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Rights and Opportunities

The Situation of Children and Women In India

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India Country Office
New Delhi
1998

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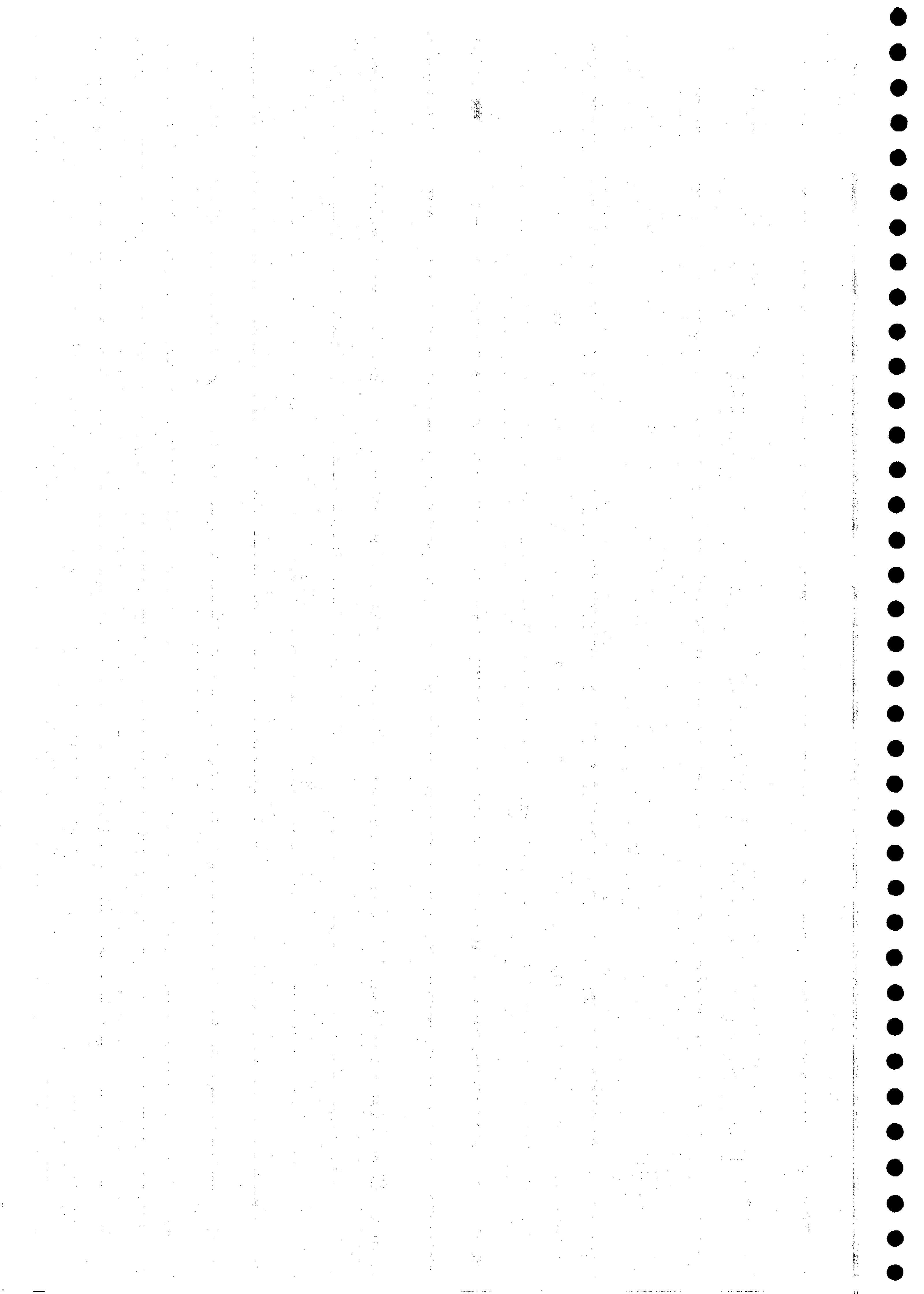

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Table of Contents

PREFACE 5

CHAPTER 1 - CHILDREN'S RIGHTS AND OPPORTUNITIES 7

1.1. INDIA'S CHILDREN 7
1.2. THE LEGAL DEFINITION OF A CHILD 9
1.3. ECONOMIC, POLITICAL AND SOCIAL TRANSITION IN INDIA 10
1.4. ENHANCING CHILDREN'S CAPABILITIES 12
1.5. RIGHTS AND OPPORTUNITIES FOR CHILDREN 14

CHAPTER 2 - CHILD RIGHTS AND WOMEN'S CAPABILITIES 18

2.1. POSITION AND CONDITION OF WOMEN 18
2.2. WOMEN'S HEALTH AND NUTRITIONAL STATUS 19
2.3. WOMEN'S EDUCATION 25
2.4. WOMEN'S WORK 27
2.5. WOMEN AND MEN 29
2.6. WOMEN'S PARTICIPATION IN DECISION-MAKING 31
2.7. WOMEN FOR WOMEN 32

CHAPTER 3 - CHILD RIGHTS IN INDIA 33

3.1. THE RIGHT TO SURVIVAL 33
3.2. THE RIGHT TO HEALTH 37
3.2.1. Treating diseases 40
3.2.2. Preventing diseases 42
3.2.3. The health care "system" 43
3.2.4. The "other" health sector 44
3.3. THE RIGHT TO HEALTHY GROWTH AND NUTRITION 45
3.3.1. Underweight, stunting and wasting 46
3.3.2. Causes 47
3.3.3. Micronutrients 50
3.4. THE RIGHT TO A SAFE AND CLEAN ENVIRONMENT 53
3.4.1. Sanitation and hygiene 54
3.4.2. Domestic water supply 56
3.4.3. Adequate safe water and sanitation for all: Future directions 62
3.5. THE RIGHT TO DEVELOPMENT 63
3.5.1. Right to early childhood development 63
3.5.2. The right to primary education 65
3.6. THE RIGHT TO PROTECTION 73
3.6.1. Discrimination at and before birth 75
3.6.2. Child labour 75
3.6.3. Child prostitution 78
3.6.4. Street children 79
3.6.5. Disabled children 80
3.6.6. Use of legislation 81
3.7. THE RIGHT TO PARTICIPATION 81
3.7.1. Role of information and advocacy 81
3.7.2. Enabling children to voice their views 82

CHAPTER 4 - EQUAL RIGHTS FOR ALL CHILDREN 84

CHAPTER 5 - AN AGENDA FOR ACTION 86

5.1. STRENGTHENING THE POSITION OF WOMEN 86
5.2. RENEWED COMMITMENT TO THE GIRL-CHILD 87
5.3. DECENTRALIZATION AND LOCAL GOVERNANCE 88

5.4. ENSURING THAT CHILDREN'S RIGHTS ARE FULFILLED THROUGH THE SOCIAL SECTORS 89
5.4.1. Health *90*
5.4.2. Nutrition *91*
5.4.3. Early child development *91*
5.4.4. Primary education *92*
5.4.5. Environment *93*
5.5. PROTECTION AND PARTICIPATION RIGHTS 93
5.6. PARTNERSHIPS 95
5.7. CONCLUSION 95

TABLE OF ACRONYMS 96

DEFINITIONS 98

INDICATORS BY STATES AND UNION TERRITORIES 101

Preface

Every five years, UNICEF prepares a document on the situation of children and women in India, often coinciding with the preparation of a new National Development Plan. The Situation Analyses that have emerged aim to provide policy makers, academics, concerned individuals as well as the UNICEF Country Office, a series of perspectives on trends of major factors affecting children. Each situation analysis has presented the data from different angles. The 1986 Situation Analysis took a sectoral approach reflecting on the situation in each of the major sectors where UNICEF has classically placed its efforts to improve coverage and services. It followed the sectoral alignment and dealt little with cross-sectoral activities or with children per se, except as they were affected by the sectors. In 1990, a life-cycle approach was adopted in order to highlight gender differentials, and to recognize, through following the life cycle of the girl, the inter-relatedness - at least in a sequential way - of the sectors and areas in which UNICEF works and supports the government. Nonetheless, the resulting Master Plan of Operations was largely a sectoral document in spite of the fact that each sector was attempting to address gender differentials in its own programme.

This Situation Analysis takes a new departure. While still concerned about gender and the differentials at each age, as well as the activities in the sectors in which UNICEF is involved in supporting children in the country, it takes children's rights as the foundation of UNICEF's work. This is a substantial shift in perspective from the previous welfare/basic needs approach that characterized UNICEF's programming so far. This, of course, does not mean UNICEF will dilute its commitment to achievable targets that has marked its work in so many areas. The ambitious goals set at the World Summit for Children remain central to its work and advocacy. A rights approach, however, demands that these goals are seen in terms of broader issues that cannot be ignored, either in terms of the way they limit or constrain the achievement of these goals or affect their sustainability; disparities that disfigure the most commendable achievement; a recognition that it is the status, position and rights of women that has a fundamental bearing on the fulfillment of many, if not all, child rights.

In a rights perspective ***process*** is as important as ***outcome***. For instance, the nineties have demonstrated that society as a whole could be mobilized to immunize their children, reaching coverage levels that were previously undreamed of and widely thought unfeasible. India itself has remarkably demonstrated that its system can indeed be mobilized to this end. A rights approach now moves us to a new way of looking at the problems that remain, one that emphasizes community involvement, and the potential of women's groups taking on responsibility for ensuring their own children's health and development, as much as government service provision. The situation analysis aims to explore and draw out these issues.

A rights approach has another major implication. It inherently changes the nature of UNICEF's work from supporting across-the-board efforts for all children to a more critical and focussed look at those who are not yet enjoying the basic rights spelled out in the Convention on the Rights of the Child (CRC), and identified through the many sectors in which UNICEF works. Similarly, in order to realise the rights of each child, one must be operative where the child lives, in the family and community, and, therefore, the line ministries and departments at national and state levels. To the community approach through the thousands of India's villages and pockets of the urban poor, that must appreciate, and indeed realize, the rights of children as a means for implementing the constitutional guarantees, political promises, and social expectations of the country.

Finally, a rights approach calls for new ways to measure progress, combining the sharp focus on problem reduction, which UNICEF has sought to encourage in all areas affecting children, with new measures that capture the extent to which children's rights are, or are not, being fulfilled. This embraces comparisons between states, between cities and districts, leading to communities themselves tracing their own progress in reducing disparity, improving gender balance and monitoring the progress in which violations of child rights are being addressed.

The Situation Analysis is, therefore, an attempt not only to bring together in one place the most up-to-date data on children, and its interpretation, but also to identify the

challenges and opportunities for India, as it embarks upon the final years of this millennium, in an attempt to assure the basic rights of its youngest citizens, the children of India.

Wherever possible, reference has been made to the most recent sources of data: principally the Census (primarily 1981 and 1991), the Sample Registration System (SRS, various years), and the National Family Health Survey (1992/93), supplemented by data from individual surveys or studies, such as the Human Development Survey (1994) conducted by NCAER, and the Sixth All India Educational Survey (1993) and the Habitation Survey (1994). In a number of areas, the quality of data has improved significantly in the last five years. In other fields, notably primary education and those areas concerning the protection rights, data is seriously incomplete or simply absent. This points to areas for future efforts in data collection and analysis. Much of the most recent innovative work in assessing programme progress has come from using specially designed sample surveys which can be mounted quickly and at low cost, yet provide representative data on key variables. This is an area where UNICEF is actively engaged in capacity building. Specifically, it is hoped that new and repeated rounds of Multi-Indicator Cluster Surveys (MICS) will allow regular monitoring of a number of indicators that are discussed in this report.

The 1998 Situation Analysis is very much a work-in-progress. The first draft was prepared in August 1996, and was revised after discussion with Government of India, states, partners in the UN family and other development agencies. It has been finalized in 1997-98 as a foundation document for the new UNICEF/Government of India Country Programme from 1st January 1999 to 31 December 2002.

Chapter 1 - Children's rights and opportunities

1.1. India's children

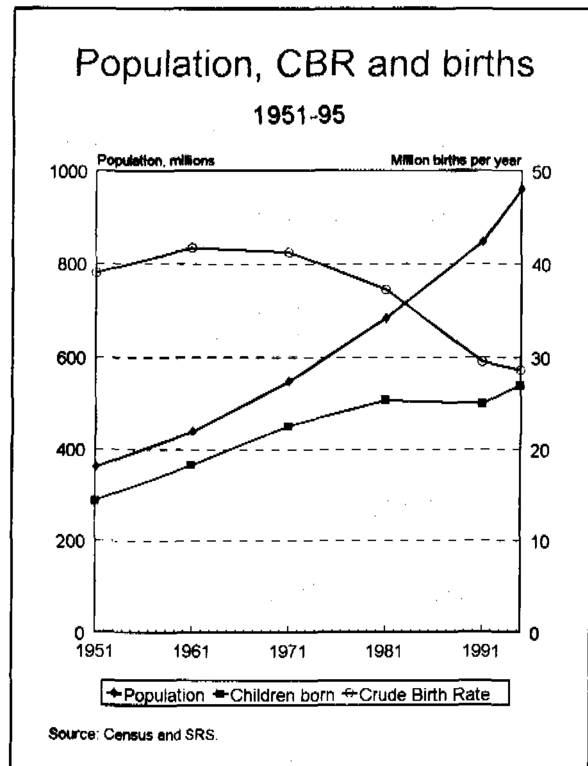
Children below 18 years of age, some 400 million today, account for more than a third of India's population estimated at 950 million in 1995. Close to 27 million children – 50 every minute - are born every year, 74 percent of them in rural areas. This is almost one-and-a-half times more than the number of children born in 1960. It is expected that the same number of children as are born today will be born even in the year 2000, as India's population is expected to rise to 1.02 billion by then.

Despite the steady decline in birth rates, and the improvements in child survival over the past 45 years, close to 3 million children under the age of five die every year, the same numbers as in 1974, depriving them of the most basic right - the right to life.

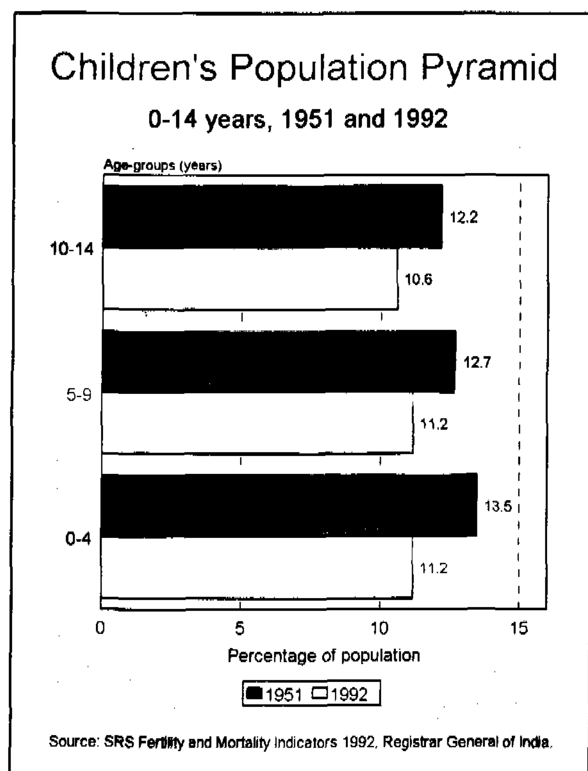
India is clearly in the midst of a demographic transition - one that varies in pace and strength across the country. Uttar Pradesh, India's most populous state (145 million) reports a birth rate of 34.7 (TFR of 5.2) and an infant mortality rate of 86 per thousand live births. Over 5 million children are born in Uttar Pradesh every year, some 20 percent of the total number born in the country, out of which 0.5 million (or 8.8 percent) die before completing the age of one. On the other hand, Kerala with a population of 29 million, has reached replacement levels with a total fertility rate of 1.7 (CBR of 17.7), and an infant mortality rate of 13 per thousand live births. Other states fall somewhere on a continuum between these two settings.

At some time in the middle of the next century, India's population will stabilize. The vital question is at what number will this be? The faster the country moves through demographic transition, the smaller that number becomes, with profound implications for the quality of life of children born then and in the coming future. Even with fulfilled ambitions of the Government's family planning programmes – a two-child family – by the year 2016, the Indian population will only stabilize in the year 2056 at 1.45 billion people.

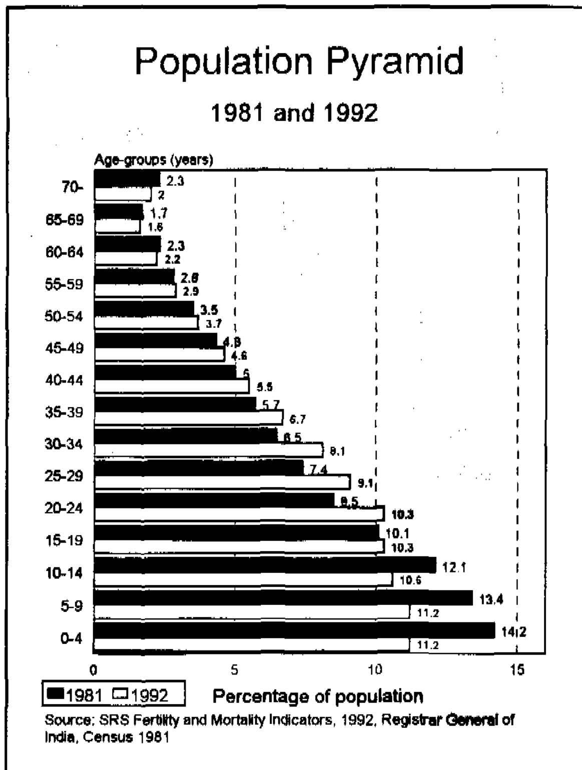
It underlines the importance of learning lessons from the experiences of those states where demographic transition has taken an early hold (such as Tamil Nadu and Kerala), and adapting and applying these ideas in areas where change has been slow or tentative.



Source: Census and SRS.

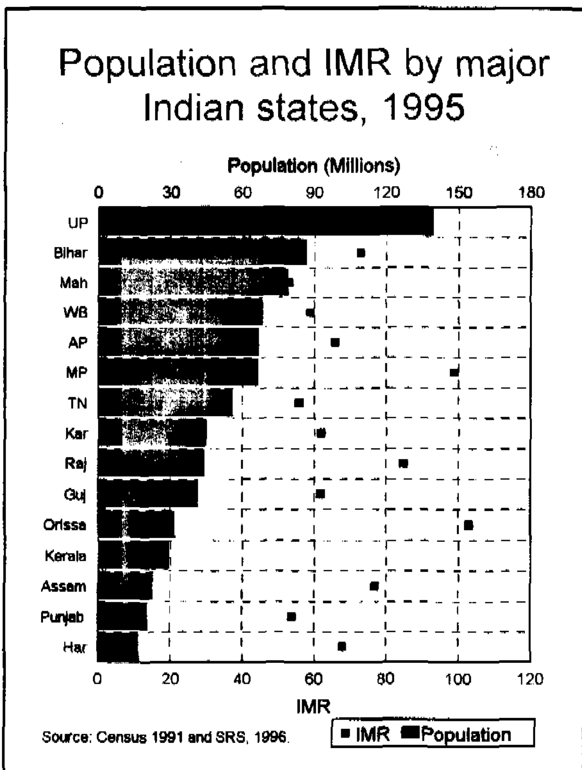


Source: SRS Fertility and Mortality Indicators 1992, Registrar General of India.



Population Pyramid
1981 and 1992

Source: SRS Fertility and Mortality Indicators, 1992, Registrar General of India, Census 1981



Population and IMR by major Indian states, 1995

Source: Census 1991 and SRS, 1996.

Indeed, the lessons are so significant that they become a recurrent theme running through this report. If Uttar Pradesh had Kerala's birth and infant survival rates, there would be 0.45 million fewer infant deaths; but more importantly, there would be 2.5 million less children born in the state. If all of India were to achieve Kerala's performance levels, there would be 2.5 million fewer child deaths—and 13 million fewer children born in the country.

Today, five states alone account for almost half (46.4 percent) of India's child population: Uttar Pradesh (17.8 percent), Bihar (11.2 percent), Madhya Pradesh (8.2 percent), Rajasthan (5.6 percent) and Orissa (3.6 percent). In the year 2000, given the fertility and mortality trends, the population of these five states is likely to rise above 50 percent. Conditions of children in this region will have a powerful influence on the national aggregates of almost all indicators.

Of the 27 million children born each year most will live in India's approximately 600,000 inhabited rural villages. Remarkable progress has been made in reaching many of these villages as part of the rural development efforts over the last three decades (with 95 percent having a school, 86 percent a source of drinking water). However, these villages are themselves made up of some 3 million hamlets or habitations, some of which are isolated and distant from service provision, many of them inhabited by the most disadvantaged groups.

An increasing percentage of India's children are also found in urban areas (from an estimated 92 million in 1991 to 125 million in 2000). Rapid urbanization has brought with it rapid growth in urban slums – in 1996 some 100 million people were estimated to be living in urban slums, a figure that is expected to rise to 120 million in 2001. While the national averages for urban areas consistently show a positive gap between urban and rural areas, social indicators for children in urban slum rank with those amongst the least favoured of rural areas. There are signs that these disparities may be increasing rather than diminishing (see Chapter 2).

Demographic trends also have a powerful influence on the quality of life children will experience growing up in their families. The average age of women at marriage is rising from 15.9 years in 1961 to 20 years in 1992 (urban 21.5 years; rural 19.3 years), leading to an increasingly delayed formation of new families. Families are getting smaller (ideal

family size is now 2.9). Women's participation in the labour market has always been considerable, unrecorded, but increasing (see Chapter 2).

As more women enter the formal labour market, new patterns of division of labour between men and women within the family are emerging, rarely to the advantage of women. Disturbing trend is that the practice of dowry appears to be on the increase in spite of it being illegal. This affects not only the age of marriage but also attitudes towards the birth of a girl child and decisions as to whether a family will invest in education for girls. Many of these changes are important for the distribution of resources within the household and the proportion of family income devoted to children. They also point towards the need to rethink conventional assumptions regarding roles of men and women in the family.

1.2. The legal definition of a child

The legal definition of a child varies depending upon the purpose: whether it is to mark out accession to political rights (e.g. the right to vote), for spelling out duties and obligations (e.g. in Juvenile Justice Systems), for affording protection (e.g. from exploitative or hazardous employment) or for establishing eligibility to receive benefits or special services (e.g. health, education and maintenance benefits). Underlying these alternative definitions are also the very varied conceptions of the child. These include viewing children as a burden involving rights to maintenance and support; regarding children as undergoing temporary disabilities entailing rights to special treatment and special positive discrimination; treating children as specially vulnerable for ensuring rights of protection; and recognizing children as resources for the country's future development, giving rise to rights of nurturing and advancement.

The very concept of a child is undergoing change in India, and it is of more than semantic importance. Traditional societies have treated children with special care only until they reach puberty, usually around age 14 for girls and 16 for boys. This, however, had declined by about 2 years in India, as in other countries, with nutritional and health improvement. Beyond puberty, traditional cultures recognize only adulthood, when boys take on responsibilities of men and girls are soon married and start bearing children, even before their own growth is complete. The concept of adolescence is intimately linked to social and economic progress and the recognition by societies of the need for children to transit into adulthood through a period, with increasing responsibility as knowledge and experience allows. The absence of the concept of adolescence leads to some of the worst problems in the present modernizing Indian society: child marriage, child prostitution, child labour and an absence of opportunities for basic education and socialization of young people. A national dialogue and understanding of the importance of adolescence is greatly needed, particularly for the vast majority who is yet to get the benefit of high school education.

These differing conceptions of the child tend to coexist in different settings with their

Legal Definition of a Child
Illustrations from laws in India

Criminal law
Indian Penal Code, 1860: Nothing is an offense that is done by a child under seven years of age (Section 82). Nothing is an offense which is done by a child above seven years of age and under 12 who has not attained sufficient maturity of understanding to judge the nature and consequence of his conduct on that occasion (Section 83).

Juvenile law
The Juvenile Justice Act, 1986: "Juvenile" is a boy who has not attained the age of 16 years, and a girl who has not attained the age of 18 years.

Family Law
The Child Marriage (Restraint) Act, 1929: "Child" means a person who, if a male, has not completed 21 years of age, and if a female, has not completed 18 years of age.

Labour Laws
The Apprentices Act, 1961: A person shall not be qualified to be engaged as an apprentice unless she is not less than 14 years of age.
The Factories Act, 1948: No child who has not completed his fourteenth year shall be required or allowed to work in any factory.
The Mines (Amendment) Act, 1983: No person below 18 years of age shall be allowed to work in any mine or part thereof.
The Child Labour (Prohibition and Regulation) Act, 1986: "Child" means any person who has not completed his fourteenth year of age.

relative importance changing over time, influenced by new norms and practices. The way a child is viewed is critical for not only his/her protection but also for the level of investment that society is prepared to make in the child. Definitions of who should be considered a child has important practical and political implications. The definition of a minor under the Suppression of Immoral Trafficking Act (SITA) as 16 years leaves the authorities little leeway in taking decisive action and proving violation of the law as a means to combat child prostitution. Overlaps and contradictions between definitions of a child under the law make this an area for re-examination and greater clarity. The definition of the child in the Convention on the Rights of the Child (CRC) as a child up to age 18 years compels us to address the needs of adolescents more adequately.

1.3. Economic, political and social transition in India

Over the past five years, three changes of considerable significance have taken place in the country. The first is the economic change that has been brought about by the reforms initiated in 1991; the second is the political change that has been ushered in by the 73rd and 74th Constitutional Amendment Acts aimed at promoting decentralization, local governance and women's participation and the third is the social transformation brought about by the changing roles of women. All of these have major implications for the well-being of children.

India has witnessed rapid economic transformation since the introduction of economic reforms in 1991. According to Government of India's Economic Survey 1995-96, the reforms initiated over the four-and-a-half years, since 1991, have triggered "a revival of strong economic growth, rapid expansion of productive employment, a reduction of poverty, a substantial boom in exports and a marked decline in inflation".

Real Gross National Product at factor cost grew at close to 7 percent for the third year now during 1996-97 significantly faster than the 0.5 percent recorded during the crisis year of 1991-92.

Estimates by the country's Planning Commission suggest that the incidence of poverty had declined from 29.9 percent in 1987-88 to below 19 percent of India's total population in 1993-94. Foodgrain production increased to 191 million tons in 1994-95 (from a little over 109 million tons in 1980) and as a result, public food stocks soared to a record level of 26 million in 1995. Industrial output registered a growth rate of 11.7 percent in 1995-96 and preliminary estimates suggest a growth rate of 8.7 percent in 1996-97.

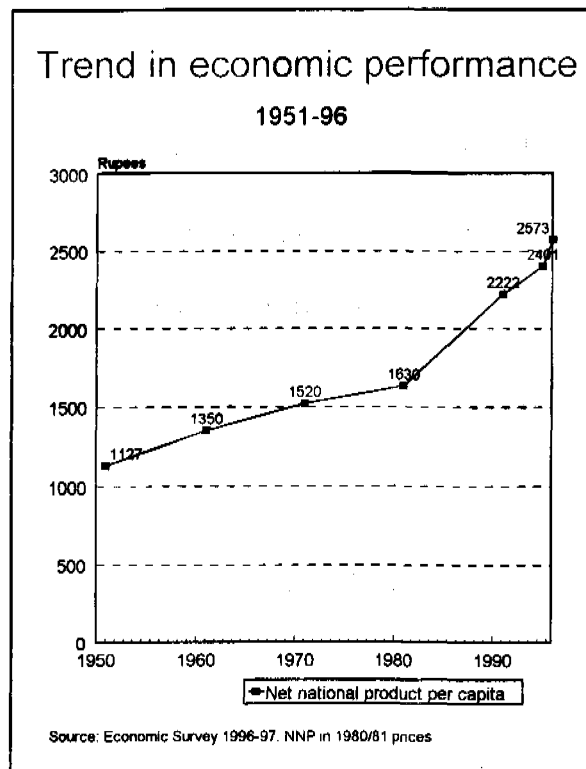
While economic reforms have resulted in substantial economic growth, the commitment to invest in human development remains a challenge. Progress in ensuring that all children are in school and in ensuring reduced levels of child malnutrition has been much less marked (see Chapters 3 and 4).

Levels of disparities, between 'worst off' and 'better off' states, and between groups within both rural and particularly urban areas remain considerable. In fact, there is some evidence of the gap widening. The implications of how economic reform will or can affect children remains an important area for further study and debate.

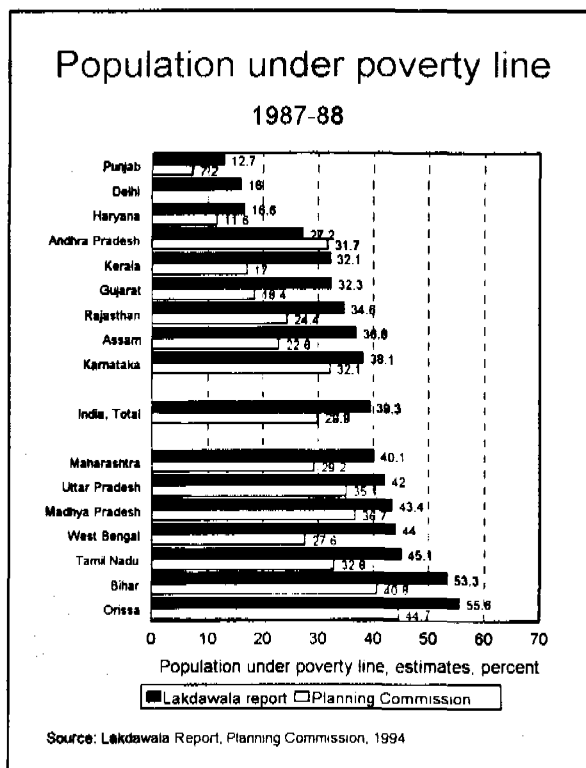
The 73rd and 74th Constitutional Amendment Acts were passed in December 1992 and became law in April 1993. These two Acts entail major changes. They provide for direct election to all seats of the *panchayats* and *nagarpalikas* at village, block, and *zilla* as well as at the ward, town and city levels. They provide for a fixed tenure of 5 years with a Constitutional stipulation that the next elections have to be held within six months from the expiry of this period or in the event of suspension. But the most far-reaching measure is the reservation under the Acts for women. Not less than one-third of the total seats and of the offices of Chairpersons at each level will be reserved for women. Also, seats will be reserved for members of the Scheduled Castes and Scheduled Tribes in accordance with their representation in the total population.

Definition of Poverty

The Planning Commission defines poverty lines as a per capita monthly expenditure of Rs 49 for the rural areas and Rs 57 in urban areas at 1973-74 all India prices. These poverty lines correspond to a total household per capita expenditure sufficient to provide, in addition, to basic non-food items – clothing, transport - a daily intake of 2400 calories per person in rural areas and 2100 in urban areas.



Source: Economic Survey 1996-97. NNP in 1980/81 prices



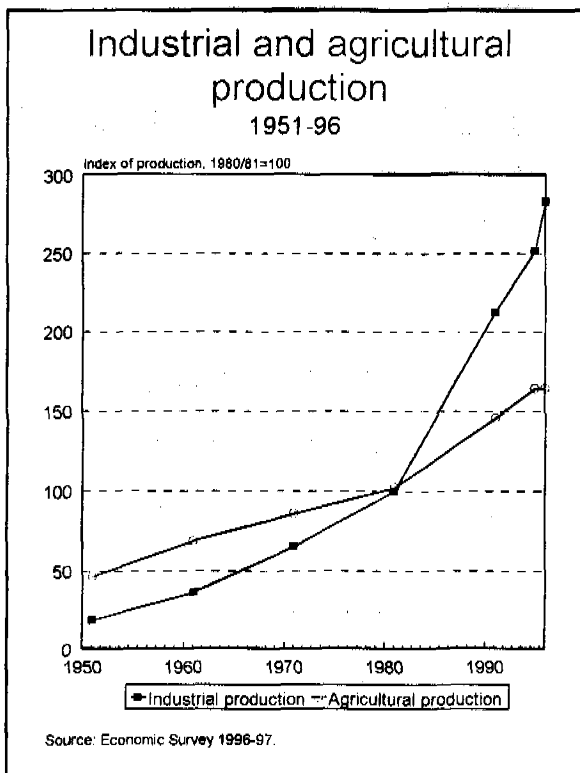
Source: Lakdawala Report, Planning Commission, 1994

As mandated by the Constitution, several states have organized and conducted election of *panchayats* in the last two years. However, as of September 1997, election has still not been held in Tamil Nadu and Bihar. In Orissa, where *panchayats* were dissolved in 1995, no fresh elections have yet been held despite the mandated provision of holding elections within six months. Much to the surprise of skeptics, women have come forward to contest in the elections; and today an estimated 720,000 of the members in 20 states are women. The exact form of devolution of various powers to *panchayats* and local bodies is yet to be decided on a state-by-state basis. However, schedule 11 of the 73rd Constitutional Amendment Act provides for 29 subjects of development that should come under the direct supervision of *panchayats*. These include many areas of direct concern for children. The impact of having women members on local bodies varies across states and communities; indeed token representation is reported. It is important to note however that this is just a beginning. Women's voice at local level will gain strength in each successive round of elections. Evidence from states, such as West Bengal and Karnataka, which have longer experience of implementing *Panchayati Raj*, suggests that, traditionally, interest in social sectors has not been strong. Empowerment of women *Panchayati Raj* members has the potential to change this significantly.

While the 74th Amendment Act governing urban areas encourages decentralization, it is far less clear and leaves lesser potential for community involvement. Urban areas too are experimenting with new forms of devolution to local bodies. The provisions in Schedule 12 of the Act are not as specific as the Schedule 11, resulting in ambiguity on what really will be the operational responsibilities of municipalities in the context of social sector development.

The third equally striking – though less widely recognized - development is the changing roles of women in society. There has been a dramatic increase in the number of women's groups throughout the country, estimated at over 250,000. These groups are vocal, demanding, articulate, informed and, above all, determined to usher in change—for themselves and their children.

The purposes for organization of the women's groups vary. Sometimes it begins with



literacy; at other times, they come together as savings and thrift societies in order to promote economic opportunities; in yet other instances, they rally around social causes such as anti-*arrack*, child marriage, and child abuse. These issues are not unrelated to each other, one often sparking change in other areas. Invariably, their interests expand to include many of the concerns for children and women—nutrition, health, clean water, safe motherhood and so on. Often these groups have found children's issues to provide a useful rallying point. The significance of these developments for children is obvious. Rights of women precede those of children in the sense that achievements for children are particularly dependent on the degree of women's autonomy and that women as mothers are the principal agents for the protection and promotion of children's rights.

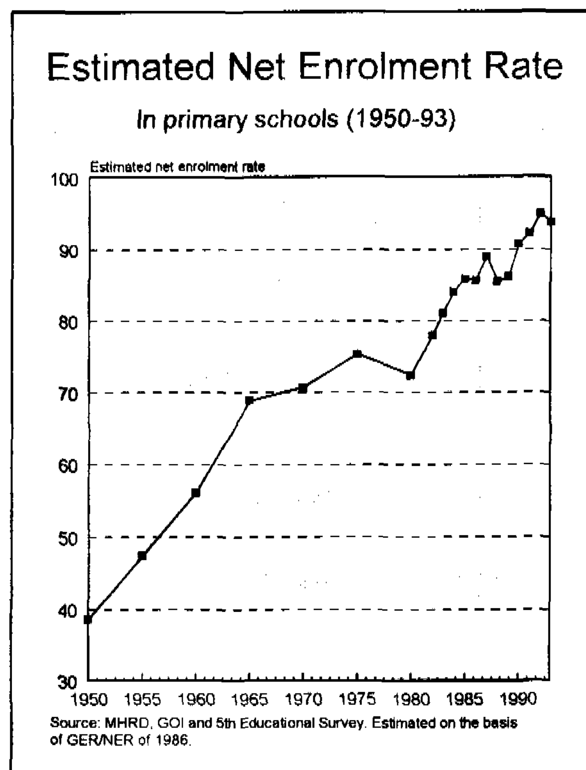
1.4. Enhancing children's capabilities

Economic progress, political developments and social transformation can be beneficial for children only when they translate into an expansion of capabilities. These would include the capability to lead a long and healthy life, to avoid preventable morbidity and mortality, to acquire and use knowledge, to be well nourished, to lead a life without discrimination, and to avoid exploitation.

However, the well-being of children depends first and foremost upon the capabilities of their parents, most of all the mother. And so, an expansion in children's capabilities can occur only if there is an enhancement of parents' capabilities, and women's freedoms in particular. At the same time, since children do not vote, even though they constitute 30 percent of the world's population of 5.5 billion and almost 40 percent of India's, it is important that their voices be heard; or that the voices of people and agencies talking on behalf of children be heard.

This has not always happened. In spite of growing economic prosperity, social benefits for children have lagged behind, depriving India's children of the opportunities they deserve. And so, from the viewpoint of a child, the balance sheet of India's development looks somewhat mixed. Life expectancy at birth increased from 33 years at the time of Independence in 1947 to 60 years in 1990-1992; and infant mortality has declined from 146 deaths per 1,000 live births in 1961 to an estimated 74 in 1995. Remarkable progress has been achieved in recording immunization coverage of more than 80 percent, in the control and eradication of guineaworm. Yet, around 2 million infants die every year today, almost the same number as in 1960; and most of the deaths are preventable. Despite the fact that the country has built up a buffer stock of 36 million tons of foodgrains, and adequate administrative and managerial capabilities to cope with droughts and famines, some 53 percent of India's children below the age of five years remain undernourished. Literacy rates have no doubt more than doubled from 24 percent in 1981 to 52 percent in 1991; yet there are nearly 60 million more illiterate persons today than there were in 1961. Only 64 percent of children in India reach grade 5 of primary school.

The proportion of girl children enrolling and completing primary school remains little more than half that of boys, and many of those completing grade 5 cannot even read and write a simple sentence.



Source: MHRD, GOI and 5th Educational Survey. Estimated on the basis of GER/NER of 1986.

National level achievements tend to make both genuine advancements in different regions, and also conceal wide disparities. Different conditions of human development confront children in the different states of India.

Both between and within communities there is a wide variation in opportunities in schooling, health, nutrition and the environment. Statistics rarely capture these very real differences, indeed they obscure by averaging out the worst disparities. Thus, there is a particular need for each community to address children's rights in its own setting and measure its own progress and the degree of comprehensiveness of these achievements.

Children over the past five years have also been affected by wider social developments. On the positive side, the country has been fortunate to have had governments at the Center pursuing similar policies for the past six years. The political disturbances in Punjab touched children too, disrupting school attendance and in the worst instances, making orphans of many. This has now subsided with the gradual return to normalcy. However, children's security was deeply threatened by the outbreak of communal violence at various times, such as the destruction of the Babri Masjid in 1992, by the continued agitation in Jammu and Kashmir, in parts of Uttar Pradesh's hills, in Assam, in some of the North Eastern states, and during caste-based clashes in different states. The predicament of children caught up in local disturbances and their needs has not been given a great deal of attention either in the media or in practical measures during such events.

It is true though that in such difficult settings, remarkable efforts have gone on to maintain services, keep schools open and provide immunization services. The Pulse Polio Immunization drive in the last three years, supported largely by mass public mobilization has demonstrated that it is indeed possible to ensure success even in these troubled regions.

Perhaps one of the most disturbing occurrence was the outbreak of plague in Surat in Gujarat in 1994 and its spread to other cities, that exposed the fragility of the country's government management systems in general and the public health system in particular. Schools were closed, families fled, and fear spread. This affected India's public

Human Development Index
Major states in India, 1993

Rank	State	HDI
1.	Kerala	0.603
2.	Punjab	0.529
3.	Maharashtra	0.523
4.	Haryana	0.489
5.	Gujarat	0.467
6.	West Bengal	0.459
7.	Himachal Pradesh	0.454
8.	Karnataka	0.448
9.	Tamil Nadu	0.438
	INDIA	**0.423**
10.	Andhra Pradesh	0.400
11.	Assam	0.379
12.	Orissa	0.373
13.	Rajasthan	0.356
14.	Bihar	0.354
15.	Madhya Pradesh	0.349
16.	Uttar Pradesh	0.348

image and commerce adversely: exports from India slowed down, numbers of tourists dropped abruptly. But perhaps more significantly, the outbreak of plague also drew public attention to the vulnerability of the poor in urban settings and a reminder of the continuing importance of adequate public health provisioning. Some 80 million out of the 217 million in urban areas now live in urban slums and other urban poor communities.

> ***Lessons from the Plague Outbreak***
>
> Two outbreaks of plague were reported in September 1994 in the Western part of the country. The first in Beed District, Maharashtra; and the second in the wealthy city of Surat, Gujarat. These outbreaks highlighted the risks of lopsided urban economic growth, and neglect of public health systems. The important role local bodies have in dealing with such crises was also a major lesson learned.
>
> Surat had experienced remarkable growth during the last decade, attracting both economic prosperity and flow of immigrant workers from other parts of the country. Despite its growing wealth, problems of irrational land use, poor planning of public amenities had led to the proliferation of slums and squatter settlements, making up a third of the population with little or no coverage of basic amenities. The existing water supply system covered only 70 percent of the city, the sewerage system covered 30 percent of the population, while inefficient garbage disposal resulted in piles of garbage accumulating in the streets. Air pollution from the surrounding industrial complexes as well as from accumulating garbage was amongst the highest in the state. The health infrastructure had become grossly inadequate to meet the expanded needs of the city, and had led to a growing cycle of outbreaks of disease during the year (diarrhoea, malaria, and typhoid). Plague became the last of a series of such outbreaks.
>
> Whereas other city administrations such as Mumbai moved swiftly to clean up the city and establish surveillance of suspected plague cases, there were grave misgivings about the way the Surat administration and the State Government handled the situation, leading to a mass exodus of 600,000 people. This happened at a time when there had been no democratically elected local government in the city for some time.
>
> Following the 1994 plague in Surat, by 1996, Surat was declared the "cleanest city" in India, through combined action by the city government, administration and citizens participation. It is a good example that dramatic improvements are possible, with political will, good management and leadership and citizens' involvement.

1.5. Rights and opportunities for children

The Convention on the Rights of the Child, drafted by the United Nations Commission of Human Rights, and adopted by the General Assembly of the United Nations on 20 November 1989, is a set of international standards and measures intended to protect and promote the well-being of children in the society. As of July 1997, all but two countries in the World have ratified the Convention, making it the most widely and most rapidly accepted human rights treaty in history. Only one country, Somalia, is yet to sign. The other country, United States of America, has signed the Convention, indicating their intention to ratify. Ratification of the CRC by state parties implies that they have the legal obligation to protect children, ensure their basic needs are met and further the participation of children in community life.

India ratified the Convention on 2 December 1992, and by doing so, reaffirmed several of the commitments made since Independence principally in the Constitution of India. For instance, according to Article 39 of the Directive Principles of State Policy contained in the Indian Constitution, the State shall direct its policy towards ensuring that "children of tender age are not abused", and that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity. It also states that childhood and youth ought to be protected against exploitation and against moral and material abandonment. Similarly, while equality before the law and the equal protection of the laws is available to every citizen, Article 15(3) empowers the State to have special laws for children and that will enable them to benefit from the fruits of equal guarantee. Article 24 prohibits the employment of children below the age of 14 years in any factory, mine or in any other hazardous occupation. And Article 45 directs the State to endeavour, within a period of ten years from the commencement of the Constitution (in 1950) to provide free and compulsory education for all children until they complete the age of 14 years.

In addition to ratifying the Convention, Government of India has also endorsed the 27 survival, protection and development goals for the year 2000, laid down by the World Summit for Children in 1990. By doing so, India has reaffirmed many of the pledges made in the National Policy for Children drawn up in 1974 which declared that "it shall be the policy of the State to provide adequate services to children, both

before and after birth and through the period of growth, to ensure their full physical, mental and social development. The State shall progressively increase the scope of such services so that, within a reasonable time, all children in the country enjoy optimum conditions for their balanced development."

The Constitution itself had, in the Directive Principles of State Policy, promised universal free primary education for all within 10 years, a promise that no longer seems distant today with the introduction in the Parliament of the Bill on Compulsory Primary Education almost 48 years after. It is hoped that the 'patient wait' of several generations of children to enjoy these promises "within a reasonable time" will soon come to an end.

Implicit in the Convention is the recognition of the importance of women for the fulfillment of children's rights. It fully endorses the rights of women as outlined in *the Convention on Elimination of all forms of Discrimination Against Women* (CEDAW) and the assurance of children's rights. In the Indian context this dimension, as discussed in Chapter 2 of this report, assumes a special significance.

The Convention draws attention to the civil, political, social, economic, and cultural rights of every child. Unlike other human rights instruments, the CRC gives equal importance to all these areas of rights, recognizing them to be interrelated and interdependent. However, for convenience, they may broadly be classified into four categories:

1. **The right to survival**, which includes the right to life, the highest attainable standards of health, nutrition, and adequate standards of living. It also includes the right to a name and a nationality. Chapter 3 of this report discusses the situation of India's children vis-a-vis their right to survival, health and nutrition, and access to a safe environment. Despite the increasing economic growth, recent trends suggest a slowing down, particularly in urban areas and the six northern and eastern Indian states (including Assam and Orissa), in the progress towards reducing avoidable infant deaths. At the same time, much needs to be done to reduce the levels of child malnutrition in the country, which is among the highest in the world. Estimated at 53 percent of children under the age of four years, India's level of malnutrition is almost twice the rates reported in Sub-Saharan Africa.

2. **The right to development**, which includes the right to education, support for early childhood development and care, social security, and the right to leisure, recreation and cultural activities. Section 3.5 in Chapter 3 focuses on two vital aspects of the right to development, namely the right to early childhood care and primary education. India has one of the largest preschool networks in its Integrated Child Development Services (ICDS) programme. India also remains one of the few countries in the world where primary education is not compulsory for children, and the country has lagged far behind in its Constitutional commitment to provide free and compulsory education for all children up to the age of fourteen years.

3. **The right to protection**, which includes freedom from all forms of exploitation, abuse, inhuman or degrading treatment and neglect, including the right to special protection in situation of emergency and armed conflicts. Section 3.6 in Chapter 3 discusses three of the most distressing forms of violation of the rights of Indian children: the use (or abuse) of child labour, the plight of street children, including those living in illegal settlements, and the abhorrent practice of child prostitution.

4. **The right to participation**, which includes respect for the views of children, freedom of expression, access to appropriate information, and freedom of thought, conscience and religion. Social and cultural norms have often prevented children from expressing themselves freely and openly in front of elders. At the same time, elders too have not always advocated strongly for children and children's causes. This is changing and in Section 3.7 in Chapter 3, the report discusses the critical role played by information dissemination and effective advocacy. The Chapter also draws attention to some of the attempts by India's children, though few in number, to be collectively heard.

A rights perspective implies not only a broadening of areas of concern for children beyond the traditional welfare-approach to activities in health, nutrition, education, but

more importantly embraces a point-of-view that each individual child should expect to enjoy each and every one of the rights accorded to her. It is society's role to respect, protect and fulfill these rights without discrimination of any kind. In earlier documents describing the Situation Analysis, the perspective has been to measure progress towards the welfare of children through the measurement of numerous parameters and trends in coverage. Satisfaction has been derived from the accomplishment of wider coverage of services and social progress.

This report assesses the situation of India's women and children, and the progress particularly over the past five years, in terms of the fulfillment of children's rights, enhancement of women's capabilities, and expansion of opportunities for all children. It is society's role to respect, protect and fulfill these rights without discrimination of any kind. This Situation Analysis, through a rights approach, is concerned more with the unfinished agenda of those not yet reached. Every child who is not enjoying her or his full rights, in each of these areas becomes focus of our attention, and should be the target of the collective efforts of the governments, UNICEF and those of the families and communities in which they live as plans are made for the year 2000 and beyond.

Reporting on the Convention

The UN Committee on the Rights of the Child, which comprises ten experts from different parts of the world, is responsible for monitoring the implementation of the Convention in the Indian context, following ratification of the CRC at the end of 1992. The Government of India has made major efforts to generate increasing awareness of child rights throughout the country, particularly through widespread dissemination of the National Plan of Action and development of a specific State Programme of Action for Children in each state of India.

Collaborative work on child rights is evolving, marked by joint national and state level consultation, substantial inputs from non-governmental organizations to India's report to the UN Committee on the Rights of the Child and public affirmations on child rights issued by the President, Prime Minister, Chief Justice of the Supreme Court, leaders of industry, non-governmental organizations legal activists, government officials and the media. Notably, the CRC reporting process has helped considerably to draw attention to abuses and extreme violations of child rights, such as in the case of child labour, trafficking and sexual exploitation of children.

India's first report to the Committee on the Rights of the Child has been submitted in 1997 and now awaits review by the UN Committee.

World Summit for Children
Goals for the year 2000

- Reduction of infant and under-five child mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less.
- Reduction of maternal mortality by half.
- Reduction of severe and moderate malnutrition among under-five children by half of 1990 levels.
- Universal access to safe drinking water.
- Universal access to sanitary means of excreta disposal.
- Universal access to basic education and achievement of primary education by at least 80 percent of primary school age children through formal schooling or non-formal education of comparable learning standard, with emphasis on reducing the current disparities between boys and girls.
- Reduction of the adult illiteracy rate (the appropriate age group to be determined by each country) to at least half its 1990 level, with emphasis on female literacy.
- Provide improvement in protection of children in especially difficult circumstances, and tackle the root causes leading to such situations.
- Special attention to the health and nutrition of the female child and to pregnant and lactating women.
- Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many.
- Access by all pregnant women to prenatal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies.
- Reduction of the rate of low birth weight (less than 2.5 kilograms) to less than 10 percent.
- Reduction of iron deficiency anaemia in women by one third of 1990 levels.
- Virtual elimination of iodine deficiency disorders.
- Virtual elimination of Vitamin A deficiency and its consequences, including blindness.
- Empowerment of all women to exclusively breastfeed their children for four to six months and to continue breastfeeding, with complementary food, for up to two years of age or beyond.
- Growth promotion and its regular monitoring to be institutionalized in all countries by the end of the nineties.
- Dissemination of knowledge and supporting services to increase food production and ensure household food security.
- Global eradication of poliomyelitis by the year 2000.
- Elimination of neonatal tetanus.
- Reduction by 95 percent in measles deaths and reduction by 90 percent in measles cases compared to pre-immunization levels by 1995 as a major step to the global eradication of measles.
- Maintenance of high level of immunization coverage (at least 90 percent of children under one year of age) against diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis and against tetanus for women of child-bearing age.
- Reduction by 50 percent in the deaths due to diarrhoea in children under the age of five years; and 25 percent reduction in the diarrhoea incidence rate.
- Reduction by one-third in the deaths due to acute respiratory infections in children under five years.
- Elimination of guineaworm disease (dracunculiasis)
- Expansion of early childhood development activities, including appropriate low-cost family and community-based interventions.
- Increased acquisition by individuals and families of the knowledge, skills and values required for better living, made available through all educational channels, including the mass media, other forms of modern and traditional communications and social action, with effectiveness measured in terms of behavioural change.

Chapter 2 - Child rights and women's capabilities

Expanding women's freedom has intrinsic importance, as well as enormous value especially for its role in improving the well-being of children. Children's rights are first and foremost dependent upon women's capabilities and the well-being of mothers. The dependence on the mother starts during pregnancy, as the health and nutritional status of the mother are critical for the birth of the healthy child. It continues through the early stages of infancy where proper breastfeeding and childcare have a profound impact on proper growth. Early caring practices are the most important determinants of nutrition and of intellectual development, particularly in the earliest months and years of life. The mother has a primary role in influencing the child's response to and success in education and is particularly important in nurturing her daughter through the critical transition from childhood into adolescence, the time that is all too often neglected with lifelong implications for a young woman. The role of the mother in the family and the way she is treated by her husband, in-laws and others is a prime determinant of behaviours in the next generation and their attitudes to women. Analyzing the situation of women therefore becomes fundamental to an understanding of children's rights and their well-being. There has been an expansion in women's capabilities in India over the years, but the levels of achievements in most parts of the country remain low. Not only are the achievement levels of women low, there is also the persistence of striking gender inequality.

2.1. Position and condition of women

Efforts to benefit women have largely focused on their condition. But it is now becoming increasingly evident that it is their position in society, their access to informed choices and their ability to make decisions, that makes the greatest difference to not only their own lives, but also those of their children. Condition refers to the material state in which women, particularly the poor, live: low wages, poor nutrition, lack of adequate health care, education, and training, lack of access to water, fuel, fodder, etc; whereas position refers to the social, economic, legal and political status of women as compared to men—for instance, equality before the law, equal representation in political bodies, equal access to employment, equal wages, and equal treatment within the community and household. Clearly, the two are interrelated. Improvements in the condition of women can help improve their position as well, and vice versa. But this does not necessarily follow. There can be improvements in the condition of women, as has happened in India, without an equal and corresponding improvement in the position of women. It is the position of women that needs to be nurtured and strengthened in order to assure that the community base for improved child rights is established and sustained.

The situation of women in terms of their condition and position needs to be understood in the larger socioeconomic, cultural and political framework of the country. Three main factors have contributed to the dis-empowerment of women, and particularly of poor women: a) a culture built on patriarchy, discriminatory notions of social hierarchy and division of labour that adversely affects women; b) an unequal distribution and control over resources with women having very limited access when compared with men; c) systemic barriers at various levels that restrict women's access, participation, and decision making powers in economic, political, and legal structures. Efforts to promote women's empowerment must therefore address all three issues.

The Constitution of India guarantees equality to all its citizens through Article 14, 15, 15(3) and 16; these have created an enabling condition for women to obtain equal rights, and inversely, for the state to discriminate in favour of women to correct imbalances in their position vis-a-vis men. Specifically, Article 14 guarantees equality for all before the law and equal protection for all under law. Article 15 and 15(3) oblige that there should be no discrimination against any citizen on grounds of religion, race, caste, sex

or place of birth. The State can discriminate in favour of women without contravening Articles 14, 15 or 16. But the fact is that discrimination against women continues despite the progress made by women in terms of achievement in different spheres of life.

Poverty in general, and extreme poverty in particular, has a significant gender dimension. Women are more sensitive than men to the extremes of poverty and its consequences. Studies reveal that (i) the percentage of adult women below the poverty line exceeds the percentage of adult men below the poverty line, both in rural and urban areas; (ii) the percentage of children in the 0-4 age-group in poor households exceeds that in non-poor households, with corresponding implications for the mobility of women and for child care services; and (iii) in both urban and rural areas, disadvantaged groups of women from Scheduled Castes and Tribes constitute a high proportion of the poor.

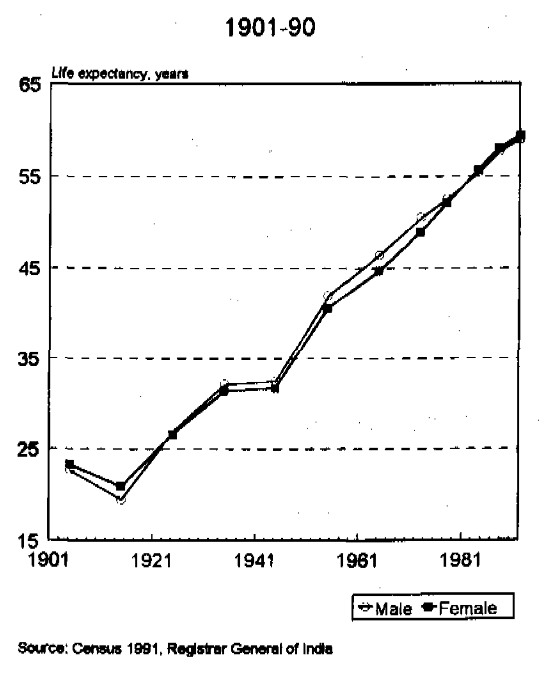
2.2. *Women's health and nutritional status*

Longevity and good health are important for women themselves. They also have a direct bearing on the lives of children. In developed societies, typically, female life expectancy at birth exceeds male life expectancy by about 5 years on account of the biological advantage that females enjoy over males. In India, the excess of female life expectancy over males is negligible. By 1992, female life expectancy at birth in India was 59.4 years whereas male life expectancy was 59 years.

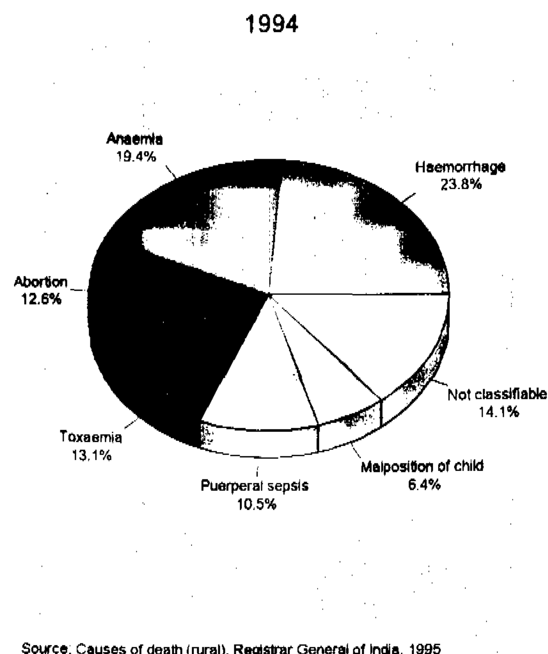
The differential is less than 5 years in all states, (with the notable exception of Kerala where women's life expectancy is 5-6 years more than men). Moreover, female life expectancy is less than that of males in Assam, Bihar, Madhya Pradesh, Orissa, and Uttar Pradesh. Such unequal levels of achievements between women in different states entail a further set of disparities. The life expectancy at birth of a girl child born in Uttar Pradesh and Madhya Pradesh is some 20 years lower than that of a girl child born in Kerala.

Much of this unequal risk is centered on the reproductive age group—in maternal mortality. According to the National Family Health Survey, around 450 women died of pregnancy-related causes for every 100,000 live births during 1990-1992.

Maternal deaths in 1993 accounted for 1.3 percent of total deaths in India, and for 15.1 percent of all deaths of women of reproductive age; these proportions have increased from 0.8 percent and 11.7 percent of deaths, respectively in 1989. These figures imply that at present between 100,000 and 125,000 Indian women die from pregnancy-related causes each year, accounting for nearly 25 percent of all maternal deaths every year in the world - many of which are preventable.



Source: Census 1991, Registrar General of India



Source: Causes of death (rural), Registrar General of India, 1995

Considerable variations in maternal mortality exist between the states. Yet, despite it's importance, there is at present no effective surveillance system to keep track of maternal mortality levels across the country.

The importance of maternal survival for child survival hardly needs to be stressed. A strong correlation between maternal and infant mortality exists not only in India but also throughout the world.

Many if not all of these maternal deaths can be avoided. The key is timely access to the health systems; women are not reaching appropriate health care when they most need it either due to physical, attitudinal or other types of barriers in the community.

Hemorrhage and anaemia are the most common causes of maternal deaths in India, each of which accounts for a fifth of maternal deaths. Neither of these has shown much change in the last ten years. Severe anaemia accounts for 20.3 percent, hemorrhage for 22.6 percent, toxemia for 12.8 percent, and abortion-related causes for 11.7 percent of the maternal deaths in the country. Herein lies the real value of regular antenatal care examinations to determine the earliest signs, such as anaemia, high blood pressure, or unusual presentation of the child as well as to educate women on when and where they should seek emergency care. These women should be immediately referred and provided for professional emergency obstetric care.

Many maternal deaths could be avoided through a range of relatively simple and low cost interventions—early treatment of anaemia or, better, it's prevention. The Medical Termination of Pregnancy (MTP) Act of 1971 failed to make abortions safe. It is estimated that there are more illegal abortions in India than there were prior to the MTP Act with about 15,000 to 20,000 abortion related deaths every year, mainly among married, multiparous women. Avoidance of unwanted pregnancy by the use of family planning methods, rather than through abortion, can, in addition to reducing births, reduce deaths as well. Use of clean and proper birth practices for normal deliveries, and timely detection of elevated levels of blood pressure and treatment for toxemia can prevent some more maternal deaths.

Statistics on antenatal registrations are improving steadily, and yet maternal deaths continue to occur in unacceptable numbers. This may be related to poor quality of antenatal care and inadequate inter-personal communication between the health functionaries and the pregnant women. Further, most maternal deaths cannot be predicted, and therefore not prevented through actions taken before the onset of obstetric complications. Traditional approaches through assessment of risks and increase in antenatal care visits do not offer avoidance of life-threatening conditions for mothers. Most obstetric complications that lead to maternal deaths are unpredictable, and can occur in any woman who is pregnant, whatever her past history or risk factors. Community studies have shown that about half of women dying of pregnancy related causes die at home. Thus, the most effective strategy for reducing maternal deaths is a clear understanding at the community level of the signs of early complications and decision making by the family on their early detection and rapid action for treatment.

Studies have shown that 10-15 percent of maternal deaths occur on the way to the hospital. Thus, recognition, timely referral and transportation to a proper and accessible emergency obstetric facility are critical steps in saving maternal lives. Additionally, of all maternal deaths, the majority, 58 percent, has been found to occur during the postnatal period (in contrast to 25 percent of deaths occurring during the antenatal period and 16 percent occurring during labour and abortion). Once again, it is evident that early recognition, referral and transportation to a center that can handle obstetric problems is critical and life-saving. Timely use of existing hospital facilities for providing emergency care to women with complications could save the majority of these women from dying.

Emphasis on antenatal care for risk detection at the primary care level leads to either denial or non-utilization of obstetric services in the review of complications. Risk detection leads to the expectation that primary health care workers will always be able to deal with the 'low risk' pregnancy. It is when these supposedly 'low risk' pregnancies encounter unexpected complications or when the 'high risk' pregnancies do not, that the credibility of the primary health care worker is lost. The first and foremost requirement is to enable women and their families to realize that all pregnancies are at risk and recognize early complications. This does not necessarily require more antenatal care, risk detection, or training of

Traditional Birth Attendants (TBA), along the patterns of past decades. Reorientation of what is done in currently conducted antenatal care, earlier detection of actual problems and training TBAs to recognize women with complications and be sure they are referred immediately to appropriate levels of care is required. Every pregnant woman, her family and the community also need to be aware of where emergency obstetric care is available. Such a facility, equipped for managing all major obstetric emergencies, should be developed, equipped in all districts within reasonable distance and reach for all communities and manpower deployed. And of course, the *most* critical readiness is to have transportation arranged to take any woman to the hospital even before the complication has occurred. This is not always easy. Here, the role of men assumes a central place in securing available transport. The community (or *panchayat*) must ensure that every woman who develops complications manages to reach the hospital, with emergency care facilities, on time.

The primary health care worker needs to be equipped and empowered to provide obstetric first aid procedures from the time the complications occur till the pregnant woman reaches the hospital facility. The simple first aid procedures include emptying the urinary bladder, treatment of shock, administration of parenteral drugs and fluids.

It is still often the case that, even after early detection and transportation of the women to the hospital, the health system is not geared to receive and direct a critically ill pregnant women with complications rapidly to the correct treatment room (especially in large hospitals) or has the appropriate life-saving measures. Most hospital facilities need to be upgraded, and quality of emergency care needs to be assured around the clock, as the life-threatening complications can occur at any time of the day or night. The requirements are not extensive or unusual: essential life-saving drugs, anesthesia, facility to cross-match and transfuse blood, and a trained person who can conduct basic emergency obstetric procedures under proper anesthesia is all that is needed. Most community health centers in India, if properly staffed, could perform these functions, but few are doing life-saving obstetric procedures today. It is here that action is feasible and needed. While there are not yet enough hospital beds to accommodate all of India's 27 million annual births, there is adequate distribution of existing obstetric facilities to handle obstetric emergencies (estimated at 15 percent of deliveries) if women are transported to these centers in time. The NCAER-Human Development Profile of India study in 1994 estimated that 10.7% of all deliveries had any one of the following complications: bleeding, prolonged labour, fever, convulsions, forceps or caesarian delivery.

The present gap that needs to be urgently filled is the lack of information and knowledge at the community level. This is directly or indirectly related to the status of women in the family and leads to delays in moving the woman to where help can be provided. Too often vital hours are lost while women are left in critical life-threatening situations as a lack of urgency impedes their access to emergency care. Too often women arrive at the hospital very late to be saved. Too often they are young women in their early twenties who should not have died. In urban areas, maternal deaths still occur with depressing regularity even when appropriate facilities are close by. Geographic distance, in their case, is not the issue. It is more due to the social distance ordinary women feel about government hospitals, and the way women are treated within facilities that act as an impediment to their timely utilization. Only 58 percent of deliveries in urban areas are taking place in institutions.

Closely underlying these deaths is poor maternal nutrition. Most (87 percent) pregnant women in India are anaemic with haemoglobin (Hb) levels less than 11 grams percent; 13 percent have Hb levels less than 8 grams percent. The risk of dying from hemorrhage and infection is five to ten times greater in anaemic women compared with non-anaemic women. Anaemia amongst women also compromises infant health by contributing to intrauterine growth retardation, to low birth weight and, ultimately, perinatal mortality. No definite time trends on levels of anaemia are available. Despite two decades of active work by the National Nutritional Anaemia Control Program, recent evaluations have failed to show any significant improvements in the incidence of anaemia among Indian women. Studies at the district level in several states indicate that few women are receiving the recommended amounts of iron and folic acid tablets during pregnancy. Further, studies on

supplementation with iron and folic acid tablets for pregnant/lactating women (evaluation in 11 states) showed that there are problems related to compliance, low coverage and lack of consumer awareness.

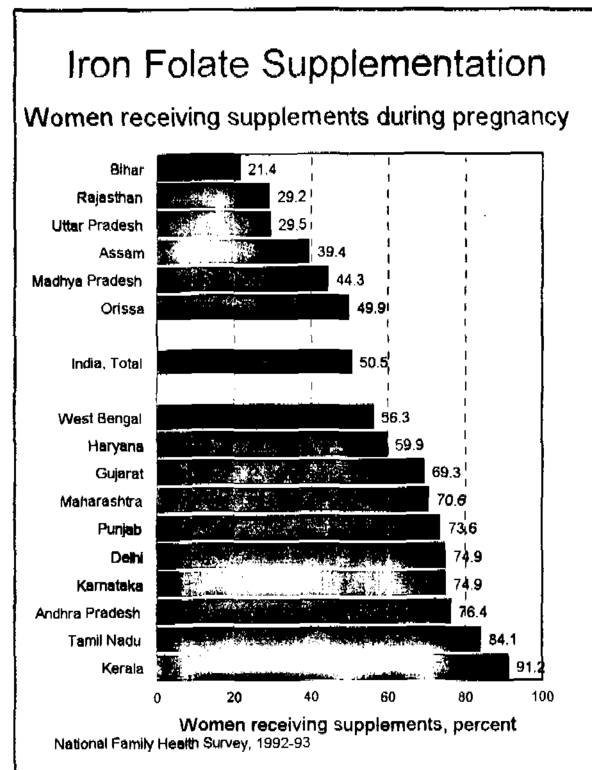
Little reliable data is available on hookworm infection or on the occurrences of malaria in pregnancy known to cause serious anaemia. In a vegetarian diet, lack of sources of readily available iron, and the fact that women get less than desirable foods in terms of quantity and quality in many families leads to nutritional deficiency. This, coupled with menstrual losses, which have begun from adolescence, leads to astounding levels of anaemia. If it were addressed during adolescence from the onset of menses with improved diet and regular iron supplements, and not considered as a problem to be addressed in pregnancy, women's overall health as well as survival would be improved.

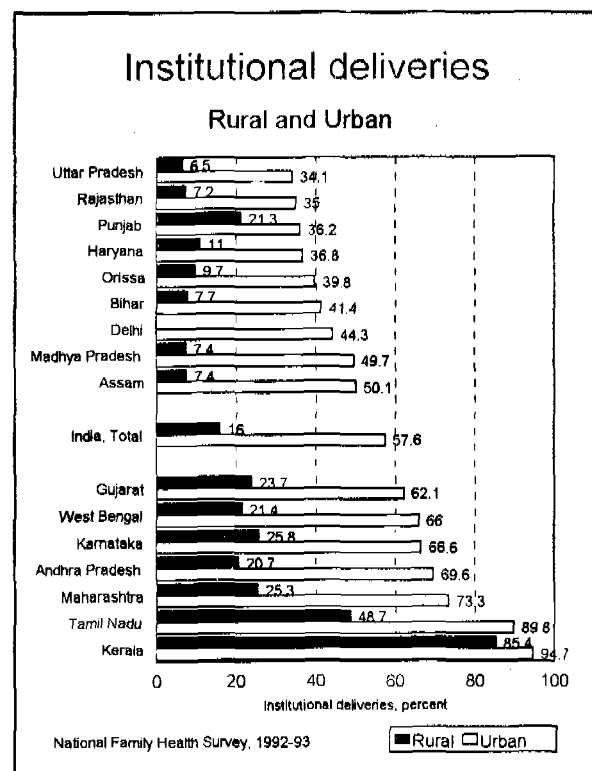
Only a quarter of all deliveries in India take place in institutions, with the majority of non-institutional deliveries attended by untrained midwives, or by women in the family or neighborhood. The NCAER-HDI study in 1994 reveals that only 23.8 percent of women received any postnatal care.

While in Kerala, nearly 90 percent of deliveries are conducted in hospitals or clinics, only 10 percent of deliveries take place in institutions in Rajasthan, Uttar Pradesh, Bihar, Madhya Pradesh and Assam. As can be expected, institutional deliveries in urban areas are higher than in rural areas, reflecting the unequal distribution and access patterns of health facilities throughout the country. In many districts of Rajasthan for instance, more than 80 percent of deliveries are conducted by untrained attendants. While the percentage of institutional deliveries is higher in urban areas, among the urban poor it is still low: In Rajasthan, almost 80% of women in urban poor areas of Class A cities delivered at home, 72 percent without help of trained attendants. The risks of infection are very high and early recognition of complications requiring emergency care and timely referral clearly not happening.

Another effective intervention to reduce maternal mortality is through prevention, i.e., avoiding unwanted births through various family planning measures. If widely practiced, there would be fewer pregnancies, better spaced, and there would be fewer abortions (one out of every eight maternal deaths is attributed to abortion-related complications).

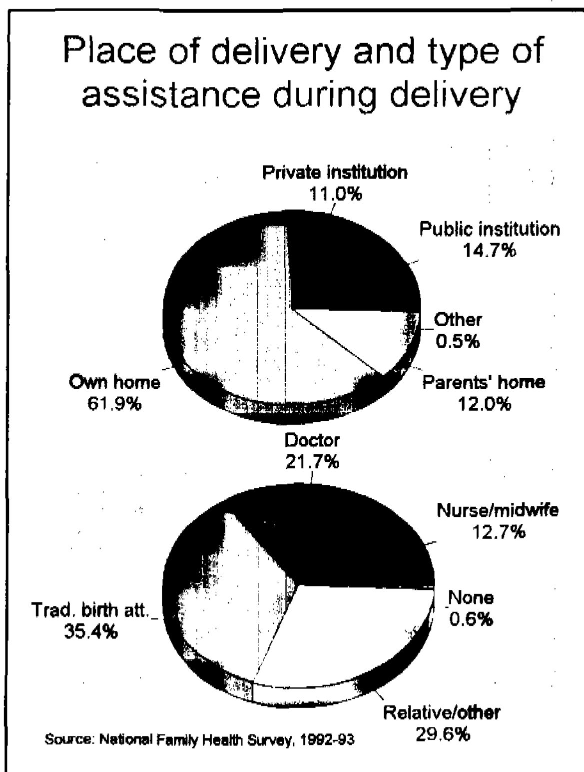
Studies in India have shown that birth intervals of less than two years significantly increase the risk of death for the mother. It is

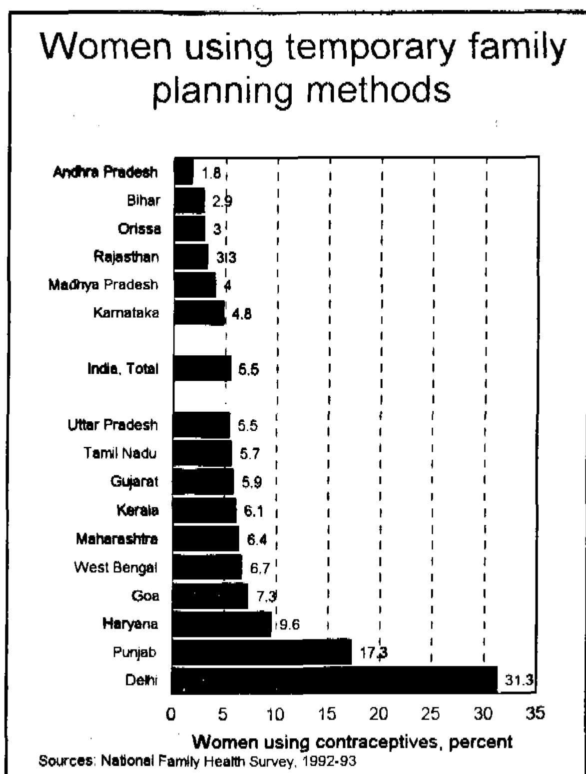




also well documented that birth intervals of less than two years seriously affect the survival and development of infants as well. Birth

spacing therefore becomes an important intervention for reducing maternal as well as infant deaths.





Fundamental to the well-being of women as well as their children is their own control over their sexuality, their choices and means to limit their fertility and their overall reproductive health. Studies show that high proportions of women suffer silently from infections of the reproductive tract, in some areas, estimated at 75 percent of women. Societal attitudes towards women seeking medical care are generally negative with the first pregnancy being an exception as elders in the family in hope for a "male child" that would keep their family "alive". The generally negative attitude of the society, together with the social stigma attached to "women's health problems", the heavy male-orientation of health services, lack of compassion, lack of privacy for women seeking care, leads to women being either unwilling or unable to consult, and to obtain medical diagnosis and appropriate treatment. In settings of urban poor, there is almost no opportunity for women to bathe with adequate water and privacy, thereby exacerbating even minor reproductive tract infections, due to the absence of desirable hygienic practices.

For a large proportion of women in society, they have little to say about contraceptive choices, and virtually nothing on the issue of protecting themselves from sexually transmitted diseases, including HIV, which could be transmitted to them by their own husbands especially those men with multiple sexual partners. Health services must fulfil the need for preventing and treating sexually transmitted diseases in both men and women. This would need major attitudinal shifts in the community as well as organizing services in a way that will be people-friendly.

It is estimated that almost 40 million new infections of reproductive tract and sexually transmitted diseases occur every year. Studies show that about 1 to 5 percent of women attending antenatal clinics have positive syphilis serology results. In a study in Jaipur, 14 percent of women attending antenatal clinics had candidiasis, 2 percent had gonorrhea and 2 percent had syphilis. With the burden of direct and long term morbidity related to reproductive tract and sexually transmitted infections being borne largely by women, there is a critical need for improving access to non-stigmatising health care for women.

Issues of reproductive health need to be viewed in the context of the overall status of

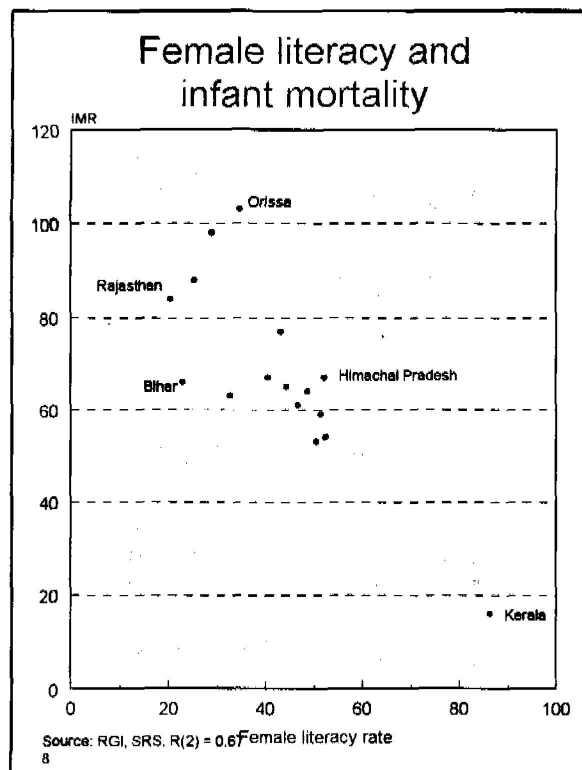
women's health and women's position in the society. This has remained neglected despite the fact that women face many health problems that are similar to men. Unfortunately, the health system is not responsive to the needs of women. Thus, more women than men continue to suffer from tuberculosis, malaria, pneumonia, and other illness due to the non-availability of female doctors, or adequate privacy in overcrowded clinics and health centers. Besides inadequate provision of gender sensitive health services, India's database on health, as in most developing countries, is weak and often limited to hospital-based information. The limitations of the existing database on health in general, and for women's health in particular, leads to constraints in planning and design of effective health interventions; and also makes assessment of progress on women's health and nutritional status very difficult.

2.3. *Women's education*

Several pathways of influence between women's educational achievements and children's well being have been identified. Education enables and empowers women to make better and more informed choices. It makes them less fatalistic about ill-health, and more confident and capable of seeking out and obtaining quality health care. Education also has a favourable impact on women's reproductive behaviour by its influence in delaying marriages, in leading to reduction of early child bearing, and through better spacing of children. Education also greatly improves the socio-economic status of the family, and causes shifts in the intra-family distribution of power in favour of the mother. As the principal custodian and guardian of the child, this enhancement of women's capabilities translates into significant gains for children.

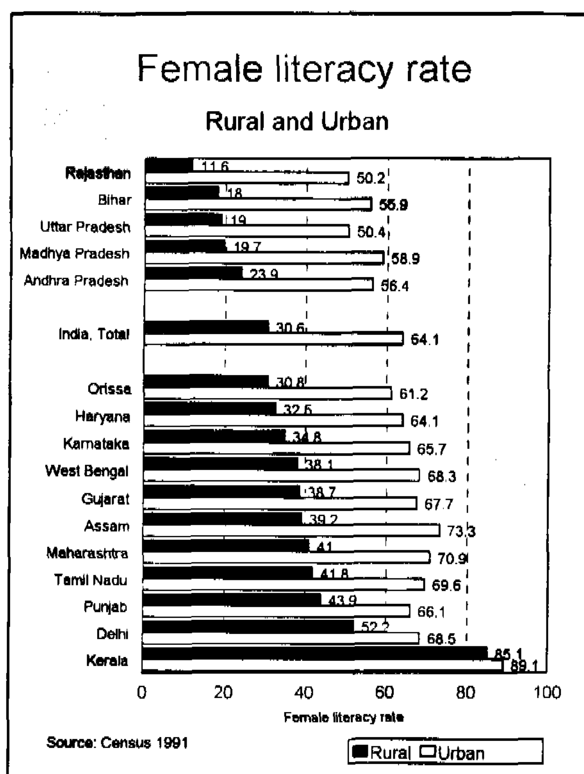
The existence of strong correlation between women's education and child survival is suggested by analyzing infant mortality rates by levels of female literacy rates in populations. This has once again been confirmed by the recent data obtained from the National Family Health Survey.

Female literacy rates (for the population older than six) increased from 15.3 percent in 1961 to 39.4 percent compared to 64 percent for males in 1991 for India as a whole. Whereas in Kerala, 86 out of every 100 women were literate in 1991, there were 25 or fewer literate women out of every 100 women in Bihar, Uttar Pradesh and Rajasthan. If we consider rural/urban differentials, a similar disparity exists. Only 44.7 out of every 100 women were literate in rural India, compared to 73.1 percent in urban areas.



Source: RGI, SRS. R(2) = 0.68

Female Literacy in Rural India (Progress from 1991 to 1994)			
States	% F/M in 1991	% F/M in 1994	Change
Haryana	60	55	-5
Himachal Pradesh	70	72	2
Punjab	78	76	-2
Bihar	45	52	7
Uttar Pradesh	44	46	2
Madhya Pradesh	49	47	-2
Orissa	55	61	6
Rajasthan	38	66	28
West Bengal	70	76	6
Gujarat	67	66	-1
Maharashtra	68	64	-4
Andhra Pradesh	60	65	5
Karnataka	60	68	8
Kerala	92	93	1
Tamil Nadu	70	72	2



Lessons from Total Literacy Campaign (TLC)

The launch of the TLC nationwide **drew** inspiration from Ernakulum district in Kerala that was declared 100 percent literate in 1990. Ernakulum's success was made possible by close collaboration between the District Administration headed by the Collector, voluntary groups especially youth, social activists and others, and was spearheaded by the *Kerala Shastra Sahitya Parishad* (KSSP). Today, the TLC extends to 417 out of 550 districts, and seeks to cover 100 million illiterate persons in the age group of 15 to 35 years by the end of 1999. In many parts of the country, the TLC movement did not stop at literacy but led to women's group formation and activism of different sorts. Village women found themselves meeting together for the first time under the aegis of TLC, providing new paradigms of what women could take up. Post literacy efforts, however, have tended to falter and lose steam across the country. This has highlighted the urgency of stemming the flow of illiterates into the poor through a much more aggressive pursuit and expansion of primary education.

Of the 90 million enrolled learners, 56 million learners were reported to have achieved the prescribed levels of literacy. An Expert Group set up to evaluate TLC in 1994, identifies five factors as minimum conditions for the success of TLC:

- a strong political commitment;
- a strong core group fully committed to TLC including the District Collector;
- mobilization of village level mass involvement and generation of popular enthusiasm;
- effective pre-launch preparations; and
- a constant monitoring process that must in itself generate and sustain commitment to enthusiasm.

Of course, this may indeed mask major disparities within urban areas themselves. Similar differences can be observed across different socio-economic groups. Compared with the overall rate of 39 percent for India as a whole, literacy rates among women belonging to Scheduled Castes was reported to be 24 percent in 1991 and as low as 18 percent among women belonging to Scheduled Tribes. The more recent NCAER-HDI study of 1994 reported only a marginal improvement to 28.2 percent amongst Scheduled Castes but a better gain of nearly 8 percent to 26.0 percent amongst Scheduled Tribes.

Even though the overall gap between male and female literacy rates is narrowing, literacy rates among women remain significantly lower than among men through the country. Again the extent of differential varies across the states and communities. Rural literacy rates among women belonging to Scheduled Tribes in Rajasthan in 1991 was 4.4 percent, far below that of men among the same community who reported a literacy rate of 33 percent. Literacy among women from Scheduled Tribes in Andhra Pradesh, Bihar, Madhya Pradesh, and Orissa is one-third the levels amongst men. Among the Scheduled Castes of Bihar, male literacy rates are also low at 31 percent with the corresponding figures for women being 7 percent.

A major impetus to the promotion of literacy among women was provided by the Total Literacy Campaigns (TLCs) launched under the National Literacy Mission set up by Government of India in 1988. Although major gains of TLC have been observed, a comparison of the proportion of female literacy over the 3 year period from 1991 to 1994, suggests that emphasis on female literacy is rather inadequate in the states of Haryana, Punjab, Madhya Pradesh, Gujarat and Maharashtra, all of which have shown a negative pattern.

Indeed, a major indirect effect of the literacy campaign has been to create an increased demand for primary education in areas where the campaign has taken place. The NCAER-HDI study 1994 clearly reveals that girl enrolment in primary school in households with a woman already literate was as high as 86.9 percent against 61.5 percent in households with a male literate and 35.8 percent when neither is literate.

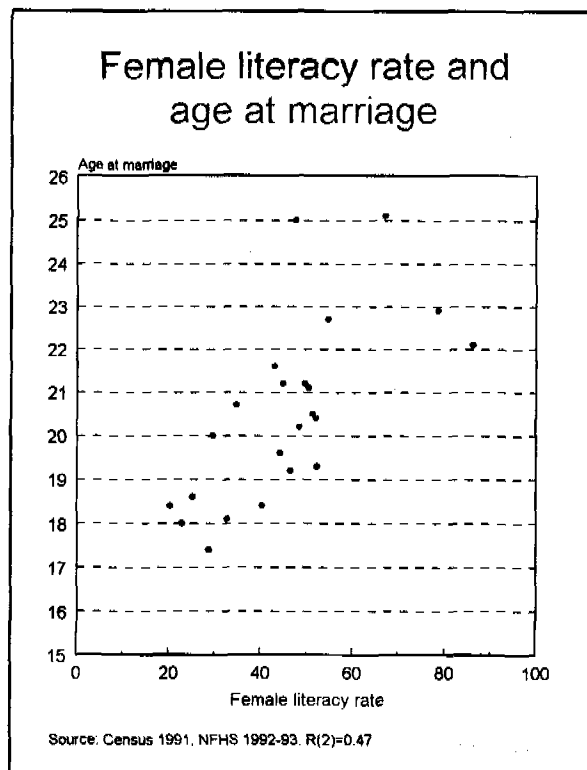
NFHS results suggested that both infant and under five mortality correlate well

with the educational status of the mother (illiterate – IMR 100.6, U5MR 140.5; literate – IMR 62.5, U5MR 83.9; high school and above – IMR 37.2; U5MR 43.2). The NCAER-HDI Survey in 1994 further documents clearly the role of women with both IMR and U5MR falling down from 104 to 76 and 146 to 110 respectively in households with a literate woman. The corresponding fall when males were literate was only marginal in the case of IMR from 104 to 91 and for U5MR at 121 from 146. The survey further underscores their joint role to show a decline of IMR to 64 and U5MR to 87 in households with both parents being literate compared to 104 and 146 in households with neither of them being literate.

Even though education can be expected to enhance a woman's capabilities and contribute to improving the well-being of children, this may not always happen. Data on Indian states reveal, for instance, that infant mortality rates can vary despite the fact that states may have more or less similar levels of female literacy. For instance, whereas Manipur and Punjab have similar female literacy rates, the infant mortality in Manipur is half the level reported in Punjab.

Several factors could block the postulated pathways of influence on child survival and development. Education, for instance, improves the propensity to seek out better health care for children. But good quality care may just not be available. Similarly, women may be educated but social norms may prevent them from freely moving out of the house to seek health care for the child. Women in low-income urban areas may live within close proximity of good quality public health care or within reach of private practitioners but still not take timely (or any) action to refer their sick child due to anxiety about who will look after siblings as well as the concern about loss of income for the family.

Again, one expects education to postpone early marriages, but very often the age at marriage is determined more by socio-cultural norms than by the level of education alone. The educational status of woman has, no doubt, an important bearing on her position and, therefore, she is in a much better position to take decisions for herself, including on when not to get married.



2.4. Women's work

A major influence on women's position and hence on the well-being of children is women's work status. Women's work has been postulated to have both positive and negative effects on children's growth and development. Employment generates additional income, which in the hands of mothers means better food, clothing and care for the child. At the same time, work outside the home makes women more confident, increases their awareness, and opens up a whole set of options. Set against these pathways is a possible negative effort through reducing the time available for care and attention that a young child needs. Employment can also interfere with breastfeeding practices for similar reasons.

In India, as in every other country, women work longer hours than men and a significant proportion of this work—about half – is spent in economic activities. As most part of women's work remains unpaid, their work stays unrecognized. Translating women's work into monetary terms is not only a matter of accounting, it is also a matter of recognizing women as a major contributor to economic activity, and a question of economic justice.

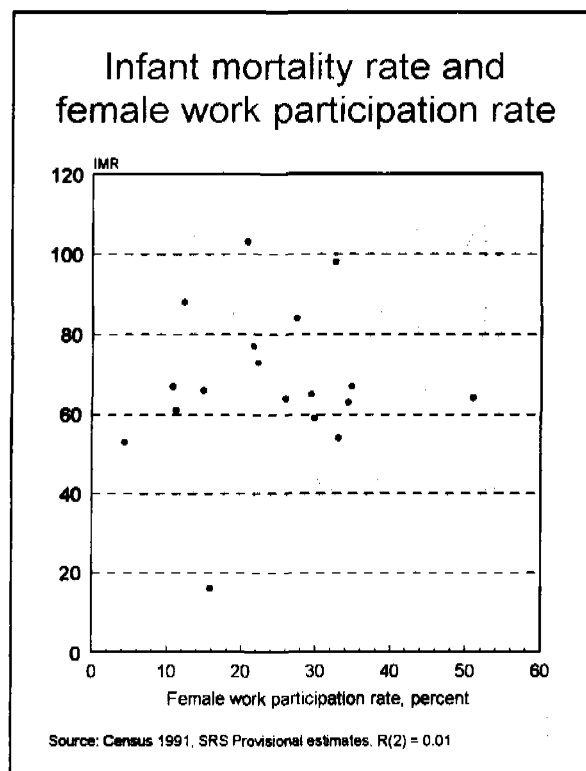
The 1995 Human Development Report points out that if women's unpaid work were properly valued, it is quite possible that women would emerge as the major breadwinners in most societies. In India, for example, if every woman were to do the same domestic chores for her neighbour as she does at home, get paid, on average, as little as Rs 20 a day, and pay her neighbour for the same service in her own household, this would result in an annual increase in reported household income of around Rs 7,000. With an adult female population of some 270 million, this would amount to a contribution of Rs 1,890 billion—a little more than 25 percent of the country's Gross National Product.

India's female work participation rate (Census 1991) was 22 percent, with male work participation rate at 52 percent. The extent of work participation by women varied across the states from less than 15 percent in Bihar (14.9 percent), Haryana (10.8 percent), Punjab (4.4 percent), Uttar Pradesh (13.8 percent), and West Bengal (11.3 percent) to over 35 percent in some of the northeastern states such as Arunachal Pradesh (37 percent), Manipur (39 percent), and Mizoram (44 percent).

In urban areas, 70 percent of the work done by the poor – including women - takes place in the informal sector. Crèche and similar facilities for the urban informal sector are extremely limited.

On balance however, it is clear that the positive effects are very strong and arguably outweigh the negative. The argument concerning caring and infant feeding practices is an argument for social action to provide more effective child care support particularly for poor women, and for strong legislation regarding maternity rights and active enforcement of legislation (for instance against infant formula promotion). These are areas where progress especially in the unorganized sector has been slow.

In addition to its direct impact at family level, there is evidence to show that a large proportion of working women tend to reduce considerably the extent of anti-female bias in society and improves general perceptions of women's economic contribution.



2.5. Women and men

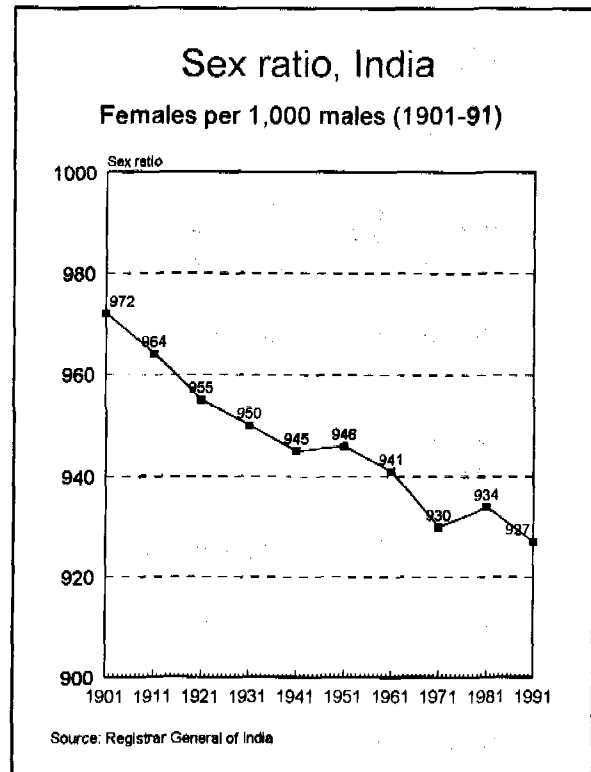
In 1991, there were 407 million girls and women in India, accounting for less than half (48 percent) of the country's population. This means a female-to-male ratio of 927 for India, ranging from 1,041 in Kerala to 865 in Haryana, 879 in Uttar Pradesh and 882 in Punjab.

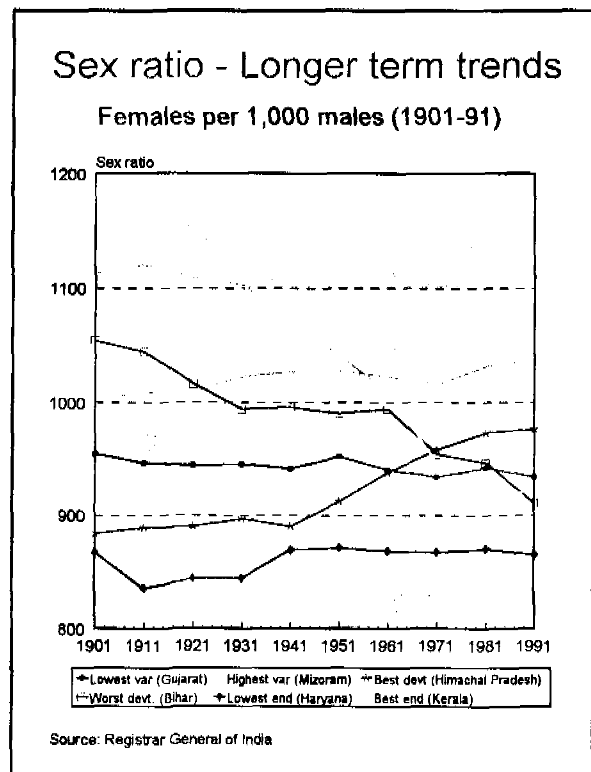
In all but a dozen countries or so, there are typically 105 women for every 100 men. At birth, boys outnumber girls by a similar proportion, and studies have shown that when men and women have access to equal care, nutrition, and health, women outlive men, and therefore outnumber them. India is one of the few countries in the world with such low female-to-male ratios resulting in what noted economist Amartya Sen highlights as some 50 million "missing" girls and women. The excess female mortality persists till the age of 30 – a symptom of a bias against females.

In seven districts, the female-to-male ratio has dropped below 80 girls for every 100 boys in the 5-14 year age group. These abnormal ratios are reflected in all age groups, including in the young children of age below 6 years.

The low and recently falling female-to-male ratio is a composite indicator that captures many dimensions of discrimination including female infanticide and foeticide, neglect of girls through inadequate nutrition, a health seeking behaviour that discriminates against girls during ill health, little or no education, early marriage, premature child-bearing, poor maternal nutrition, and inadequate access to health care for women. It is amongst the strongest reflections of an anti-female bias in society. In recent times, use of newer advances such as amniocentesis has led to increased number of foeticides in order to perpetrate the male preference. Legislation has been introduced to ban such practices, but enforcing the ban is a difficult exercise.

The extent of anti-female bias in India is by no means limited to the income poor. Punjab and Haryana, two of the richest states in terms of per capita incomes, have among the lowest female-to-male ratios (all ages): 87.4 women to 100 men in Haryana and 88 women for every 100 men in Punjab.





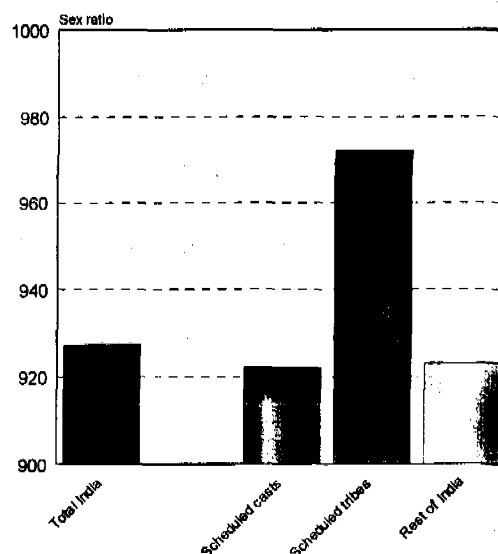
Lowest sex ratio at district level (5-14 years)		
District	State	Sex-ratio
Dholpur	Rajasthan	748
Budaun	Uttar Pradesh	764
Jalaun	Uttar Pradesh	766
Bhind	Madhya Pradesh	768
Etah	Uttar Pradesh	776
Morena	Madhya Pradesh	779
Hardoi	Uttar Pradesh	798

Unequal treatment of women can be seen even in middle and high-income families. It is reflected particularly in the situation of widows and their children and in the changing patterns of dowry and the widespread and tenacious extent of son preference. On the other hand, tribal societies, almost invariably poor by all material standards, show little anti-female bias (see Figure). Much of the anti-female bias India is the outcome of cultural beliefs, social norms, and mind-sets that combine to produce discriminatory behaviour.

The unequal achievements of women vis-a-vis men can be seen not only in survival but also in access to employment, access to land and property, to credit, and inheritance.

As a measure of gender disparities, UNDP's Human Development Report in 1995 introduced the Gender-related Development Index (GDI) for assessing gender inequality. The GDI concentrates on the same variables as the HDI, but focuses on both the inequalities between women and men (by imposing a penalty for inequality) as well as on the average achievement of women and men taken together. The GDI varies between 0 and 1, where a value of 1 indicates gender equality in terms of the four basic variables.

India's GDI value for 1994 is estimated at 0.419 compared to the maximum value of 0.939 (Canada) and a minimum value of 0.155 (Sierra Leone); and ranks 118th out of 146 countries for which the GDI has been calculated. A recent study computing the GDI for 16 Indian states reveals that whereas Kerala (with a GDI value of 0.565) would rank 73rd in the world along with China and Nicaragua, there are only 13 countries in the world that have a lower GDI value than Uttar Pradesh (0.293) and Bihar (0.306). Twice as many people live in Uttar Pradesh and Bihar (combined population of 225.4 million in 1991) than in all the 13 countries that report lower GDI values. It is against this backdrop that one has to assess the implications for the well-being of India's children.



Indicators of Gender Sensitive Data
Visible changes in Behaviour Pattern

- Increase in self-confidence and self-esteem of the poor, especially women;
- Appreciable change in division of responsibilities within the household/community, leading to reducing burden on women for water, fuel, fodder, child-care, etc;
- Willingness to publicly discuss domestic violence and exploring collective means to restrain it;
- Increase in age of marriage, willingness to educate girls and reduction in nutritional disparities within the family—between men/boys and women/girls;
- Increased awareness about health and willingness to seek medical help. More women articulating health issues – leading to better maternal health and immunization of children;
- Reduction in number of illegal abortions;
- Increased physical mobility – women's assertion of their right to attend meetings, training and also for entertainment;
- Increased participation of women in fora like *village panchayats*;
- Heightened awareness of class and caste equalities; and
- Reduction in disparities in wages for men and women.

2.6. Women's participation in decision-making

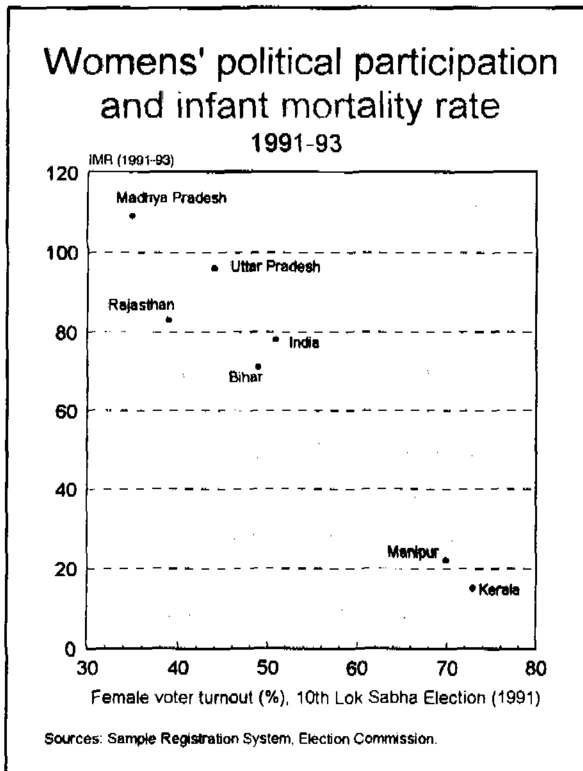
Ensuring women their political rights and encouraging greater participation in decision making is as important as assuring them of their social and economic rights. Limited evidence, as provided for instance, by Kerala and Manipur - two low IMR states, suggests a strong association between enhanced political participation by women and improvements in conditions of child survival.

Nearly twice as many women vote in Kerala and Manipur as they do in Madhya Pradesh and Rajasthan. At the same time, in both Kerala and Manipur, women enjoy far greater freedom than women in other states. Women in the two low IMR states are also known for active public activism. Women of Manipur, in particular, are well known for their collective action. In the seventies, women became famous as the "night patrollers of Manipur" for the movement that they launched to prevent misbehaviour by men under the influence of alcohol.

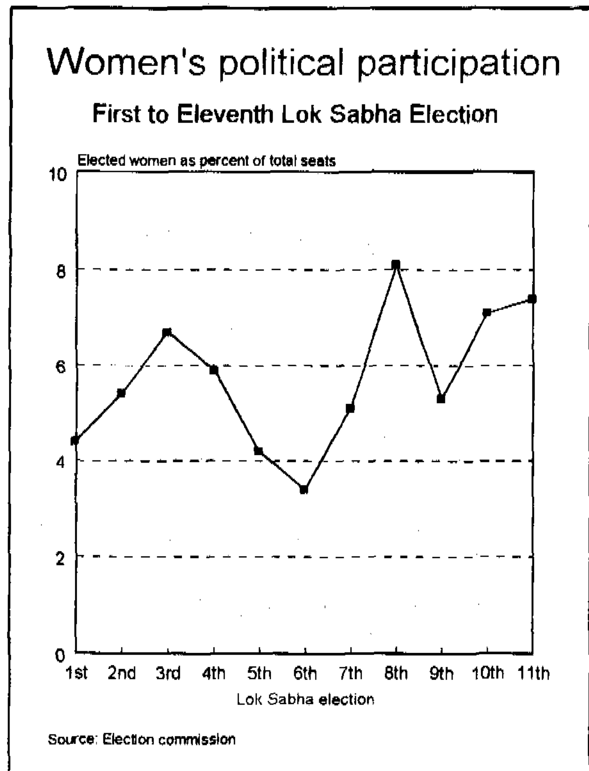
The extent of women's political representation is however very limited. Data available for the Lok Sabha elections reveal that whereas the proportion of women contestants has been increasing, the number of elected women candidates has remained low and insignificant. In this context, the recent move for constitutional amendment to provide for higher number of women elected to the parliament assumes greater relevance and importance.

Among the most significant developments of the past five years is the increasing opportunities for political participation that have opened up for women in India. The 73rd and 74th Constitutional Amendment Acts have reserved one-third of seats for women, and has also assured that one-third of the elected Chairpersons to *panchayats* and *nagarpalikas* will be women.

Responsibility for the growth and development of the child is not exclusively that of mothers and women, but of fathers and men as well. Concern ought to be with the levels of achievements of both women and men, as well as with the extent of inequality between these achievements. If gender equity is to be achieved, roles of men need to change too. Men have to find time to support women in what are traditionally women's roles and increasingly share the tasks of child rearing. New definitions of roles for fathers as well as clarity in women's role are needed.



Sources: Sample Registration System, Election Commission.



Source: Election commission

2.7. Women for women

Traditionally, in rural Indian society, women have been confined to their homes. Interacting only with direct family members, and only occasionally and briefly with other women in the community. Over the past 20 years, both non-government and government efforts to convince women to come together around a wide range of activities has enabled them to share experiences and to discover their own power when operating together for common interest. This has long been known in tribal areas. The *Nupi Lan* movement in Manipur, showed the power of women to stand up against the colonial government early in the 20th century, and again just before World War II.

The Development of Women and Children in Rural Areas, DWCRA, was initiated 20 years ago as part of the integrated rural development programme, enabling women to gather into group of 10-15 women and obtain credit, in order to work together on income-producing activities. While the successful groups gained experience and solidarity as well as an improvement in their income, problems of marketing locally-made handicrafts, village-processed foods and other products meant that many of these groups, perhaps the majority were nonviable. More recent efforts through *mahila mandals, mahila samakya* and *mahila rashtriya kosh* provided more flexible groupings of women out of common social problems in an effort to have women share experiences and find solutions even without improved income.

Most recently, government schemes for women's saving, *mahila samridhi yojana and Indira Mahila Yojana* attempt to give women their own savings account, and to encourage their combined action to take control of existing government programmes in health, education, nutrition as envisioned in the 11th Schedule of the Constitution. The proliferation of women's groups in past five years has been nothing short of remarkable. Many have emerged from the total literacy campaign, in which tens of millions of women have learned the basics of reading and writing, and more importantly, of their shared condition with women in their village, in their district, and indeed throughout the country. These have resulted in an array of empowered women's activities, ranging from savings and loan schemes in which millions of rupees are managed by women themselves, raised from their own daily savings of Rs 1 or 2 to credit schemes duly recognized as cooperative societies, such as Community Development Society in Alleppey in Kerala where 8,000 women received loans from the National Bank for Agriculture and Rural Development (NABARD). This effort was recognized for an international award—"United Nations People's Award" in 1995.

Nowhere has the impact been greater than in Andhra Pradesh. In Nellore district, in 1992, nearly half a million women participated in the literacy campaign, following which, nearly 300,000 women organized themselves into 6,500 village groups, committed to save a rupee every day, and to become self-reliant through their solidarity. They demanded, and eventually achieved, total prohibition with the elimination of *arrack* sales in the entire district. They interrupted marriage ceremonies, where the bride-to-be was under the legal age of 18 years, they rescued young children from bondage, when they were labouring and abused in individual homes or work places. Entire villages were proud that every home had a latrine, and most clubs soon bought a television set for community viewing. The movement spread to the entire state, and in the state assembly elections of 1995, they called for and achieved the election of their party, and leadership that assured statewide prohibition and the recognition of more than 60,000 women's groups, whose voices were heard daily from their own villages, all the way to Hyderabad.

In urban poor communities throughout India, in part through the government's UBSP scheme, over 100,000 groups of urban poor women have been set up since 1991, in over 500 cities and towns to work in partnership with urban poverty and other programmes. Thrift and credit has been an important mobilizing factor in many states. During the 9th Five-Year plan the government has universalized these community participatory systems (Neighbourhood Committees and Community Development Societies) as prerequisites for a range of poverty programmes targeting all 3697 cities and towns.

Chapter 3 - Child rights in India

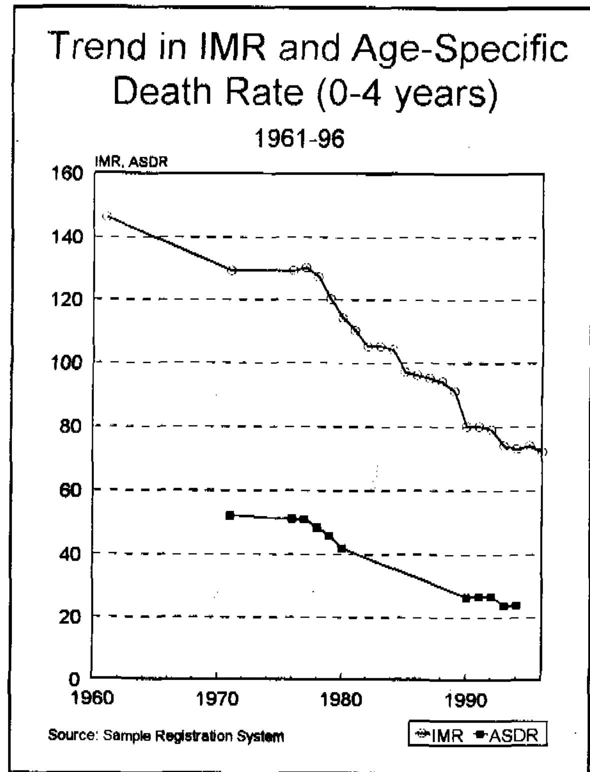
3.1. *The right to survival*

Child survival has emerged, over the past decade, as both an aim and a measure of progress for children. It is a reflection of closely related factors of health, nutrition, the child's environment and, above all, the care given to the dependent child in the earliest months and years of her life.

Survival is the most fundamental right of all. Yet, the confidence of parents that their children will survive remains grossly unequal, both across states and between groups within states.

UNICEF has long advocated the use of under-five mortality rate (U5MR) as an overall indicator of development, not only of the child but also of the entire society. It has since emerged as both the composite indicator of well-being in children as well as the quality of life in a society. Many elements other than the proximate determinants of survival are reflected in this child mortality indicator. Experience from across the world, and indeed within India itself from states such as Kerala, has shown that it is a combination of change - rather than any one change - which brings about rapid fall in mortality rates amongst children. The right to survival then needs to be seen in a framework that includes many of the concerns that are analyzed in this report - women's education and nutrition, girls education, the environment of the child as well as the quality and reach of health services. Countries experience decline in U5MR as progress is made towards equality between men and women; as progress is made against malnutrition and disease; as the environment improves that the reach and effectiveness of health services *improve*.

Although the under-five mortality rate captures both child survival and health conditions of children through the first five years of life, many countries, including India, measure more frequently and accurately the infant mortality rate (IMR), which gives the number of deaths of infants before completing the age of one for every thousand live births.



Percent reduction in IMR shortfall (assuming an IMR goal of 50 by the year 2000)	
Year	% Reduction
1981-1983 to 1984-1986	7.8
1984-1986 to 1987-1989	4.2
1987-1989 to 1990-1992	14.8

IMR – rural and urban trends			
Year	Rural IMR	Urban IMR	Rural-Urban ratio
1981-1983	116	65	1.78
1984-1986	108	62	1.74
1987-1989	102	60	1.70
1990-1992	86	52	1.65
1995-1996	79	47	1.68

Lowest and highest IMR in India			
1996	Lowest	India	Highest
IMR	13 (Kerala)	72	97 (Orissa)
Rural IMR	13 (Kerala)	78	102 (Orissa)
Urban IMR	13 (Kerala)	46	65 (Orissa)

IMR – rates of decline		
Year	% IMR decline	
	Rural	Urban
1981-1983 to 1984-1986	7.2	5.3
1984-1986 to 1987-1989	5.8	3.5
1987-1989 to 1992-1994	18.8	17.1

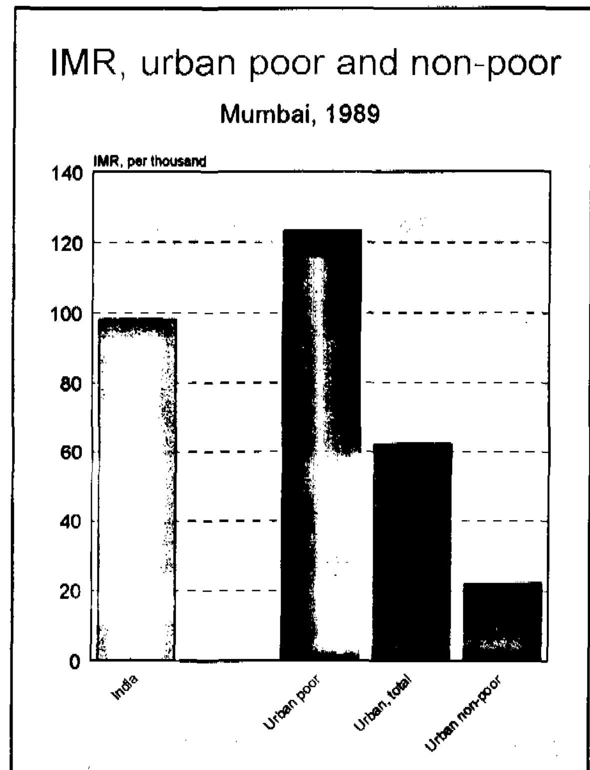
Trends in U5MR tend to parallel those in infant mortality, although mortality declines earlier in the 1-4 age group as public health, immunization and nutrition programmes have greater effects in young childhood than infancy. Nonetheless, IMR is still more frequently and accurately measured than U5MR or 1-4 child mortality rate.

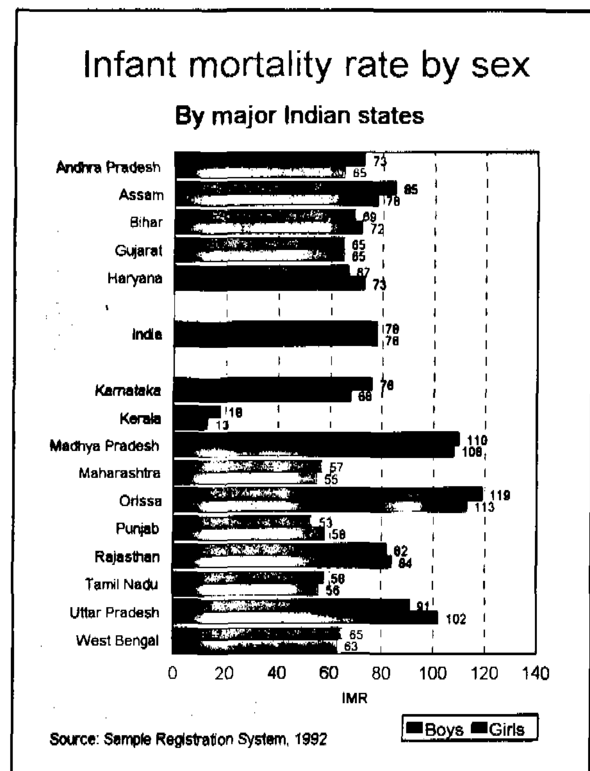
India halved its infant mortality rate from 146 in 1960 to 72 in 1996. However, the pace of reduction in IMR has not been uniform. The maximum reduction in IMR were recorded during the 3-year period between 1988 and 1991, increasingly corresponding to the onset of the economic crisis that necessitated the fiscal reforms, but coinciding with major national efforts in immunization and control of diarrhoeal diseases. Indeed, the slowing down in the *pace* of improvements in infant mortality in the nineties is a major cause of concern, showing that economic improvement and survival of young children are not necessarily linked. Direct action in the social sector yields more immediate results.

A persistent feature of child survival in India is the disparity that exists between rural and urban areas. The pace of decline in both rural and urban areas has been significantly higher during the period 1987 to 1992. Despite the improvements in both rural and urban IMR, the country's rural IMR today is still 22 percent higher than what the urban IMR was in 1981-1983. There has indeed been a decline in the ratio of rural to urban IMR, yet the rural rates are significantly higher than the urban states in all states. The differentials tend to narrow down as the level of infant mortality declines.

The pace of decline in both rural and urban areas has been significantly higher during the period 1987 to 1992.

Even though at the aggregate level, infant survival rates in urban areas are better than in rural areas, disaggregated data reveal that child survival conditions in urban slums are extremely poor, and may be deteriorated.





Source: Sample Registration System, 1992

Recent SRS results have shown a plateauing in the fall of urban infant mortality improvement, perhaps associated with the increase in urban populations. Indeed, increase in some instances have been noted especially ascribed to growth of slums.

The urban poor are exposed to numerous environmental hazards, most of them growing. Increasingly, the urban poor reside in slums along roadsides and in highly congested areas. They are dangerously exposed to air and water pollution, in intensely close contact with other humans, making disease transmission more rapid and extensive. The extremely unhealthy environment makes malnutrition, ill health and the risk of infant and child death increase dramatically. A study in 1989 in Mumbai revealed that the IMR in urban slums was 123 per thousand live births, compared to the All India IMR of 98 at that time, an overall urban rate of 62, and an infant mortality rate of 22 among urban households above the poverty line. A similar study in Delhi showed that the IMR among urban poor in slums was two-and-a-half times of the urban non-poor population.

In recent years, girls have consistently died at a greater rate than boys, a reversal of the normal trend found in most countries of the world. In the most recent years, however infant mortality of girls has approached that of boys, and may, in some progressive states, be even lower, reflecting a decline in the factors that had apparently been biased against them. In 1992, certain states however continued to have a higher IMR among girls than boys: Uttar Pradesh (102/91), Haryana (73/67), Punjab (58/53), Bihar (72/69) and Rajasthan (84/82) suggesting that the situation of the female infant is low and the biases in the early age are far from overcome.

An equally striking feature of the infant mortality record is the wide variation that exists between the states. Whereas children born in Kerala enjoy risks of infant death comparable to developed countries, a child born in Orissa or Uttar Pradesh faces risks of death comparable and at times worse than countries in Sub-Saharan Africa.

Only 29 countries in the world—all of them far richer—reported lower infant mortality rates than Kerala's rate of 16 per 1,000 live births in 1995. On the other hand, there were only 20 or so countries in the world where infant mortality rates were higher than Orissa's figure of 103 deaths per 1,000 live births. The life expectancy of a girl child born in Kerala today, around 74 years, is 20 years more than that of a girl born in Uttar Pradesh—reminding that there is much to learn from the experiences of states and communities within India that have recorded rapid improvements in the well-being of children.

Infant mortality rate declines, but the magnitude of the problem remains

Of the 18 million children born in 1960-1961, close to 2.7 million died before completing the age of one. Between 1961 and 1995 India has halved its infant mortality rate from 146 to 74. Yet in 1995, close to 2 million infants died, almost 70 percent of the number of infants dying in 1960. These absolute numbers are unlikely to change over the coming years. Current population trends suggest that by the year 2001, India's population will be close to 1,021 million (corresponding to the estimates of the Expert Committee on Population Projection using the "high" assumptions of birth rates, death rates and fertility rates). Should this be true, then there would still be some 28 million children born every year - 2 million more than the number of children born today - assuming that the country's crude birth rates declines from a level of 28.3 in 1995 to 27.6 over the next four years. Projections indicate that by the year 2000, India will reach the child survival goal of an IMR of 60 deaths per 1,000 live births. Even with this achievement, there will still be 1.7 million infants dying every year, only around 10 percent fewer infant deaths than the levels the country witnesses today.

Key survival indicators – comparisons

		Kerala	Uttar Pradesh	**India**	China	Sub Saharan Africa
Life expectancy at birth	Male	69	57	**59**	68	49
	Female	74	55	**59**	71	53
Crude death rate		6	12	**10**	8	15
Crude birth rate		18	29	**29**	19	46
Infant mortality rate		16	86	**72**	31	101
Total fertility rate		1.8	5.1	**3.7**	2.0	6.5
Literacy rate	Male	94	68	**64**	87	63
	Female	86	47	**39**	68	40
Sex ratio		104	88	**93**	94	102
Female share of labour force		11	16	**22**	43	37

By ranking of states in terms of reductions in IMR shortfall between 1983-1993, the best and worst performers are as shown in the table.

These data show that survival can improve in the best off and worst off states at comparable rates; yet, lack of improvement is also seen in both high and low mortality rates as well - the choice lies in the priority, resources accorded to programmes as well as their effectiveness to improve survival.

Infant survival in India also varies with the socioeconomic background of the family. The NCAER study in 1994 revealed that IMR of Scheduled Castes was 99 per 1000 live births and that of Scheduled Tribes was 98 per 1000 live births when the overall IMR in the study sample was 84 per 1000 live births suggesting that in certain communities the survival rates are low.

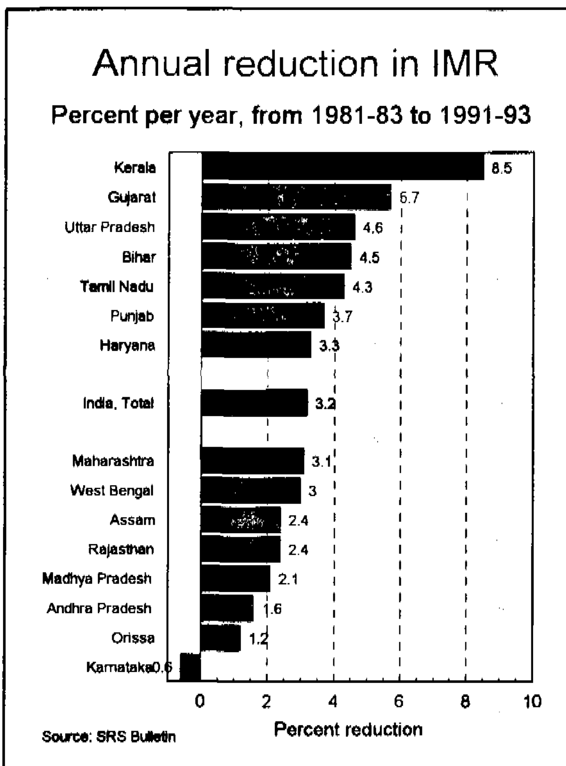
The deaths during infancy are not evenly spaced out. As the deaths due to vaccine preventable diseases and other infectious diseases have been the major focus in the last decade, infant deaths in the early neonatal and perinatal periods contribute now in greater proportions to the infant mortality. While two-and-a-half decades ago, the neonatal and post-neonatal mortality rates were similar, the post-neonatal rate decline much more rapidly from 1971 to the mid-eighties. The post-neonatal mortality rate leveled off in the eighties and did not decline again until 1989, when a decline was associated with the push for universal immunization coverage by 1990.

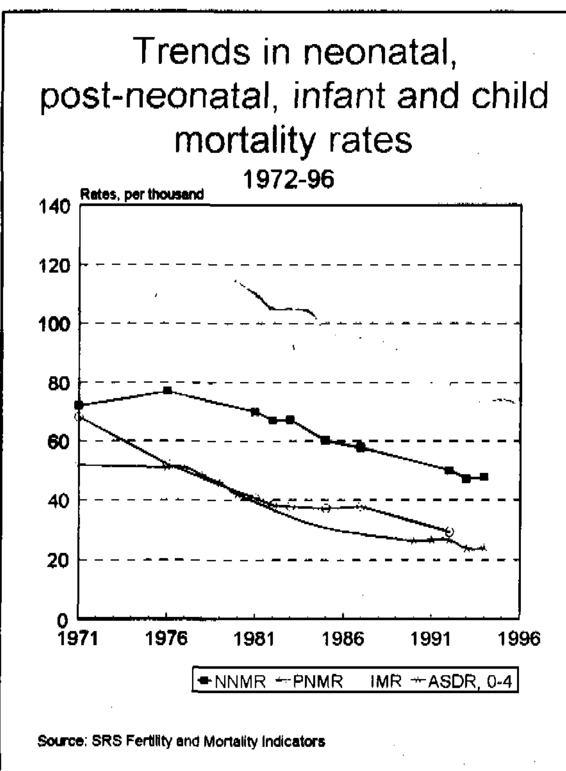
However, mortality rate between age 1 and 4 years, reflects the effects of both malnutrition and common infectious diseases on child death. It is noted that girls die at a rate 50 percent more than boys do. This is amply evident from the imbalances in the 1991 Census, showing an excess of boys under age 7 of 4.2 million over girls in the country.

Disaggregation of this data by state shows marked differences, and there is evidence that further disaggregation by district, or even communities, will show remarkable and disturbing patterns where girls die in numbers far exceeding boys. Disparity between boys and girls is ultimately a family, or at the most, a community choice. It is at this level that gender equity must be sought and campaigned for.

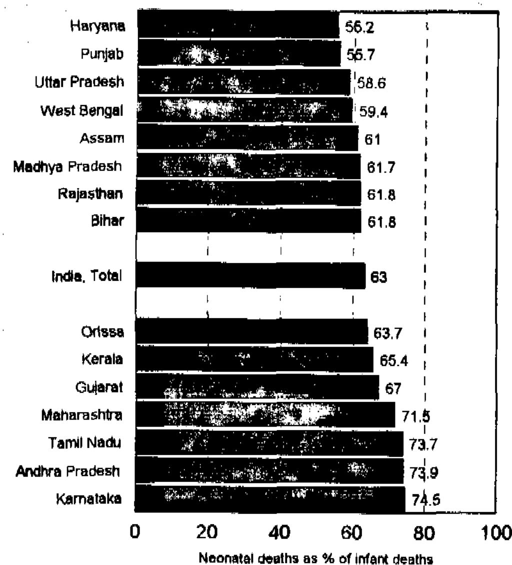
Decline of IMR in states
The fast and slow performers

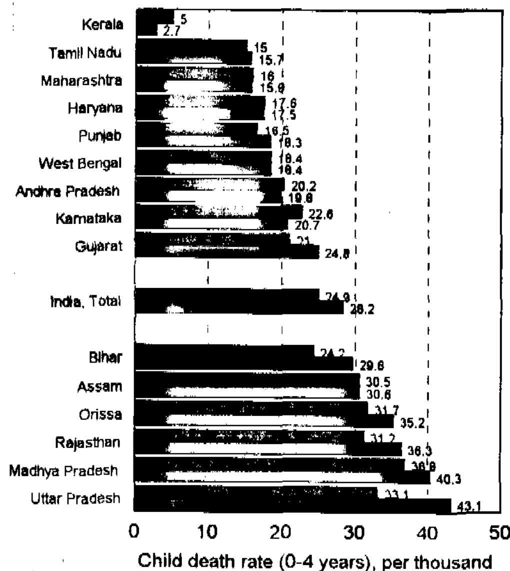
Three fast performers	Kerala	60.3%
	Gujarat	43.7%
	Uttar Pradesh	40.1%
INDIA		29.7%
Three slow performers	Orissa	16.5%
	Andhra Pradesh	16.4%
	Karnataka	2.6%





Mortality at different periods in infancy		
Of 1000 children born alive in India	Cumulative deaths	% of IMR
35 die within a week	35	31.5
15 die within the next 21 days	50	68.5
23 die within the next 11 mths	73	100.0
50 die within the next 4 years	123	168.5





Progress in public health started with young working-age adults, and worked downward through the years, affecting the youngest children last. Thus, improved survival in 20- and 30-year olds came with the reduction in epidemic infectious diseases and generally improved conditions in the work place. School children were the next to benefit and now en-

The potential for improving child survival in India

Kerala has achieved remarkable success in lowering its fertility and infant mortality rates. As against a national crude birth rate of 28.3 in 1995 and an infant mortality rate of 74, Kerala reported a crude birth rate of 17 and an IMR of 16. Tamil Nadu and Goa too have been able to bring about impressive reductions in fertility rates and infant mortality in recent times. These examples show the potential that exists within the country to reduce fertility and child mortality. The implications of such improvements can be significant. Should all of India reach Kerala's fertility and infant mortality levels, then there would be 10.2 million fewer births every year, and 1.8 million fewer infant deaths than what the country witnesses today. This would not only reduce dramatically the stress on the health care system, but would also greatly relieve families, and mothers in particular, of the enormous physical and emotional stress that accompanies child bearing and child death.

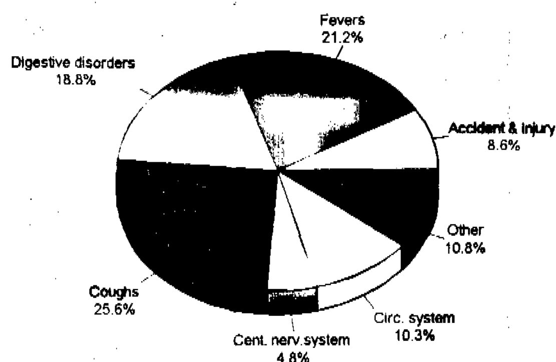
Why the success in Kerala?

Kerala has been the focus of development studies for years, trying to understand how a state in the lower quartile of per capita income could have achieved such low levels of fertility and mortality. The answer lies in a multiplicity of features, the importance of any individual one is hard to measure. Surely, female literacy and the extremely high rate of school attendance is critical. Added to this is the decentralized nature of the health services, with a health facility within walking distance of almost every home. A politically active community has traditionally demanded good service from government functionaries at all levels, be it in schools, health centres, or government offices—this is in considerable contrast to other parts of the country. Population density and the ease of communication may also contribute to the delivery and availability of social services. While some cite religious and cultural precedents, such as the high proportion of Christians (25 percent), and missionary activities in the past, matrillineal practices of the Nair community which gave women a far higher value in the family, through which property descended the generations; the incorporation of the Malabar coast, with its predominant Muslim communities into Kerala only 40 years ago, places these factors into some question. In only several decades, this highly uneducated and relatively unhealthy community has come up to the norms of Kerala, achieving good health, low fertility, high levels of education and extensive participation of women even in the most predominantly Muslim district of the country, in Malappuram. Surely, a combination of education, improvement in the status and condition of women, improvements in the reach, efficiency and utilization of health services, and a politically conscious and active community can transform Indian society in a relatively short period.

joy the lowest mortality and illness levels of any age in India today. Efforts for child survival in the last decade or so have reduced deaths in the 1-4 age group most dramatically, with protection from immunizable diseases, and treatment of the most common infections, widely available. Even amongst infants as noted earlier, the greatest progress is seen in the older months of the first year of life. Previously, diarrhoea was a major killer of these infants, a disease that is now dramatically reduced with better public health and therapeutic measures.

Recently, with decline in mortality at all ages, there has been considerable attention to the "health and demographic transition": the decline in deaths and decline in fertility that is seen as societies develop. What is less evident, yet still the most powerful feature of India's situation for child survival is the disparity between what India can and should be, and what it is for millions of its poorest citizens. "Demographic polarization" is the term given when parts of society progress to low mortality and low fertility, while other parts are left behind with persistent high mortality, high fertility, poor nutritional status, frequent illness and the concomitant misery that this brings. The challenge of survival is one of simply applying what is already known, has provided that it works, and can be afforded in India today. It is a matter of societal priorities, not of resources or of poverty, for the fall in mortality rates comes with the simplest of interventions, and the most basic of human rights, right to food, to eat, to shelter, to health care and to a safe and nurturing environment.

Causes of death, 1-4 years



Source: Survey of Causes of death (rural), 1994, RGI

3.2. The right to health

If survival is the ultimate outcome, ill-health is the proximate determinant that leads to death. The health of children depends upon a wide array of factors, including the prevalence of disease and their environment, its prevention and timely treatment. More fundamentally, health depends on nutritional status and the environment both inside and around the home.

Child health depends equally upon the condition of mothers and other caregivers, their level of awareness and knowledge, personal hygiene, the feeding practices adopted by them, and above all, the care that they give to young dependent children. It therefore depends intimately on the time, motivation, knowledge and resources of mothers. But well-being of young children also depends upon parents, siblings, grandparents and others in the community; and their knowledge, attitudes and practices. It is only when parents recognize the importance of prevention and maintenance of good health that children can enjoy their right to healthy life. It is the parents who must realize the advantages of immunization, can prevent disease, disabilities and death. It is the parents who must practice personal hygiene for the benefit of their children, and who must recognize the importance of breastfeeding, timely introduction of food and a good diet, both before birth and in early childhood.

Lifestyles of parents matter for the healthy development of the child. Rich or poor, smoking adversely affects child health. Alcoholism affects families, and particularly children. In addition to the diversion of scarce resources, there is violence within the family – often against both women and children – that accompanies alcohol abuse.

Children are exposed to the threat of HIV/AIDS predominantly by the behaviour of their parents. In India, HIV infection is transmitted predominantly through heterosexual contact (more than 80 percent), most often brought home by men through contact with infected partners, often outside the family. Women and children are ill-equipped to defend themselves from any of these onslaughts against their own health.

There are, however, several causes of infant deaths. Children die in the first month of life – and more so in the first week – of asphyxia, or not breathing properly at birth, from early infections related to unclean care of the umbilical cord, and overwhelmingly from conditions characteristic of their small size at birth. Reported figures suggest that the number of neonatal tetanus (NNT) cases is still high; some 1003 cases in 1996/97, down from 1250 in 1995/96. Approximately 70% of infant deaths occur in the first week of life. NFHS data show that the proportion of neonatal deaths occurring in the first week of life has increased from 66 percent 10-15 years ago. This increase may in itself be artificial – attributable largely to the decrease in deaths from neonatal tetanus occurring in weeks two and three. However, it does reflect the lack of significant progress in dealing with deaths in this early age group. If further reductions in infant deaths are to be achieved there is a need to focus more on the neonatal period and better newborn care.

Two critical interventions are needed to assure survival in the early days and weeks of life

a) Improved nutrition of the mother before and throughout her pregnancy, to assure a better-nourished, robust and viable child at the time of birth; and
b) Improved care of the mother during labour and delivery (and in the time immediately thereafter), assuring that the infant's emergence into the world is clean, safe and timely.

The presence of a knowledgeable assistant at the time of delivery becomes critical in order to help administer the normal process of breathing, avoid exposure to early infection, and initiate the crucial continuation of the life connection to mother through breastfeeding immediately after delivery.

Notably, the cause of two-thirds of infant deaths, those occurring during the neonatal period, are largely avoidable through the proper care of the mother – a theme found recurring throughout the life story of children in India.

In India, the average infant weighs 2600 grams at birth – one of the lowest average birth weights in the world. One-third of Indian babies are low-birth-weight (LBW), which in at least 75 percent of these cases is due to intrauterine growth retardation (IUGR), caused by maternal malnutrition, anaemia, lack of rest and improper feeding practices of mothers. Fifty-eight percent of women in Gujarat and 42 percent in Maharashtra were reported to have reduced their food intake during pregnancy. A

multi-centric study of Indian Council of Medical Research (ICMR) identified a number of risk factors such as maternal age (<18 years), weight (<40 kg), height (145 cm), weight gain during pregnancy (<5 kg), low pregnancy interval (<24 months), and low haemoglobin (<8g/dl). Other studies pointed to the fact that maternal nutrition especially maternal weight as the most significant factor. In a large prospective WHO study in the Pune district of Maharashtra, LBW babies comprised 29 percent of all babies born, but accounted for over 80 percent of all neonatal deaths and 50 percent of all post-neonatal deaths. Most of the LBW babies (83 percent) had been born at term and were not premature. Infants with LBW show impaired immunocompetence and retardation in motor, social and language development in the first five years of life.

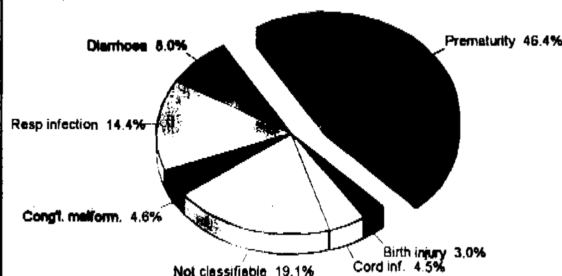
Several studies have noted that Indian women's diets during pregnancy are grossly inadequate due to food taboos, fears of delivering a baby that is too big with resultant "eating down" (less), and the fact that many women eat last in the family. Inadequate diet, together with pre-pregnancy energy deficit, anaemia, domestic smoke exposure and a high work load with little rest, are all attribute to low birth weight infants.

Strategies to tackle low birth weight start with improving adolescent health care and nutrition. Girls need better diets during their growth spurt in the immediate pubescent period, and should be assured of good health and nutrition for several years thereafter. It is only then that their body can reach adult proportions and dimensions, enabling them to give birth to a healthy child. Adolescence is a time when neglect during childhood can be made up through good nutrition, education and delay in marriage and first pregnancy. There are ways to assure a young woman her own survival and that of her child, as she enters motherhood. Longer birth intervals and reductions in teenage pregnancy rates can also play important role in decreasing the incidence of LBW, IUGR, and consequently, perinatal death. This is a major public health problem where attention needs to be directed.

The number of deaths per 1,000 infants due specifically to prematurity (including LBW) increased steadily between 1986 and 1990. The infant death rate due to prematurity did not decline below 1986 levels until 1993. Prematurity is more often a reflection of the mother's health during late pregnancy: genital tract infections, heavy work - especially lifting and carrying – psychological or physical trauma can all precipitate premature labour and the birth of the baby before she is ready.

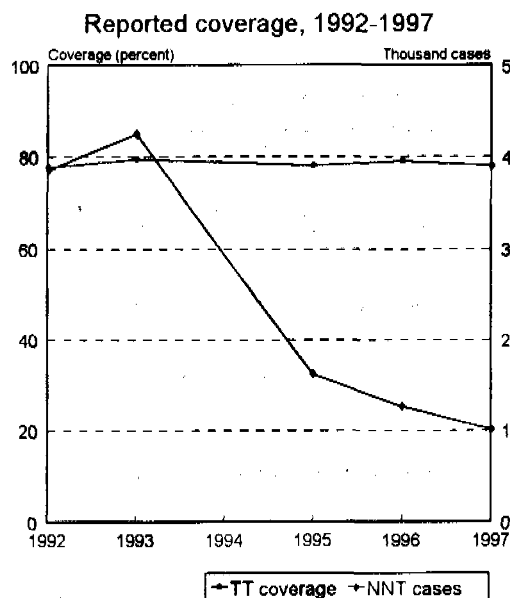
In the last 5-8 years, there has been a dramatic fall in neonatal deaths associated with neonatal tetanus. Here is an example of successful intervention. Giving pregnant women at least two doses of tetanus-toxoid prior to their delivery provides effective immune protection

Causes of infant deaths



Source: Causes of death (rural), Registrar General of India, 1994

TT coverage and neonatal tetanus

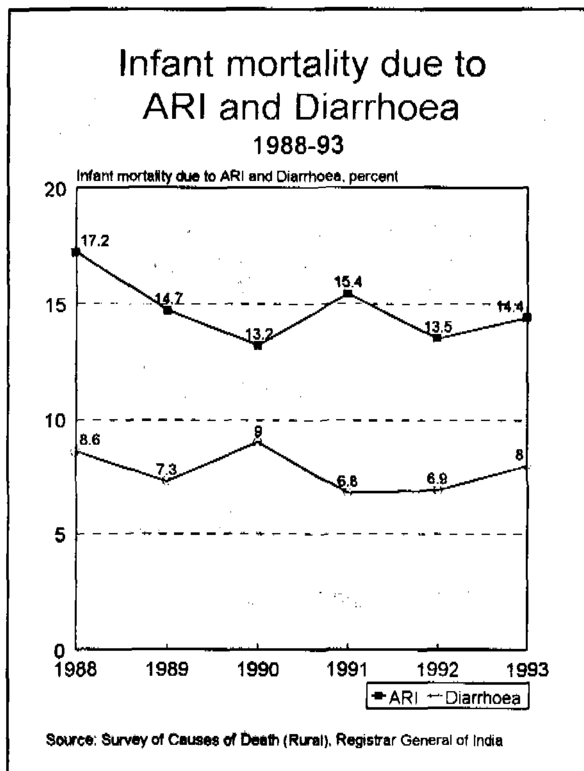


Source: Ministry of Health and Family Welfare, GOI

to the newborn infant assuring that the infant will not contract tetanus through this open wound.

From previous levels of 10-20 deaths per 1,000 live births, NNT fatality has fallen to less than one per thousand throughout India. The reduction in the incidence of NNT is reflected in the reduction of the neonatal mortality rate by nearly 30 percent from 69.9 per thousand live births in 1981 to 51.1 in 1991. NFHS in 1992-93 found a higher neonatal mortality rate for boys compared to girls (57 versus 48) suggesting both male frailty and a tendency to lower/poor reporting and recall of mortality among girls. Highest neonatal mortality rates in the states of Orissa (64.7), Uttar Pradesh (59.9), Bihar (54.8), Madhya Pradesh (53.2), West Bengal (51.8) and Assam (50.9) correlate well with the high levels of neonatal tetanus in these states. Progress in these as well as other states has been quite remarkable in the last 15 years. In many parts of the country NNT fatality is now less than one per 10,000. It demonstrates the dramatic success of immunization at a fraction of the cost of caring for the child who contracts the disease itself.

Recent research shows that immunization of mothers before or during pregnancy may also protect the newborn from other diseases such as pneumonia, thereby offering a cheap and effective solution in the foreseeable future to other threats to young child survival.



Well documented trials of using MMR, Hepatitis B and HIB vaccines at the community level are needed before they are introduced in the national immunization schedule.

Newborn care is the third area of potential intervention. The effective care of a child at delivery, assuring a smooth normal birth, initiation of breathing, maintenance of body temperature through close contact with the mother's own body, initiation of breastfeeding immediately after birth providing immune protection through colostrum, and the avoidance of unnecessary chill and thermal shock, can further reduce the high levels of deaths in the earliest days of life. The Human Development Profile of India study by NCAER (1994) suggests that nearly 44 percent of women in rural India initiate breastfeeding more than 48 hours after delivery. In states such as Punjab (77%), Rajasthan (67%), Uttar Pradesh (64%), Karnataka (60%), and Himachal Pradesh (56%) the proportion is more than 50 percent – with major implications for the survival of the LBW babies. Newborn care emerges as a critical area for further attention and search for effective strategies of reaching the mother at the right time.

3.2.1. Treating diseases

Beyond the neonatal period and throughout the rest of infancy, the major threat to children lies in lower respiratory infections – various kinds of pneumonia. To a somewhat lesser degree, in the later months of the first year, diarrhoeal diseases become a serious threat as the child is exposed increasingly to infectious agents from the environment through feeding and through exploring the world around her.

Acute Lower Respiratory Infection (ALRI) – the term for all infections of the lung or lower respiratory system – continues to claim 15-20% of infant deaths, especially in the first three or four months of life. A study in Gadchiroli in central India indicates that ARI is a significant problem among neonates. The study reported a neonatal mortality rate of 39.1 per 1,000 live births due to pneumonia related causes. The neonatal mortality rate due to all causes in this area was 97, making pneumonia the primary contributing factor in over 40 percent of deaths in the study area. Here is where future immunization of mothers with pneumococcal vaccines could offer an important protection to their children in the first weeks of life – at least against the most comon form of bacterial pneumonia, pneumococcus.

		Percentage of children suffering from cough accompanied by fast breathing	Among children with cold and fast breathing			
			Percentage taken to health facility or provider	Percentage treated with		
				Antibiotic pill or syrup	Home remedy, herbal medicine	Injection, syrup, others or no remedy
Child's age	<6 months	5.6	60.2	32.1	10.4	57.5
	6-11 months	8.4	69.6	34.4	7.7	57.9
	12-23 months	7.7	70.4	35.3	7.0	57.7
	24-35 months	6.0	64.1	31.6	6.0	62.4
	36-47 months	5.1	62.9	32.0	6.1	61.9
Sex	Male	7.1	70.8	34.2	6.8	59.0
	Female	5.9	60.8	32.3	7.5	60.2
Residence	Urban	5.1	77.1	37.4	3.4	59.2
	Rural	6.9	63.9	32.5	7.9	59.6
Mother's education	Illiterate	6.5	62.4	32.2	7.6	60.2
	Lit, <middle completed	7.7	70.4	31.5	7.3	61.2
	Middle school completed	5.9	72.0	38.2	3.1	58.7
	High school and above	4.6	84.9	44.2	5.2	50.6

Diagnosis of ALRI in children can be made reliably by recognizing rapid breathing and difficulty in breathing, especially in the very young. If treated immediately with a 3-5 days course of broad-spectrum antibiotics, a substantial proportion of these children can be saved from death. This requires early recognition and referral to a health functionary who can verify the rapid breathing and administer the needed antibiotics. While ARI can be prevented in the case of measles and pertussis to some extent, the vast majority is not preventable and therefore need early diagnosis. Appropriate case management is being given increasing attention in field worker training courses. At present, however, private practitioners are treating most young children with pneumonia – a group that has not been targeted with up-to-date information and knowledge on relevant and appropriate practices for treating children. This partly explains the relative lack of progress in this area. One fifth of children with ARI receive no treatment.

By the second half of infancy, diarrhoea takes over as the major cause of death. As children begin to crawl, dirtying hands and put various dirty objects into their mouths, they get in touch with pathogens so widespread in the environment. The introduction of foods other than breastmilk also exposes the child to pathogens from unclean preparation, water, containers and the like. It is indeed hard to imagine how a child can live with constant onslaught of intestinal infection, given the unsanitary and unhygienic environment, especially in urban slum areas. With effective treatment for dehydration through oral rehydration therapy (ORT), diarrhoeal disease has been declining over the past decade and is now relegated to the third most common cause of infant death in India. The NCAER study, however, has revealed that around one-fifth (21.8%) of caregivers of children below three years suffering from diarrhoea do not have knowledge or information on the need to give additional fluids during a diarrhoeal episode. The proportions are especially high in Karnataka (37.9%), Rajasthan (36.5%) and Bihar (35.1%).

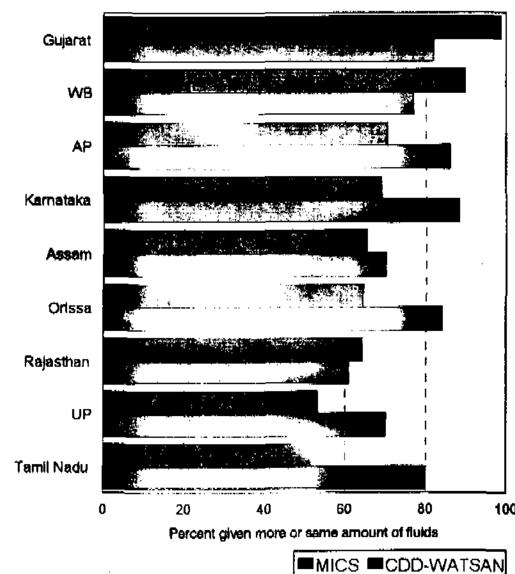
While protection from diarrhoea is provided by breastmilk of this is exclusive (i.e. no other foods or liquids during the first six months of life), unhygienic food and water expose the child to many pathogens. Deaths are usually due to dehydration, the loss of bodyfluids and lack of essential nutrients as children are not fed during diarrhoeal illness. Over 56.5% of children under three years of age with diarrhoea received less food and nourishment than recommended (NCAER, 1994). These deaths can largely be prevented by increasing fluid intake, using any available fluids in the home, or preferably oral rehydration solution (ORS) found widely in drug stores and health facilities and now recognized by a majority of the population – both urban and rural. Replacement of lost fluids as well as continued feeding – especially with breastmilk in young infants – can overcome the threat of death from diarrhoea as well as the more insidious and yet important nutritional deficit that accompanies each episode.

Multi-Indicator Cluster Surveys (MICS) data appear now to show increased use of ORT (continued/increased fluids during diarrhoea) over the past few years. While the CDD-WATSAN baseline survey (1992) found ORT use-rates of 34 percent in Maharashtra, 9 percent in West Bengal, 10 percent in Tamil Nadu and 13 percent in Andhra Pradesh, MICS (1995-96) found these use-rates to be 48.9, 57.0, 24.3 and 24.1 percent respectively.

While some caution is necessary in making comparisons between NFHS, CDD-WATSAN survey and MICS because of different definitions, sampling and survey methodologies, the numbers do appear to indicate a significant increase in the use of oral rehydration therapy.

These findings confirm what has been widely reported from paediatric hospitals in cities and rural districts throughout the country; that simple dehydration diarrhoea has been reduced substantially both as a cause of death as well as hospital admission. Children arrive at the hospital seeking help, having initiated oral rehydration therapy at home and are in a better condition, capable of continuing oral therapy for their illness along with encouragement of continued feeding to improve rapid recovery. Nonetheless, the potential of ORS and proper home management of diarrhoea is far from fully met.

Despite media and informational campaigns on the use of ORS, the NFHS in 1992-93 found that only 43 percent of mothers in India know about ORS and only a quarter of mothers have ever used ORS. The NCAER survey (1994) revealed that nearly half (47.8%) of mothers have knowledge on ORS and about one-third (36%) have given ORS. Knowledge and use of ORS is particularly low among rural women, illiterate women, very young mothers, and members of Scheduled Castes and Tribes. Among children with diarrhoea, less than a third receive either ORS or a homemade version of ORS. In Haryana, Rajasthan, Uttar Pradesh, Bihar and Gujarat, less than a quarter of children with diarrhoea receive ORS. In addition, over 58 percent of those given ORS obtained the packets from government health institutions and only 23 and 8 percent respectively from private hospitals and chemists/druggists.



Multi Indicator Cluster Surveys (1995/96), CDD-WATSAN survey (1 district/state), 1992.

Gaps between routine reports, NFHS and Coverage Evaluation Surveys.

The NFHS survey – covering 1992-93 – found a full immunization coverage rate of only 35 percent among Indian children, with 30 percent not having received any vaccinations at all. Children were less likely to be immunized if they lived in a rural area, if they were female, or if their mother's education level was low. More recent Coverage Evaluation Surveys (CES) confirm a gap between reported and surveyed data but at lower levels. In some districts, reported data may still be 20 or more percentage points higher than the findings in the CES. Such differences are greater in the 'poorer performing' states with almost no significant difference in states where coverage levels are high (e.g. Tamil Nadu).

Among the possible reasons for these discrepancies are immunization of children outside the age group listed (in the absence of detailed information on a child's age, a worker will judge by looking at the child at thereafter estimate the child's age); and multiple reporting of children who may be counted once by the provider who gave the immunization, and once by the official responsible for the areas (e.g. peri-urban children are more likely to be reported twice). However, in areas where most people receive their immunizations from private providers coverage may be underreported. The lack of standardized reporting from the first level health staff affects the quality and completeness of the data collected. The measure of the gap between reported and surveyed data is becoming an important management tool to direct attention to weak performing districts.

In spite of the fact that more than half of children with diarrhoea are taken to private health providers only a small proportion of them prescribe ORS. Efforts to improve treatment and caring practices among private health providers are necessary not only to reduce the morbidity and mortality levels associated with diarrhoea but also to reduce India's very high levels of young child malnutrition.

While the proportion of infants dying of diarrhoeal diseases has been decreasing, the rate of decrease has been slow and inconsistent. Efforts to educate parents and health workers through new, more community-oriented approaches about the use of ORS, and the need for increased fluids and feeding during diarrhoea need to be stepped up to reach those whose knowledge remains low. With a ready supply of ORS available 24 hours a day at a depot in each community – rural and urban – and the widespread knowledge and beliefs by parents and health workers alike that this is indeed a life-saving technology, deaths from diarrhoea – almost 500,000 every year – could be reduced by a further 60-70 percent.

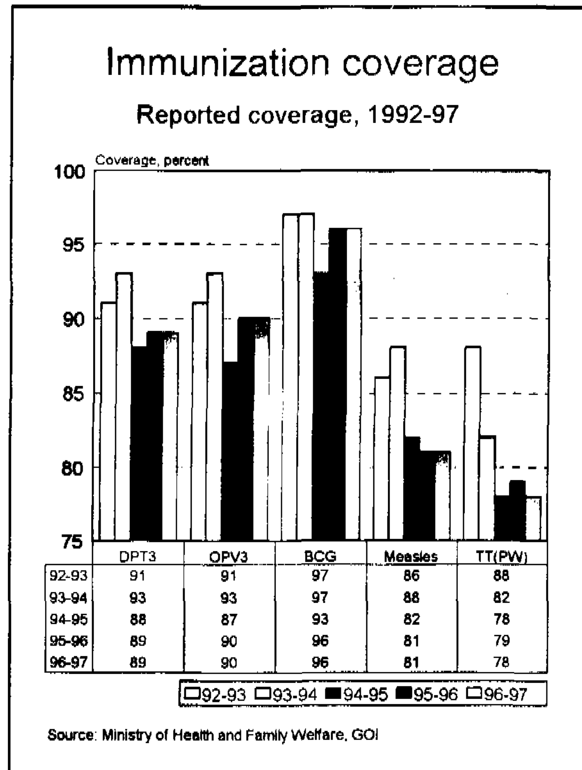
A disturbing finding that persists in most pediatric units of hospitals throughout the country is the excess number of boys (in comparison with girls) seeking medical care. For whatever disease complaint, many parents give preference to boys seeking modern health care earlier with the result that there is a decreased survival of girl children. This cause of ill-health is clearly social and *must* be addressed.

3.2.2. Preventing diseases

The success of the national EPI programme that comprised the major effort of child survival through the late eighties has been maintained and extended during the last seven years.

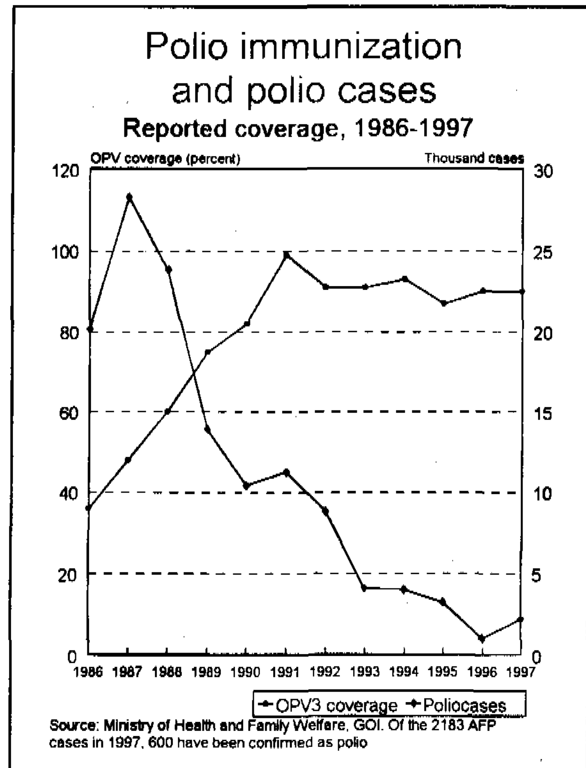
As a result, death and illness from whooping cough, pertussis, diphtheria and – most important of all – measles has been substantially reduced by as much as 80 percent of the pre-immunization levels.

Nonetheless, these diseases still claim several thousands of young lives each year and are especially severe amongst the malnourished for whom case fatality rates remain extremely high.



	DPT3	OPV3	BCG	Measles	TT(PW)
92-93	91	91	97	86	88
93-94	93	93	97	88	82
94-95	88	87	93	82	78
95-96	89	90	96	81	79
96-97	89	90	96	81	78

Source: Ministry of Health and Family Welfare, GOI

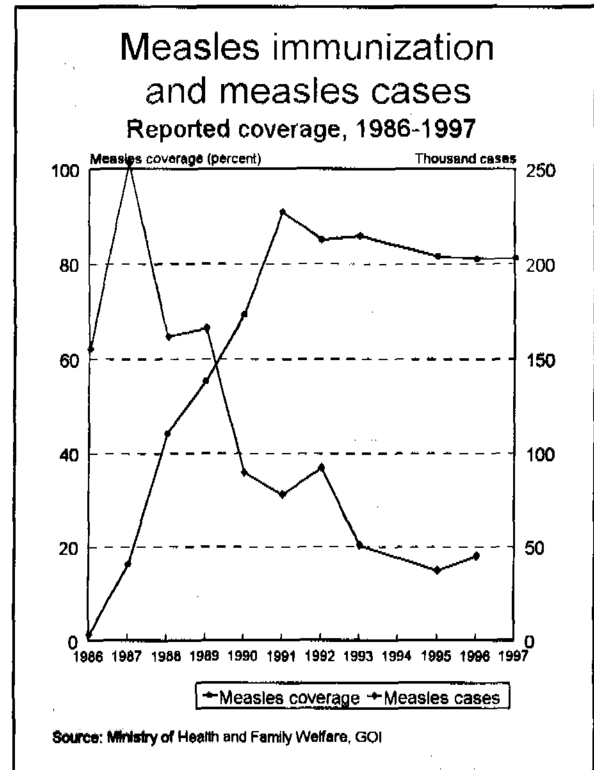


Source: Ministry of Health and Family Welfare, GOI. Of the 2183 AFP cases in 1997, 600 have been confirmed as polio

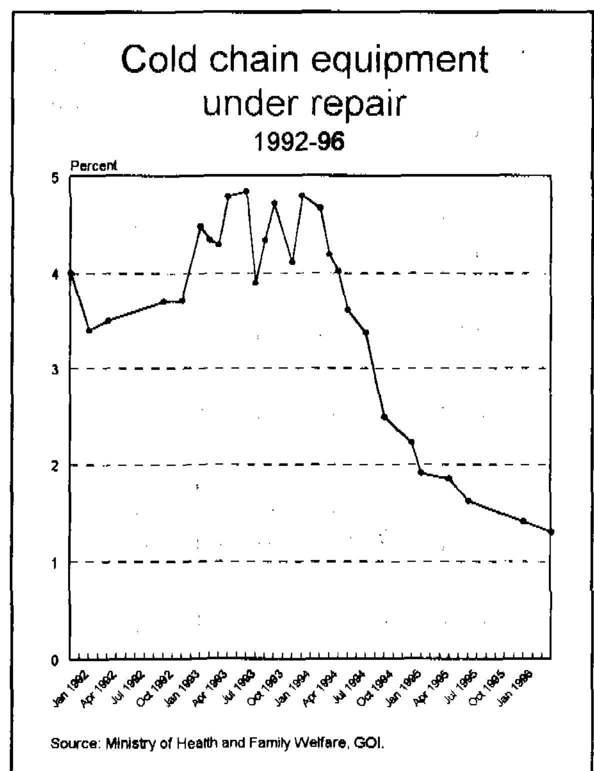
The promise of reaching full immunization to each infant before they reach one year of age is an important measure of the equity of the health care system and provides an important strategy for improving child survival and health of all children.

Coverage levels show in some districts that immunization levels have been and remained low throughout the last decade. Special measures are required to dealt with these districts either through strengthening existing systems or – more likely – through special campaigns and added resources to deal with logistic difficulties related to remoteness, seasons, lack of manpower and extremely weak infrastructure. To assume that the routine inputs will result in adequate levels of immunization in these low-performing districts is unrealistic; added analysis, alternative strategies and additional inputs are required.

Immunization also offers the prospect of protection against other important infectious diseases. In some countries hepatitis B contracted in early childhood is the major cause of adult liver-cancer and chronic liver failure later in life. In India, between 2 and 5 percent of infants are estimated to contract this infection, of those who become positive about 10% every year get chronic illness which often leads to premature death in adulthood. Three doses of vaccine during the first year can protect the child for life from this widespread infection. Vaccines against the most common causes of pneumonia, pneumococcus and haemophilus influenza are available. Although these vaccines are expensive, they are likely to be available in affordable form in the next few years. Common viral disease of children, chicken pox, German measles and perhaps the important lower respiratory infection have effective vaccines which could be included in the EPI programme in the future. Additionally, continued studies show improved vaccines against cholera, typhoid, dengue, rotavirus, haemorrhagic fever, Japanese B encephalitis, and increasingly, the prospect of an effective malaria vaccine are on the horizon. Once the concept is accepted that it is the right of every child to receive the vaccines available, government will find ways to mobilize resources to meet the incremental cost.



Source: Ministry of Health and Family Welfare, GOI



Source: Ministry of Health and Family Welfare, GOI.

Continues investment in the wide-scale availability of vaccines is the most cost-effective health intervention that India can make in the foreseeable future. The maintenance and expansion of EPI to reach every child is the most important foundation of public health – one that will make modern biotechnology of improved vaccine availability and scope accessible to each and every child, resulting in lowering morbidity and sickness rates and improvement in child survival.

3.2.3. The health care "system"

Developing the capacity to deliver basic childhood immunizations to every infant born in India was a major breakthrough in public health in the eighties. With the development of health services, the training of health care functionaries, provision of requisite supplies, supervision, monitoring and managemt, India learned how to reach into each and every community to provide essential health services. The unbroken chain of refrigeration from manufacturers to every health center, providing ice and storage for vaccines which are carried in insulated vaccine carriers to sub-centers and to each village on a monthly basis has been a critical infrastructure development. A nationwide refrigeration maintenance system has been established with remarkably low level of refrigerator breakdown at any one time.

A nationwide information system tracks both refrigerator breakdown and repair, and provides the basis for a health equipment infrastructure that could grow and expand with the sophistication of medical technology.

'EPI-plus' after 1990 showed that this system of regular monthly contact in the communities where people live for the provision of immunization services could be expanded to provide, in addition, vitamin A supplements, oral rehydration packets for the treatment of diarrhoea, and the regular supply of condoms or pills for those who wish to space their pregnancies. The monthly outreach session became a regular part of the health workers' responsibilities. Most of this work has been the job of the female multipurpose worker, the ANM, who is assigned to one of the 135,000 sub-centers, serving the over 600,000 inhabited villages throughout the rural areas of the country. Through great effort, a good number of these centers are now in their own proper buildings, many with accommodations for the ANM. But the isolated tribal and poorest communities are still without a proper building or accommodations for the worker. Added to this, the difficulty for a woman, especially if she is single, living in a lawless and isolated rural area remains a substantial constraint to the regular delivery of outreach services to the communities that need them the most. Meanwhile, the assignment of male multipurpose health workers to the same areas is lagging far behind, and as a result, the burden on women once again is the heaviest. The entire system is constrained by the lack of transportation services to enable logistical support and the regular visitation of supervisors to these important health outposts. The development of affordable transport system is one of the major challenges facing the rural health care system.

In over 4,200 (of the over 5,200) development blocks where ICDS has been initiated, health workers have begun to team up with *anganwadi* workers for an easy and more regular contact with pregnant women to provide antenatal care and to organize monthly sessions to provide immunization and other primary health care services in the community. ICDS had previously focused its attention on preschool activities and supplementary feeding for children, age 3, 4 and 5. In recent years, the alliance between ICDS and Health Department to achieve universal immunization gave greater opportunity to focus on the health and nutritional practices of the child in the first year of life, when the child is being vaccinated, and before ICDS had regular contact with the child and the mother through the *anganwadi*. The changing priority of ICDS to prenatal care and infancy will enhance the partnership between health and ICDS, to address the critical health and nutrition issues in the prenatal period, and lead to improvement of feeding and care in the first year of life.

Increasingly, these monthly health outreach sessions are organized in concert with the community itself, and with the election of *panchayats* in many villages, village health committees were established to facilitate the organization and efficiency of monthly health sessions. In those communities where responsive voluntary action meets and supplements the effort of *anganwadi* workers, the monthly visit from the health worker results in substantial improvement in preventive and primary health care.

The above describes what is as yet an unfulfilled ideal in much of the country, but already it has demonstrated the capacity of linking the health care system to each and

every household through community control and participation.

Until recently, health was seen to be the sole responsibility of the Ministry of Health and Family Welfare. Under the Child Survival and Safe Motherhood programme, the medical officers, health supervisors, health workers, hospital-based specialists and support staff were trained in appropriate clinical and non-clinical managerial skills to improve maternal and child health and survival through this coordinated programme attempting to link communities through their nearest sub-center to the primary health center, *taluka* and district hospitals equipped with specialist skills and capabilities related to child and maternal emergency care. By 1997, over 25,000 medical officers and 90,000 health workers have been trained under the CSSM programme. Other major donors supporting MCH programmes of the government and government departments were conducting training for similar functionaries often with similar material, leading to overlap of training and poor usage of time and resources. The new Reproductive Child Health programme of the Ministry of Health and Family Welfare, funded by the World Bank and other donors will integrate training at all levels and assure a more comprehensive and integrated approach to the health needs of women and children. From the communities where they live, to improved sub-centers for preventive care, normal deliveries and health promotion, to PHCs, CHCs with expanded capacity to treat common illness, to *taluka* or district hospitals, women can expect a more responsive and interconnected health care from government services.

3.2.4. The "other" health sector

Since independence, India's effort in the field of health has focused on publicly provided services, extending from urban-based medical colleges and hospitals to district hospitals, primary health centers and small rural dispensaries staffed by paramedical workers. Extensive government resources and loans and grants from international agencies have helped developing the infrastructure and human staffing of this huge system. Remarkably, little attention has been given to the existence and practices of the private sector found throughout the country in both urban and rural areas. With some 25,000 doctors in the government rural health care system, there are around one million individuals engaged in private practice of various systems of medicine, spread throughout the villages of India, as well as in every urban *bazaar* and market-place. A recent study by the World Bank has indicated that some 75 percent of health expenditure in the country is made in this private sector. More surprising is the finding that the private sector is used as much by the poor as it is by the rich, although the poor tend to consult with untrained, unlicensed local practitioners while the expenditures of the rich are at the larger specialty facilities found in the urban areas.

Private health practitioners come from a wide range of backgrounds, most with no formal training, having learned as apprentices or keen observers of other elder healers. Some have been trained in traditional Indian systems of medicine, but a majority of them use (often misuse) modern allopathic medicines as they are seen to be more powerful, act faster and are more popular, even amongst the unsophisticated and illiterate rural public. These practitioners earn their living largely by selling the medicines they prescribe and provide to their clients, adding a small mark-up to the price they have paid from drug sellers in the nearby towns and cities. Conveniently located in most villages or small towns they are culturally accepted, often familiar personages who provide a service which is welcome, convenient and widely viewed to be effective. As a self-financing and ubiquitous part of the health-care system of India today, they need to be brought more fully into the health care system through training and through regular contact to improve the quality of care they provide, and to assure that they recognize conditions requiring referral and treatment beyond their own capacity. The lack of recognition and acceptance of the private health practitioner by the public health system and the non-use of this valuable resources in planning for health care needs of the public is a major challenge to the health care system of India between now and the end of the century for shaping the health of its people in the years ahead.

Ultimately, as envisioned in the declaration in 1978 at Alma Ata, health must be in the hands of the community under the control of those lives who are most affected. The community needs to take steps for ensuring proper provisioning of health services, of health care workers are responsive and they receive technical training and support from higher levels of the system. Village health committees have shown their value in states, such as Mad-

hya Pradesh for their improved responsiveness of centralized services, and can assure that even the poor avail of free public care. Communities are all too often passive with respect to their expectations of health care providers, especially those coming from the government. Lessons must be drawn from the success of rural health practitioners to understand how they work effectively in response to community needs, and at the same time improve the quality of care they provide. Communities need to be involved in setting standards and in monitoring their accomplishments.

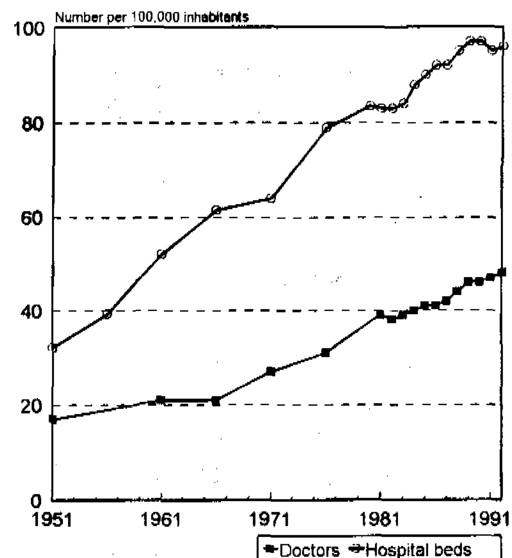
Today, health care information systems are designed only to send information centrally. It is rarely used by those who collect it, and never seen, much less understood by those whose lives it describes. India has developed an impressive Sample Registration System, providing vital statistics from a representative 2 percent sample. However, an effective mortality investigation scheme for determining causes of death and an elaborate system of monthly reports on progress relating to immunization, family planning, and in the case of ICDS on nutrition of younger children are yet to be geared for action at community level. Little or no information is collected locally and used at that level to assess community needs, priorities and progress.

In a few outstanding experiments, such as TINP in Tamil Nadu, communities monitor important parameters of well being, such as the number of children immunized, the number of children malnourished, or number of users of family planning methods. An improved system of helping communities to identify indicators of importance to investigate failures of the system, such as the reasons for child and maternal death, and to call upon government workers to be accountable for services provided is an important next step in assuring the health of entire populations, and especially responsive service for the needs of mothers and children.

Sources of vital statistics

Several sources of vital and health statistics are available on the national and state level, including

- Causes of Mortality Rural (reported annually);
- Sample Registration System data (vital statistics from a representative 2 percent sample).
- Health Management Information System of the Central Bureau of Health Intelligence (MOHFW) linked to the NICNET and the
- CSSM (now RCH) Management Information System developed and maintained by the NIDC,
- Monthly Monitoring Reports and Monthly Progress reports of the ICDS programme under the Department of Women and Child Development



3.3. The right to healthy growth and nutrition

Even effective preventive measures delivered by a well-functioning health care system cannot offset the pernicious effect of under-nutrition on the health, well-being and ultimate survival of India's children. Few realize the startling fact that 53 percent of India's children are substantially malnourished. This is nearly twice the rate reported in Sub-Saharan African countries, and accounts for nearly 60 million malnourished children under the age of 5. This nutritional deprivation is more or less invisible, for it is not the swollen belly and shriveled bodies of severe deprivation seen in refugee camps or in times of famine. Under-nutrition in India is manifested in poor growth, reflected in small size of the child, and ultimately a short, underweight and small adult, less capable of both physical and mental performance required for successful competition in today's world. This is aggravated by deficiencies in vitamin A, in iron and, in many parts of India, of iodine. The absence of these micronutrients

(required in infinitely small quantities of the diet each day) is called ***hidden malnutrition***, as it is largely invisible. Thus, the marked decline in the clinical form of severe malnutrition, kwashiorkor, marasmus, and blinding keratomalacia which used to be the main public health nutrition problems in India in the sixties, have virtually disappeared, leaving behind a more widespread, but nonetheless invisible, sub-clinical malnutrition throughout the land, with serious consequences on morbidity and mortality, and profound impact on children's mental and physical growth.

Recent studies show that more than 50 percent of childhood deaths are directly associated with (and inferentially caused by) malnutrition, 80 percent of that by mild and moderate forms, largely invisible. Compared to the risks facing a well nourished child, risk of death from common childhood diseases is doubled for a mildly malnourished child, tripled from moderately malnourished and maybe as high as eight times for a severely malnourished child.

Estimates based on NFHS underweight prevalence data for 7 states indicate that close to 60 percent of all childhood deaths are associated with malnutrition. Of this 60 percent, the percentage of deaths attributable to the potentiating effect of mild and moderate malnutrition is approximately 79 percent.

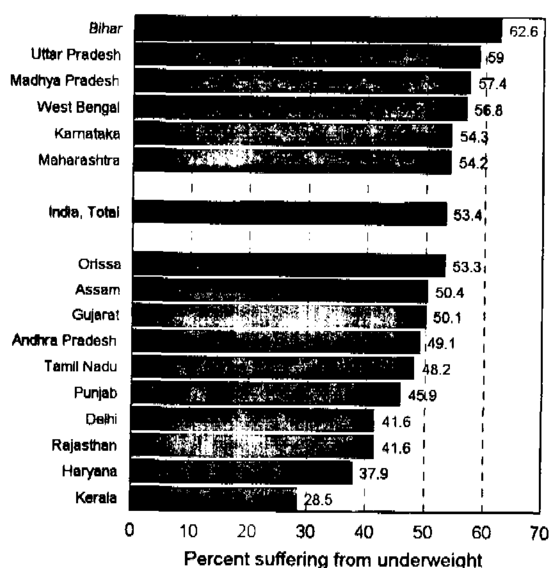
Until recently, scholars who questioned the use of international standards to classify Indian children dismissed figures of high rates of child malnutrition in India. Nationwide studies by the Nutrition Foundation of India have established beyond doubt that global standards of height and weight apply to Indian children as well, at least until early adolescence. In a well-nourished child population, only 2-3 percent would be expected to be classified by these norms as malnourished. India has over 50 percent.

The under-nutrition in children below four years was higher in Scheduled Castes (57.5%) and Scheduled Tribes (56.8%). NFHS also revealed that there is a strong correlation between the educational level of the mother and the child's nutrition: Malnutrition by weight-for-age was 59.2 percent in children of illiterate mothers compared to 30.3 percent in those with mother's who had a completed high school.

Nutrition rights

Healthy growth of the child is an outcome of many factors. In the early years it depends crucially upon the interaction of food intake and infection. But these are in turn determined by household food security, access to health care, to a safe environment, and above all upon the care that the child receives. Amongst these, inadequate food and health have been long recognized as prime contributors to poor nutrition. The environment, and caring practices in the family (and the related question of available parental, often the mothers', time) have been relatively neglected as causative factors. For a child to realize her/his right to nutrition, all of these factors need to be present. The right of the child to healthy growth, then, is closely linked to the fulfillment of other rights, and particularly those of her/his mother.

Children under four suffering from underweight



Source: National Family Health Survey, 1992-93. Weight for age, less than minus 2 SD for IRP.

	Weight for age		Mortality associated with malnutrition	
	<80%	<60%	Total malnutrition	Mild-moderate malnutrition
Goa	40.8	2.0	46.3	84.4
Haryana	43.8	1.7	48.7	86.2
Karnataka	57.0	5.0	57.4	74.2
Maharashtra	60.3	5.5	59.2	74.0
Orissa	57.0	4.9	57.4	74.3
Tamil Nadu	55.7	3.4	56.7	77.8
Uttar Pradesh	65.0	9.0	61.5	83.3
Total	59.9	6.2	58.8	78.7

There is a suggestion that poor growth in the early months and years of life may be a useful adaptation to poverty, the smaller child, and eventually smaller adult requiring less food for daily activity and an overall smaller claim on the nutritional resources of society. Not only is this a gross violation of the right of every human being to a healthy and full development, but also disregards the loss of human capital inherent in a smaller physical and mental capacity associated with under-nutrition.

3.3.1. Underweight, stunting and wasting

Two major national surveys provide data on the nutritional status of Indian children. The National Nutrition Monitoring Bureau's survey between 1988-1990, which covered eight states, reported that out of all children in the age group of 1 to 5 years, 69 percent were underweight, 65 percent stunted, and 20 percent were wasted. The second source is the more recent National Family Health Survey (1992-93) which covers 25 Indian states. While the data are not exactly comparable, either in age group measured or in the population surveyed, they found a striking 53.4 percent of children of age 0-4 years below the expected weight for the age (**underweight**), 52 percent below their expected height (**stunted**) and in 17.5 percent of children, the weight was substantially less than a normal child of that height, whatever the age (**wasting** or excessively thin). Both the surveys point to chronic malnutrition among young children, who were basically too small in weight and height for their age.

Of the larger states, underweight prevalence ranges from 28.5 percent in Kerala to 62.6 percent in Bihar. Of the nearly 60 million children under 4 years who are malnourished, 60 percent live in the five large contiguous states Uttar Pradesh, Bihar, West Bengal, Madhya Pradesh and Maharashtra. A recent study has reported significantly higher prevalence of severe malnutrition (<60 percent weight for age) in children from scheduled castes and tribes, compared to the dominant and higher caste groups.

It is, however, possible to get a picture of nutritional trends using NNMB's surveys of 1974-1979 and 1988-1990 as the latter was designed to be comparable to allow for trend assessment. The comparison showed a rate of decline in underweight prevalence of less than 1 percent per year during the eighties.

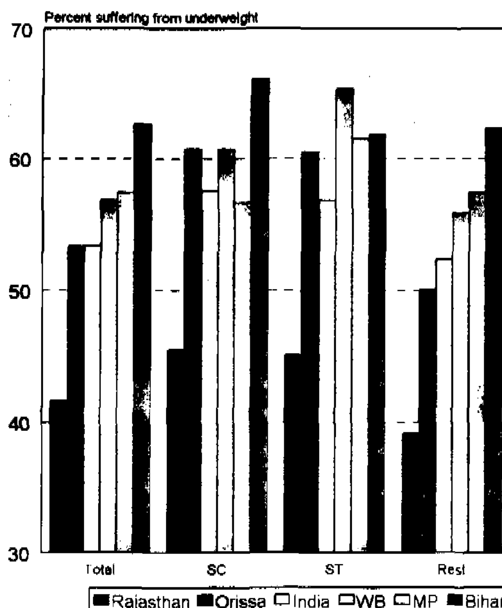
Measuring child malnutrition

Anthropometric data on the weights and heights of under 4 year old children were collected within the National Family Health Survey in order to classify child nutritional status according to the three main indices:

- ***weight-for-age*** (indicating the degree of 'underweight')
- ***height-for-age*** (indicating the degree of 'stunting')
- ***weight-for-height*** (indicating the degree of 'wasting')

The nutritional status of children according to these measures is compared to the nutritional status of an international reference population enabling the degree of 'underweight' etc. for any child population to be determined. An international reference population, such as the NCHS/WHO reference is valid for use in any country, as empirically, it has been shown that well-nourished children essentially exhibit similar patterns of growth regardless of their country of origin.

If a child suffers a sudden short-lived nutritional insult s/he is more likely to become 'wasted' (temporarily at least) than stunted. If a child has been suffering repeated or prolonged growth faltering s/he is likely to become short for his/her age and consequently 'stunted'. The weight-for-age measurement can be viewed as a summary indicator of a child's nutritional status and a composite of both wasting and stunting.



Source: National Family Health Survey, 1992-93

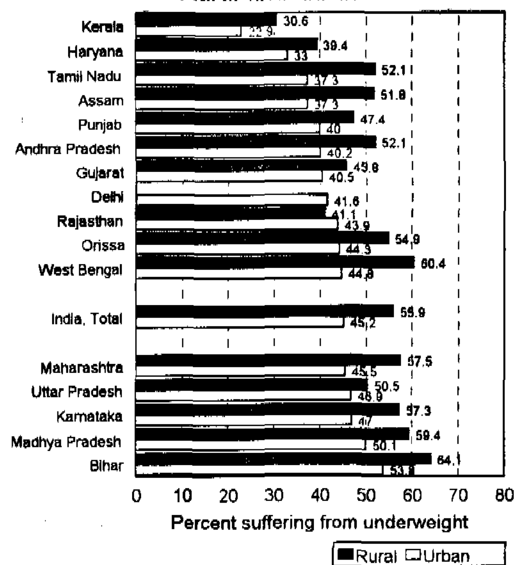
As for other indicators, malnutrition levels in urban areas appear to better at 45.2 percent in urban India when it is 55.9 percent in rural India.

These differences can be noted in the figure. However, they may well be under-represented. Unfortunately, urban nutrition data are not disaggregated into slum and non-slum populations. Analysis of nutritional status of children from NFHS for urban areas indicates that those in slums (households with no toilets) suffer malnutrition in greater numbers by weight for age criteria.

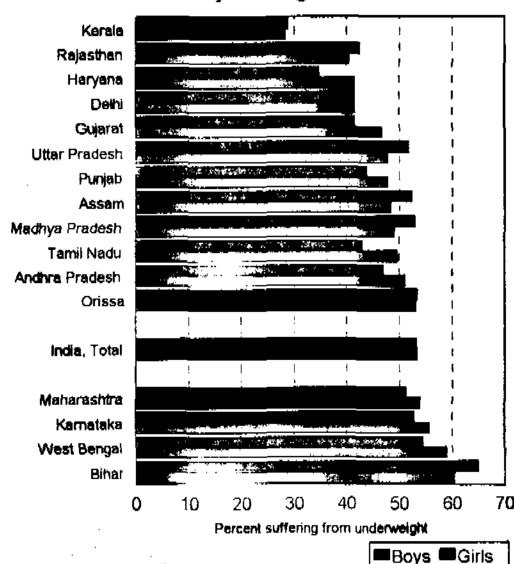
The table on this page suggests that children in poorer homes suffer malnutrition by weight for age criteria in proportions which are in the range of 1.5 to 2 times for moderate and severe grades, and from 1.5 to 4 times for severe grades.

There are however a number of smaller studies of nutritional status at the household level that show boys consistently faring better than girls. To some extent, this is also revealed by the NFHS data on "severe" malnutrition. It is worth pointing out however that mortality rates among girls in the age group of 12-48 months (42 per 1000 live births) far exceeds that of boys in the same age group (29.4 per 1000 live births). This striking gender differential could well be the outcome of severe malnutrition and fatal disease prevalence being more in girls than in boys. Unraveling this 'puzzle' of the NFHS gender data is an important area for further research and investigation.

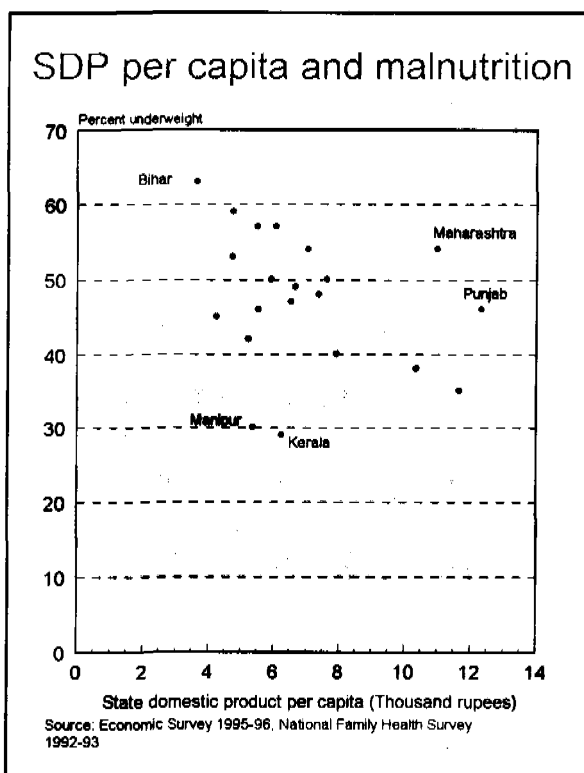
State	Weight for age, less than -2 SD		Weight for age, less than -3 SD	
	Households with		Households with	
	toilet	no toilet	toilet	No toilet
Andhra Pradesh	35.5	63.8	7.7	23.2
Assam	37.0	75.8	10.9	15.2
Bihar	48.2	74.1	21.3	44.2
Gujarat	42.0	55.5	11.9	20.0
Haryana	27.2	51.5	3.9	11.9
Karnataka	43.4	65.7	14.6	32.4
Kerala	23.5	40.0	3.3	0.0
Madhya Pradesh	49.4	60.9	10.3	13.5
Maharashtra	47.0	63.1	17.1	21.4
Orissa	41.9	61.0	8.6	24.8
Punjab	39.8	58.0	14.4	24.0
Rajasthan	43.1	72.1	20.3	39.7
Tamil Nadu	35.7	44.2	9.7	16.3
Uttar Pradesh	52.3	72.4	18.6	31.3
West Bengal	35.9	67.6	4.4	26.7
Delhi	44.2	63.1	13.1	21.6

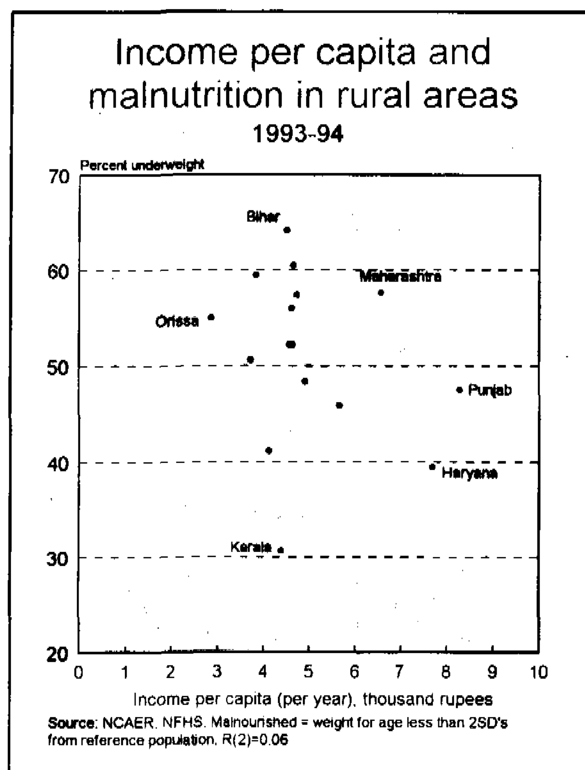


Source: National Family Health Survey, 1992-93. Weight for age, less than minus 2 SD for IRP.



Source: National Family Health Survey, 1992-93. Weight for age, less than minus 2 SD for IRP.





3.3.2. Causes

The key to India's high rates of malnutrition is not to be found in the obvious. Although poverty is a major underlying determinant, just as in other low-income countries, the lack of family resources would be expected to result in a malnutrition level of not more than 30 percent of children. Even considering varying estimates of the poverty line, these are unlikely to account for malnutrition in 55 percent of children in India, even if it was assumed that all children in poverty would be malnourished, a finding that we know is not the case. Poverty may then account for approximately half of the observed malnutrition, no more. The figure below suggests that even with low SDP, as given in the states of Kerala and Manipur, the levels of malnutrition are low.

Additional analysis of malnutrition levels in rural India suggests no correlation with the per capita income. Bihar, with similar per capita income as Kerala, exhibits malnutrition levels that are more than double that in Kerala. Maharashtra, with almost double per capita income as in Orissa, has malnutrition levels that are similar.

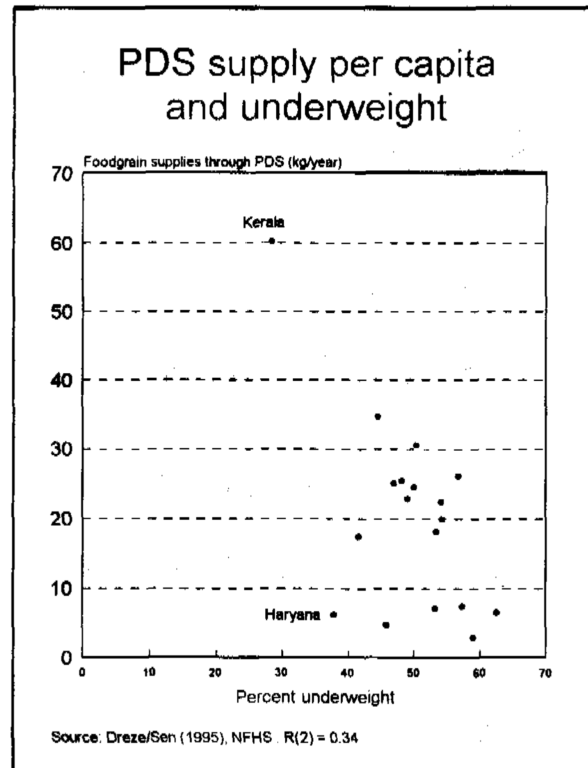
While economic improvements alone cannot change the nutritional status of children, the answer is not to be found in increasing food production and availability either. Foodgrain production went up from 109 million tons in 1980 to 191 million tons in 1995, almost a double increase, whereas population has increased only by a little more than one-third over this period. The Government has also built up a buffer stock of foodgrain, further increased the network of the public distribution system (PDS), and created an administrative machinery to deal with famines and droughts reasonably effectively. Yet, malnutrition rates do not appear to respond to these inputs alone.

Neither is it a question of food availability at the household level. Under-nutrition starts early and occurs mostly in the first 12 to 18 months of life. Thus, feeding a very young child adequately requires very little food. Take a typical one year old child whose daily requirement is 1000 calories but whose intake is often only 700; the difference of 300 calories (75 grams of rice or wheat or any other cereal) amounts to no more than 2 or 3 percent of the family's overall needs.

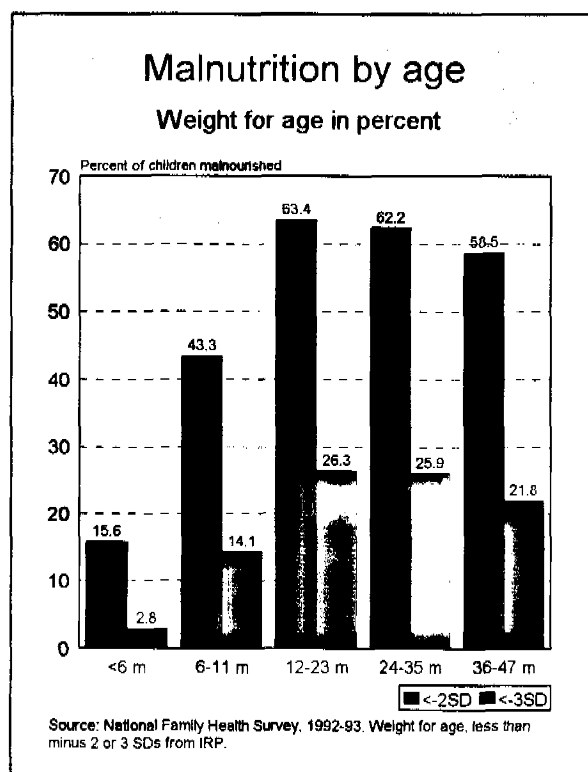
The first important cause of malnutrition is *low birth weight*, itself a form of malnutrition which began in the mother's womb. As

discussed in section 3.1, over one-third of all babies in India are born with low birth weight, weighing less than 2500 grams. This is closely associated with poor growth not only in infancy but also throughout most of childhood. Low birth-weight is a *prospective* marker of future growth and development and a *retrospective* marker of the mother's nutritional and health status. The proportion of babies born with low weight reflects the condition of women, and particularly their health and nutrition, not only during pregnancy, but also over the entire childhood and young lives. Often, girls, women and mothers in particular eat last, after the men and boys have been fed the most and the best food. No special effort is made to give mothers additional food or the rest required during pregnancy. As many as 30-40 percent of women are married before the legal age of marriage (18 years) and conceive their first child before attaining full growth of height or pelvic structure. Hence, the risk to life of mother and the first-born is much higher. The prevalence of anaemia in women, which is about 60 percent rises even higher during pregnancy to a staggering figure of 85 percent and more. Anaemia in mothers is also a contributing factor to low birth-weight. A poorly nourished woman can simply not reliably give birth to a well-nourished child.

But women's status and well being is undergoing a rapid change. One important sign is an extraordinary rise in the number of pregnant women now being reached for antenatal services, approximately 80 percent of pregnant women receiving some sort of health care during pregnancy as opposed to a little more than 30 percent only a decade ago. This has resulted in a dramatic fall in neonatal tetanus, and with improved administration of iron tablets during pregnancy and better attention to nutritional guidance, a fall in low birth-weight could be predicted. Increasing action by women is also revealed in the rapid rise of organized women's groups of all kinds - from credit and thrift societies to trade unions - from a small number in 1980 to several thousands in 1990 and tens of thousand today. Together with the increasing participation of women in *Panchayats*, such public action may ultimately translate into improved nutritional status of women and their newborns.



Source: Dreze/Sen (1995), NFHS. R(2) = 0.34



Source: National Family Health Survey, 1992-93. Weight for age, less than minus 2 or 3 SDs from IRP.

Many still assume that it is the lack of food that causes poor nutrition. This, in some sense, may be correct when one views the age at which malnutrition sets in.

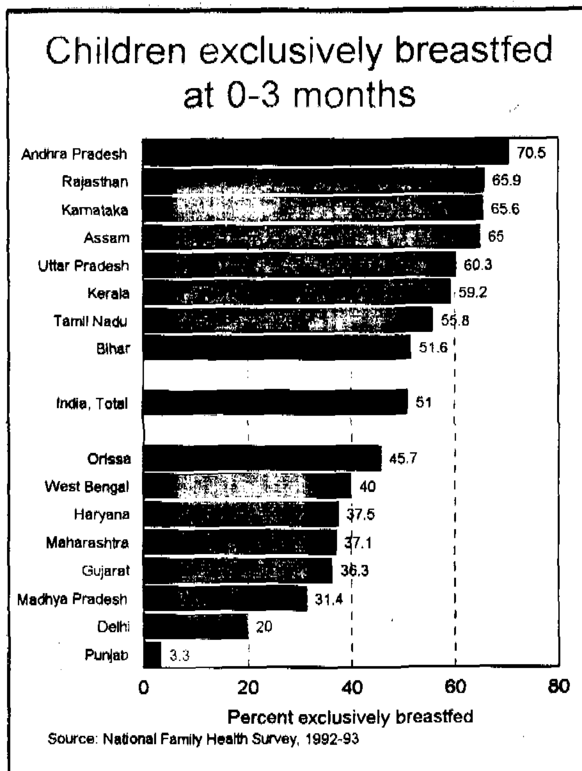
Deterioration in growth begins by 4 months of age and rises sharply until 12 months, a time when many children are still receiving only mother's breastmilk. Beyond this time, most children grow normally, although it is smaller size than one would expect for their age. In the period before 4 months, growth is typically protected by the high quality of breastmilk and frequent breastfeeding. While exclusive breastfeeding should be adequate for the child until 6 months of age, data indicates that growth of many children falters earlier, reflecting either inadequate breastfeeding practice (inadequate feeding frequency, inadequate nutrition of the lactating mother with possibly introduction of non-nutritive feeds through bottle or other means which decrease the flow of breastmilk). Beyond 4 months, breastfeeding provides much of what a child needs, but the higher energy required for growth and increased activity must be provided from other foods over and above the breastmilk. The difference between survival and good growth is the addition of complementary foods amounting to as little as 200-300 Kcal (50-60 grams of cereal) per day.

Food availability at the household level is seldom a problem for children between the ages of 4 and 12 months, for the amounts required are small; the issue is more of proper care and attention to the child's needs. While feeding, a young child requires very little food; the food must be clean and administered frequently in small quantities as the child's appetite and stomach are both small at this age. A child may have to be fed at least 4 times a day in addition to frequent breastfeeding to achieve an adequate food intake for optimal growth. Care of the child enters into the picture in yet another way. The incidence of diseases is dependent upon several factors including the availability of clean water, safe sanitation, and the patterns of population settlements that may lead to a dirty environment. What matters the most is the environment of the child and the conditions of the child's home. Personal hygiene, hand-washing habits, and practices relating to latrines use, safe refuse disposal, cleanliness of clothes, and protecting food from contamination of flies all affect the child's nutrition. There is evidence that improved sanitation results in improved nutritional status. The reflection that a child is susceptible to the overall environment in which she lives, suggests population density and the onslaught of infections transmitted by unsanitary habits of others sharing the child's environment are also threats to a child's health and survival. The quality of childcare is, therefore, a complex of habits and practices that serve to protect the child.

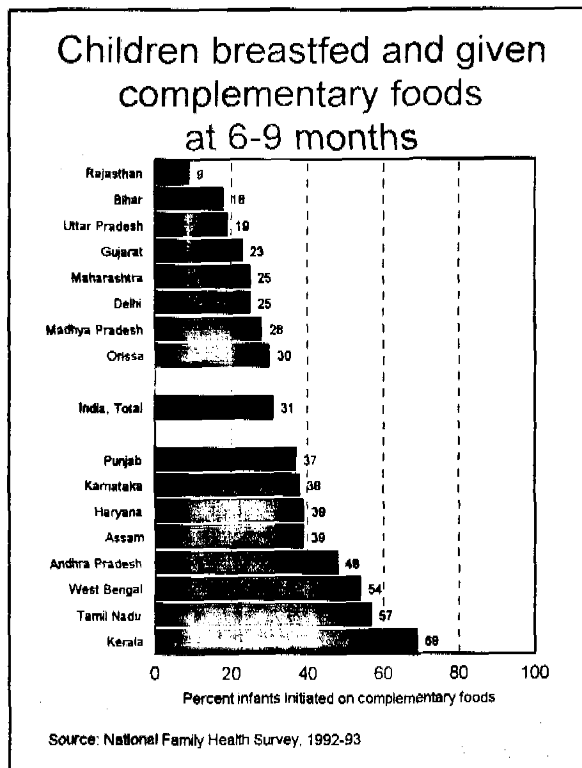
A child's nutritional well-being is also determined by the frequency, severity, and duration of infection. Disease reduces a child's appetite as well as limits the absorption of nutrients that he or she eats. Here lack of knowledge on the part of parents becomes a factor. Children who are ill are often not fed or poorly fed. Those with diarrhoea, the most common illness at this age, need to be given extra fluids as well as continued feeding in order to recover quickly from their illness, as well as not to lose weight caused by the illness itself from fever and catabolic processes in the body. Following each bout of illness, children should be fed extra food to make up for what they did not eat, and losses while they were sick. The NFHS (1992-93) reports that in about 12 percent of infants, breastfeeding was actually reduced. The Multi-Indicator Cluster Surveys (1995-96) suggest that continued feeding rate during diarrhoea in children of age less than five years varies from 26.1 percent in Karnataka to 79.3 percent in West Bengal.

The third major cause of malnutrition is related to inadequate breastfeeding and incorrect complementary feeding. Exactly how a child is fed in the first few hours of life is critical. A child must be given the breastmilk within an hour of delivery as the early colostrum provides both immunity and protection to the child, minimizing the probability of infection, and improving both breastmilk production from the mother's breast as well as bonding with the mother. Breastmilk contains the optimal composition of nutrients as well as factors that facilitate their rapid absorption and use in the infant's body metabolism.

Breastfeeding on demand through the first six months of life enables appropriate nutrients, immune substances and necessary calories and proteins to be provided to the child.



Source: National Family Health Survey, 1992-93



Source: National Family Health Survey, 1992-93

From the age of 6 months, however, breastmilk alone is not sufficient. It is essential to introduce complementary foods, prepared in a safe and hygienic way, and fed frequently to the child if growth faltering is to be prevented. The timing, total quantity and frequency is important. If foods are introduced too late, the child's growth will falter. If they are introduced too early, growth is threatened by infection and by decline in breastmilk as a result of decreased suckling. Thus, poor infant feeding practices lead to faltering growth as early as 3 or 4 months. Children between 4 and 12 months of age have maximum risks of growth faltering, as they do not eat by themselves. They need to be fed. Hence, the importance of care in the growth of the child. The amount of time this can take is itself a luxury to the poor, especially overworked mothers. With fathers seldom taking responsibility for feeding a young child, and mothers invariably coping with the burden of domestic work and, in many cases, outside work, the child may be left to the care of a sibling nearly as young. Left to the caring of another child only a few years older, the baby invariably fails to get adequate quantities of food, and is exposed to inadequate hygiene.

Less than one-third of 6-9 month old babies are currently receiving complementary foods throughout India. When national data are disaggregated, the problem is revealed even more dramatically. In Rajasthan, only 9 percent of infants receive foods in addition to breastmilk, contrasted to over 69 percent of the same age group in Kerala.

In order to support appropriate behavioural changes in feeding of young children, there is an urgent need to provide information support and counseling to women during pregnancy and up to when the child is two years old. Every opportunity of contact through service delivery must be used optimally during this period to counsel caregivers to ensure continued breastfeeding with the introduction of adequate amounts of complementary feeding.

This points to one critical factor that is the most crucial and neglected determination of whether a child grows well: "quality of child care". This embodies not only how well and frequently a child is fed; it covers measures taken to prevent disease, to promote hygiene, and includes a degree of stimulation and interaction with adults that result in improved child appetite and increased food intake. No doubt, mothers are the principal care providers; but

fathers and men too have a role, not only in assisting women, but more importantly in caring for women, and assuring that they themselves receive adequate rest, adequate diet, and time to care for their children. After all, it is only when mothers are cared for that children fare better. It is too close an association to be so severely neglected.

3.3.3. Micronutrients

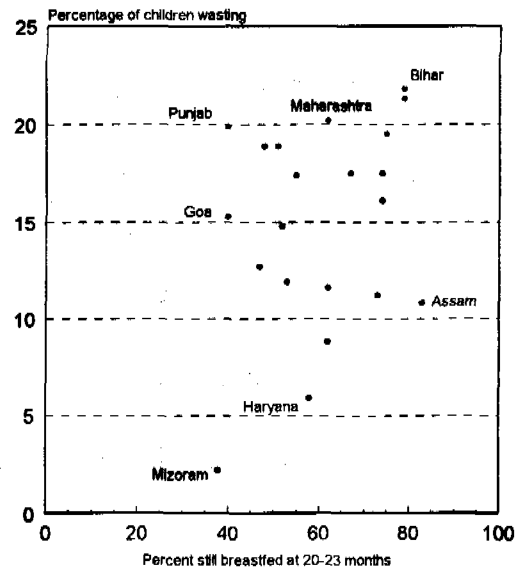
Care of the mothers includes care during pregnancy, fortification of diets with essential minerals and vitamins, and ensuring that iodized salt is consumed to avoid iodine deficiency. As seen earlier, it also means preventing and reducing the high levels of anaemia with adequate amounts of iron and folic acid during pregnancy. It is only when mothers are cared for thus will the right of every child to adequate micronutrients be assured. During pregnancy and lactation, the micronutrient needs of a mother increase considerably when their diet during adolescence and prior to pregnancy is already grossly inadequate.

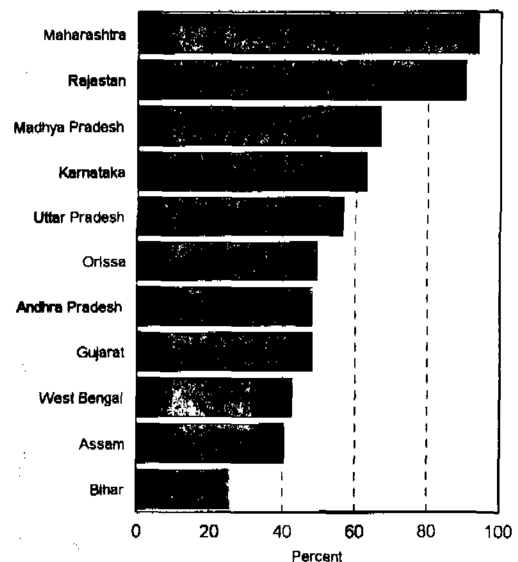
It is estimated that with the level of micronutrient deficiencies that exist today in India, the country suffers significant social burdens and economic losses each year entirely due to inadequate vitamin A, iron and iodine:

- 380,000 deaths
- 210,000 children born cretins or blinded as preschoolers
- 25 million person-years of work lost due to lethargy or more severe disability
- 6.8 million student years wasted.

At least 5.7 percent of all Indian children suffer from a varying degree of eye disorders associated with vitamin A deficiency (VAD). As per the National Blindness Survey, over 3 percent of children suffer from VAD in 19 of the 32 states and union territories. The more recent NCAER survey (1994) again suggested high levels of Bitot spots and night blindness in children (0-4 years, and 5-10 years) in the states of Madhya Pradesh, Rajasthan and Himachal Pradesh.

Vitamin A, long recognized for its importance for good vision, is now regarded as the single most important invention for survival, as it improves immunity. Children with even mild forms of vitamin A deficiency have a risk of diarrhoea and acute respiratory infections, which is 2-3 times more of normal children. Inadequate vitamin A in a pregnant woman leads to inadequate stored levels of vitamin A in the newborn, and also lowers the vitamin A content in breastmilk. Vitamin A must, therefore, be obtained through breastfeeding, consumption of green and yellow vegetables, high dose supplements linked to the EPI, and fortification of selected foods, like milk, sugar or *vanaspati*. A large number of





Baby-friendliness in Hospitals

Being "baby friendly" essentially implies ensuring proper care and exclusive breastfeeding of the child for four to six months. Not all mothers realize the importance of exclusive breastfeeding for the survival and healthy development of a newborn baby. This is vital information that needs to be transmitted to every mother whenever and wherever the child is born.

The marketing and sale of commercial baby foods poses a major threat to the healthy growth and survival of a newborn. Advertisements have created a misleading impression among caregivers about the need to reinforce or even replace breastfeeding even for newly born babies with enriched powdered milk. It is rarely if at all communicated that powder milk is recommended only when breastmilk for the newborn is found to be inadequate. Little was done to address the problem that poor parents rarely had the means to ensure that the feeding bottle was properly sterilized; nor did they always use the right quantity of powder milk. As a result, many children fell ill and their growth faltered. The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 came into force on 1 August 1993.

Strong advocacy and public campaigns have supplemented this effort, and to an extent, reversed the trend to switch to commercial baby foods. The recently launched "Baby Friendly Hospital Initiative" (BFHI) has helped to promote knowledge about exclusive breastfeeding to mothers who deliver their babies in BFHI certified-hospitals. As of 31 December 1997, 1223 hospitals were Baby Friendly.

people in the slums buy foods that are already prepared or processed, and are more vulnerable to vitamin A deficiency due to poor vitamin A intake and recurrent infections. Here lies a major opportunity for improving the quality of diet by fortification with vitamin A, and other essentials for growth and immunity, including micronutrients.

Seven years ago, less than 20 percent of the salt consumed in India was fortified with iodine. India, it was believed, had nearly 300 million people living in iodine-deficient areas with an estimated several million people suffering from mental retardation due to iodine deficiency. With continued use of topsoil and environmental degradation over the years, studies have revealed that no state in India is free from iodine deficiency. Over the past 7 years, due to the concerted effort by the Salt Department of the Ministry of Industry, Ministry of Health and Family Welfare, and encouraged by the Ministry of Human Resource Development and other departments, including Railways and Transport, as well as with the involvement of private salt producers, more than 70 percent of edible salt in India is iodized, and the problem of iodine deficiency disorders, goiter, mental retardation, deaf mutism and other neurologic deficits are well under way to elimination.

Legislation is still incomplete, or lacking in Kerala, Tamil Nadu and Maharashtra. Paradoxically, the more progressive areas of the country seem to have taken this threat less seriously than others in spite of the presence of IDD throughout the country. The Prevention of Food Adulteration Act has been amended to define non-iodized edible salt as "adulterated". Attention is needed to assure that all the edible salt is iodized, bringing freedom from this totally unnecessary nutritional deficiency, not only to the entire human population of India, but to the domestic animal population as well. Continued vigilance and monitoring of iodine levels in salt at manufacturers, at inter-state transport, border crossing, at sales and at the household level are needed to assure the virtual elimination of IDD by the year 2000, an attainable goal over the next two years.

Micronutrient disorders, the common ones of vitamin A, iron, and less well defined, vitamin B, vitamin C and common minerals are best obtained through a varied diet, including a range of vegetables and fruits, legumes, dairy products, as well as staple cereals and calorie sources. For the large and rapidly increasing urban population, substantial parts of the diet are now provided through processed foods, or, as in rural areas, through centrally provided food stocks and public fair price shops, PDS. The increasing importance of processed food and centrally provided food staples highlights the potentials of fortification, which can be done economically and efficiently, wherever food is handled and processed at a cost which is indistinguishable and can be absorbed in the normal prices of food products. Investigation and definition of food fortification standards and the alliance with food-processing industry, as well as Food Ministry, offer important means of improving the diet of all Indians, especially children. Food supplements are a last but important recourse to diets deficient in the central nutrients.

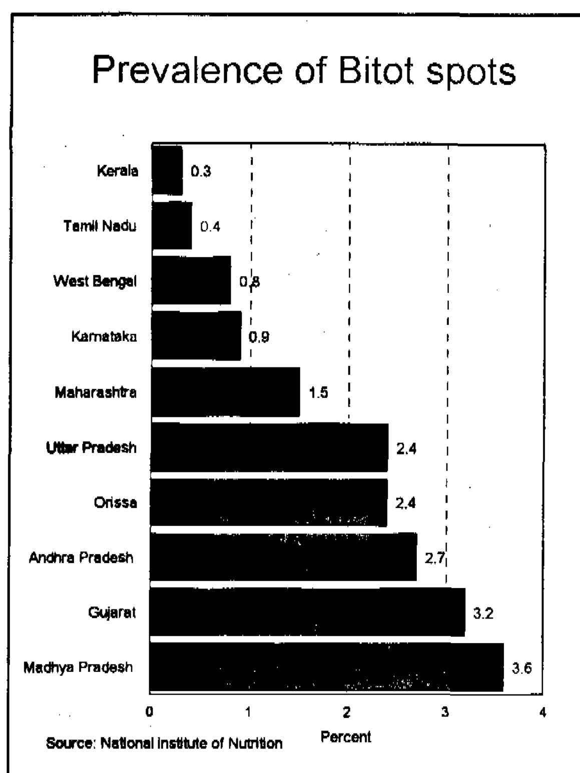
Iron can be provided through oral tablets ideally in women throughout their lifetime of menstruation in a weekly dose, easily affordable, costing less than Rs. 5 per woman per year. More severe deficiencies of iron can be treated through injected iron, or, in life-threatening cases, through intravenous iron injection, or occasionally life-saving blood transfusion.

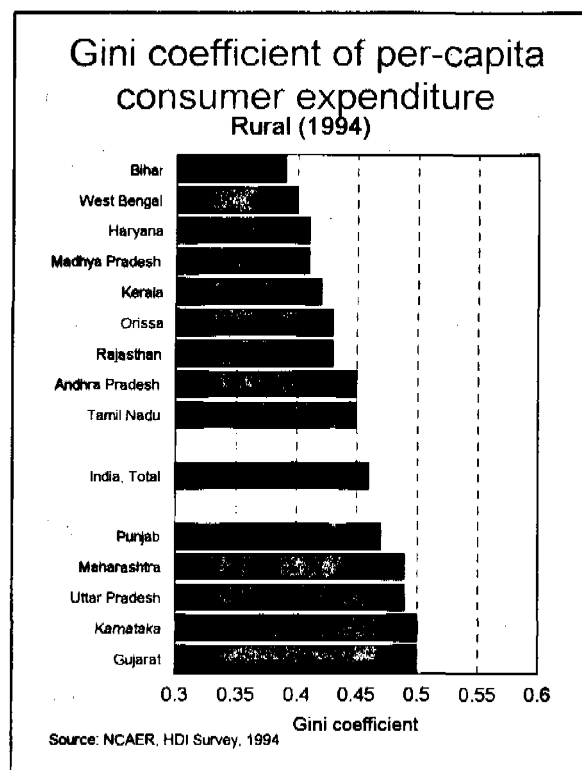
Iron is covered in the chapter on the situation of women, but it should be pointed out that anaemia that starts in childhood is particularly important to address during adolescence for girls. Inadequate information on levels of anaemia during adolescence and operational research to try out strategies for reducing anaemia and its implication for maternal nutrition and perinatal mortality would be a major priority in the next 3-5 years.

In many countries, a broad multivitamin supplement is provided to children during their preschool years, through preschool lunches, and particularly to pregnant women throughout their pregnancy, to assure optimal development of both the child in the womb as well as resilience of their mother throughout pregnancy. As Indian society improves its basic health, attention to such supplements will become an appropriate investment of individuals as well as society.

Household food security for all is a goal for the World Summit for Children, yet remains poorly defined. No doubt, the public distribution system with nearly 400,000 fair-price shops makes an important contribution to assuring that each family has access to essential food commodities at a fair price. The present government is considering measures to extend this system more widely, and to make its benefits more selectively available to the poor. It is estimated that if every poor family were to receive its basic needs in foodgrain from this system, 36 million tons would be required, compared with the current level of 22-23 million tons that get allocated with an offtake of 14-18 million tons. This includes the foodgrain that gets distributed to the many non-poor who have access to it.

The isolated tribal villages found in almost every state experience the greatest problem of food security. Not only is road access seasonal and often interrupted, but also these communities are more dependent upon their own production and activities of hunting and gathering in the forests, making food shortfalls and seasonal insecurity a chronic and widespread problem. In Orissa, some of these remote tribal areas have experienced periodic famine. Starting in 1992, and working with local NGOs, UNICEF assisted the district administration to establish grain banks in 906 villages, enabling those who required food in short seasons to borrow and replace, at a later time, essential grains for subsistence. These stocks have grown and the communities have





prospered, and are thus no longer vulnerable to the depredations of moneylenders, who had previously exploited these seasonal hunger periods. Out of this shared communal activity for food security have arisen joint efforts to eradicate literacy, to provide basic primary health care in villages through volunteers, and community savings schemes, freeing entire villages from bondage to wealthy moneylenders in the

Prevalence of Iodine Deficiency Disorders in Kerala State

No state in India, including coastal states such as Orissa, Tamil Nadu and Kerala are free from iodine deficiency. Surveys conducted by the Directorate of Health Services, Government of Kerala, during 1989-94 have show the prevalence of endemic goiter in all the 14 districts – with 13 districts being identified to have IDD as a public health program with total goiter rates of over five percent. There is an urgent need to take preventive measures before the situation worsens. Kerala, unfortunately, remains the only state in Southern India that has not yet mandated the use of iodized salt as an article of food. This has resulted in only high cost refined and free flowing premium brand variety of iodized salt being marketed in the state.

towns. This programme is expanding in Orissa, and provides a model for similar areas throughout the country.

The Integrated Child Development Services (ICDS) began as a scheme 23 years ago in an effort to rationalize the various feeding programmes for undernourished children into a single scheme that combined elements of health, nutrition and education. UNICEF has supported the ICDS since its inception in 1975. It is now in its final phase of expansion to reach every one of the over 5,200 development blocks of the country, providing prenatal services to pregnant women, immunization, supplementary nutrition, health education, care of children in the first year or two of life and preschool activities in local village *anganwadis*, usually accompanied by a mid-day meal for those aged 3, 4 and 5. The pace of expansion has often led to inadequate supervision and sacrificed the quality in this comprehensive child survival and development programme. The local women recruited as *anganwadi* workers, varying in educational backgrounds, are provided with a three-month training conducted by one of the over 300 training institutions run predominantly by voluntary agencies throughout the country that have trained the more than 400,000 *anganwadi* workers serving today.

The quality of training has been varied, and retraining much neglected, but for each 20-25 *anganwadis* is assigned a supervisor, a home-science or social work graduate, who is expected to upgrade skills and abilities throughout the year. The activities in the *anganwadi* have tended to focus on the preschool age group, and the provision of a small supplementary meal once a day. Nonetheless, in recent years, with close working relationships between health workers and *anganwadi* workers, and a growing appreciation of the critical goal of intrauterine nutrition, and child care in the first year of life, the nutritional component of ICDS is switching in a major way towards education and care of pregnant women, and of breastfeeding and complementary feeding practices in the first year of the child's life. This requires close and intensive interaction of health professionals to support and guide the *anganwadi* worker in this critical health and nutritional role.

In order to divert the natural attention given to preschool activities and the mid-day meal provided therein, the expansion *anganwadis* will now have to begin by enrolling a cohort of pregnant women, and focusing on their needs and those of their children as they are born and grow up, rather than initiating the entire programme from the outset. Thus, worker and community alike will need to recognize that activities aimed at improved nutrition during pregnancy and child caring practices in the first year of life are the first and fundamental priority of the ICDS in close collaboration with the local health worker, and that preschools would be initiated only as the children grow older, and the feeding component would be seen as the mid-day meal, rather than a substitute, or as often mistakenly termed, "giving nutrition" to all the children who are often already malnourished. This conceptual change in the functioning and priorities of ICDS will allow it to fit squarely into the health education continuum of the community, bridging the time of pregnancy and early life when nutrition and health are predominant concerns into early preschool and child development, preparing a child for successful entry into and completiòn of primary school. Thus, ICDS will become the linking programme at the community level between health and education, optimally bridging both of these important functions.

Among the challenges of ICDS are also the expansion to more effectively meet the needs of children in cities, especially those living in informal settlements.

3.4. The right to a safe and clean environment

A clean environment and adequate safe water are essential prerequisites for all children to develop and grow in good health. A child's environment is influenced by many factors, some within the control of the household and the community, some beyond their control. The most immediate environment is the family and the home, where hygiene practices, such as hand washing, latrine use and the safe handling of drinking water are critical. Outside the home, the child's environment widens to include the community, where safe water supply, waste management and drainage are crucial. Beyond the habitation, the management of land, forest and water has a direct bearing on the living conditions of the communities depending on these resources. A series of micro-watersheds makes up major watersheds, within which hundreds or thousands of communities live. Mismanagement of micro-watersheds in the upper reaches impacts on the environment of communities living downstream.

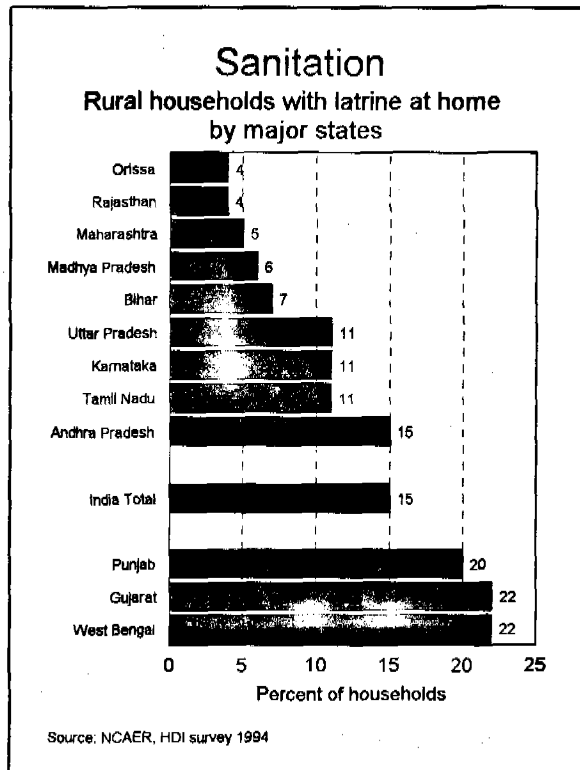
A child's water and sanitation environment may be perceived as a series of interdependent 'zones'. Centered on the child, these zones extend to the household, to the community, to the micro-watershed and outward to the macro-watershed. In order to ensure a child's right to clean surroundings and adequate safe water, it is necessary to protect and improve the environment at each level. Over-exploitation or mismanagement of natural resources leads to environmental degradation, manifested by declining ground water tables, contamination of aquifers, floods, droughts and falling crop yields. Such environmental decline has an adverse impact on the children living in these surroundings, impairing their health and retarding their development.

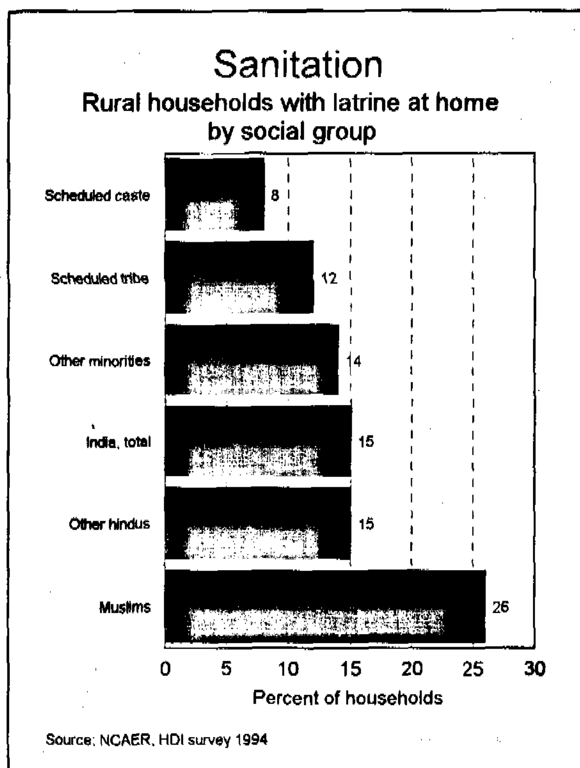
Social attitudes are at the heart of environmental concerns. Much of hygiene and sanitation is in the mind, rooted in conceptions of purity, pollution and dignity of labour. An individual's responsibility with respect to the disposal of waste remains particularly relevant. Governments have a vital role in establishing a supportive regulatory framework to protect rights that are vulnerable to being ignored or overridden by powerful interests. Schools as transmitters of values to the next generation become central; so too does media in its role of shaping what is acceptable social behaviour.

Well-managed and integrated water and sanitation programmes are crucial to a child's right to a safe environment. No longer can countries afford the narrow focus of water supply systems or latrine construction programmes. Sanitation must expand beyond latrine construction to include personal hygiene practices, safe water and food handling, garbage disposal, drainage and latrine use. Similarly, water supply must expand and incorporate elements such as community-based environmental protection of water resources, water point sanitation and sound management of the watershed, so as to protect and sustain the source. The explicit interrelationships between the quality of a child's environment and health, nutrition and caring practices have been explained earlier. Women, and their position in respect to household and community decision-making, emerge as critical to healthy environment at all levels — from household to watershed.

3.4.1. Sanitation and Hygiene

There is irrefutable evidence linking sanitation to health and nutritional status. Data collected in the late 1980s from eight countries in Africa, Asia and the Americas have reported the greater impact of improved sanitation, as compared to improved water supply. Improvements in water and sanitation together were synergistic in producing larger impact than either of them alone, particularly in rural areas. Studies in the eighties have shown that, improved quality of water was associated with a one-sixth reduction in diarrhoea. However, improvements in excreta disposal resulted in a one-third reduction in diarrhoea. Improvements in hygiene, primarily hand washing, were found to have as high an impact as excreta disposal. Besides reducing the incidence and severity of diarrhoea, the use of sanitary latrines also reduced the incidence of worm manifestations - ascariasis and hookworm. The highest rates of diarrhoea were found among urban children whose families did not have latrines, regardless of their water supply situation. Moving from no excreta disposal to pit latrines or similar faecal disposal systems was equivalent to a 44 per cent reduction in diarrhoea prevalence, while the similar figure for water was found to be much less.





At the field level, rural water supply programmes are not integrated with sanitation, nor are they integrated or coordinated with primary health care or education programmes. If the main objective of water supply and sanitation programmes is to contribute to better health, the focus of attention should move from water supply improvements to sanitation and hygiene practices. A programme that solely pursues water supply improvements will not achieve any significant health benefits for the population.

Relative to the attention given to safe water, sanitation programmes have had a very late start. Ten years ago, only three per cent of the households in India had a latrine. For some time it was thought that only a government programme providing subsidised household latrines could increase sanitation coverage. Consequently, there was hardly any emphasis on personal, domestic or environmental hygiene. It was therefore not surprising that the general population perceived little or no relation between sanitation and health. Open defecation was generally not seen as a health hazard. Convenience and privacy were the most important motivating factors for households opting to build their own toilets. A survey of 15 districts in as many states in 1992 indicated that, while a majority of households kept their drinking water containers covered, the positive effects of this habit were negated when people were seen to dip their fingers in the water while retrieving and using the water. Among households with a toilet, while most adult members were avoiding open-air defecation, use by children was still low. Cleaning hands after defecation was considered important, warranting handwashing with soap or ash. But for all other activities, such as cooking, serving food and eating, caregivers were only washing their hands with water.

There is now a distinct change in the strategy for promoting sanitation by the government. The Central Rural Sanitation Programme now promotes sanitation as a seven-component package: handling of drinking water, disposal of waste water, disposal of human excreta, disposal of garbage and animal excreta, home sanitation and food hygiene, personal hygiene and village sanitation. Investments for ensuring access to safe drinking water will bring the desired health benefits only when complemented by investments in all of the seven components of sanitation. Safe water use depends critically on the cleanliness of the

household environment and on the household's hygiene and sanitation practices.

The right to a clean environment is inherently the right to be protected from contamination by others. It is a collective value that must be protected collectively by the community, for a contaminated environment is harmful to all even though it may only be a few that infringes upon this right. Individual action is required, and to be encouraged, but it is broad community-wide adherence to desired behaviour that is essential. Thus, hygiene and sanitation are a matter of attitude as much as personal behaviour. While the use of sanitary latrines is a positive behaviour, a sanitary latrine alone is not in itself sufficient to make the environment protective. Related practices, such as hand washing, personal and public disposal of waste and attitudes towards the environmental space of others are also required.

Till recently, the focus in sanitation has been on hardware, initially on designs of sanitary latrines that proved expensive and of low priority to users. Increasingly however there is a shift towards appropriate and low-cost technologies. Rural latrine coverage is slowly increasing, from three per cent of the population in 1985, to 11 per cent in 1989 and to an estimated 20 per cent in 1995. It is encouraging to note the number of toilets constructed through private initiative. A comparison of data available from the census (1991), the HDI Survey (1994) and reports from MRAE, show that during the period 1991-1994, while 1.4 million toilets were constructed through the subsidised programme, the number added through private initiative was over six million. Data available from the HDI Survey of NCAER (1994) show wide variations in household latrine coverage among different social groups, with ST/SCs standing out as the most disadvantaged groups.

Recent years have seen initiatives at the local level (e.g. in the districts of Medinipur of West Bengal and Periyar of Tamil Nadu) when entire communities have worked together, often with the support of NGOs and government, to expand sanitation in their areas. In these areas, efforts have concentrated around the schools and among school-age youth whose involvement helps to change traditional notions of sanitation and public hygiene in households.

Increasing awareness and willingness to pay

Growing evidence suggests that effective communication of the benefits of ensuring proper sanitation within the household increases the willingness to pay for sanitation improvements even among very poor families. The success of the Rural Sanitary Marts points to the merits of different latrine designs at a modest profit, thereby reducing the need for large subsidies to all sections of society. Connected to a nearby production center, the mart provides concrete rings, slabs, pans and other equipment necessary for making latrines of various designs, starting with simple designs at Rs. 300 up to the more sophisticated twin-pit latrine with water seal that can cost as much as Rs. 4000. Local masons are taught how to construct all models. Even women have been trained as masons and may run the shop as well. In addition to latrines, the shop provides family hygiene supplies: brooms, soap, toothbrushes, and others. Now, in nearly 400 blocks, sanitary marts provide a profitable business, leading to improve sanitation and family hygiene.

Urban sanitation in crisis

More than a quarter of India's population, some 217 million people, live in the 3,768 urban agglomerations/cities/towns. The decade 1981-91 witnessed the urban population growing at an annual rate of 3.6 percent. The Lakahdawala Committee estimated that 40 percent of the urban population in India, 80 million people, live in abject poverty in slums or as squatters. Growing numbers of urban poor suffer from problems such as overcrowding and deplorable housing, while basic services such as drinking water, sanitation, health and education are often poor and sometimes lacking completely. As per the Planning Commission's estimates (1994), less than 20 per cent of the urban population has flush type toilets connected to a sewerage system, 14 per cent have water based toilets connected to septic tanks, 33 per cent have bucket or dry latrines and the remaining 33 per cent do not have any kind of latrine whatsoever. A study of 127 towns by National Institute of Urban Affairs indicates that one-third of the population was not covered by any drainage system. A similar study of 153 sample towns revealed that over 27 per cent of the waste generated in the towns remained uncollected and scattered on the streets; in some cases it exceeded 50 per cent.

The promotion of sanitation is shifting away from support for hardware to promoting behavioural change, supplemented by alternate delivery systems and appropriate market and credit mechanisms. This change is exemplified by the promise of substantial government commitments in the Ninth Five Year Plan, and the proposed adoption of a national Sanitation Mission.

The need for private initiative and community action is equally important in urban slums. Here individual behaviour intimately affects the well being of the entire community, and it is community action that is needed to establish expectations and enforce the norms of hygienic behaviour for the sake of common rights.

Urban slums and informal settlements present a challenge to sanitation, especially systems useable by children and women. Some positive innovation has been seen in the "slum networking approach" which is underway in several cities (e.g. Baroda) in which community residents provide up to 50% of costs for a comprehensive environment package featuring individual latrines, in partnership with the local government and NGOs. In cities throughout India as part of the UBSP community system, women are opting for individual sanitation in lieu of community toilets that do not meet their needs. In a 1996 study of community pay and use toilets in slum resettlement colonies of Delhi, it was found that less than 30% of children interviewed use such services, primarily due to distance from home. A national consultation on sanitation for women and children in 1997 sponsored by DWCD in association with both urban and rural ministries concluded that new strategies to more effectively meet the needs of children and women, the majority users in poor communities is required.

3.4.2. Domestic water supply

The use of adequate quantities of safe water is critical for the healthy growth of children. Vectors of many diseases breed in water: dengue, encephalitis, malaria and guineaworm. The use of polluted water transmits other diseases: cholera, hepatitis, typhoid, poliomyelitis and diarrhoea of all kinds. Adequate quantities of water are necessary to avoid dysentery, eye and skin diseases and other conditions that require bathing and personal hygiene. Water can contain toxins or unpalatable contaminants, resulting from industrial pollution, or from natural geo-chemical processes associated with ground water development. Whereas the better off can afford to buy the water they require and often do not think much of this need, poor people are continually vulnerable to diseases that arise out of the use of poor quality and inadequate quantities of water.

The success of drilling rigs and deep well handpumps

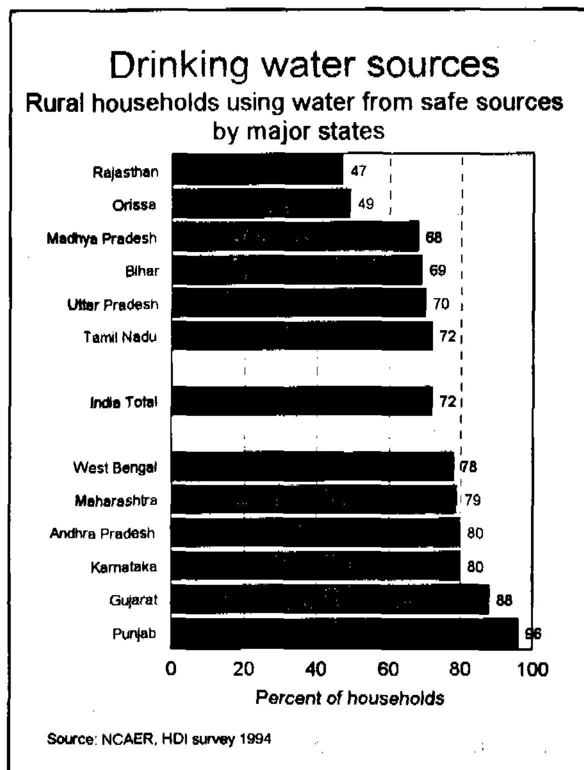
Handpumps

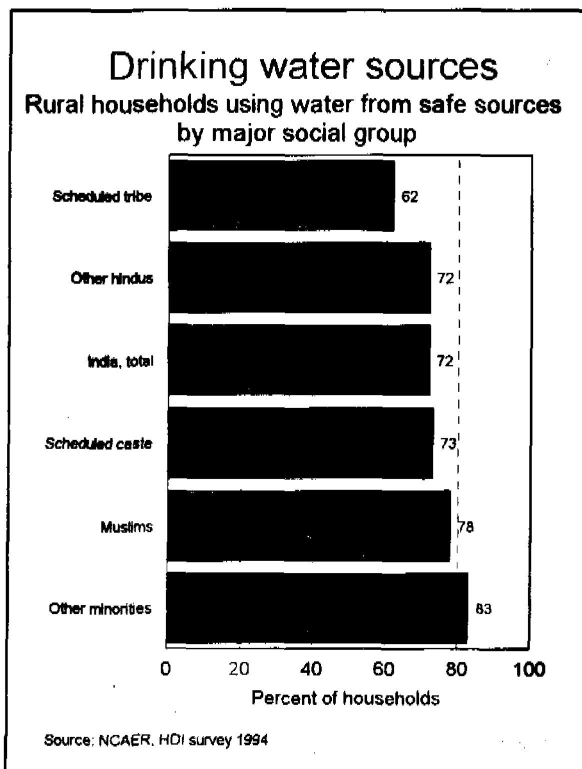
When UNICEF found, in 1974, that only 25 per cent of the deepwell handpumps installed in Tamil Nadu and Maharashtra were working, urgent action was needed. By 1977, the Government and UNICEF, working closely with NGOs, had developed a sturdy, cost-effective pump, suitable for local manufacturing in the large numbers required for the ambitious rural water supply programme. The India Mark II pump was standardised in 1980. From 1981 till 1993, UNICEF supported quality control of the Mark II pump purchased by the State Governments. By 1995, nearly 2.6 million Mark II pumps were in place in rural India - and the world's best known deepwell handpump was being exported to 40 countries.

Despite its popularity, the Mark II pump is not particularly easy to maintain, requiring special tools and heavy equipment even for routine maintenance. As the number of Mark II pumps increased manifold over the years, the burden of maintaining the large number of pumps became increasingly unmanageable. The importance of involving the rural users in pump maintenance was increasingly felt. So in 1987, the Mark III pump was developed, which allowed trained villagers to do most of the routine maintenance. In 1990, the TARA pump was introduced for shallower pumping depths, which is still easier for trained villagers to maintain and repair. At present, the development of the Mark III pump continues, aiming to reduce the current high cost of the pump.

Drilling rigs

In 1969, UNICEF commenced assistance to the Government for the drilling of wells in the hard rock which underlies about 70 per cent of the country. From 1979, more versatile, hydraulically powered rigs were imported for faster drilling and better quality bores. During the 1980s, considerable efforts were made to manufacture these rigs in India. Since 1989, all the drilling rigs used in the rural water supply programme are indigenously produced, allowing UNICEF to phase out assistance for the supply of drilling rigs. Of the 150,000 borewells drilled in 1995, 161 UNICEF supplied rigs and 645 Government supplied rigs drilled about 20 per cent, while the remaining 80 per cent were drilled by privately owned rigs, contracted by the State Governments. UNICEF is gradually phasing out the supply of imported spare parts for the UNICEF supplied rigs.





Coverage and use

The country's success from the early eighties in providing basic access to safe drinking water throughout the country is reflected in the fact that 89 per cent of all habitations have access to such a safe source of water.

The national Habitation Survey (1991-94) by the Rajiv Gandhi National Drinking Water Mission (RGNDWM) revealed that 56 per cent of India's 1.32 million rural habitations had access to safe water, as per the norms of 40 liters per capita per day (lpcd) within a horizontal distance of 1,600 meters, or, in the hills, a vertical distance of 100 meters. Another 33 per cent had access to a safe water supply providing less than 40 lpcd. Eleven per cent of habitations remained without a safe drinking water source. Of the population served by public water supply schemes, about 70 per cent are served by handpump technology, while 30 per cent get their water from piped schemes.

The mere physical creation of a safe water source in or near a habitation does not always result in the use of safe water by all households of that habitation. For convenience sake, households will often use nearby polluted sources, rather than more distant safe sources of water. Physical barriers, social considerations of caste and class and other factors can also deny access. It is therefore common to find that even within communities that are on record as 'fully covered', smaller or larger numbers of households still do not use water from safe sources throughout the year. The NCAER HDI Survey of 1994 reports that 72 per cent of households report taking their drinking water from a protected source. This figure, which includes sources created through private initiative, contrasts with the full and partial coverage through public water sources of 89 per cent, as reported by the Habitation Survey conducted by RGNDWM in 1994. Government programmes for rural water supply specifically aim to reach disadvantaged groups such as Scheduled Castes and Scheduled Tribes (SC/STs). At least 35 per cent of the central government rural water supply programme funds must be used for SC/STs.

The HDI Survey of 1994 indicates that safe water use among the Scheduled Castes is virtually the same as for the rest of the rural population. However, safe water use among the Scheduled Tribes lags country coverage to some extent. This is probably a reflection of the remoteness and inaccessible terrain of the areas where the tribal population lives.

The results of the Habitation Survey pointed to the re-emergence of more than 150,000 habitations without a safe source of drinking water. Reasons given are the exclusion of private safe water sources from the survey, falling water tables leaving sources dry, malfunctioning of water systems and the inclusion of multiple habitations which were earlier on record as single villages.

Guineaworm eradication

GOI/UNICEF cooperation for the eradication of guineaworm disease started in 1984. Impressive gains have been made in the twelve years since. India reported zero cases stage in 1997. Total eradication of the disease can be declared after a three-year surveillance period, provided no new cases are detected. Guineaworm cases have declined dramatically, from 39,792 in 1984 to zero cases in 1997.

The successful containment and imminent eradication of guineaworm in India illustrates many lessons for a broader and more integrated approach to the environment. Intersectoral action in the endemic regions of Rajasthan, Madhya Pradesh, Karnataka, Maharashtra, Andhra Pradesh and Gujarat, including safe water supplies, community mobilisation, effective case surveillance and guineaworm extraction, contributed to an effective response to an age-old scourge.

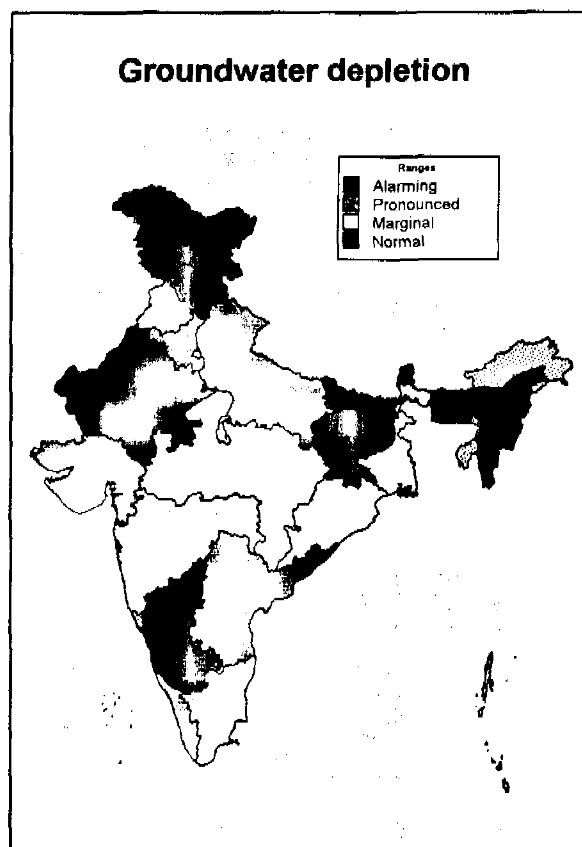
Ground water management

Groundwater is the source of 80 per cent of domestic water supply and possibly half of urban and industrial uses. Groundwater is of fundamental importance to agriculture, especially in periods of drought when it is the primary reliable source of irrigation. Management of this resource is therefore of crucial importance to domestic water supply, food security and economic development.

Annual water precipitation in India is estimated to be 400 million hectare meters, 75 per cent occurring during the four monsoon months. The country is using only ten per cent of its annual rainfall and it is expected that even after another 40 years use will go up only to around 25 per cent. To that extent, the country has a rich water resource base. Current annual requirements for domestic use, based on 40 lpcd, are estimated at 13.5 million hectare metres of water, less than four per cent of the total annual precipitation.

Groundwater levels are decreasing worldwide. Fresh water requirements are increasing at double the rate at which the global population is growing. While groundwater levels are also declining in major parts of India, the extent varies from one region to another. Water levels are particularly affected in drought-prone areas and in places where there has been over-pumping for agricultural or industrial needs. Although areas in many states are affected, there is serious groundwater depletion in Rajasthan, Uttar Pradesh, Andhra Pradesh, Punjab, Kerala and parts of Gujarat.

Declines in groundwater tables are not due to handpumps or excessive pumping for domestic purposes. Most groundwater development has been through private investment by millions of individual farmers. Availing of institutional credit and encouraged by subsidised energy supplies, there are now 17 million energised wells, supplying more than half of the irrigated area. This compares to about 2.6 million handpumps on deep borewells for domestic water supply in the country. Declining ground water tables are more pronounced where there is heavy pumping of water for industrial and urban use. The use of submersible pumps and the subsidies for the electricity used to power these pumps encourage the uncontrolled and unsustainable exploitation of groundwater. The uncontrolled abstraction of water for irrigation can reach critical stages



more quickly where water is drawn from hard rock strata underlying most of the country, as these strata contain only comparatively small quantities of water.

Private trading in ground water exists in many parts of the country. These water 'markets' function in a legal vacuum and there is little information on the forms these markets take under different environmental conditions. Prices are mostly related to pumping costs and profit margins, which vary depending on the level of competition. Sellers are mostly larger landowners, taking advantage of their de-facto control over the water beneath their land and usually availing of loans for wells and subsidies for power, sell water to their less resourceful neighbours. Presently only relatively small quantities of groundwater are traded and overall impact is probably negligible.

Deforestation and environmental degradation reduce the natural recharge of groundwater. Although artificial recharge of ground water and watershed development have been initiated in many states, efforts have so far only had an initial and tentative impact on the overall environmental condition and on groundwater levels in the rural areas. Surface ponds and percolation tanks have high rates of evaporation, while infiltration often decreases because of siltation and clogging.

To sustain the borewells with deepwell handpumps, on which about half the rural population depend for their drinking water, it is imperative to halt and reverse the decline in ground water levels seen in many areas.

Environmental considerations

The uncontrolled exploitation of ground water resources has profound long-term environmental consequences. India has about 30 major enactments related to the protection of the environment, which are administered by the central and state governments. The Environment (Protection) Act of 1986 is an umbrella Act for the protection of the environment. Relevant to the water environment, this Act has (among others) the following features:

- nation-wide programme for prevention, control and abatement of environmental pollution;
- empower any person to enter, inspect, sample and test;
- establish/recognise environmental laboratories;
- regulate, close, prohibit industries, processes, operations;
- require governments, organisations and persons to furnish information; etc.

The jurisdiction of civil courts is barred under the Act. The Central Pollution Control Board is the national apex body for assessment, monitoring and control of water and air pollution. The Board carries the executive responsibilities

The water quality challenge: Fluoride, arsenic, iron and saline

High levels of fluoride in groundwater is a serious problem, particularly in arid and semi-arid regions, placing at risk some 25 million people throughout the country. There is some evidence to suggest that large-scale abstraction of groundwater from hard rock strata is associated with increased fluoride levels. Excess levels of fluoride impart no particular smell, taste or colour to the water. Insidiously, the use of such water affects the health of the user. Resulting medical problems are dental fluorosis, skeletal fluorosis (causing crippling deformity of the bone joints) and several problems related to the soft body tissues, such as muscles, erythrocytes, the gastro-intestinal system, etc. Defluoridation units fitted to handpumps have been tested in several states. Although the technology is effective, regular maintenance poses problems, leaving most of the handpump-attached defluoridation units defunct. The installation of new handpump-attached units has now been halted. Research to develop a defluoridation filter for household use is continuing. Government efforts to control fluorosis center on the provision of alternative water sources free of excess fluoride, usually piped water schemes.

In many parts of the country, ground water contains excess iron. Water rich in iron stains food and laundry. The water has a foul smell and a bad taste, and people reject these sources for drinking purposes. Simple techniques have been devised to remove the iron from water at the handpump. But these removal tanks require regular maintenance, which neither the water agencies nor the user communities provide. More often than not, iron removal plants are disconnected and left unused. This results in the paradoxical situation that the handpumps in these areas are used for bathing and cleaning utensils, but drinking water is taken from unsafe but more palatable sources, such as dugwells or ponds.

High arsenic content in ground water has been reported in eight districts of West Bengal, where four million people are potentially at risk. Chronic arsenic poisoning leads to a host of medical problems, with melanosis, keratosis, and skin, liver and renal deficiencies and cancer.

In the often densely populated coastal areas, saline intrusions resulting from groundwater extraction are widespread. Chennai city, for example, now relies on water supplies from very distant sources, after no additional local fresh water resources were available. Here, the unreliable and inadequate supply of water often leaves large numbers of people dependent on water-tankers, particularly when the monsoon rains are less than normal. Even in Haryana, far from the sea, the water quality in many areas is declining as over-pumping draws native saline water into fresh water aquifers.

for enforcing the Acts for Prevention and Control of Pollution of Water (1974) and Air (1978). Twenty-three states/UTs have adopted the Act and State Pollution Control Boards have been constituted. The Ministry of Environment and Forests promotes environmental awareness and disseminates information through the Environmental Information System network.

The environmental implications of large-scale groundwater development in the country are rapidly emerging. Increasing areas are affected by groundwater overdraft. Dropping groundwater tables resulting from large-scale groundwater development can have a major impact on the flows of surface streams. Unless base flows in rivers are maintained, downstream users can lose access to water at critical times and pollution of both surface and groundwater is likely to increase. Overall, to avoid adverse environmental impact while increasing groundwater development requires a high degree of information and analysis of the complex river and aquifer system dynamics.

Groundwater drawn from deep strata is typically free from bacterial contamination. However, a large proportion of the handpumps installed on deep borewells provide water which is bacteriologically contaminated. The physical environment around the handpump, the frequently broken state of the platform and the accumulation of waste water nearby the handpump can easily contaminate the water in the borehole, particularly when unlined borewells in hard rock lack a proper sanitary seal. It is the responsibility of the government water agency to ensure that proper well construction techniques are practiced, including the proper siting of the borewell away from potential sources of pollution and the sanitary sealing of borewells. Community action can help by ensuring proper drainage, by keeping the pump environment clean and by securing early repair in case of damage to the platform.

Natural groundwater may contain dissolved minerals. The type and concentration of minerals in groundwater depend on the contact time, the hydro-geological strata through which the groundwater percolates and on various other parameters of water quality. Large-scale groundwater development results in changes in the water chemical balance, often increasing the concentration of certain substances beyond acceptable levels.

Groundwater pollution represents perhaps the principal groundwater management challenge. While Center and State Pollution Control Boards focus on pollution caused by industrial and municipal effluents, pollution from agricultural fertilisers and pesticides is in all likelihood a far more formidable challenge. In India, the use of chemical fertilisers is reaching levels commonly found in western countries. There is, however, virtually no data on water pollution from fertilisers and pesticides. Groundwater pollution or quality decline can reduce water availability, which are far less easily reversed than overdraft.

Legal framework

The underlying problem is that water is generally not perceived as a limited commodity. Rapidly increasing agricultural, industrial and domestic needs compete with each other for the limited available fresh water resources. When large-scale deep tubewells draw down the water table underneath surrounding communities, they are tapping a resource that, by rights, belongs to others. Yet there is nowhere in place a strong legislative and pricing framework to regulate and manage water as a common property and resource, so as to arrest and reverse the present trends towards uncontrolled, unsustainable exploitation.

The Constitution of India allocates to the States the full authority over water within their borders. Under common law in India, extraction of percolating water is the statutory right of every landowner. The legislative role of the central government has been limited to the development of model groundwater legislation, in the form of a National Water Policy (1987) prepared by the Ministry of Water Resources and the 'Model Bill' drafted by the Central

When a woman rides out...

A woman mason? A woman handpump repairer? For conservative rural India, most will say impossible. Yet this is reality in some remote interior villages of Uttar Pradesh, in Banda district., a region otherwise known for grossly low literacy rates and bandits. Today one can see revolutionary sights as women on bicycles, riding from village to village, for repairing and maintaining community handpumps. Or one finds a woman deftly building a concrete and granite house, on contract for a fellow villager. The money that the work brings in is of course important. But more important is the new knowledge and skills that have improved the quality of life for them and their families. Now there is a registered cooperative of women handpump mechanics and masons, called Vanangana, which was recently given a contract by U.P. Jal Nigam to repair and maintain all handpumps in one block of Banda.
(*Adapted from a newspaper article by Subhadra Menon*)

Ground Water Board.

The Model Bill takes a centralised, regulatory and technical approach, while socio-economic-political aspects are largely ignored. Similarly, the scope of the Bill is largely confined to the regulation of groundwater extraction, while related considerations of water pollution, conservation, efficiency in use and other environmental considerations are largely overlooked.

Groundwater in India is reaching a crossroads. While recognizably highly political, the challenge is now to make the transition from ground water development to environmentally sustainable management of groundwater resources. Major new initiatives are needed to address the increasingly adverse impact of groundwater development, if the right to an adequate supply of safe water for domestic use is to be enjoyed by all, now and in the future.

Community participation, women's empowerment and sustainability

Programmes to conserve and enhance watersheds and recharge ground water are currently undertaken by state governments and NGOs. The Government of India issued common guidelines for watershed development in 1994-95. These guidelines unequivocally recognize that, for watershed development programmes to have a long-term sustained positive impact, the programme must be founded on community organisation, participation and contributions with external agencies, including government departments, in a supporting and facilitating role. There is as yet no substantial evidence that these guidelines have been wholeheartedly adopted in watershed management programmes in the states.

The rural water supply programme evolved from drought relief and drought proofing measures in the late sixties and seventies. As such, it was considered unnecessary to involve the user communities in the provision of services. Gradually, the free provision of water supplies by government gained political acceptance and priority as a vital component of the welfare state. As a result, the users of handpumps will usually inform that the handpump belongs to the government that has done nothing to ensure proper drainage or platform maintenance and repair. This is a reflection of the lack of community participation in the rural water supply programme in the country. By not involving the future users in the planning and construction of community water supplies, it is but inevitable that community members look upon the village handpumps and piped water schemes as government property, for which government is responsible and which users can use and abuse at will.

Gradually though the importance of community action is becoming apparent with the emergence of water and sanitation committees in different parts of the country. These committees function within the *Gram Panchayat* and help to plan and manage water resources. Although equal participation by women is still a distant dream, there is in-

Handpump maintenance - working towards a community-based system

A three-tier maintenance system introduced in 1976 is still in use in many parts of the country today. It consists of a mobile repair team at district level (for 500 pumps), a trained mechanic at block level (for 100 pumps) and a caretaker (for one pump). The entire system is managed and funded by government, with little or no involvement or participation by user communities.

From 1986, an alternate system was introduced, whereby local people were trained as pump mechanics, and equipped with tools and spares. From 1988, women were trained as pump caretakers and mechanics, with resounding success. The concept of women caretakers and mechanics has since been replicated in small demonstration projects in most of the major States.

Community Based Handpump Maintenance - Key Factors for Success

- Village management through Water Committees, under the umbrella of the *Gram Panchayat*.
- Wherever long-term NGO support is assured, one caretaker (preferably a woman) for each handpump: responsible for routine maintenance, reporting breakdowns to the mechanics or government authorities, keeping the area around the pump clean.
- One mechanic, preferably a woman, for several handpumps: for most repairs.
- The mechanic is paid for the work (s)he completes.
- Government back-up for major faults, which mechanics cannot fix.
- Intensive training and re-training of Committee members, caretakers and mechanics.
- The users and/or *Gram Panchayat* meet(s) the cost of handpump spares
- Active management by Government essential.
- Use of village-friendly pumps and tools.
- Cooperation of Government Water Agency and NGOs: community mobilisation and organisation by NGOs, community capacity building jointly by NGO and Govt. water agency; drilling of wells and installation of pumps by the Govt. water agency.

creasing recognition of the need to ensure maximum participation of women in the Committees. Women need to influence the decision on location of water sites and be actively involved in the planning of such supplies.

The Constitution (Seventy-third Amendment) Act, 1992, provides for the delegation of powers and responsibilities to the *Panchayati Raj* institutions, including the responsibility for drinking water, minor irrigation, water management and watershed development. While some states are adopting the principles of the Act in full, other states have chosen to ignore major stipulations of the Act. Even where states have moved to transfer responsibilities for rural water supply operation and maintenance to the *Panchayats*, it has often been done without creating adequate capacity and ensuring sufficient resources within these *Panchayat* bodies to cope with these new responsibilities.

Villagers who have participated in the choice of the tubewell site and provided volunteers to be trained in its maintenance, own the well and keep it working more effectively than those serviced by distant government employees. Women who can repair handpumps by themselves feel empowered, not only by the reliability of their water supply, but also by the new skills they have learned as mechanics, breaking the stereotype of their own helplessness in the face of men's contraptions and inventions.

Factors facilitating a greater degree of community participation include a supportive policy environment, inclusion of community participation from the inception of a project, adequate institutional arrangements, functional village level institutions, active participation of NGOs, and proper assessment of community needs and preferences. While community participation is very important for the ultimate outcome of projects, it is not a panacea solving all problems as it is but one of several factors that affect ultimate outcome and long-term sustainability.

A completely different aspect of popular participation in the provision of safe water is through the legal system. In recent years, public interest litigation has been brought to the courts, seeking compensation for rural people who, through their use of water with excess fluoride from government installed tubewells, have suffered irreversible skeletal damage. Other litigation has sought to limit water pollution and to maintain base flows in major river systems. As reasonable access to safe water is increasingly seen as a right rather than a privilege, increasing public awareness may have more and more communities and concerned individuals seeking redress through the courts.

Women, water and healthy environment

Access to water sources has implications for the time and energy spent by women. Time released by improving access to water often means more time available for food production related activities, income generation, leisure and self-development. This has a potential impact on the health and nutrition of women and children. Studies in mountainous areas have shown that women save up to three hours a day when water sources are provided close to their homes. Energy savings in the range of more than 300 kcal have been documented (UNICEF, 1993). Where the provision of water is done in conjunction with hygiene education and improved sanitation, the impact on health and nutrition is likely to be high.

Traditional and alternative systems of water supply

Neglect of traditional systems and their disdain for anything managed by the people, meant no effort was made to revive the traditional water harvesting systems or build new systems in ways that complemented traditional systems. Traditional systems to harvest water for domestic purposes continue to have relevance today, particularly in areas where ground water is not available or where water quality problems exist. In some areas, traditional systems can provide an essential supplementary source of water, used when piped schemes or borewells run dry during certain times of the year. Traditionally, people in water-scarce areas used their limited available water judiciously, but now these practices are fading. Water conservation education is a necessity in the country. The revival of traditional systems depends on the ability of water supply programmes to base solutions on the needs and capacities of the users, requiring social rather than technical engineering skills.

Indigenous management innovations are not limited to the range of traditional practices, which have been in use for hundreds of years. Local communities have developed many water management innovations relatively recently, in response to newly emerging problems arising from new technologies used in ground water abstraction. Such local responses include collector wells with multiple horizontal and

vertical bores, ponds to store water for use when electric power fails, underground pipes for irrigation and collection of monsoon run-off water in dug wells.

3.4.3. Adequate safe water and sanitation for all: Future directions

With regard to the environment, rights and responsibilities are clearly inter-related. The right to a safe and healthy environment cannot be bestowed by governments on a passive population. Concomitant with the right to live in a healthy and unpolluted environment, families and communities have responsibilities and obligations to maintain and sustain their environment and refrain from unsustainable exploitation and pollution. Communities and individuals are obliged to actively strive to ensure that their rights to a clean and healthy environment are realised and sustained.

The perenniality of a community's water supply depends on the proper management of the local watershed. However, the management of the watershed beyond the community's environs is in the hands of others.

Flora and fauna, irrigation, agriculture, industries, urban centers and the rural masses all compete for a finite water resource. Individual households and communities have a right to the water beneath their lands. However, this right may be abrogated by competing users if they over-exploit or pollute the water resources that are freely at their disposal. The current link between land ownership and the right to use the underlying ground water and the absence of defined rights of the landless to ground water is a major constraint in the development of management structures. Until public awareness and political commitment to accord first priority to domestic water supply eventually ensure that relevant legislation is enacted and enforced, the more resourceful will continue to use water at will, infringing on the rights of less resourceful community members.

- **Fulfilling rights**: While nearly **90** per cent of the rural population have access to safe water, only about 60 per cent have access to at least the minimum quantity of 40 liters per person per day. Over the coming years, priority needs to be given to ensure access to at least the minimum quantity for the entire rural population. As regards sanitation, people should be offered a range of low-cost technological options with a varying price tag so that the poor and disadvantaged can afford to have a toilet of their own. Providing toilets in girls' schools and in those with coeducation can facilitate a girl child's right to basic education.

- **Enhancing rights**: For habitations with access to the necessary minimum supplies of water, future investments are needed to enhance the levels of service: from 40 to 55 liters per person per day, from 1,600 meters to the safe water source to 500 meters, and from 250 users per supply point to 150 users. Similarly, establishment of alternative delivery and credit mechanisms should go to scale so that those who wish to have toilets and other sanitary facilities and services have easy access to the required materials and know-how. Such improved levels of service will require tremendous investments, which the Government is unlikely to have available. Increasingly, there will be a need to generate resources from outside the government: from the private sector, NGOs but also from the users of such improved services.

- **Sustaining rights**: realising community participation in the operation and maintenance of the widely scattered rural water schemes has proven extraordinarily difficult. Nevertheless, the user communities need to assume major responsibilities to sustain public water supplies. Government responsibilities will evolve from providing and managing basic services to facilitating community action, well rejuvenation and the replacement of worn-out pumps. Concerted efforts must be made to achieve sound management of groundwater resources at all levels. In the absence of effective people's participation in the management of groundwater, the rich and powerful will chase falling groundwater levels by drilling increasingly deeper wells, leaving the poor without access and facing the adverse environmental consequences of groundwater overdraft. For sanitation, hygiene education and social mobilisation should be an integral part. Attempts should be made to make sanitation a way of life.

- **Giving meaning to rights**: a significant proportion of the water sources considered and promoted as safe are in fact polluted with bacteriological or chemical contaminants. Water quality concerns require to be

given increasing attention in the coming years. Provision of toilets alone does not guarantee its utilisation – particularly by children. How to ensure use of toilets by all members of the family should be an important thrust area.

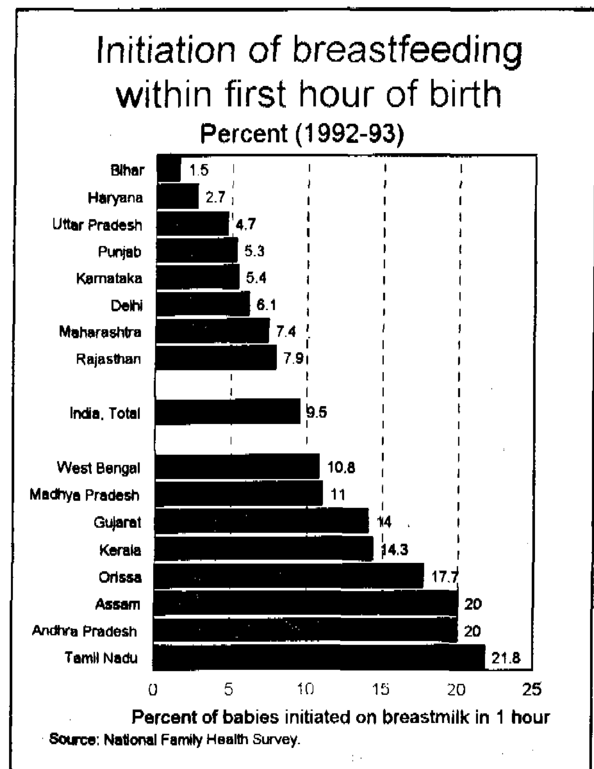
- **Equal rights for all**: while expanding water supply and sanitation services, care is needed to safeguard the rights of vulnerable and disadvantaged groups, particularly Scheduled Tribes, the rural poor, the urban poor in informal settlements and resettlement areas, communities living in remote areas, and those without access to a minimum supply of safe water, throughout the year.

3.5. *The right to development*

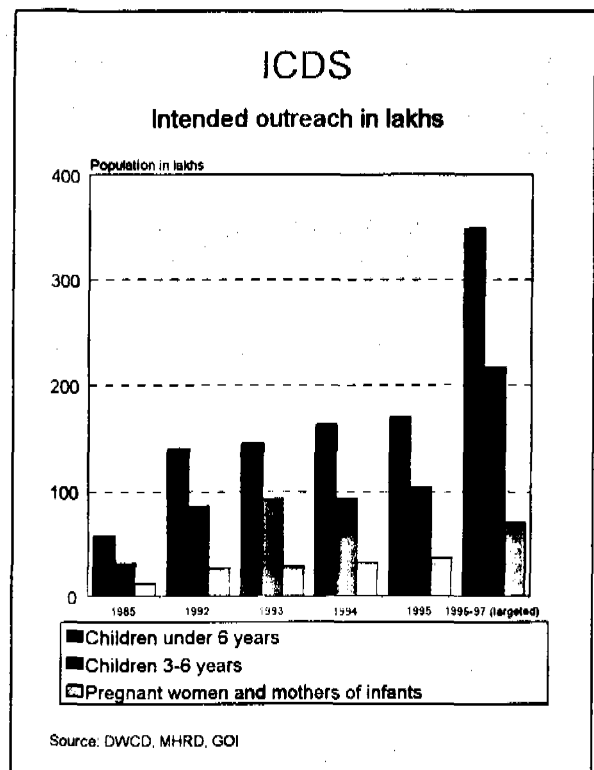
The right to development of every child begins in the womb, and continues through birth and early in childhood, and is intimately related to the well-being of the mother and caring practices affecting women at earlier stages of their lives. The fulfillment of the child's right to development calls for fulfillment of child's basic needs for protection, health, food, care and affection, security, interaction and stimulation, and learning through exploration and discovery in an environment that is safe and nurturing. The right to development also includes the important right to primary education. Of all the rights, this last is perhaps the least controversial but the least close to achievement at the present time.

Despite being guaranteed to all children in the Constitution, the right to complete primary education remains the right of relatively few. Paradoxically, the benefits of primary education (as with education at higher levels) are highly desired and sought after by those whose children are presently in school where it is perceived as a right. It is not perceived as a right for those children who either fall outside it or are never enrolled, or drop out. Many if not most of these children find themselves in one form or another of child labour. The right to primary education is still an exclusive right that is only gradually becoming broadened. It is a right closely tied to notions of equity, with contrasted achievements in providing access to a reasonable quality of primary schooling, an important measure of equality of opportunity across different groups.

The right to development is a right that should eschew gender bias; a girl has the same right as a boy to attention, stimulation of talents and potential and development of her personality. Yet the rights of the girl child are so often neglected. As noted earlier, differentials begin in terms of feeding and care seeking practices. Later, the girl child should have the same right to primary schooling as her brother. Yet so often it is the girl who is not enrolled or drops out after class one or two - not even having acquired the basic skills of reading and writing. She must remain at home to work, while her brothers enjoy school and play. While some progress has been made, particularly in the last five years, the girl child remains strikingly disadvantaged in her right to schooling. The right to development includes the right to achieve full development potential of children who are either born with or acquire physical, sensory or mental disability.



Source: National Family Health Survey.



Source: DWCD, MHRD, GOI

3.5.1. Right to early childhood development

Much of the early support needed by the child comes first from the parents and the immediate family environment. However, parents and society, including government share the obligation to ensure the child's early development. Mothers more than fathers play a crucial role in the first few days and months of a child's life. For a newborn child, the care and comfort, physical and emotional, are crucial. Babies need to be carried, cuddled, talked to, and sung to. Should fathers take on the joy of such early care, with sons or daughters alike, the resulting bonding would do much to redress the neglect of girls, as they grow older. The important place of early childhood is well recognized in Indian culture and society. In traditional societies, this was the minimum that babies would receive. The pressure of poverty with changing family structures, and the lack of knowledge this leads to, rob many families of the opportunity to realize this basic right. Gender inequality sharpens this loss for girls.

Practices surrounding childbirth cast long shadows. Failure to breastfeed within an hour and separation from the mother diminishes bonding and establishment of exclusive breastfeeding. Rejection of colostrum can deprive the child of vital reserves of vitamin A, as well as the important immune protection it provides.

Differences in infant feeding practices between boys and girls lead to girls being weaned earlier. Paradoxically, being taken off the breast early may favour girls' nutritional state as exclusive breastfeeding, beyond the desirable 6 months, may deprive the boy of needed complementary food to avoid malnutrition. The girl may receive low status food, but if given with adequate frequency and amount, the resulting better nutrition is serendipitous.

Adequate care and attention for the very young child becomes increasingly difficult where mothers in nuclear families work, especially in urban areas. In the organized sector this calls for provisions of maternity leave; at present the law provides for just three months paid leave, but to enable proper exclusive breastfeeding to six months, it should be extended in duration. Mechanisms should also be extended to the very large number of women working in the unorganized sector. The Pay Commission for Central Government Employees has indeed made recommendations for extending maternity leave to its employees but implementation is still a far cry. The absence of proper crèches and day care centers gives rise to reliance on child care providers, many of whom are untrained or entrusting the care of the young child to older siblings, most often girls who themselves are then often obliged to forego or abandon schooling to look after their younger brothers and sisters. With limited time and resources, the larger share goes to the boy, to the detriment of girls at all ages.

The growth of a child to infancy and beyond through the first three years of life requires special age-specific opportunities for development, as well as concerns of health, nutrition, and hygiene discussed earlier. Early childhood development at this stage calls for greater attention to play activities that build self-esteem, develop fine motor skill and skills in physical discrimination. Equally important is the "bonding" and development of relationships between the child and caregiver, and also amongst peers, resulting in emotional and cognitive development, apart from socialization. It is at this crucial stage in a child's life that the seeds of personality formation are sown.

The Integrated Child Development Services (ICDS) needs to be designed so that it can cover this vital period of early growth and development in way that is appropriate to the age of the child. The worker needs more knowledge in the importance and methods of early childhood stimulation and care that must be imparted to new mothers in the privacy and quiet of their own home. Parents and especially mothers need to be encouraged and supported to ensure her child is receiving 'needed care' and stimulation at home. Ideally, an *anganwadi* should not start with an *anganwadi* feeding center for the older children, but the *anganwadi* worker could spend the first months with mothers who have young children under three months, informing them about caring practices, answering questions on feeding etc. As the children mature, the focus would enlarge to early stimulation and health needs of the very young child. Six months is the age when growth faltering takes place, so attention to monitoring growth is particularly important and the link with health services for immunization and management of childhood illness. As this cohort of children reaches age one, stimulation for recognition, language development and imparting of skills in home play will have to be carried out along with changing of the diet.

By the age of three, an *anganwadi* center could then be established with the participation of the parents who the *anganwadi* worker has come to know well. ICDS, as a result of relevant interaction from the child's birth, then becomes a center for early learning and preparation for socialization and school. Currently, 11.5 million children in the age group 3-6 years participate in various activities at the *anganwadi* center against the child population of almost 100 million in that age group, in the 4,200 ICDS blocks that are functional. The period between the ages of three and six years is one of rapid physical and mental development when the child begins to assert as an individual.

This might be the time when two individuals become needed in the ICDS structure; one to continue the work with the next generation of mothers with their newborns and infants, the other to continue the development of the *anganwadi* into a preschool center, linking up now with the primary schoolteacher and getting the child familiar with routines and behaviours needed to help learning in school. Depending on the way the community perceives the benefits of the *anganwadi*, the second functionary could very well be a community-supported resource.

Anganwadis need to be linked both functionally and physically, with primary schools for providing a transition from the family environment to the primary school. This will enable helpful suggestions and supervision by experienced teachers of the *anganwadi* worker in her preschool education activities, and at the same time, enable young children to be left in the *anganwadi*, while older children, especially girls attend primary school. The preschool function of the *anganwadi* needs to be thought of as a direct link to the primary school, and everything possible to strengthen the development and learning continuum across the young child's life encouraged.

Early childhood is also the most appropriate time to identify and address disability, physical as well as mental. Early detection of physical and learning disabilities is critical for initiating the special kind of care that can be provided in the home to ensure that the child develops to his potential. It is also the time when it is most appropriate to instill in such children a sense of confidence to overcome a challenge rather than learn to live with a disability.

Change in early childcare practices is not easily brought about, especially as the above calls for fathers to share and assume responsibilities of the family far more than they have in the past - particularly for the period when the child is very young. One way to attempt this is to target newly-weds with information important for them. By reaching them together, at a time when the couple moves to forming their family, both husband and wife are much more likely to be receptive and open to advice and counseling. This is a time around which incentive schemes can be built to encourage appropriate timing of the first child, spacing for the next child, address issues related to weight gain during pregnancy and detect and treat anaemia in a young woman, create positive attitudes towards the girl child; and when the child is born, provide helpful advice for the first days, on holding the baby, putting the child immediately to the breast, and advice for stimulation during the first year of life. A role that the *panchayats* could take on at the community level or linked with women's groups who could help establish bonds between the newly married young woman and others women like her in similar circumstances, loosening some of the all too often inward looking constricting bonds that the new family of in-laws is keen to impose, and men could be en-

Teaching mothers to help children with delayed development

Under the guidance of the Childhood Development Centre in Trivandrum, *anganwadi* workers have been taught to screen newborns and children in the early months of life for developmental delay. This enables the Medical College Hospital to identify and develop a programme for training mothers, both physical exercises in the case of cerebral palsy, and appropriate mental stimulation in keeping with the child's capacity, to enable both mother and child to have a sense of progress, and to avoid more permanent defects of birth injuries and deformities, which if dealt with early, and on a daily basis, can eventually be ameliorated if not corrected. *Anganwadi* workers have shown their ability to both detect and guide mothers in the daily physical and mental therapy, making a huge difference to the eventual outcome of these children.

Earlier, in the 1980's the National Institute for Public Cooperation and Child Development (NIPCCD) introduced on the basis of an experimental research the "disability detection and prevention" as a part of the ICDS curriculum for the *anganwadi* workers, supervisors and CDPOs. In the absence of clear linkages with the health system of the kind attempted by the Medical College of Trivandrum, such initiatives have not borne fruit.

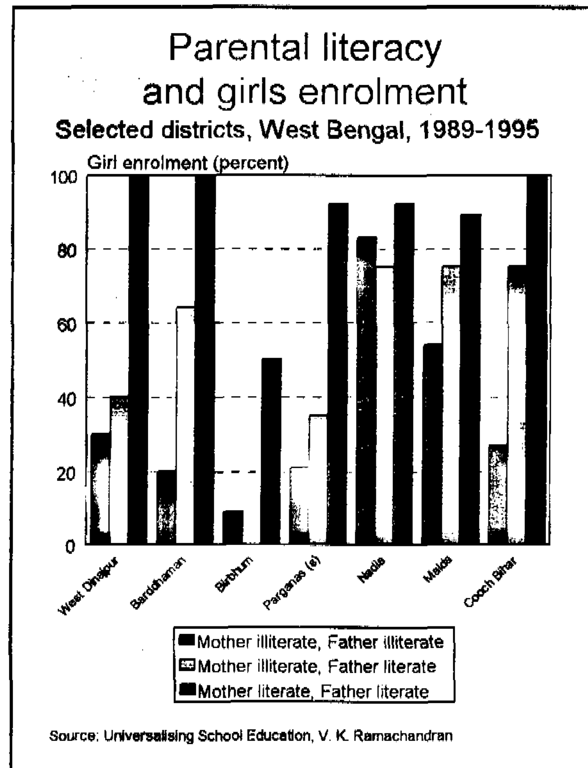
couraged and lauded for their role in caring for their young wife and newborn child.

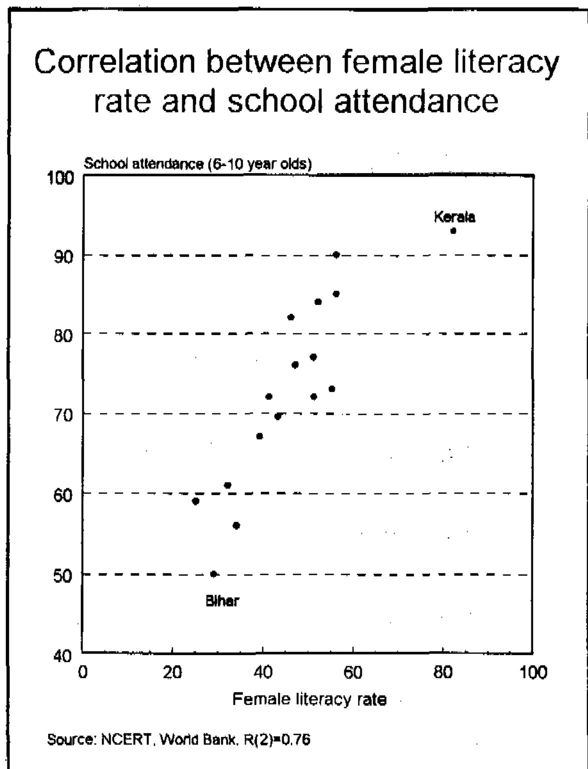
Not all parents recognize that it is in the best interest of children, boys and girls, to attend formal primary school. In a country where nearly 60 percent of mothers and 35 percent of fathers cannot read and write, children in many households grow up with very limited interaction with the benefits of numeracy and literacy. They miss the opportunity for sufficient encouragement that instills in them a sense of curiosity and a strong desire for learning.

The most powerful predictor of school enrolment and continuation is the educational status of the parents, both father and mother. In a family with no literate parent, there is a high likelihood of failing to enroll or early dropout from primary school. The literacy and schooling experience of the mother is particularly important, and to a large degree determines whether girls will be given their right and opportunity to formal primary education. Thus, girls of unschooled parents represent a particularly high-risk group, needing special motivation and attention to encourage schooling. The correlation between state female literacy and school attendance is high (a coefficient of 0.76) and is equally so between total literacy and primary school completion rates (0.77). Experience from the total literacy campaign (TLC) has shown that when adult women have learned to read and write, even at the simplest levels, they demand formal education for their own children, recognizing the benefits of literacy and a formal education, of which they themselves were deprived. Thus, an important fall-out of the TLC is a heightened awareness of the value schooling, and greater enrolment of participants who are newly literate.

3.5.2. The right to primary education

The *Constitution of India* as well as the *Convention on the Rights of the Child* argue forcefully for ensuring the right of every child to free and compulsory education. Ensuring universal primary education in the Indian context is a prerequisite for sustainable economic and social development. Basic education is most typically perceived as a passport to a job. In reality, this may or may not be the case, and most may not get the job of their choice. Nevertheless, ensuring universal primary education has several other consequences.





Primary education improves access to health, enables people to use economic opportunities better, facilitates public discussion and contributes to women's empowerment by encouraging them to articulate their demands, organize politically to oppose discrimination, and helps to create an environment where injustices such as child labour are not perpetuated.

Enhancing a child's capabilities through basic education has both intrinsic as well as instrumental significance for society. Apart from the direct benefits that accrue to the individual child, primary education imparts a broad set of values that transcend the specific knowledge acquired during the time at school and deals with the kind of person that child will become. This includes not only civic skills but also tolerance and concepts of equity, encouraging the breakdown of communal and gender stereotypes. In the case of girls in particular, it is pointed out that the process of socialization that takes place during schooling has profound effects on child survival. The mechanism relating girls education to improved outcomes related to their role as women and mothers has already been explored and emphasized in earlier sections of this report. Perhaps more important is the opportunity primary schooling gives to counter many of the inequalities girls are likely to encounter later in their lives.

Several attempts in the past to improve the quality of education and ensure universal schooling have not met with adequate success. ***Operation Blackboard***, for instance, though launched around an attractive concept of supplying a minimum package of essential inputs to each and every classroom in the country proved expensive and difficult to operationalize, highlighting the problems faced in trying to meet material needs of schools in a top-down fashion. The provision of materials designed and manufactured at a central level, and delivered to schools has proven of little value and less relevance to education in rural areas.

More recently, Government of India has given a strong push to the universalization of primary education (UPE). The District Primary Education Programme (DPEP) has been the most recent and important of national initiatives towards UPE. Several other initiatives have also been launched by state Governments, such as the Bihar Education Project, and in the area of teacher training and motivation. All these initiatives seek to develop local capacities for local planning. The principle of local planning is a sound one, yet the large amount of resources available at each DPEP district need new institutional arrangements that will not undermine teacher initiatives and the involvement of communities in the improvement of their own school environment. BEP which took on primary education in India's most difficult and challenging state has spread a broad net of activities, but now faces a major challenge of managing an expanding range of diverse activities. Urgently needed are a decentralized and locally responsive approach with community involvement as its most central principle, and immediate efforts to make the school attractive, relevant, and responsive to local needs. Experiments where teachers are given the raw materials and guidance to develop their own educational tools and learning materials are proving successful. At the same time, activities supported by NGOs such as ***Lok Jumbish*** and ***Shiksha Karmi*** have shown the important role that communities can play in getting children into school and keeping them there. They also demonstrate that the community can find resources within itself, and that if suitably trained and supported, like paramedicals, community members can take on the role of teachers.

Strong and sustained advocacy during the late eighties and early nineties helped to establish the idea that universal primary education (UPE) was not only necessary but also feasible within a decade. The 1993 EFA meeting in Delhi was followed by a broad enthusiasm to set ambitious time-bound goals and move forward to universalizing primary education. It led to a renewed commitment of government to spend 6 percent of national GDP on education (and of that 50 percent on primary education). This has been a commitment that has been renewed by successive governments showing cross-party support the initiative enjoys. This is also a commitment that has been endorsed strongly by successive newly elected governments at the center and in several states.

Innovation and political will are critical for ensuring that compulsory primary education is provided to every child in India as an important right. Commitment and increased political will are noted as evidenced in DPEP and donor interest in support of primary education. The Central Government has also been consistently increasing its allocation to primary education over the last three years. However a

major share of these increases are for the ambitious mid-day meals programme in primary schools.

The task of making primary education truly universal is tied to seven issues that also point to possible solutions – the poor physical state of schools, low attendance and drop out, high student-teacher ratios, low motivation and competence of teachers, irrelevant and uninteresting curriculum, low levels of achievements, and lack of community involvement. They are all interrelated in important ways that do not make for engaged learning, although each is presented below separately.

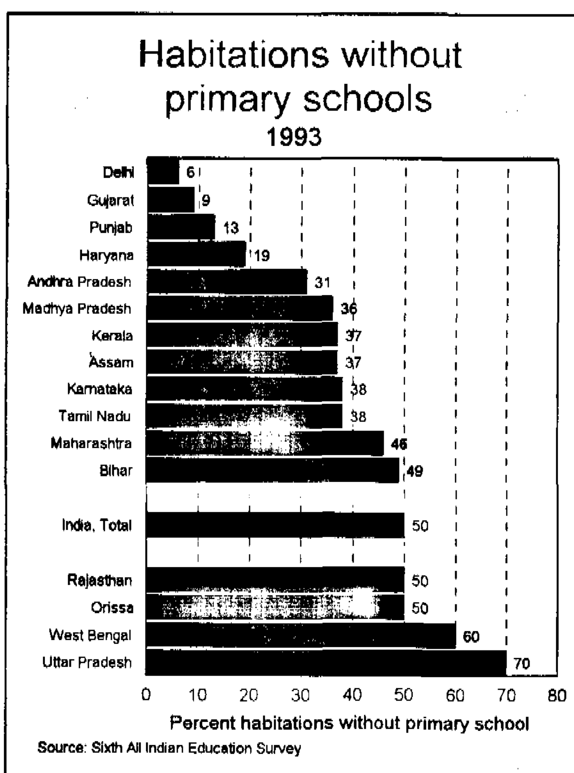
1. The poor state of primary schools:
Achievements in terms of physical construction of schools are impressive. The number of primary schools across the country increased from 209,871 in 1950-1951 to 581,000 in 1994-1995. By 1986, 95 percent of rural populations and for 80 percent of the villages had primary schools within a walking distance of one kilometer. In terms of magnitudes, these are considerable achievements; but they need to be assessed in terms of the adequacy of assuring the right of all children to attend and complete schooling.

National averages, as in other sectors, conceal major variations within the country. Provisional data from the Sixth All India Educational Survey (1995) reveal that at the national level, only 50 percent of rural habitations had a primary school located in them. Over 80 percent of rural habitations had primary schools in Gujarat, Mizoram, Nagaland, Punjab, Haryana, Chandigarh and Delhi, whereas less than 40 percent of rural habitations had a primary school in Uttar Pradesh. Arunachal Pradesh, Himachal Pradesh, Tripura, and West Bengal.

The need to have schools within easy walking distance of the habitation is no doubt important for the youngest children who are small and need protection. But distance from home also emerges repeatedly in surveys as a factor that deters parent from sending older children and particularly older girls to schools. It is here that provisioning of schools is least adequate. At the national level, less than 14 percent of India's 1.06 million habitations had an upper primary school in 1993. The proportion varied from 3 percent or less in Bihar, Himachal Pradesh, Madhya Pradesh, and Uttar Pradesh to a few states having more than 15 percent (Goa, Kerala, Haryana, and Mizoram).

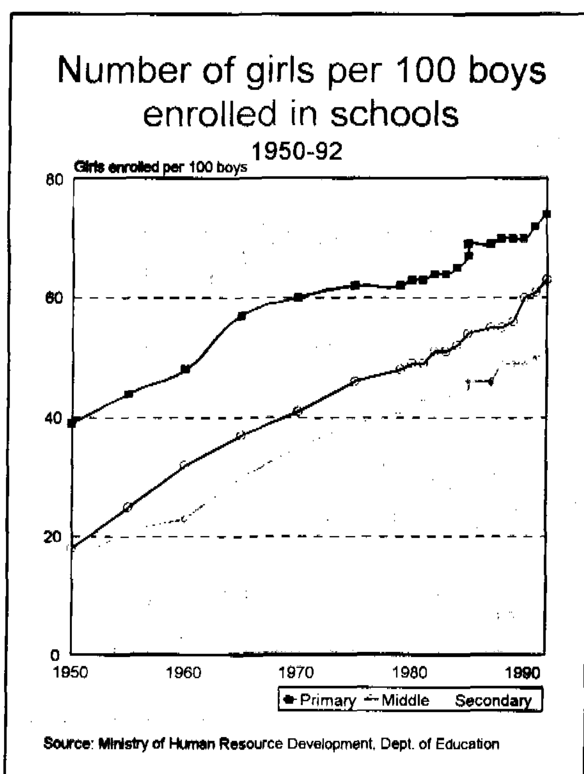
Detailed analysis on the physical structure of schools from the Sixth All India Educational Surveys are awaited. In 1987 more than 8 percent of schools had no building, almost 6 percent operated in thatched huts, and 14 percent occupied *kutcha* (mud) buildings. Nationwide, 1.5 million classrooms were available, almost 700,000 short of the goal of one classroom for every 40 children enrolled. Nonetheless, in many states where education has progressed at a slow pace, the condition of the school building itself is often poor, severely wanting in repairs, and lacking in regular maintenance. On occasion, rooms are either unusable with dangerous broken roofs and walls, or used for other purposes, such as godowns or animal sheds. Many of the schools do not have blackboards, or any provision for purchase of chalk. Most do not have access to teaching materials. Government schools in urban areas in general are better equipped. However, they too often lack space, drinking-water facilities, and toilets. Classrooms are poorly ventilated. World Bank estimates in 1996 suggest that about 110,250 classrooms would be needed each year for the next 10 years, about 30 percent of existing classrooms would require rebuilding, 80 percent would need water and toilet facilities.

Physical facilities and buildings clearly remain a priority area for investment. At the



same time, however, buildings in themselves, while important, are not necessarily the critical factor. Much can be done now within existing provisions to transform what is available into acceptable and even attractive teaching environments. Community members supervised by technical specialists, using durable but locally available materials, it has been noted, can also undertake construction and augmentation of physical infrastructure for primary schools.

In most communities, schools are allowed to deteriorate as communities expect government workers to maintain and repair school buildings. On the other hand, where the communities feel ownership, they repair the roof, paint the walls, and improve the condition of the play area around the school. No amount of government money can replace community pride and involvement in maintaining and beautifying their own school. It is here that teachers have shown what is possible in projects as diverse as *Lok Jumbish* in Rajasthan, and in districts taken up under the "Joyful Learning" initiatives in Madhya Pradesh, Uttar Pradesh, Maharashtra, Gujarat, Orissa and West Bengal. Here, teachers have learned to make use of local materials and the help of local communities and artists to make their classrooms bright and attractive. The "joyful classrooms", painted with coloured pictures, and the blackboard encompassing the entire perimeter of the room at the level of children's height, converts the school from a neglected government building to a source of community pride. It makes for a classroom environment of engaged learning, a place where children are pleased to come and to learn with a feeling of belonging.



2. Low student attendance despite high enrollments:

Gross enrolment rates of children in the age groups 6 to 10 years have continued to rise from 42.6% in 1950-51 to over 140% (largely due to overage students who are enrolled) in 1994-95. These are impressive gains, with the gap between boys and girls narrowing significantly. It appears that in the mid-1990s about three-quarters of the children aged 6 to 10 were enrolled in grades 1 to 5. 1991 census figures back-estimated to 1986 show an age cohort of 100.3 million children, for a net enrollment rate of 67.9 percent.

Gross enrolment figures, however, give a very imperfect picture of the numbers of children actually in school. Not much is known about the net enrolment rates (age appropriate enrolment in each class), or more importantly, about attendance rates. Alternative estimates offer some useful proxies. The National Sample Survey of 1987-1988 reported that only 40 percent of rural girls in the age group of 5 to 9 years and 42 percent of rural girls in the age group of 10 to 14 years attended school regularly. The corresponding figures for boys were higher: 53 percent for boys in the age group of 5 to 9 years and 66 percent in the age group of 10 to 14 years. The Survey also revealed that more than 50 percent of rural girls and 26 percent of rural boys in the age group of 10 to 12 years had never been enrolled in school. Dreze and Sen in 1995 estimated that 50 percent of girls and 26 percent of boys aged 12 to 14 never enrolled in school.

The National Family Health Survey 1992-1993 also gathered information on attendance by asking every child in the age group of 6 to 15 years whether he or she was still in school. The responses to this general question – which tends to be interpreted more as being currently enrolled rather than regularly attending – reveal that 68.4 percent of children 6-10 years old (75.5 percent of boys and 61.3 percent of girls) and 66.2 of children 11-14 years were reported to be in school; for rural areas this figure drops to 63.5 percent for children aged 6-10 years and 61.2 percent for chil-

dren 10-14 years. The proportion was over 90 percent in Kerala. Himachal Pradesh, Manipur, Mizoram, and Goa. It was as low as 51 percent in Bihar. Access to primary school also varies by caste and social position in society. The large gap between official enrolment figures and actual attendance reveals how much more there is to accomplish in terms of ensuring universal primary education.

If UPE is to be achieved, it is important to set time-bound targets for bringing all children into primary schools. Many consider, in view of the present low attendance rates, that universal primary education would be a disaster, overwhelming already overcrowded schools with children who would learn very little. Therefore, an incremental approach – increasing universal attendance by one year at a time has been adopted in many communities, proving that even the large numbers can be accommodated progressively. The focus is on getting all children of grade one age cohort into school, and then, year by year, working up the system to ensure little dropout is possible. Such a strategy requires, in the first round, active mobilization of the community around enrolment drives for Class 1. It also requires that attention be paid to reducing the burden on teachers and improving the space available for teaching. At the same time, it requires transforming the quality of teacher-learning in the classroom, so that children indeed stay in school. The "Joyful Learning" already initiated in several schools across many states, has shown that improving the classroom environment itself makes it very attractive for children to attend school regularly. Children then stay in school when it involves classes that are full of songs, child acting, games, and role-plays. This is often backed by the enthusiastic support of the parents who see the result of inspired teachers that want children to seek and enjoy their educational experience.

If primary education is to be made universal, this will simultaneously address the extensive problem of child labour. Each cohort of children that is brought into school and retained there, throughout at least primary, and eventually upper primary school, will be protected from working full-time – thereby eliminating the scourge of child labour, which deprives so many children of their right to education.

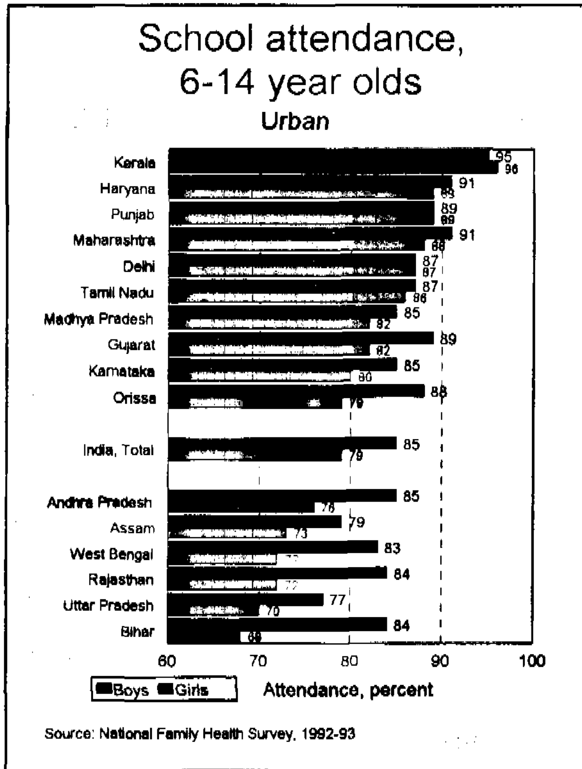
Much of the success of these efforts, of course, depends upon the teacher's motivation. If interaction in the classroom has to be improved, it is essential that teachers play a crucial role. Devoid of appropriate motivation and teaching aids, the quality of classroom interaction is unlikely to improve, and teachers themselves are unlikely to succeed in creating an environment of engaged learning through primary schooling.

Achieving the desired contact hours

Minimum Levels of Learning (MLL) assumes a certain minimum number of contact hours. Let us say between 120 -150 days of school in the year. If teacher attendance rate is only 50 percent, this reduces the number of contact days to 50-75 a year. If the effective teaching hours is equal to 3 hours a day, effective contact then becomes 25-35 equivalent days a year. In such scenarios, expecting children to achieve certain minimum levels of learning becomes a non-starter. A shift from minimum levels of learning by student to ensuring minimum levels of teaching-learning is called for as an integral strategy for ensuring the educational rights of all children.

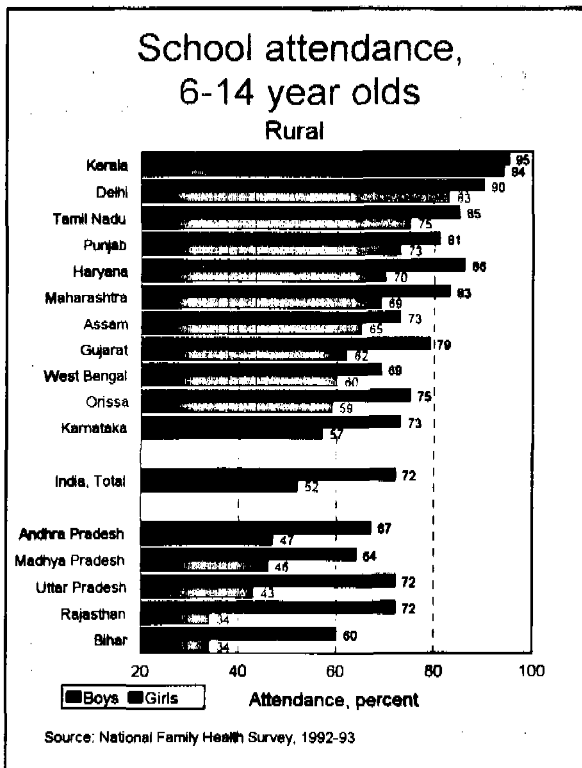
Access to primary education – is more schools the answer?

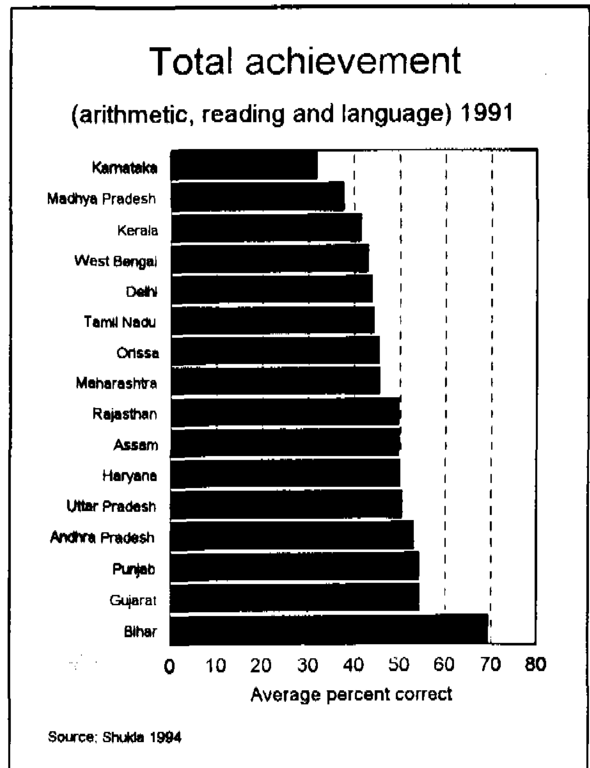
It is important to recognize provisioning of schools by itself is not sufficient to ensure equal access to all children. Neither is the non-availability of schools within the habitation an obvious deterrent. According to the National Sample Survey, for instance, 63 percent of rural girls in the age group of 5 to 9 years in Himachal Pradesh were attending school in 1987-1988 when only 21 percent of the rural habitations—the lowest proportion in India—were reported to have a primary school in 1993. On the other hand, only 20 percent of rural girls in the age group of 5 to 9 years were attending school in Bihar in 1987-1988 when 51 percent of the rural habitations in the State had a primary school situated within the habitation.



3. Low learning achievements despite attendance:

Only very recently, since the launch of the DPEP, has any effort been made to assess learning achievements of primary school children in a systematic way. The results of a survey carried out in 23 states by NCERT (sample of 65,000 urban and rural grade 4 students) in 1991 threw up some interesting results. Even in Kerala, which has the highest literacy rates in the country, only 41% of students got the correct answer in an achievement test of arithmetic, reading and language. The proportion varied from 31.8% in Karnataka to a surprisingly high 69.3% in Bihar with an average of 46.4 percent. Interestingly, students in Madhya Pradesh fared better than their counterparts in Gujarat and Punjab. Students in West Bengal fared worse than students in Uttar Pradesh. Students correctly answered fewer than half the arithmetic questions in 19 of the 23 states and fewer than half the reading comprehension questions in 16 states, and they correctly spelled fewer than half the words on a spelling test in 15 of 21 states. These low and varying levels of achievements point to the need to focus on the quality of education as much as on the physical provisioning of schools.

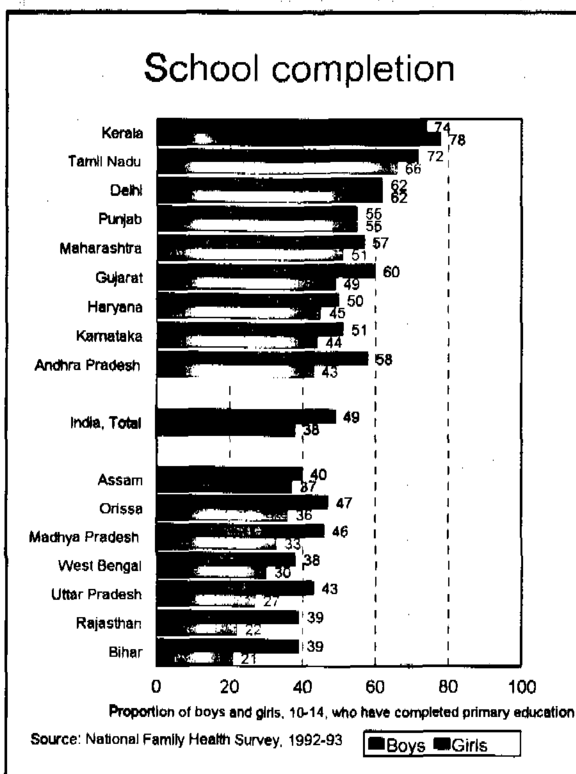


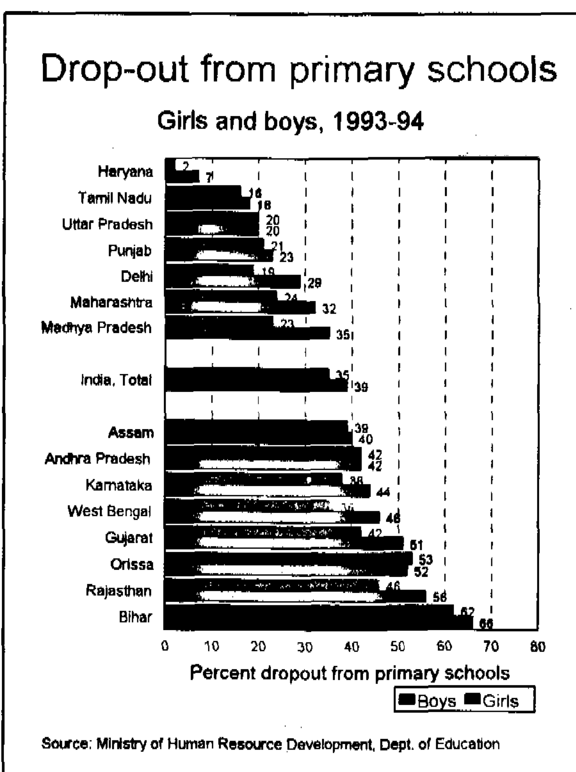


4. Making schools and the learning environment more interesting

Current estimates suggest that of the children enrolled, almost 50 percent drop out before completing even five years of schooling. The dropout rate is the maximum (estimated in the Sixth All India Education Survey to be approximately 25 percent) between the first and second grades of schooling. There are important differences across states with dropout in grades 1-5 ranging from 18 percent in Tamil Nadu to 66 percent in Bihar. Female dropout rates are at least 5 percent higher than of boys in the six large northern states and in Karnataka (although reported lower than boys in a number of smaller states). A major factor responsible for the high dropout rates is the failure to make the teaching-learning environment more stimulating. The quality of teacher-learning processes in the classroom remains a crucial determinant of whether a child will stay for a further year. It is here that change is most needed. In many schools, classroom interaction between teacher and student is very formal – most often heavily teacher-centered with children learning by rote memorization. There still tends to be a demanding and rigorous academic regime that obliges teachers to concentrate on covering the syllabus rather than on the learning process itself. There is very little child-to-teacher interaction. Classroom discipline and punishment are widely practiced and taken as normal.

Efforts have been made to redress these problems through the introduction of Minimum Levels of Learning (MLL). Throughout the country, the expected competencies of children at each grade of school, in the fields of language, mathematics, and general knowledge have been identified, and can clearly be measured. Teachers are now expected to assure that each child achieves these competencies, or MLLs during the course of their study. Advance students can help the slower ones, and the teacher can give extra attention if a child is not demonstrating the expected competencies.



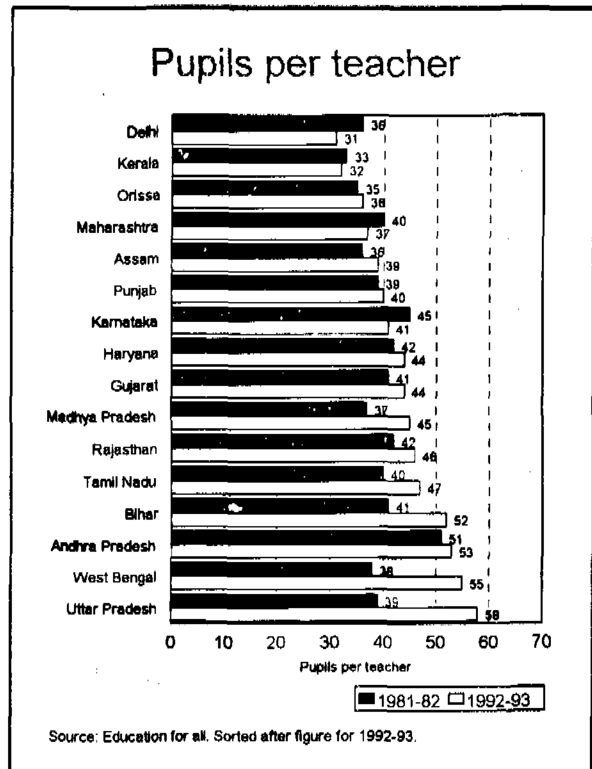


These are not used to hold children back from advancing to the next class, but rather to measure progress, and to focus attention if a child is not demonstrating the expected competencies. But, even these tend to be somewhat insensitive to the diversity of children; textbooks are rarely written from a child's point of view; with very little material and activities for slow learners. Insensitivity in classroom methods to the different learning needs, styles, and background of children almost inevitably leads to dropout. Parents' achievement in children's education is perhaps the most powerful intervention for enhancing learning achievement in India and elsewhere. Providing a supporting home environment is part of the family's responsibility and obligations towards their children.

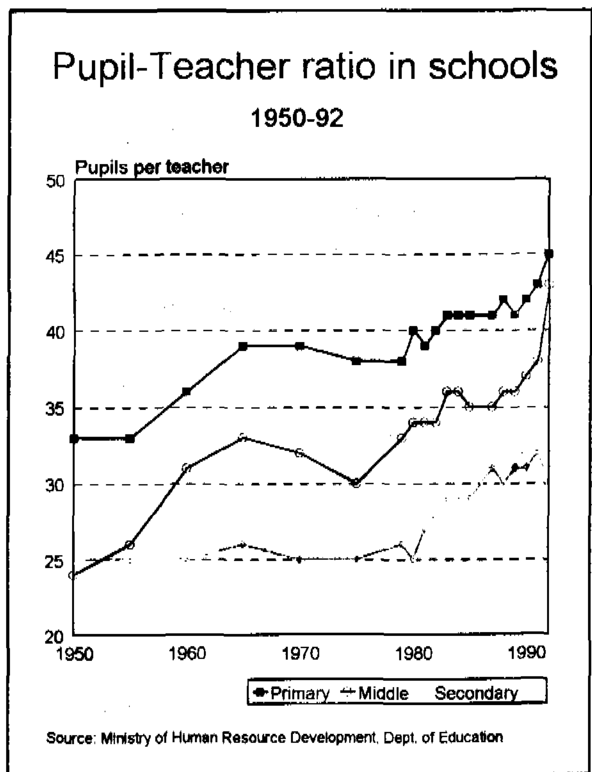
5. Overcrowding and high pupil teacher ratios:

Related to the problem of heavy syllabi is also the problem of overcrowding in classrooms. Over-crowding of primary schools is reported in both rural and urban areas. In rural areas, the reasons are to be found in the dominance of single and two teacher schools. Even in two-teacher schools, it is often the case that one teacher is absent; and so the burden of handling a single large class falls back on one teacher. Overcrowding is also reported in urban schools.

A survey of primary schools in Ambedkar Nagar, a resettlement colony in South Delhi, carried out in August 1995, found that most of the classrooms were overcrowded even though the school operated two shifts – morning shift for girls and afternoon shift for boys. As against the official norm of 50 students per class, the number attending (enrolled will be more) varied between 70 to 100 student per class.



Source: Education for all. Sorted after figure for 1992-93.

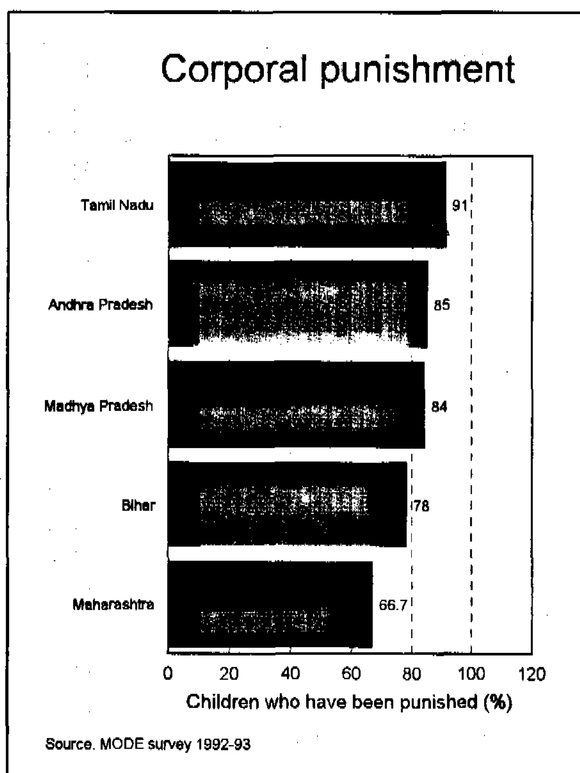


Source: Ministry of Human Resource Development, Dept. of Education

Even though there are more teachers per school in urban areas, there are also, on average, more students enrolled in school. The number of primary school teachers increased from 538,000 in 1950-1951 to almost 2 million in 1993, yet teacher pupil ratios remain extremely high. The teacher pupil ratio increased from about 45 to 1 in 1986 to 49 to 1 in 1993. Reversing this trend and reducing it to an average of 40 to 1 would require an additional 460,000 teachers.

Answers to high student-teacher ratios lie in 'theme' teaching, where all classes are studying the same subject the same time, the higher classes at more advanced levels, and lower classes in the same room, dealing with the same themes at a simpler level. This enables children to help other children through child-to-child methodologies, an approach now widely used in advanced education systems of the west. Further training of teachers in the specific skills of multigrade teaching is necessary.

These methods are only, now being explored and tried out, need expansion throughout the country. The use of non-formally trained volunteers from the community itself, or parateachers, such as *Shiksha Karmis* can make a huge contribution, extending the teachers' own availability, while providing adult guidance in the classroom. Parent volunteers can often oversee assigned work among small groups of children, allowing the teacher to focus on those who need special attention, or indeed an another class. Parateachers in many countries throughout the world have been found to function effectively after brief periods of training, following teacher role models and established classroom procedures. Children themselves, either advanced performers in their own class, or from older age groups, can be effective teachers, guiding slower or younger children in basic skills, thereby reinforcing their own learning at the same time. The participation of children as educators, rather than just recipients of education in child-to-child activities is a much underutilized resource.



6. Improving the effectiveness of teachers

Several surveys in educationally backward regions reveal that one of the most chronic problems of primary schooling in the country is the low motivation, frequent absenteeism among teachers and lack of performance incentives. A survey of 1907 teachers (1579 rural and 328 urban) in 8 states (Assam, Haryana, Karnataka, Kerala, MP, Maharashtra, Orissa and Tamil Nadu) revealed that whereas almost half of the teachers joined teaching because of interest in teaching, rest for other reasons (certainly not because of interest in teaching young children).

A survey of primary schools in Uttar Pradesh revealed that few schools had full attendance of teachers at the time of visit to the school. In some cases, especially where there was only one teacher, the school remained closed for the day. Teachers come late and leave early, especially if they are not resident in the village. Even when teachers are present, they are not always found to be teaching. In many of the educationally backward regions, teachers seldom teach, on average, for more than three hours a day. The situation becomes even more difficult when a single teacher has to cope with multigrade teaching with the curriculum having to be compressed in three hours a day. Teachers also can easily be bogged down with administrative problems, and all too often the teacher is called upon to assist other government programmes. All teachers are called for election duty, census and other surveys, and are often expected to help in nutrition and health drives, providing information to the community on government policies, and a host of other tasks as various government programmes attempt to reach into each community, where the only full-time worker is the schoolteacher. These are unfortunate diversions from an already over-busy and demanding schedule in school.

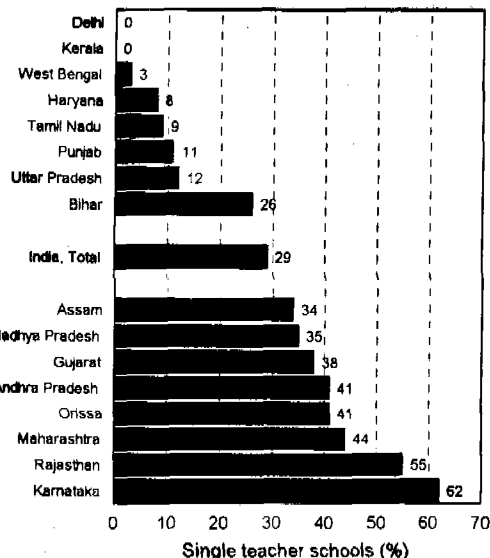
Transforming the environment of the classroom and engaging children in the learning process, was the strong recommendation of the 1994 Yashpal Committee. This requires a massive effort to build up teachers' competencies and develop systems of continuing education.

Experiments that have 'empowered' teachers suggest that when they make their own classroom teaching materials, they are better used, in a more innovative and joyful way. Teachers meet on a monthly basis to share their own innovations, giving them a sense of accomplishment and pride as their colleagues take up their best ideas. Not surprisingly, innovations are merging from primary classrooms and rural schoolteachers themselves are more relevant, more practical and more appreciated than those materials developed by centralized experts and dropped down on the system.

During the last 5 years, dramatic changes have occurred with innovations from the teachers themselves. The *Shiksha Samakhya* programme in Madhya Pradesh has obtained the agreement of teachers to take on innovative and joyful learning approaches in their classroom in exchange for improved and reformed administrative procedures relating to their pay, leave and other entitlements.

The teachers themselves have become the prime motivators, taking pride in the high levels of attendance and retention, their close relationship with the community, and the transformation of the physical appearance of their schools and the joyful activities that occur in the classrooms. This programme has extended to surrounding states through the *AnandShiksha* programme in Maharashtra, Guru *Mitra Yojana* in Rajasthan. The Teachers' Union in U.P. developed *Ruchi... Shiksha*, directed by teachers to assure that every child would find a place in school and continue their education through at least 5 primary years. When teachers are given the responsibility and the flexibility, and encouraged to work together, sharing experiences from neighbouring primary schools, they have transformed the situation of primary education, and the resulting attitudes of family and children alike in tens of thousands of schools in a short period of time.

Answers here lie in improving what are often insufficient and often irrelevant preservice and in-service training. It also means providing mechanisms for continuous education and support from the cluster level. The key role must be in developing links of accountability and building in appropriate performance incentives with local *panchayats*, and Village Education Committees. At the same time, efforts must be made to ensure that teachers come to school regularly, and that they do spend time with students in an effective and creative atmosphere.



7. Community involvement

A final critical area for action lies in strengthening the links between primary schools and the community. It is a striking feature of primary education at the present time that there is almost no community involvement and ownership in primary schools. In its absence, the school begins to deteriorate. Where communities are active (with Village Education Committees established or where *panchayats* have shown interest), much has been done, both in terms of making teachers more accountable and in improving the physical quality of the school itself. The responsibility for the primary school eventually must rest with the community with the local *panchayat*. This is not the case now. Reporting relationships of teachers is to the Department of Education, and to an inspection system of the department. They are not accountable to the community or to parents. The enactment of the 73rd and 74th Constitutional Amendment empowers *panchayats* and *nagar palikas* to manage and run schools. In states where *panchayats* and *nagar palikas* are already playing that role, there has been evidence of its impact in opening of schools, in enrolment ratios (especially of marginalised

sections), in improved pupil attendance and retention (although the same study found *panchayats* less effective in terms of buildings, teacher pupil ratios and working conditions of teachers).

This brief survey of the state of primary schooling would not be complete without mention of the impact of a growing privatization of education. The poor quality state of primary schooling in the public sector has generated opportunities for private (sometimes unqualified) entrepreneurs to enter the market. There has been a rapid expansion of private primary schools in both rural and urban areas. Surveys reveal that in Lucknow, as many as 25 percent of primary schools are private. In Patna, the proportion is reported to be even higher at 33 percent. In general, these private schools charge fees, often employ teachers without the expected minimum academic levels and training, and do not adhere to any standards or norms. Very often day-care centers are made attractive by use of uniforms and teaching English. Nonetheless, should the government harness the energy and self financing of the private sector, assuring good standards and a reasonable curriculum, the privatization of primary education could remove some of the burden from the public exchequer.

While the Constitution envisioned free compulsory elementary education till the age of 14 years, this has not yet been realized, except, perhaps in Kerala. Legislation has been weak and unenforceable, although a recent act in Tamil Nadu, promises to make this a reality in that state. Appropriate legislation, allowing for an incremental approach, one year at a time, to ensure each and every child enters and remains in school through at least 5 years of primary education, and preferably through 8, would provide a social compulsion to be overseen by local *panchayats*, rather than through legal inspectors and legal action. It is important to note that compulsion in education is primarily upon the states, insisting that schools, teachers and learning materials be made available wherever children live. The answers to the vexing problem of child labour would be solved when effective compulsory education laws are put into place, and society is seen to respect them.

Should primary education be made compulsory and universally available to all children, free of cost, non-formal education centers should become redundant over time. The National Policy on Education 1992 advocates the non-formal education programme for children in the age group of 6 to 14 years as an alternative channel for those who cannot attend school. This is reiterated in the annual report of the Ministry of Human Resources Development 1995 which states:

> *"Despite considerable expansion of formal system of education, the achievement of UEE (universal elementary education) goals remain a distant dream as a large group of children remain outside the formal system due to various socio-economic constraints. In order to reach this large segment of marginalized children, Government of India, department of education has been running, since 1979-1980, a programme of non-formal education for children of 6-14 age group who have remained outside the formal system. These include drop-outs of the formal system, children from habitations without schools, working children, children who assist in performing domestic chores like fetching fuel, fodder, water, attending to siblings, grazing cattle, etc. And girls who are unable to attend formal school."*

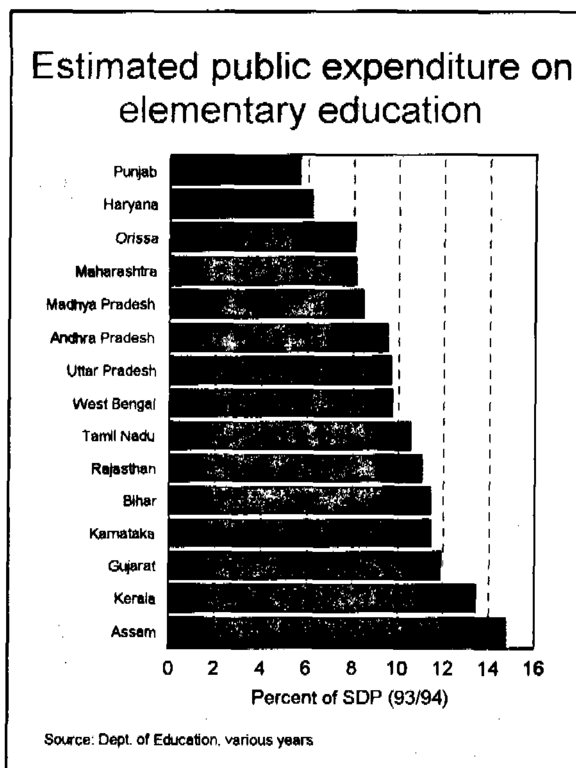
There has been rapid expansion of the non-formal education (NFE) centers over the past 10 years. In 1986, there were 126,000 NFE centers (of which 20,500 were exclusively girls' centers) with an enrolment of 3.65 million children. By March 1992, the number of NFE centers had more than doubled to 272,000, the number of girls' centers quadrupled to 81,600 and the number of children enrolled went up to 6.8 million. There is a crucial point involved here. The presence of a dual-track system of NFE alongside the primary school system can become an excuse for society's failure to make adequate provision to ensure all children are in primary school. Success of the NFE needs to be assessed in terms of how many children do indeed enter the formal system afterwards, and the extent to which it avoids becoming institutionalized as a second class option within the education system, acceptable to the poor.

There have been numerous efforts to provide schooling for the deprived: special schools for girls, special dormitory schools for tribal children, double shift in urban areas, and incentives of all kinds, including free uniforms, books, and most recently, the provision of a mid-day meal, in the hopes that more children would attend more regularly. Considerable investment in primary education is being made in an array of incentives. These should be ana-

lyzed to see if similar allocation of resources applied to improve quality, large number of teachers, better classroom environment, and teaching materials would not have an even greater effect on enrolment and retention. The idea of paying incentives for people to send their children to school perpetuates the public belief that it may not be in the family's interest, but it is in the interest of the government for them to do so; and, therefore, they should be compensated to allow their children to attend. This undermines the value of education in the public mind, and gives credence to the idea that the poor should not be expected to send their children to school on their own.

Experience in India, over the past five years, has shown the way to reaching universal education, and the recent moves to universalize the ICDS system into every village of the country, combined with a commitment to 6 percent GDP for education (3 percent GDP for primary education) should make the attainment of this goal in the next few years possible.

State governments fund about 60 percent of their expenditure from their own tax and nontax sources. They collect about 35 percent of all taxes and are responsible for about 55 percent of all government expenditure. Federal transfers account for about 40 percent of state government revenues – covering half of plan expenditures and a quarter of non-plan spending. Although allocation for education is uneven across states, the centrally sponsored scheme 'Operation Blackboard' attempted to reduce the horizontal imbalance. While the total per capita allocation across all states between 1989-90 and 1994-95 was Rs. 11.8, it was only Rs. 10.9 for the five educationally backward states. The total government expenditure on education in 1994-95 amounted to 3.5 percent of the GDP, higher than the previous five years but less than the peak of 3.8 percent in 1989-90. With the education expenditures of other departments, it rose to 4.2 percent in 1994-95. Of the 4.2 percent only 1.6 percent is spent on primary education. While computing the ratios at state level, it is difficult to make GDP estimates and therefore expenditure on elementary education (Grades 1 to 8) as a ratio of SDP has been shown. In 1992-93, state education spending ranged from 3.0 to 7.5 percent of the domestic product in major states.



3.6. The right to protection

Assuring children of the right to protection implies safeguarding them against all forms of exploitation, abuse, inhuman or degrading treatment, and neglect including the right to special protection in situations of emergency and armed conflicts. Children in this sense are no different from other weak and voiceless groups. They are abused because they are weak and their rights need to be protected. Of all the forms of abuse and exploitation of Indian children, the most serious violations are the abuse of child labour, the plight of street children, and the abhorrent practice of child prostitution.

There are today, in India, many estimates of children engaged in full-time work, depriving them of the opportunity of school, and of the normal activities of childhood. While the Census suggests 18 to 20 million children engaged in child labour, the ORG survey-based estimate of 44 million is seen by most to be more correct, and some suggest that a 100 million not attending school are all defined as child labour. The Government admits to over 2 million children employed in hazard-

ous industries, clearly against the law. Limited data suggests that some 20 percent of half a million commercial sex workers are children but studies show that well in excess of 50 percent of prostitutes were forced into this work as children, often at a tender age of 10 or 12 years.

There are about 420,000 street children, 12 million disabled, and far more subject to child abuse in their homes. Another 14 million are growing up in regions affected by civil disturbance at some point of time every year, either political or caste. These figures emphasize how many millions of children need society's protection. They are a stock statement of how much remains to be done in a country proud to be the world's largest democracy under the rule of law.

The right to protection is made up of both 'negative' and 'positive' rights. Negative rights are those that demand that a child's rights should not be infringed upon. They should be protected from exploitation and abuse. The most extreme case is where a child is being used instrumentally for the profit of others, and where conditions are hazardous to a child's health: a child prostitute who is involuntarily obliged to have sexual relations below the age of consent, and in addition is also exposed to the risk of sexually transmitted disease including HIV/AIDS; a child who works in hazardous industries at a pittance and whose health and very life is physically endangered. Less extreme perhaps but still denying the child his or her right to education is the 'bonded' child who in agriculture or at times even in an urban middle class home, often unable to pay off the debt which her parents may have incurred many years earlier. The 'negative' rights needing protection also extend to those of the street child; whose struggle for survival is based around activities that often bring him or her into conflict with the law and its rules of conduct. Protection against exploitation and failure to be protected under the law are important for this child too.

In these cases, the role of legislation and enforcement is often central. But even laws are not enough. How often is it heard that children of the poor should be allowed to work, even if bonded, and that education for them has no meaning or value, in any case? These starkly undemocratic social attitudes must be changed, if all children are to enjoy their right of protection. In the extreme case, imagine the child who is forced into sex and contracts HIV/AIDS, is locked up and treated as an object of fear and subject to social ostracism.

Consider the right of the disabled child to be treated as other children, and given the opportunity to develop his or her own potential without discrimination, and with dignity. Too often, they are singled aside, or provided no chance to be a part of the mainstream. Additionally, the CRC guarantees them the positive right to special services, in which the society must invest to diminish the impact of their disability.

The abdication of protection rights to children often takes place at a very young age, but also lies in the absence of societal recognition of the right to adolescence. Childhood seem to end abruptly, and adult responsibilities and behaviours assumed. For boys, this may be at a young age when they enter the work force. All too often, child marriage leaves the girl prematurely into a role as child-bearer, making her house-bound from that age onwards, without ever having had the opportunity to grow to physical maturity, and to experience the opportunity of association with other young people of her own age outside of marriage. When society condones marriage of a child, it is only a small step to blind acceptance of prostitution at the same age. The right to adolescence, and the implied transition from the total dependency of childhood, to a graded assumption of responsibility, consistent with the age and maturity of the child, is an integral part of the evolution of the society towards the realization of child rights.

Many of these rights and their denial are deeply embedded in social practice. Government alone cannot be expected to fulfill all these rights. They can be supported by legislation. It is up to society, however, and its main constituent members, panchayats, community organizations, NGOs, religious organizations, the media, and civil society in its broadest sense, to mobilize opinion around norms that are felt to reflect societies cherished values. It is the role of government in that sense, to use all the platforms at its disposal as tribunes to establish those norms and from which desirable behaviour is not only acknowledged but broadcast and regularly reinforced. It is within this norm setting role for government, in alliance with the judiciary and the media that many of these protection rights fall.

Just as in the case of most diseases and malnutrition, it is much more complicated (and expensive) to rehabilitate than to prevent

such abuses. Without denying the need for action on the ground amongst children affected, most attention has to be directed to prevention at the earliest stage possible. Unless a preventive strategy is given pride of place, the denial of these rights will continue to defy solution despite the best of efforts.

While the family is in most instances the first protector of child rights, it is increasingly evident that many abuses of children, particularly girls, take place within the family, around which a veil of silence is cast. Society has an obligation not only to see that families protect child rights but also help families to enact that protection.

3.6.1. Discrimination at and before birth

Once born, it would seem axiomatic that the right of every child, boy or girl, to be loved and cared for on an equal basis must be assured. Yet all children are not guaranteed even this with son preference already weighing the odds of survival against girls. In its worst form this is manifested in female infanticide. The methods adopted for the killing of innocent newborn babies are often grotesque. A number of recent research studies, news-reports and documentaries that have documented the practice confirm the continuation of this practice in many different parts of India. There is no systematic data available on the extent of female infanticide in India, although the practice is known to be prevalent in Madurai and Salem districts of Tamil Nadu, and in parts of Bihar, Haryana and Rajasthan.

Traditionally, astrologers, untrained birth attendants, religious charlatans, soothsayers and quacks, dominated the practice of sex determination. The consequences for the mother of predicting the birth of a girl child were often fatal. Family and societal pressures forced them to adopt extremely risky practices for inducing a miscarriage. If this failed, many mothers were forced to undergo illegal abortions carried out by numerous abhorrent practices.

Modern life styles and modern technology rather than helping to solve the problem are exacerbating it. The mounting pressures of today's society to have a small family, combined with son preference and the increasing availability of ultrasound medical facilities for prenatal sex determination, contribute to a growing but still under researched phenomenon of female foeticide. Medical termination of pregnancy has been available to women in India for the past 25 years for contraception failure or to preserve health of the mother on demand. Yet the practice of illegal abortions continues in many parts of the country perpetuated by the unfortunate social taboo attached to a woman who frequently bears girls and not boys. Limited data available from legal abortion clinics report that almost 90 percent of foetuses aborted are female suggesting a very strong association between sex determination and abortion.

> ***Origins of gender***
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> If a girl child is born, biologically speaking, it is the man who is responsible, not the woman. It is the male sperm that carries the sex chromosome that determines the sex of the child. Widespread ignorance of this fact has perpetuated a tragic situation where women are often helpless victims of son preference having to face society's condemnation and even the risks of death from abortion, legal or otherwise.

Media groups and non-governmental organizations have played a critical role in publicizing the practice of female foeticide and demanding public action. As a response, Parliament passed the Prenatal Sex Determination Technique (Regulation and Prevention of Misuse) Bill. Now an Act, it permits prenatal diagnostic techniques on women only in specified conditions and in approved institutions. But much more needs to be done. It is essential in the Indian context to emphasize the importance of fatherhood, and ensure that men accept responsibility as fathers for their children. This is not an easy task. Ultimately, mind-sets must change; society should recognize the full social and economic contribution of women.

3.6.2. Child labour

On December 10, 1994 - Human Rights Day, 250 child workers wrote a letter to the President of India. It said, "*...Sir, we are children who belong to the poor families and communities, we work very hard and honestly to earn some money so that it helps us to survive. Perhaps you are not aware that through our hard, exploitative labour we do contribute substantially to the national income of our country. We also bring in foreign exchange through the sale of tea, gems, carpets and embroidered sarees. However when it comes to giving us the basic rights, there seems to be no commitment from you.*"

Figures for the number of child workers in India vary from 11.3 million according to the 1991 Census of India; 17.4 million according to the National Sample Survey of 1983; to another 1983 figure of 44 million ac-

cording to the Operations Research Group. More than half of India's children between the ages of six to fourteen does not go to school. That becomes a staggering figure of 105 million children, most of whom work full time. Children in India work, and their work often accounts for their absence from school. Ten percent of marginal workers and five percent of those working more than 185 days a year are under the age of 15, according to an estimate by N. Burra.

The figures available on child labour are a decade and a half old. In the last fifteen years, the incidence of child labour certainly has not declined. In fact, it may have significantly increased to multiples of the known figure. Also, figures vary enormously depending on the definition used.

Child workers share a poverty stricken background. But poverty in itself does not account for the existence of child labour. Child labour exists primarily because it is cheap and can be easily exploited. Discrimination against certain caste and tribal groups results in debt and bondage, and children pass their entire childhood in a debilitating life of labour. In the organized sector, child labour is banned and so, by default, children who work here are not protected by law. In the unorganized sector, where even adults are not covered by legislation, the plight of the child is even worse. Made vulnerable under these circumstances, children become malleable objects that can be exploited to the benefit of the factory owner, the fireworks manufacturer, the glass bangles maker, the diamond processor, the brick maker, the hotelier, the rich farmer, the carpet exporter, and the local *dada*.

Child labour appears to be ubiquitous in India. Children work as bonded labourers in the glass industry, *beedi* industry, in matchmaking, carpet weaving, slate-pencil making, mining, handlooms and agriculture. Sometimes entire families are bonded to the employers. A study of the match industry reports that often the child in the womb is pledged to the factory, and consumption and maternity loans are obtained on the undertaking that the child born, girl or boy, would work for the factory. A report on the mine industry points to children who work in mines of private companies, in trenches ninety centimeters wide and one meter high, where adults could only crawl. As soon as children grow, and their size is no longer profitable, they are often cursorily dismissed without compensation. It is reported that in the final polishing of gems with oxides, the entire labour force consists of children below the age of fourteen years.

In cities, child workers contribute to the city's economy as waste recyclers, dishwashers, cleaners, truck-loaders, waiters, coolies. By doing such jobs, children contribute significantly to the very foundation on which the city's larger economy rests. Yet, besides being exploitative, their job environments are unhealthy and hazardous. Children are also employed to clean sewerage pipes. This means being lowered into the sewerage and inhaling poisonous gases. Cleaning fish at the dock means bleeding nails and sore hands. Domestic work means long working hours, and possible physical violence or sexual abuse. In return, the child worker gets little. Being a child, she gets less than an adult wage, for the same and sometimes more work. Besides, other external forces such as crime, police harassment, drugs,

Brass making

The job of the moulder is a very delicate operation and if there is a slight mistake or accident the boy can get very badly injured and can even lose his limbs. He wears no protective gear and stands barefoot on top of the furnace to either put in the crucible or to remove it. The temperature in the furnace is about 1100 degrees C. As one exporter/manufacturer, explaining the processes in his factory, said: *"See how dexterous this young child is. He has to be. Because even if a drop of molten brass falls on his foot there will be a hole in it."*

From 'Born to Work', Neera Burra

Supreme Court leads the way for elimination of hazardous child labour in India

On the eve of the global release of the State of World's Children, 1997 focussing on Child Labour, the Supreme Court of India in a landmark judgment paved the way for preventing exploitation of children and safeguarding their economic, social and humanitarian rights by banning child labour and ordering the establishment of a Child Labour Rehabilitation Fund. In addition to decrying that no child may be employed in bonded or hazardous labour, the judgement put the onus on the employer and directed the employer of children to deposit Rs. 20,000 as compensation for each child in the fund and directed the central and state governments to deal with the problem of child labour through ensuring that an adult member of the family receives suitable employment and that the child is assured education. The judgment was followed by nation-wide surveys on child labour and efforts are still ongoing to implement and report to the Supreme Court on the compliance of its directives.

sexual abuse, shelterlessness create a living milieu which irrevocably damages a child's physical and emotional life.

A huge and invisible number of children are agricultural workers. They work on their own land because their parents need help, or on other people's farms for very little money. Other children, mainly girls, work at home, looking after younger children, fetching wood and water, cleaning. Neither agricultural work nor domestic work is counted as child labour by the Indian law. And so, there are no estimates for the number of children who are made to stay away from school to do this work.

The reality is that child labour exists because of a system which keeps them poor and uneducated. Child labour exists because it is cheap and because children can easily be terrorized into working far more than adults for much less money. They can be exploited mercilessly for a long time. The figure for adult unemployment in India is nearly 39 million. And according to some estimates, the country has 44 million child workers. The similarity between these two figures is no coincidence. While adults remain unemployed or underemployed, children work at lower wages. A paper on the economic consequences of the abolition of child labour points out: *"Abolishing child labour would directly and indirectly raise wage costs, and reduce the degree to which it neutralizes the adverse effect that high trading costs have on profit margins or prices."*

The government has not imposed a total ban on child labour because they feel that the survival of the poor depends on it. But there has been little success in alleviating poverty so that it impacts on the prevalence of child labour or even in regulating child labour. To date, there has not been a single conviction under the Child Labour (Prohibition and Regulation) Act. Cases have been registered but result in small fines or remain languishing in the courts of law. Many state governments have not created even the regulatory infrastructure visualized by the act. Besides, it is argues that if child labour is removed from traditional trades, then the traditional craft will die out and children who have not been trained since early childhood will not be able to make a vocation out of a traditional craft.

These are positions that need close scrutiny. On the one hand they ostensibly are trying to tackle the problem and on the other allowing employers and parents to perpetuate child labour. The only real solution would be to prevent child labour through compulsory education, coupled with measures that will help the family to allow the child to remain in school. These include community development initiatives centered on women's development and relief from debt dependency through group thrift and credit schemes.

The Supreme Court in a landmark judgement in December 1996 called for urgent measures to eliminate hazardous child labour and imposed fines on employers as well as an implementation mechanism with reporting back to the court.

India is not even close to making sure that each of its' children will grow up knowing at least to read and write. Yet, even with the existing 700,000 primary schools, and 2 million primary schoolteachers, this could be accomplished if flexibility were allowed in the educational system to accommodate more children in double shifts, shortening the length of the school-day, and incrementally bringing a new class of children into the school each year, and retaining them for a minimum of five years to reach the required basic skills of a literate person. The future it holds out for each of its' million of child workers seems to be one of further exploitation and denial. As for the children, they know they have to go on working. But they have questions. The letter from the child workers to the President continues... " *Why is it that we are denied access to education? Why is it when we are sick the doctors and nurses in government hospitals brush us aside and do not give us the medical treatment? Why is that employers are not punished for violating the Child Labour Prohibition and Regulation Act of 1986? The Juvenile Justice Act of 1986 is supposed to protect us children but instead it has become an instrument of torture and harassment. We are picked up by police, harassed, beaten up, abused and sent to remand homes for no crime having committed.....We are treated as criminals. What is our crime - being poor?"*

But removing children from the horrors of child labour is possible, though often costly. The MV Foundation, an NGO in Andhra Pradesh has attempted to create a consensus among villagers that every child has a right to freedom from exploitative labour. It has drawn upon the support of young volunteers, parents and local officials in withdrawing children from work. Through setting up night schools and education camps, the MV Foundation has managed to rehabilitate child labour and eventually mainstream them into the formal school system. Women's groups in North Arcot Tamil Nadu have saved and paid off loans from unscrupulous moneylenders in the *beedi* industry,

who had taken their children in bondage. These children have been put into non-formal schools to accelerate learning, and are integrated into the normal school system. The solidarity of women's groups has enabled them to help each other, and to assure that every child receives an education.

These and other experiences show conclusively that child labour is neither necessary nor desirable for the health of a given industry, even a cottage industry, nor are families invariably as dependent as many think on the income of child labour. The prospect for their future for generations, seen to be inevitable poverty, are vastly improved when children are taken out of labour and offered education.

3.6.3. Child prostitution

- *"Prostitution: They catch them young"*
- *"Four lakh child prostitutes"*
- *"15 percent prostitutes are children"*
- *"Father held for forcing girl into prostitution"*

These are the headlines from Indian newspapers. According to the Central Advisory Committee on Child Prostitution Aid, only the six metropolitan cities in India - Mumbai, Delhi, Calcutta, Chennai, Hyderabad and Bangalore - there are about a hundred thousand prostitutes. Out of these, 15 percent are below fifteen years of age and about 24 percent are between sixteen to eighteen years. Unofficial estimates say India has two million prostitutes, of which 20 percent are below fifteen. But almost all of them became victims of exploitation when they are children, less than 15 years old.

Not only does child prostitution in certain communities and social systems in India have a sanction, it is encouraged and perpetuated with pride. For instance, amongst the Rajnat tribe in Rajasthan, prostitution has always been a means of livelihood. When a Rajnat girl reaches puberty, she is initiated into prostitution through a ceremony where the highest bidder buys the right to her virginity. Girls from the Bachada tribe in Madhya Pradesh are also initiated into prostitution. They charge Rs. 20 for sex and any extra payment is given to girls below ten years of age as an incentive to join the profession when they are a little older. Prostitution also has links with the historical exploitation of the lower castes, whose women were forced into sex by powerful upper caste men. The *devadasi* system, whereby young girls are bought from their parents and dedicated to a temple, their virginity violated by the "philanthropist" who pays the most, continue to provide a constant flow of young girls to urban brothels as a perversion of this ancient religious tradition.

A Central Advisory Committee study conducted in 1994 found that 44 percent of all prostitutes were forced to join the profession because of economic necessity, nearly 25 percent ended up as commercial sex workers after being deserted by their husbands and almost 12 percent were tricked into it.

The people who make profits out of prostitution - the sex traffickers - take advantage of the tradition-bound groups and exploit other victims through their poverty-stricken backgrounds. They also thrive on mythical beliefs such as that sexual intercourse with virgins cure sexually transmitted diseases. The trafficking networks operate across South Asia. Much of India's growing urban demand for child prostitutes is fed by Nepal and Bangladesh. Estimates of child prostitutes living and working out of city brothels are difficult to make because the adults involved, aware of the enormity of their crime, make sure that the children are hidden at all times.

Unfortunately, that doesn't mean that if the children were visible, the crime would be brought to book. It's a well-known fact that not only do city police get a big cut in the profits made by the pimps, but they also use the prostitutes themselves. Every now and then, the police do carry out raids on brothels. And when that happens, the prostitute gets treated like a criminal instead of the victim of crime. The real criminals - the pimps, the madams, the traffickers and the clients go scot-free.

Meanwhile, the child prostitutes are direct targets of HIV/AIDS and other sexually transmitted diseases, especially because they are used by carriers who believe that sex with a virgin would cure them. Rates for "virgins" in big cities can range between Rs. 6,000 and Rs. 25,000 in the "higher class" brothels. After they have been broken into the world of prostitution, the children still run high health risks, with very little or no awareness at all about safe sex. Even if the child prostitute in question did know how to protect herself, she has little if any effective control over practices of those to whom she is obliged to submit.

Once lured from the village, and sold to a brothel in the city, these young girls are in a commercial trap. The madam who pays for her has to "recover" her costs; and reap a re-

turn. This can carry on for years, before the girl now an adult sex worker can buy her freedom. By this time it is often too late.

The structure seems impenetrable. The child grows up and continues her life as a sex worker. She has children who have very little choice and are often forced by her mother's clients to follow in the mother's footsteps. Women and children who are part of this trap could have access to choices if they were able to reach the world outside in a capacity other than as a prostitute, or if another side of the world outside - one that abhors this practice of exploitation - could reach in to them.

Access to prostitutes is near impossible to those who want to work towards changing the situation. The brothel establishment strictly guards the status quo. So far, only health workers have been able to intervene in a small way in the bigger, established red light areas in cities. This has been allowed by pimps who are beginning to understand the threat of HIV/AIDS and STDs and want their prostitutes to know about safe sex, if only to guard their profits, which would slump with rising public awareness about unsafe sex. Health workers try to impart awareness and have also been able to work with the children of prostitutes.

Strategies towards ending prostitution need to have a large preventive component. At a direct and immediate level, this means working in areas which are known for selling their children, changing attitudes, and creating other choices. It means mobilizing youth themselves to protect each other from illegal marriage or open sale, by group action and public exposure. It is a role for panchayats and village women's groups. It also means rallying for the enforcement of universal compulsory education, and providing people who are victims of poverty with other sources of income.

For those who are already behind the bars of brothels, life outside is just as terrifying as it is inside. Prostitutes who are rescued are seldom accepted back. Rejected by their families and ostracized by the rest of society as well, many feel that to continue as prostitutes is the only realistic option open to them. Rehabilitative strategies must focus on creating other realities - so that thousands of children can grow up in a world which will no longer allow them to be sold.

The consequences of turning a blind eye to this enormous problem can be severe. Nothing can hurt India's public image more than the fact that the country is doing little to address the problem of child prostitution. In this era of globalization, this can have serious repercussions on the country's trade and commerce. It can hurt exports, industry, and livelihoods of several thousands. But worse, it undermines the very foundation of a democratic society living under the rule of law.

Much could be done immediately, were this taken up by every women's organization in the country: DWCRA, *Mahila Mandals*, *Indira Mahila Yojana*, *Mahila Samakhya*, and especially the *panchayat* in each village. A special wing of police should be created to infiltrate the trade and take extraordinary and rapid penal measures against those who are selling, procuring and perpetrating the traffic in girls. Enforcement of existing laws against child marriage would do much to protect the unsuspecting poor family and their young daughters. This can only be done at the local level, and of course through the elusive promise of Education For All, the ultimate answer to many of society's worst problems.

3.6.4. Street children

They get abused and run away from home in a village to the big city they've dreamed about. Or their families abandon them on the streets. Or they find themselves alone in the urban jungle after a manmade or natural calamity. India's street children, an estimated 414,700 of them scattered over urban areas live a life of the moment. Deeply rooted in their present, in their daily struggle to survive, they brush aside their pasts and their uncertain tomorrows. Children who spend their days on the streets trying to earn their livelihood, but return to their families either everyday or keep up some sort of contact with their urban or rural homes also count as street children. They too share the basic situation of trying to survive on the mean streets - with the children who are absolutely alone.

The problems of street children have grown with urbanization and grow as the city grows. While earning money for themselves or their families, street children service several needs of the city. Large numbers of them become ragpickers - often this is the first job a child on the street learns to do - because it has no initial costs, other than that of one big sack which is easily acquired. Once a ragpicker, the child learns to rummage through piles of garbage, separately sorting paper, plastic, metal and glass and selling it at the end of the day to

a scrap dealer. The job involves long working hours and lots of cuts and bruises, but it gives a child relatively easy access to a source of income. Other ways are working in restaurants, picking loads off trucks or at railway stations, polishing shoes, working in mechanic shops or as hawkers. Girls generally either work as ragpickers, hawkers or domestic workers.

Children who are unable to earn enough from this kind of work or begging are forced into theft, crime or prostitution. Even if a child is not directly exploited by the local mafia, he or she has to pay them a part of their earnings and live in constant fear of abuse. Children have to deal with brutality not just from the local *goondas* but also from the police. Children who met for a street children's' conference in Mumbai in 1994 recounted some chilling accounts about encounters with the police. Shiva from Chennai says, *"The police harasses us even when we are earning our living as ragpickers. At night when we return from the cinema, we are taken to the police station and accused of crimes we have never heard of. The police break our knuckles and ankles and kick us with their iron-soled boots."* The police also take advantage of the Juvenile Justice Act of 1986 and pick up street children and send them to remand homes which are badly and insensitively run. Street children feel they have as much to fear from adults inside the remand homes as from the ones outside. At the same conference for street children, Nasrul from Hyderabad said, *"If you can't run these remand homes properly, please shut them. They have no use for us. Outside, four people beat us up. Inside the remand homes, ten people beat us up."*

Children on the streets have no access to education or health facilities. A very small number are reached by non-governmental groups. The rest continue to lead insecure, unhealthy lives. Sukhu Ram, a child who came to Delhi to work so that he could send money back home says: *"These days all kinds of diseases are spreading. If something happens there won't be anyone to take care of our dead bodies. We roam around for one or two rupees? If the disease attacks us, we are going to die."*

While specific figures are not available, a substantial proportion of the 37 million children living in urban poverty are living in informal (illegal) settlements or other temporary situations which include living along railway lines; *nullahs* (drainage canals); fringe areas of cities; on the streets themselves; on construction sites; and even in the alleyways of posh colonies. For children living in unrecognized/illegal communities, access to basic services including water, sanitation, ICDS, and in some cases even education is denied. Access of their families to public distribution system through denial of ration cards is also found. The issues associated with illegal squatting are complex. However, on the basis of the CRC, a national workshop held in 1997 on the rights of urban disadvantaged children noted that the rights of the child should take precedence over issues that related to "tenure or security of tenure" of parental residence. This has important implications for all government services and programmes in cities.

Related to illegal settlements is the removal of such colonies by forced eviction; violence (e.g. fires set under suspicious circumstances by land owners); or resettlement schemes of the government likewise have implications on children. Arrangements to provide for the immediate and basic needs of children who are victims of such removals are unsatisfactory, and often many years after such removals there are still no provisions for ICDS, primary education, shelter, water, sanitation or child care while the families try to re-establish their lives.

In all the major cities, many NGOs are working towards improving life for the street child. They provide night shelters, non formal education and some provide vocational training. NGOs can make critical interventions in a street child's life. But so far they have been able to reach only a small percentage of any city's street children. For reaching more children, initiatives could come from local citizens' groups or even government bodies after being sensitized to the situation of the street child. The existing government programmes of education, health, nutrition, vocational training, self-employment should be made to reach street children. At the government policy level, as for the other major child related problems of child labour and prostitution, the problem of street children will end only after education is made compulsory, rural initiatives are taken to provide meaningful employment to adults and stem urban migration.

If society cannot immediately prevent the sad problem of children on the street, at least it can assure that police stations are child-friendly, and that adequate shelters are made to assure such children are not abused. Can we not afford the social services needed to reintegrate these children into their own homes? Can we not assure that these street children are

treated with dignity and under the watchful arm of a beneficent law enforcement? If they represent the breakdown and family values, is it not society's job to recreate and rehabilitate that family?

3.6.5. Disabled children

Another category of children who face discrimination and neglect are those with disability. A striking feature of Indian society is to treat such children as "handicapped" and setup separate facilities for them. There is very little public consciousness of the need to integrate such children into the mainstream.

What is most urgently needed is first and foremost to prevent avoidable disability among children: vitamin A to prevent blindness; iodized salt to prevent mental retardation; polio vaccination to eliminate paralysis from polio; prenatal and obstetric care to avoid birth injury. But even then, disability of one form or another affects 5 percent to as much as 10 percent of children.

Fulfillment of the disabled child's rights means explicitly that disabled children get the same treatment as other children. They have a right to health care, to be dealt with like others in the primary school, ensure dignity, self reliance and active participation in the community. Still need to establish that it is the right of child to be brought into the mainstream and treated as regular citizens -not so much right to special schools that withdraw the child from his or her peers, the idea that a community takes pride in having integrated these groups into community rather than being embarrassed by them. Such an approach, however, does not absolve the state from providing special services needed by these groups but gives it a community base, and with help from outside encourages them to live with dignity and productively within the community, without facing discrimination.

3.6.6. Use of legislation

Legislation can play a central and activist role in dealing with exploitation of children, be it the elimination of child labour, the treatment of street children, or the prevention of child prostitution. Till now, the laws of India have not been revised to conform to India's commitments under the CRC. Legal reform for children is an urgent need. The National Human Rights Commission (NRHC) has of late taken a very keen interest in ensuring that the rights of children are protected legally and otherwise. They have established a special body to oversee actions to eliminate child prostitution. They have called upon states to initiate immediate action, to remove children from hazardous child labour, and to take legal action against those employing children in such industries. The sheer magnitude of the problem is daunting, and the specific actions that the society needs to take for rehabilitation, are temporary at best, as well as extremely expensive. The NHRC recognizes and is actively pushing for a powerful legislation to ensure universal compulsory primary education with all that implies for investment in the education system, as well as the social responsibility of families and communities to see that this right is fulfilled.

In all these areas of child protection rights, there is need for more information; more reliable data on the extent of the problem; on trends; on understanding the nature of the problem and possible solutions. There is need for an open and frank public debate on what courses of action are needed. Inevitably it takes time. It took 10 years for the girl child to be recognized as a legitimate concern; in the last five years, child labour has become a topic that cannot be wished away. Child prostitution is just beginning to be given notice. In yet another area, if the rights of children on the street are to be protected and fulfilled, appropriate legal measures to give them a legal identity will be required. Urban poor in squatter settlements, illegal or unrecognised slums do not have the same rights and access to development services. Fundamentally, child rights are only going to be protected when the community itself is concerned about them, and fulfills them for each child.

3.7. The right to participation

Assuring every child the right to participation includes respect for the views of children, freedom of expression, access to appropriate information, and freedom of thought, conscience and religion. This can be achieved in two ways: one, by enabling citizens to act as better spokespersons for children; and two, by encouraging children themselves to voice their concerns, and to participate actively in programmes designed to improve their own well-being, as well as others in their society. Children and adolescents can be a major force for social progress.

3.7.1. Role of information and advocacy

Acting as a window to the world, or indeed, to new worlds, information has two critical roles. One is to help people make informed choices by educating them and the other is to help change harmful attitudes. Information is the first step one has to take in the maze of problem solving. Information can help solve complex children's' problems - of child prostitution, child labour, abandonment, abuse - by helping the actors in the problem take a close look at it, perhaps with renewed vision. And it can help others to understand the problem and to tackle it in an appropriate way.

Information also helps in changing generally held attitudes and mind-sets which act against the well-being of children. For instance, an attitude like what use is education to a poor working child, when so many educated adults are unemployed anyway. Useful information can motivate adults to make necessary interventions in the lives of the children they come into contact with. For instance people who employ children to do their housework could be encouraged to invest in their education.

The media - newspapers, magazines, radio, television and the popular and folk media - can help in communicating information about children's problems to various specifically targeted groups of people. Not only can the media be used to spread awareness on children's issues, they can also play a role in the formation of citizen's groups to tackle these issues. Interactive programmes on television and radio and street plays have the potential to evoke high degrees of response. The media can also play a critical role in development. Quite literally, they can be critics of policies or social systems which create children's problems. They can create awareness on whether government or NGO programmes or government policies are reaching children, whether they work or not. This can create a forum for a public debate and lead to positive changes.

So far, the government has used the mass media, successfully to an extent to put across the message of family planning. The 1992-93 National Family Health Survey (NFHS) found that knowledge of family planning was almost universal, with 99 percent urban and 94 percent rural respondents recognizing at least one modern method of family planning. But the survey also found that only 47 percent of the married women surveyed had ever used contraception. Fewer still were aware of HIV/AIDS, or how to prevent it.

But media messages have to be supplemented by education to be more effective. Besides, the exposure, especially of the rural community to the media has to rise, before the message can translate itself into practice. The NFHS showed that 47 percent of the respondents were not exposed to any mass media, only 44 percent of women listen to the radio at least once a week and 32 percent watch television.

The audio-visual media can be effective in giving information to a largely illiterate audience. Often, because of the mass nature of the television and radio medium, messages are too general and therefore have less of an impact. Here, it's been found that video messages, taped and taken to specific target groups have had a far greater impact. A combination of several media together have also been found to be more effective. For instance during the outbreak of gastroenteritis in Delhi, a successful mix of radio, television and the major local Hindi newspapers were used to spread the message—of oral rehydration at the onset of diarrhoea and how to ensure protected sources of drinking water. But most powerful of all is face-to-face communication with a trusted and known individual. The success of the massive polio immunization days over the past three year were largely a result of person-to-person communication and social movements that assured, in only two days, more than 95 percent of all children under age five in India, wherever they were found, received the polio vaccine.

Information and advocacy can help set policy priorities. This has raised public de-

mands for universal primary education. It could trigger public action in the case of child labour. Public dialogue and demand, fuelled by an informed and persistent media, could end violation of child rights in the form of child prostitution.

Media has a powerful influence on the behaviours and expectations of the young. The portrayal of children, and especially young adults, in the visual media is a source of considerable concern, inculcating values, aspirations and behaviours, which are certainly far outside of the prevailing culture in the interests of a progressive society. A proper balance between complete and irresponsible freedom in the public media, and a responsible role to guide society's taste and expectations needs to be found. Children, rather than being led by the media into new vogues and antisocial activities could participate within the media itself to portray appropriate responsible role models and expectations for the country of their own future.

3.7.2. Enabling children to voice their views

Another way of enhancing participation by children is to develop mechanisms for their voices to be heard. This includes improving communication between children, and between children and the rest of society.

It is in enabling children to be heard that their rights are perhaps least realized. Within the family, the community, the local school, more opportunities for children to participate fully in their own culture, to express their ideas, beliefs and desires, and, as they grow older, to become increasingly responsible for their own actions and, as members of society for how resources will be invested to shape the future. Some small but significant initiatives have begun: in some states, ***shishu or bal panchayats*** have been established, inviting children representative of their community to debate, discuss and advise on how their own communities can better respond to the needs of the poor. In 24 Parganas, West Bengal, a ***shishu panchayat*** carried out community surveys in an entire block, identifying weaknesses in government services and supplies of water, health care, education and general responsiveness to the people's needs. The elected adult *panchayat* attended a day-long ***shishu panchayat*** meeting, when the children responsibly and in a mature and thoughtful manner presented suggestions for specific programmes that should be carried out. The ***panchayat*** then met on a further day to chalk out their plans in response to the young people's suggestions, and in partnership with them are carrying out improvements in government's programmes.

The right to adolescence is inherently recognized in the CRC through its frequent reference through the involvement of children in decisions affecting their lives according to their age, maturity and capacity. The recognition of a process of transition from childhood to adulthood, during which a young person needs guidance, patience, and increasing responsibility as experience and education, enable youth to play a full role in adult society. This is widely recognized to occur over a course of many years, and the reason for which the CRC clearly defines adulthood as only after the child reaches 18. The protection of the right to adolescence and the utilization of this time period for an increasingly responsible and mature involvement of children in society is a critical and important transition.

Youth activities are highly developed in India through the *Nehru Yuvak Kendra Sangathan*, with more than 200,000 village-based youth clubs. Those in higher education often join the *National Student Samiti* (NSS), with activities in all universities and hundreds of Senior Secondary Schools. Thousands of young people serve their communities through the National Volunteer Scheme (a domestic peace corps where young people work at the block level on social action programmes with subsistent support form the Government). While many of these youth organizations involve young adults above the age of 18, the Department of Youth and Sports is increasingly turning its attention to younger age groups beginning at 10 years. Young people are involved through a wide range of activities in increasing their awareness, promoting education, participating in health drives, improving community sanitation, informing each others of the dangers and the way to prevent HIV/AIDS, understanding and avoiding drug abuse, and participating in activities to improve gender balance throughout all ages of the society. Thousands of youth groups participated in the salt march in North India, testing household salt for the presence of iodine in over 500,000 households in one day. Hundreds of thousands of young people assisted in the Pulse-Polio Immunization Campaign, and have been active each year in school enrolment drives, especially attempting to assure that every 6-year-old goes to

school. On a smaller scale, youth has rehabilitated several thousand primary schools and *anganwadis*, have established reforestation schemes in their own villages, have encouraged women's savings programme through Mahila *Samridhi Yojana and Indira Mahila Yojana*, and have been a key element of the National AIDS Controls Organization's campaign, especially in the North-Eastern states. Hundreds of thousands of young people have been trained in vocational skills through *Nehru Yuvak Kendras* (NYK) in their own leadership training, and *panchayati raj* training activities have involved tens of thousands of members in local governance and specific village-based projects to improve health, family planning, blood donation, immunization, construction of latrines, assisting in eye camps for cataract extraction, improving wasteland development and horticulture plantation, reforestation. Without doubt, the millions of young people, both in and out of school add much to their society and to their own experience and commitment to social action through participation in organized youth activities, scouts, and the like. This is a vast resource that could be far better utilized in a partnership for programmes for children.

Chapter 4 – Equal rights for all children

India's future depends upon assuring all children their right to survival, development, participation and protection. This requires an expansion and equitable distribution of opportunities, of all kinds, for all children; and for mothers and women in all fields – economic, social and political. The mid-decade progress on the goals for the year 2000 showed substantial improvement in many areas but the shortfall from promises made is yet wide and daunting.

Far too often, we take satisfaction in the accomplishments and progress that has been made and pay less attention to the shortfall – to our failure to reach 20, 30 or even 40 percent who certainly are most in need of essential services and basic needs, as guaranteed in the CRC, in the Constitution and in national policies. It is a focus on the unreached - the job yet to be done – that must guide the planning and prioritization of strategies if India as a nation is to meet the promises already made.

The pursuit of universal coverage, wherever and whenever it has been attempted, has proven most successful in terms of reaching up to levels of 60, 80, sometimes even 90 percent – but rarely more than that. If India has done well with respect to immunization it is because the programme was intended to provide universal coverage. If India has not done well in the field of basic education it is because the country has never – and sadly not even until today – instituted a programme of universal compulsory primary education.

Striving for universal coverage in terms of assuring every child his or her right implies accepting and adhering to the principle of non-discrimination among children.

Experience suggests that universal programmes have the highest probability of success as they often receive maximum backing by all sections of society, much more than the support that is generated for the economic rationality of "targeting" and the political rationality of helping only the poor. Indeed, without universalization, no one can be considered to be "left out", but until recently efforts at high coverage programmes have been considered successful if they reached the vast majority. It is a combination of universal approach linked to a commitment to reach those most difficult and most isolated, most often neglected and left out to reduce the disparities of the society that a rights approach adds a new dimension – the necessity of reaching all.

Universal approaches are worthy of support but leave behind segments of the unreached. An inevitable outcome of pursuing universal entitlements for all children is that some groups will receive them first, some later, others not at all. Universal public programmes may confer right to every child but do not necessarily imply that opportunities are created for ensuring access. Even with the best of intentions, universal public programmes rarely manage to reach all the poor – at least not initially – and certainly not the poorest and the most deprived. Disparities begin to show up, reflecting the unequal distribution of opportunities in society. This can be seen in every sphere of activity. Children born in urban slums face six times higher risks of death than other children. Children of Scheduled Casts and Scheduled Tribes are less likely to be immunized than other children are. Children living in hilly regions are less likely to go to school than other children are. The message is clear: To ensure quality of rights to every child, expansion of opportunities has to emphasize the more socially and economically backward communities, among populations that live in difficult-to-reach areas. The additional costs of reaching the unreached tend to be very high. And this must be recognised if equality of opportunities is to be ensured.

Yes, programmes may need more resources. But there are a number of cost-effective and even cost-less interventions. Extra care of the mother costs no money. Salt iodization is inexpensive. Practicing public hygiene is a matter of the mind. So with breastfeeding, proper feeding of children. The list is long.

The ***conventional welfare approach*** was predominantly based on treating people as recipients or beneficiaries of government programmes, and depended upon selective programmes that were remedial in nature. The ***basic needs approach*** was more directly aimed at ensuring a minimum basket of goods and services and relied on treating the deprived as beneficiaries of targeted inputs.

But ***a rights approach*** to child development differs in many ways from the welfare

or even the basic needs approach. A rights approach treats people as subjects, not objects. They are claimants who are entitled to a set of basic capabilities. As people in society exist under a wide array of circumstances, the realization of these rights can only be done through their full participation and involvement. This implies that government services cannot be "delivered", but rather must involve the people in their design and sustainable provision. Herein lies the value of the convergence of government social sector programmes at the community level, wherein a partnership is established between government outreach workers and community inhabitants, taking up their own responsibility to guide and utilize the resources that government is expending on their behalf and in their interest. Thus, a rights approach obliges the State to respect, protect, facilitate and fulfill the rights of all children by adopting an approach that is both participatory and universal.

A rights approach is about disparities – not so much the quantity or level of service. Therefore, it is not so much the availability of food, but its distribution that matters. It is not merely an expansion in the physical provisioning of all health and educational services, but the equal access of all children to these services. In this quest for universalism in all, we must put our attention on those whose are still deprived because they represent those most in need and the most deprived of their rights.

The community itself can assure that the so-called negative rights are realized virtually immediately. These do not depend on resources but rather on how the society conducts itself in terms of infringing upon the basic civil and political liberties of its members. The so-called positive rights require a more progressive approach according to the availability of resources. The expansion and improved quality of schools, more convenient and extensive health services - resource limitation are no excuse for inaction. An improved resource allocation to the social sector is an integral part of a nation's obligation under the CRC. Many authors have analyzed the trends in social sector expenditure. More than simply a sum of public allocations, the level at which public finance is collected and disbursed is a critical issue in enabling community control, modification and involvement in the realization of social progress. Disparity between states, between districts and communities within them, characterize India's development. There is a strong tendency for the most deprived and poor to have the smallest proportion of public expenditure as well – partly of our inefficiency, partly corruption, and partly because pro-active reallocation of public resources is greatly needed.

	Welfare approach	Basic needs approach	Rights approach
Motivation	Charity	Need fulfillment	Entitlement, guarantee
Perception of children and their families	Recipients	Beneficiaries	Claimants
People's involvement	Passive	Consultative	Participatory
Impact on people	Dependency	Empowering	Creating
Nature of programmes	Remedial	Targeted	Universal
Demands on state	Voluntary	Discretionary	Non-discretionary
State responsibility	To act benevolent	To provide adequately	To respect, protect, facilitate and fulfill all rights

Chapter 5 - An agenda for action

This report has attempted to identify the progress for women and children and focus on the challenge that lies ahead, not only with the view to advocating a rights approach to children, but also to identifying the actions which can and should be taken to substantially improve the situation of India's children. While some elements of the Situation Analysis can only be viewed with alarm, much is amenable to rapid and effective improvement within the resources available to India today. The problems and major issues in malnutrition, in primary education, in child labour and other protection issues, in health and survival, in water, hygiene and the environment, and in the situation of women can be dramatically altered if Indian society determines to do so.

This section identifies some of the actions which can and should be taken immediately and more medium term actions that are affordable and will transform the situation of children, thereby meeting national objectives, the goals of the World Summit for Children and the country's obligations under the Convention on the Rights of the Child.

5.1. Strengthening the position of women

If there is one underlying theme of this report, it is that, in the present context in India, children's rights cannot be realized if women's rights are not addressed squarely and forcefully. Women often remain marginalized in decision-making, in the family, the community and in the society, and their opportunity for solidarity remains severely restricted by current social relations. The report argues that it is the 'position' of women in society that needs to be enhanced in its many dimensions. While it does not shy away from recognizing the difficulties in bringing about changes in such a profound area of gender relations-closely embedded as it is in economic and social structures and culture - there are reasons for optimism.

First is the recent progress on group formation amongst women, a process itself that has intrinsic importance. Women's groups of all kinds are being organized, with hundreds of thousands of such groups already in place. Most visible in Andhra Pradesh and Kerala, organizing around thrift and credit, they are also significant forces of change in the more conservative areas of the country, such as Rajasthan and Bihar. Women in poor communities in different parts of the country repeatedly say that meeting around thrift and credit was often the first time women in their community had ever met together to join in a common endeavour. The mutuality of thrift and credit acts as a binding agent, giving women the reason to meet together regularly, and allows them to identify leaders and spokespersons. Group formation quickly leads to discussion of other vital issues that affect women's lives. Healthcare, and is high real costs to poor families, often emerges as a central item of concern and a source of indebtedness.

Such groups need to be recognized and registered, especially at the local level, in order to authorize or enable them to participate fully in government programmes, such as credit etc. How can they be encouraged, provided with resources, and with technical guidance brought into a dialogue with government functionaries? What mechanism can be developed to encourage government programmes to work with and through them giving them the flexibility to determine their own agenda in partnership with government?

A second positive development lies in women's increasingly active role in *panchayati raj* and *nagar palika* institutions. The reservation of a third of elected members for women at each level of the third tier of local government promises of bring about far reaching change in women's status. It will not happen automatically though. Outcomes are likely to be contrasted across the country. At the same time, and if imaginatively supported, newly elected women on local councils have the potential to be amongst the most potent forces of change in the coming period.

They need to be supported with orientation about their roles, ways of understanding their own situation, and where they can contribute most effectively. They need to understand their role, responsibilities and authority with respect to Schedule 11, especially under health, education, welfare etc. Can we keep track of women once elected-what they are doing, what they are endorsed to do by the community, and highlight the positive examples that are already emerging from panchayats.

Women's rights go far beyond the physical benefits of development programmes. There is a pressing need to address women's rights in the social and family sphere. We need to combat violence against women in dowry deaths, and on a more mundane but important level, within the family itself. Such violence often spills over to affect children. Even if not physically, it often takes place in the presence of children, causing intense stress in the family, and setting in place inter-generational patterns/attitudes that are all the more difficult to change. In all programmes designed for or on behalf of women, women themselves need to be much more central to decision-making, involved in the planning of programmes, with poor women seen as actors rather than passive beneficiaries of programme inputs. How can we make the society more aware of the Convention on the Elimination of Discrimination Against Women, to debate, discuss and realize the basic rights of women, and to take specific action at the community level to stop violence against women? Can we find new and more sensitive measures of progress on this key area so it can be monitored closely?

5.2. Renewed commitment to the girl-child

The material situation of the girl-child has arguably improved more over the last decade than previous periods - more girls go to and stay in school, evidence of excess malnutrition amongst girls is less marked. Yet, the rights of the girl-child are increasingly threatened. Firstly, the report notes that the number of "missing girls", as measured by the sex ratio, is possibly increasing rather than decreasing. This is partly related to the spread of new and relatively inexpensive technology for sex determination. One cannot easily control access to and use of new medical technologies. It is, however, important to challenge prevailing patriarchal attitudes and mindsets of both men and women, that sees a girl as a liability rather than an asset.

There is an urgent need for the media to highlight positive models of families valuing girls in themselves, contributing to their own family economically, thereby challenging the widespread belief that investing in a girl is investing in someone else's well-being.

Equally deep-seated and entrenched are caring practices for the young infant girl, and expectations of the roles that the girl-child should play in the family. She is often expected to look after a younger sibling, or attend to household or minor agricultural chores, often forcing her to drop prematurely out of school. These social attitudes change only slowly, but they are changing. One of the most important sources of change in values is girls' education. Evidence from the south, Kerala and Tamil Nadu, confirms how powerful this intervention can be. Indeed, there is a remarkable universality in the lessons that have been drawn from across the world, pointing to the high social and economic returns that come from investing in girls' education.

There is need to accelerate this process. Progress on girls attending and staying in school is under way but not nearly fast enough, and ensuring that all girls stay for a minimum of five years of primary schooling remains a huge task in large parts of the country. Only if primary education is made an accepted obligation of the state will primary education ever become truly universal in the country. Until that happens, the girl-child will remain last in line for schooling.

Two other areas for urgent action concerning the girl-child are highlighted in the text. The first concerns one of the worst violations of child rights-and one that continues to

flourish-in the form of child prostitution. There is now open recognition of extensive trafficking and sale of children for purposes of prostitution, operating both within the country and across national frontiers of Nepal and Bangladesh. A second related issue is that of child marriage, still prevalent in many parts of Madhya Pradesh, Rajasthan, U.P and Bihar.

Each of these denials of girls' fundamental rights raises much broader issues about society's values and what it will tolerate. The move against these extreme violations of girls' rights call for new alliances of civil society, activist NGOs, a proactive judiciary, the media as well as the government.

The nature of these violations requires more documentation, and understanding of causal mechanisms. Change has to come at source, but also in social attitudes. Change will only come if there is outrage against such exploitation of children. How can this be channeled into effective social action? Urgent action across countries is also clearly needed-in the framework of SAARC-to put a stop to this unacceptable trade in children.

The girl-child grows rapidly into adolescence. It is the unmet needs of the adolescent, and particularly the adolescent girl, which is one of the striking conclusions of this survey. Adolescence is a period still needing protection, but in a graduated way, with adolescents themselves increasingly taking the responsibility for themselves. Many of the schemes that have been designed to reach out to adolescents are gravely lacking in effectiveness and impact. While increasingly recognized, solutions remain poorly sketched in.

Can we develop community-based activities for adolescent girls to assure improvement in their nutrition, health and their access to knowledge on reproduction and family life? Organizing adolescent girls around a range of activities can offer them self-esteem, solidarity with peers and an enhanced learning environment.

5.3. Decentralization and local governance

New partnerships need to be forged with the community across all development efforts. This is particularly between the frontline worker and the community that he or she serves, building on recent constitutional amendments that mandate the creation of a 'third tier' of the local government - *panchayati raj* in the rural areas, *nagarpalikas* in urban areas.

Progress across the country in attributing responsibility to panchayats (and attributing resources to fulfill these responsibilities) has been uneven, and still meets with opposition from those who benefit from the status quo. These may be local politicians or MLAs who fear a dilution on their own grassroots political base, or government bureaucrats still ill at ease in working for and being asked to be accountable to locally-elected bodies.

The argument of this report is that earlier experience of *panchayati raj* is not necessarily the best guide to how the future will shape the practice of local government. Two critical differences include the emphasis on the *gram sabha*, the regular meeting of all members of the community to hear reports of action taken by the *panchayat* and decide issues, and the election of women as both members and *panchayat* chairpersons. While progress on both these fronts is till in its early stages, and risk, as always, being taken over by powerful local interests and castes, they offer a new and critical platform for long term change. If the *gram sabha* can take place on a regular basis, it will be issues of education, drinking water, quality of health care and issues that affect women and children which will appear much more forthrightly on local political agendas. These need to become the issues around which elections are fought and performance of *panchayat* members judged. There is still a major agenda of institutional change ahead:

- ***There is a pressing need for the right to information and transparency, so community members could know how resources are used and distributed.***
- ***Local governments need to be given the resources and authority to fulfill their new mandate in the social sectors under Schedule 11. Failure to address this gap will put the credibility of the new constitutional reform seriously at risk.***

- ***These recent changes need to be actively supported with an investment in community monitoring. If communities can themselves set their own development goals, especially goals for children, and monitor progress towards them, a major sea change in development will take place.***

Urban areas face a special set of problems underlined in the report. One of the paradoxes of present day India is that, while the quality of life in urban areas is superior in many respects to that in rural areas, there is no planned system that reaches out to provide an effective public health system to all the population, let alone the poor. In health, an unregulated private sector steps into fill the gap but at a high cost to poor families. *Nagar palikas* are still not fully empowered. Reorganization of social services in urban areas is urgently needed, and their financing base is an area requiring special attention from policy-makers.

Information on urban dwellers must be disaggregated to focus on the situation of the poor, their health, nutrition, education, housing and the situation of their environment. While organizations of urban dwellers, especially women are gaining ground, means are needed to link them more closely with essential services, which continue to neglect and bypass the poorest in urban areas. There is an urgent need to better define the urban agenda under the 12th Schedule for meeting the needs of and rights of children.

5.4. Ensuring that children's rights are fulfilled through the social sectors

The perspective of rights adopted for this situation analysis has underlined that many issues affecting children and women cannot be treated, as they so often are within sectoral boxes. Causes of poor health and nutrition are complex and interrelated, often cutting across traditional divisions of labour that mark current development efforts. Efforts to universalize primary education go hand in hand with those to eliminate child labour. The environment of the child involves family behaviours and knowledge, collective action in improving/maintaining water systems, and increasing attention to community management of watersheds etc., all calling for intersectoral action. Rights of children and women, in this sense, are not divisible. The situation analysis has pointed to a number of gaps-the synergies that are not at present being realized-but it also has pointed to many opportunities that currently exist, and which have given rise to the recent emphasis on 'convergence' as a priority for the Ninth Plan.

Any effort to bring about the much-needed convergence of different sectors has to recognize that there is a crisis in the delivery system. Village-level functionaries still look upwards to their line department for instructions, and do not feel themselves accountable to the community, let alone working with other parts of the government's development extension outreach. The situation analysis points to the crucial importance of teamwork between field workers at the grassroots level, and the need to strengthen accountability to the community, through *panchayati raj* and *nagar palika* mechanisms, where these are in place and working or through other community groups.

A rights approach reminds us that development deals with and centers on people, and needs to be people-based. All the rest of development effort needs to be as facilitators. Participation, ownership and sustainability become not only desired as outcomes, but necessary processes that inform the way development is designed and implemented. The report points to a common set of actions that are needed in all social sector areas: what could be called a "***common agenda***":

- ***The creation of community demand for quality services is a need across all sectors. It calls for community empowerment, including a special role for women and youth, and a focus on those often excluded from current development efforts.***
- ***In many, if not all, sectors the current 'quality' of service delivery at different levels remains poor. Efforts need to focus on the needs of the frontline worker, make service-providers more accountable to the community they serve, and provide quality of service to match community demand.***

- ***A third and new ingredient calls for a much clearer articulation of the responsibilities of the family and community itself to take action to fulfill the rights of every child.***

While the focus is on community action and convergence, a rights perspective also underlines that it is the obligation of the state to provide adequate resources to meet what are increasingly recognized as minimum rights in each sector of health, education, nutrition, drinking water, etc. There is no reason to believe that governments cannot afford the public spending needed on such vital services. It reminds us that the society is making a choice in its allocation of resources: between defense and education, between subsidies that are often captured by the better off, and direct provision of a adequate primary health care and quality schooling. Government is still too often preoccupied by the former rather than the latter, failing to see what can be done within existing resources. Many of these 'doables' are captured in the goals set out in the World Summit for Children for the year 2000.

5.4.1. Health

Within health, the neglect of maternal deaths needs to be seen as a rights issue rather than a mere failure of service delivery. Strategies are needed that set maternal mortality clearly as a priority for action. They have to be set in a framework of gender discrimination and attitudes towards women, as well as concentrating on measures that the health system can put in place within the existing resources. These include:

- ***Provision of emergency obstetric care as a key intervention - one that is till limited in geographic availability and quality. EOC has to be assured in all district and sub district health services within a time-bound period;***
- ***Massive efforts to inform women and communities about actions they can take to prevent many of these avoidable deaths;***
- ***Every death of a woman related to childbirth should be subject to a social audit, a reasoned discussion by the community itself along with health workers, in order to determine how such tragedies can be avoided.***

For children, the report urgently reminds that there is still a large unfinished agenda and extensive unmet needs in child health. Reported data conceal rather than highlight the extent of the shortfall in reaching all children with basic protection from immunizable disease, prevention of death from pneumonia or diarrhoeal disease, often closely linked to malnutrition. It calls for a renewed commitment to child health as attention and concern swings towards another neglected area of reproductive health. Achievements in child health need to be protected and extended within this broader and more complex goal of improving quality of care in the health services. While gains in infant mortality have taken place, neonatal mortality has stagnated, calling for new strategies that focus on the first two months of life, a period dominated by the experience of pregnancy and quality of service in delivery. High returns can be gained by:

- ***Renewed emphasis on the training needs of the frontline worker, emphasizing skills in communication, and collaborating with the community, especially in ensuring that the essentials of newborn care, ARI and diarrhoea management reach every child. Many of these problems can be managed in the community itself. How can this shift be brought about?***
- ***Strengthening the linkages between health and ICDS programme delivery structures through joint training of ANMs and AWWs, and their supervisors. This remains a central challenge for the new EU/IBRD supported RCH project and for achieving many health and nutrition goals. Can this link be institutionalized through local decentralized planning of both programmes together?***

5.4.2. Nutrition

In nutrition, first and foremost, there is a need for a national consensus to be created that recognizes the true nature of the problem. Especially, regarding the position of women and their lack of choices which leads to malnutrition in their children. Low birth weight is one

striking measure of women's deprivation. Poor complementary feeding practices, that give rise to the sharp increase in the incidence of malnutrition between the ages of 4 and 12 months, is another and is linked to the importance of adequate breastfeeding for the first six months.

An even stronger effort has to be made to improve the position of women and girls. They need to be given more effective access to education, and empowered in a manner that they can make informed choices. While such a consensus is growing nationally, it still needs constant strengthening. It now has to be transformed into action on a large scale in the field. Such action has to be intersectoral, based on the recognition that improvements in nutrition will not come from inputs in the nutrition sector per se.

- ***Measures are needed at the family and community level so that women are better cared for, not only during pregnancy but during adolescence, and particularly have their work burden reduced. They need to have access to the health worker, to health services, to proper institutional care during delivery, be informed about the benefits of postponing early marriages, proper spacing and timing of births, and supported in their efforts to change long-entrenched social norms and practices. How can this access and knowledge be provided to every woman?***
- ***This is not only a matter of expanding the physical provisioning of services-necessary no doubt. If the health status of women has to improve, society has to change its attitudes towards women. The strong anti-female bias in the Indian society has to disappear. How can men and fathers be brought to recognize and share responsibility for bringing up children, and, in doing so, enable women to care better for themselves?***
- ***Finally, how can the considerable national efforts to improve nutrition be reoriented to focus on healthy growth in the first year of life, when malnutrition in the child develops, and is almost entirely unrecognized? Assuring adequate food intake by women during pregnancy, support of exclusive breastfeeding, and the timely introduction of appropriate complementary foods are well-established objectives. Can these be enshrined as nutrition rights and promulgated through all media channels?***

5.4.3. Early child development

Easily child development has been a central objective of the national ICDS programme for twenty years. Attention during this time has been on expansion of services so that ICDS could be universalized-now close to achievement. ICDS constitutes a crucial link between health and education sectors, and between the preschool and primary school systems. In many ways, the potential of this huge network of *anganwadi* centers and workers is still to be fulfilled.

- ***Attention now needs to shift to the quality of services provided, and create space for innovation. For early child development, there is need to reach out to the primary care givers in the family.***
- ***Much more needs to be done to raise awareness of the need for early child stimulation and age-dependent milestones, focusing on health/nutrition/hygiene behaviours and knowledge in the first year of life, moving to growth monitoring, early stimulation and language development.***
- ***Much of this requires action reaching out to the family rather than center-based, calling for teamwork between ICDS and health workers. Recruitment of an additional village level worker for such outreach work would allow the present anganwadi worker to concentrate on preschool activities, and forge closer links with the primary school.***
- ***Specific actions need to be identified to enroll the community in improving their own child care resources, especially in the setting up of the anganwadi. Crèches for working mothers, improved child play and safe environment need to be organized and run by the community itself.***
- ***ICDS in urban areas is deserving of special attention, as the population densities in urban slums make the anganwadi an important community resource from and around which other services can be delivered. There is a need to both expand as well as adjust ICDS norms to the conditions found in congested urban slums and informal settlements.***

5.4.4. Primary education

The need for rapid universalization of primary education (UPE) as a right of all children runs as a common thread through the report. The report underlines both recent progress and the scale of the challenge ahead.

A crucial area for action remains the attitudes of policy-makers to recognize the urgency of moving decisively towards universal primary education. Many policy statements endorsing UPE as a goal have been made, yet the commitment to fulfill this key right of all children within a reasonable time-frame remains uncertain, and sometimes wavers. Resources on a large scale still need to be injected into the sector at both national and state level with an explicit place for community ownership and involvement. These commitments need to be made ironclad, defended at all costs against any possible austerity budgetary cuts.

We are also looking for a new model of what the school is. A place where children learn joyfully and which opens out to the community. While calling for action to ensure all children attend school, a revolution is also needed in the way teachers see their role in the classroom and feel themselves accountable to the community. The report underlines the many initiatives that are currently under way across the country, experimenting with these new ideas and approaches. These need to be taken up much more widely and forcefully. Specifically,

- ***Much greater focus is needed on helping the teacher, especially those faced with large classes and few resources. There has been an extraordinary and enthusiastic response of teachers to increased awareness of what they can do themselves, empowered by support of their peers. These efforts now need to be broadened with the dissemination of innovative experiences: wider use of parateachers; multigrade teaching; ways to individualize teaching; tailoring the teachers' approach to each child; linking up with the community and environment as a source of life skills; and using child to child methodologies.***
- ***The support the teacher needs from peer supervisors needs to be provided in an imaginative and supportive way. Cluster Resource Centers at sub block level offer the potential to provide recurrent training needed and the link between the school and the formal in-service training system.***
- ***Fundamentally, however, it is argued in this analysis that only if there is a commitment to compulsory primary education, and a clear strategy towards its implementation adopted, will society address the right of every child to education, in the 50th year of India's independence, nothing would be more fitting than recognition of primary education as fundamental right, as already implied under the constitution.***
- ***For this, there has to be a groundswell at national and state level, demonstrating how compulsory primary education can be implemented, using an incremental approach highlighting positive actions, and winning the support of political parties.***

Success in universalizing primary education is closely linked to the degree of success likely in tackling the problem of child labour. Child labour and children out of school are two sides of the same coin. Joint strategies are needed to ensure children who are taken out of child labour indeed have the option of a reasonable quality of education. While elimination of child labour is seen as an enormous challenge, with the rehabilitation of the millions of children in child labour an expensive and difficult process, it is clear that universalizing primary education is the only most effective means of prevention, so that new cohorts of children do not enter into labour. Assuring that every child enters school at the proper age, and remains there through a minimum of 5 full years of learning, offers a workable and affordable means to a phased elimination of all child labour within the next decade.

5.4.5. Environment

The child environment brings together what have in the past offer been seen as fragmented parts of a jigsaw. At one level the environment is dependent on individual action, hygiene, handwashing an excreta disposal practices. It is also critical to have community pressure too for changes in attitudes and values .The report underlines the relationship between rights to drinking water and threats to the ecosystem and the wider environment as watersheds de-

grade. It also underlines the importance of women's role in the sector, not only as fetches and users of water, but as key agents of change and potential proctors of the environment. There is need for urgent new dialogue on the issues related to the environment and policy breakthroughs and institutional reform in tackling the highly political and charged concerns of water use.

- ***Firstly, in sustaining the large investment in safe drinking water provision that was made during the eighties and early nineties. Community based operation and maintenance systems need to be rapidly universalized. How can panchayati raj institutions be brought effectively in to this framework?***
- ***Secondly, in seeing long term issues of sustainability in terms of wider water use trends, and protecting the environment from overuse and exploitation issues of water quality are raising an entirely new set of legal and programmatic concerns. Technological solutions are urgently needed to problems of arsenic, fluoride and iron as well as bacterial infiltration in community water supplies.***
- ***Thirdly, in setting a policy and institutional framework for the management, and regulation and competing water use. Equity between users needs to be assured, across rural/urban areas, across income groups, across different social groups and castes. Drinking water needs to be seen as a right that is met for all before other users draw on available water resources.***
- ***Fourthly, in giving a further impetus to the still neglected areas of sanitation. In both rural and urban areas , sanitation has to be placed on a much higher priority in terms of resource and attention.***

Convergence between all five areas identified above remain the central concern for sustainability. They are all interrelated, and if successfully addressed, would result in many synergies. Formally national goals offer lie with sectors as their individual responsibility. To achieve them successfully requires intersectoral work. This is where current structures are still not well developed and need the highest level of administrative action. Interest in convergence has waxed and waned in India's development in the sixties, lost sight of as sectoral ministries have gained in strength, each wanting to ensure service delivery in a vertical fashion. Now is the time for renewed attention to structural issues; opened up by the constitutional amendment, but also because the strength of individual sectors is much greater than in the past.

5.5. Protection and participation rights

A rights approach encourages a fresh analysis of old problems that have traditionally been seen as concerns of welfare and charity. Central to this new paradigm is that rights imply obligations at family community, state and international levels. The protection rights of children are particularly subject to this new way of thinking.

The report brought to the forefront a number of blatant violations on the Convention on the Rights of the Child, many of which are now being taken up by the National Human Rights Commission. The persistence of child labour, the neglected needs and discrimination faced by street-children and the disabled, all featured strongly. Problems are often overlapping, with poor families particularly vulnerable, with the girl child and the street-child often bearing the burden of multiple discriminations. The analysis of the report repeatedly returned to the importance of prevention. Its argument is that while sensitive action is often needed to help children directly affected by violations, one is often left dealing with symptoms not causes. The bulk of society's resources and attention have to be directed to addressing underlying sources of the problem: hence, the unabashed preeminence given in this report to fundamental issues, such as primary education and changes in the status of women.

Attention to the rights of children and women at the family level reminds that it is within the family that rights are sometimes most flagrantly abused. Data on child abuse is scarce but evidence suggests that it is widespread within families. The situation analysis pointed out that domestic child labour and abuse is common. Violence against women, dowry deaths are often shrouded inside the

family institution. What can be done to open this domain for debate and public discussion of what values are important, within the family as much as in society and particularly important at the present time?

Participation of children is a relatively unfamiliar concept in India as in many other countries. It easily lends itself to tokenism. The serious proposition put forward, however, is that children do have voices and these need to be heard. Particularly about matters that concern them; also, about what is happening to the environment and trends in society at large. Rather than be ignored, these voices are to be given space and nurtured. What are the institutions that can provide fora for children hear, debate and participate? These need to be explored and supported.

The role of the media on protection rights, indeed on all child rights, is critical, especially in opening up issues that had previously been met with denial for wider debate. Many of the problems do not yet have obvious solutions - there are no technologies that can easily be put to work. Solutions will emerge only if issues are debated widely and attention drawn to success stories. The media has a special role in ensuring that such a debate takes place and holding government responsible for its commitments to children, and, where needed, drawing attention to shortfalls.

There needs to be an assurance that information and media is appropriate for children of all ages, and will contribute constructively in their positive development, self image and responsible behaviours. Stereotypes in the portrayal of the child, particularly the girl-child need to be regularly challenged. "Doable" actions in this growing area of UNICEF concern include:

- ***The Convention on the Rights of the Child remains relatively unknown amongst the public. Its wide dissemination in public format, and discussion by both adult society and children can bring significant change. Action is needed in bringing the legal system in conformity with the Convention.***
- ***Addressing child labour, a change in the 1986 legislation from protection and regulation to elimination would signal that child labour is not acceptable to society, and make provisions actionable in major sectors not covered by the existing Act.***
- ***There needs to be a major initiative to end bonded labour as envisaged by the recent SAARC commitment to Eliminate Bonded Labour by the year 2000. This needs to be a multi-sectoral effort involving action on existing legislation and independent monitoring of progress, with a nationwide information campaign on the legal rights of bonded children and its prohibition.***
- ***Prevention of child prostitution calls for public action in uncontrovertible terms, both within the country and taken up as an area of cooperation in a bilateral context with neighbouring countries.***
- ***The rights of the disabled child remain a key area of concern, calling for mainstreaming of the disabled child in community institutions, in ICDS and later in primary school. What can be done to enforce the recent Disability Act, and to confront the multiple discrimination the disabled child faces?***

Changes accompanying and stimulated by liberalization can promote or undermine progress to fulfill child rights. There are clearly important shifts in mindsets under way. The private sector is showing increasing concern for social issues. The economic and budgetary impact of liberalization and adjustment are as yet unclear, and could sharpen quickly in the period ahead. The situation of children needs to be monitored closely and tracked during such a period of rapid economic change.

In all these areas, the role of legislation and enforcement is limited, though it may have symbolic value. The importance of societal action takes pride of place. How to win and sustain that social action is a question that only the Indian society can answer. The Convention on the Rights of the Child asks the nation to find those answers and measure itself against the yardsticks included therein.

5.6. Partnerships

A rights approach calls for broad partnerships with the civil society to fulfill and respect the rights of children. Clearly, rights cannot be fulfilled through government actions alone. Government's role is important in setting standards, raising public awareness and providing vision of what values and standards it wants to see become a norm in society. There is a need for other parts of civil society to be involved, reaching out especially to those groups who have been outside the reach of conventional programmes, in partnerships with NGOs and community groups.

One of the areas of greatest potential in partnerships is that of adolescents, both boys and girls. Not only as beneficiaries but to involve them as active participants in development. In particular, the role of youth at the community level could be substantially enhanced, both for the value of their participation in planning and implementation of programmes and for the tremendous human resource this represents in moulding a better society. The outreach of the NYK/NSS, Scouts and Guides and NVS Volunteers is unique and offers untapped opportunities for mobilization in support of community development as well as empowerment of the young people so involved.

5.7. Conclusion

The situation of children in India is varied and complex, but as this report has shown, there are many commonalities in communities of all sizes and composition. This can form the basis of a common agenda owned by the community, supported by the government and private sector resources in support of participatory processes that will assure the rights of every child. In addition to the common needs and opportunities, there is a wide array of special situations, problems and resources that require a differentiated approach between each community, enabling a higher degree of responsiveness as well as ownership of problems and their solution. Thus, while there is unity in the goals, there must be diversity in their responses. Therefore, the process of decentralization of the planning and implementation of national programmes, and their adaptation to local realities, is critical to the success of development efforts and to the realization of the rights of every child.

In view of this situation, the thrust of UNICEF's attention must change substantially. While it must continue its role in the gathering of information, its objective analysis and dissemination, it should assume a larger role in helping conceptualize its issues, explore and identify feasible actions, demonstrate their practical implementation in the field, and present well documented results to the government and other partners for wide-spread implementation. It is particularly important to increase our role in monitoring, in measuring progress in both the processes and outputs towards the fulfillment of commitments to children. UNICEF enjoys a level of credibility with its government partners and in the eyes of the public, that must be continually earned and renewed through valid and well-documented observations and interpretation of the situation of children. As we reach towards fulfillment of the goals for the year 2000, we must be constantly developing the vision for India's children for the early decades of the next century. This ongoing dialogue must emerge from a sound basis of field experience, of widening partnerships, of objective data, and a broad societal commitment that places children first.

Table of Acronyms

ADB	Asian Development Bank
AFP	Acute Flaccid Paralysis
ANM	Auxiliary Nurse Midwives
ARI	Acute Respiratory Infections
AWW	Anganwadi Worker
BEP	Bihar Education Programme
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
CES	Coverage Evaluation Surveys
CCA	Convergent Community Action
CMT	Country Management Team
CPMP	Country Programme Management Plan
CRC	Convention on the Rights of the Child
CSSM	Child Survival and Safe Motherhood
DPEP	District Primary Education Programme
DWCD	Department of Women and Child Development
DWCRA	Development of Women and Children in Rural Areas
ECD	Early Childhood Development
EPI	Expanded Programme on Immunization
FRU	First Referral Unit
GDI	Gender-related Development Index
GDP	Gross Domestic Product
GOI	Government of India
HDI	Human Development Index
ICDS	Integrated Child Development Services
IDD	Iodine Deficiency Disorders
IDF	India Development Forum
ILO	International Labour Organisation
IMR	Infant Mortality Rate
KAP	Knowledge, Attitude and Practices
LBW	Low Birth Weight
MICS	Multi-Indicator Cluster Survey
MLL	Minimum Levels of Learning
MPO	Master Plan of Operation
MMR	Maternal Mortality Ratio
NCAER	National Council for Applied Economic Research
NEEM	National Elementary Education Mission
NFHS	National Family Health Survey
NNT	Neonatal Tetanus
NGO	Non-Governmental Organisation
NHRC	National Human Rights Commission
PHC	Primary Health Care
PLA	Participatory Learning and Action
PRI	Panchayati Raj Insitutions
ProMS	Programme Management System
RCH	Reproductive and Child Health
SCOPE	Support for Community-based Primary Education
SRS	Sample Registration System
SUPER	Support for Primary Education Renewal
TFA	Target Free Approach
TBA	Traditional Birth Attendant
U5MR	Under Five Mortality Rate
UBSP	Urban Basic Services for the Poor
UNDAF	United Nations Development Assistance Framework

UNFPA	United Nations Population Fund
UNDG	United Nations Development Group (UNDP, UNFPA, UNICEF & WFP)
UNDGO	United Nations Development Group Office
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UPE	Universal Primary Education
VPD	Vaccine Preventable Diseases
WFP	World Food Programme

Definitions

Age Specific Fertility Rate

$$ASFR = \frac{Number\ of\ live\ births\ in\ a\ particular\ age\ group}{Mid-year\ female\ population\ in\ the\ same\ age\ group} * 1000$$

Annual rate of reduction in IMR
Calculated as the 1 minus the n'th root of the difference between the IMR at the end and the beginning of the period in question, n being the number of years in the period. For example the annual rate of reduction in IMR in the period 1981-83 and 1991-93 be calculated the following way:

$$Annual\ reduction\ of\ IMR_{1981/83-91/93} = 1 - \sqrt[10]{pop_{1991/93} - pop_{1981/83}}$$

ARI Treatment, percentage taken to a health facility or provider
Includes treatment at government/municipal hospital, private hospital/clinic, PHC, sub-center, doctor or other health professional.

Child
According to the Convention on the Rights of the Child, a child is a person younger than 18 years.

Crude Birth Rate (CBR)

$$CBR = \frac{Number\ of\ live\ births\ during\ the\ year}{Mid-year\ population} * 1000$$

Crude Death Rate (CDR)

$$CDR = \frac{Number\ of\ deaths\ during\ the\ year}{Mid-year\ population} * 1000$$

Fully Immunized
A fully immunized child is defined as a child having received BCG, measles and three doses of DPT and three doses of polio vaccine.

Gender-related Development Index (GDI)
The GDI is the gender adjusted HDI. It uses the same variables as the HDI. The difference is that the GDI adjust the average achievement of each country in life expectancy, educational attainment and income with the disparity in achievement between men and women. For this gender-sensitive adjustment a weighing formula that expresses a moderate aversion to inequality has been applied. As the HDI, the GDI cannot exceed 1 and gender development is higher for higher GDI. The highest GDI in 1994 was 0.939 (Canada) and the lowest 0.155 (Sierra Leone).

Gross enrolment ratio (GER)

$$GER = \frac{School\ enrolment\ in\ particular\ class}{Total\ population\ in\ corresponding\ age\ group} * 100$$

Human Development Index (HDI)
The HDI is based on three indicators: longevity, as measured by life expectancy at birth; educational attainment, as measured by a combination of adult literacy (two-thirds weight) and combined primary, secondary and tertiary enrolment ratios (one-third weight); and standard of living, as measured by real

GDP per capita (PPP$). The higher the HDI value the higher human development. The HDI cannot exceed 1. The highest HDI-value in 1994 was 0.960 (Canada) and the lowest 0.176 (Sierra Leone)

Infant Mortality Rate (IMR)

$$IMR = \frac{Annual\ number\ of\ infant\ deaths}{Annual\ number\ of\ live\ births} * 1000$$

Life expectancy at birth

The number of years a newborn child would live if subject to the mortality risks prevailing for the cross-section of population at the time of child's birth.

Literate

A person who can read and write with understanding.

Maternal Mortality Ratio

$$MMR = \frac{Annual\ no.\ of\ deaths\ of\ women\ from\ pregnancy\ related\ causes}{Annual\ number\ of\ live\ births} * 100,000$$

Neo-natal Mortality Rate (NMR)

$$NMR = \frac{Annual\ number\ of\ infant\ deaths\ of\ less\ than\ 28\ days}{Annual\ number\ of\ live\ births} * 1000$$

Peri-natal Mortality Rate (PMR)

$$PMR = \frac{Annual\ number\ of\ still\ births + infant\ deaths\ of\ less\ than\ 7\ days}{Annual\ number\ of\ live\ births} * 1000$$

Population annual growth

Calculated as the 1 minus the n'th root of the difference between the population at the end and the beginning of the period in question, n being the number of years in the period. For example the annual population growth in the period 1951-81 be calculated the following way:

$$Population\ annual\ growth_{1951\text{-}81} = 1 - \sqrt[30]{pop_{1981} - pop_{1951}}$$

Post Neo-natal Mortality Rate (PNMR)

$$PNMR = \frac{Annual\ number\ of\ infant\ deaths\ of\ over\ 28\ days}{Annual\ number\ of\ live\ births} * 1000$$

Sex ratio

The number of females per 1,000 males in a population.

Stunting, moderate and severe

Assessed by height for age as those more than 2 standard deviations below the median of the International Reference Population, recommended by the World Health Organisation (WHO).

Teacher-pupil ratio

$$Teacher\text{ - }pupil\ ratio = \frac{Total\ enrolment\ in\ type\ of\ school}{Total\ number\ of\ teachers\ in\ type\ of\ school}$$

Total Fertility Rate (TFR)
The number of children that would be born per women, if she were to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates. Is calculated as:

$$TFR = \frac{5 * \sum_{15\text{-}19}^{45\text{-}49} Age\ Specific\ Fertility\ Rate}{1000}$$

Trained health personnel
Defined as a doctor, nurse and midwife.

TT-immunized women
Covers women who received either two or more doses of TT and women who received one dose (booster dose), but had completed the immunization programme during an earlier pregnancy.

Under-five Mortality Rate (U5MR)
For a calendar period, deaths and exposure (q) in that period are first tabulated for the relevant age intervals, 0, 1-2, 3-5, 6-11, 12-23, 24-35, 36-47, and 48-59 months. Then age interval specific probabilities of survival are calculated (1-q). Finally, the U5MR is calculated by multiplying the relevant age interval survival probabilities together and subtracting the product from 1, i.e.

$$U5MR = 1 - [(1-q_0)(1-q_{1\text{-}2})(1-q_{3\text{-}5})(1-q_{6\text{-}11})(1-q_{12\text{-}23})(1-q_{24\text{-}35})(1-q_{36\text{-}47})(1-q_{48\text{-}59})]$$

Underweight, moderate and severe
Assessed by weight for age as those more than 2 standard deviations below the median of the International Reference Population, recommended by the World Health Organisation (WHO).

Wasting, moderate and severe
Assessed by height for weight as those more than 2 standard deviations below the median of the International Reference Population, recommended by the World Health Organisation (WHO).

Indicators by States and Union Territories

In this Situation Analysis, we have tried to convey both the diversity and magnitude of the situation facing by children and women in India today. For a country that has more children than there are on the whole African continent, this is by no means an easy task. On the following 15 pages, data collected from numerous sources have been grouped and listed to provide the opportunity for further analysis and as a reference tool for any concerned with the well-being of children in India.

The tables have been grouped as follows :

1. Basic Indicators
2. Survival
3. Health
4. Nutrition
5. Education
6. Demography
7. Economy
8. Housing
9. Gender
10. Rural/urban
11. Marriage
12. Politics
13. Scheduled Caste/Scheduled Tribes
14. Crime

The sources for each indicator is indicated at the bottom of the column, however the main sources for these tables are as follows:

- Census, various years, Registrar General of India
- Sample Registration System, various years, Registrar General of India
- Planning Commission, Government of India, 1994
- Lakdawala Report, Planning Commission, Government of India, 1994
- Economic Survey, various years, Ministry of Finance, Government of India
- Annual Reports, Ministry of Human Resource Development (MHRD), Government of India,
- Crime in India, Ministry of Home, 1994
- Election Commission
- National Family Health Survey, IIPS, Mumbai
- Fifth and Sixth All India Educational Surveys, NCERT
- National Council for Applied Economic Research (NCAER), HDI Survey 1994-95

Table 1 Basic indicators

Table 1 Basic indicators	Infant mortality rate	Under five mortality rate	Population, thousands	Estimated population, thousands	Estimated annual births, thousands	Estimated annual number of infant deaths, thousands	SDP, per capita, rupees	Life expectancy at birth, years: male	Life expectancy at birth, years: female	Literacy rate, population 7+, percent
	1996	1992-93	1991	1996	1996	1996	1994-95	1990-92		1991
Andhra Pradesh	66	91.2	66,508	74,119	1,682.5	111.0	7,155	59.0	61.5	44.1
Arunachal Pradesh	n.a.	72.0	865	1,011	n.a.	n.a.	8,744	n.a.	n.a.	41.6
Assam	75	142.2	22,414	24,984	692.0	51.9	5,999	54.8	53.8	52.9
Bihar	72	127.5	86,374	96,005	3,081.8	221.9	3,816	60.4	58.3	38.5
Goa	n.a.	38.9	1,170	1,260	n.a.	n.a.	14,736	n.a.	n.a.	75.5
Gujarat	62	104.0	41,310	45,477	1,159.7	71.9	10,576	59.1	61.3	61.3
Haryana	68	98.7	16,464	18,583	535.2	36.4	12,158	62.2	63.6	55.8
Himachal Pradesh	n.a.	69.1	5,171	5,683	130.7	n.a.	7,784	63.8	64.2	63.9
Jammu and Kashmir	n.a.	59.1	7,719	8,764	n.a.	n.a	4,244	a.	n.a.	n.a.
Karnataka	53	87.3	44 977	49.499	1,138.5	60.3	8,082	60.0	63.6	56.0
Kerala	13	32.0	29,099	31,112	553.8	7.2	6,983	68.8	74.4	89.8
Madhya Pradesh	97	130.3	66,181	74,534	2,414.9	234.2	5,845	54.1	53.5	44.2
Maharashtra	48	70.3	78,937	88,512	2,053.5	98.6	13,112	63.1	64.7	64.9
Manipur	n.a.	61.7	1,837	2,089	n.a.	n.a.	5,362	n.a.	n.a.	59.9
Meghalaya	n.a.	86.9	1,775	2,046	n.a.	n.a.	6,136	n.a.	n.a.	49.1
Mizoram	n.a.	29.3	690	815	n.a.	n.a.	7,517	n.a.	n.a.	82.3
Nagaland	n.a.	20.7	1,210	1,511	n.a.	n.a.	6,638	n.a.	n.a.	61.6
Orissa	95	131.0	31,660	34,690	929.7	88.3	5,157	55.9	54.8	49.1
Punjab	95	68.0	20,282	22,292	523.9	49.8	14,188	65.4	67.5	58.5
Rajasthan	86	102.6	44,006	49,873	1,610.9	138.5	5,220	57.6	57.8	38.6
Sikkim	n.a.	n.a.	406	461	n.a.	n.a.	5,729	n.a.	n.a.	56.9
Tamil Nadu	54	86.5	55,859	60,004	1,152.1	62.2	8,941	61.0	63.2	62.7
Tripura	n.a.	104.6	2,757	3,195	n.a.	n.a.	4,252	n.a.	n.a.	60.4
Uttar Pradesh	85	141.3	139,112	155,832	5,298.3	450.4	5,331	56.8	54.6	41.6
West Bengal	55	99.3	68,078	76,031	1,733.5	95.3	6,877	60.5	62.0	57.7
Andaman & Nicobar Is	n.a.	n.a.	281	342	n.a.	n.a.	n.a.	n.a.	n.a.	73.0
Chandigarh	n.a.	n.a.	642	765	n.a.	n.a.	n.a.	n.a.	n.a.	77.8
Dadra & Nagar Haveli	n.a.	n.a.	138	160	n.a.	n.a.	n.a.	n.a.	n.a.	40.7
Daman & Diu	n.a.	n.a.	102	115	n.a.	n.a.	n.a.	n.a.	n.a.	71.2
Delhi	n.a.	83.1	9,421	11,593	n.a.	n.a.	17,068	n.a.	n.a.	75.3
Lakshadweep	n.a.	n.a.	52	59	n.a.	n.a.	n.a.	n.a.	n.a.	81.8
Pondicherry	n.a.	n.a.	808	934	n.a.	n.a.	n.a.	n.a.	n.a.	74.7
India, Total	72	109.3	846,303	941,832	25,806.2	1,858.0	n.a.	59.0	59.4	52.2
Source/Comments	SRS estimate, provisional	NFHS	Census 1991	Estimated	Estimated	Estimated	Economic Survey	Unpublished estimates from SRS, quoted in Dreze/Sen		Census 1991

Table 2 Survival indicators	Neonatal mortality rate	Post-neonatal mortality rate	Peri-natal mortality rate	Infant mortality			Annual rate of reduction in IMR, percent			Death rate, 0-4 years	Estimated number of children dying, thousands		
											before the age of one	before the age of five	between the age of one and five
	1994	1992	1994	1981-93	1989-91	1992-94	1981-83 to 1989-91	1989-91 to 1991-93	1981-83 to 1991-93	1992	1996		
Andhra Pradesh	47.7	18.5	47.8	81	74	67	1.1	3.6	1.6	20.0	136	171	35
Arunachal Pradesh	n.a.	n.a.	n.a.	n.a.	80	n.a.	n.a.	17.4	n.a.	n.a.	2	n.a.	n.a.
Assam	51.3	30.0	45.9	100	82	78	2.5	1.9	2.4	30.5	60	93	33
Bihar	44.3	27.7	35.0	110	79	70	4.2	5.5	4.5	26.8	212	396	184
Goa	n.a.	n.a.	n.a.	n.a.	23	n.a.	n.a.	7.2	n.a.	n.a.	n.a.	n.a.	n.a.
Gujarat	44.4	22.2	43.0	111	75	63	5.0	8.3	5.7	23.7	87	124	37
Haryana	45.0	33.6	44.0	95	73	70	3.3	2.9	3.2	22.8	43	62	19
Himachal Pradesh	41.7	23.6	33.4	n.a.	73	43	n.a.	3.6	n.a.	17.6	11	13	2
Jammu and Kashmir	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Karnataka	44.7	18.5	47.8	68	76	69	-1.4	2.7	-0.6	21.7	98	127	29
Kerala	12.6	5.8	20.5	34	18	15	8.3	9.5	8.5	3.9	10	12	2
Madhya Pradesh	60.2	39.7	51.0	134	115	103	1.9	2.7	2.1	38.5	292	401	110
Maharashtra	41.1	16.9	40.3	76	59	55	3.2	2.6	3.1	15.9	135	178	43
Manipur	n.a.	n.a.	n.a.	n.a.	29	n.a.	n.a.	14.8	n.a.	n.a.	1	n.a.	n.a.
Meghalaya	n.a.	n.a.	n.a.	n.a.	57	n.a.	n.a.	4.7	n.a.	n.a.	4	n.a.	n.a.
Mizoram	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Nagaland	n.a.	n.a.	n.a.	n.a.	18	n.a.	n.a.	60.4	n.a.	n.a.	n.a.	n.a.	n.a.
Orissa	70.6	41.7	63.1	131	122	109	0.9	2.6	1.2	33.4	121	150	29
Punjab	26.7	24.9	31.7	79	59	55	3.7	3.6	3.7	17.4	36	46	10
Rajasthan	53.3	34.4	46.1	105	86	85	2.5	1.8	2.4	33.6	144	233	89
Sikkim	n.a.	n.a.	n.a.	n.a.	56	n.a.	n.a.	11.6	n.a.	n.a.	0	n.a.	n.a.
Tamil Nadu	41.8	15.4	44.6	87	62	58	4.3	4.3	4.3	15.3	75	98	23
Tripura	n.a.	n.a.	n.a.	n.a.	52	n.a.	n.a.	3.0	n.a.	n.a.	n.a.	n.a.	n.a.
Uttar Pradesh	53.3	40.6	41.0	151	105	93	4.6	4.6	4.6	37.8	540	863	323
West Bengal	39.8	26.3	42.0	87	70	62	2.8	3.8	3.0	18.4	135	177	42
Andaman & Nicobar Is	n.a.	n.a.	n.a.	n.a.	36	n.a.	n.a.	1.4	n.a.	n.a.	n.a.	n.a.	n.a.
Chandigarh	n.a.	n.a.	n.a.	n.a.	27	n.a.	n.a.	29.9	n.a.	n.a.	n.a.	n.a.	n.a.
Dadra & Nagar Haveli	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Daman & Diu	n.a.	n.a.	n.a.	n.a.	56	n.a.	n.a.	3.8	n.a.	n.a.	n.a.	n.a.	n.a.
Delhi	n.a.	n.a.	n.a.	n.a.	48	n.a.	n.a.	12.4	n.a.	n.a.	11	n.a.	n.a.
Lakshadweep	n.a.	n.a.	n.a.	n.a.	38	n.a.	n.a.	12.5	n.a.	n.a.	n.a.	n.a.	n.a.
Pondicherry	n.a.	n.a.	n.a.	n.a.	30	n.a.	n.a.	11.8	n.a.	n.a.	n.a.	n.a.	n.a.
India, Total	**47.7**	**29.4**	**42.5**	**107**	**84**	**76**	**3.1**	**3.8**	**3.2**	**26.5**	**2,216**	**3,260**	**1,044**
Source/Comments	SRS	SRS	SRS	SRS	SRS	SRS	Calculated			SRS	Estimated		

Table 3 Health indicators

Table 3 Health indicators	Fully immunized children 12-23 months, percent			Children who received ORS or RHS, pct	ARI Treatment % taken to health facility	Pct treated w/antibiotic pill/syrup or given injection	TT-immunized women	Blood Pressure check-up, percent	Births attended by trained health personnel, percent			Institutional deliveries, percent			Any health facility in village	More than 5 km to any health facility	Number of hospital beds per million persons	
	male	female	total						rural	urban	total	rural	urban	total			rural	urban
	1994			1992-93	1992-93	1992-93	1994	1994	1992-93			1992-93			1992-93	1992-93	1992	
Andhra Pradesh	68.7	70.4	69.6	32.5	68.7	90.4	78.2	67.1	39.7	78.3	49.3	20.7	69.6	32.8	38.5	17.1	76	1,827
Arunachal Pradesh	n.a.	n.a.	n.a.	33.3	50.0	34.6	n.a.	n.a.	16.4	53.0	21.3	15.6	48.2	19.9	n.a.	n.a.	n.a.	n.a.
Assam	n.a.	n.a.	n.a.	35.2	40.7	15.0	n.a.	n.a.	14.1	56.8	17.8	7.4	50.1	11.1	31.6	14.4	175	4,414
Bihar	33.1	42.1	37.5	23.0	72.9	81.1	48.0	15.1	14.0	52.0	18.9	7.7	41.4	12.1	41.9	22.6	31	2,276
Goa	n.a.	n.a.	n.a.	41.4	82.3	48.4	n.a.	n.a.	86.8	90.1	88.4	85.1	88.7	86.8	61.3	11.6	n.a.	n.a.
Gujarat	72.9	76.2	74.6	20.7	73.3	52.3	71.1	46.2	32.0	65.7	42.6	23.7	62.1	35.6	32.5	27.2	185	2,904
Haryana	79.4	67.6	73.9	19.5	83.2	37.4	75.4	18.9	24.1	52.5	30.3	11.0	36.8	16.7	46.1	9.7	44	1,593
Himachal Pradesh	62.5	51.0	57.2	44.9	77.7	35.7	74.5	38.8	22.2	67.4	25.6	12.6	57.2	16.0	28.8	15.5	102	1,871
Jammu and Kashmir	n.a.	n.a.	n.a.	44.4	77.6	22.9	n.a.	n.a.	25.4	67.2	31.2	17.8	47.0	21.9	48.1	10.3	77	4,215
Karnataka	74.7	71.2	73.0	34.0	74.0	69.9	77.6	56.8	40.3	77.2	50.9	25.8	66.6	37.5	35.0	26.4	81	2,297
Kerala	80.9	76.2	78.6	37.8	81.3	47.4	95.0	94.4	87.6	95.7	89.7	85.4	94.7	87.8	98.2	0.0	1,768	4,230
Madhya Pradesh	55.2	51.0	53.2	33.0	61.8	87.3	36.6	14.6	22.1	61.1	30.0	7.4	49.7	15.9	17.2	26.8	39	1,313
Maharashtra	n.a.	n.a.	n.a.	41.7	72.6	61.5	82.4	38.9	37.6	77.8	53.1	25.3	73.3	43.9	34.8	30.3	250	3,251
Manipur	n.a.	n.a.	n.a.	63.1	39.5	26.3	n.a.	n.a.	31.0	63.1	40.5	16.6	38.2	23.0	n.a.	n.a.	n.a.	n.a.
Meghalaya	n.a.	n.a.	n.a.	40.7	86.8	50.0	n.a.	n.a.	27.4	76.3	37.0	19.0	73.4	29.6	n.a.	n.a.	n.a.	n.a.
Mizoram	n.a.	n.a.	n.a.	24.5	n.a.	n.a.	n.a.	n.a.	40.5	80.6	61.5	29.7	66.3	48.9	n.a.	n.a.	n.a.	n.a.
Nagaland	n.a.	n.a.	n.a.	24.6	31.6	23.7	n.a.	n.a.	18.1	45.6	22.2	5.2	10.9	6.0	n.a.	n.a.	n.a.	n.a.
Orissa	55.5	49.4	52.7	41.1	56.4	25.4	58.2	21.7	15.6	48.7	20.5	9.7	39.8	14.1	93.2	2.3	107	2,610
Punjab	62.0	62.1	62.0	32.7	91.5	19.1	77.2	44.2	44.7	60.1	48.4	21.3	36.2	24.8	40.5	5.2	196	2,040
Rajasthan	24.4	18.3	21.3	22.7	54.3	53.5	32.7	17.9	17.4	45.2	21.8	7.2	35.0	11.6	35.3	22.5	38	2,039
Sikkim	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Tamil Nadu	87.5	77.5	82.8	27.1	67.4	75.5	93.3	73.9	59.7	91.8	71.2	48.7	89.8	63.4	57.1	6.2	115	2,336
Tripura	n.a.	n.a.	n.a.	n.a.	59.6	14.9	n.a.	n.a.	26.0	80.8	33.4	22.8	80.8	30.7	n.a.	n.a.	n.a.	n.a.
Uttar Pradesh	42.4	40.2	41.3	22.6	68.3	71.3	47.2	11.2	11.6	44.2	17.2	6.5	34.1	11.2	23.3	18.2	23	1,619
West Bengal	30.7	31.7	31.2	74.7	61.7	19.0	56.2	16.2	23.1	66.5	33.0	21.4	66.0	31.5	40.4	17.8	154	2,479
Andaman & Nicobar Is	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Chandigarh	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Dadra & Nagar Haveli	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Daman & Diu	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Delhi	n.a.	n.a.	n.a.	39.4	88.0	42.2	n.a.	n.a.	n.a.	53.0	53.0	n.a.	44.3	44.3	n.a.	n.a.	n.a.	n.a.
Lakshadweep	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Pondicherry	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
India, Total	49.4	47.5	48.5	30.6	66.3	56.5	57.4	27.8	25.0	65.3	34.2	16.0	57.6	25.5	n.a.	n.a.	152	2,409
Source/Comments			NCAER	NFHS	NFHS	NFHS	NCAER	NCAER			NFHS			NFHS		NFHS		

Table 4 Nutrition indicators	Initiation of breastfeeding within first hour of birth	Children exclusively breastfed, 0-3 months, percent	Children breastfed with complementary foods, 6-9 months, percent	Children still breastfed, 20-23 months, percent	Under-fours suffering from underweight, (moderate & severe), pct	Under-fours suffering from wasting, (moderate & severe), pct	Under-fours suffering from stunting, (moderate & severe), pct	Estimated number of malnourished children	Per capita supply of foodgrains through the PDS, kg/year	Population receiving subsidized foodgrains from the PDS, percent		Availability of iodized salt as percent of total requirements
										rural	urban	
	1992-93	1992-93	1992-93	1992-93	1992-93	1992-93	1992-93	1992-93	1986-87	1986-87		1995
Andhra Pradesh	20.0	70.5	47.8	67.7	49.1	n.a	n.a	3,030,424	22.8	59.7	51.4	17
Arunachal Pradesh	40.6	73.9	35.8	73.0	39.7	11.2	53.9	n.a.	n.a.	n.a	n.a.	n.a.
Assam	20.0	65.0	39.2	82.5	50.4	10.8	52.2	1,102,569	30.5	24.6	43.0	98
Bihar	1.5	51.6	18.1	79.3	62.6	21.8	60.9	6,661,475	6.5	1.7	7.1	78
Goa	28.8	10.8	33.9	40.0	35.0	15.3	32.5	n.a	n.a.	n.a	n.a	n.a
Gujarat	14.0	36.3	22.9	48.1	50.1	18.9	48.2	1,887,484	24.5	44.5	32.0	88
Haryana	2.7	37.5	38.5	58.3	37.9	5.9	46.7	743,775	6.2	3.1	7.1	95
Himachal Pradesh	12.2	36.4	39.9	54.7	47.0	n.a	n.a	254,697	25.0	28.2	25.3	90
Jammu and Kashmir	7.1	16.9	44.8	51.8	44.5	14.8	40.8	n.a	34.6	23.3	78.6	n.a
Karnataka	5.4	65.6	38.2	54.5	54.3	17.4	47.6	2,285,957	19.9	61.9	62.7	18
Kerala	14.3	59.2	69.3	61.7	28.5	11.6	27.4	650,177	60.2	87.7	87.0	n.a.
Madhya Pradesh	11.0	31.4	27.7	65.4	57.4	n.a.	n.a	4,315,436	7.4	9.1	17.4	95
Maharashtra	7.4	37.1	25.0	62.2	54.2	20.2	48.5	4,381,077	22.4	47.7	43.8	82
Manipur	12.1	70.4	50.0	61.5	30.1	8.8	33.6	n.a.	n.a.	n.a.	n.a.	100
Meghalaya	8.3	18.0	56.3	51.4	45.5	18.9	50.8	n.a.	n.a	n.a.	n.a.	n.a.
Mizoram	29.9	45.5	64.3	37.9	28.1	2.2	41.3	n.a	n.a.	n.a.	n.a.	98
Nagaland	64.3	61.1	43.5	46.9	28.7	12.7	32.4	n.a	n.a.	n.a.	n.a.	96
Orissa	17.7	45.7	30.2	78.9	53.3	21.3	48.2	4,308,329	7.1	1.7	13.8	n.a.
Punjab	5.3	3.3	37.3	40.4	45.9	19.9	40.0	871,362	4.7	0.1	4.6	n.a.
Rajasthan	7.9	65.9	9.4	74.8	41.6	19.5	43.1	2,079,617	17.4	8.8	5.6	31
Sikkim	n.a.	n.a	n.a.	n.a.	n.a	n.a	n.a.	n.a	n.a	n.a.	n.a	96
Tamil Nadu	21.8	55.8	56.5	35.5	48.2	n.a	n.a	2,218,539	25.4	53.5	55.4	22
Tripura	7.3	47.9	65.0	74.2	48.8	17.5	46.0	n.a	n.a	n.a.	n.a.	n.a.
Uttar Pradesh	4.7	60.3	19.4	73.8	59.0	16.1	59.5	9,717,828	2.9	2.1	7.0	98
West Bengal	10.8	40.0	53.6	83.6	56.8	n.a	n.a	3,928,698	26.1	26.9	59.8	n.a.
Andaman & Nicobar Is	n.a	n.a	n.a.	n.a.	n.a.	n.a	n.a	n.a	n.a.	n.a.	n.a	n.a.
Chandigarh	n.a.	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	n.a	n.a	n.a.	n.a	n.a
Dadra & Nagar Haveli	n.a.	n.a	n.a.	n.a.	n.a.	n.a	n.a	n.a	n.a	n.a.	n.a.	n.a
Daman & Diu	n.a	n.a	n.a.	n.a.	n.a	n.a	n.a	n.a	n.a.	n.a.	n.a.	n.a
Delhi	6.1	20.0	25.1	52.8	41.6	11.9	43.2	n.a	n.a	n.a.	n.a	92
Lakshadweep	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a.	n.a	n.a
Pondicherry	n.a	n.a	n.a	n.a	n.a.	n.a	n.a	n.a	n.a	n.a.	n.a	n.a
India, Total	9.5	51.0	31.4	66.6	53.4	17.5	52.0	47,361,807	18.1	26.8	35.5	85
Source/Comments	NFHS p 272	NFHS p 280	NFHS p 280	NFHS p 280	NFHS	NFHS	NFHS	Estimated		Dreze/Sen appendix A 3		Salt commissioner estimate

Table 5 Education Indicators

Table 5 Education Indicators	Children, (10-14), who have not completed primary school, pct		Children, 6-10 years, attending school, percent		Est. no. of children not in school, thousand	Estimated number of child labourers		Illiterates, 7+ thousands		Primary school GER	Upper Primary school GER	Drop-out rates, primary	Drop-out rates, elementary	Habitation with primary school, percent	Habitations with upper primary school, percent	Pupil - teacher ratio		Estimated spending on primary education, rs. per pupil
	male	female	male	female		male	female	male	female							rural	urban	
	1992-93		1992-93		1992	1996		1991		1993-94	1993-94	1993-94	1993-94	1993	1993	1993	-	1992-93
Andhra Pradesh	42.0	57.1	73.4	59.9	5,467.5	1,065,572.0	792,187.0	12,640	18,416	108.4	63.7	42.2	62.8	69.2	12.2	44	38	616
Arunachal Pradesh	70.4	72.7	71.6	58.4	n.a.	n.a.	n.a.	181	217	115.8	54.5	60.5	68.7	34.6	8.7	25	25	1,528
Assam	60.3	63.1	75.7	67.3	1,601.7	n.a.	n.a.	3,592	4,885	130.0	77.7	39.1	67.6	62.7	15.4	27	26	896
Bihar	60.8	78.6	60.6	38.5	10,263.7	.877,787.0	283,448.0	17,168	25,040	78.1	34.7	63.4	78.7	51.2	11.9	45	44	815
Goa	31.0	29.3	95.5	93.2	n.a.	n.a.	n.a.	86	167	98.0	96.4	-2.6	12.3	76.7	24.6	23	26	1,627
Gujarat	40.5	50.9	82.6	70.5	2,288.7	301,428.0	133,613.0	4,787	8,561	119.1	69.6	46.3	60.0	90.7	49.3	36	39	1,021
Haryana	50.3	55.1	87.5	76.7	726.6	129,391.0	31,211.0	2,214	3,675	102.8	70.9	3.9	23.9	81.2	32.0	40	38	615
Himachal Pradesh	38.5	43.8	94.4	89.1	112.3	23,402.0	34,463.0	539	1,026	119.1	111.2	26.3	19.7	21.0	5.7	28	29	1,036
Jammu and Kashmir	50.9	52.7	91.9	81.3	n.a.	n.a.	n.a.	n.a.	n.a.	88.8	64.7	48.7	56.5	58.5	15.1	22	20	1,267
Karnataka	48.7	56.2	79.7	71.1	3,065.0	636,591.0	383,211.0	6,264	10,222	119.9	65.0	40.8	63.0	62.4	25.1	46	42	842
Kerala	25.7	22.3	95.2	95.5	295.1	26,509.0	26,352.0	787	1,789	102.3	107.0	-4.2	0.9	62.9	34.4	31	30	1,418
Madhya Pradesh	54.2	66.7	66.0	55.2	5,863.3	947,181.0	653,450.0	11,460	18,164	104.5	66.9	28.4	44.7	64.3	12.6	39	32	518
Maharashtra	42.8	48.7	87.5	82.2	3,227.3	693,824.0	589,712.0	7,943	15,042	119.4	80.7	27.6	49.8	54.2	20.9	33	40	875
Manipur	56.8	66.9	92.2	88.6	n.a.	n.a.	n.a.	222	392	98.2	73.2	68.3	72.3	48.8	20.6	16	19	1,108
Meghalaya	77.8	71.2	74.1	77.1	n.a.	n.a.	n.a.	333	370	74.8	40.5	32.1	57.7	57.7	11.4	22	27	686
Mizoram	44.9	44.3	90.1	85.4	n.a.	n.a.	n.a.	42	57	135.6	107.5	57.6	52.4	87.9	56.2	17	22	2,734
Nagaland	48.4	46.1	91.3	89.2	n.a.	n.a.	n.a.	174	210	106.3	69.5	31.7	38.1	85.6	21.6	13	25	832
Orissa	53.5	63.7	77.9	65.5	2,069.3	399,622.0	136,290.0	4,926	8,471	96.8	57.0	52.5	61.2	49.6	13.7	31	33	584
Punjab	45.3	44.9	85.7	81.6	860.6	171,871.0	8,538.0	3,095	3,948	90.6	67.8	21.7	39.2	86.8	23.6	32	40	911
Rajasthan	61.4	77.5	72.4	42.4	4,369.4	501,924.0	245,494.0	8,290	13,307	91.0	53.9	48.9	65.4	50.1	14.1	32	27	854
Sikkim	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	61	82	117.6	59.6	82.3	78.4	54.1	15.0	14	18	367
Tamil Nadu	28.5	33.7	92.0	87.4	2,025.2	539,754.0	604,835.0	6,426	11,649	145.0	101.4	17.3	36.3	62.0	14.8	45	46	897
Tripura	73.1	72.7	78.6	78.0	n.a.	n.a.	n.a.	343	551	130.3	82.8	63.5	68.4	39.3	11.7	23	21	1,167
Uttar Pradesh	56.7	73.0	71.1	50.2	13,243.8	1,271,610.0	237,708.0	26,298	38,470	89.3	55.0	19.9	37.5	30.1	8.2	40	35	649
West Bengal	61.9	70.2	72.5	66.6	4,771.7	458,310.0	108,863.0	9,540	14,367	123.9	93.8	40.4	46.7	40.4	6.7	42	36	475
Andaman & Nicobar Is	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	27	36	93.2	79.9	9.8	27.3	53.9	20.2	19	25	n.a.
Chandigarh	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	55	66	64.8	62.7	-14.9	-9.1	78.4	43.2	31	26	n.a.
Dadra & Nagar Haveli	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	26	39	109.9	48.0	47.0	62.2	33.0	8.0	34	28	n.a.
Daman & Diu	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	8	17	0.0	0.0	-5.3	0.0	41.8	20.9	29	35	n.a.
Delhi	37.6	38.5	89.2	87.5	n.a.	n.a.	n.a.	777	1,154	86.8	79.9	25.7	25.4	93.7	78.2	36	30	n.a.
Lakshadweep	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2	6	141.5	111.3	15.5	52.2	73.3	46.7	18	21	n.a.
Pondicherry	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	57	119	140.1	132.2	-8.0	7.5	45.5	17.8	32	28	n.a.
India, Total	**51.5**	**62.2**	**75.0**	**61.3**	**63,261.1**	**8,044,778.0**	**4,269,395.0**	**128,362**	**200,516**	**104.5**	**67.7**	**36.3**	**52.8**	**50.3**	**13.8**	**37**	**36**	**687**
Source/Comments	NFHS		NFHS	do	Estimated	D P Caudhri	A dynamic profile of child labour	Census 1991		Ministry of HRD		Department of Education, Annual Report 1994-95,		6th AIES 1993, table 1, page 26.				Calculated

Table 6 Demographic Indicators

Table 6 Demographic Indicators	Population, millions				Female to male ratio			Population annual growth rate		Pers per km2	Est. urban slum popl. thousands	Crude birth rate			Crude death rate			Life expectancy at birth, years		Total fertility rate		Women using contraceptives, pct	Women sterilized, pct	Women using modern temp method, pct	Condom use, percent
	< 5	< 14	< 18	total	< 5	< 14	< 18											male	female						
	1996	1996	1996	1991	1992	1992	1992	51-81	81-91	1991	1991	1971	1981	1996	1971	1981	1996	1990-92		1981	1994	1992-93	1992-93	1992-93	1992-93
Andhra Pradesh	8.6	25.1	29.7	972	939	952	952	1.83	2.19	242	4,313	34.8	31.7	22.9	14.6	11.1	8.3	59.0	61.5	4.0	2.4	47.0	38.1	1.8	0.7
Arunachal Pradesh	n.a.	n.a.	n.a.	859	n.a.	n.a.	n.a.	n.a.	3.19	10	22	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	23.6	10.3	8.6	0.7
Assam	3.0	9.0	10.5	923	953	949	952	2.74	2.19	286	448	38.5	33.0	22.2	17.8	12.6	9.5	54.8	53.8	4.1	2.4	42.8	12.1	5.4	1.7
Bihar	14.8	38.1	44.7	911	899	902	890	1.98	2.14	497	2,691	n.a.	39.1	24.3	n.a.	13.9	10.2	60.4	58.3	5.7	3.5	23.1	17.3	2.9	1.3
Goa	n.a.	n.a.	n.a.	967	n.a.	n.a.	n.a.	2.05	1.50	316	83	25.4	15.5	n.a.	8.8	6.8	n.a.	n.a.	n.a.	n.a.	n.a.	47.8	29.5	7.3	3.9
Gujarat	5.2	15.7	18.6	934	910	910	902	2.50	1.94	211	2,581	40.0	34.5	24.5	16.4	12.0	7.6	59.1	61.3	4.3	2.7	49.3	37.5	5.9	1.8
Haryana	2.7	7.0	8.3	865	842	856	847	2.78	2.45	372	684	42.1	36.5	25.8	9.9	11.3	8.1	62.2	63.6	5.0	3.0	49.7	29.7	9.6	5.2
Himachal Pradesh	0.8	2.1	2.5	976	883	892	887	1.97	1.91	93	126	37.3	31.5	18.9	15.6	11.1	8.0	63.8	64.2	3.8	2.0	58.4	32.6	8.6	5.3
Jammu and Kashmir	n.a.	n.a.	n.a.	923	n.a.	n.a.	n.a.	2.05	2.57	76	592	31.6	31.6	n.a.	10.8	9.0	n.a.	n.a.	n.a.	4.5	n.a.	49.4	25.3	10.0	5.9
Karnataka	5.8	17.4	20.7	960	943	949	945	2.19	1.93	235	1,293	31.7	28.3	22.7	12.1	9.1	7.6	60.0	63.6	3.6	2.4	49.1	41.0	4.8	1.2
Kerala	3.2	9.5	11.5	1,036	946	952	956	2.12	1.35	749	1,222	31.1	25.6	18.0	9.0	6.6	6.2	68.8	74.4	2.8	1.8	63.3	41.8	6.1	2.9
Madhya Pradesh	10.4	27.7	32.4	931	945	929	918	2.34	2.41	149	2,103	39.1	37.6	24.4	15.6	16.6	11.1	54.1	53.5	5.2	2.8	36.5	26.4	4.0	2.2
Maharashtra	11.2	30.6	35.9	934	926	915	914	2.27	2.32	257	7,872	32.2	28.5	23.0	12.3	9.6	7.4	63.1	64.7	3.6	2.6	53.7	40.0	6.4	2.5
Manipur	n.a.	n.a.	n.a.	958	n.a.	n.a.	n.a.	3.05	2.60	82	85	n.a.	26.6	n.a.	n.a.	6.6	n.a.	n.a.	n.a.	n.a.	n.a.	34.9	10.9	10.3	1.2
Meghalaya	n.a.	n.a.	n.a.	955	n.a.	n.a.	n.a.	2.67	2.88	79	83	n.a.	32.6	n.a.	n.a.	8.2	n.a.	n.a.	n.a.	n.a.	n.a.	20.7	9.4	5.1	0.5
Mizoram	n.a.	n.a.	n.a.	921	n.a.	n.a.	n.a.	3.12	3.40	33	57	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	53.8	44.5	8.3	0.7
Nagaland	n.a.	n.a.	n.a.	886	n.a.	n.a.	n.a.	4.40	4.55	73	42	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	13.0	6.3	6.5	2.1
Orissa	4.5	12.0	14.4	971	933	937	941	1.98	1.84	203	843	34.6	33.1	22.7	15.5	13.1	10.7	55.9	54.8	4.3	2.5	36.3	28.2	3.0	0.6
Punjab	2.6	7.6	9.0	882	874	874	863	2.04	1.91	403	1,414	34.2	30.3	22.0	10.4	9.4	7.5	65.4	67.5	4.0	2.6	58.7	31.5	17.3	8.9
Rajasthan	6.9	18.7	21.9	910	884	893	886	2.58	2.53	129	2,400	42.4	37.1	27.2	16.8	14.3	9.1	57.6	57.8	5.2	3.4	31.8	25.3	3.3	1.5
Sikkim	n.a.	n.a.	n.a.	878	n.a.	n.a.	n.a.	2.81	2.54	57	10	n.a.	31.0	n.a.	n.a.	8.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Tamil Nadu	6.4	19.2	22.9	974	946	946	947	1.59	1.44	429	3,571	31.4	28.0	18.3	14.4	11.8	7.9	61.0	63.2	3.4	1.9	49.8	37.5	5.7	1.6
Tripura	n.a.	n.a.	n.a.	945	n.a.	n.a.	n.a.	3.97	2.99	263	74	n.a.	n.a.	n.a.	n.a.	8.0	n.a.	n.a.	n.a.	n.a.	n.a.	56.1	16.7	9.5	1.6
Uttar Pradesh	22.8	60.8	70.8	879	885	875	857	1.89	2.30	473	5,839	44.9	39.6	29.6	20.1	16.3	10.2	56.8	54.6	5.8	4.0	19.8	11.7	5.5	3.2
West Bengal	9.6	26.0	30.8	917	946	941	939	2.46	2.23	767	5,195	n.a.	33.2	17.6	n.a.	11.0	7.8	60.5	62.0	4.2	2.0	57.4	26.3	6.7	1.9
Andaman & Nicobar Is	n.a.	n.a.	n.a.	818	n.a.	n.a.	n.a.	6.21	4.05	34	35	n.a.	34.0	n.a.	n.a.	8.4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Chandigarh	n.a.	n.a.	n.a.	790	n.a.	n.a.	n.a.	10.24	3.58	5,632	161	n.a.	24.6	n.a.	n.a.	2.4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Dadra & Nagar Haveli	n.a.	n.a.	n.a.	952	n.a.	n.a.	n.a.	3.10	2.94	282	2	n.a.	36.8	n.a.	n.a.	14.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Daman & Diu	n.a.	n.a.	n.a.	969	n.a.	n.a.	n.a.	1.63	2.55	907	10	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Delhi	n.a.	n.a.	n.a.	827	n.a.	n.a.	n.a.	4.33	4.24	6,352	2,248	33.6	26.9	n.a.	7.6	7.1	n.a.	n.a.	n.a.	n.a.	n.a.	60.3	20.0	31.3	20.5
Lakshadweep	n.a.	n.a.	n.a.	943	n.a.	n.a.	n.a.	2.19	2.54	1,616	6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Pondicherry	n.a.	n.a.	n.a.	979	n.a.	n.a.	n.a.	2.17	2.94	1,642	153	n.a.	21.7	n.a.	n.a.	7.3	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
India, Total	123.0	339.0	399.1	927	913	914	907	2.15	2.16	273	46,261	36.9	33.9	23.1	14.9	12.5	8.9	59.0	59.4	4.5	2.7	40.6	27.3	5.5	2.4
Source/Comments	Estimated using SRS and Census data			Census 91	Estimated using SRS figures					Census	A compendium on Indian slums, 1996	NFHS	SRS	SRS	NFHS	SRS	SRS	SRS	SRS	NFHS	SRS	NFHS	NFHS	NFHS	NFHS

Table 7 Economic Indicators	SDP per capita, rupees	SDP Annual Growth			Annual consumer expenditure, per capita		Income per household, Rs/year	Income per capita, Rs/year	Hhouseholds using PDS, percent	Gini coefficient of per-capita consumer expenditure	Population under poverty line, total, percent	Population under poverty line, millions	State expenditure on education as percent of total state budget	Estimated public expenditure on elementary education as percentage of SDP
					rural	urban	rural	rural	rural	rural				
	1994-95	80/81-85/86	85/86-90/91	90/91-94/95	1987-88		1994	1994	1994	1994	1987-88	1987-88	1993-94	1993-94*
Andhra Pradesh	7,155	10.7	15.5	14.8	44.7	57.9	22,459	4,574	69	0.45	27.2	16.8	21.0	954.9
Arunachal Pradesh	8,744	15.8	10.8	16.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	37.5	0.3	11.6	488.7
Assam	5,999	14.5	9.2	14.3	41.7	73.9	n.a.	n.a.	n.a.	n.a.	36.8	8.5	24.6	1,476.8
Bihar	3,816	11.8	7.6	18.2	37.2	47.4	27,397	4,503	5	0.39	53.4	44.0	20.1	1,145.3
Goa	14,736	8.2	13.6	18.8	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	23.4	0.3	19.5	561.4
Gujarat	10,578	10.7	12.8	21.6	40.8	57.4	31,379	5,652	50	0.50	32.3	12.9	20.8	1,189.6
Haryana	12,158	11.1	13.4	17.5	56.8	65.3	48,256	7,691	9	0.41	16.6	2.6	16.1	622.1
Himachal Pradesh	7,784	9.2	13.1	16.6	54.2	96.1	28,272	4,915	76	0.40	15.5	0.8	21.2	784.2
Jammu and Kashmir	4,244	10.1	4.8	5.4	47.6	63.0	n.a.	n.a.	n.a.	n.a.	23.2	1.6	11.3	512.8
Karnataka	8,082	10.5	12.8	20.6	39.9	53.2	27.101	4,722	78	0.50	38.1	16.2	21.4	1,146.1
Kerala	6,983	9.7	11.9	18.5	52.2	64.4	22,158	4,400	80	0.42	32.1	9.2	26.3	1,344.3
Madhya Pradesh	5,845	8.9	14.3	12.9	37.2	57.3	23,323	3,838	37	0.41	43.4	26.6	18.2	844.5
Maharashtra	13,112	9.5	13.8	21.5	42.6	86.5	35,590	6,567	55	0.49	40.1	29.4	17.8	815.8
Manipur	5,362	10.4	11.4	10.5	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	32.9	0.6	24.1	624.8
Meghalaya	6,136	10.6	15.0	10.6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	34.6	0.5	17.6	295.8
Mizoram	7,517	15.6	11.0	18.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	32.5	0.2	15.1	950.3
Nagaland	6,638	12.3	14.1	9.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	34.9	0.3	12.0	297.6
Orissa	5,157	10.6	7.2	18.8	33.4	58.1	16,248	2,859	6	0.43	55.6	16.8	19.8	810.2
Punjab	14,188	11.4	12.9	19.1	63.1	73.3	48,588	8,284	6	0.47	12.7	2.5	17.2	568.5
Rajasthan	5,220	10.1	16.2	7.6	40.7	57.6	26,503	4,123	25	0.43	34.6	14.1	20.9	1,106.4
Sikkim	5,729	14.0	10.9	4.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	34.7	0.1	17.0	177.6
Tamil Nadu	8,941	11.8	14.1	20.8	38.7	55.5	21,031	4,629	83	0.45	45.1	24.3	21.3	1,055.0
Tripura	4,252	9.3	10.7	8.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	36.8	0.9	20.2	801.4
Uttar Pradesh	5,331	9.4	12.0	14.8	37.7	55.1	23,817	3,728	7	0.49	42.0	53.7	18.8	968.4
West Bengal	6,877	10.0	12.5	13.7	40.5	65.1	26,659	4,647	11	0.40	44.0	27.7	26.9	975.0
												0.0		
Andaman & Nicobar Is	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	45.2	0.1	12.1	n.a.
Chandigarh	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	12.9	0.1	20.2	n.a.
Dadra & Nagar Haveli	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	18.7	0.0	11.8	n.a.
Daman & Diu	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	16.3	468.3
Delhi	17,068	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	16.0	1.3	29.6	n.a.
Lakshadweep	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	37.3	0.0	11.1	n.a.
Pondicherry	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	44.7	0.3	15.4	648.5
												0.0		
India, Total	n.a.	n.a.	n.a.	n.a.	41.2	61.2	28,395	4,614	36	0.46	39.3	312.7	11.5	499.1
	Economic Survey				Rs per month at 1970/71 prices		NCAER report, table W1, p. 107. Data covers rural India only		NCAER	NCAER	Report of the expert group on estimation of proportion and number of poor (Lakdawala report, 1993)		Ministry of HRD Department of Education.	Estimated

Table 8 Housing characteristics	Households with electricity, percent	Households with safe drinking water, percent	Households with any toilet facility, percent	Households using wood as fuel for cooking, percent	Households with pucca house construction, percent	Rural habitations with water, percent		
						not covered	partially covered	fully covered
	1991	1991	1991	1991	1991		1991-93	
Andhra Pradesh	46.3	55.1	54.6	80.9	38.4	5.4	41.1	53.5
Arunachal Pradesh	40.9	70.0	75.1	87.8	14.9	11.9	37.5	50.7
Assam	18.7	45.9	86.1	88.0	14.6	19.0	37.8	43.2
Bihar	12.6	58.8	56.5	44.0	30.2	9.1	14.0	76.9
Goa	84.7	43.4	55.8	57.8	50.7	5.6	55.3	39.1
Gujarat	65.9	69.8	65.7	54.9	56.9	4.3	26.5	69.2
Haryana	70.4	74.3	64.3	52.1	50.1	0.0	51.2	48.8
Himachal Pradesh	87.0	77.3	60.0	82.3	53.0	11.1	36.1	52.9
Jammu and Kashmir	n.a.	n.a.	n.a.	n.a.	n.a.	8.1	57.8	34.1
Karnataka	52.5	71.7	62.5	78.6	42.6	5.8	51.2	43.0
Kerala	48.4	18.9	72.7	92.4	56.0	34.3	65.0	0.7
Madhya Pradesh	43.3	53.4	53.0	75.0	30.5	9.1	42.3	48.6
Maharashtra	69.4	68.5	64.5	49.3	52.2	1.7	31.5	66.9
Manipur	50.9	38.7	70.2	85.5	5.4	17.0	52.4	30.6
Meghalaya	29.2	36.2	85.7	85.4	13.3	39.0	19.6	41.5
Mizoram	59.2	16.2	84.4	74.8	19.1	7.4	76.8	15.8
Nagaland	53.4	53.4	75.1	93.1	12.6	23.0	59.8	17.2
Orissa	23.5	39.1	49.3	73.5	18.7	16.4	45.2	38.4
Punjab	82.3	92.7	73.2	36.4	77.0	51.4	2.1	48.6
Rajasthan	35.0	59.0	62.3	78.1	56.1	8.3	37.3	54.4
Sikkim	60.7	73.2	77.7	74.5	27.0	2.5	77.3	20.2
Tamil Nadu	54.7	67.4	57.5	80.4	45.5	1.1	71.1	27.9
Tripura	36.9	37.2	96.3	91.5	5.5	30.3	22.8	46.9
Uttar Pradesh	21.9	62.2	66.5	50.4	41.0	10.8	54.1	35.1
West Bengal	32.9	°2.0	78.8	32.1	32.6	27.1	42.2	30.7
Andaman & Nicobar Is	63.5	67.9	65.7	71.5	10.4	0.8	17.6	81.8
Chandigarh	83.1	97.7	79.8	7.2	82.5	n.a.	n.a.	n.a.
Dadra & Nagar Haveli	54.4	45.6	65.1	79.1	20.8	n.a.	n.a.	n.a.
Daman & Diu	94.1	71.4	45.8	49.8	79.8	n.a.	n.a.	n.a.
Delhi	79.5	95.8	66.6	4.7	85.6	0.4	25.6	74.0
Lakshadweep	98.5	11.9	64.7	90.7	88.8	0.0	99.9	0.1
Pondicherry	63.6	88.8	50.0	65.2	44.9	n.a.	n.a.	n.a.
India, Total	42.4	62.3	63.9	61.5	41.6	11.1	41.4	47.6

Sources

Census 1991, A brief analysis of the housing tables of 1991 Census. Paper 2 of 1993, page 38, table 3.3, 2nd column

Report of the survey on the status of drinking water supply in rural habitations, Ministry of Rural Development, annex 6, p.16

Table 9.1 Gender differentials	Infant mortality rate			Crude death rate, 0-4 years			Excess of female mortality over male mortality, percent			Life expectancy at birth, years			Literacy rate, percent			Primary gross enrollment rate	
	male	female	female to male ratio	male	female	female to male ratio	< 1 year	0-4 years	5-14 years	male	female	female to male ratio	male	female	Female to male ratio	male	female
	1992			1992			1992			1990-92			1991			1993	
Andhra Pradesh	73	68	0.93	20.2	18.8	0.98	-6.8	-2.0	-6.3	59.0	61.5	1.04	55.1	32.7	0.59	99.8	86.5
Arunachal Pradesh	n.a.	n.a.	n.a	n.a.	n.a.	n.a.	n.a	n.a.	n.a	n.a.	n.a.	n.a.	51.5	29.7	0.58	141.0	119.9
Assam	86	78	0.91	30.5	30.6	1.00	-9.3	0.3	14.8	54.8	53.8	0.98	61.9	43.0	0.70	98.9	86.6
Bihar	71	74	1.04	24.2	29.6	1.22	4.2	22.3	40.0	60.4	58.3	0.97	52.5	22.9	0.44	92.2	53.2
Goa	n.a.	n.a.	n.a	n.a.	n.a.	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	83.6	67.1	0.80	105.8	102.7
Gujarat	66	69	1.05	21.0	24.8	1.18	4.5	8.3	6.2	59.1	61.3	1.04	73.1	48.6	0.67	114.5	96.4
Haryana	73	78	1.07	17.6	17.5	0.99	6.8	17.5	0.0	62.2	63.6	1.02	69.1	40.5	0.59	86.7	80.6
Himachal Pradesh	67	66	0.99	n.a.	n.a.	n.a.	n.a.	-0.6	162.5	63.6	64.2	1.01	75.4	52.1	0.69	121.1	100.2
Jammu and Kashmir	n.a.	n.a.	n.a.	n.a.	n.a	n.a.	n.a	n.a.	n.a	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	90.5	56.2
Karnataka	77	67	0.87	22.6	20.7	0.92	-13.0	-8.4	25.0	60.0	63.6	1.06	67.3	44.3	0.66	12.4	114.1
Kerala	21	12	0.57	5.0	2.7	0.54	-42.9	-46.0	14.3	68.8	74.4	1.08	93.6	86.2	0.92	96.9	95.3
Madhya Pradesh	109	98	0.90	36.8	40.3	1.10	-10.1	9.5	36.0	54.1	53.5	0.99	58.4	28.8	0.49	108.6	86.5
Maharashtra	61	57	0.93	16.0	15.9	0.99	-6.6	-0.6	27.3	63.1	64.7	1.03	76.6	52.3	0.68	122.6	114.7
Manipur	n.a.	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	71.6	47.6	0.66	135.9	127.6
Meghalaya	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	53.1	44.9	0.84	132.0	136.7
Mizoram	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	85.6	78.6	0.92	157.8	146.4
Nagaland	n.a.	n.a.	n.a.	n.a.	n.a.	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	67.6	54.7	0.81	103.5	99.9
Orissa	114	116	1.02	31.7	35.2	1.11	1.8	11.0	0.0	55.9	54.6	0.98	63.1	34.7	0.55	114.4	87.1
Punjab	54	60	1.11	16.5	18.3	1.11	11.1	10.9	50.0	65.4	67.5	1.03	65.7	50.4	0.77	89.6	81.4
Rajasthan	88	92	1.05	31.2	36.3	1.16	4.5	16.3	70.6	57.6	57.8	1.00	55.0	20.4	0.37	110.4	58.5
Sikkim	n.a	n.a.	n.a.	n.a.	n.a	n.a	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	65.7	46.7	0.71	138.5	126.8
Tamil Nadu	58	59	1.02	15.0	15.7	1.05	1.7	4.7	10.0	61.0	63.2	1.04	73.7	51.3	0.70	150.6	136.1
Tripura	n.a	n.a	n.a.	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a.	n.a.	70.6	49.6	0.70	133.1	119.9
Uttar Pradesh	92	105	1.14	33.1	43.1	1.30	14.1	30.2	61.5	56.8	54.6	0.96	55.7	25.3	0.45	90.4	59.5
West Bengal	67	62	0.93	18.4	18.4	1.00	-7.5	0.0	28.6	60.5	62.0	1.02	67.8	46.6	0.69	110.3	97.7
Andaman & Nicobar Is	n.a.	n.a.	n.a.	n.a.	n.a.	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	79.0	65.5	0.83	141.5	123.4
Chandigarh	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	82.0	72.3	0.88	97.9	94.5
Dadra & Nagar Haveli	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	53.6	27.0	0.50	127.0	97.4
Daman & Diu	n.a.	n.a	n.a.	n.a.	n.a.	n.a	n.a.	n.a.	n.a.	n.a.	n.a	n.a.	82.7	59.4	0.72	90.9	90.9
Delhi	n.a.	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a	n.a.	82.0	67.0	0.82	108.3	112.2
Lakshadweep	n.a	n.a	n.a.	n.a	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	90.2	72.9	0.81	141.0	154.0
Pondicherry	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	83.7	65.6	0.78	121.0	114.1
India, Total	79	80	1.01	24.9	28.2	1.13	1.3	13.3	31.6	59.0	59.4	1.01	64.1	39.3	0.61	106.2	85.0
	SRS, Fertility and Mortality Indicators, 1992.			SRS, Fertility and Mortality Indicators, 1992.			SRS, Fertility and Mortality Indicators 1992.			Unpublished estimates from SRS, quoted in Dreze/Sen			Census 1991 Final Population Totals, table 6, pp. 210-217			6th AIES, p. 42	

Table 9.2 Gender differentials (cont.)	Children completing 5 years of schooling, pct		Proportion of rural children attending school, 6-10 years		Proportion of rural children attending school, 11-14 years		Proportion of never enrolled children, 12-14 years, rural		Proportion of never enrolled children, 12-14 years, urban		Work participation rate			Proportion of female primary school teachers	Percentage of children under 4 underweight		
	female	Total	male	female	male	female	male	female	male	female	male	female	female to male ratio		male	female	female to male ratio
	1993		1992-93		1992-93		1987-88		1987-88		1991			1993-94	1992-93		
Andhra Pradesh	43.3	46.2	68.9	51.9	63.5	37.1	32.7	59.7	9.4	18.9	55.48	34.32	0.62	31.6	47.1	51.1	1.08
Arunachal Pradesh	42.2	41.8	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	53.76	37.49	0.70	23.0	41.2	37.9	0.92
Assam	33.3	35.1	75.2	66.6	70.5	62.9	22.9	28.5	5.1	18.0	46.45	21.61	0.47	28.8	52.4	48.5	0.93
Bihar	35.1	38.6	57.0	34.0	64.9	33.0	41.9	67.3	19.5	38.0	47.92	14.86	0.31	20.0	64.9	60.4	0.93
Goa	97.0	100.7	95.0	94.1	93.6	91.8	n.a.	n.a.	n.a.	n.a.	49.56	20.52	0.41	63.8	35.6	34.0	0.96
Gujarat	60.2	64.6	78.9	64.0	78.7	57.9	22.5	38.7	10.2	17.7	53.57	25.96	0.48	38.7	41.6	46.7	1.12
Haryana	74.1	78.4	85.9	71.9	85.8	65.8	12.9	42.4	6.2	14.6	48.51	10.76	0.22	46.2	34.9	41.6	1.19
Himachal Pradesh	72.7	70.5	94.0	88.5	93.1	85.1	n.a.	n.a.	n.a.	n.a.	50.64	34.81	0.69	39.9	47.8	46.1	0.96
Jammu and Kashmir	57.5	59.3	90.9	79.1	90.3	74.1	21.5	47.6	18.9	29.3	n.a.	n.a.	n.a.	38.9	41.6	47.5	1.14
Karnataka	54.6	59.4	76.4	64.8	67.2	46.4	26.0	46.5	11.7	17.4	54.09	29.39	0.54	32.6	52.9	55.8	1.05
Kerala	107.6	109.3	94.9	95.0	94.8	93.6	0.4	1.8	0.1	0.6	47.58	15.85	0.33	67.3	28.8	28.3	0.98
Madhya Pradesh	57.1	61.4	61.0	47.3	69.7	44.5	30.6	66.4	6.6	18.1	52.26	32.68	0.63	24.8	53.0	49.1	0.93
Maharashtra	66.3	70.4	84.9	77.5	80.8	56.2	12.6	27.7	4.6	12.4	52.17	33.11	0.63	39.0	51.3	54.0	1.05
Manipur	54.9	55.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	45.27	38.96	0.86	30.5	30.0	30.1	1.00
Meghalaya	31.9	33.6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	50.07	34.93	0.70	46.2	48.9	41.6	0.85
Mizoram	44.5	44.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	53.87	43.52	0.81	46.2	26.8	29.5	1.10
Nagaland	46.2	45.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	46.86	37.96	0.81	34.0	31.7	26.0	0.82
Orissa	46.0	49.5	75.8	63.0	72.9	52.5	34.0	54.7	20.2	20.3	53.79	20.79	0.39	23.1	53.4	53.2	1.00
Punjab	71.1	72.6	83.8	77.5	77.4	67.5	22.6	33.3	7.9	7.9	54.22	4.40	0.08	58.5	43.9	47.9	1.09
Rajasthan	26.7	33.1	69.9	36.4	75.2	28.6	26.1	81.7	12.5	36.0	49.30	27.40	0.56	27.1	42.5	40.5	0.95
Sikkim	53.2	50.5	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	51.26	30.41	0.59	34.1	n.a.	n.a.	n.a.
Tamil Nadu	81.2	80.5	90.8	83.6	77.7	62.8	11.5	26.3	3.7	5.6	56.39	29.89	0.53	41.1	43.1	49.7	1.15
Tripura	42.7	45.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	47.55	13.76	0.29	22.4	47.7	50.0	1.05
Uttar Pradesh	43.2	47.5	69.5	45.4	75.1	38.2	27.2	68.0	19.2	38.8	49.68	12.32	0.25	25.3	51.8	47.8	0.92
West Bengal	43.4	47.2	68.9	72.5	68.1	55.0	34.6	45.9	13.0	15.2	51.40	11.25	0.22	23.0	54.7	59.0	1.08
Andaman & Nicobar Is	81.8	81.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	53.32	13.13	0.25	39.5	n.a.	n.a.	n.a.
Chandigarh	84.6	83.7	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	54.34	10.39	0.19	93.4	n.a.	n.a.	n.a.
Dadra & Nagar Haveli	39.3	44.6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	57.50	48.79	0.85	35.0	n.a.	n.a.	n.a.
Daman & Diu	93.9	96.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	51.63	23.17	0.45	54.2	n.a.	n.a.	n.a.
Delhi	70.6	73.4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	51.72	7.35	0.14	59.9	41.6	41.6	1.00
Lakshadweep	84.5	90.4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	44.17	7.60	0.17	31.3	n.a.	n.a.	n.a.
Pondicherry	108.1	109.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	50.55	15.24	0.30	50.8	n.a.	n.a.	n.a.
India, Total	52.0	54.6	72.2	62.2	71.4	55.0	26.4	50.7	10.9	19.3	51.55	22.25	0.43	31.4	53.3	53.4	1.00
Sources	6thAIES	6thAIES	NFHS	NFHS	NFHS	NFHS					Economic Survey 1995-96, table 9.2 quoted from Census 1991. Total workers as percentage of total population			6th AIES, table 7, pp. 46ff	NFHS		

Table 10 Rural/Urban Gaps	Popl. pct Rural	Annual growth rate of population Rural		Popl. pct Urban	Annual growth rate of urban population Urban		Crude birth rates		Crude death rates		Infant mortality rate		Population under poverty line, percent		Literacy rate		Children, 6-14 years, who are illiterate, rural, percent		Children, 6-14 years, who are illiterate, urban, percent		Rural children, 6-14 years who attend school, percent		Urban children, 6-14 years who attend school, percent		Underweight children, moderate and severe, percent	
							rural	urban	rural	urban	rural	urban	rural	urban	rural	urban	male	female	male	female	male	female	male	female	rural	urban
	1991	1951-81	1981-91	1991	1951-81	1981-91	1996		1996		1996		1987-88		1991		1992/93		1992/93		1992/93		1992/93		1992/93	
Andhra Pradesh	73.1	1.6	1.7	26.9	2.8	3.7	23.5	20.2	9.1	5.7	73	39	20.9	44.6	35.7	68.4	32.3	51.9	14.4	19.0	66.8	46.6	85.0	76.3	52.1	40.2
Arunachal Pradesh	87.2	n.a	2.5	12.8	n.a	10.3	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	39.4	17.3	37.0	71.6	n.a.	n.a.	n.a.	n.a.	76.1	64.6	82.4	71.1	40.3	25.9
Assam	88.9	2.5	2.1	11.1	5.6	3.4	28.9	20.6	10.1	5.7	79	37	39.4	17.3	49.3	79.4	31.9	39.0	16.9	21.7	73.4	65.2	79.4	72.6	51.8	37.3
Bihar	86.9	1.8	2.1	13.1	4.1	2.7	33.1	23.6	10.6	6.9	74	54	52.6	57.7	33.8	67.9	40.1	64.3	13.8	29.8	59.8	33.6	84.3	67.8	64.1	53.8
Goa	59.0	1.2	0.1	41.0	5.2	4.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	17.8	33.7	72.3	80.1	4.4	7.2	4.4	6.2	94.3	93.0	95.0	91.8	36.2	33.2
Gujarat	65.5	2.3	1.4	34.5	3.0	3.0	26.8	22.9	8.2	6.2	68	46	28.7	39.6	53.1	76.5	23.7	38.8	13.9	17.6	78.8	61.7	89.2	81.8	45.8	40.5
Haryana	75.4	2.6	2.1	24.6	3.6	3.7	30.1	24.0	8.4	6.9	70	60	16.2	17.8	19.9	73.7	20.7	34.6	14.4	16.7	85.9	69.5	90.8	88.8	39.4	33.0
Himachal Pradesh	91.3	1.9	1.8	8.7	2.5	3.3	23.5	16.3	8.2	5.8	63	34	16.3	6.2	61.9	84.2	5.8	10.9	2.6	5.1	93.6	87.1	96.4	93.8	48.3	30.2
Jammu and Kashmir	76.2	1.8	2.2	23.8	3.4	3.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	25.7	14.8	n.a.	n.a.	21.1	29.7	7.7	9.1	90.7	79.0	95.2	96.3	46.8	31.0
Karnataka	69.1	1.9	1.6	30.9	3.0	2.6	24.1	20.3	8.6	5.4	65	20	32.8	49.1	47.7	74.2	28.2	40.4	14.9	18.2	72.8	57.3	84.6	80.1	57.3	47.0
Kerala	73.6	1.9	0.4	26.4	3.3	4.9	17.8	17.7	6.2	5.9	13	13	29.1	43.4	38.9	92.3	8.1	5.7	5.1	3.9	94.8	94.3	94.5	98.3	30.6	22.9
Madhya Pradesh	76.8	2.0	2.0	23.2	4.1	3.8	34.2	22.9	11.8	7.6	102	61	41.9	48.2	35.9	70.8	37.9	52.8	19.2	20.3	64.3	46.3	84.7	81.6	59.4	50.1
Maharashtra	61.3	2.0	1.7	38.7	2.9	3.3	24.9	20.6	8.7	5.4	58	31	40.8	39.0	55.5	79.2	15.6	29.7	8.0	11.8	83.3	69.2	90.7	87.8	57.5	45.5
Manipur	72.5	2.0	2.4	27.5	17.7	3.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	39.4	17.3	55.8	70.5	n.a.	n.a.	n.a.	n.a.	92.1	83.9	96.2	93.5	31.6	25.9
Meghalaya	81.4	2.3	2.8	18.6	4.8	3.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	39.4	17.3	41.1	81.7	n.a.	n.a.	n.a.	n.a.	69.9	71.6	93.8	92.5	47.2	37.5
Mizoram	53.9	2.3	-0.0	46.1	10.0	10.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	39.4	17.3	72.5	93.5	n.a.	n.a.	n.a.	n.a.	89.5	84.2	96.5	93.0	22.0	34.5
Nagaland	82.8	3.9	4.3	17.2	11.9	5.6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	39.4	17.3	57.2	93.1	n.a.	n.a.	n.a.	n.a.	88.0	86.8	96.7	97.3	30.5	19.7
Orissa	86.6	1.7	1.7	13.4	5.7	3.1	27.6	21.1	11.1	7.5	98	65	57.6	44.1	45.5	72.0	23.3	39.3	10.3	19.3	74.7	58.9	88.2	78.6	54.9	44.3
Punjab	70.5	1.8	1.6	29.5	2.9	2.6	25.1	19.1	7.9	6.1	55	40	12.8	12.9	52.8	72.1	28.9	34.9	22.3	22.4	81.1	73.1	88.9	89.0	47.4	40.0
Rajasthan	77.1	2.5	2.3	22.9	3.0	3.4	33.9	25.1	9.5	7.1	90	60	33.2	39.0	30.4	65.3	31.4	66.5	22.1	28.8	72.0	33.5	84.2	71.9	41.1	43.9
Sikkim	90.9	2.3	3.4	9.1	10.2	-3.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	39.4	17.3	54.4	80.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Tamil Nadu	65.8	1.2	1.3	34.2	2.8	1.8	19.9	17.8	8.7	6.3	60	39	45.8	43.9	54.6	78.0	13.4	20.2	9.4	10.2	85.3	74.8	87.3	86.4	52.1	37.3
Tripura	84.7	3.8	2.5	15.3	5.7	6.5	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	39.4	17.3	56.1	83.1	n.a.	n.a.	n.a.	n.a.	81.0	74.0	86.2	89.9	53.0	31.6
Uttar Pradesh	80.2	1.7	2.1	19.8	2.8	3.3	35.2	28.0	10.6	8.2	88	44	41.1	45.2	36.7	61.0	35.4	61.0	26.1	32.0	71.7	42.6	77.1	69.5	50.5	46.9
West Bengal	72.5	2.3	2.1	27.5	2.8	2.6	25.3	15.7	8.0	7.2	57	44	48.3	57.6	50.5	75.3	26.8	36.1	11.4	18.2	68.6	60.1	83.3	71.8	60.4	44.8
Andaman & Nicobar Is	73.3	6.2	4.0	26.7	6.4	4.2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	45.8	43.9	69.7	81.7	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Chandigarh	10.3	n.a.	8.7	89.7	n.a.	3.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	12.9	12.9	59.1	79.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Dadra & Nagar Haveli	91.5	n.a.	2.7	8.5	n.a.	5.4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	17.6	33.7	37.0	78.4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Daman & Diu	53.2	1.7	0.8	46.8	1.5	5.1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a	61.6	81.6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Delhi	10.1	1.3	7.7	89.9	4.7	3.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1.3	16.9	66.9	76.2	0.0	0.0	12.1	14.4	89.9	82.8	87.3	86.6	0.0	41.6
Lakshadweep	43.7	n.a.	0.4	56.3	n.a.	4.6	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	29.1	43.4	78.9	84.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Pondicherry	36.0	n.a.	0.1	64.0	n.a	5.0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	45.8	43.9	65.4	79.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
India, Total	**74.3**	**1.9**	**1.8**	**25.7**	**3.2**	**3.2**	**29.3**	**21.4**	**9.7**	**6.5**	**78**	**48**	**39.1**	**40.1**	**44.7**	**73.1**	**30.0**	**47.6**	**15.3**	**19.9**	**72.2**	**52.2**	**85.3**	**79.2**	**55.9**	**45.2**
	Census 91	Census 91	Census 91	Census 91	Census 91	Census 91	SRS	SRS	SRS	SRS	SRS	SRS	Report of the expert group on estimation of proportion and number of poor		Census 91	Census 91	NFHS	do	do	do	NFHS, p 56	do	NFHS, p. 56	do	NFHS	do

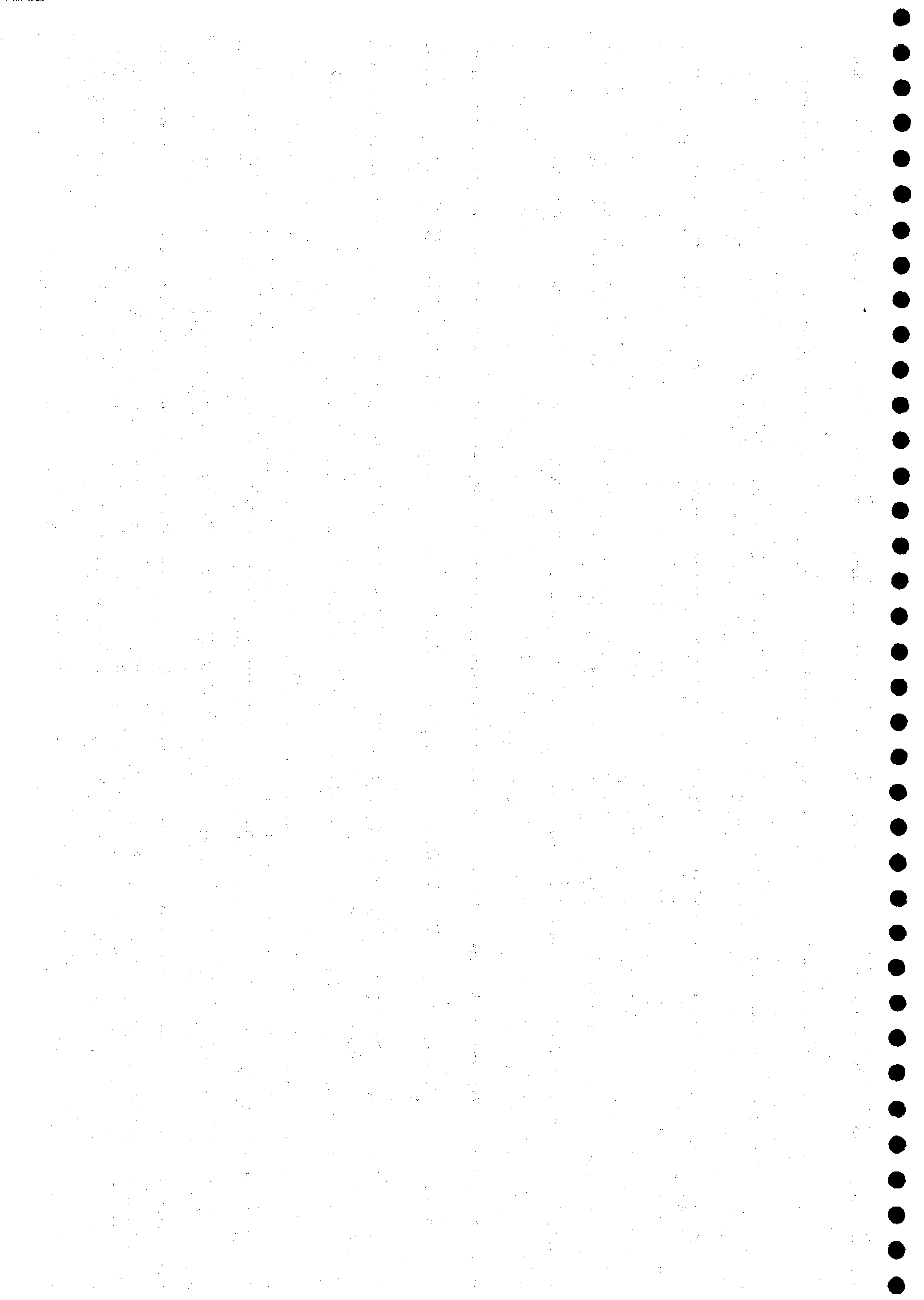

Table 11 Nuptial indicators	Currently married women, percent			Singulate mean age at marriage, years			
	15-19 years	20-24 years	30-34 years	male	female	male	female
	1992-93			1981		1992-93	
Andhra Pradesh	52.2	85.7	91.9	23.1	17.3	23.6	18.1
Arunachal Pradesh	28.6	75.8	91.3	n.a.	n.a.	24.9	20.0
Assam	31.0	60.9	87.2	n.a.	n.a.	27.9	21.6
Bihar	50.3	88.6	96.1	21.6	16.6	23.2	18.0
Goa	3.1	28.8	86.2	28.5	23.0	30.6	25.1
Gujarat	22.0	74.5	95.2	23.3	19.6	23.9	20.2
Haryana	44.1	88.4	97.2	25.2	17.9	23.1	18.4
Himachal Pradesh	19.3	74.9	92.6	24.2	19.1	25.0	20.4
Jammu and Kashmir	18.0	62.9	94.6	n.a.	n.a.	26.3	21.2
Karnataka	37.0	72.6	90.0	26.0	19.3	26.1	19.6
Kerala	13.4	52.8	87.3	27.5	22.1	28.1	22.1
Madhya Pradesh	61.9	88.7	94.2	20.8	16.6	22.0	17.4
Maharashtra	36.2	78.3	92.3	24.4	18.8	24.9	19.3
Manipur	6.0	41.0	81.7	27.3	23.4	28.3	25.0
Meghalaya	18.3	61.0	88.1	26.0	21.0	25.1	21.2
Mizoram	9.2	40.8	80.2	n.a.	n.a.	27.8	22.9
Nagaland	11.3	50.6	81.3	29.0	24.8	25.8	22.7
Orissa	27.5	70.9	93.5	24.3	19.1	25.6	20.7
Punjab	14.4	66.9	96.0	25.0	21.1	24.8	21.1
Rajasthan	38.3	87.5	97.2	20.6	16.1	22.7	18.4
Sikkim	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Tamil Nadu	24.4	71.4	88.8	26.1	20.3	26.4	20.5
Tripura	25.8	61.5	85.8	26.8	20.3	27.3	21.2
Uttar Pradesh	39.6	88.0	96.3	21.3	16.7	23.0	18.6
West Bengal	40.0	77.5	88.7	26.0	19.3	25.9	19.2
Andaman & Nicobar Is	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Chandigarh	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Dadra & Nagar Haveli	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Daman & Diu	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Delhi	18.6	69.5	95.3	24.3	20.5	24.3	20.9
Lakshadweep	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Pondicherry	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
India, Total	**38.4**	**79.4**	**93.2**	**23.5**	**18.4**	**25.0**	**20.0**
			NFHS, p. 76	1981 Census, cited in NFHS study, p. 78, table 4.3		NFHS, table 4.3, p. 78	

Table 12 Political indicators

	Voter turnout ratio in XIth Lok Sabha election		Performance of women candidates				Number of women PR members	Total number of PR members	Percentage of women representatives in Panchayati Raj
	female	total	number of seats	female candidates	number of females elected	Proportion of women represented in Lok Sabha			
Andhra Pradesh	59.6	63.0	42	90	3	7.1	78,650	258,045	30.5
Arunachal Pradesh	52.5	55.0	2	0	0	0.0	125	7,015	1.8
Assam	76.5	78.5	14	9	1	7.1	9,370	28,140	33.3
Bihar	50.4	59.5	54	41	3	5.6	n.a.	n.a.	n.a.
Goa	52.5	56.3	2	0	0	0.0	475	1,432	33.2
Gujarat	29.6	35.9	26	18	2	7.7	22,880	68,581	33.4
Haryana	68.8	70.5	10	9	1	10.0	18,836	56,880	33.1
Himachal Pradesh	56.0	57.6	4	2	0	0.0	6,706	20,171	33.2
Jammu and Kashmir	39.1	49.0	6	8	0	0.0	n.a.	n.a.	n.a.
Karnataka	55.5	60.2	28	71	1	3.6	39,367	84,886	46.4
Kerala	70.3	71.1	20	10	0	0.0	4,623	12,528	36.9
Madhya Pradesh	47.0	54.1	40	75	5	12.5	187,236	494,433	37.9
Maharashtra	47.6	52.5	48	42	2	4.2	75,559	225,164	33.6
Manipur	73.8	75.0	2	3	0	0.0	315	944	33.4
Meghalaya	61.0	61.6	2	1	0	0.0	n.a.	n.a.	n.a.
Mizoram	73.9	73.4	1	0	0	0.0	n.a.	n.a.	n.a.
Nagaland	85.5	88.3	1	0	0	0.0	n.a.	n.a.	n.a.
Orissa	54.6	59.2	21	8	2	9.5	29,074	87,224	33.3
Punjab	61.1	62.3	13	17	1	7.7	24,247	81,698	29.7
Rajasthan	36.7	43.4	25	25	4	16.0	38,701	119,151	32.5
Sikkim	73.9	77.4	1	0	0	0.0	341	1,025	33.3
Tamil Nadu	64.9	66.9	39	15	0	0.0	15,962	47,887	33.3
Tripura	77.5	79.1	2	2	0	0.0	1,900	5,693	33.4
Uttar Pradesh	41.0	46.5	85	107	9	10.6	140,264	461,439	30.4
West Bengal	80.9	82.7	42	21	4	9.5	25,157	71,578	35.0
Andaman & Nicobar Is	61.1	62.0	1	0	0	0.0	n.a.	n.a.	n.a.
Chandigarh	58.6	58.4	1	0	0	0.0	n.a.	n.a.	n.a.
Dadra & Nagar Haveli	79.0	77.0	1	0	0	0.0	n.a.	n.a.	n.a.
Daman & Diu	75.5	70.7	1	0	0	0.0	n.a.	n.a.	n.a.
Delhi	49.2	50.6	7	24	2	28.6	n.a.	n.a.	n.a.
Lakshadweep	91.4	89.0	1	0	0	0.0	n.a.	n.a.	n.a.
Pondicherry	76.1	75.4	1	1	0	0.0	n.a.	n.a.	n.a.
India, Total	53.4	57.9	543	599	40	7.4	719,788	2,133,914	33.7

Source: Election commission. Statistical report on general elections. 1996

Table 13 Scheduled castes and tribes	Proportion of population			Female to male ratio			Infant mortality rate			Under 5 mortality rate			Literacy rate			Female work participation rate		
	Scheduled caste	Scheduled tribe	Others	Scheduled caste	Scheduled tribe	Total population	Scheduled caste	Scheduled tribe	Other	Scheduled caste	Scheduled tribe	Other	Scheduled caste	Scheduled tribe	Total Population	Scheduled caste	Scheduled tribe	Total Population
		1991			1991			1992-93			1992-93			1991			1991	
Andhra Pradesh	15.9	6.3	77.8	969	960	972	94.4	85.4	68.0	114.8	134.4	89.1	31.6	17.2	44.1	46.7	50.6	34.3
Arunachal Pradesh	0.5	63.7	35.9	627	998	859	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	57.3	34.5	41.6	12.4	44.1	37.5
Assam	7.4	12.8	79.8	919	967	923	n.a.	89.6	95.3	n.a.	150.3	144.5	53.9	49.2	52.9	18.1	33.8	21.6
Bihar	14.6	7.7	77.8	914	971	911	120.4	87.2	94.0	171.0	135.6	132.3	19.5	26.8	38.5	23.5	37.7	14.9
Goa	2.1	0.0	97.9	967	889	967	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	58.7	42.9	75.5	26.1	18.1	20.5
Gujarat	7.4	14.9	77.7	925	967	934	69.9	91.5	69.9	119.3	126.7	97.7	61.1	36.5	61.3	26.0	46.9	26.0
Haryana	19.8	-	80.3	860	-	865	83.9	n.a.	78.0	126.6	n.a.	99.9	39.2	n.a.	55.9	11.7	n.a.	10.8
Himachal Pradesh	25.3	4.2	70.5	967	981	976	61.7	n.a.	64.0	93.6	n.a.	80.7	53.2	47.1	63.9	35.6	45.6	34.8
Jammu and Kashmir	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	57.7	n.a.	47.4	80.3	n.a.	63.9	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Karnataka	16.4	4.3	79.4	962	961	960	98.4	85.6	70.6	126.0	120.3	97.1	38.1	36.0	56.0	36.6	39.6	29.4
Kerala	9.9	1.1	89.0	1,029	996	1,036	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	79.7	57.2	89.8	31.7	36.9	15.9
Madhya Pradesh	14.6	23.3	62.2	915	985	931	124.1	103.1	90.1	167.8	166.6	129.8	35.1	21.5	44.2	35.3	48.3	32.7
Maharashtra	11.1	9.3	79.6	944	968	934	85.2	66.4	52.2	124.0	98.8	69.2	56.5	36.8	64.9	36.2	49.7	33.1
Manipur	2.0	34.4	63.6	973	959	958	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	56.4	53.6	59.9	31.0	46.0	39.0
Meghalaya	0.5	85.5	14.0	821	997	955	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	44.3	46.7	49.1	13.9	37.8	34.9
Mizoram	0.1	94.8	5.2	157	982	921	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	77.9	82.7	82.3	10.6	44.0	43.5
Nagaland	-	87.7	12.3	-	946	886	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	60.6	61.7	n.a.	40.2	38.0
Orissa	16.2	22.2	61.6	975	1,002	971	160.8	113.4	115.3	175.8	148.8	128.1	36.8	22.3	49.1	23.4	39.8	20.8
Punjab	28.3	-	71.7	873	-	882	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	41.1	n.a.	58.5	5.4	n.a.	4.4
Rajasthan	17.3	12.4	70.3	899	930	910	90.5	75.4	71.1	121.7	123.8	96.9	26.3	19.4	38.6	28.9	40.6	27.4
Sikkim	5.9	22.4	71.7	939	914	878	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	51.0	59.0	56.9	26.8	31.6	30.4
Tamil Nadu	19.2	1.0	79.8	978	960	874	90.0	n.a.	64.8	127.3	n.a.	84.7	46.7	27.9	62.7	40.9	44.5	29.9
Tripura	16.4	31.0	52.7	949	965	845	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	56.7	40.4	60.4	8.9	25.3	13.8
Uttar Pradesh	21.1	0.2	78.7	877	914	879	138.1	167.5	110.2	202.1	222.9	151.3	26.9	35.7	41.6	17.6	32.9	12.3
West Bengal	23.6	5.6	70.8	931	964	917	96.8	107.1	77.3	136.7	133.0	101.9	42.2	27.8	57.7	13.2	41.0	11.3
Andaman & Nicobar Is	-	9.5	90.5	-	947	818	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	56.6	73.0	n.a.	27.4	13.1
Chandigarh	16.5	-	83.5	810	-	790	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	55.4	n.a.	77.8	9.5	n.a.	10.4
Dadra & Nagar Haveli	2.0	79.0	19.0	925	1,022	952	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	77.6	28.2	40.7	26.9	55.5	48.8
Daman & Diu	3.8	11.5	84.6	1,067	931	969	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	79.2	52.9	71.2	17.9	40.5	23.2
Delhi	19.1	-	81.0	834	-	827	66.1	n.a.	62.1	82.7	n.a.	78.1	57.8	n.a.	75.3	7.5	n.a.	7.4
Lakshadweep	-	93.2	6.8	-	994	943	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	80.6	81.8	n.a.	7.3	7.6
Pondicherry	16.3	-	83.8	983	-	979	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	56.3	n.a.	74.7	30.5	n.a.	15.2
India, Total	16.5	8.1	75.4	922	972	927	107.3	90.5	82.2	149.1	135.2	111.5	37.4	29.6	52.2	22.3	23.0	43.7
	Census 1991						NFHS, SR, table 8.4						Census 1991					

Table 14
Juvenile crime

Juveniles apprehended for committing crime under local and special laws and Indian Penal Code

	Boys	Girls	Total	Illiterate	Homeless	Income less than 500 rs	Old delinquents	Illiterate, percent	Homeless, percent	Income less than 500 rs, percent	Old delinquents, percent
Andhra Pradesh	1,720	295	2,015	1016	453	1374	99	50.4	22.5	68.2	4.9
Arunachal Pradesh	24	2	26	11	2	0	7	42.3	7.7	0.0	26.9
Assam	256	20	276	103	15	76	24	37.3	5.4	27.5	8.7
Bihar	1,408	146	1,554	476	260	598	145	30.6	16.7	38.5	9.3
Goa	18	9	27	12	0	11	0	44.4	0.0	40.7	0.0
Gujarat	1,377	1,636	3,013	1049	90	1386	554	34.8	3.0	46.0	18.4
Haryana	148	36	184	61	29	67	17	33.2	15.8	36.4	9.2
Himachal Pradesh	49	28	77	9	0	17	0	11.7	0.0	22.1	0.0
Jammu and Kashmir	14	0	14	0	0	12	0	0.0	0.0	85.7	0.0
Karnataka	380	127	507	269	49	336	34	53.1	9.7	66.3	6.7
Kerala	148	8	156	17	18	108	6	10.9	11.5	69.2	3.8
Madhya Pradesh	3,220	314	3,534	1307	259	211	245	37.0	7.3	6.0	6.9
Maharashtra	3,252	460	3,712	1175	316	2178	552	31.7	8.5	58.7	14.9
Manipur	7	0	7	1	0	2	0	14.3	0.0	28.6	0.0
Meghalaya	78	1	79	41	28	42	32	51.9	35.4	53.2	40.5
Mizoram	37	23	60	6	0	16	0	10.0	0.0	26.7	0.0
Nagaland	25	25	50	0	0	15	9	0.0	0.0	30.0	18.0
Orissa	93	1	94	52	4	78	0	55.3	4.3	83.0	0.0
Punjab	2	1	3	0	0	0	0	0.0	0.0	0.0	0.0
Rajasthan	450	232	682	295	35	370	34	43.3	5.1	54.3	5.0
Sikkim	23	0	23	7	0	11	5	30.4	0.0	47.8	21.7
Tamil Nadu	4,335	423	4,758	1100	781	3297	424	23.1	16.4	69.3	8.9
Tripura	10	21	31	10	3	16	0	32.3	9.7	51.6	0.0
Uttar Pradesh	120	21	141	78	13	108	11	55.3	9.2	76.6	7.8
West Bengal	35	8	43	19	1	36	0	44.2	2.3	83.7	0.0
Andaman & Nicobar Is	3	4	7	0	0	2	0	0.0	0.0	28.6	0.0
Chandigarh	4	0	4	0	0	0	0	0.0	0.0	0.0	0.0
Dadra & Nagar Haveli	4	0	4	0	0	0	2	0.0	0.0	0.0	50.0
Daman & Diu	6	2	8	0	0	6	0	0.0	0.0	75.0	0.0
Delhi	209	51	260	2	0	260	0	0.8	0.0	100.0	0.0
Lakshadweep	0	0	0	0	0	0	0	n.a.	n.a.	n.a.	n.a.
Pondicherry	19	8	27	12	1	16	0	44.4	3.7	59.3	0.0
India, Total	17,474	3,902	21,376	7,128	2,357	10,649	2,200	33.3	11.0	49.8	10.3

Source: Crime in India 1994, Ministry of Home