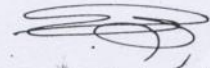# PREFACE

The Economics & Statistics Division of Department of Planning, Government of Uttar Pradesh was entrusted to bring out report on MDG goals. This report 'Millennium Development Goals Uttar Pradesh State Report 2015' captures Uttar Pradesh's achievements and challenges in respect of Goals and Targets, set at the United Nations Millennium Summit 2000, to monitor global poverty, hunger, illiteracy, gender inequality, disease and environmental degradation.

The MDGs are interlinked. An all-round development in related sector is required to achieve a single target .For instance, achievement of health targets are dependent on achievement of targets of sanitation, availability of safe drinking water, clean environment, reduction of poverty and malnutrition, spread of literacy and so on.

This report contains updated information about the progress achieved so far in respect of eight goals disaggregated into12 targets and 35 indicators, relevant for India. UP's scorecard of MDG achievement shows a mix progress: by reducing poverty head count ratio to near 50%of the level in 1990, fighting deadly diseases, progress in education and women's empowerment, U.P. has contributed significantly in to the Indian scorecard of MDGs; while the State is lagging behind in addressing the targets of eradication of hunger and ensuring sanitation facilities. Detailed discussions on Goal wise performance are presented in the relevant chapter of this report.

I wish to place on record my sincere appreciation for the team of officers led by Shri Sanjay Kumar Srivastava, Dy.Director and Shri Amlendu Rai, Dy.Director, Coordination Division for their concerted efforts and valuable contribution in bringing out this report.

Girija Shankar Katiyar

Director

Lucknow

Dated: 13/04/2016

FORWARD

I am glad to place before you the Report 'Millennium Development Goals Uttar Pradesh State Report 2015' brought out by Economics & Statistics Division of Department of Planning, Government of Uttar Pradesh.

The year 2015 being terminal year for the present MDG, is the right time to assess our own progress vis-à-vis the Millennium Development Goals. This report is an attempt in this regard. It give us a benchmark to set our goals for post 2015 development agenda of the State.

According to the report, the measures undertaken to achieve the MDGs goal are yielding desirable result and a real and positive change is taking place in the lives of the people of the State . The report, also identifies areas where the progress made by State is not at the desired level. Therefore these areas are needed to be given more focus attention in post 2015 development agenda.

I sincerely hope this report will generate useful deliberations among policy makers, academicians, intellectuals, research scholars, subject matter specialists, and people at large. I congratulate Shri Girja Shankar Katiyar, Director, Economics & Statistics Division and his team for bringing out this very useful report which showcases progress of U.P. on various socio-economic indicators vis-a-vis MDGs.

(Arun Kumar Sinha)

Principal Secretary (Planning)

Lucknow

Dated:13/4/2016

Officers Associated with this Report

Sh.Girija Shankar Katiyar
Director

Sh.Sanjay Kumar Srivastava
Deputy Director

Sh. Amlendu Rai
Deputy Director

Ms.Reshma Bala
Eco. & Statistics Officer

CONTENTS

Chapter1

Introduction

In September 2000, world leaders came together at the United Nations Headquarters in New York to adopt the United Nations Millennium Declaration. The Declaration committed nations to a new global partnership to reduce extreme poverty, and set out a series of eight time-bound targets that have become known as the **Millennium Development Goals (MDGs)**. The MDGs are drawn from the actions and targets contained in the Millennium Declaration**.** The Millennium Development Goals (MDGs) are eight goals to be achieved by 2015. The eight (8) Goals as under:

Goal 1: Eradicate Extreme Poverty and Hunger
Goal 2: Achieve Universal Primary Education
Goal 3: Promote Gender Equality and Empower Women
Goal 4: Reduce Child Mortality
Goal 5: Improve Maternal Health
Goal 6: Combat HIV/AIDS, Malaria and TB
Goal 7: Ensure Environmental Sustainability
Goal 8: Develop Global Partnership for Development

Eighteen (18) targets were set as quantitative benchmarks for attaining the goals. The United Nations Development Group (UNDG) in 2003 provided a framework of 53 indicators (48 basic + 5 alternative) which are categorized according to targets, for measuring the progress towards individual targets. India's MDG framework is based on UNDG's MDG 2003 framework, and it includes all the eight goals, 12 out of the 18 Targets (Targets 1 to 11 & 18) which are relevant for India and related 35 indicators. The targets and Indicators are as follow-

<u>GOALS, TARGETS AND INDICATORS</u>

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Target 1: Halve , between 1990 and 2015, the proportion of people whose income is less than a dollar a day .

- Indicator 1A: Poverty Headcount Ratio (percentage of population below the national poverty line)

- Indicator 2:   Poverty Gap Ratio

- Indicator 3:   Share of poorest quintile in national consumption

- Indicator 4:   Prevalence of underweight children under three years of age.

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

- Indicator 6:   Net Enrolment Ratio in primary education.

- Indicator 7:   Proportion of pupils starting Grade 1 who reach Grade 5.

- Indicator 8:   Literacy rate of 15-24 year olds.

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

- Indicator 9:   Ratio of girls to boys in primary, secondary and tertiary education

- Indicator 10:   Ratio of literate women to men, 15-24 years old

- Indicator 11:   Share of women in wage employment in the non-agricultural sector

- Indicator 12:   Proportion of seats held by women in National Parliament

GOAL 4: REDUCE CHILD MORTALITY

- Indicator 13:   Under-Five Mortality Rate

- Indicator 14:   Infant Mortality Rate

- Indicator 15:   Proportion of one year old children immunised against measles

GOAL 5: IMPROVE MATERNAL HEALTH

- Indicator 16:   Maternal Mortality Ratio (MMR)

- Indicator 17:   Proportion of births attended by skilled health personnel

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

TARGET 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

- Indicator 18:   HIV prevalence among pregnant women aged 15-24 years

- Indicator 19:   Condom use rate of the contraceptive prevalence rate (Condom use to overall contraceptive use among currently married women, 15-49 yrs, percent)

- Indicator 19A: Condom use at last high risk sex (Condom use rate among non-regular sex partners 15-24 yrs)

- Indicator 19B: Percentage of population aged 15-24 years with comprehensive   correct knowledge of HIV/AIDS

TARGET 8 : Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases.

- Indicator 21:   Prevalence and death rates associated with Malaria.

- Indicator 22:   Proportion of population in Malaria risk areas using effective Malaria prevention and treatment measures (Percentage of population covered under use of residuary spray in high risk areas)

- Indicator 23:   Prevalence and death rates associated with Tuberculosis

- Indicator 24:   Proportion of Tuberculosis cases detected and cured under DOTS

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

TARGET 9 : Integrate the principle of sustainable development into country policies and programmes and reverse the loss of environmental resources

- Indicator 25:   Proportion of land area covered by forest

- Indicator 26:   Ratio of area protected (to maintain biological diversity) to surface area

- Indicator 27:   Energy use per unit of GDP (Rupee)

- Indicator 28: Carbon Dioxide emissions per capita and consumption of Ozone depleting Chloro-fluoro Carbons (ODP tons)

✓ Indicator 29: Proportion of the Households using solid fuels

TARGET 10: Halve , by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation

✓ Indicator 30: Proportion of population with sustainable access to an improved water source, urban and rural

✓ Indicator 31: Proportion of population with access to improved sanitation, urban and rural

TARGET 11: By 2020,to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

✓ Indicator 32: Slum population as percentage of urban population

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

TARGET 18: In cooperation with the private sector,make available the benefits of new technologies,especially information and communication

✓ Indicator 47: Telephone lines and cellular subscribers per 100 population
✓ Indicator 48A: Internet subscribers per 100 population
✓ Indicator 48B: Personal computers per 100 population

The Millennium Development Goals, in fact, emphasized the effectiveness of Statistics in monitoring development process at national and sub-national levels, by specifying measurable indicators for the targets.

In U.P., the state statistical system does not have independent statistical machinery exclusively focused on quantitative monitoring of the MDGs. The Directorate of Economics & Statistics, which is entrusted with the statistical tracking of MDGs in U.P., is monitoring the progress under MDGs on the basis of data-sets available at National / State level, generated by the subject matter Ministries/Departments. Currently the monitoring is limited to the national and State/ UT levels. The statistical monitoring of MDGs is presently not done at sub- State/ District level, due to non – availability data. Availability of reliable official statistics with regular periodicity is extremely important for effective statistical

monitoring. The difficulties faced while statistically tracking the MDGs in U.P, are mainly related to-

 • Data gap issues:

Non –availability of data at Sub –State level prevented statistical monitoring at bottom level. At sub state level, estimates for various indicators are not available from Surveys conducted at national level. In order to generate estimates at sub state level, sufficiently large samples are required from each district making the total sample size so large, that, it is not found feasible due to cost and other organisational considerations.

 • Periodicity issues:

a) Non availability of data updates annually: The National Sample Survey Office (NSSO) conducts surveys every year, but the topics are repeated once in five years, as a result, data for inter survey years are not available.

b) Irregular periodicity: Data on various important health indicators are obtained from National Family Health Survey (NFHS), the latest survey in this series corresponds to the period 2005-06 and the NFHS - 4 (2014-15) conducted after a long gap is in progress.

 • Incomplete coverage:

Data from Administrative records most of the times; suffer from incomplete coverage; for example, registration of births and deaths done by Civil Registration System, or mortality data from the hospitals suffer from incomplete coverage.

A detailed account and analysis of UP's achievement for all the MDGs and targets with respect to the related indicators as per India's MDG framework is presented in the following chapters. Also, in the subsequent chapters, elaborate discussion has been attempted highlighting the strong points of various Policies and beneficiary oriented Programmes. While providing outlines of the various development plans which inter-alia envisage attainment of the MDG targets, this Report also takes a close look at the programme components and their performance in producing desired results.

CHAPTER 2

Overview

The eight Million Development Goals (MDGs) form a blueprint agreed to by all the world's countries and all the world's leading developing institutions. They have galvanized unprecedented efforts to meet the needs of the world's poorest. In U.P. there has been considerable emphasis on all the MDGs and in fifteen years,vi.e between 2000 and 2015 the state of U.P. has made significant progress in attaining the MDG targets. A brief of the performance of U.P. in achieving the MDGs is presented below:

✓ **MDG 1: Eradicate extreme poverty and hunger**

➢ Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

✓ The ***Poverty Head Count Ratio (PHCR)*** estimate for U.P. was 50.67% in 1990. In order to meet the target the PHCR level has to be 25.34% by 2015. In 2011-12, the PHCR for U.P. was 29.43%, and likely achievement by 2015 will be 27.94% which shows that, U.P. has missed her MDG target narrowly.

✓ During 2004-05 to 2011-12, the ***Poverty Gap Ratio*** reduced both in rural and urban areas. While the rural PGR declined from 9.164 in 2004-05 to 5.68 in 2011-12 in the urban areas it declined from 7.802 to 5.29 during the same period. A nearly 38% and 32% decline in PGR in rural and urban areas, respectively, during 2004-05 to 2011-12 reflects that the conditions of poor have improved both in urban and rural areas.

✓ In 2004-05, in U.P. according to PSMS-IV, ***the share of the poorest quintile in the total consumption*** was 12.64 % which further declined to 11.72% in 2009-10 signifying the worsening of the condition of poorest quintile. While the rural PGR declined from 9.164 in 2004-05 to 5.68 in 2011-12 in the urban areas it declined from 7.802 to 5.29 during the same period. A nearly 50% decline in PGR both in rural and urban areas during 2004-05 to 2011-12, reflects that the conditions of poor have improved both in urban and rural areas.

➢Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

✓ For U.P. it is estimated that in 1990, ***the proportion of underweight children below 3 years*** 56.78 %. In order to meet the target, the proportion of under-weight children should decrease to 28.39 % by 2015. The National Family Health Survey shows that, the proportion of under-weight children below 3 year declined from 48.1 % in 1998-99 to 41.6 % in 2005-06. At this rate of decline the proportion of underweight children below 3 years is expected to reduce to 33.81 % by 2015, which indicates U.P. is falling short of the target.

✓ **Goal 2: Achieve Universal Primary Education**

➢ TARGET 3: Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education.

✓ The *Net Enrolment Ratio (NER)* in primary education (age 6-10 years) was estimated at 78.2 per cent in 1999-2000 (PSMS-II) and the NER has increased to 84.0 per cent in 2009-10 (PSMS_IV) .The U_DISE data shows that NER has reached to 97.74 per cent in 2005-06 (U-DISE). However, the NER has decreased to 95.64 per cent in 2014-15. .Hence State is unlikely to meet the target of universal achievement.

✓ The results from DISE report 2011-12, shows a steady increasing trend over the years in the estimate of the indicator *'ratio of enrolment of Grade V to Grade I (Survival Rate)'* from 54.09 in 2003-04 to 87.0 in 2014-15.

✓ The *youth (15-24 years) literacy rate* has increased from 67 % to 81.57 per cent during the period 1991-2011 and the trend shows U.P is likely to reach 91.68 % youth literacy by 2015. The male and female youth literacy rate is likely to be at 92.51% and 93.31% respectively.

✓ **Goal 3: Promote Gender Equality and Empower Women**

➢ Target 4: Eliminate gender disparity in primary, secondary education, preferably by 2005, and in all levels of education, no later than 2015

✓ In primary education the enrolment was unfavourable to females as *Gender Parity Index (GPI) of Gross Enrolment Ratio (GER)* was 0.94 in 2004-05. However this ratio turned favourable to females in 2011-12 and stood to 1.03. In Secondary education although GPI of GER has increased to 0.84 in 2011-12 from 0.68 in 2004-15, still it is unfavourable to females. In tertiary level of education, however, the GPI of GER is 1.14 in 2010-11 and 1.00 in 2011-12.

✓ As per Census 2011, the *ratio of female youth literacy rate to male youth literacy rate* is 0.85 for rural area and 0.96 for urban area. At State as a whole it stood to 0.87.

✓ The NSS 68th round (2011-12) results had estimated the *percentage share of females in wage employment in the non- agricultural sector* as 10.0% with corresponding figures for rural and urban areas as 8.0% and 13.1 % respectively. This is an improvement in the status as NSS 66th round (2009-10) had reported that the share of women in wage employment is 8.2 % at state level and the corresponding estimates for rural and urban area of the state pegged at 7.3% and 9.8% respectively. Clearly state has missed the target of 50%.

✓ As in May 2012, U.P. India's most populous state, has only 35 women representatives out of 403 members in Vidhan Sabha, and and hence presently the proportion of seats in Vidhan Sabha is held by women is only 8.68 % against the target of 50%.

✓ **Goal 4: Reduce Child Mortality**

➢ TARGET 5: Reduce by two-thirds, between 1990 and 2015, the under-five Mortality Rate

✓ *Under Five Mortality Ratio (U5MR)* was estimated at 152 deaths per 1000 live births in 1990. In order to achieve the Target 5, the U5MR is to be reduced to 51 deaths per 1000 live births by 2015. As per SRS 2013, the U5MR is at 64 deaths per 1000 live births and as per the historical trend, it is likely to reach 63.61 deaths per 1000 live births, missing the target narrowly. However, an overall reduction in U5MR of nearly 58% happened during 1990 to 2013, registering a faster decline in the recent past, and if this rate of reduction is sustained, the achievement by 2015 is likely to be very close to the target by 2015.

✓ In U.P., *Infant Mortality Rate* was estimated at 99 per 1,000 live births in 1990. As per SRS 2013, the IMR is at 50 and as per the historical trend; it is likely to reach 50 by 2015, against the target of 33 infant deaths per 1000 live births by 2015. However, with the sharp decline in the recent years, the gap between the likely achievement and the target is expected to be narrowed.

✓ The Coverage Evaluation Survey (CES), 2009 carried out by UNICEF and Government of India, shows that, in U.P. *the proportion of one year old children immunised against measles* is 52.8 % in 2009. Although, there is improvement in the coverage which was 33.5% in 1998-99, yet at this rate of improvement, U.P. is likely to achieve about 68.1% coverage by 2015 , which is well below at national level likely achievement of 89.1% and thus U.P.is likely to fall short of universal coverage.

✓ **Goal 5: Improve Maternal Health**

➢ *Target 6: Reduce by three quarters between 1990 and 2015, the Maternal Morality Ratio*

✓ In 1990, the estimated **MMR** was 855.1 per 1,00,000 live births. In order to meet the MDG target, the MMR should be reduced to 213.8 per 1,00,000 live births by 2015. As per the latest estimates, the MMR status for the State is at the level of 285 in 2011-13. As per the historical trend, MMR is likely to reach the level of 241.96 maternal deaths by 2015, however, assuming the recent sharper decline is sustained, U.P.is likely to be slightly nearer to the MDG target.

✓ The Coverage Evaluation Survey conducted by Government of India and UNICEF in 2009 shows that in U.P.64.2% percentage of **births were attended by skilled health personnel** in 2009. Although, considerable progress has been achieved over the years in improving the proportion of births attended by skilled personnel, U.P. is likely to reach the level of 66.7 % vis –a vis the targeted universal coverage by 2015 . The latest results of Sample Registration System (SRS) 2013, reveal that, the percentage of live births attended by skilled health personnel (Government hospitals, Private hospital, qualified professional) is 80.2% in 2013, which indicates a better status.

✓ **Goal 6: Combat HIV/AIDS, Malaria and other Diseases**

➢ *TARGET 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS*

✓ The **prevalence of HIV among Pregnant women aged 15-24 years** is showing a declining trend from 0.42 % in 2004 to 0.15% in 2012-13.

✓ According to NFHS –III in 2005-06**, Condom use rate of the contraceptive prevalence rate (**Condom use to overall contraceptive use among currently married women, 15-49 years,%**)** was only 8.6 % at state level.

✓ According to Behavioural Surveillance Survey (BSS) conducted in 2001 & 2006, the national estimates for **Condom use at last high-risk sex (%)** (Proportion of population aged 15-24 years who used condom during last sex with non-regular partner) registered a decline from 48.8 % in 2006 to 46.0 % in 2009.

✓ According to Behavioural Surveillance Survey (BSS), the national estimate for **proportion of population aged 15-24 years with comprehensive correct Knowledge of HIV/AIDS (%)** in 2006 was 29% which worsen to 21% in 2009.

➢ *TARGET 8: Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases.*

✓ The **Annual Parasite Incidence (API) rate** – In India Malaria has consistently come down from 2.12 per thousand in 2001 to 0.72 per thousand in 2013, but slightly increased to 0.88 in 2014 (P) but confirmed **deaths due to malaria** in 2013 was 440 and in 2014 (P), 578 malaria deaths have been registered. In U.P. API rate was 0.3 per thousand in 2011 and came down to 0.2 per thousand in 2014(P). There was no confirmed death due to malaria in 2013 & 2014(P).

✓ In India, **Tuberculosis prevalence per lakh population** has reduced from 465 in year 1990 to 195 in 2014. TB Incidence per lakh population has reduced from 216 in year 1990 to 167 in 2014. **Tuberculosis mortality per lakh population** has reduced from 38 in year 1990 to 17 in 2014.

✓ **Goal 7: Ensure Environmental Sustainability**

➢ *TARGET 9: Integrate the principle of sustainable development into country policies and programmes and reverse the loss of environmental resources.*

✓ As per assessment in 2013, the total **forest cover of the state** is 14349 sq.km which is 5.95 % of the geographic area of the state. During 2011-2013, there is an increase of 11 sq. km in forest cover.

In 2013 Uttar Pradesh has 1 National park of area 490.00 sq.km. and 11 Wild life sanctuaries comprising of an area of 5538.32 sq.km. and 13 bird sancturaies of area 188.85 sq.km. The ratio of *protected area* to geographical area of state is 2.4% and this ratio has remained constant since 2003.

✓ **Per-capita Energy Consumption** (PEC) (the ratio of the estimate of total energy consumption during the year to the estimated mid-year population of that year) for India has

increased from 6205.25 KWh in 2011-12 to 6748.61 KWh in 2012-13, thus, the percentage annual increase of 8.76%. In the absence of State level data, analysis for U.P. could not be done.

✓ In 2013, the estimated **CO2 emission** (Million Tonnes) for India is 1954.02. The Carbon dioxide emission showed a percentage increase of 235.57% in 2014 over 1990 for India. In the absence of State level data, analysis for U.P. could not be done.

✓ In 2010, **consumption of CFC** is estimated at 290.733 ODP tonnes (ODP –Ozone Depletion Potential), down from 5614 ODP tones in 2000. From the year 2000, the CFC consumption decreased steadily till 2008, but showed minor increase in 2010. In the absence of State level data, analysis for U.P. could not be done.

✓ As per Census 2011, 79.8 % *households of Uttar Pradesh are using solid fuels* (fire wood / crop residue/cow dung cake/ coke, etc) for cooking against 85.7% in 2001. Census 2011, further reveals that, in Rural areas 92.9% households and in Urban areas 3.5 % households are using solid fuels for cooking.

TARGET 10: Halve, by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation

✓ During 2012, in U.P. 96.2 % households had **access to improved source of drinking water** while 96.6 % households in rural and 95 % households in urban area had access to improved source of drinking water. The target of halving the proportion of households without access to safe drinking water sources from its 1990 level to be reached by 2015, has already been achieved.

✓ The NSS 2012 revealed 60.1 % of households at all India level had no latrine facilities. The NSS 2012 shows that 75.3 % and 10.7 % households in rural U.P. and urban U.P. respectively had no **access to sanitation**. Towards achieving the target of access to basic sanitation facility in households, in urban areas, the 2015 target is likely to be met ,against the target of 14.18%, and the progress is quite lagging behind in rural areas vis-a- vis the target of 46.77%. At whole State level, 2015 target is unlikely to be met vis –a –vis the target of 38.09%.

➢ *TARGET 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers*

✓ As per 69th round NSS (Jan- Dec 2012), at all-India level, and at U.P. state level, only 10.8 percent and 2.6 percent respectively of urban dwelling units were situated in slum. However, Census 2011 reported that in U.P. 12.8% of urban households are located in slums.. Census further reveals that in 2011, 14.02 % of the urban population lives in slums.

✓ **Goal 8: Develop a global partnership for development**

➢ *Target 18: In co-operation with the private sector, make available the benefits of new*

technologies, especially information and communication.

✓ The overall **tele-density** in the state has shown some progress and is at 58.31 % as on 31st July 2014.

✓ The **internet subscribers per 100 population** accessing internet through wireline and wireless connections for India was 20.83 in june 2014 whereas it was 11.9 for U.P.

U.P. progress towards achieving MDGs is summarized as below:

MDGs and Targets –Summary of Progress achieved by Uttar Pradesh	
Goal 1:Eradicate extreme poverty and hunger	
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day .	Narrowly missed the target.
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Slow or almost off -track
Goal 2:Achieve Universal Primary Education	
TARGET 3: Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education.	Narrowly missed the target.
Goal 3:Promote Gender Equality and Empower Women	
Target 4: Eliminate gender disparity in primary, secondary education, preferably by 2005, and in all levels of education, no later than 2015	On-track in Primary and Tertiary Education but missed target in case of secondary education.
Goal 4: Reduce Child Mortality	
TARGET 5: Reduce by two-thirds, between 1990 and 2015, the under-five Mortality Rate.	Moderately on-track due to sharp decline in recent years
Goal 5: Improve Maternal Health	
Target 6: Reduce by three quarters between 1990 and 2015, the Maternal Morality Ratio	Moderately on-track due to sharp decline in recent years
Goal 6: Combat HIV/AIDS, Malaria and other Diseases	
TARGET 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	On track as trend reversal in HIV prevalence has been achieved.
TARGET 8: Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases.	Moderately on track as trend reversal has been achieved for Annual Parasite Incidence of Malaria and for prevalence of T.B.
Goal 7: Ensure Environmental Sustainability	
TARGET 9: Integrate the principle of sustainable development into country policies and programmes and reverse the loss of environmental resources.	Off-track
TARGET 10: Halve, by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation .	On track for indicator of drinking water but slow for indicator of sanitation.

TARGET 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	The pattern is not statistically discernable.
Goal 8: Develop a global partnership for development	
Target 18: In co-operation with the private sector, make available the benefits of new technologies, especially information and communication.	Slow on track

----

CHAPTER 3

Uttar Pradesh and Million Development Goals

Keeping in view the country's commitment to attainment of Millennium Development Goals and need to improve the position of the country in Human Development Index list, the Planning Commission, GOI fixed state specific monitor-able targets, for the Twelfth Plan. These include targets for Agriculture growth, Poverty reduction, Employment generation, School enrolment, Reduction in gender gap in literacy, Reduction in IMR and MMR, and Access to clean drinking water. Government of Uttar Pradesh has also committed itself to attainment of these targets. To realise the goals of MDGs, GOUP has fixed following monitor-able targets to be achieved by the end of Twelfth Five Year Plan :

- ✓ *To reduce infant mortality rate from the level of 61 to 32*
- ✓ *To reduce maternal mortality rate from the level of 359 to 200*
- ✓ *Reduction in total fertility rate from 3.5 to2.8*
- ✓ *To reduce malnutrition of children below 3 years of age from 47.0 to 23.5 percent*
- ✓ *Reduction in anaemic ever-married women in the reproductive age group (15-49 years) from 51.6 to 20 percent*
- ✓ *Sex ratio in age group 0-6 years to be improved from 899 to 924*
- ✓ *Drop out in the elementary education up to the level of 5 percent*
- ✓ *Literacy rate to be increased up to the level of 85 percent and gender gap in literacy to lowered up to 10 percentage points*
- ✓ *10 percent rate of growth in State's economy*
- ✓ *Targets for primary, secondary and tertiary sectors of economy are fixed at the level of 5.0, 11.2 and 11.9 per cent respectively.*

The indicators relating to social infrastructure viz. Education, health, nutrition and sanitation reveals that the position of India among other nations of the world is not satisfactory. India is currently placed at 134th (HDI value 0.547) position in the Human Development Report 2011. Likewise Uttar Pradesh is also on 16th position among the 17 major states in respect of human development index in 2005. Thus it is clear that if Uttar Pradesh fails to achieve the set goals/targets , then India will also not be able to achieve the Millennium Development Goals by the year 2015. Hence monitor-able targets need to be rigorously monitored during the Plan period.

ERADICATE
EXTREME POVERTY
AND HUNGER

1

CHAPTER 4

Eliminating extreme poverty and hunger

People living in poverty are often socially excluded and marginalized. Their right to effectively participate in public affairs is frequently ignored and thus elimination of poverty is much more than a humanitarian issue, as it is more of a human rights issue. Thus eradication of poverty and hunger being the basis of all development process, the Millennium Development Goals have given foremost priority to it and the first Goal among the 8 Developmental Goals is on targeting elimination of extreme poverty and hunger.

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Target 1: Halve , between 1990 and 2015, the proportion of people whose income is less than a dollar a day .

1. Indicator 1A: Poverty Headcount Ratio (percentage of population below the national poverty line)

2. Indicator 2:   Poverty Gap Ratio

3. Indicator 3:   Share of poorest quintile in national consumption

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

4. Indicator 4:   Prevalence of underweight children under three years


Indicator 1A : Poverty Headcount Ratio (PHCR)

The **Poverty Headcount Ratio** (PHR) is the proportion of population whose per capita income/consumption expenditure is below an official threshold(s) set by the National Government. The Planning Commission in the Government of India estimates poverty at National and State levels using the poverty lines as defined and applying it to the distribution of persons by household per capita monthly consumption expenditure. The poverty ratio according to the Government of India definition is at variance with that according to international definition. India unlike most countries has different poverty lines at sub-national level in the sense that the poverty ratios are estimated for different States of the country separately for rural and urban areas with reference to corresponding State specific poverty lines and then combined to arrive at State level Head Count Ratios.

In India, the erstwhile Planning Commission had periodically released poverty estimates on the basis of large sample surveys on household consumer expenditure by National Sample Survey Office under the Ministry of Statistics & Programme implementation. The methodology for poverty estimation has been reviewed frequently by the central government and revised accordingly. As of now, the official Poverty Head Count Ratio (PHCR) estimates are based on the Tendulkar methodology and PHCR estimates using this methodology are available for 1993-94, 2004-5 and 2011-12 separately for rural urban and Total at the all India and State. / UT level. The trend in poverty reduction is evident from the decline in the estimates of number of people below poverty line. The actual reduction in the numbers of poor happened during 2004- 05 to 2011-12, when nearly 132 Lakh people were lifted above the poverty line in the state.

The MDG target 1 stipulates that, the percentage of people below state poverty line be brought down to half of its 1990 level. The State PHCR estimate (total) was 50.67% in 1990. In order to meet the requirement of indicator 1A, the PHCR level has to be 25.34 % by 2015. The poverty estimate show that total PHCR of the state was 21.94 % in 2011-12 and likely achievement by 2015 was to be 27.94%, which shows that U.P has not reached the target in terms of Indicator 1A.. The Rural and Urban PHCR estimate were 50.9% and 38.3 % respectively in 1993-94. In 2011-12 the rural PHCR estimate is 30.4 % and urban PHCR estimate is 29.6 % reflecting that both in Rural and urban areas the requirement of Indicator 1A has not been met.

Fig.4.01 Number of people below Poverty Line (in Lakh)
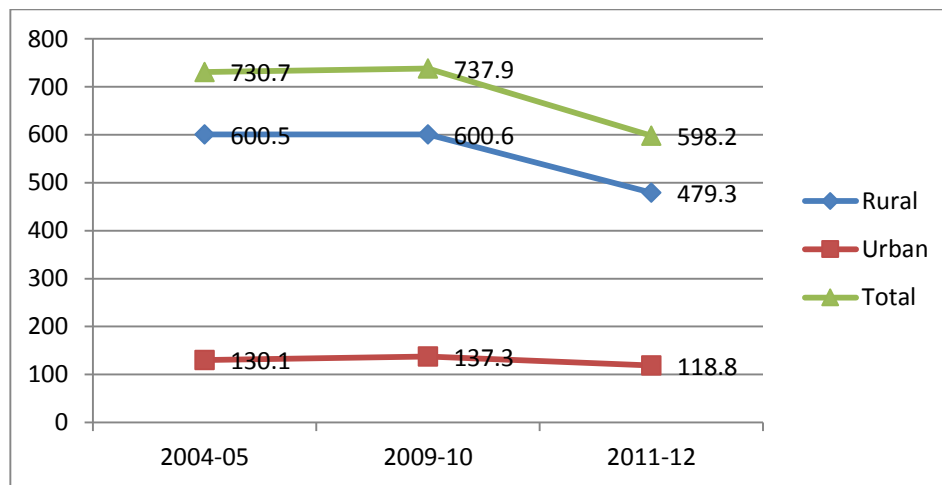
Source: PSMS –IV Survey of GOUP

Fig 4.02 Trend in Poverty Head Count Ratio-U.P. Total
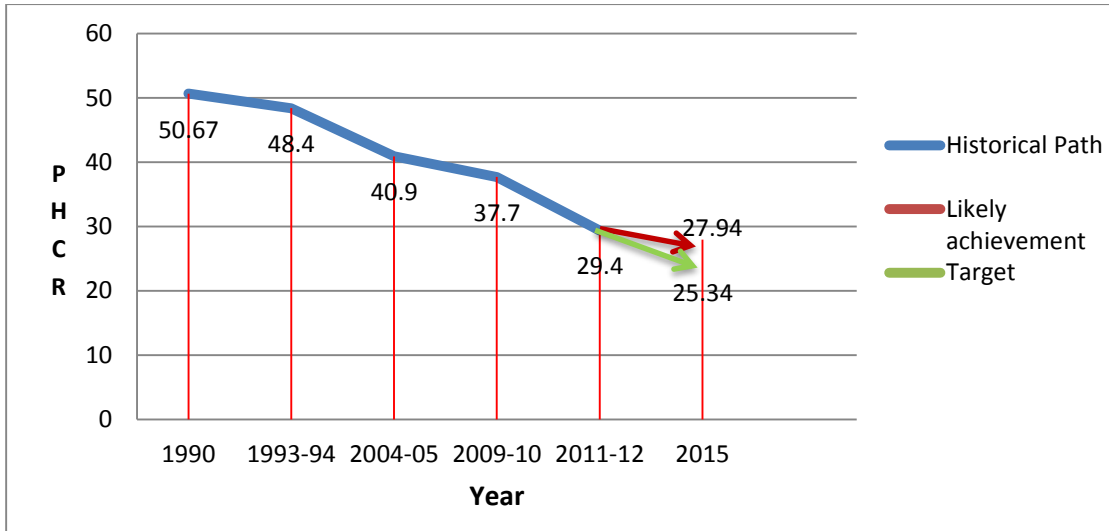
Source: Planning Commission (Now renamed as NITI Aayog)

During 1993-94 and 2004-05, while the Total poverty reduced by 7.5 percentage points, the urban poverty declined by 4.2 percentage points and rural poverty declined by 8.2 percentage points. The rate of reduction of poverty picked up in both rural and urban areas during the period between 2004-05 to 2011-12. During this period, poverty declined by 12.3 percentage points in rural areas and by 8.0 percentage points in urban areas and that resulted in decline of total poverty by 11.5 percentage points. The historical trend shows that, both in rural and urban areas, the MDG target of elimination of poverty is not achieved by 2015.
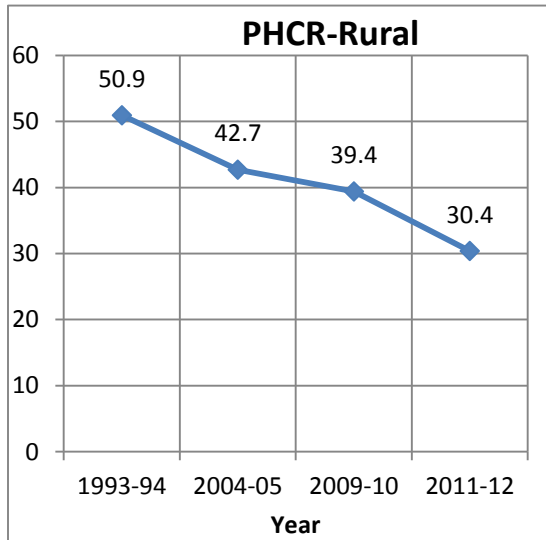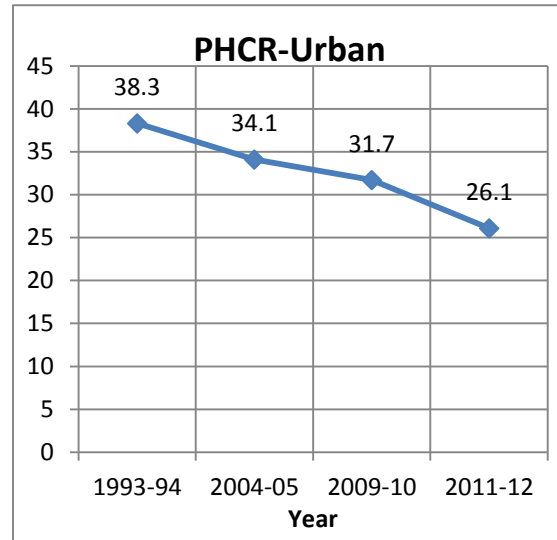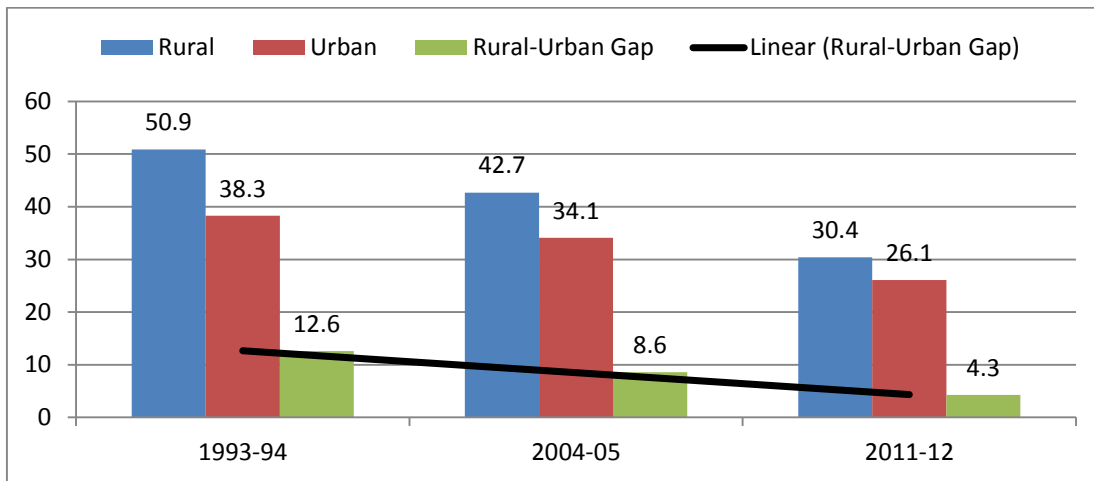

Fig 4.03-Trend in PHCR_Rural

Fig 4.04-Trend in PHCR-Urban

Source: PSMS-IV,GOUP

The Rural –Urban gap in poverty head count ratio is still persisting significantly, though the gap has come down from 12.6 percentage points in 1993-94 to 4.3 percentage points, in 2011-12.

Fig 4.5 Trend to rural urban gap in PHCR

Economics & Statistics Division (ESD), U.P. regularly participate in National Sample Surveys, conducted by NSSO, GOI. Usually it participates on matching sample basis. With the objective to generate socio-economic estimates for sub state level, in the 61st and 66th round of NSS, the state sample size was doubled. It helped generating poverty estimates for the Western, Central, Eastern and Southern region of the State. However the PHCR estimated through state sample data showed higher incidence of poverty compared to estimated arrived by planning commission, for both Rural and Urban sector , for years 2004-05 and 2009-10 .

An analysis of Table 4.1 shows that PHCR varies from 30 to 50 percent point ,among different regions of the state. This variation is quite large in rural sector comparison to urban sector for the year 2009-10. Central region has highest PHCR as about 50 percent its populations were found below poverty line where as lowest poverty level (30.07 percent) was observed in Western region of the state. Eastern region which has highest population share of state having also moderately high PHCR (44.39 percent) followed by Southern region. Comparison of HCR across region and sector, it is found that in all region , urban part have less PHCR compared to their rural counterpart except urban part of Western region. Further it is also observed that among rural part of different regions, PHCR is highest in Central region where about 54 percent populations were below poverty line in year 2009-10. For urban sector, PHCR was highest for Western region (38.86 percent).

Analysing the trends of PHCR across regions and sector, it is found that PHCR decreased by 7.99 & 3.76 percentage point in rural part of Western and Eastern regions respectively, where

as it increased by 10.11 &14.70 percentage   point respectively in rural part of the Central &Southern region between years 2004-05 to 2009-10. Similarly analysing changes in PHCR for urban part of each region, it is found that PHCR decreased in all region, except in Western region where it increased by 4.87 percentage point from year 2004-05 to 2009-10.

Table 4.1: PHCR for different Sectors And Regions of the State U.P.

Sl.No.	Region	NSS 61st Rnd.(2004-05)			NSS 66th Rnd.(2009-10)		
		Rural	Urban	All	Rural	Urban	All
1	Western	38.85	33.99	37.61	30.86	38.86	33.07
2	Central	44.02	34.52	41.81	54.13	32.92	50.13
3	Eastern	49.23	44.14	48.75	45.47	35.25	44.39
4	Southern	26.57	30.64	27.40	41.27	28.41	38.04
5	U.P.	44.24	36.49	42.81	42.50	35.95	41.24

Source: PSMS-IV,GOUP

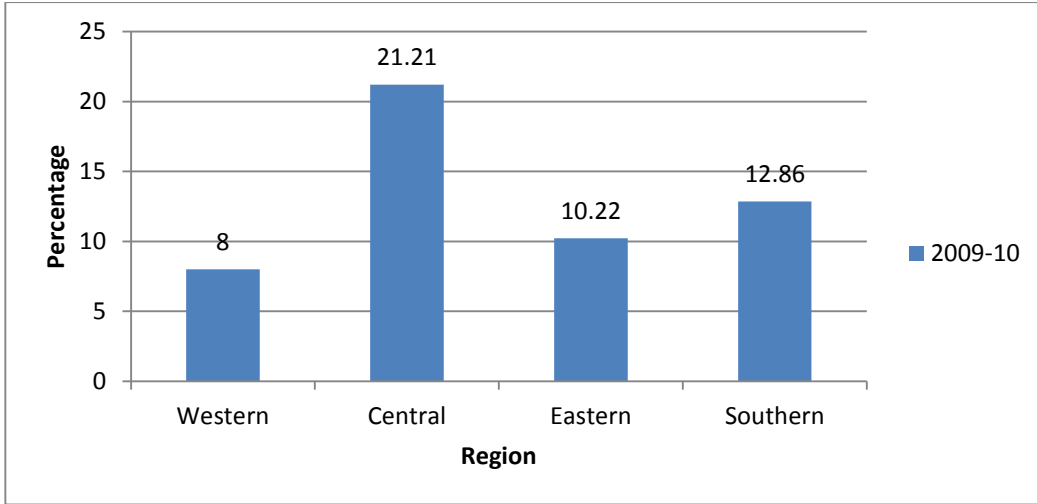Note-Based on MRP schedule type-1 data.

Fig 4.6: Region-wise Trend in PHCR-Total
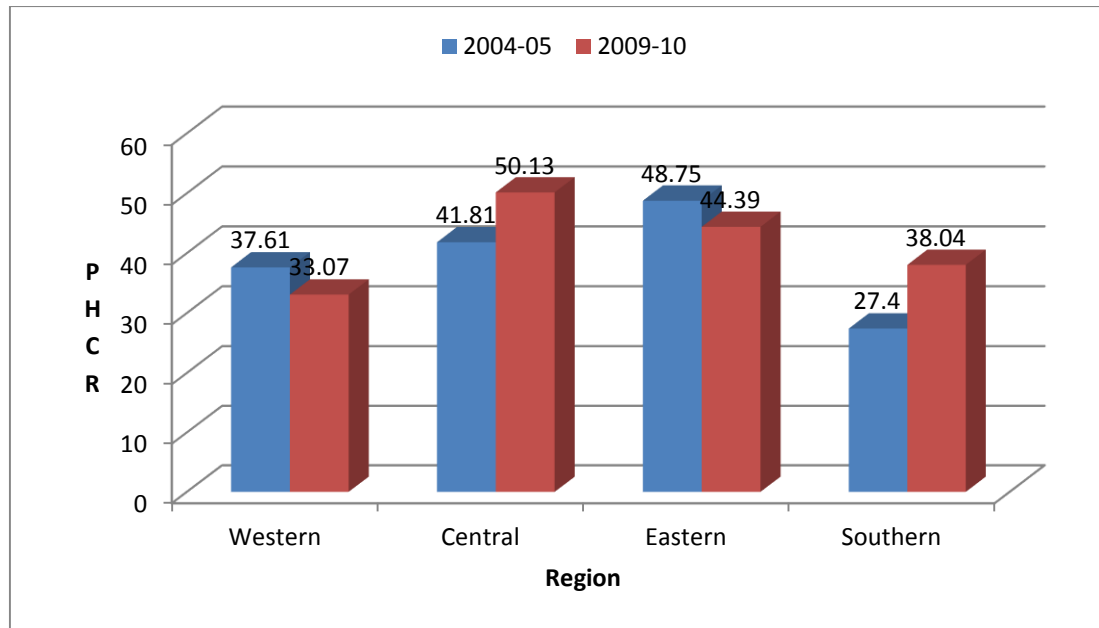
Source: PSMS-IV,GOUP

Thus rural-urban gap in PHCR persisted in regions also. In 2009-10 it was highest for Central region and was least for Western region.

Fig 4.7: Region-wise Rural -Urban gap in PHCR

Source: PSMS-IV,GOUP

## Indicator 2 : Poverty GAP Ratio (PGR)

The **Poverty Gap Ratio** is the gap by which mean consumption of the poor below poverty line falls short of the poverty line. It indicates the depth of poverty; the more the PGR, the worse is the condition of the poor. While the number of poor people indicates spread of poverty, PGR indicates the depth. During 2004-05 to 2011-12, PGR also reduced in both rural and urban areas. While the rural PGR declined from 9.164 in 2004-05 to 5.68 in 2011-12 in the urban areas it declined from 7.802 to 5.29 during the same period. A nearly 50% decline in PGR both in rural and urban areas during 2004-05 to 2011-12, reflects that the conditions of poor have improved both in urban and rural areas.

Fig 4.8: Trend in Poverty Gap Ratio (PGR) for U.P.
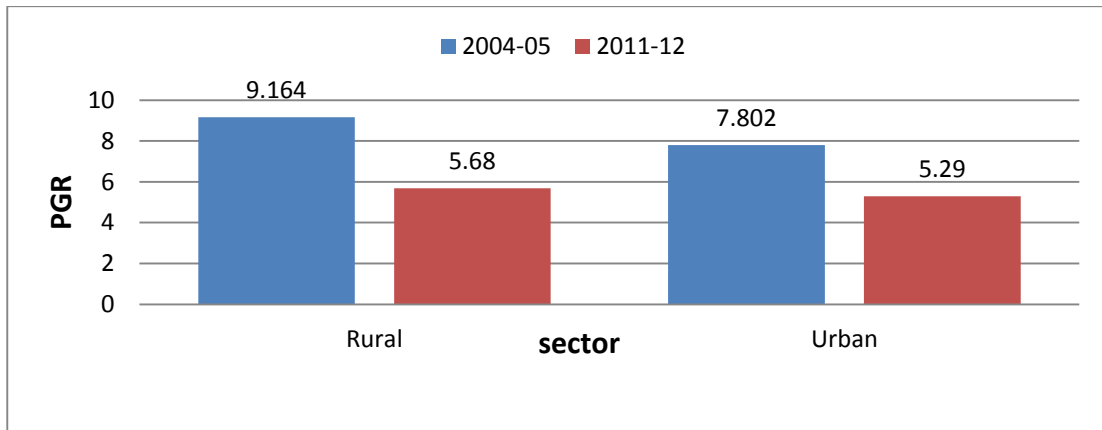
Although, at State level PGR declined substantially in both rural and urban areas during 2004-5 to 2011-12, but scenario vary from Region to Region. According to PSMS Survey-2009 of GOUP, Rural PGR of Central and Southern Region and Urban PGR of Western and Central region increased between 2004-05 and 2009-10, implying worsening of the condition of poor in these regions.

Fig 4.9: Trend in Poverty Gap Ratio (PGR) for different regions of U.P.
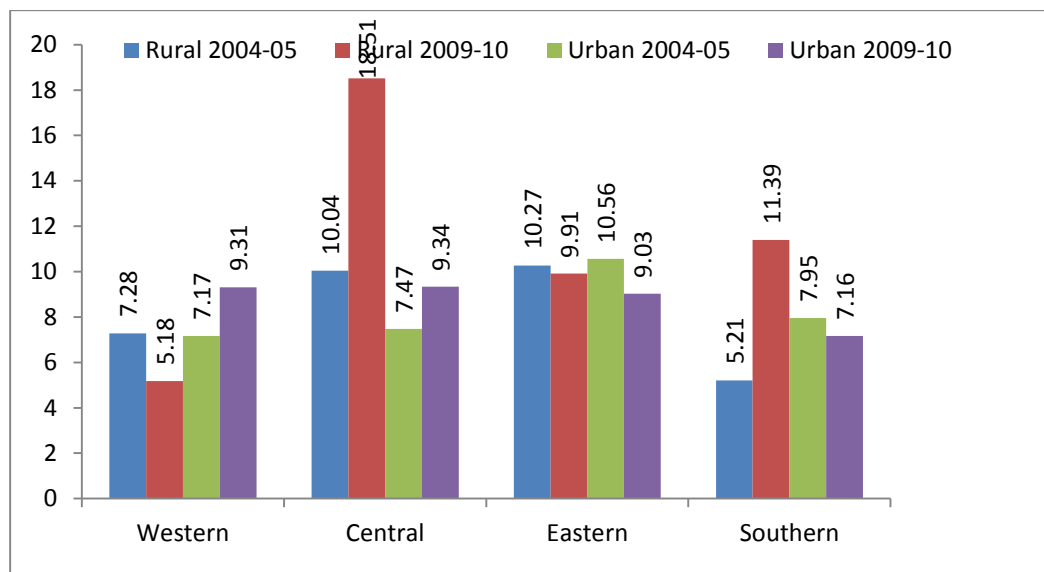
Indicator 3: Share of poorest quintile in national consumption

The share of poorest quintile in national consumption is defined as the share of a country's national consumption or income that accrues to the poorest quintile (fifth) of the population. This indicator is expressed as a percentage. Poorest quintile is the bottom 20% of the population, ranked by income or consumption levels. The indicator provides information about the distribution of consumption or income of the poorest fifth of the population. Because the consumption of the poorest fifth is expressed as a percentage of total household consumption (or income), this indicator is a 'relative inequality' measure. In a situation of income or consumption being equally distributed, the expected share of the poorest quintile is 20%. However, the ground reality varies much from this ideal situation, as both in rural and urban areas, the share of poorest 20% in national consumption was always less than 10% during 1993-2012, and over the years, a declining trend has been observed. Same is the case with U.P. According to PSMS-IV, in 2004-05 , the share of poorest 20% in State level consumption was 12.64 % which further declined to 11.72% in 2009-10 signifying the worsening of the condition of poorest quintile.

Table 4.2: Share of poorest quintile in state level consumption

Region	Share of poorest quintile					
	2004-05			2009-10		
	Rural	Urban	Overall	Rural	Urban	Overall
Western	13.72	12.10	13.03	14.00	12.9	13.54
Central	12.61	10.76	11.60	11.32	8.13	10.08
Eastern	12.81	12.21	12.60	12.43	10.55	12.00
Southern	11.08	9.75	10.89	10.99	11.11	9.96
State	13.17	11.74	12.64	12.34	10.92	11.72

Note-PSMS-2009-10 Survey

It is evident that, at state level, the share of the poorest quintile in the total consumption is lower in the urban areas than in rural areas. During 2004-05 to 2009-10, in urban areas, the indicator showed a decline from 11.74 % in 2004-05 to 10.92 % in 2009-10. In rural areas, the share of poorest quintile steadily declined from 13.17 % in 2004-05 to 12.34 % in 2009-10.

Considering the MRP (Mixed Reference Period) Method, in 2009-10 among the regions, Western (14.00%) reported the highest share for the poorest quintile in the total consumption followed by Eastern (12.43%),Central (11.32%) and Southern (10.99%) in rural areas. For urban areas, Western topped with 12.9% share for the poorest quintile in the total consumption followed by Southern (11.11%), Eastern (10.55 %) and Central (8.13%).

Indicator 4: Prevalence of underweight children under 3 years of age.

Malnutrition among its citizen is a very severe social problem, faced by any Country, as it affects productivity in many ways. The problem of malnutrition is especially critical in case of women and children. A women's nutritional status has important implications for her health as well as the health of her children because a malnourished woman is very likely to give birth to a malnourished child vulnerable to disease and infection. Under nutrition not only retards a child's growth but also affects their future productivity and capabilities thus adequate nutrition is critical to a child's development. First 60 months after birth is extremely important because at this delicate age, children are vulnerable to growth retardation, micronutrient deficiencies, and common childhood illness. Highlighting the crucial importance of nutritional status of children, Indicator 4 under target 2 has been identified as 'Prevalence of underweight children Under 5 years of age'. In India, data on this indicator for the reference age group are not available for all time points. The National Family Health Survey (NFHS) collected data on underweight children between 0-35 months and 0-47 months of age in 1992-93 (NFHS-1) , between 0-35 months in 1998-99 (NFHS-2) and between 0-35 months as well as 0-59 months in 2005-06 (NFHS-3).Thus the survey results are comparable only for the age group 0-35 months in India and therefore, target 2 is measured in terms of nutritional status of children below 3 years.

It is estimated that in 1990, 56.78 % of children below 3 years were underweight. In order to meet the target, the proportion of under-weight children should decrease to 28.39 % by

2015. The NFHS shows that, the proportion of under-weight children below 3 year declined from 51.7 % in 1998-99 to 41.6 % in 2005-06. At this rate of decline the proportion of underweight children below 3 years is expected to reduce to 33.81 % by 2015, which indicates U.P. is falling short of the target.

Fig 4.10: Trend in proportion of underweight Children (<3yrs) in U.P.
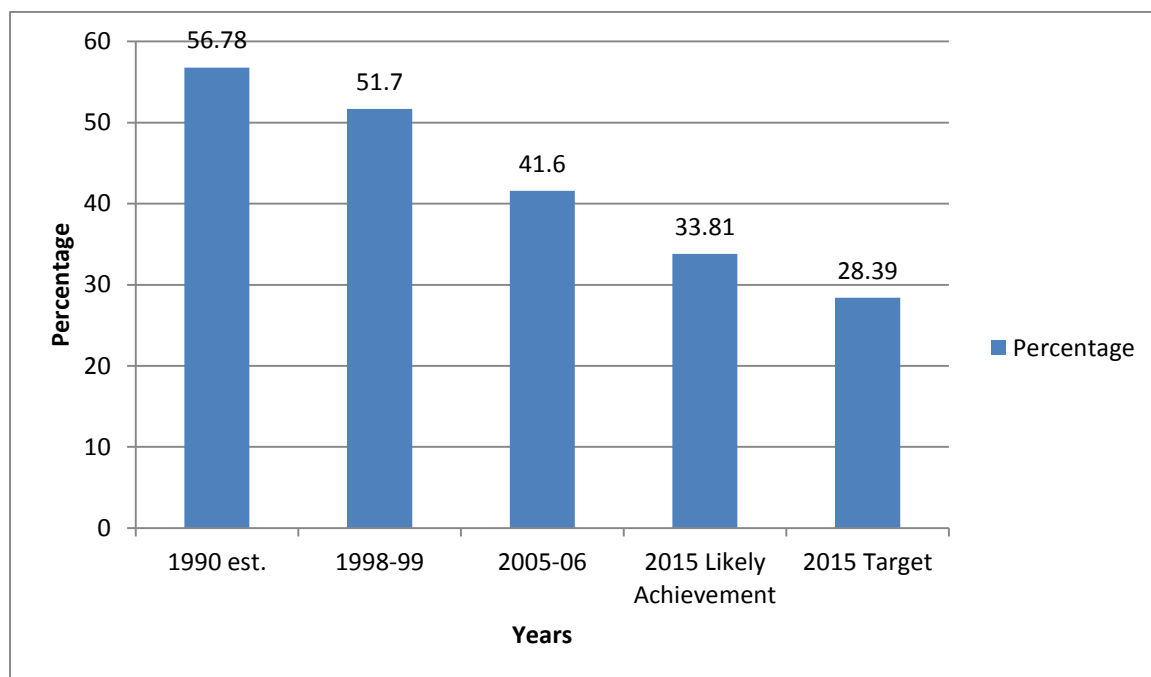
Source: NFHS-2 & NFHS-3

Table 4.3 :Trends in nutritional status of children below 3 years in U.P.

	NFHS-2 (1998-99)			NFHS-3 (2005-06)		
	Urban	Rural	Total	Urban	Rural	Total
Children Stunted (Height for age) %	46.7	57.3	55.5	46.6	53.6	52.4
Children Wasted (Weight for height) %	9.5	11.4	11.1	16.5	20.3	19.5
Children Underweight (Weight for age)%	42.6	53.6	51.7	31.8	43.7	41.6

Source: NFHS-2 & NFHS-3

Despite efforts to improve the nutritional status of young children, especially through the Integrated Child Development Services (ICDS) programme, there has not been much improvement in the nutritional status of children under three years of age in recent years.

• The percentage of children who are too short for their age (stunted) decreased by less than one percentage point per year over the seven years between the two surveys, from 55.5 percent in NFHS-2 to 52.4 percent in NFHS-3.

• The percentage of children who are underweight decreased, by ten percentage points.

• Wasting (low weight-for-height) among young children has actually become somewhat worse over time, increasing from 11.1percent in NFHS-2 to 19.5 percent in NFHS-3.

As evident from the NFHS, under- nutrition is substantially higher in rural areas than in urban areas. While in the urban areas the proportion of under-weight children below 3 years decreased from 42.6% in 1998-99 to 31.8% in 2005-6, the decrease was lower in rural areas from 53.6% in 1998-99 to 43.7% during the same time. In addition to underweight, stunting was also highly prevalent among children below three years of age. As per NFHS-3, even in urban areas, one in every 2 children is stunted, that is short in height for age and in rural areas almost half of the children are stunted.

ACHIEVE UNIVERSAL
PRIMARY EDUCATION

CHAPTER 5

Towards universalization of primary education

The essence of Human Resource Development is education, which plays a significant and remedial role in balancing the socio-economic fabric of the society. Emphasising this aspect, the Goal 2 of the Millennium Development Goals is aiming at achieving universal primary education.


GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

TARGET 3: Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education.

- Indicator 6:   Net Enrolment Ratio in primary education.

- Indicator 7:   Proportion of pupils starting Grade 1 who reach Grade 5.

- Indicator 8:   Literacy rate of 15-24 year olds.

Education is a unique investment in the present, bearing invaluable benefits in the future. According to ' *Elementary Education in India :Trends 2005-06 to 2014-15*',brought out by National University of Educational Planning and Administration and DISE data , the overall increase in enrolment in primary education during the period 2002-03 to 2014-15 was 7.03 million . The enrolment in primary education reached the highest level in 2012-13 (26.6 million) and then declined to 25.9 million in 2013-14 and to 25.8 million in 2014-15. Between 2011-12 and 2014-15, the total enrolment in primary education decreased by 4.5 million, with the enrolment of girls and boys decreasing by 2.13 million and 2.32 million respectively. One of the reasons for the decline in enrolment in primary education is the declining child population age 0-6 years. The child population in the age group 0-6 years has declined by 0.833 million between 2001 and 2011 (Census of India, 2001 & 2011).
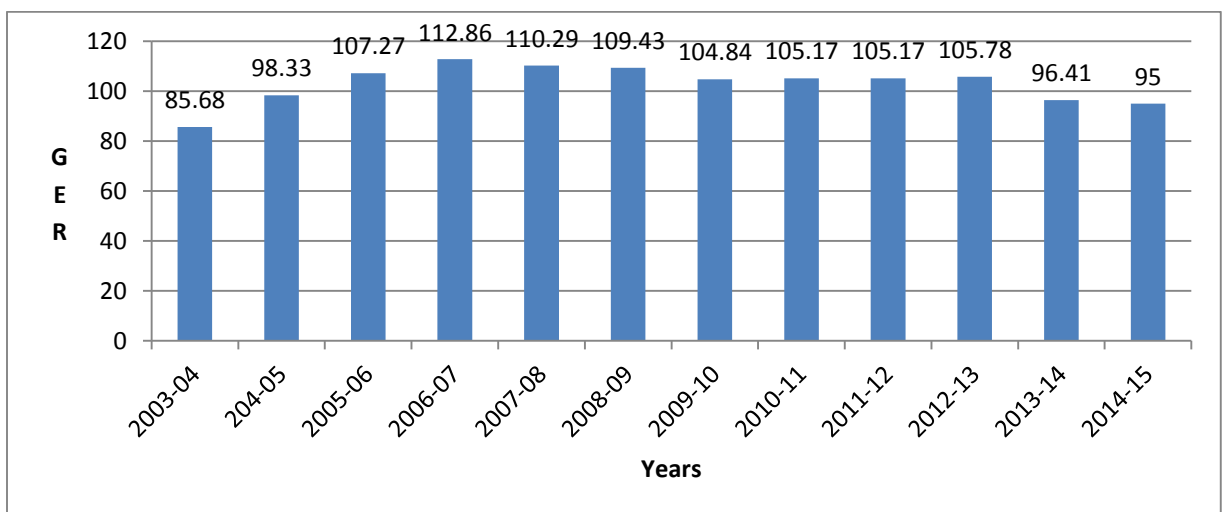
Fig 5.01: Trend in enrolment in primary education in U.P.
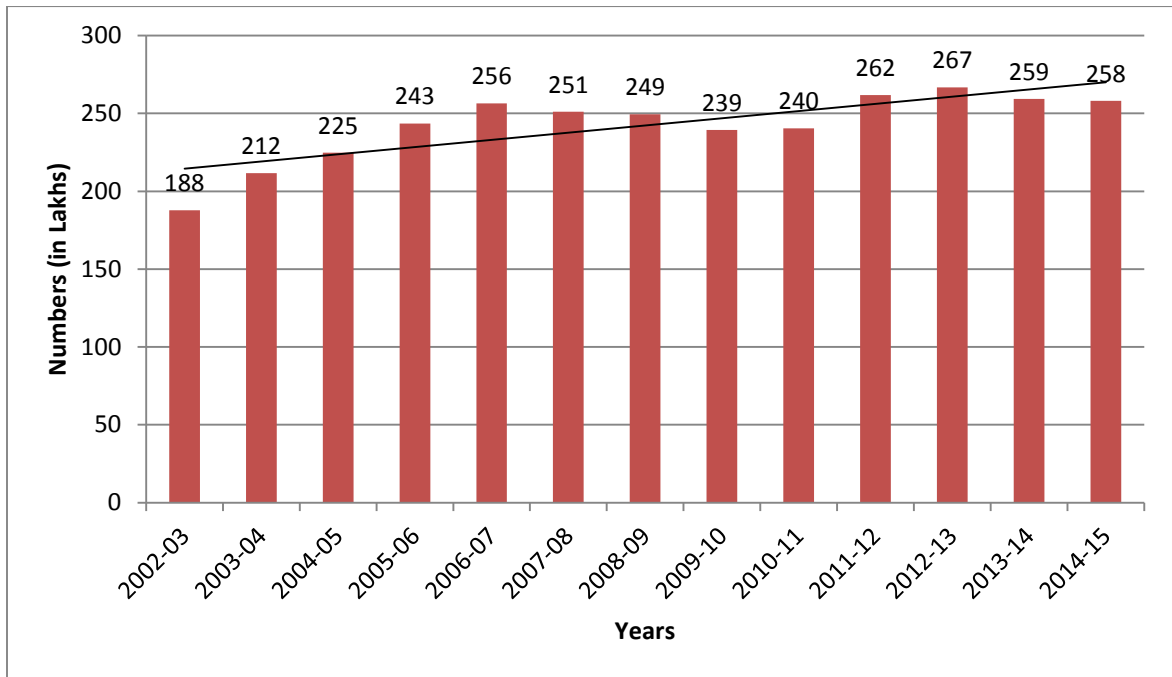
Source: M/o Human Resource Development

The Gross Enrolment Ratio (GER) in primary education increased from 85.68 per cent in 2003-04 to 112.86 per cent in 2006-07 and then declined to 95.0 per cent in 2014-15. The overall increase in gross enrolment ratio in primary education during the period 2003-04 to 2014-15 was 10.8 percentage points (from 85.68 per cent in to 95.0 per cent).

Fig 5.02: Trend in Gross Enrolment Ratio

Source: M/o Human Resource Development

Indicator 6: Net Enrolment Ratio in Primary Education

Net primary enrolment ratio is the ratio of the number of children of official school age (as defined by the national education system) who are enrolled in primary school to the total population of children of official school age. Based on the available data, the Net Enrolment Rate (NER) in primary education (age 6-10 years) was estimated at 97.74 per cent in 2005-06 (U-DISE). The NER has decreased to 95.64 per cent in 2014-15.

The Age-Specific Enrolment Ratio (ASER-children of a specific single-age/age group, i.e. 6 to 10+ years or 11 to 13+ years, enrolled, irrespective of level of education, as a percentage of the population of the same single/age group) for children of age 6-10 years was 89.11 per cent for the year 2014-15.

Indicator 7: Proportion of pupils starting Grade 1 who reach Grade 5

4.6. One of the goals of the Sarva Shiksha Abhiyan (SSA) has been to achieve universal retention by enabling children enrolled in Class I to complete eight years of elementary education. Universalisation of primary education addresses two major target groups, the out of school children during the primary school going age and the children who were forced to drop out even before completion of primary grade classes due to social and /or economic impediments. The investment made in terms of expansion of schooling facilities, bridging gender and social category gaps in elementary education, and quality improvement initiatives, have contributed substantially to reduction in drop-out rates(from 15.50 % in 2003-04 to 7.1 % in 2014-15) and improved retention rates (from 51.12 % in 2003-04 to 90.1 % in 2014-15) in primary education.

The proportion of pupils starting grade 1 who reach grade 5, known as the *survival rate* to grade 5, is the percentage of a cohort of pupils enrolled in grade 1 of the primary level of education in a given school year who are expected to reach grade 5. The ideal result from a cohort study is at present not available in the official statistics of the country. However the results from DISE reports, shows a steady increasing trend over the years in the estimate of the indicator '*ratio of enrolment of Grade V to Grade I*' from 54.09 in 2003-04 to 87.0 in 2014-15.

**Fig 5.03: Trend in Ratio of Grade V to Grade I**

28
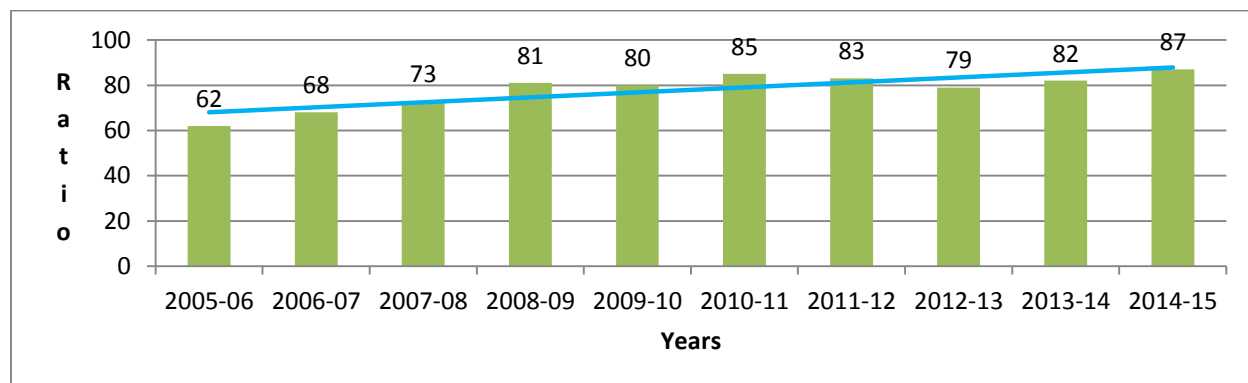
Indicator 8 : Literacy rate of 15-24 year olds

Literacy rate of 15–24 year-olds, or the youth literacy rate, is the percentage of the population 15– 24 years old who can both read and write with understanding a short simple statement on everyday life. In India, a person aged 7 years and above who can both read and write with understanding in any language has been taken as literate. It is not necessary for a person to have received any formal education or passed any minimum educational standard for being treated as literate.

The literacy rate for population in the age group 15-24 years has shown an upward trend. Using the Census data, the youth literacy rate (literacy rate in the age group of 15-24 years) can be computed. The literacy rate in the age group of 15-24 years has increased from 51.1% in 1991 to 66.5 % in 2001 . The youth literacy rate was 81.57% in 2011 census . The trend shows U.P is likely to reach 91.69 % which shows that U.P. is very to the target of 100% youth literacy by 2015.

Fig 5.04: Trend in Youth Literacy
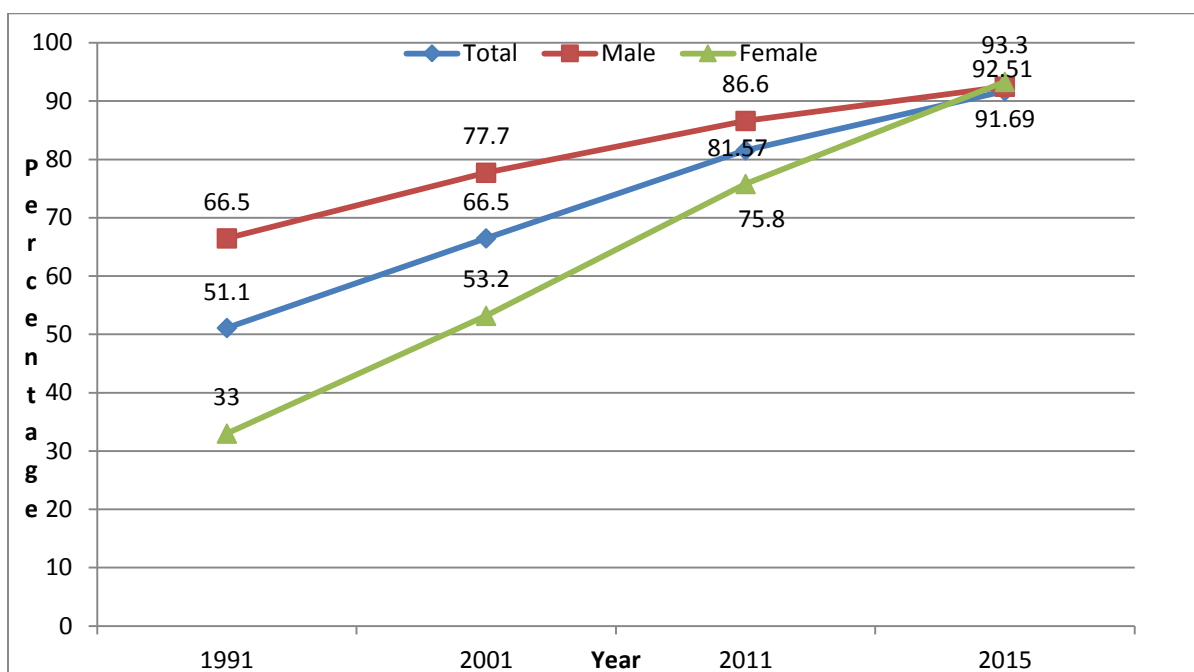
Source : Census 1991,2001,2011

During the 1999-2011, the increase in youth literacy was higher among females than males and gender gap is also declining.

Table 5.01: Youth Literacy (15-24 years) Literacy rate by Sex

1991			2001			2011		
Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
66.5	33	51.1	77.7	53.2	66.5	86.6	75.8	81.6
Gender Gap		33.5	Gender Gap		24.5	Gender Gap		10.8

Source : Census 1991,2001,2011
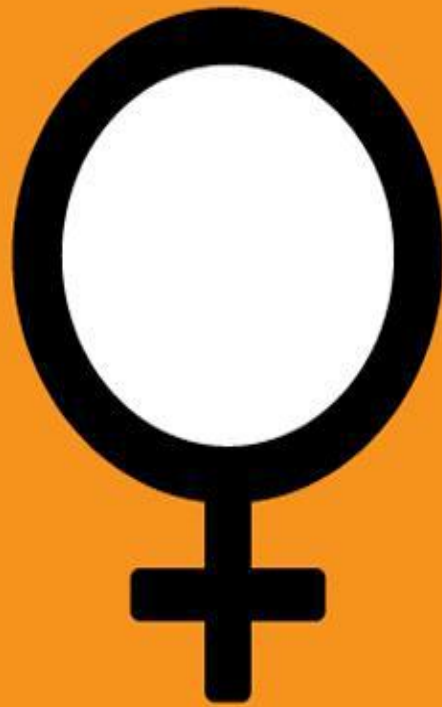
PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

CHAPTER 6

Promoting gender equality and empowerment of women

Gender equality is a precondition for all round development and reducing poverty. It will be achieved only when women and men enjoy the same opportunities, rights and obligations in all spheres of life. This means sharing equally, power and influence, and having equal opportunities in economic and social spheres. Empowered women make invaluable contribution to the improvement of health conditions and educational status and productivity of whole families and communities, which in turn improve prospects for the next generation.

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Target 4: Eliminate gender disparity in primary, secondary education, preferably by 2005, and in all levels of education, no later than 2015

- Indicator 9:   Ratio of girls to boys in primary, secondary and tertiary education

- Indicator 10:   Ratio of literate women to men, 15-24 years old

- Indicator 11:   Share of women in wage employment in the non-agricultural sector

- Indicator 12:   Proportion of seats held by women in National Parliament

---

Indicator 9 : Ratio of girls to boys in primary, secondary and tertiary education.

Education is the single most important factor to ensure gender equality and empowerment. Enrolment of girls in primary education, survival and transition to higher levels of education lead to achieving gender parity in education. During 2005-06 to 2013-14, substantial progress has been achieved towards gender parity in education as revealed by some important indicators.

Table 6.01: Trend in Indicators related to girls enrolment in education

Indicator	Level of education	2005-06	2014-15
Enrolment of girls as percentage of total enrolment	Primary education (Classes I-V)	47.8	48.8
	Upper primary education (Classes VI-VIII)	45.3	50.0
	Secondary (IX –X) and higher secondary (XI –XII) education (2006-07)	36.6	44.5
Number of girls per 100 boys enrolled	Primary education (Classes I-V)	91	95
	Upper primary education (Classes VI-VIII)	83	100
	Secondary (IX –X) and higher secondary (XI –XII) education(2006-07)	86	93

Source :U-DISE 2014-15, Sankhyakiya diary,U.P.2015

It is evident that, during 2005-06 to 2013-14, the enrolment of girls is improving and the gender gap in enrolment is diminishing in all levels of education.The *Gender Parity Index (GPI)* is the ratio of the number of female students enrolled at primary, secondary and tertiary levels of education to the corresponding number of male students in each level. The *Gross Enrolment Ratio (GER)* is the number of pupils enrolled in a given level of education, regardless of age, expressed as a percentage of the population in the theoretical age group for the same level of education. *GPI of GER* is the ratio of GER of the girls to that of boys in primary, secondary and tertiary education. Thus, the GPI (GER), which is free from the effects of the population structure of the appropriate age groups, for each level of education, is taken as the appropriate indicator to monitor the gender equality in education.

Gender Parity Index for GER in primary, secondary and higher education has been improving steadily.At present, in primary education the enrolment is favourable to females as GPI has crossed the level of 1. In Secondary education, a rapid progress has been observed during the recent past towards gender parity. In tertiary level of education also gender parity has been achieved.

Table 6.02: Trend in Gender Parity Index (GPI) Of GER

Year	Primary Classes	Secondary Classes	Higher Education
2004-05	0.94	0.68	0.74
2005-06	0.93	0.67	0.74
2006-07	0.93	0.67	0.69
2007-08	1.05	0.81	0.63
2010-11	1.05	0.79	1.14
2011-12	1.03	0.84	1

Source-India Country report 2015

Indicator 10: Ratio of literate women to men, 15-24 year old

The ratio of literate women to men, 15–24 year old (literacy gender parity index) is the ratio of the female literacy rate to the male literacy rate for the age group 15–24. The literacy rate for population in the age group 15-24 years has shown an upward trend for females as well as males. The youth literacy rate has increased from 51.1% to 81.6% during the period 1991-2011. This period saw a higher increase in literacy rate among female youths (from 33% to 75.8%) compared to male youths (from 66.5% to 86.6%). Over the years, the gap between male and female youth literacy rate has been reduced considerably.

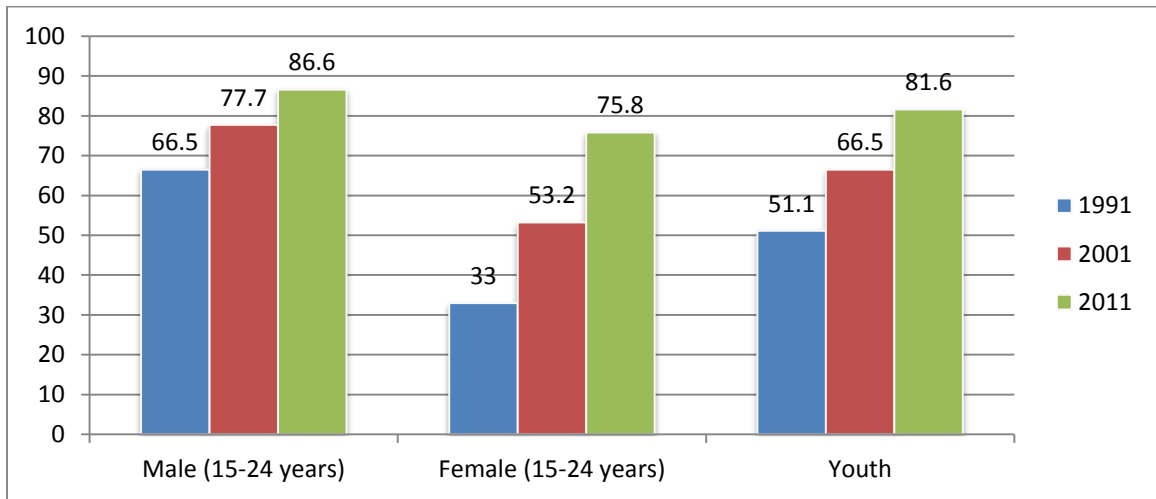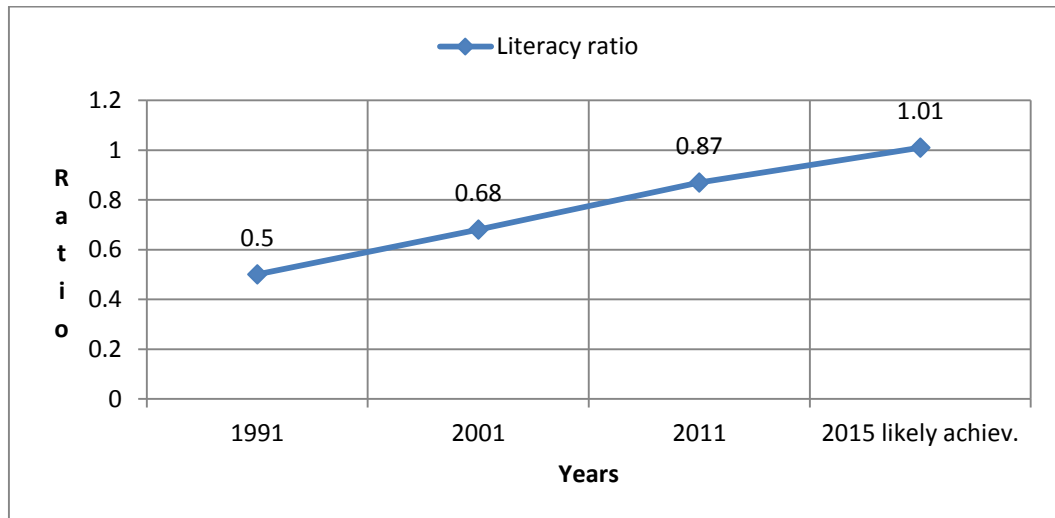**Fig 6.01: Trend in youth literacy rate**

Fig 6.02: Ratio of Female literacy rate to Male literacy rate for 15-24 years

As per Census 2011, for U.P. the ratio of female youth literacy rate to male youth literacy rate was 0.87 . During the decade 1991 -2001, the percentage increase in ratio of female youth literacy rate to male youth literacy rate is 36 % whereas during 2001 -2011, the growth was 29.4 %. With the progress achieved during 1991 – 2011, U.P. is likely to achieve the gender parity in youth literacy rate by 2015. The ratio of female youth literacy rate to male youth literacy rate was 0.85 for rural area and 0.96 for urban area.

Indicator 11 : Share of Women in Wage Employment in the Non- Agricultural Sector

The indicator '*Share of Women in Wage Employment in the Non-Agricultural Sector*' is defined as the share of female workers in the non-agricultural sector expressed as a percentage of total employment in the sector. This measures the degree to which labour markets are open to women in industry and service sectors, which affects not only equal employment opportunity for women but also economic efficiency through flexibility in the labour market and reflect economic factors in social empowerment of women.

The NSS 68th round (2011-12) results had estimated the percentage share of females in wage employment in the non- agricultural sector as 10 % with corresponding figures for rural and urban areas as 8 % and 13.1 % respectively. This is an improvement in the status as NSS 66th round (2009-10) had reported that the share of women in wage employment is 8.2 % at national level and the corresponding estimates for rural and urban U.P pegged at 7.3 % and 9.8 % respectively. It is projected that, at this rate of progress, the share of women in wage employment can at best reach a level of about 10.41 % by 2015. The NSS 68th round (2011-12) results had estimated the percentage share of females in wage employment in the non-agricultural sector at all India level as 19.3% with corresponding figures for rural and urban areas as 19.9% and 18.7% respectively.

**Fig 6.03: Trend in share of women in wage employment in non agricultural sector**
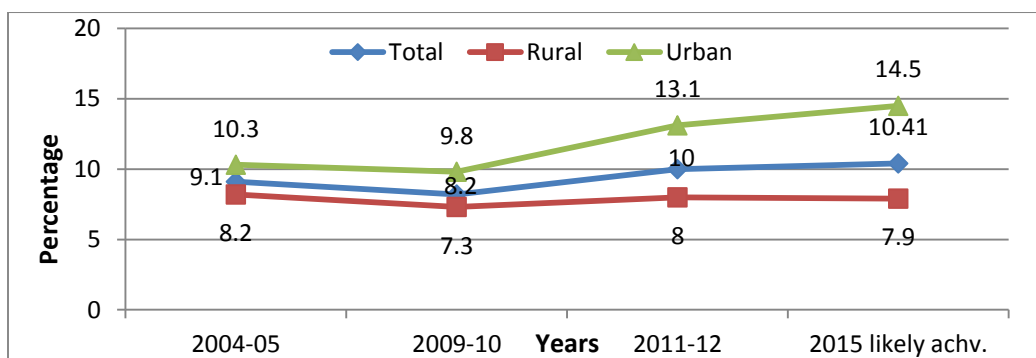
Source : NSSO

In India as well as in U.P. , the labour market of non-agricultural sector are greatly male dominated and a 50:50 situation for men and women is too ideal to be true, given the market dynamics and existing socio-cultural framework.

Indicator 12 : Proportion of seats held by women in Vidhan Sabha

U.P. has witnessed 16 General elections to the Vidhan sabha so far. As in May 2012, U.P. has only 35 women representatives out of 403 members in Vidhan sabha, and at present, 8.68 % seats of State Vidhan sabha is held by women.

Fig 6.04: Percentage of women member in Vidhan sabha of U.P.
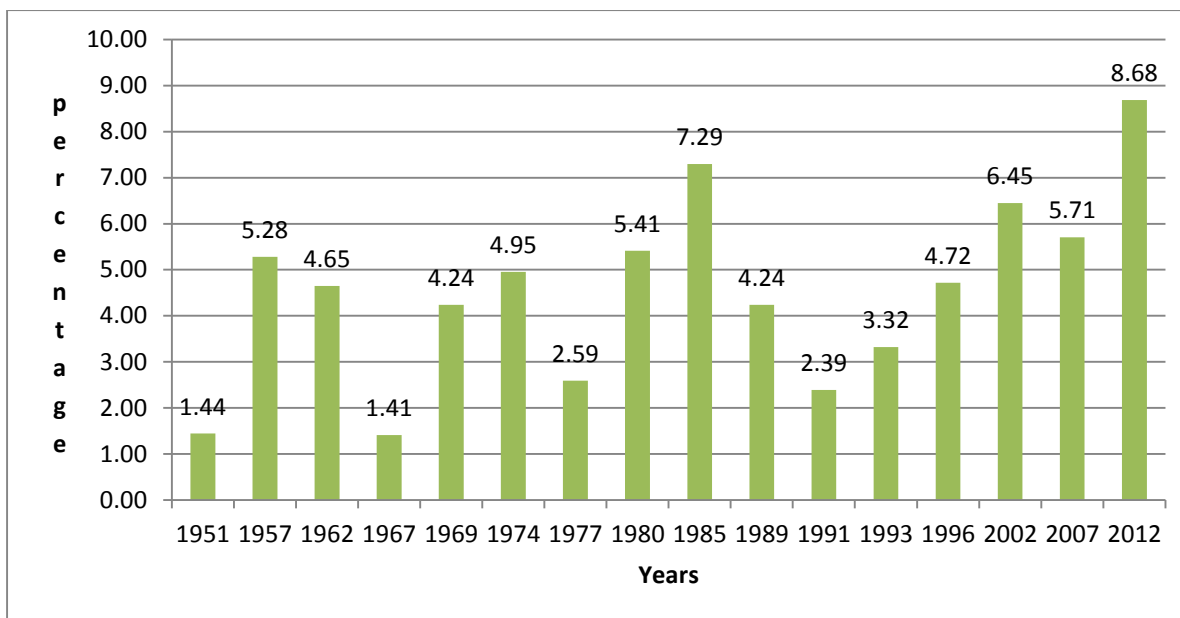
As in January 2015, India, the world's largest democracy, has only 65 women representatives out of 542 members in Lok Sabha, while there are 31 female representatives in the 242 member Rajya Sabha and at present, 12.24% seats of Indian Parliament is held by women. According to data released by Inter Parliamentary Union (IPU), India ranks 115 in the World for proportion of National Parliament seats held by Women.

REDUCE CHILD MORTALITY

CHAPTER 7

Reducing Child Mortality

Children are the most valuable assets for every country. A child's life is highly vulnerable to various diseases and substantial number of children lose their lives every day all around the world. In many cases, the child mortality happens due to causes which are preventable with adequate attention and care. The Millennium Development Goal 4 highlights the urgent need for reducing child mortality.

GOAL 4: REDUCE CHILD MORTALITY

TARGET 5: Reduce by two-thirds, between 1990 and 2015, the under-five Mortality Rate

- Indicator 13:   Under-Five Mortality Rate

- Indicator 14:   Infant Mortality Rate

- Indicator 15:   Proportion of one year old children immunised against measles


Indicator 13: Under-Five Mortality Rate.

The ***under-five mortality rate (U5MR) is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rates.*** Majority of the under five deaths are neonatal deaths which are mainly due to complications and infections happened during birth. In addition to this, the U5MR is sensitive to a wide variety of drivers such as the nutritional status of mothers, level of immunization, availability of child and maternal care services, economic conditions in the family, etc.

In India, the Office of the Registrar General of India (ORGI) regularly releases reliable estimates of fertility and mortality using data collected through Sample Registration System (SRS). For, U.P. the Under Five Mortality Ratio (U5MR) was estimated at 152 deaths per 1000 live births in 1990. In order to achieve the Target 5, the U5MR is to be reduced to 51 deaths per 1000 live births by 2015. As per SRS 2013, the U5MR is at 64 deaths per 1000 live births and as per the historical trend, it is likely to reach 63.61 deaths per 1000 live births, missing the target narrowly. However, an overall reduction in U5MR of nearly 58% happened during 1990 to 2013,

registering a faster decline in the recent past, and if this rate of reduction is sustained, the achievement by 2015 is likely to be very close to the target by 2015.

Fig.7.01: Trend in U5MR
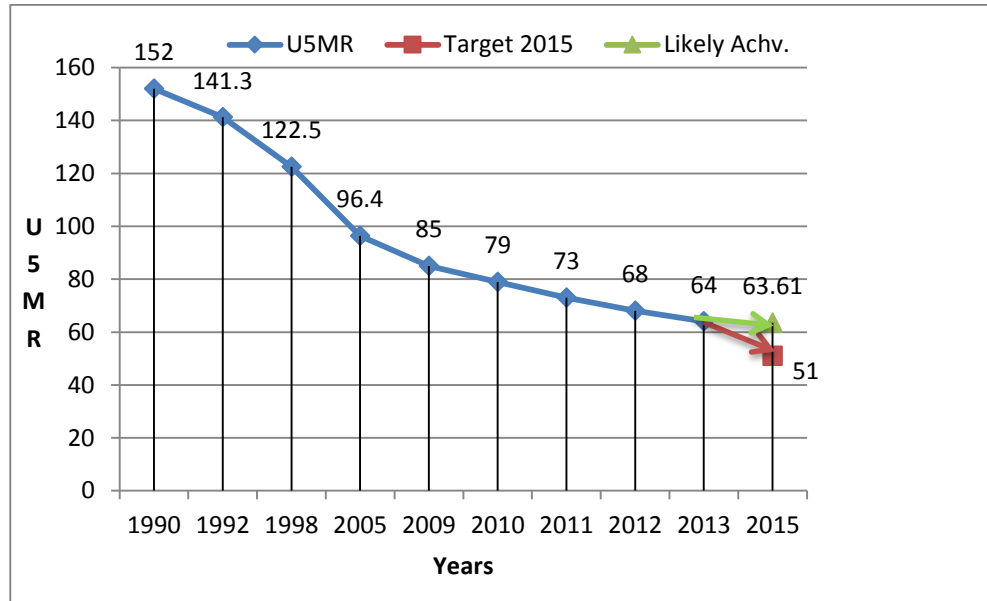
Source-SRS data of office of Registrar General of India

In U.P., the rural areas, registered high U5MR compared to the urban areas. As per the latest SRS data, in 2013, the U5MR in rural and urban areas are 68 and 44 deaths per 1000 live births respectively. During 2010-13, the Urban U5MR declined by 16 points from 60 to 44 deaths per 1000 live births while the decline noted in rural U5MR during the same period was 14 points from 82 to 68 deaths per 1000 live births. During this period, the rural – urban gap in U5MR increased marginally.

Fig. 7.02: Trend in U5MR by residence
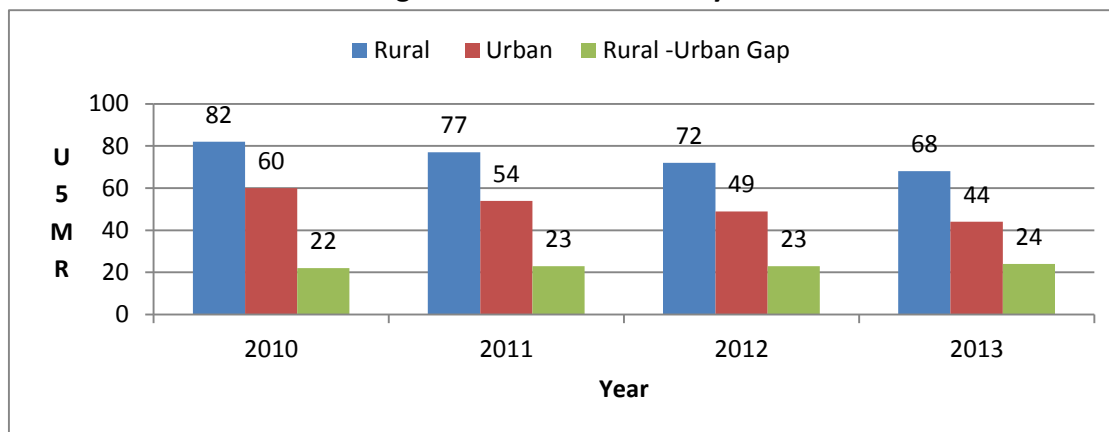
In U.P., Under Five Mortality Rate is higher for females than males at state level and this is true for both rural and urban areas. The gap between female U5MR and male U5MR was higher in rural areas. As per the latest SRS data, in 2013, for U.P., the U5MR for female and male children are 70 and 60 deaths per 1000 live births respectively. In 2013, in rural areas, U5MR was 75 for females whereas for males it was 62 and in urban areas, U5MR is 43 for female children and 45 for male children. During 2010-2013, U.P., the U5MR for male children declined from 71 to 60 deaths per 1000 live births, while the reduction in female U5MR was from 87 to 70 deaths. In rural areas, the decline in U5MR for male children was from 74 to 62 deaths per 1000 live births, whereas the female U5MR declined from 92 to 75 deaths per 1000 live births during this period. In urban areas, the decline in U5MR for male children was from 59 to 45 deaths per 1000 live births, whereas the female U5MR declined from 60 to 43 deaths per 1000 live births during this period. In fact according to 2013 SRS estimates U5MR of urban females is lower than that of urban males. It is encouraging sign.

Table 7.01: Trend in U5MR by residence /sex

Year	State			Rural			Urban		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
2010	79	71	87	82	74	92	60	59	60
2011	73	67	81	77	69	85	54	52	55
2012	68	62	75	72	65	80	49	48	50
2013	64	60	70	68	62	75	44	45	43

Source-SRS data of office of Registrar General of India

The NFHS 3 (2005- 06) results had emphasised the importance of female education in reducing the child mortality as U5MR decreased rapidly with increasing level of mothers' education.

Examining the performance of different States in reducing the U5MR, it is evident that, while the States of Andhra Pradesh, Delhi, Himachal Pradesh, Jammu & Kashmir, Karnataka,

Kerala, Maharashtra, Punjab, Tamil Nadu and West Bengal have already crossed the national level target of U5MR ,whereas the States of Uttar Pradesh, Himachal Pradesh, Rajasthan, Madhya Pradesh, Odisha, and Assam are likely to miss their respective State level targets by significant (> 10 points) gap.

Indicator 14: Infant Mortality Rate

The *Infant Mortality Rate (IMR)* is the number of death in children under 1 year of age per 1000 live births. The factors influencing infant mortality are likely to influence the health status of the whole population such as health of mothers and extent of pre/post natal care, general living conditions, rates of illness, their economic development and the quality of the environment. Thus IMR is a very sensitive indicator of health not only for children but also for the population as a whole. High neo - natal (less than 29 days of birth) mortality still continues to be a significant contributor to the infant mortality rate in India. In 2013, for U.P., 70% of the total infant deaths were neo - natal deaths. For U.P., the neo –natal mortality rate is 35 and ranges from 20 in urban areas to 38 in rural areas. Among the bigger States, neo – natal mortality ranges from 37 in Odisha to 6 in Kerala. In U.P., IMR was estimated at 99 per 1,000 live births in 1990. As per SRS 2013, the IMR is at 50 and as per the historical trend; it is likely to reach 50 by 2015, against the target of 33 infant deaths per 1000 live births by 2015. However, with the sharp decline in the recent years, the gap between the likely achievement and the target is expected to be narrowed.
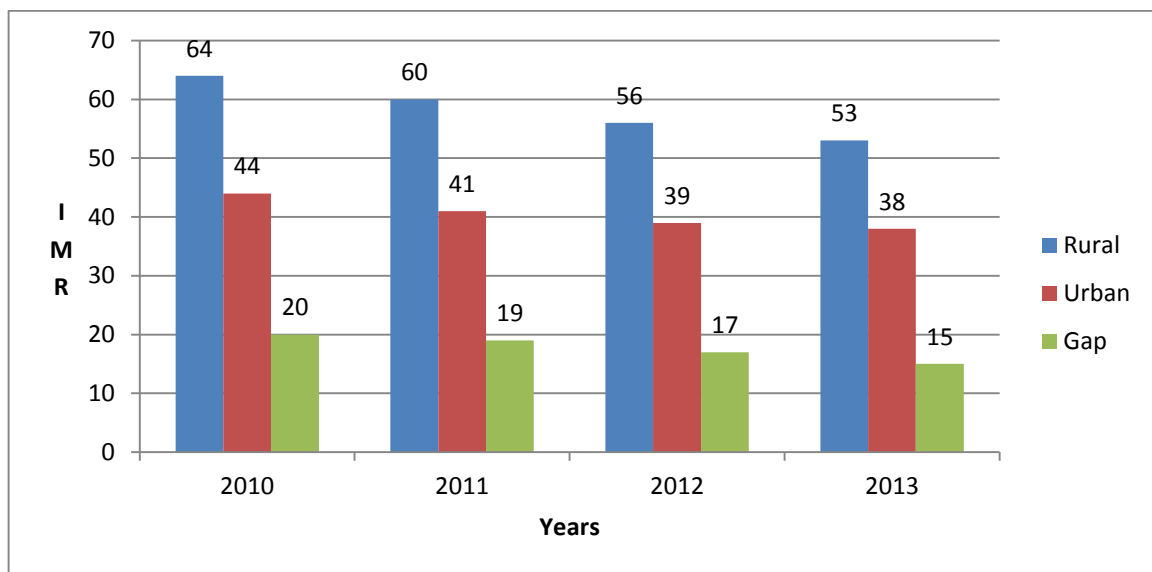
Fig. 7.03: Trend in IMR
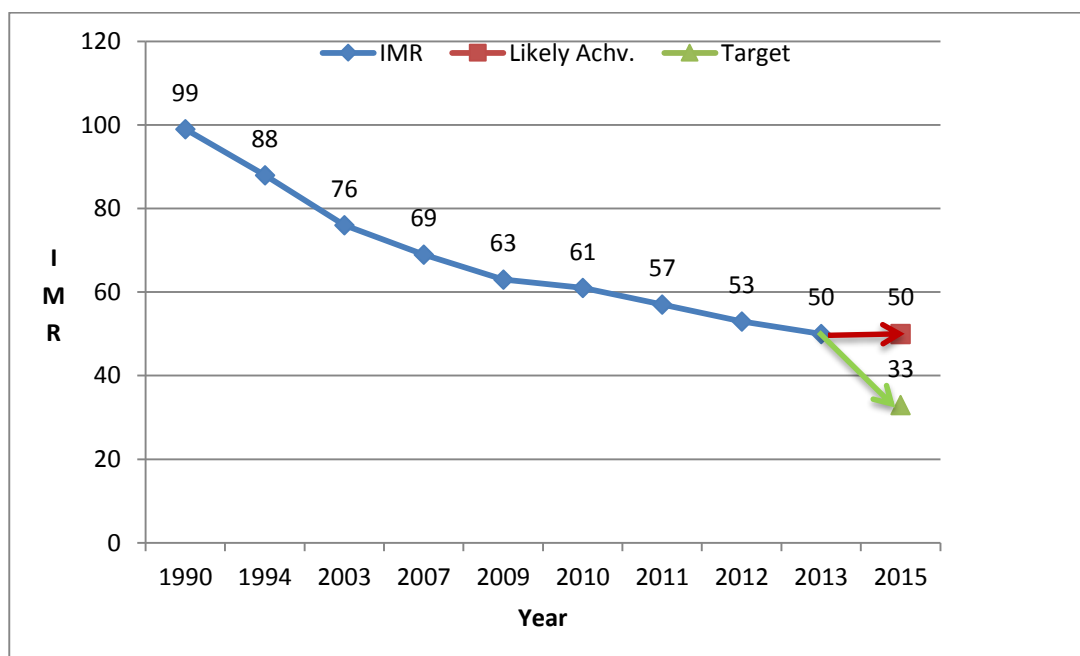
Source: Sample Registration System, Office of Registrar General of India

For U.P., the Sample Registration System 2013 reveals that, 17.9 % of the total deaths were infant deaths. Significant decline in IMR has been observed both in rural and urban areas over years. However, IMR in the rural areas continues to be at a much higher level than the urban IMR. Although the rural urban gap is slowly decreasing, the latest data show that even in 2013 the rural - urban gap in IMR is significant (rural IMR: 53 , urban IMR: 38).

Fig. 7.04: Trend in IMR by residence

Source: Sample Registration System, Office of Registrar General of India

SRS data shows that IMR is more for female babies than male babies and in 2013, female IMR is at 63, whereas male IMR is 58 per 1000 live births. During 2010 to 2013, female IMR has declined from 63 to 52 infant deaths per 1000 live births and the decline in male IMR is from 58 to 49 infant deaths per 1000 live births.

Fig. 7.05: Trend in IMR by sex
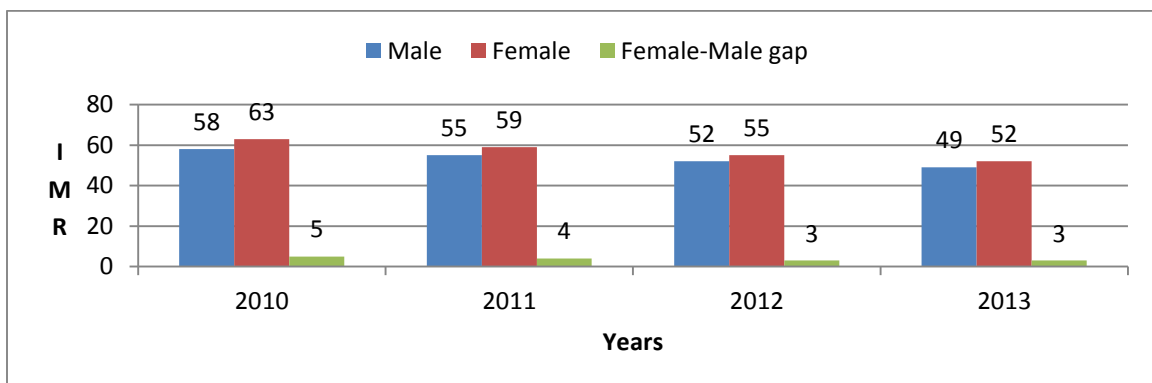
Source: Sample Registration System, Office of Registrar General of India

Indicator 15: Proportion of one year old children immunised against measles.

The proportion of 1-year-old children immunized against measles is the percentage of children under one year of age who have received at least one dose of measles vaccine. The indicator provides a measure of the coverage and quality of the child health-care system in the country with the assumption that its level of coverage is likely to represent coverage by other antigens like BCG, DPT, and polio as well, as these are given before the antigen of measles could be given. Besides, among these vaccine-preventable diseases of childhood, measles is the leading cause of child mortality. ***In order to achieve the prescribed MDG target for reducing child mortality, it is desirable to achieve 100% coverage of one year old children immunised against measles.*** The Coverage Evaluation Survey (CES), 2009 carried out by UNICEF and Government of India, shows that, U.P. is lagging in the task of achieving universal coverage of one year old children immunised against measles. The CES estimates the proportion of one year old children immunised against measles at 52.8 % in 2009. Although, there is improvement in the coverage which was 33.5% in 1998-99, yet at this rate of improvement, U.P. is likely to achieve about 68.1% coverage by 2015 , which is well below at national level likely achievement of 89.1% and thus U.P.is likely to fall short of universal coverage.

There is also a rural-urban gap in the coverage of measles immunisation as in the rural areas the coverage is 50.5 % as compared to 61.8 % in the urban areas.

Fig.7.06 Proportion of One year old immunised against measles (%)
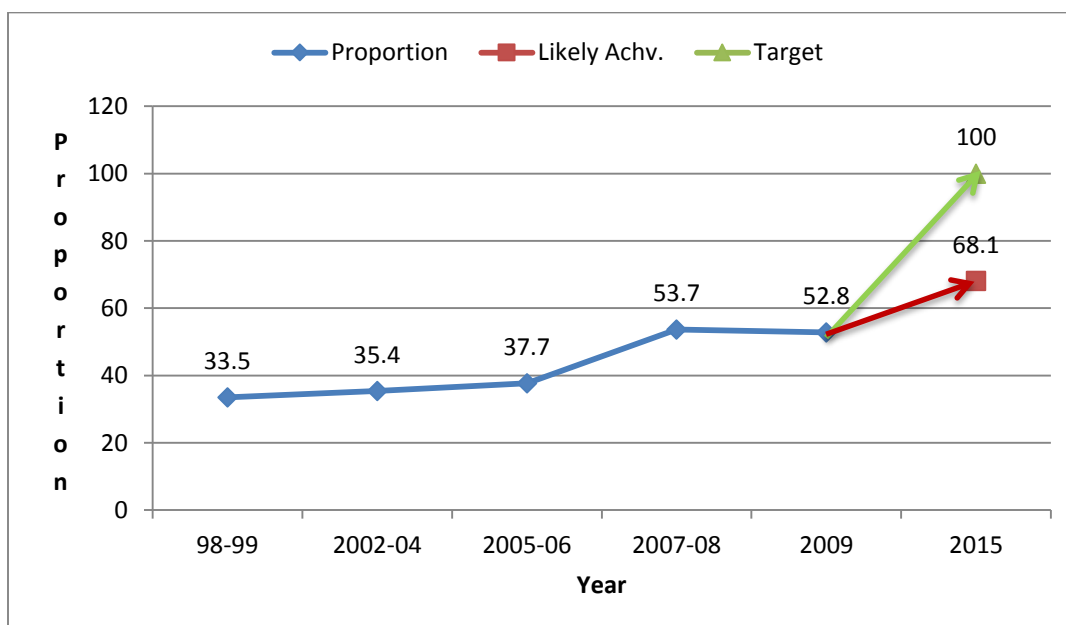
There exists considerable inter-state and intra-state variation in immunisation coverage against measles. More than 90% children of age one year have received measles vaccination in Andhra Pradesh (90.4%), Maharashtra (91.2%), Goa (91.5%) and Himachal Pradesh (96.2%), whereas the percentage of such children was as low as 48.2% in Arunachal Pradesh, 52.2% in Nagaland and 52.8% in Uttar Pradesh. Going by their historical rate of increase in coverage the major States, Uttar Pradesh, Mizoram, Chhattisgarh and Haryana are likely to miss the target by a large margin.
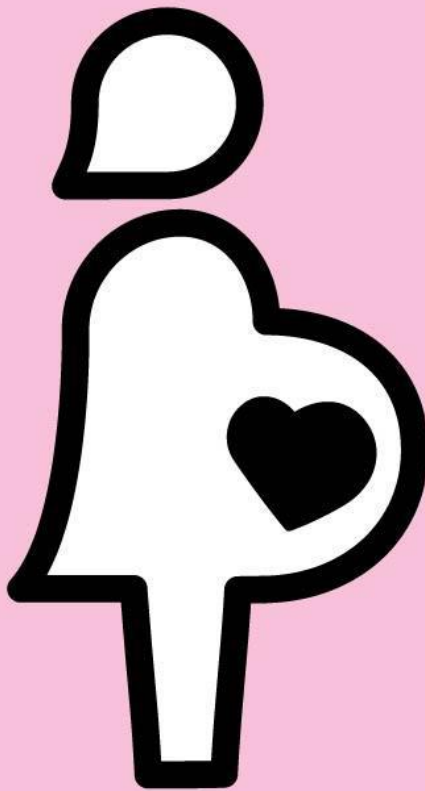
IMPROVE MATERNAL HEALTH

CHAPTER 8

Saving The Mothers

The importance of maternal health in the overall development and wellbeing of the society cannot be over emphasized. The crucial importance of maternal health was underscored by the 5th goal of the United Nations Millennium Development Goals which is aiming at improving maternal health.

GOAL 5: IMPROVE MATERNAL HEALTH

Target 6: Reduce by three quarters between 1990 and 2015, the Maternal Morality Ratio

- Indicator 16:   Maternal Mortality Ratio (MMR)

- Indicator 17:   Proportion of births attended by skilled health personnel

---

Indicator 16: Maternal Mortality Ratio

The *Maternal Mortality Ratio* (**MMR**) *is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.* Such deaths are affected by various factors, including general health status, education and services during pregnancy and childbirth. Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. Improving access to ante natal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth will reduce maternal deaths significantly. As reduction in MMR is dependent on various health care factors, the MMR is also used as a measure of the quality of a health care system.

The Office of the Registrar General of India (ORGI) under the Ministry of Home Affairs, Government of India provides estimates of *Maternal Mortality Ratio (MMR)* using demographic data collected through the Sample Registration System (SRS). The maternal deaths being a rare event require prohibitively large sample size to provide robust estimates. In order to

enhance the SRS sample size, the MMR estimates are derived by pooling 3 years data to yield reliable estimates of MMR. The first Report on maternal mortality in India (1997-2003) – trends, causes and Risk Factors was released in October, 2006 and the latest estimates are available for the period 2011-13.

The MDG 5 stipulates that the MMR level be reduced by three fourths between 1990 and 2015. In 1990 the estimated MMR was 855.1 per 1,00,000 live births. In order to meet the MDG target, the MMR should be reduced to 213.8 per 1,00,000 live births by 2015. As per the latest ORGI estimates, the MMR status at all India level is at 285 in 2011-13. MMR is a slow moving social indicator. U.P. is unlikely to achieve the target level of 213.8 per 1,00,000 live births by 2015. As per the historical trend, MMR is likely to reach the level of 241.96 maternal deaths by 2015. However, assuming the recent sharper decline is sustained , U.P. is likely to be slightly nearer to the MDG target.

Fig 8.01 :Trend in Maternal mortality ratio (Deaths per 100000 live births)
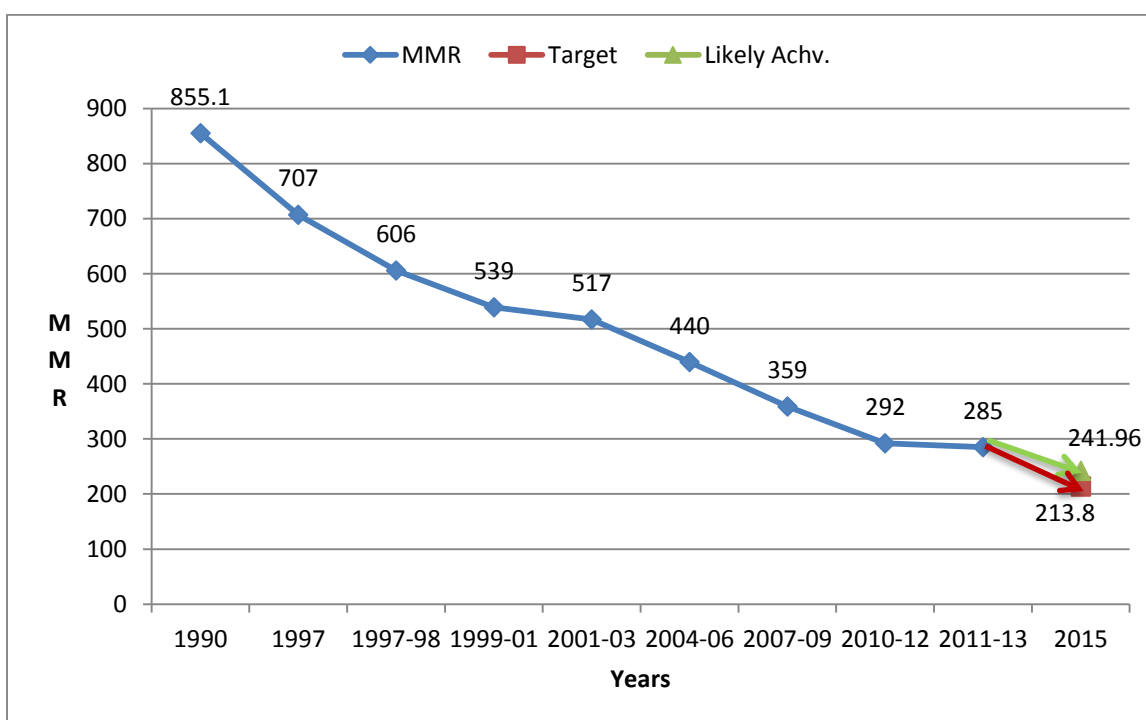
Source: Sample Registration System, Office of Registrar General of India

Performance of States in reducing MMR

Among the major States, the MMR ranges from 61 in Kerala to 300 in Assam in 2011-13. In the States of Bihar/ Jharkhand (208), Madhya Pradesh / Chhattisgarh (221), Orissa (222),

Rajasthan (244), Uttar Pradesh / Uttarakhand (285) and Assam (300), the MMR estimates were reportedly higher than the estimate at all India level (167). Four States i.e. UP, Bihar, MP and Rajasthan together contributes to 67 % of MMR in the country.

The Office of Registrar General of India (ORGI), also releases estimates for Maternal Mortality Rate and Life Time Risk. *Maternal Mortality Rate (MM Rate) is defined as the number of maternal deaths to women in the ages 15-49 per lakh of women in that age group.* In U.P., MM rate is also declining over the years. MM rate was 53.8 in 2004 -06, it decreased to 27.6 in 2011-13. MM rate vary widely among the States. While MM rate is as low as 3.2 in Kerala, Maharashtra 4.1 and 4.5 in Tamil Nadu, the rate was 27.6 in Uttar Pradesh/ Uttarakhand, 23.9 in Rajasthan and 21.4 in Bihar/ Jharkhand. *The Life time Risk is defined as the probability that, one women of reproductive age (15-49) will die due to child birth or puerperium (6 weeks after delivery)* assuming that chance of death is uniformly distributed across the entire reproductive span. At All India level, the Life Time Risk is 0.4% and among States, it varies from 0.1% in Kerala and Maharashtra and 1 % in Uttar Pradesh.

Fig 8.02 :Trend in MM Rate in U.P. and India
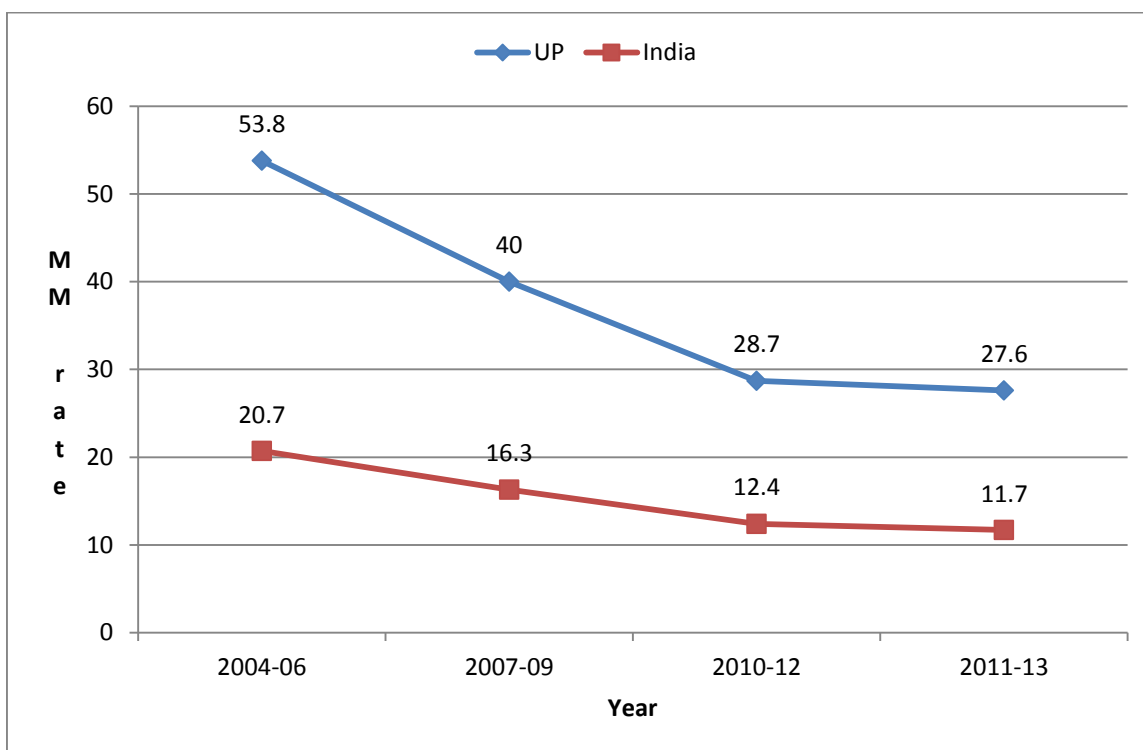
Source: Sample Registration System, Office of Registrar General of India

Fig 8.03 :Trend in Life Time Risk in U.P. and India
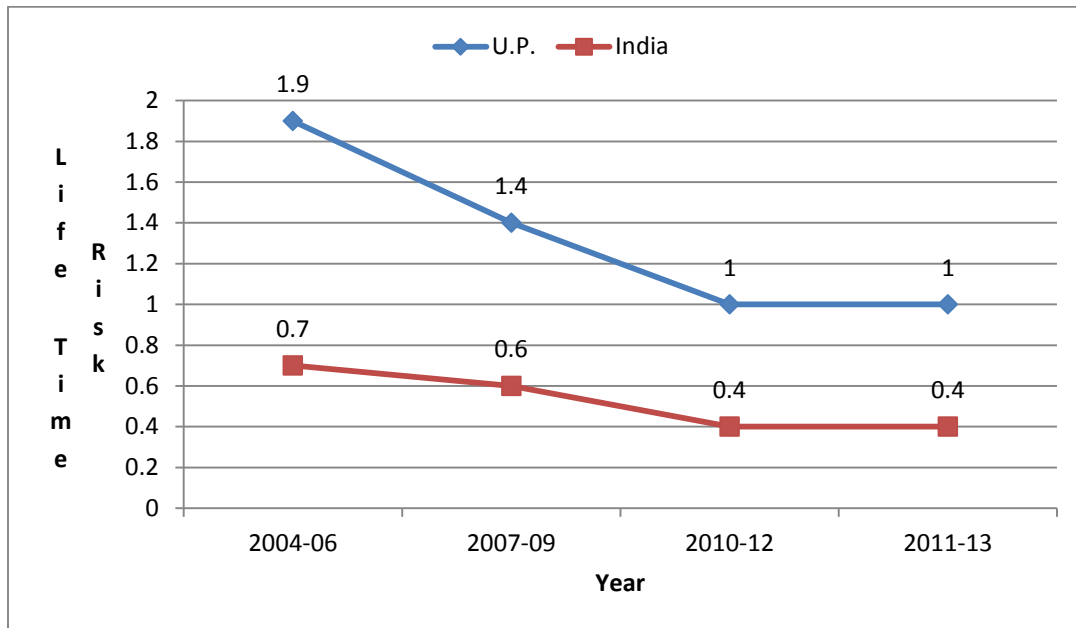
Indicator 17 : Proportion of births attended by skilled health personnel

In order to reduce maternal mortality and infant mortality, it is extremely important that all births be attended by skilled health personnel, as timely management and treatment can make the difference between life and death. The ***proportion of births attended by skilled health personnel** is the percentage of deliveries attended by personnel trained to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; to conduct deliveries on their own; and to care for new-borns.* Skilled health personnel include only those who are properly trained and who have appropriate equipment and drugs. Traditional birth attendants, even if they have received a short training course, are not to be included. For this indicator there is no bench mark value to be attained by 2015, however, for attaining the prescribed target for MMR, the desirable level of attainment for this indicator is taken as 100% by 2015.

The Coverage Evaluation Survey conducted by Government of India and UNICEF in 2009 shows that at National level 76.2% percentage of births were attended by skilled health personnel in 2009. For Uttar Pradesh the percentage was 64.2. Although, considerable progress has been achieved over the years in improving the proportion of births attended by skilled personnel, U.P. is likely to reach the level of 66.7 % vis–a-vis the targeted universal coverage. The latest results of Sample Registration System (SRS) 2013 reveal that, the percentage of live

births attended by skilled health personnel (Government hospitals, Private hospital, qualified professional) is 80.2 % in 2013, which indicates a better status. Also, with the recent sharp progress in the percentage of births attended by skilled health personnel during 2007-09, the gap between the likely achievement and the target in 2015 is likely to be narrowed down.

Fig.8.04: Percentage of births attended by skilled health personnel
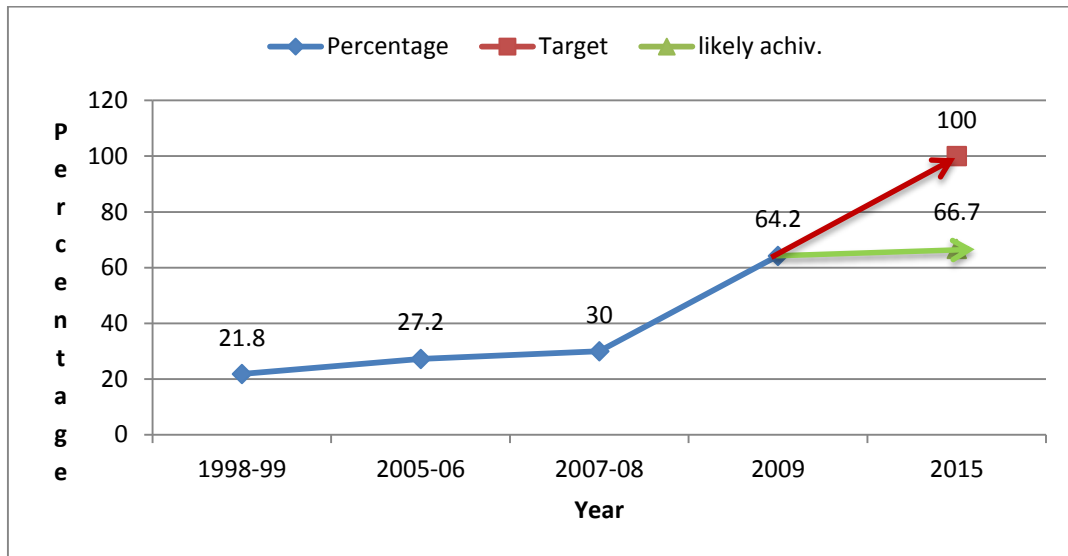
Source: NFHS, DLHS, CES

In 2013, in rural areas of U.P., 77.3% and in urban areas of U.P. 95.4 % of live births were attended by skilled health personnel. Clearly, U.P. which is lagging behind from 100% coverage of live births by skilled health personnel, the rural–urban gap is very significant even though the coverage in urban areas is very near to the target.

COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

CHAPTER 9

Combating life-threatening diseases

The diseases like HIV / AIDS together with Malaria and TB are causing major health challenges to population around the World. In order to face this challenge, the Goal 6 of the Millennium Development Goals, is committed to fight the deadly diseases of HIV/ AIDs, Malaria and TB.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

TARGET 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.

- Indicator 18: HIV prevalence among pregnant women aged 15-24 years

- Indicator 19: Condom use rate of the contraceptive prevalence rate

- Indicator 19A: Condom use at last high risk sex

- Indicator 19B:Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS

TARGET 8 : Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases.

- Indicator 21:   Prevalence and death rates associated with Malaria.

- Indicator 22:   Proportion of population in Malaria risk areas using effective Malaria prevention and treatment measures (Percentage of population covered under use of residuary spray in high risk areas)

- Indicator 23:   Prevalence and death rates associated with Tuberculosis

- Indicator 24:   Proportion of Tuberculosis cases detected and cured under DOTS


Estimating the number of people living with HIV in a state is vital not only to assess the burden of the disease, but also to understand the future need for treatment and to plan testing programmes in specific geographical areas.

The current round of **estimates of number of people living with HIV** is highest in Andhra Pradesh at around 4.19 lakh followed by Maharashtra at 3.16 lakh in 2011. The other states with the estimated number of HIV infections more than one lakh in 2011 are Karnataka (2.09 lakh), Tamil Nadu (1.33 lakh), West Bengal (1.34 lakh), Gujarat (1.27 lakh), Bihar (1.24 lakh), **Uttar Pradesh (1.23 lakh)** and Odisha (1.04 lakh). Regarding the proportional distribution of estimated number of people living with HIV by states, Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu collectively account for approximately 53% of all infections in 2011. Eleven northern and central states of Bihar, Chhattisgarh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Odisha, Punjab, Rajasthan, Uttar Pradesh and West Bengal on the other hand account for approximately 42% of the total number of people living with HIV. The other states account for 5% of the total infections among adults and children. Analysis of 2007–11 estimates for number of people living with HIV indicate a stable to declining trend .

State level *adult HIV prevalence is the total number of adults (15–49 years) estimated to be living with HIV in a State calculated as a percent out of the total adult (15–49 years) population.* In U.P, over the years the prevalence rate of HIV / AIDs among 15-49 years of age-group population has declined. The adult HIV prevalence at state level has steadily declined from estimated level of 0.12 % in 2008 to 0.10 % in 2011.

The *HIV prevalence among the young population (15–24 years)* at national level has declined from 0.15% in 2007 to 0.11% in 2011. For Uttar Pradesh also the HIV prevalence among the young population has declined from 0.06% in 2007 to 0.04 % in 2011.

Fig.9.01: Trend in Estimated Adult (15-49 age group) HIV Prevalence in U.P and India
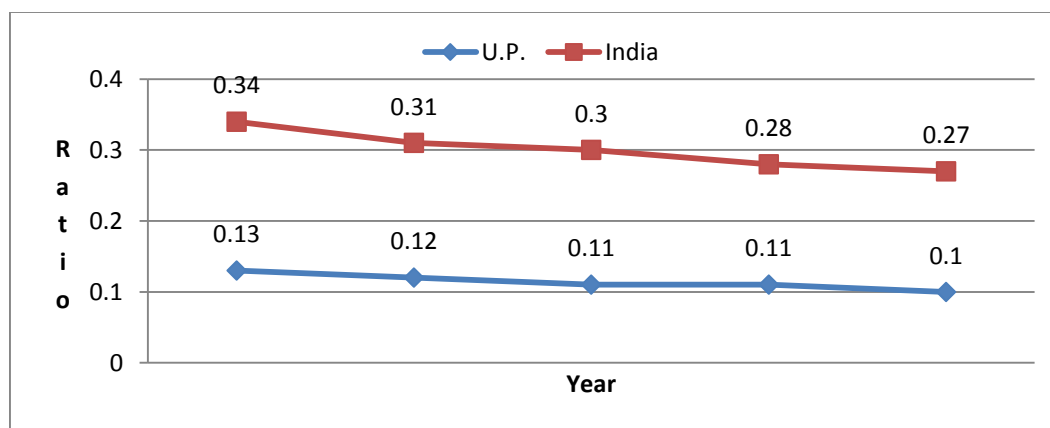
Source: HIV Estimation 2012, D/o AIDS Control

The status of new HIV / AIDs infections also matters a lot, in assessing the disease burden. India is estimated to have around 1.16 lakh (0.72–1.99 lakh) annual new HIV infections among adults (15+ years) and around 14,500 (10,974–19,346) new HIV infections among children (<15 years) in 2011. Among states, Andhra Pradesh is estimated to have the highest number (16,603) of new adult HIV infections in 2011 followed by Odisha (12,703), Jharkhand (9,085), Karnataka (9,024), Bihar (7,797), Uttar Pradesh (7,745) and West Bengal (7,289).

Using globally accepted methodologies and updated evidence on survival to HIV with and without treatment, it is estimated that about 1.48 lakh (1.14 lakhs-1.78 lakhs) people died of AIDS related causes in 2011 in India. Deaths among HIV infected children account for 7% of all AIDS-related deaths. In 2011, the states of Andhra Pradesh and Maharashtra accounted for the highest number of AIDS related deaths at estimated numbers of approximately 31,000 and 24,000 respectively, followed by Karnataka and West Bengal with more than 10,000 annual AIDS-related deaths.

To ensure the delivery of treatment to persons living with HIV, the estimates for total number of people needing treatment have been generated. These estimates are calculated considering the national guidelines for initiation of ART in adults and children. Based on the assumptions on progression and survival of adults and children infected with HIV, it was estimated that in U.P. around 36217 PLHIV needed Anti-retroviral Treatment (ART) in 2014. This included 34037 adults (15+ years) and 2180 children (<15 years).

Fig. 9.02 Number of PLHIV alive and on ART as on 30/9/ 2014
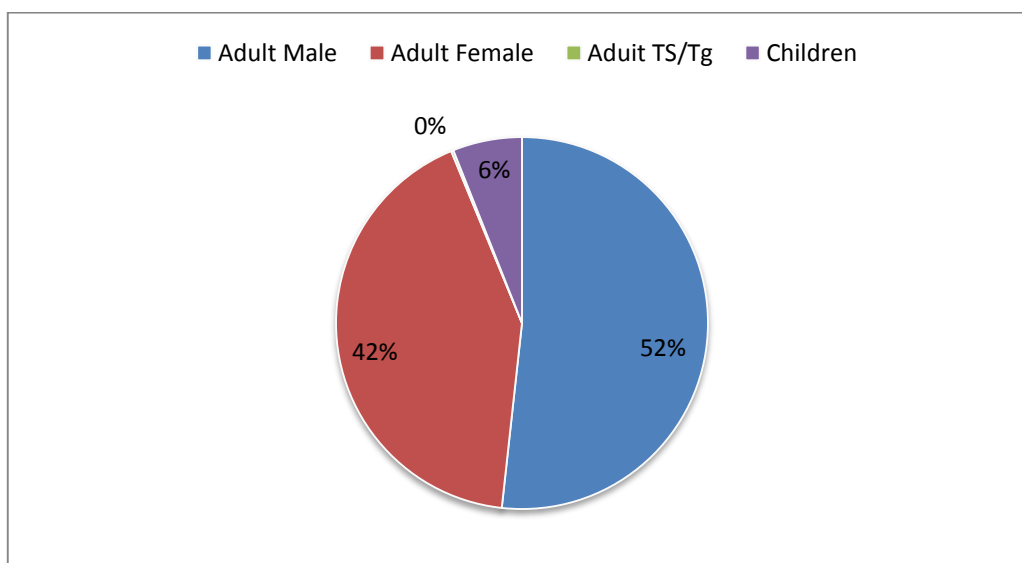
Source: D/o AIDS Control

The statistics as presented above, reveals the epidemic HIV/AIDs in India is under control, however, the disease burden continues to be substantial.

Indicator 18 : HIV prevalence among pregnant women aged 15-24 years (%)

The prevalence of HIV among Pregnant women aged 15-24 years is showing a declining trend from 0.42 % in 2004 to 0.15% in 2012-13.

Fig. 9.03: Trend in HIV prevalence among Pregnant Women aged 15-24yrs (%)
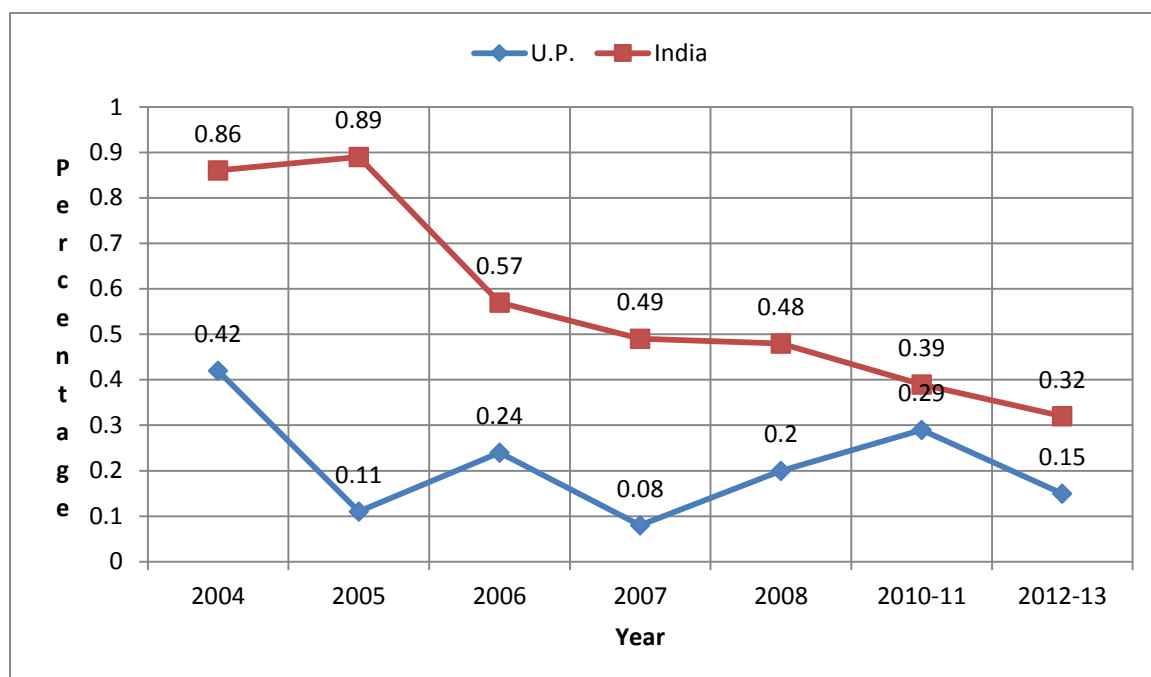
Source: HIV Sentinel Surveillance, D/o AIDS Control

During 2008-13, the indicator showed a declining trend in U.P. and State has already achieved the MDG target.

Indicator 19 : Condom use rate of the contraceptive prevalence rate (*Condom use to overall contraceptive use among currently married women, 15-49 years, %*)

According to NFHS –III, in 2005-06, condom use rate of the contraceptive prevalence rate was only 5.2 % at all India level. For U.P. it improved from 4% in 1998-99 (NFHS-II) to 8.6 % in 2005-06 (NFHS –III,).

Indicator 19A : Condom use at last high-risk sex

The Behavioural Surveillance Survey (BSS) conducted to monitor the changes in knowledge and behaviour indicators in different risk groups with respect to HIV/AIDS, indicates that Condom use among non-regular sex partners is quite prevalent at national level. According to BSS conducted in 2001 & 2006, the national estimates for Condom use at last high-risk sex

(%) (Proportion of population aged 15-24 years who used condom during last sex with non-regular partner) registered a 19% increase from 51.9% in 2001 to 61.7% in 2006. In 2009, BSS was conducted in six states (Uttar Pradesh, Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra and Manipur) as part of Mid-Term Review of NACP-III.

Table 9.01 : Condom use at last high-risk sex (%) - Proportion of population aged 15-24 years who used condom during last sex with non-regular partner

States	2006	2009
Uttar Pradesh	48.8	46
Andhra Pradesh	63.6	89
Karnataka	81.1	87
Tamil Nadu	46.4	-
Maharashtra	77.8	92
Manipur	76.6	-

Source: Behavioural Surveillance Survey, D/o AIDS Control

Among the above States, in which Behavioural Surveillance Survey was conducted in 2006 and 2009, the Condom use at last high-risk sex (%) showed an improvement except the State of Uttar Pradesh.

Indicator19B : Proportion of population aged 15-24 years with comprehensive correct Knowledge of HIV/AIDS (%)

Comprehensive Correct knowledge about HIV transmission and Prevention is constructed as 'Percentage of Population aged 15-24 years who could correctly identify the two major ways of preventing the sexual transmission of HIV (Consistent condom use and having one faithful uninfected sex partner), reject the two most common local misconceptions about HIV transmission (transmission of HIV/AIDS through mosquito bites and sharing of meals with HIV/AIDS patients), and who know that a healthy-looking person can transmit HIV.

According to BSS, the national estimate for proportion of population aged 15-24 years with comprehensive correct Knowledge of HIV/AIDS2 (%) in 2006 was 32.9% reporting betterment from 2001 (22.2%). The estimates of the indicator for the States in which BSS was conducted in 2009 are as follows:

Table 9.02 : Comprehensive Correct Knowledge about HIV Transmission and Prevention

Sates	2006	2009
Uttar Pradesh	29	21

Andhra Pradesh	28	19
Karnataka	23	10
Tamil Nadu	30	56
Maharashtra	49	24
Manipur	43	

*Source :Behavioural Surveillance Survey, D/o AIDS Control*

It is alarming to note that, among the above States in which BSS 2006 & 2009 were conducted, a decline in the comprehensive and correct knowledge about HIV was observed in the States of Uttar Pradesh, Andhra Pradesh, Karnataka, Maharashtra whereas Tamil Nadu showed a significant improvement.

Indicator 21: Prevalence and death rates associated with Malaria.

Malaria continues to pose a major public health threat in different parts of the country. Malaria is an acute parasitic illness mainly caused by *Plasmodium Vivax* and *Plasmodium falciparum* in India. However sporadic cases of *P.malariae* are also reported. The diagnosis is confirmed by microscopic examination of a blood smear and Rapid Diagnostic Tests. Majority of the patients recover from the acute episode within a week. The cases, particularly due to Plasmodium falciparum are critical as it is sometimes prone to develop severity and death, if not treated early. One of the reasons attributed to rise in proportion of P.falciparum cases is resistance to chloroquine, which was used for a long time as the first line of treatment of malaria cases. Passive surveillance of malaria is carried out by PHCs, Malaria Clinics, CHCs and other secondary and tertiary level health institutions that patients visit for treatment. Apart from that, ASHA- a village volunteer is involved in the programme to provide diagnostic and treatment services at the village level as a part of introduction of intervention like Rapid Diagnostic Tests and use of Artemisinin Combination Therapy (ACT) for the treatment of Pf cases.

At national level, during 2011, the malaria incidence was around 1.31 million cases, 0.67 million Pf cases and 754 deaths; while during 2012, 1.01 million cases, 0.53 Pf cases and 519 deaths were reported. About 91% of malaria cases and 99% of deaths due to malaria are reported from high disease burden states namely North-eastern (NE) States, Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and West Bengal. However, other States are also vulnerable and have local and focal upsurge. During 2013, 0.88 million cases, 0.46 Pf cases and 440 deaths have been reported. During 2014 1.07 million cases, 0.70 million Pf cases and 578 deaths have been reported. Malaria situation in the State of U.P. is ,as reflected in surveillance data from 2010-2014 is given below.

Fig.9.04: Annual Parasite Incidence (per 1000 population)
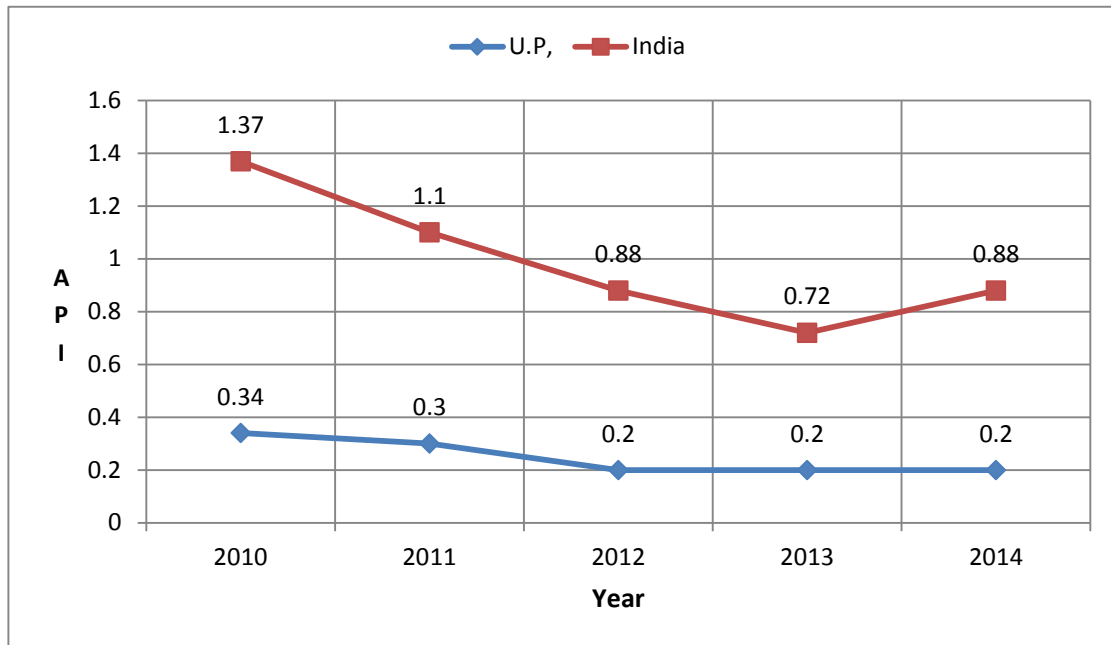
The load of total malaria cases, has shown a declining trend since 2010.

Table 9.03 : Epidemiological Situation (2010-2014) in U.P.

Year	Population (in '000)	Total Malaria Cases	P.Falciparum cases (million)	Pf %	API	Deaths due to malaria
2010	188095	64606	1382	2.14	0.34	0
2011	194373	56968	1857	3.3	0.30	0
2012	203972	47400	740	1.6	0.20	0
2013	203972	48346	590	1.2	0.20	0
2014	203972	41674	326	0.8	0.20	0

The reported Pf cases declined from 1382 in 2010 to 326 cases in 2014. The Pf % has gradually decreased from 2.14% in 2010 to 0.8 % in 2014 (provisional). The Annual Parasite Incidence (API) rate has consistently come down from 0.34 per thousand in 2010 to 0.20 per thousand in 2014 , confirmed deaths due to malaria was 0 from 2010 to 2014.

Indicator 22: Proportion of population in Malaria risk areas using effective

Malaria prevention and treatment measures (*Percentage of population covered under use of residuary spray in high risk areas*)

No data is available on above indicators. Hence no analysis can be done.

Indicator 23:Prevalence and death rates associated with Tuberculosis

Tuberculosis (TB) is an infectious disease caused by a Bacterium, Mycobacterium tuberculosis. It is spread through the air by a person suffering from TB. A single patient can infect 10 or more people in a year. TB is the most common opportunistic infection in people living with HIV virus. As the HIV breaks down the immune system, HIV infected people are at greatly increased risk of TB. Without HIV, the lifetime risk of developing TB in TB infected people is 10%, compared to at least 50% in HIV co-infected. HIV is also the most powerful risk factor for progression from TB infection to TB disease. TB in turn accelerates the progression of HIV to AIDS and shortens the survival of patients with HIV infection. Thus, TB and HIV are closely interlinked. With large numbers of HIV-positive individuals in India, it is likely that HIV may worsen the TB epidemic in the absence of a robust TB control programme. However, even among HIV infected people, TB can be cured. Directly Observed Treatment Short-course (DOTS) is as effective among HIV infected TB patients as among those who are HIV negative.

Today in India, two deaths occur every three minutes due to tuberculosis (TB). With proper care and treatment, TB patients can be cured and the battle against TB can be won. As per WHO estimations, in India, Tuberculosis prevalence per lakh population has reduced from 465 in year 1990 to 211 in 2013. TB Incidence per lakh population has reduced from 216 in year 1990 to 171 in 2013. Tuberculosis mortality per lakh population has reduced from 38 in year 1990 to 19 in 2013.

Table 9.04 : Tuberculosis situation in India

Year	Incidence (Per lakh population)	Prevalence (Per lakh population)	Mortality
1990	216	465	38
1995	216	465	38
2000	216	438	39
2005	209	365	36
2009	190	289	29
2010	185	269	27
2011	181	249	24
2012	176	230	22
2013	171	211	19
2014	167	195	17

Source: M/o Health and Family Welfare

Indicator 24: Proportion of Tuberculosis cases detected and cured under DOTS

Modern anti-TB treatment can cure virtually all patients. It is, however, very important that treatment be taken for the prescribed duration, which in every case is a minimum of 6 months. Because treatment is of such a long duration and patients feel better after just 1-2 months, and because many TB patients face other problems such as poverty and unemployment, treatment is often interrupted. Therefore, just providing anti-TB medication is not sufficient to ensure that patients are cured. ***The DOTS (Directly Observed Treatment, Short-course) strategy*** ensures that infectious TB patients are diagnosed and treated effectively till cure, by ensuring availability of the full course of drugs and a system for monitoring patient compliance to the treatment.

The *Revised National Tuberculosis Control Programme (RNTCP),* based on the DOTS strategy, began as a pilot in 1993 and was launched as a national programme in 1997. Rapid RNTCP expansion began in late 1998 and the entire country was covered under DOTS by 24th March 2006. RNTCP follows the global method of cohort analysis for describing case finding and treatment outcomes. Timely data collection and dissemination are hallmarks of the RNTCP surveillance and data management systems.

Over the 15-year analysis period (from 1999 to2014), under RNTCP, the population covered increased from 139 million to 1.26 billion populations. As expected from service expansion, the absolute number of TB suspects examined by smear microscopy annually has increased manifold, from 0.96 million to 8.7 million. Over the same time period, the rate of TB suspect examination increased by 50%, from 421 per 1,00,000 population covered by RNTCP services to 694 per 1,00,000 population in 2014. Similarly, the rate of sputum smear positive cases diagnosed by microscopy has increased by 20%, from 65 to 79 per 1,00,000 population by the year 2008, remained at that level for 4 years and has started decreasing to 73 per 1,00,000 in year 2014 .The average number of suspects examined for every sputum smear positive case diagnosed has gradually increased at the rate of 2% per year, from 2001 to 2014.

Table 9.05 : TB case finding Activities (1999-2014)

Year	Total population of India covered under RNTCP (millions)	Sputum Microscopy Services (RNTCP)			
		Suspects examined		Sputum smear positive cases diagnosed	
		Number	Rate	Number	Rate
1999	139	n/a	421	n/a	65
2000	241	9,56,113	517	148610	73
2010	1192	7550522	633	939062	79
2011	1210	7875158	651	953032	79
2012	1228	7867194	640	933905	76
2013	1247	8121514	651	928190	74

| 2014 | 1266 | 8783551 | 694 | 929043 | 73 |

Treatment outcomes of pulmonary sputum-positive cases notified under RNTCP is summarized in Table 9.06. Among NSP cases, the treatment success rate has been >85% since the year 2001. The death rate and failure rate has been about 5% and 2% respectively. The default rates has decreased from 9% for the cohort of TB patients registered in 1999 to 6% for the cohort of patients registered in 2013. Among smear positive re-treatment cases the treatment success rate has been ~ 70% since implementation. The death rate has shown increase from 7% to 8%, failure rate about 5%. High default rates >13% has been an area of concern among the re-treatment cases.

Table 9.06. Treatment Outcomes among Notified New TB Cases (1999-2013)

New Smear Positive Cases				
Year	Success	Deaths	Failure	Default
1999	82%	5%	3%	9%
2000	84%	4%	3%	8%
2001	85%	5%	3%	7%
2002	87%	4%	3%	6%
2003	86%	5%	2%	6%
2004	86%	4%	2%	7%
2005	86%	5%	2%	7%
2006	86%	5%	2%	6%
2007	87%	5%	2%	6%
2008	87%	4%	2%	6%
2009	87%	4%	2%	6%
2010	88%	4%	2%	6%
2011	88%	4%	2%	5%
2012	87%	4%	2%	6%
2013	88%	4%	2%	6%

Source: TB India 2015

Table 9.07. Treatment Outcomes among Notified Smear-positive Re-treatment TB Cases (1999-2013)

Smear Positive Re-treatment				
Year	Success	Deaths	Failure	Default
1999	68%	7%	6%	18%
2000	69%	7%	6%	16%
2001	71%	7%	6%	15%
2002	72%	7%	6%	14%
2003	70%	8%	6%	15%
2004	71%	7%	6%	16%
2005	69%	7%	6%	17%
2006	69%	8%	6%	16%
2007	70%	8%	5%	15%

2008	71%	8%	5%	14%
2009	71%	8%	6%	14%
2010	71%	8%	5%	14%
2011	71%	8%	5%	14%
2012	70%	8%	5%	14%
2013	71%	8%	5%	13%

Source: TB India 2015

Table 9.08: Treatment Outcome of New TB Cases Registered in 2013 in U.P.

	Registered	Cured	Completed	Died	Failure	Default	Trans Out
New Smear Positive Cases(NSP)							
U.P.	127268	85%	4%	3%	1%	6%	1%
India	615609	84%	4%	4%	2%	6%	1%
Smear Positive Re-treatment							
U.P.	17704	70%	79%	6%	2%	11%	1%
India	101326	67%	75%	7%	4%	11%	1%

The statistics points out that the epidemics of HIV/ AIDS, Malaria and TB are under control because of enormous effort and mobilisation over the past decade in India. This guard cannot be lowered. While the trend has been reversed in terms of prevalence rates, in absolute numbers, India's figures for these diseases are still substantial. Hence more focussed and intensive initiatives need to be sustained in the fight against these deadly diseases.

ENSURE
ENVIRONMENTAL
SUSTAINABILITY

CHAPTER 9

Safeguarding the environment

Impacts of Environment are immense as they act at varying level influencing the quality of human life. The development activities undertaken to improve the living standard of people, at large, sometimes affect the natural environment adversely in many ways and cause severe threats to bio diversity. The MDG -7 addresses the concern for sustainable development to reverse environment degradation and loss with focus on improving/ monitoring indicators associated with it.

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

TARGET 9 : Integrate the principle of sustainable development into country policies and programmes and reverse the loss of environmental resources

- Indicator 25: Proportion of land area covered by forest
- Indicator 26: Ratio of area protected (to maintain biological diversity) to surface area
- Indicator 27: Energy use per unit of GDP (Rupee)
- Indicator 28: Carbon Dioxide emissions per capita and consumption of Ozone depleting Chloro-fluoro Carbons (ODP tons)
- ✓ Indicator 29: Proportion of the Households using solid fuels

TARGET 10: Halve , by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation

- ✓ Indicator 30: Proportion of population with sustainable access to an improved water source, urban and rural
- ✓ Indicator 31: Proportion of population with access to improved sanitation, urban and rural

TARGET 11: By 2020,to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

- ✓ Indicator 32: Slum population as percentage of urban population


Indicator 25 : Proportion of land area covered by forests

       Improving forest cover and protected areas are measures towards ensuring sustainable environment and bio diversity. Forest cover includes all lands which have a tree canopy density of 10% and above and have a minimum area of one hectare. Hence, all tree species along with bamboos, fruit bearing trees, coconut, palm, etc and all trees including forest, private, and community of institutional lands meeting these criteria have been termed as forest cover.

       As per assessment in 2013, the total forest cover of the country is 697898 sq. km which is 21.23% of the geographic area of the country. During 2011-2013, there is an increase of 5871 sq. km in forest cover.

       As far as Uttar Pradesh is concerned, in 2013 total forest cover is 14349 sq. km which is 5.95 % of the geographical area of the state. 99.51 % of the forest is under ownership of forest department, GOUP. Rest of the forests are under Panchayats, Municipalities, Cantonment Board and Private ownership. During the period 2011-2013 state added a mere 11 sq.km forest cover. It is evident that state is off track in this indicator and MDG target have not been met.

Table 9.01: Year wise Recorded Area under Forest in U.P.(in sq.km.)
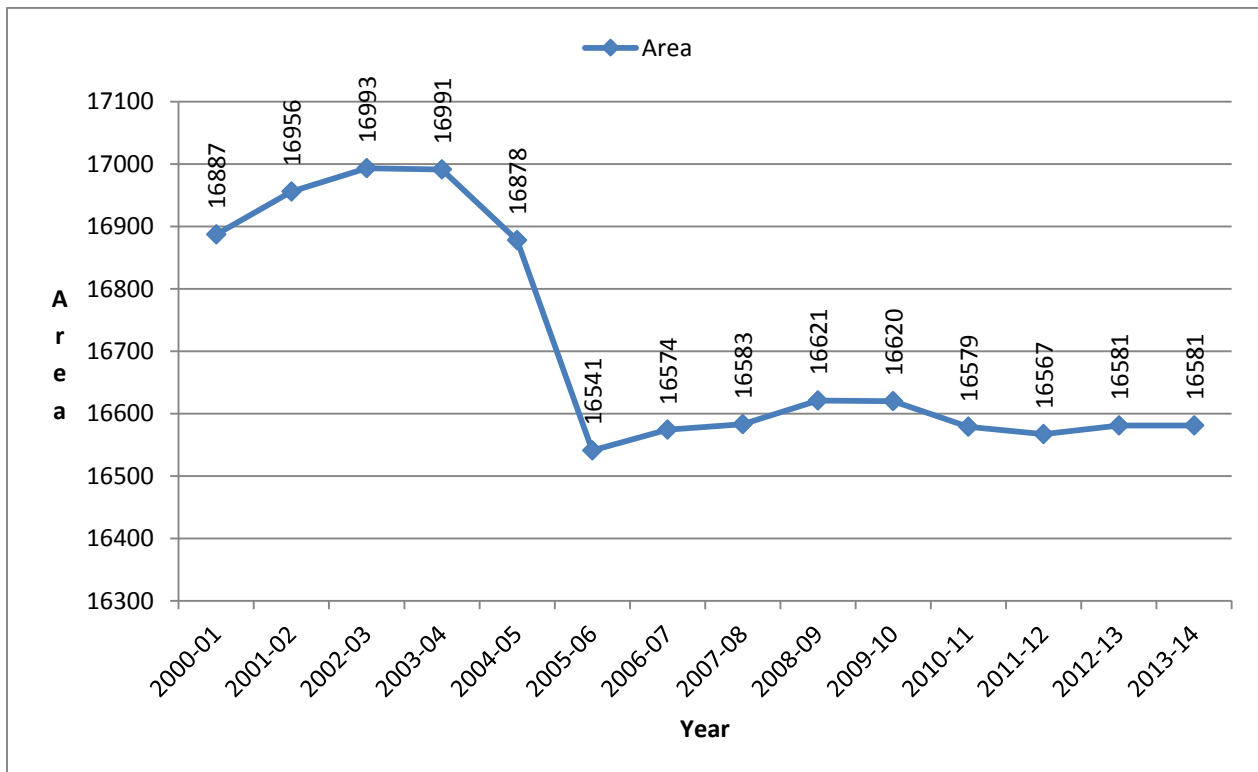
Source: U.P. Forest Statistics 2014.

Table 9.02: Year wise percentage of forest to geographical area (1995-2013)
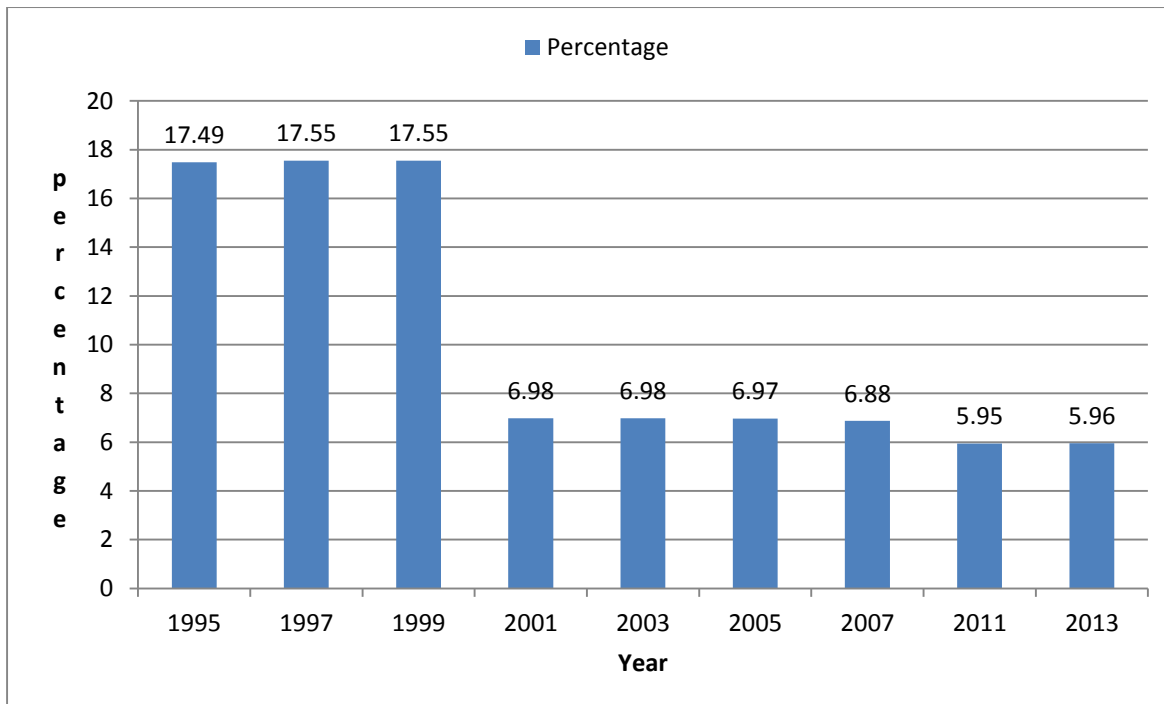
Source :Compendium of Environment Statistics,2010 ,India State of Forest Report 2011,13.

Indicator 26 : Ratio of area protected to maintain biological diversity to surface area

Protected areas are those in which human occupation or at least the exploitation of resources is limited. There are several kinds of protected areas, which vary by level of protection depending on the enabling laws of each country or the regulations of the international organizations involved.

India, a mega-diverse country with only 2.4% of the world's land area, harbours 7-8% of all recorded species, including over 45,000 species of plants and 91,000 species of animals. It is also amongst the few countries that have developed a biogeographic classification for conservation planning, and has mapped biodiversity-rich areas in the country. Of the 34 global biodiversity hotspots, four are present in India, represented by the Himalaya, the Western Ghats, the North-east, and the Nicobar Islands.

India has taken significant steps in inventorizing her vast and diverse biological heritage. In 2014, there are 692 protected areas which is 4.83% of the total geographic area of the Country. The country has 23 marine Protected Areas (PAs) in peninsular India and 106 in the islands.

66

In 2013 Uttar Pradesh has 1 National park of area 490.00 sq.km. and 11 Wild life sanctuaries comprising of an area of 5538.32 sq.km. and 13 bird sancturaies of area 188.85 sq.km. The ratio of protected area to geographical area of state is 2.4% and this ratio has remained constant since 2003. According to 2013 census the number of lions were reduced to 118 from 283 found in 2003.

Indicator 27 : Energy use per unit of GDP (Rupee)

Per-capita Energy Consumption (PEC) *during a year is computed as the ratio of the estimate of total energy consumption during the year to the estimated mid-year population of that year.*

Energy Intensity *is defined as the amount of energy consumed for generating one unit of Gross Domestic Product (at constant prices).*

PEC and Energy intensity are the most commonly used policy indicators, both at national and international levels. In the absence of data on consumption of non-conventional energy from various sources, particularly in rural areas in the developing countries, including India, these two indicators are generally computed on the basis of consumption of conventional energy. Electricity, Coal & Lignite and Crude Petroleum were the main sources of energy consumption accounting for 59.28%, 19.61% and 18.09% of total consumption respectively. The total consumption of energy from conventional sources increased from 46,958 petajoules in 2011-12 to 50,741 petajoules in 2012-13, showing an increase of 8.06%.

Per-capita Energy Consumption (PEC) (the ratio of the estimate of total energy consumption during the year to the estimated mid-year population of that year) increased from 6205.25 KWh in 2011-12 to 6748.61 KWh in 2012-13, and thus, exhibiting a percentage annual increase of 8.76%.

The *Energy Intensity* (amount of energy consumed for generating one unit of Gross Domestic Product) (at 1999-2000 prices) has shown an increase from 0.1453 KWh in 2011-12 to 0.1518 KWh in 2012-13 which in terms of annual percentage increase works out to 4.49%.

In the absence of state level data on total energy consumption it is not possible to analyse the status of Uttar Pradesh on above two indicators.

Fig.9.03: Trend in Energy Intensity (KWH) per rupee@
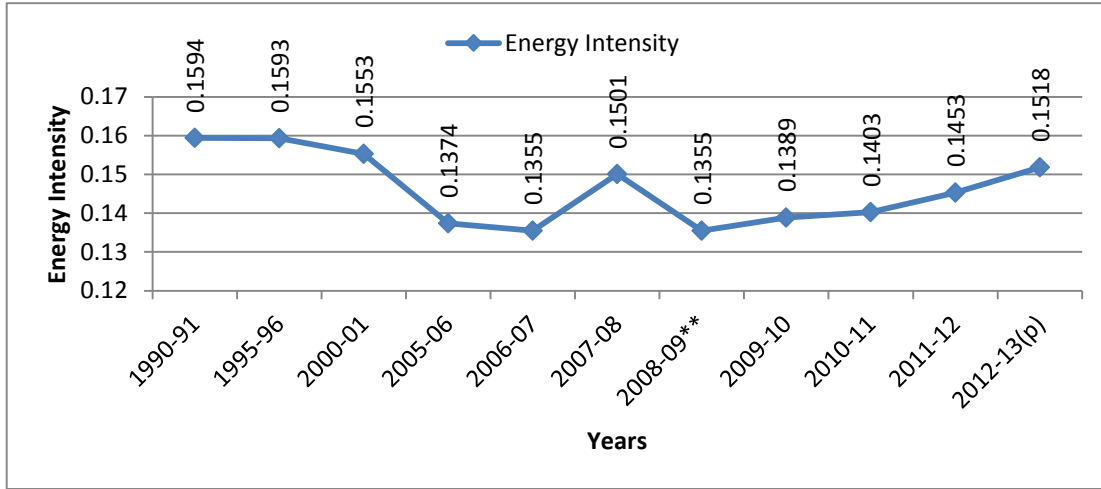
*Source: Energy Statistics 2014, Ministry of Statistics and Programme Implementation ** GDP at 2004-05 prices*

Indicator 28: Carbon Dioxide emission per capita and consumption of Ozone - depleting Chlorofluoro Carbons (ODP tons)

Carbon dioxide (CO_2) is the primary greenhouse gas emitted through human activities. Human activities are altering the carbon cycle—both by adding more CO_2 to the atmosphere and by influencing the ability of natural sinks, like forests, to remove CO_2 from the atmosphere. While CO_2 emissions come from a variety of natural sources, human-related emissions are responsible for the increase that has occurred in the atmosphere since the Industrial revolution. As per the Key World Energy Statistics 2014, by International Energy Agency, the per capita CO_2 emission (Million Tonnes - MT) of India is 1.58 (MT) whereas the corresponding estimate for world and Asia are respectively 4.51 (MT) and 1.59 (MT). In India, the per capita CO_2 emission (MT) increased steadily during 1990 to 2014.

Fig 9.04: Trend in Per Capita CO2 emission (MT) in India
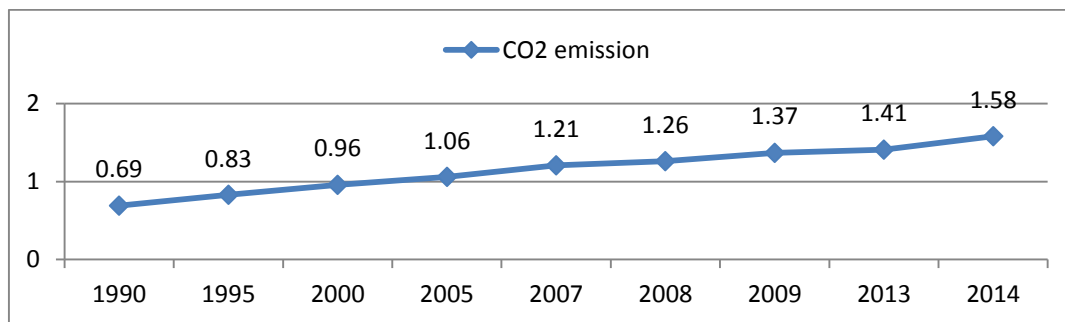
Source: 2014 Key energy statistics by International Energy Agency

In 2013, the estimated CO2 emission (Million Tonnes) for India is 1954.02. The Carbon dioxide emission showed a percentage increase of 235.57% in 2014 over 1990 for India whereas the corresponding increase for the World was 51.36%. During 2009 to 2014, the percentage increase in CO2 emission was 23.22% for India and 9.43% for the world.

India, being a party to the Montreal Protocol and all its amendments, has been successfully implementing the ODS (Ozone Depleting Substances) Programme in the Country. It has set up comprehensive regulatory and fiscal measures in the Country and has also been assessing the Montreal Protocol's financial mechanism for this endeavor. India has phased out production and consumption of CFCs (Chloro Fluro Carbon), CTC (Carbon Tetra Chloride) and halons as of 1st of January 2010, except use of pharmaceutical grade CFCs. In 2010, consumption of CFC is estimated at 290.733 ODP tonnes (ODP –Ozone Depletion Potential), down from 5614 ODP tones in 2000. From the year 2000, the CFC consumption decreased steadily till 2008, but showed minor increase in 2010.

Fig. 9.05: Consumption of CFCs ODP tonne

Source: Ozone Cell, M/o Environment, Forests and Climate Change

In the absence of state level data on CO2 emission and CFC it is not possible to analyse the status of Uttar Pradesh on above indicators.
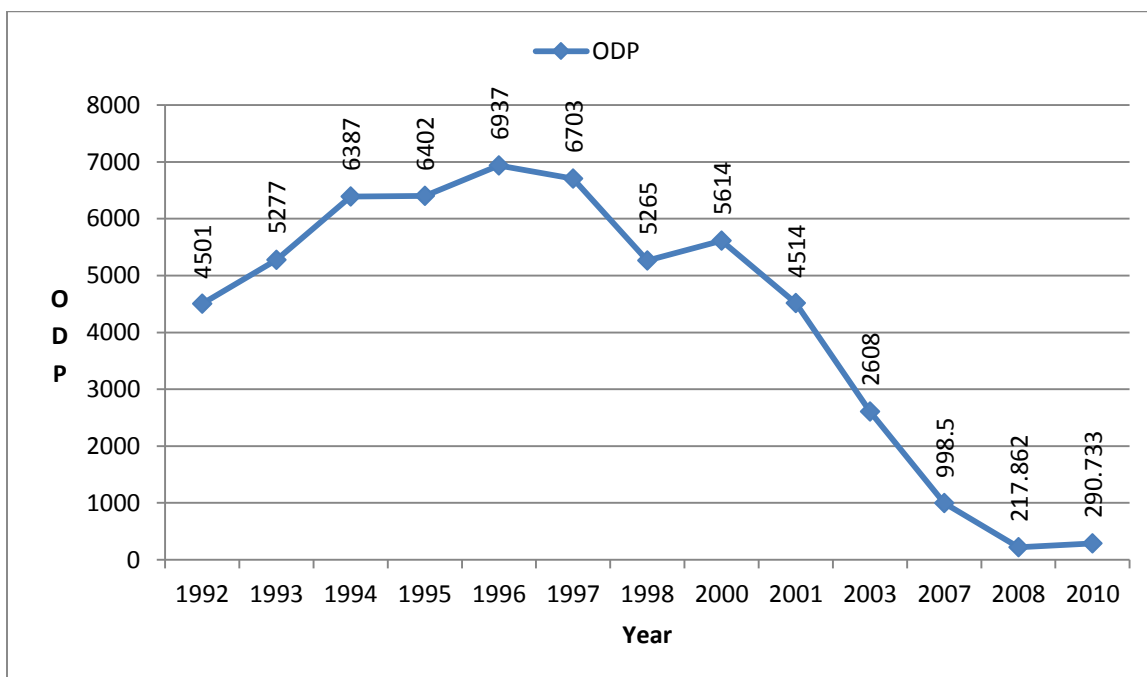
Indicator 29: Proportion of the Households using solid fuels

As per Census 2011, 79.8 % households of Uttar Pradesh are using solid fuels (fire wood / crop residue/cow dung cake/ coke, etc) for cooking against 85.7% in 2001. Census 2011, further reveals that, in Rural areas 92.9% households and in Urban areas 3.5 % households are using solid fuels for cooking.

Table 9.01: Percentage of Households by fuel used for cooking in U.P.-Census 2011 (%)

Description	All U.P.	Rural	Urban
Firewood	47.7	54.4	24.8
Crop residue	8.7	10.5	2.5
Cow dung Cake	23.1	27.9	6.9
Coal, Lignite, Charcoal	0.25	0.12	0.71
Kerosene	0.72	0.23	2.43
LNG/PNG	18.9	6.39	61.7
Electricity	0.09	0.08	0.12
Biogas	0.16	0.13	0.24
Others	0.12	0.12	0.13

Source: Office of Registrar General of India

Table9.02: Percentage of Households Fuel Used for cooking in U.P. -Decadal change

Description	Solid Fuel	Solid Fuel	Kerosene	Kerosene	LPG/PNG	LPG/PNG
	2001	*2011*	*2001*	*2011*	*2001*	*2011*
Total	85.7	79.8	2.28	0.70	11.3	18.9
Rural	96.4	96.3	0.50	0.20	2.6	6.4
Urban	43.3	34.9	9.4	2.4	46.0	61.7

Source: Office of Registrar General of India

During 2001- 2011, there is an increase of 7.6 points in the use of LPG (Liquefied Petroleum Gas) / PNG (Piped Natural Gas) for cooking. Further use of kerosene as source of fuel has decreased by 69.2% during period 2001- 2011.

# Indicator 30 :Proportion of population with sustainable access to an improved water source- urban and rural

The study of the drinking water facility requires analysing the access to different sources of drinking water and sufficiency of drinking water. The accessibility of drinking water at household level has other aspect like the distances travelled by members of a household to reach

the source of drinking water. The quality of drinking water is also a very important component in maintaining good health of the population. Many households attempt to improve the quality of water they drink by adopting various methods for treating the water before drinking.

In NSS 69th round (July- Dec 2012), the improved source of drinking water include: 'bottled water3', 'piped water into dwelling', 'piped water to yard/plot', 'public tap / standpipe', 'tube well/borehole', 'protected well', 'protected spring', and 'rainwater collection'. During 2012, at all U.P. level, 96.2 % households had improved source of drinking water while 96.6% households in rural and 95.0% households in urban area had access to improved source of drinking water.

The Census provides details of sources of drinking water accessed by the households. In 2011, in rural U.P., Hand Pump (73.0 %) is the main source of drinking water followed by Tap (13%). In urban U.P., Tap water (45 %) is the major source followed by Hand Pump (37.0%).

**Fig.9.06: Source of drinking water in U.P. (%) - Census 2011**
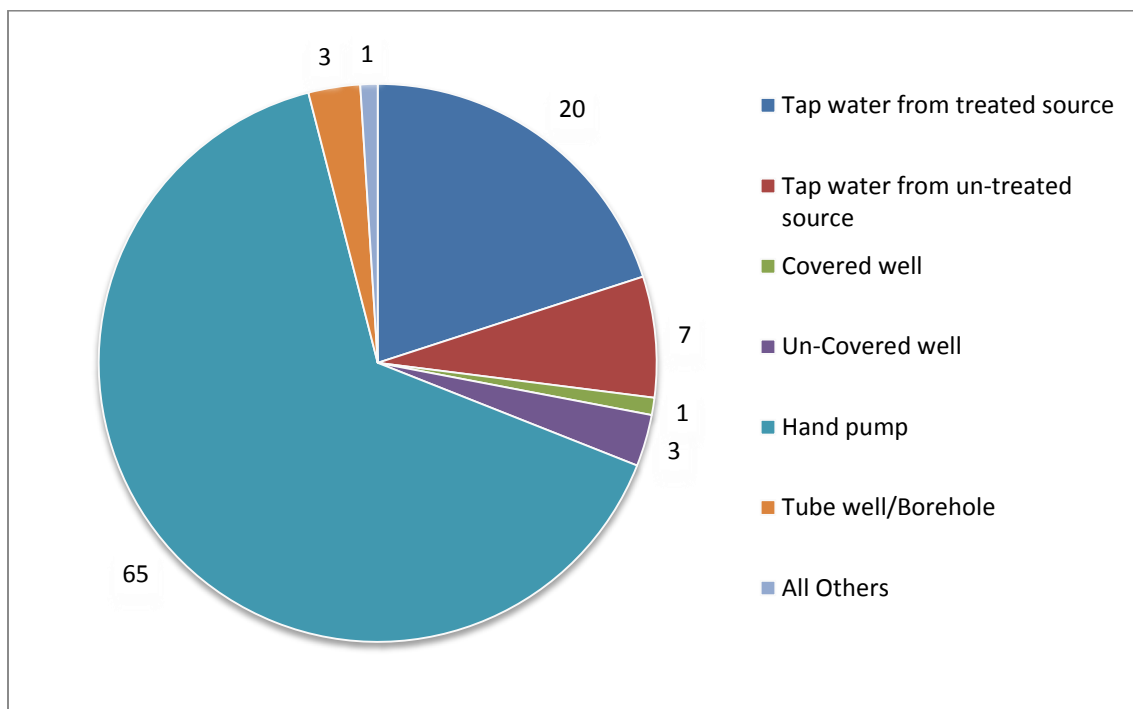
Though the major source of drinking water continued to remain the same during the last decade in rural and urban areas, there was shift in the percentage of population accessing the various source of drinking water and at rural, urban and State level.

Table 9.03: Sources of Drinking Water (%) – Census

``	Tap		Well		Hand pump / Tube well		Other Sources	
	2001	2011	2001	2011	2001	2011	2001	2011
Rural U.P.	16	20	14	5	69	74	1	1
Urban U.P.	55	52	2	0	43	47	1	1
All U.P.	24	27	12	4	64	68	1	1

In 1990, 62.2 % of households have access to safe drinking water. It means that in 1991, 37.8% of households do not have access to safe drinking water. MDG goal is to reduce by 2015, the percentage of household not having access to safe drinking water to 18.9%. i.e by 2015, 81.1 % of households has to have access to safe drinking water. The prevailing trend over time suggests, the target of halving the proportion of households without access to safe drinking water sources from its 1990 level, has already been achieved as latest NSS data shows that in 2012,96.2% of household have access to safe drinking water. In rural areas as the latest NSS data shows that 96.6 % of households have access to improved drinking water sources against the target of 78.3%. In urban areas in 2012, 95% households have access to improved drinking water source vis −a vis the target of 92.9 % by 2015.

Figure 9.0.7 : Trend in access to safe drinking water in households in India (in per cent)
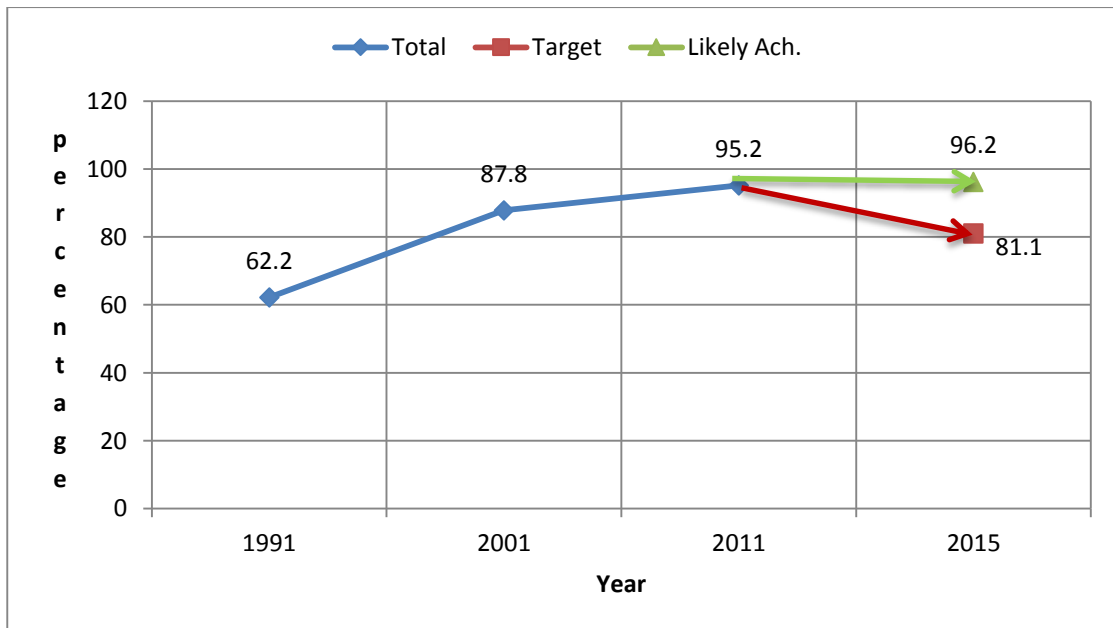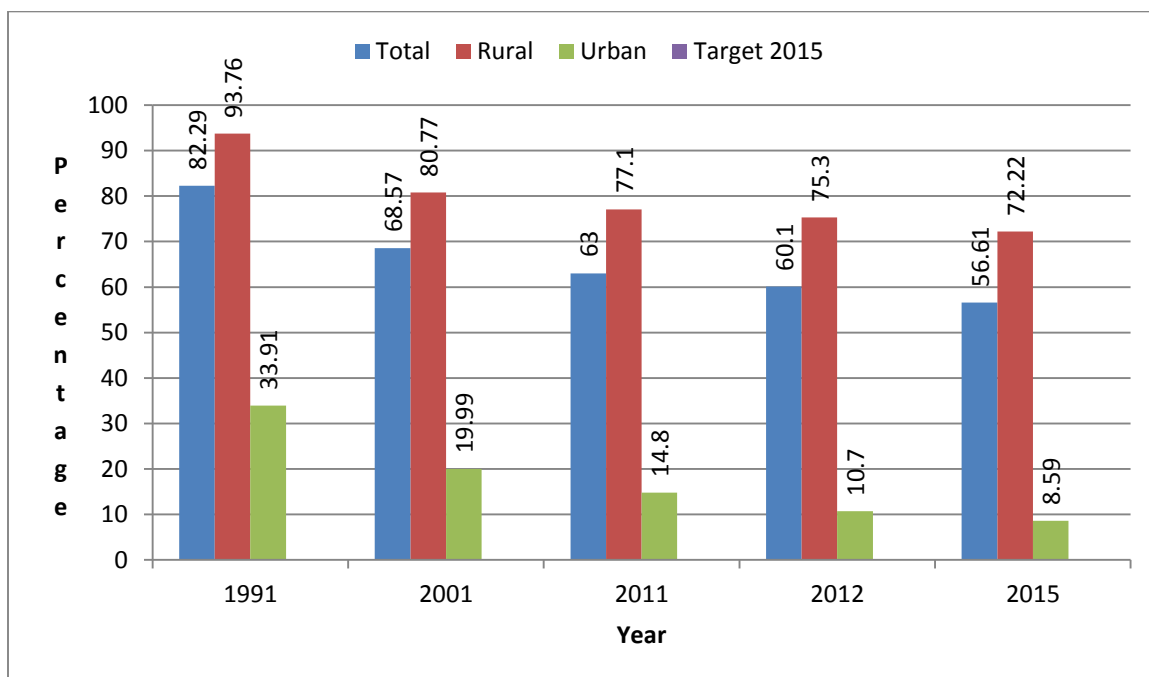

Source: Census data

Basic Sanitation facility to households

The sanitation facility available to the households is having a huge impact on the living conditions and it is closely related to the health and hygiene of the members of households. In World Health Organization and United Nations Children's Fund's Global Water Supply and Sanitation Assessment 2000 Report, sanitation was defined to include connection to a sewer or septic tank system, pour-flush latrine, simple pit or ventilated improved pit latrine, with allowance for acceptable local technologies.

The census 2011 revealed that, though the percentage of households with access to sanitation facility recorded an improvement of 5.57 percentage points during the last decade, still more than 60% of the State's households have no latrine facility. In 2011, the percentage of households with no latrine reduced to 63% from 68.57% in 2001. Census 2011 revealed that, in rural areas 69.3% households are not having latrine facility, whereas in urban areas the corresponding figure is 18.6% in 2011. The NSS 2012 revealed 60.1% of households at State level had no latrine facilities. The NSS 2012 shows that 75.3 % and 10.7% households in rural U.P. and urban U.P. respectively had no access to sanitation.

Fig.9.08: Percentage of households without access to sanitation

According to Census 1991, around 82.29 per cent of Uttar Pradesh's population had No Latrine facility in their households and practicing Open defecation. To achieve the MDG (7) in this regard U.P. would have to achieve 58.85 per cent households with latrine facility to reduce

by half the proportion of people without sustainable access to basic sanitation facility at the end of year 2015. Towards achieving the target of access to basic sanitation facility in households, in urban areas, the 2015 target is likely to be met as the percentage of households without sanitation facility is likely to be 8.59% in 2015 against the target of 16.95 %, and the progress is quite lagging behind in rural areas as likely achievement in 2015 is 72.22% of households without sanitation facility vis-a- vis the target of 46.88 %. At State level, 2015 target is unlikely to be met the percentage of households without sanitation facility is likely to be 56.61% vis –a – vis the target of 41.14%.

Fig. 9.09: Percentage of households without access to sanitation –State Level
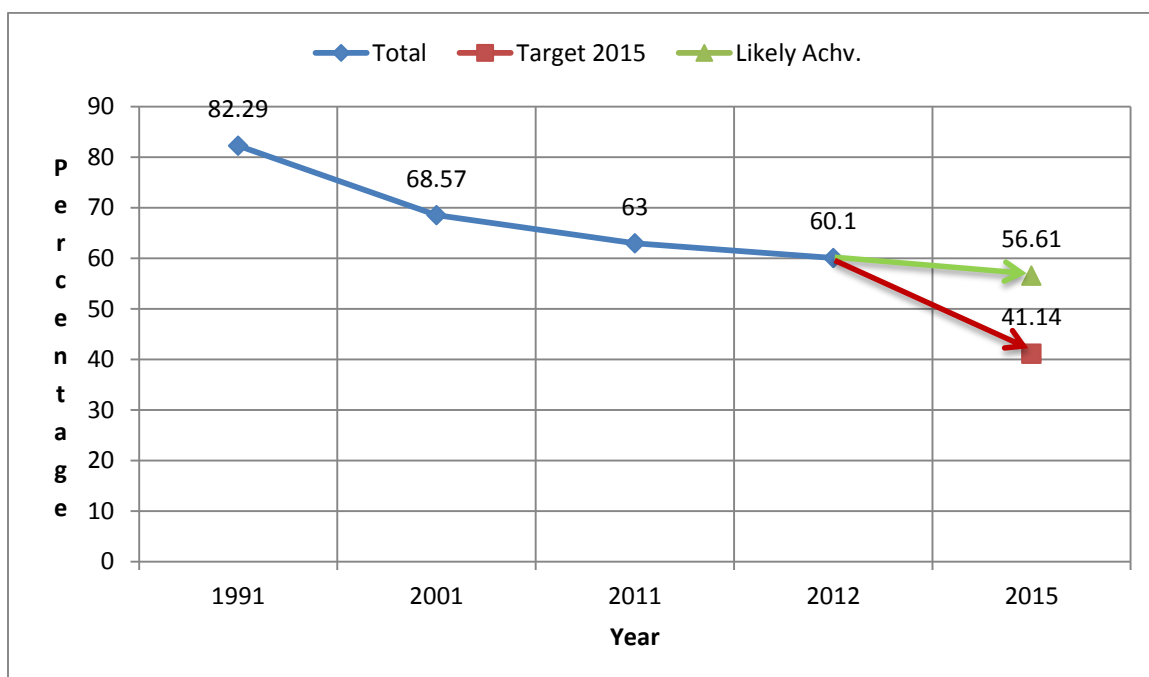
Source: Census, O/o Registrar General of India, NSS 69th round

Indicator 32: Slum population as percentage of urban population

The Millennium Development Goal 7 also aims at improving the living condition of slum dwellers. In India, Census, and National Sample Survey are two sources which report slum data at national level. However, the definitions used in population census 2011 and NSS 2012, differs as shown below.

Table 9.04: Definition of Slum

Census 2011	NSS 2012
• All notified areas in a town or city notified as 'Slum' by State, UT administration or local government under any act including a 'Slum Act'	• Areas notified as slums by the concerned municipalities, corporations, local bodies or development authorities were termed 'notified

may be considered as 'notified slums'. • All areas recognised as 'Slum' by State, UT administration or local government, Housing and Slum Boards, which may not have been formally notified as slum under any act may be considered as 'recognised slums'. • A compact area of at least 300 population or about 60-70 households of poorly built congested tenements, in unhygienic environment, usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities. Such areas should be identified by the Charge Officer and also inspected by an Officer nominated by Directorate of Census operations. Such areas may be considered as 'identified slums'.	slums'. • Also, any compact settlement with a collection of poorly built tenements, mostly of temporary nature, crowded together, usually with inadequate sanitary and drinking water facilities in unhygienic conditions, was considered a slum by the survey, provided at least 20 households lived there. Such a settlement, if not a notified slum, was called a non-notified slum. (Note that while a non-notified slum had to consist of at least 20 households, no such restriction was imposed in case of notified slums.) • Slums: The word "slum" covered both notified slums and non-notified slums

As per 69th round NSS (Jan- Dec 2012), at all-India level, and at U.P. state level, only 10.8 percent and 2.6 percent respectively of urban dwelling units were situated in slum. However, Census 2011 reported that in U.P. 12.8% of urban households are located in slums.. Census further reveals that in 2011, 14.02 % of the urban population lives in slums.

Table 9.05: Number of Statutory and slum reported towns with type wise slum population

Name of State/ Union territory	Towns		Type wise Slum Population			
	Statutory towns	Slum reported towns	Total population	Notified slums	Recognised slums	Identified slums
U.P.	648	293	62,39,965	5,62,548	46,78,926	9,99,091
India	4041	2,613	6,54,94,604	2,25,35,133	2,01,31,336	2,28,28,135

Table 9.06: Populations & Slum Populations In Urban Uttar Pradesh 1981-2011

Year	Total Population(Lakh)	Slum Population(lakh)	Percentage
1981	199.0	25.8	12.96
1991	276.1	58.4	21.15
2001	365.4	77.1	21.10
2011	444.9	62.39	14.02

Source: Census, O/o Registrar General of India,
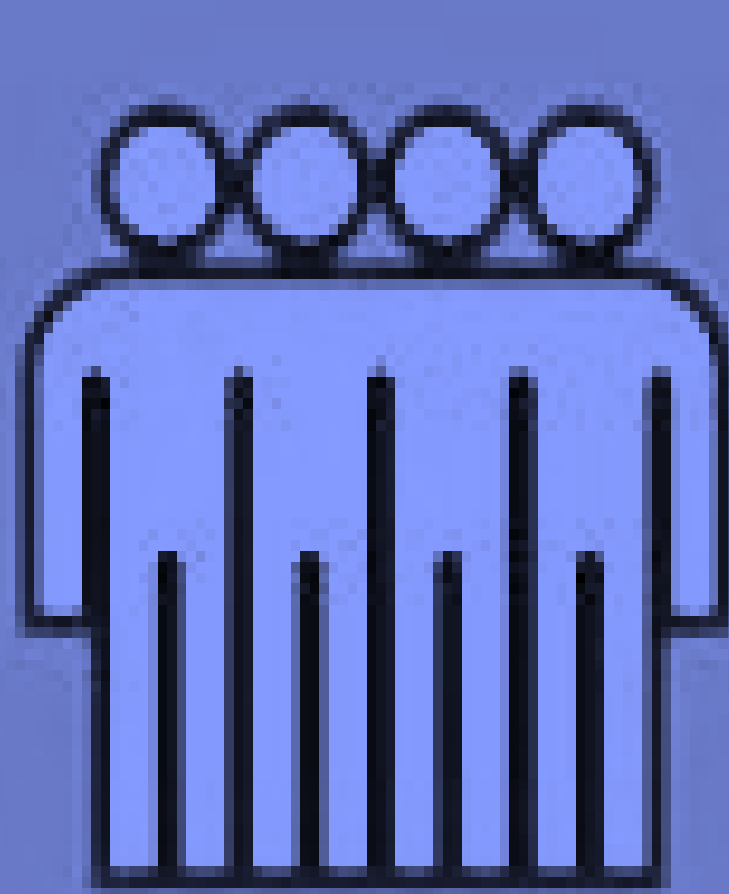
GLOBAL
PARTNERSHIP FOR
DEVELOPMENT

CHAPTER 10
Progressing Telecom and IT sectors

Telecommunications has evolved as a basic infrastructure like electricity, roads, etc. and has also emerged as one of the critical components of economic growth required for overall socio-economic development of the country. Importance of information and Communication Technology is emphasized in Target 18 under Goal 8 of MDGs.

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

TARGET 18: In cooperation with the private sector,make available the benefits of new technologies,especially information and communication

✓ Indicator 47:   Telephone lines and cellular subscribers per 100 population

✓ Indicator 48A: Internet subscribers per 100 population

✓ Indicator 48B: Personal computers per 100 population

The Indian telecom sector has registered a phenomenal growth during the past few years and has become second largest telephone network in the world, only after China. A series of reform measures by the Government, the wireless technology and active participation by private sector played an important role in the exponential growth of telecom sector in the country.

Indicator 47: Telephone lines and cellular subscribers per 100 population

The U.P. telecom network, as on Sept 2015 , has 13.94 million telephone connections, including 13.85 million wireless telephone connections. The number of telephone subscribers in U.P. increased from 13.84 million at the end of June-2015 to 13.95 million at the end of Sept 2015, registering a monthly growth of 0.24%. The quarter, June-2015 to Sept-2015, recorded a net addition of 10.06 million in telephone subscription.

The telecom sector in U.P. has shown robust growth during the past few years. It has also undergone a substantial change in terms of mobile versus fixed phones and public versus private participation. The wireless telephone services play a major role in improving the tele-density. As per the status of 30th Sept 2015, the share of wireless telephones in total telephones is 99.32%. as compared to 96.3% in March 2010.

Private sector contributes significantly towards ensuring better telecom connectivity. The share of private sector in total telephones has increased to 91.1% in Sept 2015, from 81.4% in March 2010. Private sector plays a predominant role in wireless telecom sector, while Public sector PSUs are the major players in wire line sector.

Fig.10.01: Market share of Private and PSU Operators in Telecom Sector on Sept 2015
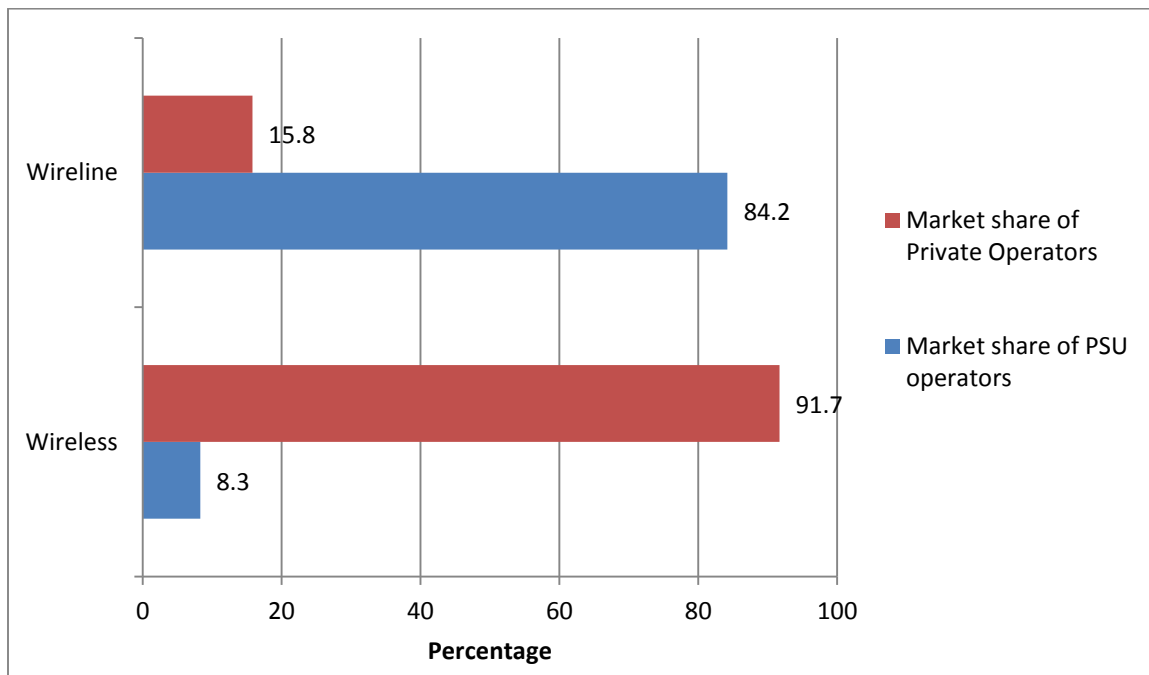
Source: Telecom Regulatory authority of India (TRAI)

Tele-density, which shows the number of telephones per 100 populations, is an important indicator of telecom penetration in the country. Overall tele-density in the country is 76% as on 31st July 2014. The teledensity among the State/ service areas, is lowest in Bihar (47.24) and highest in Delhi (230.49) as on 31/7/2014. U.P. has a tele density of 58.31% which is well below national average.

Indicator 48A: Internet subscribers per 100 population

The huge leap in telecom sector along with the advances in IT sector has led to massive expansion in the internet subscriber base. Total number of Internet subscribers has increased from 16.18 million at the end of March-10 to 324.95 million at the end of Sept-15 with an annual average growth of 38%.

The *internet subscribers per 100 population* accessing internet through wireline and wireless connections has increased from 16.15 in June 2013 to 20.83 in June 2014. This rapid growth is possible due to various proactive and positive decisions of the Government and

contribution of both the public and the private sectors. The latest status of internet subscribers (service area wise) shows internet penetration is lowest in Bihar (9.41%) and highest in Delhi (77.58%).

Fig. 10.02 Number of Internet subscribers per 100 population (as on 31/6/2014)
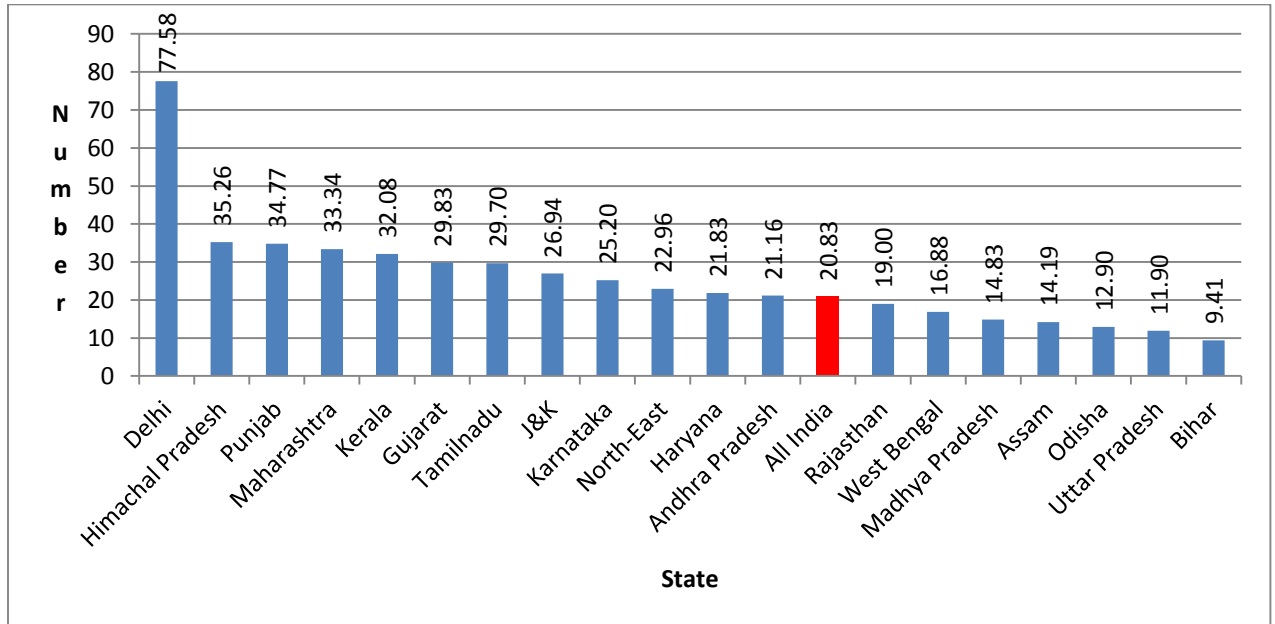
Source: Telecom Regulatory authority of India (TRAI)

With technology development, Laptops, tablets, etc have become major tools serving the purpose of personal computers in addition to Desk top computers. Further, internet access through mobiles is transforming the entire scenario.

Appendix

MDGs and Targets –Summary of Progress achieved by U.P.				
Indicator		**Year 1990 Actual/est. value**	**Latest status**	**MDG target 2015**	**Likely achievement 2015**

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

TARGET 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Missed Target Narrowly

Indicator		Year 1990	Latest status	MDG target	Likely achievement
*Proportion of population below poverty line (%)		50.67	29.43 (2011-12)	25.34	27.94
Poverty Gap Ratio	Rural	No base year Target	5.68 (2011-12)		
	Urban		5.29 (2011-12)		
Share of poorest quintile in national consumption (URP method)	Rural	No base year Target	10.2 (2011-12)		
	Urban		7.10 (2011-12)		

TARGET 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Slow or almost off-track

Indicator	Year 1990	Latest status	MDG target	Likely achievement
Proportion of under-weight children below 3 years (%)	56.78	41.6 (2005-06)	28.39	33.81

MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

TARGET 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling-

Missed Target Narrowly

Indicator	Year 1990	Latest status	MDG target	Likely achievement
**Net Enrolment Ratio in primary grade (%)	78.2 (99-2000)	95.64 (14-15)	100	

MDGs and Targets –Summary of Progress achieved by U.P.				
Indicator	**Year 1990 Actual/est. value**	**Latest status**	**MDG target 2015**	**Likely achievement 2015**
Proportion of pupils starting grade 1 who reach grade 5	Absolute targets for 2015	87 (14-15)	100	
Literacy rate of 15-24 year olds	66.5	81.57 (2011)	100	91.69 (2014-15

MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

TARGET 4 : Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

On-track in Primary and Tertiary education. Missed target narrowly in case of secondary education.

Ratio of girls to boys in primary education (Gender Parity Index of GER)	0.94 (2004-05)	1.03 (2011-12)	1.00	1.00
Ratio of girls to boys in secondary education (Gender Parity Index of GER)	0.68 (2004-05)	0.89 (2011-12)	1.00	
Ratio of girls to boys in tertiary education (Gender Parity Index of GER)	0.74 (2004-05)	1.00 (2011-12)	1.00	1.00
Female literacy rate: Male literacy rate of 15-24 year olds	0.50 (1991)	0.87 (2011)	1.00	
Share of women in wage employment in the non-agricultural sector (%)	8.2 (2009-10)	10.0 (2011-12)	50	10.41
Proportion of seats held by women in vidhan sabha (%)	Absolute targets for 2015	8.68 (2012)	50	

MDGs and Targets –Summary of Progress achieved by U.P.				
Indicator	**Year 1990 Actual/est. value**	**Latest status**	**MDG target 2015**	**Likely achievement 2015**

MDG 4: REDUCE CHILD MORTALITY

TARGET 5 : Reduce by two-thirds, between 1990 and 2015, the Under- Five Morality Rate

Moderately on – track due to the sharp decline in recent years

Indicator	Year 1990	Latest status	MDG target 2015	Likely achievement 2015
Under five mortality rate (per 1000 live births)	152 (1990)	64 (2013)	51	63.61
Infant Mortality rate (per 1000 live births)	99 (1990)	50 (2013)	33	39
Proportion of 1 year-old children immunized against measles	33.5 (98-99)	52.8 (2009)	100	68.1

MDG5 5: IMPROVE MATERNAL HEALTH

TARGET 6 : Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Slow or off-track

Indicator	Year 1990	Latest status	MDG target 2015	Likely achievement 2015
Maternal mortality ratio (per 100,000 live births)	855.1	285 (2011-13)	213.8	241.96
Proportion of births attended by skilled health personnel (%)	21.8 (98-99)	64.2 (2009)	100	66.7

MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

TARGET 7 : Have halted by 2015 and begun to reverse the spread of HIV/AIDS

On-track as trend reversal in HIV prevalence has achieved

MDGs and Targets –Summary of Progress achieved by U.P.

Indicator	Year 1990 Actual/est. value	Latest status	MDG target 2015	Likely achievement 2015
HIV Prevalence among pregnant women aged 15-24 years (%)	Target is trend reversal and not based on base year value	0.15 (2012-13)		Trend Reversal
***Condom use rate of the contraceptive prevalence rate (%)		8.6 (2005-06)		Achieved
^Condom use at last high-risk sex(%)		46 (2009)		
Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS		21 (2009)		

TARGET 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Moderately on-track as trend reversal has achieved for Annual Parasite Incidence of Malaria and for prevalence of TB

Annual parasite incidence (API) rate (Malaria)	0.30 (2010)	0.20 (2014)	Target is reversal of trend	Achieved reversal trend
Prevalence of TB (including HIV) per 100,000 population	465	195	Target is reversal of trend	Achieved reversal trend
Proportion of population in Malaria risk areas using effective Malaria prevention and treatment measures		Data not Available		

MDGs and Targets –Summary of Progress achieved by U.P.

Indicator	Year 1990 Actual/est. value	Latest status	MDG target 2015	Likely achievement 2015
Deaths due to TB per 100,000 population	38	17		

MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

TARGET 9: Integrate the principle of sustainable development into country policies and programmes and reverse the loss of environmental resources.

Moderately on-track

Indicator	Year 1990 Actual/est. value	Latest status	MDG target 2015	Likely achievement 2015
Area covered under forests as percentage of geographical area	Target is trend reversal and not based on base year value	5.95 (2013)		
Ratio of area protected to maintain biological diversity to surface area (%)		2.37 (2013)		
Energy use per GDP (Rupee)		State Level Data not available		
Carbon dioxide emissions per capita		State Level Data not available		
Consumption of ozone-depleting CFCs (ODP tons)		State Level Data not available		
Proportion of population using solid fuels (%)		79.8 (2011)		

TARGET 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

On-track for the indicator of drinking water, but slow for the indicator of Sanitation

MDGs and Targets –Summary of Progress achieved by U.P.					
Indicator		**Year 1990 Actual/est. value**	**Latest status**	**MDG target 2015**	**Likely achievement 2015**
Households with sustainable access to an improved water source, (%)	Urban	62.2	95 (2012)	92.9	Target Achieved
	Rural		96.6	78.3	Target Achieved
Households without access to sanitation (%)	Urban	33.91	10.7 (2012)	16.59	8.59
	Rural	93.76	75.3 (2012)	46.88	72.22

TARGET 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

The pattern not statistically discernible

Slum population as percentage of urban population	21.15 (1991)	14.02 (2011)		

MDG 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

TARGET 18 : In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

On-track

Telephone per 100 population		Target is increasing trend and not based on base year value	58.31 (2014)		
Internet subscribers per 100 Population	accessing internet through wireline and wireless connections		11.90 (2014)		
Personal computers per 100 population			Data not available		