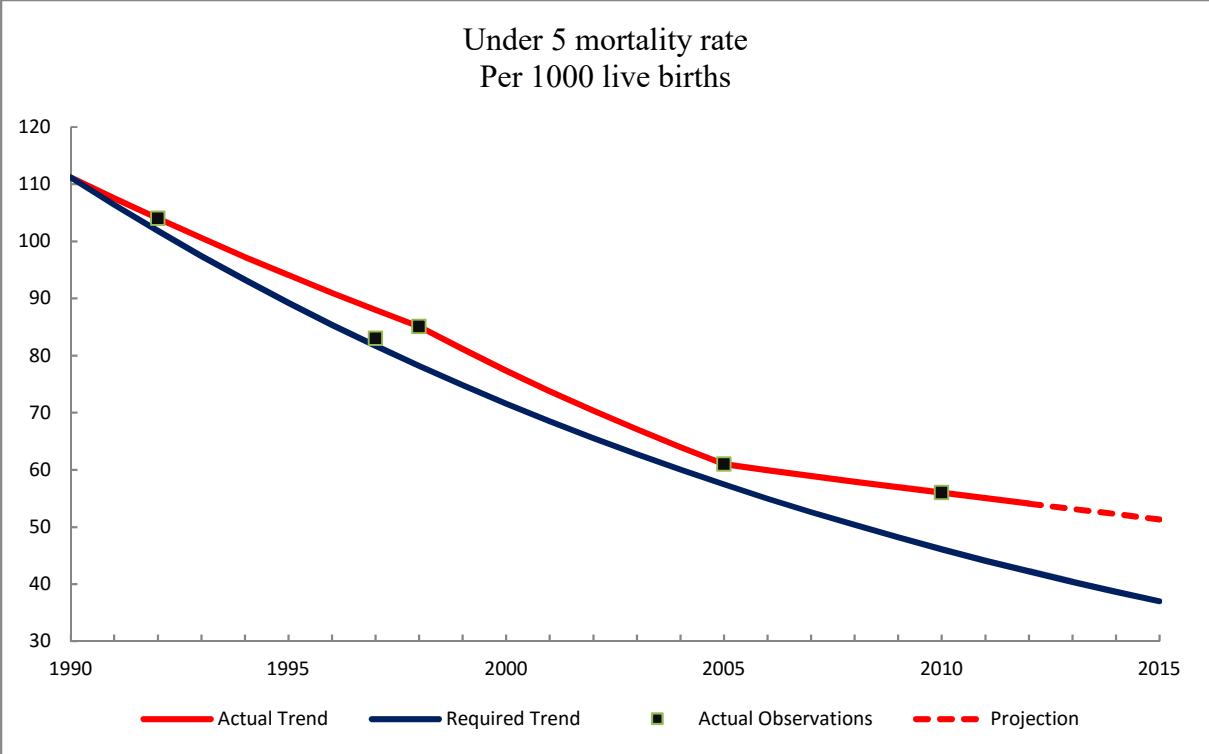
Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Year	Monitoring indicators		
Trend and projection	Under-five mortality rate	Infant mortality rate	Proportion of children 1 year old immunized against measles
	(Per 1000 live births)	(Per 1000 live births)	(Percent)
1990	111	72	53.55
1995	94	63	59.63
2000	77	55	64.19
2005	61	48	65.70
2010	56	42	67.24
2015	51	37	68.80
Target for the year 2015	37	24	100.00
The prospect	The target is unlikely to be achieved	The target is unlikely to be achieved	The target is unlikely to be achieved
<i>Progress</i>	<i>Unsatisfactory</i>	<i>Unsatisfactory</i>	<i>Unsatisfactory</i>

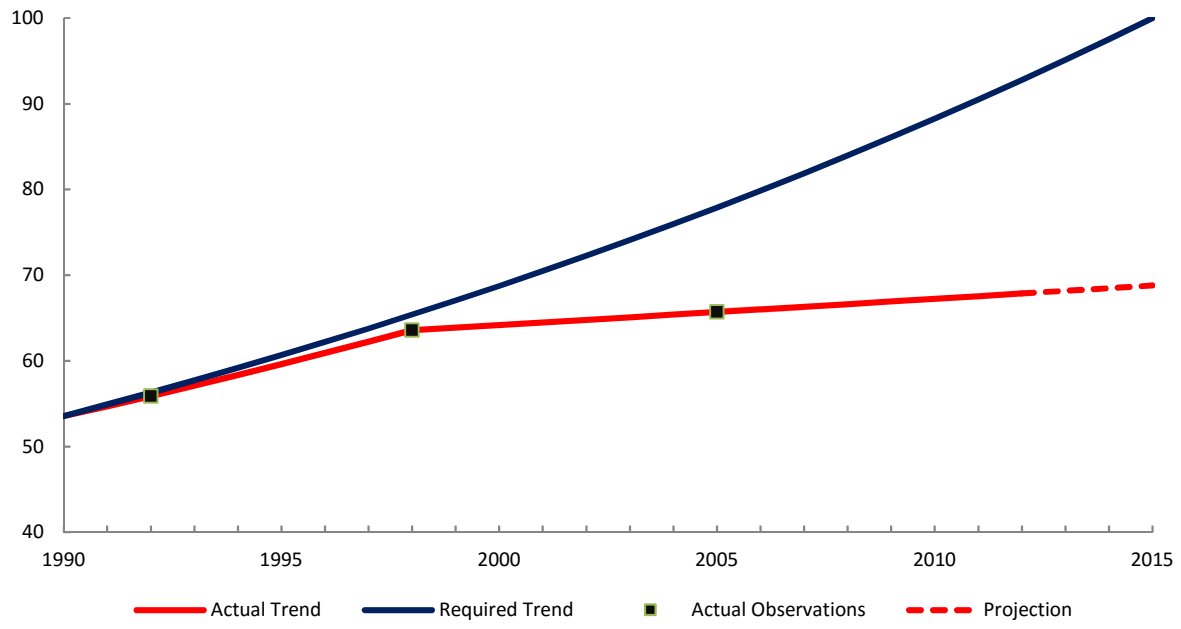
The progress of the State in terms of reduction in child mortality is a major cause for concern. On the basis of the past trend, it can be inferred that the State will not be able to achieve the target by 2015 in any of the three indicators mentioned above. The trend in the reduction of child mortality in the State suggests that there is an immediate need of serious introspection of the approach adopted for accelerating the reduction in child mortality.

One of the reasons for slower than expected transition in child mortality in the State may be the unacceptably high prevalence of child under nutrition that appears to have persisted despite all economic growth and progress and reduction in poverty. The close relationship between child under-nutrition and child mortality is well-known and child under-nutrition is globally termed as the silent tragedy for children.

The State also needs to push the agenda of universal child immunization in its development discourse as the past trend indicates that a substantial proportion of children in the State are still devoid of full immunization which is perhaps the most effective yet low-cost appropriate technology to accelerate reduction in mortality in children below 5 years of age.



Infants immunised against measles Percent



MILLENNIUM DEVELOPMENT GOAL 5

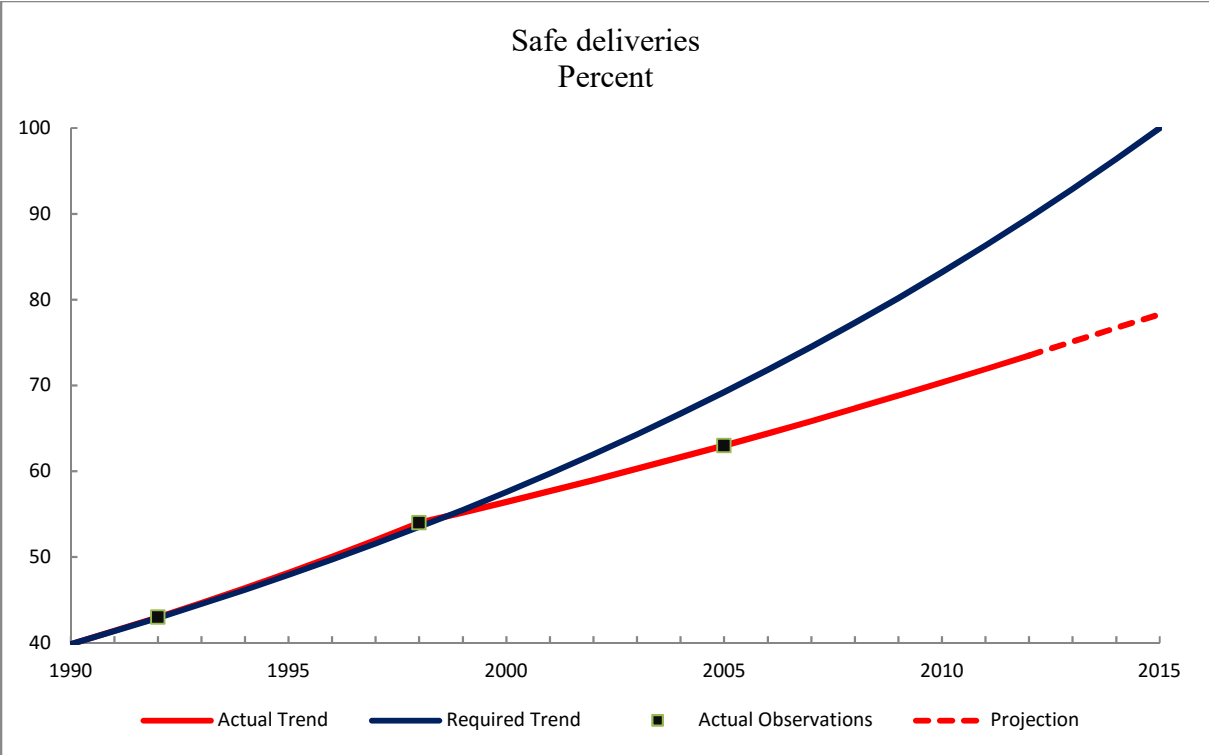
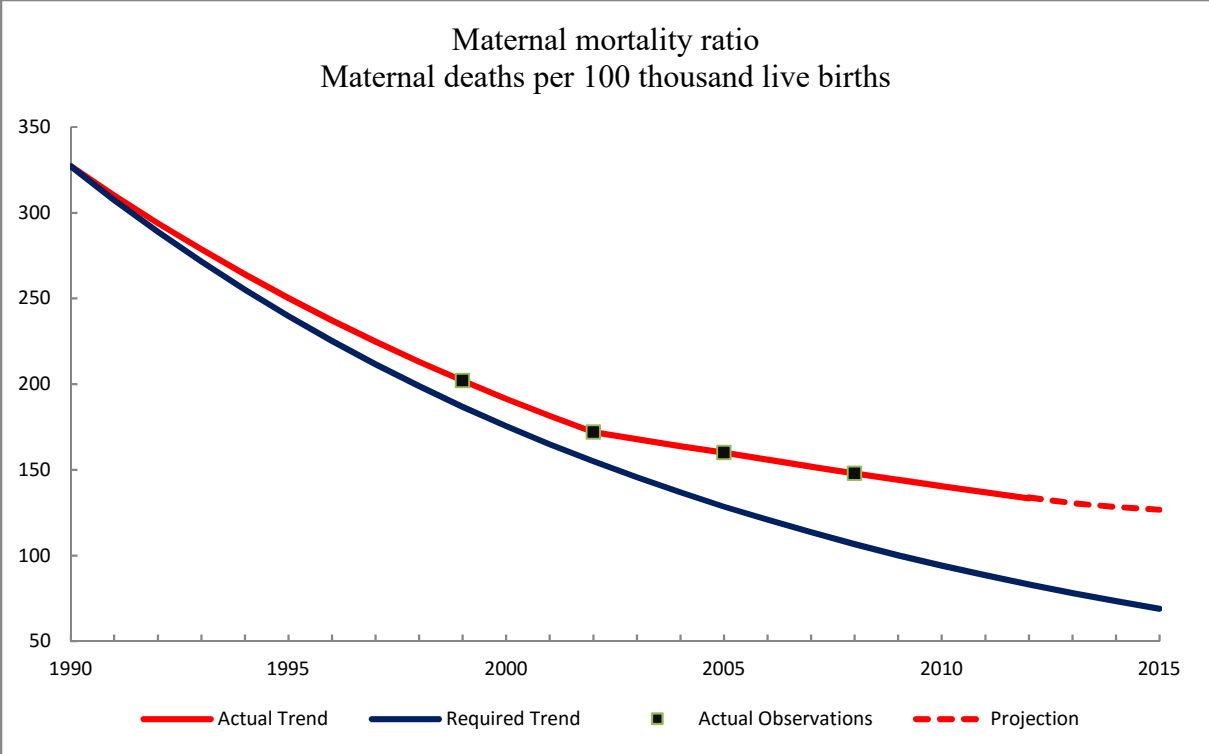
Improve maternal health

*Reduce by three quarters, between 1990 and 2015,
the maternal mortality ratio*

Year	Monitoring indicators	
Trend and projection	Maternal mortality ratio	Proportion of births attended by skilled health personnel (Percent)
	(Per 100 thousand live births)	
1990	327	39.87
1995	250	48.12
2000	191	56.41
2005	160	62.97
2010	141	70.30
2015	127	78.30
Target for the year 2015	69	100.00
The prospect	The target is unlikely to be achieved	The target is unlikely to be achieved
Progress	<i>Unsatisfactory</i>	<i>Unsatisfactory</i>

The State's progress towards improving the maternal health is also unsatisfactory and there is little possibility that targets in reducing maternal mortality ratio – risk of death associated with complications of pregnancy and delivery – and in terms of skilled attendance at birth will be achieved by 2015. The inadequacy of the efforts towards improving maternal health is reflected in the gap between the required rate and the actual trend in the maternal mortality ratio which has been increasing since 1990. Similarly, the gap between the required rate and the actual trend in proportion of deliveries attended by skilled personnel also appears to have increased after 1998. The State needs to reverse these trends so as to ensure that improvement in the health of women of the State is accelerated in the immediate future.

The State government has launched a very innovative e-Mamta framework to track every pregnant woman in the State so that essential antenatal, natal and postnatal care services can be provided to the woman at the right time. It is not known at present to what extent e-Mamta has contributing towards universalizing maternal health care in the State. Accelerating improvements in maternal health require innovative approaches on three fronts – universalizing skilled attendance at birth, ensuring appropriate health care during antenatal, natal and postnatal period to all women during pregnancy, delivery and immediately after delivery and proper spacing between successive births through the use of appropriate family planning methods.



MILLENNIUM DEVELOPMENT GOAL 6

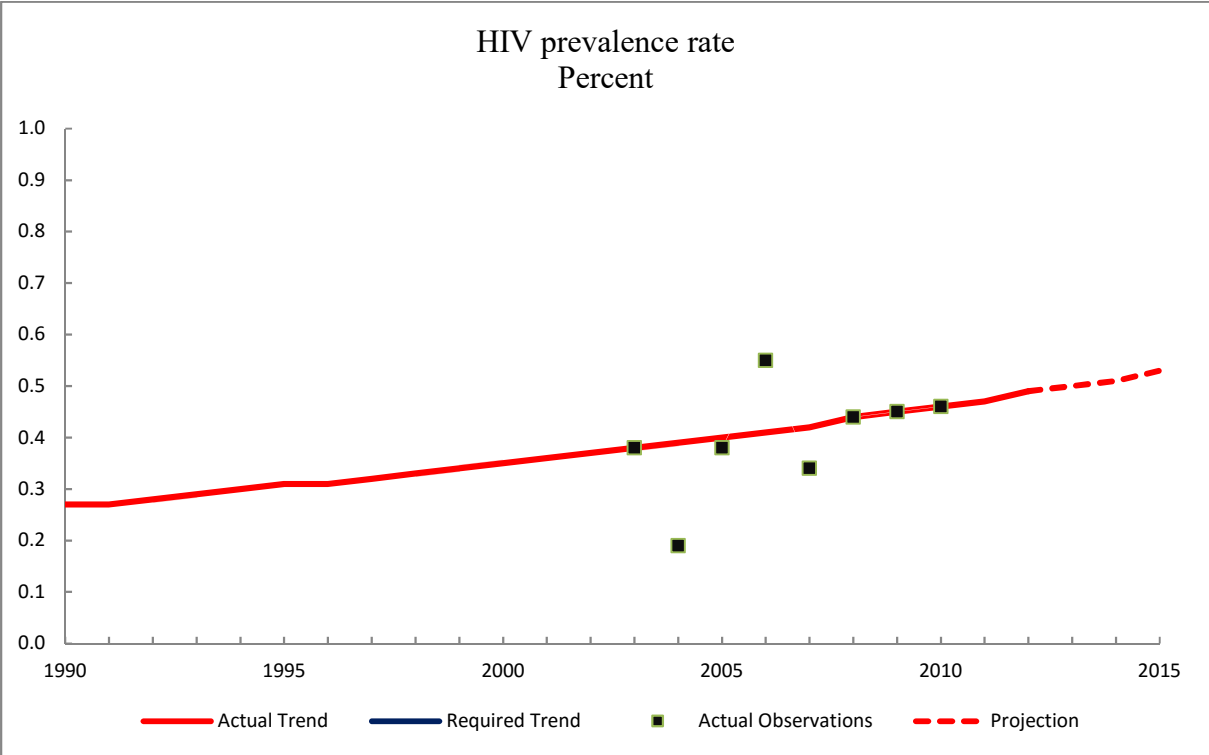
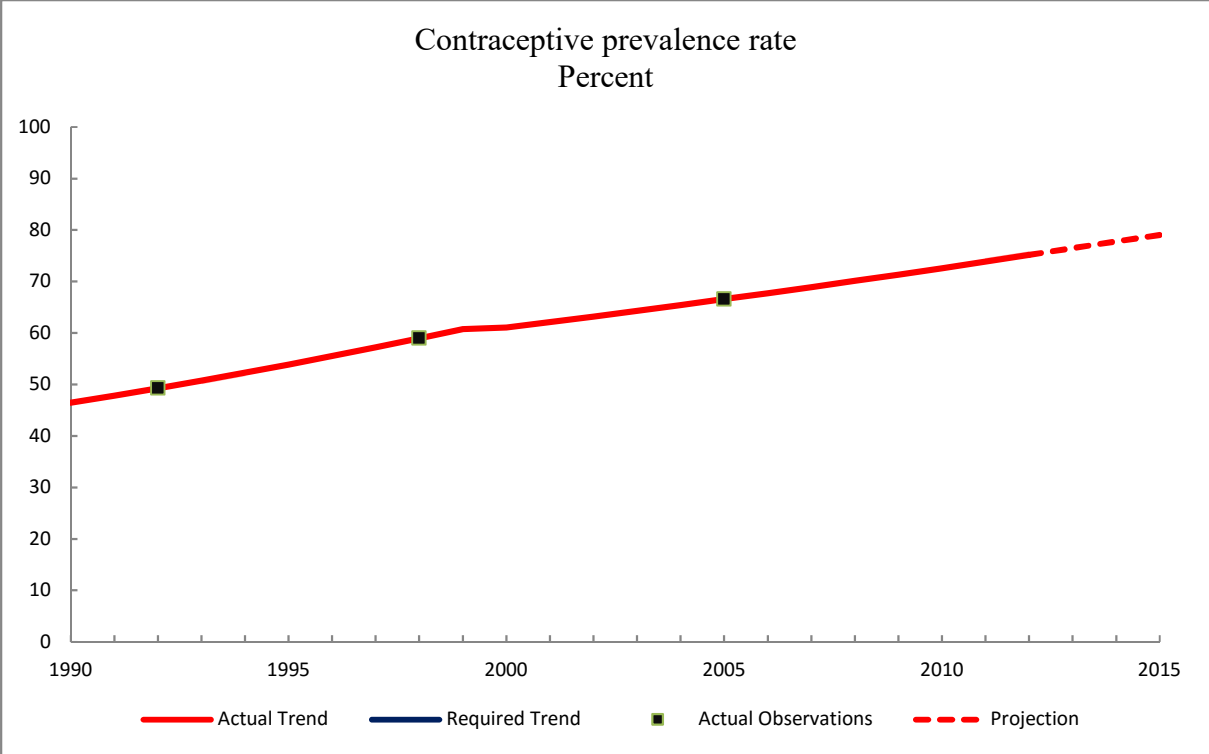
Combat HIV/AIDS, Malaria and other diseases

*Halt by 2015, and begun to reverse,
spread of HIV/AIDS,
incidence of malaria and other major diseases*

Year	Monitoring indicators	
Trend and projection	Contraceptive prevalence rate (Percent)	HIV prevalence among ANC clinic attendance (Percent)
1990	46.44	0.27
1995	53.88	0.31
2000	61.07	0.35
2005	66.59	0.40
2010	72.59	0.46
2015	79.05	0.53
Target for the year 2015	No target given	Reverse the trend
The Prospect Progress	<i>Satisfactory</i>	<i>Unsatisfactory</i>

Very limited information is available at present to make an assessment of the progress in terms of combating HIV/AIDS, malaria and other diseases in the State. In the context of combating HIV/AIDS, the progress of the State requires improvement. It is projected that by the year 2015, almost 80 per cent of the currently married women in the State will be using some type of contraceptive methods. However, the impact of such a high rate of prevalence of contraception in combating HIV/AIDS will be limited because most of this contraceptive use will be confined to terminal methods, particularly female sterilization, going by the current trends. Protected sex is the key to combatting the spread of HIV/AIDS and use of condoms is critical for the purpose. However, according to the National Family Health Survey 2005-06, less than 6 per cent of the currently married couples were using condoms and, according to the District Level Household and Facility Survey, this proportion decreased to about 4 per cent in 2007.

There is little evidence that the State will be able to reverse the increasing trend in the prevalence of HIV by the year 2015 unless special efforts are made in this direction. The prevalence of HIV-positive cases in females attending antenatal care clinics in the State has been increasing in the past, and there is every probability that with the current efforts, this prevalence will continue to increase till 2015 when this prevalence will be at its highest. Reversing the trend after 2015 will be critically dependent upon the interventions introduced by the State right now. Rapid urbanization of the State in the coming years will be a major challenge in reversing the trend.



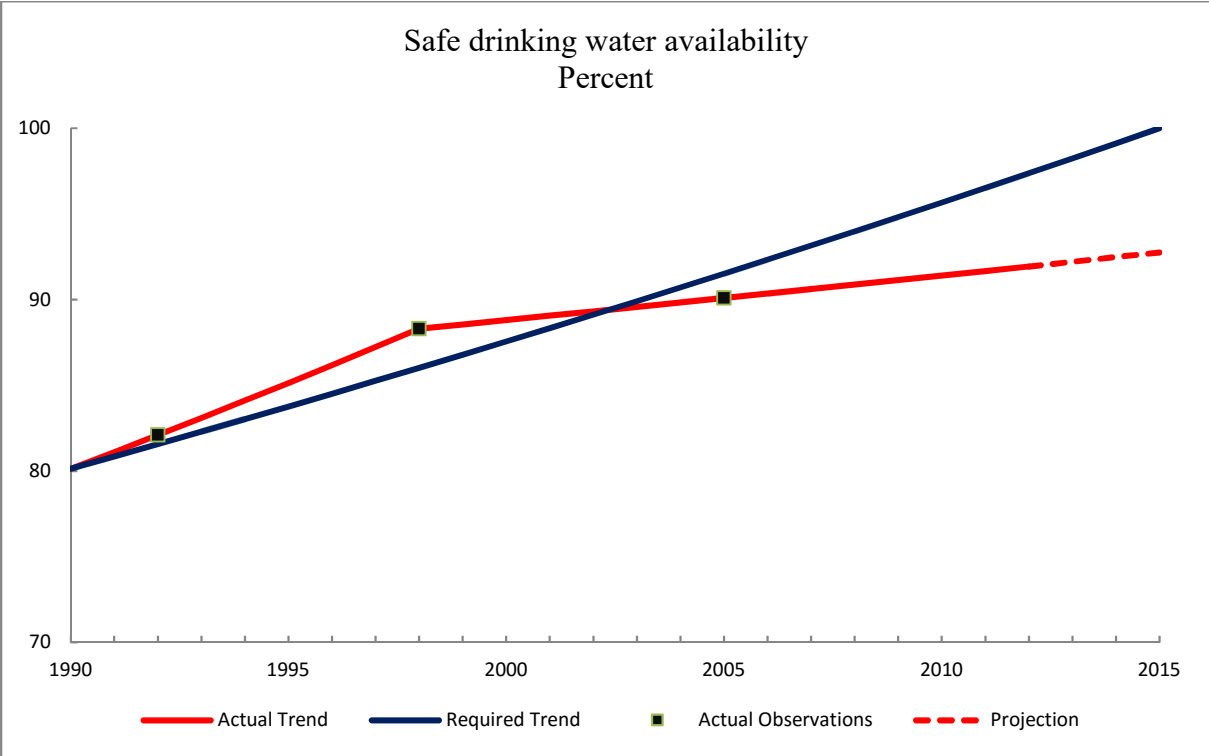
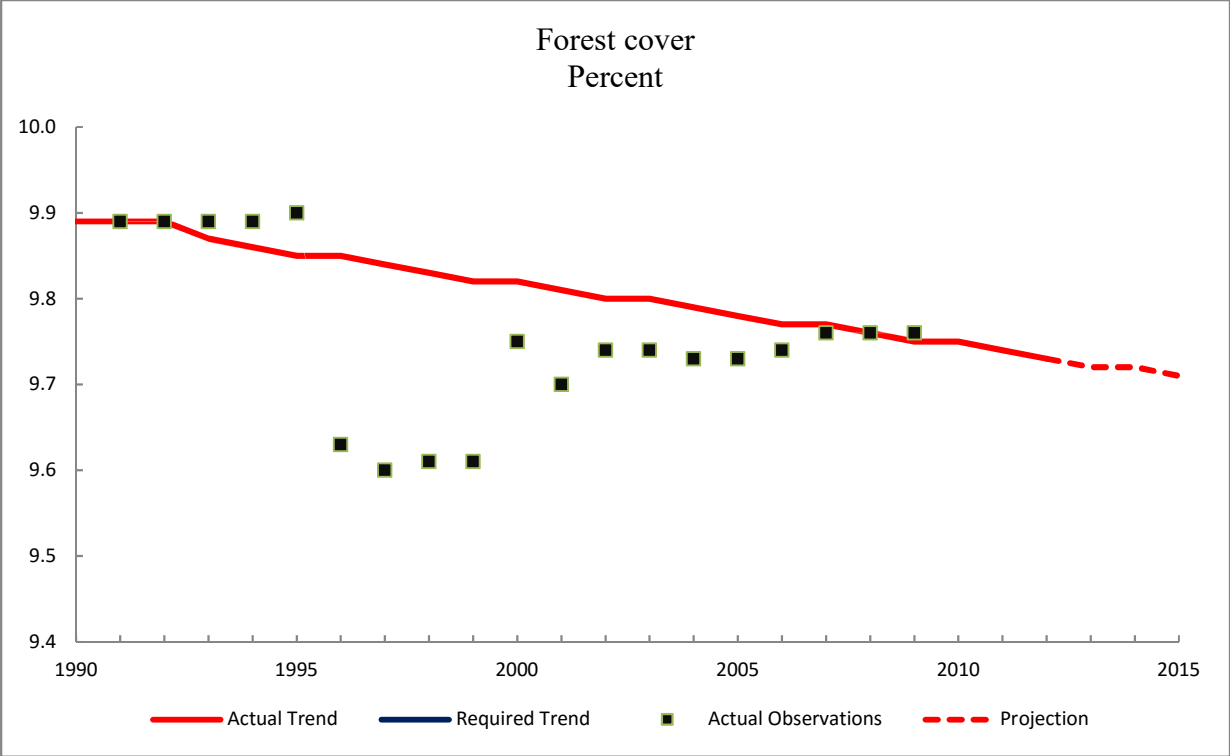
MILLENNIUM DEVELOPMENT GOAL 7

Ensure environment sustainability
*Integrate principles of sustainable development
 into state policies and programmes
 and reverse the loss of environmental resources*
*Halve, by 2015, the proportion of people
 without sustainable access to safe drinking water*
*Achieve, by 2020, a significant improvement
 in the lives of at least 100 million slum-dwellers*

Year	Monitoring indicators		
Trend and projection	Proportion of area covered with forest	Proportion of population with access to safe drinking water	Proportion of people with access to improved sanitation
	(Percent)	(Percent)	(Percent)
1990	9.89	80.13	NA
1995	9.85	85.14	NA
2000	9.82	88.81	NA
2005	9.78	90.10	NA
2010	9.75	91.41	62.62
2015	9.71	92.75	Na
Target for the year 2015	No target given	100.00	No target given
The prospect		The target is likely to be achieved	
Progress		Satisfactory	

In the context of environmental sustainability, the progress of the State appears to be satisfactory. The State appears to be able to reverse the loss of environmental resources, particularly, forest cover, although forest cover in the State is well below the global norm of 35 per cent. There is, however, little information available at the State level about the other dimensions of environmental sustainability.

On the other hand, the State appears to have achieved the goal of reducing by half the proportion of population with access to safe drinking water. By the year 2015, almost 93 per cent of the state's population is projected to be having access to safe drinking water. In 1990, almost one fifth of the population of the State was not having access to safe drinking water. This proportion is likely to be reduced to almost 7 per cent by the year 2015. In terms of improved sanitation facilities, too, the progress of the State appears to be more or less satisfactory in urban areas. Availability of improved sanitation facilities in urban areas has a direct relevance to the living conditions of the slum population.



MILLENNIUM DEVELOPMENT GOAL 8

Develop global partnership for development

*Develop and implement strategies for decent and productive work for youth
Make available the benefits of new technologies,
especially information and communications*

Year	Monitoring indicators		
Trend and projection	Unemployment rate (Per 1000)	Telephone (Land lines and mobiles) (Per 100 households)	Personal computers (Per 100 households)
1990	Na	Na	Na
1995	Na	Na	Na
2000	Na	Na	Na
2005	11	Na	Na
2010	11	55.11	3.41
2015	Na	Na	Na
Target for the year 2015	No target fixed	No target fixed	No target fixed
The prospect	No target	No target	No target

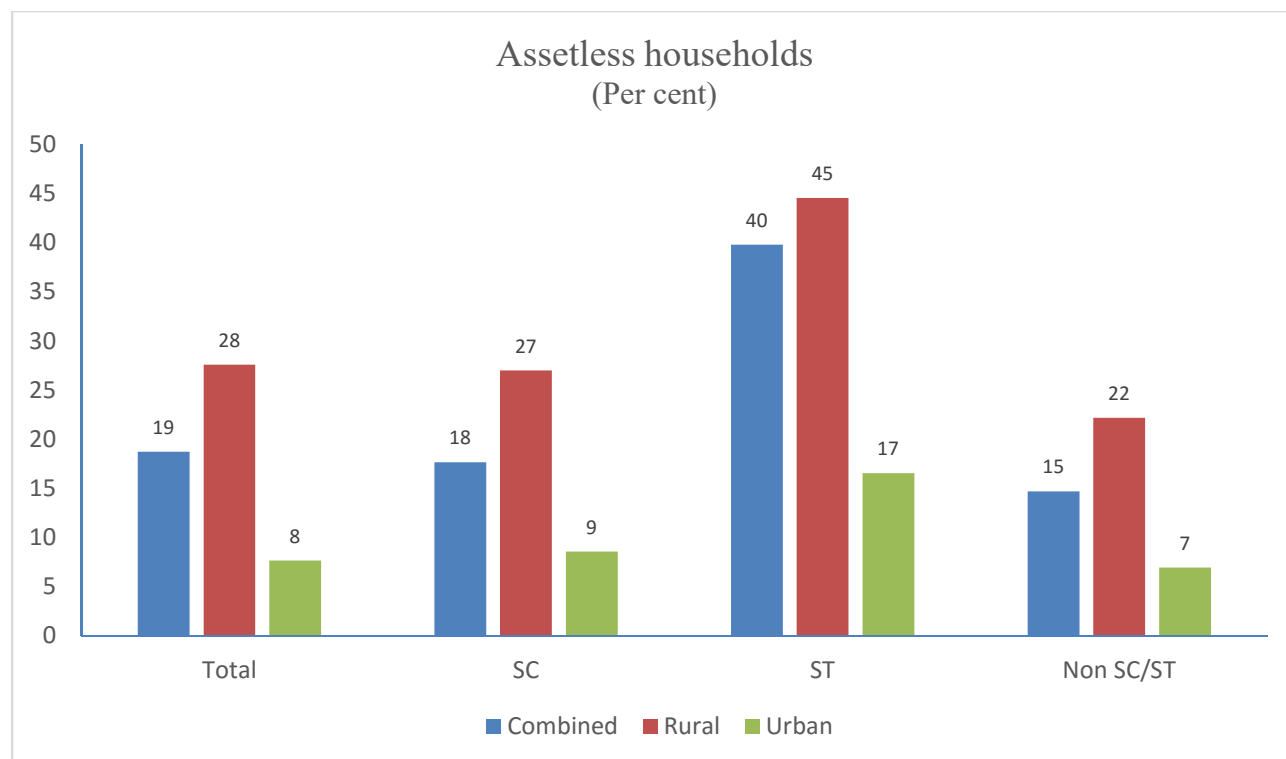
The unemployment rate in Gujarat is quite low which indicates that most of the employable persons in the State are engaged in a productive activity. According to the National Sample Survey, the unemployment rate in Gujarat was only 11 per 1000 during the period 1009-10. The latest estimates suggest that this rate has come down to 5 per 1000 during the period 2011-12.

According to the Census 2011, more than 55 per cent of the households in the State have telephone – either fixed-line or mobile phones. Compared to fixed-line phones, the availability of mobile phones is very high. The proportion of households having a mobile phone was more than 52 per cent according to Census 2011. In comparison, the proportion of households having a fixed-line phone was quite small – only around 2.4 per cent.

The proportion of households in the State having a personal computer at the time of the 2011 population census is estimated to be around 3.4 per cent. Availability of personal computers at the household level appears to be largely confined to urban areas, especially big towns and cities of the State. In rural areas, personal computers are generally not available at the household level. Moreover, the penetration of internet also appears to be confined to urban areas only as only around 0.5 per cent of the households in the State reported to be having internet connectivity according to Census 2011.

III. SOCIAL CLASS DISPARITIES

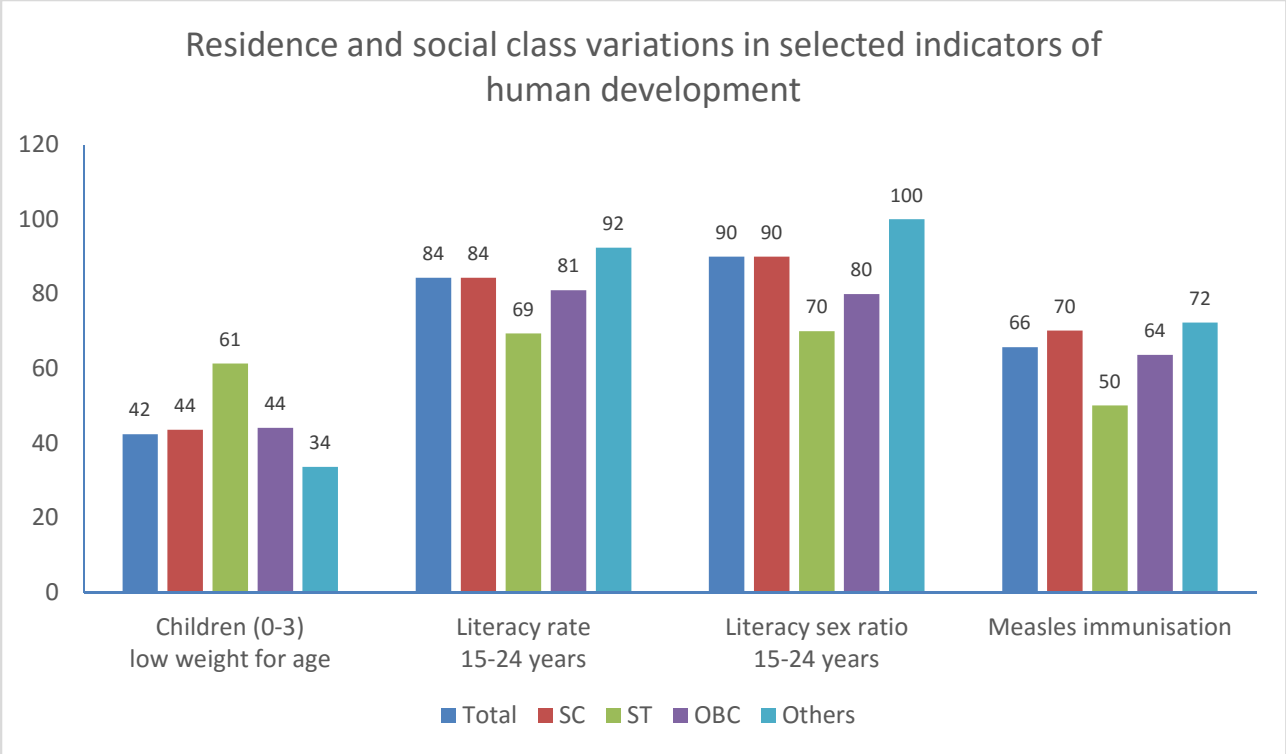
A major challenge to human progress in Gujarat is urban-rural and social class disparities in almost all dimensions of human development that have persisted over time. Reducing these disparities may go a long way in accelerating human progress in Gujarat as the State economy provides ample opportunities for productive participation of an average individual in the social and economic production system. There is a need for institutionalizing an evidence-based decentralized approach in planning and programming human development activities and programmes so as to effectively address the human development needs of marginalized sections of the community.



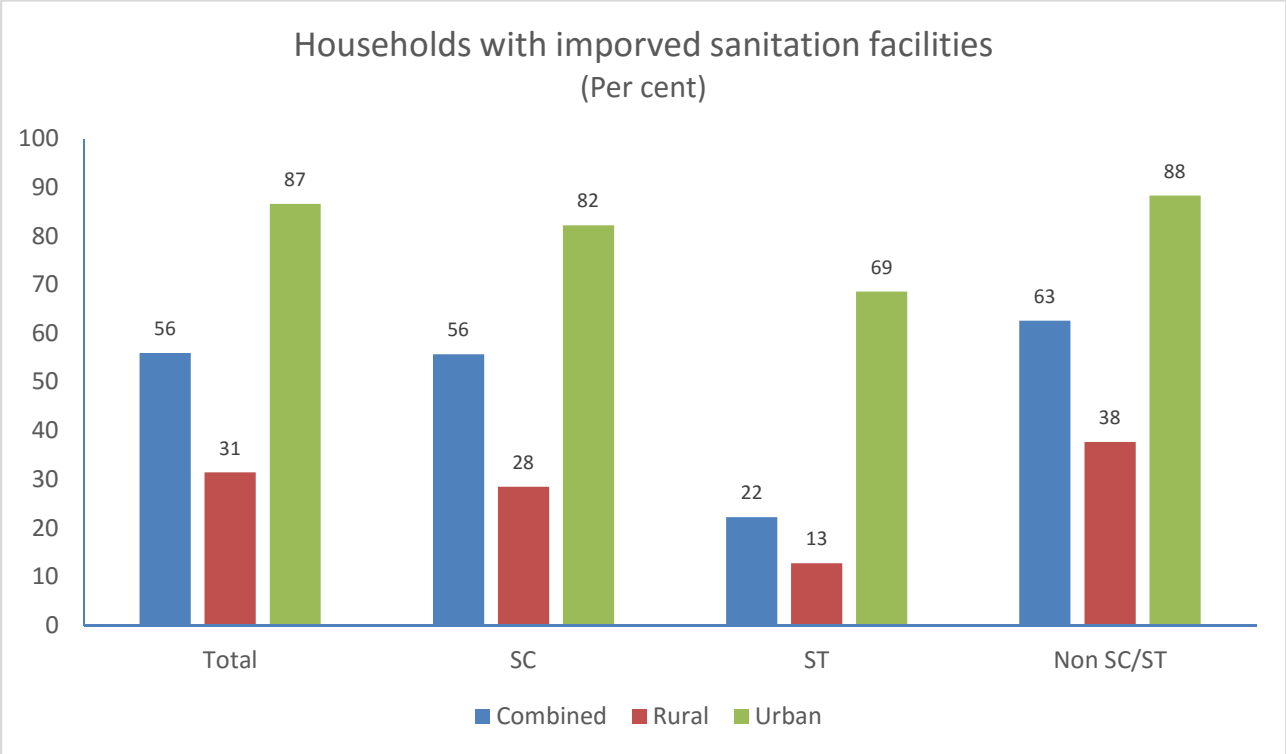
During the 2011 Census, information about the following household assets was collected from every household:

1. Radio/Transistor
2. Television
3. Computer with or without internet
4. Telephone – landline and mobile
5. Bicycle
6. Two wheeler auto
7. Four wheeler auto

The proportion of households having none of the above assets is an indicator of household level poverty.



Remarks: All figures in the chart are in percentages.



Remarks: All figures are in percentages.

IV. CONCLUSIONS

The progress towards achieving MDGs in Gujarat may be characterized as mixed. The State has progressed satisfactorily in terms of reduction in poverty, universal primary education, gender equity in primary education and in the provision of safe drinking water. The MDGs goals in these indicators of human development have either been achieved or there is every probability that they will be achieved by the year 2015.

With regard to other MDGs, the State needs to mobilise significant additional efforts to accelerate the progress and there is a possibility that in some of the indicators, the State may not be able to achieve the MDGs despite all additional efforts. This is especially the case with the reduction in the risk of death during the first five years of life and reduction in the risk of death in women associated with the complications of pregnancy and delivery. An accelerated reduction in these risks requires appropriate policies and programmes to translate the dividends accrued through rapid economic growth that the State has witnessed into entitlements for the people, especially for the poorest and the most marginalized sections.

A major challenge to achieving the MDGs in Gujarat is reducing and ultimately eliminating social class and rural-urban disparities in different dimensions of human development. These disparities appear to be quite strong in terms of their strength and persistence. It appears that the state's rapid economic progress has not been able to dent these disparities which again emphasizes the need for appropriate policies and programmes that can translate the dividends of economic growth into entitlements for the people.

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