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MSWE-002
Women and Child
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Block

3

STATUS OF CHILDREN IN INDIA

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BLOCK INTRODUCTION

In previous block you learned about women and development initiatives. In the present block you will study about "Status of children in India". There are four units in this block.

The **first unit** on 'Profile of Children in India' discusses the demographic profile of the children in India. This Unit outlines the educational advancement of the children and explain the status of children in the domain of health and nutrition, using various indicators.

In the **second unit** on 'Girl Children: A Vulnerable Group' you will learn about the status of girls in Indian society. You will be able to discuss the policies and programmes for the development of girls.

The **third unit** of this block discusses the 'Children in Critical Circumstances'. This unit identifies the children living in critical circumstances and analyzes the difficulties faced by the children in critical circumstances. You will be able to recognize the living condition and deprivation of rights of children living in critical circumstances.

The **last unit** on 'Situation of Adolescents' focuses on the adolescence. The unit discusses the influence of peer pressure, interpersonal relationships and socialization of the adolescents.

After going through this block you will have a comprehensive understanding of the status of children in India.

UNIT 1 PROFILE OF CHILDREN IN INDIA

Structure

1.0 OBJECTIVES

Children are a nation's future and the assessment of their status would help in framing policies and programmes for their development.

After studying this unit, you should be able to:

● discuss the demographic profile of the children in India;

● identify the educational advancement of the children; and

● explain the status of children in the domain of health and nutrition, using various indicators.

1.1 INTRODUCTION

India constitutes 17 per cent of the world's total population in an area which is 2.4 per cent of the world's total area. In 2001, the world population was estimated to be 6.137 million and has been growing at the rate of 78 million a year, with India adding almost 18 million a year to the world total in the last decade of the twentieth century (GOI 2002). India's population, which was around 238 million in 1901, became 439 million in 1961, 846 million in 1991 and was 1.027 billion in 2001 (Yojana 2006).

Children form a large proportion of this growing population. Their survival and protection are important for a nation's development. The statistics on child population, sex ratio, enrolment rates, dropout rates and retention rates, infant and child mortality, birth weight, immunization etc. provide a lens to gauge their status in Indian society. Children are entitled to a joyful childhood that can come with nutritious diet, learning without burden and a supportive environment that develops their capacities to the fullest.

1.2 DEMOGRAPHY

India reached the one billion population mark in 2001 and has the largest child population in the world. Still less than 5 per cent of the Union budget is allocated to children. Only 0.92 per cent of this is allocated for child protection (Miller 2008). It can be assumed that in the age group of 0-18 years there are approximately 400 million children constituting 40 percent of the population. Children between 0 to 5 years would number about 130 million (GOI 2002). Life expectancy at birth

which was 37.1 years for males and 36.1 years for females in 1951 rose to 64.1 years for males and 65.4 years for females in 2001-2006.

Child population (0-14 years) as a percentage to the total population in major States is given in Table 1.1. The highest percentage of child population is in Bihar (40.8 per cent) followed closely by Uttar Pradesh (40.1 per cent), Rajasthan (38.3 per cent), Madhya Pradesh (38.2 per cent), Assam (37.6 per cent) and Haryana (37.2 per cent). There is also a slight preponderance of males over females indicating gender disparity. This situation is prevalent in Kerala also, exceptions are Assam and West Bengal.

TABLE 1.1
Percentage of Children (0-14 years) to Total Population in Major States, 1998

India & Bigger States	Total	Males	Females
Andhra Pradesh	33.1	33.6	32.7
Assam	37.6	37.3	38
Bihar	40.8	41.3	40.2
Gujarat	32.7	33.4	32.1
Haryana	36.2	36.7	35.6
Himachal Pradesh	31.7	33.9	29.7
Karnataka	31.4	31.8	31
Kerala	27.3	29	25.7
Madhya Pradesh	38.2	38.6	37.8
Maharashtra	33.3	33.8	32.8
Orissa	34.2	34.7	33.7
Punjab	31.8	32.9	30.6
Rajasthan	38.3	38.8	37.7
Tamil Nadu	28.1	28.7	27.5
Uttar Pradesh	40.1	40.6	39.7
West Bengal	32.8	32.7	33
India	**35.6**	**36.1**	**35.1**

Source: Yojana 2006: 12

Sex Ratio of the Child Population (0-6 years)

It is defined as the number of females in the age-group 0-6 years per 1000 males in the same age-group in the population. According to the 2001 Census, the sex ratio in this age group is 927. It has decreased at a much faster pace than the overall sex ratio of the country as Table 1.2 shows. In some parts of the country, between the population totals of 1991 and 2001 there is no decline (including Kerala) while the ratio has fallen steeply in others like Punjab, Haryana, Gujarat, and Maharashtra which are among the prosperous states of India (Dreze and Sen 2006). In fact, the declining sex ratio in the child population possibly has a cascading impact on population over a period of time resulting in diminishing the sex ratio of the country.

TABLE 1.2

Sex Ratio of Total Population and Child Population in the Age-Group 0-6 1961-2001

Year	Sex ratio in the age group 0-6 years	Over all sex ratio
1961	976	941
1971	964	930
1981	962	934
1991	945	927
2001	927	933

Source: Census of India 2001: 96

The States and Union Territories with sex ratio of the child population below the national ratio, according to the 2001 Census, are Himachal Pradesh (897), Punjab (793), Chandigarh (845), Uttaranchal (906), Haryana (820), Delhi (865), Rajasthan (909), Uttar Pradesh (916), Gujarat (878), Daman & Diu (925) and Maharashtra (917). Punjab with child sex ratio of 793 was at the bottom with Sikkim (986) at the top.

Gender inequality exists in our society and the sex differentials in natality substantiate this. In male-dominated societies, parents usually want the new born baby to be a boy rather than a girl. Sex-selective abortion has become quite prevalent with the easy availability of modern techniques to determine the gender of the foetus. In East Asia, China, South Korea, Singapore and Taiwan this form of 'high-tech sexism' has existed and it is becoming widespread in India too. Though the Pre-Natal Diagnostic Techniques Act 1994, in order to check female foeticide, prohibits determination and disclosure of the sex of foetus (except when it is an essential part of medical investigation), yet the enforcement of the law is inadequate. One of the reasons for this is that mothers refuse to give evidence regarding the use of such techniques. Natality inequality is also because of 'son-preference' which many mothers have and is quite a worrying issue. In such a situation women's critical agency has to be developed where they question and reassess the established norms and values, according to Dreze and Sen (2006).

Child Marriage

Child marriage still exists in our society. Women in the age group 18-29 years were asked about their age at marriage in National Family Health Survey (NFHS-3). Though we have the Child Marriage Restraint Act, 1929 which prohibits marriage of girls below 18 years, yet the majority (53.4 per cent) of rural women (in the age-group 18-29 years) in India were married before they turned 18. In the following states, the percentages are much higher than the national level: Jharkhand 70 per cent, Bihar 69 per cent, Rajasthan 67 per cent, Andhra Pradesh 63 per cent, West Bengal 62 per cent, Madhya Pradesh 60 per cent and Uttar Pradesh 59 per cent. In the BIMARU (the demographically sick states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) states, the figures are high.

Unlike this, the comparable figure for rural Kerala is 20 per cent and in Himachal Pradesh only 14 per cent. In Manipur it is 16 per cent and in Jammu and Kashmir 19 per cent. With regard to urban areas, the overall figure for women married before they turned 18 is 30 per cent, compared to 38 per cent in Bihar, 36 per cent in Rajasthan, 33 per cent in Jharkhand, 32 per cent in Uttar Pradesh and 33 per cent in West Bengal. In urban Andhra Pradesh, it is 43 per cent. Thus, Andhra Pradesh has a high incidence of child marriages in both rural and urban areas. In

the urban areas of Jammu and Kashmir only 9 per cent girls were married before they turned 18, in Kerala 12 per cent, in Himachal Pradesh 14 per cent and in Uttaranchal 17 per cent. This shows that in the hilly states of Jammu and Kashmir, Himachal Pradesh and Uttaranchal, girls are not married off early. However, coastal Kerala has the best performance (Bose 2007).

Check Your Progress I

Note: Use the space provided for your answer.

1) Discuss the reasons for low sex ratio of the child population in India.

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2) Explain the prevalence of child marriage in India.

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1.3 EDUCATION AND LITERACY

Education is an important indicator of development in a society. It is an essential input for the well-being of an individual enabling her/him to interpret the social, political and economic environment better and respond effectively. High literacy levels ensure social advancement whereby initiatives taken in the fields of gender equality and women's development and empowerment yield substantial results.

According to the Census of India 2001, 65.38 per cent of our population is literate. The Census considers a person aged seven and above, who can both read and write, with understanding in any language as literate. 75.85 per cent males and 54.16 per cent females are literate. Seven States/ Union Territory having less than fifty per cent female literacy rates are Rajasthan, Arunachal Pradesh, Dadra and Nagar Haveli, Uttar Pradesh, Jammu & Kashmir, Jharkhand, and Bihar. Bihar with female literacy of 33.57 per cent is at the bottom with Kerala (87.86 per cent) at the top.

The Education For All Development Index (EDI), to indicate achievement of EFA, includes four EFA goals which are universal primary education (UPE), adult literacy, the quality of education and gender parity. Of 129 countries, India ranks 105 with a low EDI of 0.797. Countries like Malyasia (0.945), Indonesia (0.935), and Vietnam (0.899) have Medium EDI. While Norway, United Kingdom (0.995), along with others, has High EDI (UN EFA Report 2008).

In India, Kerala is ranked foremost among the 21 major states in the composite EDI prepared for the primary and upper primary levels of schooling for 2006-07. Delhi comes second, followed by Tamil Nadu, Himachal Pradesh and Karnataka. EDI was computed using 23 indices like number of schools per 1000 child

population, average student-classroom ratio, pupil-teacher ratio, gross enrollment ratio and gender parity index. Bihar and Jharkhand are ranked 35 and 34 in case of composite primary and upper primary levels of education with an EDI as low as 0.321 and 0.381 respectively (Kumar 2008).

School Dropouts

At the primary stage, 94 per cent of the rural population has a school within a kilometer while at the upper primary level, 84 per cent of the rural population has a school within three kilometers (Yojana 2006). Although the gross enrollment ratio in classes I-V was 107.8 per cent total, (boys 110.7 per cent, girls 104.7 per cent), the dropout rates were high (total 29 per cent, boys 31.81 per cent, girls 25.42 per cent). Enrollment ratios in classes VI-VIII was only 69.9 per cent total (boys 74.3 per cent, girls 65.1 per cent). The drop out rate from classes I-VIII was 50.84 per cent (boys 50.49 per cent, girls 51.28).

In the case of scheduled castes, the gross enrollment ratio in classes I-V was 115.3 per cent (boys 123.3 per cent, girls 106.6 per cent), the dropout rate were 34.2 per cent total (boys 32.7 per cent, girls 36.1 per cent). Compared to that of the overall, though the enrollment of children is better, yet the high dropout rate shows the need to make efforts to improve retention. For scheduled tribes, the enrolment was 121.9 per cent for total, (boys 128.1, and girls 115.5 per cent). The dropout rates were 42.3 per cent for total, (boys 42.6 per cent, girls 42 per cent). This shows that the enrollment of scheduled tribes is better than scheduled castes. However, the high dropout rates among the scheduled tribes need immediate attention.

For scheduled castes, in classes VI-VIII the enrolment ratio was 70.2 per cent total, (boys 77.9 per cent and girls 61.5 per cent). The dropout rate from classes I-VIII was 57.3 per cent total, (boys 55.2 per cent and girls 60 per cent). In the case of scheduled tribes, the enrolment ratio was 67 per cent total, (boys 73.9 per cent and girls 59.5 per cent). The dropout rate from classes I-VIII was 65.9 per cent, (boys 65 per cent and girls 67.1 per cent).

The dropout rate from classes I-X was 61.92 per cent total. Dropout rate for boys was 60.41 per cent and for girls 63.88 per cent. In the case of scheduled castes, it was 71.3 per cent total (boys 69.1 per cent and girls 74.2 per cent). Among scheduled tribes, the dropout rate was 79 per cent total (boys 77.8 per cent and girls 80.7 per cent). This data shows that we are unable to retain scheduled caste and scheduled tribe students at the level of Secondary education. The scheduled tribe students dropout much more than even the scheduled caste students. Girls dropout much more than boys at this level of education. All the figures are provisional figures for 2004-05 (GOI, SES 2007).

Child Labour and Education

Childhood is lost in the pangs of labour. Deprived of health, education and overall survival, many children continue to perish. According to the United Nations, 55 per cent of the workforce in India is constituted of child labour. Shantha Sinha (1999) observes that by the official estimates there are 17 million child labourers. Of these, two million are engaged in hazardous occupations. However, independent sources claim that the number of child labourers is close to 100 million. Figures are important since they decide the target group of children for whom specific policies and programmes have to be designed. The number of children not going to school is around 74 million, according to the official estimates. Of these, if 17 million are child labourers, what about the rest 57 million children? Sinha (1999) argues that we need to recognize that all out of school children are child labourers. Only then can we commit ourselves to bringing them to schools. The M. V. Foundation has done path-breaking work on the issue of child labour in Ranga Reddy District of Andhra Pradesh. They were able to bring 400,000 children

engaged in work back to school. This became possible due to community mobilization whereby families realized the importance of child's right to education (Miller 2008).

Check Your Progress II

Note: Use the space provided for your answer.

1) Discuss the status of children in India focusing on education.

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1.4 HEALTH AND NUTRITION

World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Table 1.3 compares India with Sri Lanka and China on various indicators like infant mortality rate, under-five mortality, maternal mortality, etc.

Table 1.3: India and Comparable Countries

	India	Sri Lanka	China
Infant Mortality (per 1000 live births)	**60** (2003)	**13** (2003)	**30** (2003)
One-year olds fully (5) immunized for measles	**58** (2002-04)	**99** (2003)	**84** (2003)
Population with sustainable access to improved sanitation (%)	**30** (2002)	**91** (2002)	**44** (2002)
Under-five mortality (per 1,000 live births)	**87** (2003)	**15** (2003)	**37** (2003)
Births Attended by skilled birth attendants (5)	**47.6** (2002-04)	**97** (1995-2003)	**97** (1995-2003)
Maternal Mortality (per 1,000 deliveries)	**407** (adjusted 2000)	**92** (adjusted 2000)	**56** (adjusted 2000)

Source: Yojana (2007): 25

The infant mortality rate of India is quite high in India compared to that of Sri Lanka and China. Unlike India, Sri Lanka has attained nearly full immunization for measles. Sanitation facilities also are better in Sri Lanka than in China or India. Under-five mortality is lowest in Sri Lanka and relatively high in India. In the case of skilled birth attendants for birth, Sri Lanka and China have a higher percentage than India. Maternal mortality rate is lowest in China followed by Sri Lanka and lastly India. India has quite a lot to learn from the experiences of her neighbours on these indices.

Infant and Child Mortality Rate

The Infant Mortality Rate (IMR) is an important indicator that shows the level of development of a nation. IMR is the number of deaths per 1000 population before the first birthday. The probability of dying between the first and fifth birthdays is child mortality. Under-five mortality is the probability of dying before the fifth birthday. According to NFHS-3 2005-06 estimates, infant mortality in India has declined from 77 deaths per 1,000 live births in 1991-95 in the age group to 57 deaths per 1,000 live births in 2001-05, thus implying an average rate of decline of 2 infant deaths per 1,000 live births per year. Table 1.4 gives the details for 29 states (including Delhi National Capital territory) but excluding union territories (UTs).

Table 1.4: Early Childhood Mortality Rates (Deaths per '000 children in age group)

States	Infant Mortality	Under-Five Mortality	% of children who had all Basic Vaccinations
India	57	74	44
Uttar Pradesh	73	96	23
Chattisgarh	71	90	49
Madhya Pradesh	70	94	40
Jharkhand	69	93	34
Assam	66	85	31
Rajasthan	65	85	27
Orissa	65	91	52
Bihar	62	85	33
Arunachal Pradesh	61	88	28
Andhra Pradesh	54	63	46
Tripura	52	59	50
Gujarat	50	61	45
West Bengal	48	60	64
Jammu and Kashmir	45	51	67
Meghalaya	45	71	33
Karnataka	43	55	55
Uttaranchal	42	57	60
Haryana	42	52	65
Punjab	42	52	60
Delhi	40	47	63
Nagaland	38	65	21
Maharashtra	38	47	59
Himachal Pradesh	36	42	74
Mizoram	34	53	47

Sikkim	34	40	70
Tamil Nadu	30	36	81
Manipur	30	42	47
Goa	15	20	79
Kerala	15	16	75

Source: Bose (2007): 11

Infant mortality is highest in Uttar Pradesh (73) and lowest in Kerala and Goa (15). With respect to under-five mortality, Uttar Pradesh also has the highest rate (96) and Kerala has the lowest rate (15). Apart from Uttar Pradesh, high levels of infant and child mortality are found in Chhattisgarh and Madhya Pradesh in the central region; Assam and Arunachal Pradesh in the northeastern region; Jharkhand, Orissa, and Bihar in the eastern region; and Rajasthan in the northern region. In contrast, all states in the southern and western regions have lower levels of infant and child mortality. Nationally, a girl child's disadvantage with regard to survival is most evident in the under-five mortality rate: 79 girls per 1,000 births die before their fifth birthday, compared with 70 boys per 1,000 births. Dreze and Sen (2006) emphasize that countries like India, Pakistan, Bangladesh, China, West Asia etc. that have gender inequality also tend to have a higher female to male mortality in this age group. However in Europe, America or sub-Saharan Africa females have better survival chances. In India, female mortality is much higher in the 0-4 age group i.e. under-five mortality.

Among the largest religious groups, Hindus have the highest rate of infant mortality (59), followed by Buddhists/Neo-Buddhists (53), Muslims (52), Sikhs (46), and Christians (42) Although scheduled tribes have a lower infant mortality rate (62) than scheduled castes (66), the under-five mortality rate is higher among scheduled tribes (96) than among scheduled castes (88).

According to NFHS-3, examining the data for all India, it is seen that infant and child mortality rates decrease steadily with an increase in mother's schooling. The infant mortality rate is 70 for children whose mothers have no schooling compared with 50 for children whose mothers have 5-7 years of schooling and 26 for children whose mothers have 12 or more years of schooling. Children whose mothers have no education are more than twice as likely to die before their first birthday as children whose mothers have completed at least 10 years of school. The impact of female literacy on child mortality is significant. Dreze and Sen (2006) state that an increase in crude female literacy rate from 22 per cent (the actual 1981 figure) to 75 per cent reduces the predicted value for under-five mortality for males and females combined from 156 per thousand to 110 per thousand. Male literacy or even poverty reduction are unable to impact in such a manner. This shows how vital women's agency (here female literacy) is for child survival.

The main causes of infant and child deaths are premature birth, acute respiratory infections, diarrhoeal diseases, vaccine preventable diseases where immunization coverage, maternal care and newborn care are inadequate (Yojana 2006).

Immunization

Universal immunization of children against the six vaccine-preventable diseases (namely, tuberculosis, diphtheria, whooping cough, tetanus, polio, and measles) is crucial to reducing infant and child mortality. Children who received BCG (vaccination against tuberculosis), measles, and three doses each of DPT and polio are considered to be fully vaccinated. NFHS-3 gives data for the coverage of the immunization programme in both rural and urban areas along with the overall (See Table 1.5). Vaccination coverage are far from universal in the case of all

vaccines- BCG, polio, DPT and measles. The national immunization coverage has reduced slightly in urban areas from 61 per cent in 1998-99 to 58 per cent in 2005-06. In rural areas, it has increased slightly from 37 per cent to 39 per cent for the same period.

Table 1.5: Child Immunization (Data from NFHS-3)

	Overall	Urban	Rural
Children 12-23 months fully immunized (BCG, measles and three doses each of polio/DPT)	44	58	39
Children aged 12-23 months who have received BCG	78	87	75
Children aged 12-23 months who have received three doses of polio vaccine	78	83	77
Children aged 12-23 months who have received Three doses of DPT vaccine	55	69	50
Children aged 12-23 months who have received measles vaccine	59	72	54

Source: Kumar 2007: 1338

Inspite of the immunization programme of the Government of India, in India as a whole, only 44 per cent of the children have had all basic vaccinations (See Table 1.4). The percentage of children who are fully vaccinated ranges from 21 percent in Nagaland to 81 percent in Tamil Nadu. Tamil Nadu, Goa, Kerala and Himachal Pradesh stand out in full immunization coverage as about three-fourths or more of children in each of these states are fully immunized. Among the more populous states, Uttar Pradesh (23 percent), Rajasthan (27 percent), Assam (31 percent), Bihar (33 percent), Jharkhand (34 percent), and Madhya Pradesh (40 percent) stand out as having a much lower percentage of children fully vaccinated than the national average. As these states account for nearly one-third of the total population of the country, their low vaccination coverage pulls down the coverage rate for the country as a whole. In addition to Nagaland and Assam, some of the other northeastern states (Arunachal Pradesh and Meghalaya) also have a relatively poor record on vaccination coverage (NFHS-3, 2005-06).

Nutrition

WHO states that nutrition is an input to and foundation for health and development of children. Better nutrition is important for strong immune systems, less illness and good health. India has a large number of people suffering from endemic or chronic hunger. The National Sample Surveys show a decline in calorie intake. In rural India, the average calorie intake per capita per day fell from 2266 Kcal in 1972-73 to 2183 in 1993-94 and further to 2149 in 1999-2000. In 1999-2000, almost 77 per cent of the rural population consumed less than the poverty line calorie requirement of 2400 calories. Swaminathan (2007) states that there is a decline in cereal intake as data suggests. This is due to distress rather than choice because it has happened in the context of a declining overall calorie intake and prevalence of high levels of malnutrition. One-third of the world's malnourished children are in India. Efforts made to reduce the absolute number of malnourished children have yielded slow and low results. To fulfill the Millennium Development Goals, India had to reduce the percentage of malnourished children to 27 per cent by 2005. However, the number of malnourished children has reduced to only 46 per cent. This goal has to be achieved by 2011 now. The Survey by National Nutrition Monitoring Bureau (NMMB) shows that even today there is a deficit of

over 500 Kcal in the intakes of children one to three years old and about 700 Kcal among those three to six years old. Children lack access to food in both quantitative and qualitative terms (Sinha 2008).

The NFHS-3 data presents data on three much used measures of child malnutrition among children under three years: stunting (deficit in height-for-age), wasting (deficit in weight for height) and the proportion of underweight (weight for age) children. Birth weight is a vital indicator of a child's vulnerability to the risk of childhood illness and survival chances. Children whose birth weight is less than 2.5 kg are considered to have a higher than average risk of early childhood death.

As highlighted in Table 1.6 according to NFHS-3, 46 per cent of children below three years of age were underweight, 38 per cent were stunted and 19 per cent were wasted. In sub-Saharan Africa, the corresponding levels of child malnutrition are much lower where 28 per cent of children below five years are underweight, 37 per cent are stunted and 9 per cent are wasted. In China, only 8 per cent of similar children are underweight and 14 per cent are stunted. In general, undernourishment is higher among rural than urban children. In 2005-06, the proportion of underweight children in urban areas was 36 per cent as against 49 per cent in rural areas. In the same way, the level of stunting and wasting are higher in rural than in urban areas (Kumar 2007).

Table 1.6: Nutritional Status of Children (NFHS-3, 2005-06)

	Urban (per cent)	Rural (per cent)	All-India (per cent)
Children under three years who are			
Stunted	31	41	38
Wasted	17	20	19
Underweight	36	49	46

Source: Kumar 2007: 1338

Undernourishment levels vary substantially across Indian states. Table 1.7 presents data on proportion of stunting, wasting and underweight among children below three years across Indian states. The proportion of underweight children varies from less than 30 per cent in Punjab, Kerala and Jammu and Kashmir to over 50 per cent of children in Chhattisgarh, Bihar, Jharkhand and Madhya Pradesh. The proportion of stunted children is the lowest in Kerala (21 per cent), Tamil Nadu (25 per cent) and Himachal Pradesh (27 per cent) and highest in Gujarat and Bihar (42 per cent), Chhattisgarh (45 per cent) and Uttar Pradesh (46 per cent). The amount of wasting among children is the least in Punjab (9 per cent), Andhra Pradesh and Assam (13 per cent) and Uttar Pradesh (14 per cent) while it is maximum in Bihar (28 per cent), Jharkhand (31 per cent) and Madhya Pradesh (33 per cent).

Table 1.7: Malnutrition among Indian Children below three years (NFHS-3, 2005-06)

	Stunted (Per cent)	Wasted (Per cent)	Under-weight (Per cent)
1 Punjab	28	9	27
2 Kerala	21	16	29
3 Jammu and Kashmir	28	15	29
4 Tamil Nadu	25	22	33

5 Himachal Pradesh	27	19	36
6 Andhra Pradesh	34	13	37
7 Uttaranchal	32	16	38
8 Maharashtra	38	15	40
9 Assam	35	13	40
10 Karnataka	38	18	41
11 Haryana	36	17	42
12 West Bengal	33	19	44
13 Orissa	38	19	44
14 Rajasthan	34	20	44
15 Uttar Pradesh	46	14	47
16 Gujarat	42	17	47
17 Chhattisgarh	45	18	52
18 Bihar	42	28	58
19 Jharkhand	41	31	59
20 Madhya Pradesh	40	33	60
India	**38**	**19**	**46**

Notes: States ranked in descending order of per cent underweight children. Figures have been rounded off.

Source: Kumar 2007: 1339

The four states with lowest proportion of underweight children are Punjab, Kerala, Jammu and Kashmir and Tamil Nadu which have better provisioning of health services, care of newborn children and nutritional status of women than the four high malnutrition states of Chhattisgarh, Bihar, Jharkhand and Madhya Pradesh (Kumar 2007). This analysis shows the importance of universalization of the Integrated Child Development Services (ICDS) scheme for the children under six. The mid-day meal programme for children in primary and upper-primary schools also plays a significant role in reducing hunger.

Prevalence of Anaemia in Children (6-59 Months)

Anaemia among young children adversely affects cognitive performance, behavioural and motor development, coordination, language development and scholastic achievement and also increases morbidity from infectious diseases, according to Kumar (2007). In India as a whole, 70 per cent of the children have some degree of anaemia (such as mild, moderate, severe etc). Even in the demographically progressive states like Andhra Pradesh, Karnataka and Tamil Nadu the prevalence rate is as high as in the states of Bihar, Jharkhand, Uttar Pradesh, Madhya Pradesh and Rajasthan (Bose 2007).

Water and Sanitation

The right to water, a component of the right to life, is fundamental for an individual's existence. In the world, each year around one billion people have no choice but to use harmful sources of water. This crisis kills around 3,900 children every day (Yojana 2007). Several billion persons lack adequate sanitation which is the major cause of water contamination and diseases linked to water. According to the United Nations 'the human right to water entitles everyone to sufficient, safe, acceptable,

physically accessible and affordable water for personal and domestic uses'. It also observes that 'this right contains freedoms including the right to maintain access to existing water supplies necessary for the right to water, the right to be free from arbitrary disconnections or contamination of water supplies; and entitlements which include the right to a system of water supply and management that provides equality of opportunity for people to enjoy the right to water.

In India, over 480 million people lack access to safe drinking water. India has been ranked 133rd among 180 countries for its poor water availability of 1880 cubic metres per person annually (Pangare & Pangare 2007). Diarrhoea claims some 450,000 lives annually, more than in any other country (UNDP Human Development Report 2006). About 92.5 per cent people in rural areas and 90.2 per cent in urban areas had access to safe drinking water in India in 1998. Access to adequate sanitation was available to 70 per cent in urban areas, 8.1 per cent in rural areas and 49.3 per cent of the total population in India in 1998 (Yojana 2006). 28 per cent schools do not have water and 45 per cent schools do not have toilets (Education Report 2007).

HIV/AIDS

National adult HIV prevalence in India is approximately 0.36 percent, amounting to between 2 and 3.1 million people based on the 2006 estimates, according to National Aids Control Organization (NACO). If an average figure is taken, this comes to 2.5 million people living with HIV and AIDS. Almost 50 percent of the previous estimate of 5.2 million. Annually between 100,000 to 200,000 infected pregnancies and about 30,000 infected babies are born (Yojana 2006).

Adequate care and support response to these children has to be ensured. The National AIDS Control Programme-III (2006-2011) plans to improve this through early diagnosis and treatment of HIV exposed children; comprehensive guidelines on paediatric HIV care for each level of the health system; special training to counsellors for counselling HIV positive children; linkages with social sector programmes for accessing social support for infected children; outreach and transportation subsidy to facilitate anti-retroviral therapy and follow up, nutritional, educational, recreational and skill development support, and by establishing and enforcing minimum standards of care and protection in institutional, foster care and community-based care systems.

The intervention on Prevention of Mother to Child Transmission of HIV (PMTCT) is important for children. Mundle (2003) states that PMTCT aims to counsel pregnant women on HIV and to inform them about the disease, its mode of transmission, means of prevention of the disease and to improve antenatal care.

Leprosy

India has around 0.52 million patients in the country and the prevalence rate of leprosy is 5.20 per 10,000 persons. About 14-20 per cent of the patients are children. The number of child leprosy cases was 103, 518 in 2000-01, which constitutes 18.49 per cent of the total number of cases. Efforts are being made to reduce the case load to 1 or less per 10,000 population (Yojana 2006).

Check Your Progress III

Note: Use the space provided for your answer.

1) Discuss the health and nutritional status of Indian children.

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2) What, according to you, ensures a safe and secure childhood for children? Discuss.

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1.5 LET US SUM UP

The child population in India is large emphasizing the need to focus on child-centred policies and programmes. In this unit we have reviewed the profile of Indian children. Sex ratio of the child population is low due to discrimination against the girl child that starts from birth itself. The educational status of children leaves much to be demanded. The enrolment rates are increasing. However, high dropout rates and poor retention of children in schools poses as a major challenge. The health indicators show that there are many undernourished children who are being denied their basic right to live and grow. Infant and child mortality rate need to be reduced ensuring the survival of children. Water and sanitation facilities have to be provided to children on an urgent basis. Right to food, education, good health and adequate nutrition are entitlements of a child and cannot be denied if a nation has to progress.

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UNIT 2   GIRL CHILDREN: A VULNERABLE GROUP

Structure

2.0   OBJECTIVES

This unit aims at providing you an overview of the vulnerable situation of girl children in India. It will also describe various policies and programmes for empowerment of girl children.

After studying this unit, you should be able to:

● discuss the perspective and framework for analyzing the situation of girls in India;

● describe the status of girls in Indian society; and

● discuss the policies and programmes for development of girls.

2.1   INTRODUCTION

As per 2001 census, India has around 157.86 million children, constituting 15.42 percent of the country's population, who are below the age of six years. Of these, 157.86 million children, 75.95 million children are girls and 81.91 million are boys. Public focus came upon the Girl Child only since the late 1980s. Before this, a 'gendered' view of childhood was seldom taken. Public agencies as well as most child lobbies used to look at childhood for both boys and girls as a uniformly vulnerable and critical period during which children needed the same levels and types of services, such as nutrition, healthcare, education, cognitive stimulation, shelter, play opportunities etc. This general, non-gendered view remained predominant, although data collected by researchers from the field showed that girls had less access to breast feeding and were less often likely to be taken to public hospitals when ill as compared to boys. Immunization figures showed higher drop out as well as lower completion rates for girls. Enrollment and dropout figures carried the same tale.

Similarly, the girl child remained invisible in the eyes of the "women's rights" or "women's development" constituency. Here, the tendency was to identify "women" only in terms of adult age groups and to deal with patriarchal oppression and exploitation of women who had reached the child bearing age. There were no separate planning provisions for the 'girl child' either amongst children or amongst women. The gendered links with childhood or womanhood were also not apparent.

From the 1990s, the Ministry of Women and Child Development has tried to include the girl child on its agenda. It has accepted that discrimination against the girl child is not merely a result of poverty and illiteracy, but is rooted in traditionally ingrained attitudes and mindset (Report of the Working Group on Eleventh Plan).

2.2 PERSPECTIVE AND FRAMEWORK

The Constitution of India offers all citizens, including children, certain basic Fundamental Rights – the right to life and liberty, the right to equality, right to freedom, right against exploitation, right to freedom of religion, right to conserve culture and education; the right to constitutional remedies for the enforcement of fundamental rights. Further, the Directive Principles of State Policy (which are not justiciable, but are fundamental in making policies for governance) directs the State to ensure that all children are provided with services and opportunities to grow and develop in a safe and secure environment.

To realize the letter and spirit of the Constitution, the State has formulated a number of legislations such as the Child Marriage Restraint Act 1929 (called the Sharda Act), Immoral Traffic Prevention Act 1956, the Child Labour (Prohibition and Regulations Act) and the Juvenile Justice (Care and Protection of Children) Act, 2000. In addition, a number of policies and plans (National Policy for Children 1974, National Policy on Education 1986, National Policy on Child Labour, National Charter for Children 2004 and National Plan of Action for Children 2005) have been formulated.

India is a signatory to a number of international instruments such as the UN Convention on the Rights of the Child, with its two Optional Protocols, and Convention on the Elimination of all forms of Discrimination against Women (CEDAW). CEDAW is considered to be an international bill of rights for women. These affirm India's commitment to the development of women and children. It has also accepted without reservation the international commitments of 'World fit for Children' adopted by the UN General Assembly Special Session on Children in 2002, and the Beijing Platform for Action for the advancement of women and girls adopted by the World Conference on Women in 1995.

2.3 STATUS OF GIRL CHILD IN INDIA

The girl child's life is full of challenges from the time she takes birth till she attains 18 years of age. First of all, many people abort their female foetus foreseeing the 'burden' that a girl brings forth. If she takes birth, she usually dies within the first year of birth due to neglect and lack of care. These practices are referred to as female foeticide and female infanticide. If girls still manage to survive, they are meted out unequal treatment in the family as well as in society. Lack of proper nutrition, low basic education, poor emotional well-being and numerous other challenges impede the growth of their capabilities. Table 2.1 shows the life chart of a girl child and the disadvantages she suffers at various stages of life.

Girl Child In the Eleventh Five Year Plan [Working Group on Development of Children for the Eleventh Five Year Plan (2007-2012)- A Report] calls adolescence (11-18 years) an important period in our lives when we require guidance and support. It is a critical time when physical, hormonal, cognitive, psychological and sexual changes take place. Alongside, there are pressures of social expectations and constraints, career, marriage related anxiety and such dilemmas. Adolescents constitute 21.4 per cent of the total population in India.

Table 2.1: Life chart of a girl child

Years	Problems faced
Before birth to one year	● Foeticide and Infanticide ● Infant mortality ● Discrimination in breast feeding and infant food ● Neglect of health (immunization)
1 to 11 years (this includes specific problems faced by age groups 1-5 years and 6-11 years)	● Discrimination in access to food and health care ● Malnutrition and anaemia ● Health problems like polio and diarrhoea ● Iodine, Vitamin A and Micronutrient deficiency ● Low school enrollment and School drop outs ● Vulnerable to trafficking, child labour, child marriage ● Abuse, exploitation and violence ● Domestic chores ● Looking after siblings ● Restriction on mobility and play ● Discrimination in overall treatment and parental care
11 to 18 years (Adolescents)	● Poor health ● Low literacy level ● Restriction on mobility and play ● Frequent illness due to Malnutrition (especially micronutrient deficiencies, anaemia in particular) ● Child Marriage ● Early Child bearing ● Morbidity and mortality ● Poor access/denial to information and services ● Early and frequent pregnancy coupled with abortions ● Marital and domestic violence ● Dowry harassment, desertion, polygamy, divorce ● Child labour, trafficking ● STDs and HIV/AIDs ● Heavy domestic work including commuting long distances to collect firewood/drinking water ● Unpaid and unrecognized work, and drudgery ● No voice either in Home or society

Sex Ratio

Sex ratio is said to be the most visible indicator (though not a complete indicator) of women's status in society. India's sex ratio is 933 while in China it is 944, Bangladesh 953 and Pakistan 938 per thousand males (Census 2001). Dreze and Sen (2002) state that the low female-male ratio in India is not due to hidden female infanticide which the death statistics are unable to capture. In fact, anthropological evidence suggests that female infanticide usually happens quite immediately after birth. Most of the female mortality happens during childhood after the age of one, when inequality is visible in the first year of birth. The all-India level neo-natal and infant mortality rates are the same for males and females. It is among the older children that significant anti-female bias in mortality exists. The neglect of females in age group beyond that of a year happens in intra-household dimensions and is mainly due to son-preference. The practices that cause female infanticide have become a part and parcel of society and are not always drastic so as to cause girl child killing through asphyxiation, drowning and poisoning.

Gender inequality includes sex differentials in mortality and also in natality. The mere wish to have sons has got transformed into reality by the help of modern techniques which can detect the sex of the foetus and abort, if it is a female. In the 0-6 age group the female-male ratio of the population has fallen from 945 girls per thousand boys in 1991 to 927 girls per thousand boys in 2001. States like Kerala have marked an increase from 958 to 963 along with the North-Eastern states of Sikkim (from 965 to 986), Mizoram (from 969 to 971), Tripura (from 967 to 975) and Union Territory of Lakshadweep (from 941 to 974). However, as expected, the female-male ratio in the 0-6 age group has reduced sharply in Punjab (from 875 in 1991 to 793 in 2001), Haryana (from 879 to 820), Gujarat (from 928 to 878), and Maharashtra (946 to 917) which are the rich states. The existing evidence suggests that there is a fall in female births compared to male births due to sex-selective abortion. Indian laws ban Pre-natal Diagnostic Techniques test except when it is a by-product of a medical investigation. However, the implementation of this law is not so effective. Dreze and Sen (2002) argue that women's agency plays an important role in reducing sex differential in fertility and mortality rates. But it cannot on its own reduce sex differentials at birth and also abortion of female foetuses. According to them, apart from the freedom and power to act what is also important is the power to reassess and question existing norms and values which require critical agency of women.

Education

Girls' education is important to empower women and enable them to realize their capabilities and entitlements. It also impacts demographic indicators such as fertility and infant mortality in a positive manner. The effect of female education on fertility becomes evident from the Kerala experience. The total fertility rate for India is 2.76 children born per woman (2008 estimate). In Kerala it has fallen below the 'replacement level' of 2.1 to 1.8 (Dreze and Sen 2002: 254). Education up to five years is seen to influence the age of marriage. To illustrate, of the total decline in birth rate from 1981 to 2001, it is found that 63 percent decline has been due to an increase in the age of marriage. Mother's education affects the nutritional status of children desirably. Children whose mothers have some education but have not completed middle level are less likely to be stunted, wasted or underweight in comparison to those whose mothers are illiterate. Children whose mothers have completed middle school or higher education are less likely to suffer malnutrition (Upadhyay and Sikdar 2008: 38).

Growth in Enrollment of Girls

Enrollment is an important indicator in assessing the participation of girls in education. After Independence, girls' education has increased although not as much

as desired. Girls' enrollment increased 11 times at the primary stage from 5.4 million in 1950-61 to 61.1 million in 2004-05. In the upper-primary stage, it increased 45 times from 0.5 million in 1950-51 to 22.7 million in 2004-05. The increase in enrollment at Secondary/Senior Secondary accounted 77 times increase, from 0.2 million in 1950-51 to 15.4 million in 2004-05 (Selected Educational Statistics 2007).

Girls' Enrollment

Since 1950-51, girls' participation has increased manyfold in Primary, Middle, Secondary/Senior Secondary stages and Higher Education levels. It has increased from 28.1 percent to 46.7 percent, from 16.1 percent to 44.4 percent, from 13.3 percent to 41.5 percent, and from 10.0 percent to 38.9 percent respectively. However, girl's participation is still below fifty percent at all stages of education (Selected Educational Statistics 2007). Girls have to bear the burden of working at home as well as outside which forces them to neglect their education. Due to social and economic factors that dissuade parents from educating girls, many remain uneducated. It is a little known fact that among the world's exploited child workers, girls outnumber boys.

Drop-outs

Drop-out rates represent the percentage of pupils who drop out from a given grade or cycle or level of education in a given school year. From 1960-61 to 2004-05, there is a decline in the drop-out rates for girls and boys at both the primary and elementary levels. The girls' drop-out rate has reduced from 70.9 percent to 25.42 percent at the primary level and from 85 percent to 51.28 percent at the elementary level. In fact at the primary level, the gap between boys and girls with regard to dropout has come to parity with that of boys (Selected Educational Statistics 2007).

Health

Countries with significant gender inequality like India, Pakistan, Bangladesh, China and West Asia have higher female to male mortality in the age-group of 0-4 years unlike in Europe, America, and Sub-Saharan Africa where female children have higher survival chances. In India, female mortality is higher than male mortality in this age-group. This is especially so in regions with pervasive gender inequality. Female labour force participation has a positive effect on survival chances of girls vis-a-vis boys. A problem still remains. Sometimes the double burden of household and outside work constrains women in looking after the health of their children. This may not be as significant a factor as female literacy which negatively impacts under-five mortality. Female literacy affects female under-five mortality more than male under-five mortality. For instance, increase in crude literacy rate from 22 per cent to 75 percent in 1981 reduces under-five mortality from 156 per thousand to 110 per thousand (Dreze and Sen 2002: 251).

Amartya Sen and Sunil Sengupta (1983) have studied the nutritional level for children under five in two large villages using weight-for-age as an indicator. They found that in the beginning the male and female infants are at the same level of nutrition but gradual deprivation causes girls to become undernourished. Girls become underfed not only because of being fed unevenly but more because of lack of proper health care. Jocelyn Kynch and Sen (1983) studied admissions data from two large public hospitals in Mumbai only to find that girls admitted to hospitals were more ill than boys. This shows that girls have to be terribly ill before being taken to a hospital (cited in Sen 2001).

The magnitude of girl child mortality is reflected from the fact that every year, about 12 million girls are born in India; a third of these girls die in the first year of their life; three million, or 25 per cent, do not survive to see their fifteenth birthday. The child mortality rate between 0-4 years for girl child is 20.6 percent, two percent

more than that of boys (18.6 percent). The root cause of malnutrition amongst girls is not just poverty and lack of nutritious food, but also fundamentally the lack of value of girls. Discriminatory feeding practices reveal that girls' nutritional intake is inferior in quality and quantity. Boys have access to more nutritious food; boys are given first priority with the available food within the family; female infants are breastfed less frequently, for shorter duration and over a shorter period than boys. Gender discrimination results in malnutrition of girls on a large scale; 56 percent of girls (15-19 years) continue to suffer from anaemia; 45 per cent of the girls suffer from stunted growth as opposed to 20 percent of boys. Due to dietary deficiencies, adolescent girls do not achieve their potential weight and height. Also, 35 per cent of rural adolescent girls have a weight below 38 kg and a height below 145 cm. Anaemia is often responsible for miscarriages, still births, premature births, low birth-weight babies and maternal mortality during childbirth. Undernourished girls who grow into undernourished mothers continue a vicious intergenerational cycle of under nutrition and wastage of women (Girl Child in the Eleventh Five-Year Plan).

Violence

A woman (girl) has to bear the burden of her body throughout her life. A patriarchal society perceives women as 'objects of desire' who are meek and powerless. According to Ghadially (1998), violence against women is an attack not only on her body but also on her personhood. Women have to face violence of various kinds in every stage of their lives. This curtails their mobility and freedom. Rape, the most heinous of crimes against women, establishes dominance and unequal power structure in society.

According to the report 'Crime in India 2006', there were 19,365 victims of rape in the country. Of these, 8.2 percent (1,593) of the total victims of rape were girls under the 15 years of age, while 17.4 per cent (3,364) were teenaged girls (15-18 years). In many cases, offenders were known to the victim. Sometimes parents/ close family members were involved and other times neighbours or relatives. This shows vulnerability of girls and the dreadful proportion of crime against them.

Trafficking and Commercial Sexual Exploitation

The buying/selling of girls for prostitution is girl trafficking. It violates human rights and damages the self-respect and dignity of the individual. In India, various laws such as Juvenile Justice (Care and Protection) Act of 2000 (JJA), Immoral Traffic (Prevention) Act of 1956 (ITPA) have been legislated to provide support, care and protection to children in various States. A decrease of 55 per cent has been observed in such cases with 67 cases being reported during 2006 as compared to 149 cases in 2005. Bihar (42) and Orissa (12) have reported the highest number of such cases accounting for 62.7 percent and 17.9 percent respectively of total such cases at the national level (Crime in India 2006).

Children of Sex workers

Prostitution has existed in our country for centuries causing sexual, social and psychological exploitation of women in our society. Given the vulnerable state of women prostitutes, definitely their daughters are also susceptible to becoming an easy prey to the 'flesh trade'. A study was done in Kerala to understand the life of children of sex workers. Using the case study method, the researcher conducted interviews with five children (three girls and two boys) about their family, culture, socialization, self-esteem, economic status and physical environment, finance and expectations from life. Jayasree concludes that it will be an erroneous belief to put children of sex workers in a compartment labelling them as those with problems and the children with a better life on the other side. Children's lives are affected by many aspects that include cultural, physical environment available, socialization

process and the social context and so on. Therefore, children in difficult circumstance may develop better coping skills than those in better conditions. However, children of sex workers undergo shame when they are despised and ostracized from the community.

Child Marriages

Child marriages still continue despite the fact that the Child Marriage Restraint Act was enacted as far back as in 1929. In 2008, 78 such cases have been reported, three of which were recorded in Rajasthan alone. According to NFHS-3 (2005-06), 45 percent of women aged 20-24 years were married before the legal age of 18 years. This figure was 50 percent seven years earlier. According to NFHS-2 Report (1998-99) there are stark variations between States on this figure. About half of the women aged 25-49 married before the age of 15 in Madhya Pradesh (52.6%), Bihar (51.0%), Uttar Pradesh (49.7%), Andhra Pradesh (48.9%), and Rajasthan (47.8 %). About four-fifths of the women of these States-Madhya Pradesh (78.5%), Bihar (83.9%), Uttar Pradesh (79.6%), Andhra Pradesh (79.8%) and Rajasthan (81.5%) were married before reaching the legal minimum age of 18 years.

The efficacy of the Act has been limited in preventing child marriage as thrust of the Act is on 'prevention' and not declaring the marriage null and void after it has occurred. The amendments to CMRA is under preparation by the Ministry of Women and Child Development and the amended bill is likely to be called the 'Prohibition of Child Marriage Bill' with emphasis on 'prohibition' instead of just 'prevention'.

Media

The advent of liberalization and globalization seems to have affected the childhood of girls in a significant manner. Media is presenting sexualized images of girls in advertisements for sale of products. The concern among young girls even as young as 10-14 years is to look beautiful, slim and trendy. This mad rush to start early is reducing the gap between childhood and adulthood, causing a loss of innocence. Meenakshi Gigi Durham, who has done research on adolescent girls and the media, emphasizes this point. In her book 'The Lolita Effect: The Media Sexualisation of Young Girls and What We Can Do About It' (2008), she examines the sexualization of 'tween' girls, those between eight to twelve years old, in advertising and pop culture because of the market which seeks to create lifetime consumers. Certain myths are nurtured like the perfect body, the need to exhibit it and also to be attractive to the opposite sex. Media projects such images of ideal body shapes and beauty which are highly improbable. These are used by the market to persuade the potential consumers, in this case girls. The impact on girls is usually devastating. Under pressure to meet these standards, they develop a lower self-esteem and often develop eating disorders like anorexia nervosa. A recent survey found that girls even 10-year-olds face anxiety when it comes to fulfilling standards of beauty. The solution to such a predicament is parental guidance whereby such issues can be discussed and girls can reflect upon the perverse role that media plays (Cheong 2008; Walia 2008).

Check Your Progress I

Note: Use the space provided for your answer.

1) Critically look at the Education and health status of girl child in India.

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2) How can the life of girl child be made more secure and safer?

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2.4 POLICY RECOMMENDATIONS

Since Independence various policies have been framed to improve the status of girls and women in India. The National Policy for Children 1974 declares children to be a "supremely important asset". It emphasizes a comprehensive health programme, and free and compulsory education for all children till 14 years of age focusing on girls. The policy states that "special efforts will be made to reduce the prevailing wastage and stagnation in schools, particularly in the case of girls and children of the weaker sections of the society" among other provisions. It suggests the need to form a 'national board for children' to plan, review and implement policies for children. The National Policy for Child Labour (1987) highlights the importance of "attracting and retaining girls from among working children, to NFE centres".

The National Charter for Children 2004 states that for protection of the girl child, the State and community shall ensure that crimes and atrocities committed against the girl child, including child marriage, discriminatory practices, forcing girls into prostitution and trafficking are speedily eradicated. The State along with the community will undertake measures, including social, educational and legal, to ensure that there is greater respect for the girl child in the family and society. Serious measures will be taken to ensure that the practice of child marriage is speedily abolished. In order to empower adolescents the charter observes that special programmes will be undertaken to improve the health and nutritional status of the adolescent girl.

In this section, we shall discuss the policies in education in brief. Recent policies on women point to a departure from the earlier welfare approach. Though welfare and development of women is essential, still the emphasis now is on empowerment. We shall examine these policies in this context (Nayar 2001). The **National Committee on Women's Education (1958-59)**, popularly known as the Durgabai Deshmukh Committee was the first committee after independence under the chairpersonship of Durgabai Deshmukh. It was set up to analyze the development of women's education in India. It recommended appointment of school mothers especially in those schools where there were no women teachers, provision of attendance scholarships, women's education week and emphasized on the need to channelize public opinion in favour of women's education. With respect to curriculum, the Committee suggested identical curriculum for boys and girls till the middle stage, after which, girls could be introduced to pre-vocational courses such as typing, tailoring or teaching. It also recommended the need to revise textbooks to refrain from gender stereotypical depictions. Overall, the Committee took a detailed view of women's needs in relation to each level of education. Thereafter, the **Education Commission (1964-66)** under the chairpersonship of

Dr. Kothari (hence known as the Kothari Commission) emphasized the implementation of special programmes recommended by the earlier committees on women's education. It favoured common curricula for boys and girls. The **National Policy on Education 1968** states that education of girls needs to receive emphasis not only on grounds of social justice but also social transformation. **National Policy on Education 1986** (NPE-1986) states that equality of educational opportunity will be provided to all disadvantaged sections including girls. It lays special emphasis on the removal of disparities and on equalization of educational opportunity by attending to the specific needs of those who have been denied equality so far. Recognizing that education can prove to be a tool for attaining empowerment of women, the policy observes "education will be used as an agent of basic change in the status of women…The removal of women's illiteracy and obstacles inhibiting their access to, and retention in elementary education will receive overriding priority, through provision of special support services…" (Chapter IV, 4.2 and 4.3).

National Policy for the Empowerment of Women 2001 elaborates the rights of the girl child. All forms of discrimination against the girl child and violation of her rights will be eliminated by undertaking strong measures both preventive and punitive, within and outside the family. These would relate specifically to strict enforcement of laws against prenatal sex selection and the practices of female foeticide, female infanticide, child marriage, child abuse and child prostitution etc. Removal of discrimination in the treatment of the girl child within the family and outside and projection of a positive image of the girl child will be actively fostered. In implementing programmes for eliminating child labour the policy states, there will be special focus on the girl child.

National Plan of Action for Children 2005

The National Plan of Action for Children 2005 commits itself to ensure rights to all children until the age of 18 years. It aims to ensure survival, protection, development and participation of a child so that she/he attains full potential and becomes an enlightened citizen. The plan suggests the need to abolish female foeticide, female infanticide and child marriage to ensure well-being of girls. With specific goals, objectives and strategies it aims to achieve equality of status for the girl child.

Check Your Progress II

Note: Use the space provided for your answer.

1) Enlist the policy provisions for the girl child in India.

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2.5 PROGRAMME INTERVENTIONS

Programme initiatives are based on the ideas of advocacy, social mobilization, prevention, participation, development, rights, recovery and integration, training and capacity building. The awareness campaigns encourage girls' education and develop public opinion against child marriages and child labour. The focus is on ensuring participation of girls in all spheres leading to capacity-building and their

all-round development. The programmes follow "girl-friendly" strategies which focus on equalizing opportunities for girls unlike "girl-centred" ones which try to change structural patterns of society to empower the girl child (Weiner 1985).

Sarva Shiksha Abhiyan with Special Focus on the Girl Child

The scheme of Sarva Shiksha Abhiyan (SSA) was started in the year 2001-02 with the objective of universalization of elementary education. It is an attempt to provide an opportunity for improving human capabilities to all children including the girl child, through provision of community-owned quality education in a mission mode. Reaching out to the girl child is central to the efforts to universalize elementary education. Sarva Shiksha Abhiyan, or 'Education for All' programme, recognizes that ensuring girl's education requires changes not only in the education system but also in societal norms and attitudes. A two-pronged gender strategy has, therefore, been adopted to make the education system responsive to the needs of girls through targeted interventions which serve as a pull factor to enhance access and retention of girls in schools and on the other hand, to generate a community demand for girls' education through training and mobilization. Education of girls has been a high priority with the Government of India.

The targeted provision for girls under Sarva Shiksha Abhiyan includes free textbooks to all girls upto class VIII, separate toilets for girls, back-to-school camps for out-of-school girls, bridge courses for older girls, recruitment of 50 percent women teachers, early childhood care and education centres in/near schools/ convergence with ICDS programme etc., teachers' sensitization programmes to promote equitable learning opportunities, gender-sensitive teaching-learning materials including textbooks, intensive community mobilization efforts, 'innovation fund' per district for need-based interventions for ensuring girls' attendance and retention.

Through the SSA, efforts are being made to generate a community demand for girls' education and enabling conditions for people's and women's participation, to create the push factors necessary to guarantee girls education. Motivation and mobilization of parents and the community at large; enhancing the role of women and mothers in school-related activities and participation in school committees; and strengthening the linkages between the school, teachers and communities are some of the ways in which the enabling conditions are being created.

In addition, to target pockets where girls education is lagging behind, the Government of India has launched two focused interventions for girls - the National Programme for Education of Girls at Elementary Level (NPEGEL) and the Kasturba Gandhi Balika Vidyalaya (KGBV) to reach out to girls from marginalized social groups in over 3,000 educationally backward blocks in the country where the female rural literacy is below the national average and the gender gap in literacy is above the national average.

National Programme for Education of Girls at Elementary Level (NPEGEL)

Government of India has declared its commitment to achieve Universalization of Elementary Education by 2010. This entails a special thrust on girls' education as well as greater rigour in planning, targeting and actually implementing the interventions designed. Statistics reveal that despite the efforts that have been made, gender disparities persist in enrollment of girls, especially in rural areas and among disadvantaged groups. The disparity is more acute in the enrollment of Scheduled Castes and Scheduled Tribes, especially at upper primary level.

Sarva Shiksha Abhiyan has limited financial provisions for girls' education in the form of free textbooks and innovations at district levels. So, the National Programme for Education of Girls at Elementary Level (NPEGEL) has been formulated for providing additional support for education of underprivileged/disadvantaged girls

at elementary level. The target group includes out of school girls, drop out girls, overage girls who have not completed elementary education, working girls, girls from marginalized social groups, girls with low attendance and with low levels of achievement, and girls rescued from work, trafficked children, daughters of sex workers, displaced girls including girls in disturbed areas and urban settings. NPEGEL is a part of SSA and will be implemented under its umbrella but as a distinct and separate gender component plan of SSA.

The Kasturba Gandhi Balika Vidyalaya (KGBV) scheme has since 1st April, 2007 got merged with the SSA programme as a separate component. It was launched by the Government of India in August, 2004 for setting up residential schools at upper primary level for girls belonging predominantly to the SC, ST, OBC and minorities in difficult areas. The KGBV ran as a separate scheme but in harmony with SSA, NPEGEL and Mahila Samakhya (MS) in the initial years.

Janshala: The Government of India collaborated with UN agencies like ILO, UNICEF, UNESCO, UNFPA to provide support for Universalization of Elementary Education and started the Janshala. It is a community-based education programme to make primary education accessible to girls. This Block-based programme started in blocks selected on the basis of female literacy, child labour, scheduled caste and scheduled tribe population. Now, it is operational in 139 blocks in nine states of Karnataka, Andhra Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand, Orissa, Maharashtra, Rajasthan, Uttar Pradesh. It also covers cities of Hyderabad, Puri, Cuttack, Jodhpur, Lucknow and Bhillai. It caters to 110 lakh children (2007: 11)

Nutrition Approved for Adolescent Girls: The Government of India is continuing with the Nutrition Programme for Adolescent Girls (NPAG) in the year 2007-08 on a pilot project basis. The project is being implemented in 51 identified districts i.e. in two backward districts each in major states, identified on the basis of ranking developed by Rural Development Division of the Planning Commission and in the most populous district excluding the capital district each, in smaller states/ UTs. Undernourished adolescent girls in the age group 11-19 years with body weight less than 30 kg in the age group of 11 to 15 years and below 35 kg in the age group of 15-19 years are covered under this scheme. Free foodgrain at the rate of 6 kg per beneficiary per month, is provided to these undernourished adolescent girls. The programme has been operationalized through the administrative set up of ICDS at the state, district, block and anganwadi centre level. The success of the intervention depends on effective linkages with the Public Distribution System (PDS) and effective synergy and convergence with health services (DWCD 2007-08).

Conditional Cash Transfer for Girl Child with Insurance Cover: The Ministry of Women and Child Development has launched a new Pilot Scheme "Conditional Cash Transfer for Girl Child with Insurance Cover (CCT)" wherein cash transfers will be made to the family of the girl child (preferably the mother) on fulfilling certain specific conditionalities (Birth registration, immunization, school enrollment and retention, delay in marriage of the girl child till age of 18 years). In addition, an insurance coverage to the tune of Rs 1 lakh would be taken for the girl child born on and after a cut-off date proposed. The central tenet of CCT is the linking of cash to behaviour by providing money to poor families contingent upon certain verifiable actions.

The objective of the Scheme is two-fold:

a) The direct and tangible objective is to provide a set of staggered financial incentives for families to encourage them to retain the girl child and educate her etc.

b) The more subtle and intangible objective is to change the attitudinal mindset of the family towards the girl - by linking cash transfers to her well-being.

This will force the families to look upon the girl as an asset rather than a liability since her very existence has led to cash inflow to the family.

The Scheme is being implemented as a pilot in eleven Blocks in seven States (Andhra Pradesh, Chattisgarh, Jharkhand, Uttar Pradesh, Bihar, Punjab and Orissa). These Blocks except in Punjab are educationally backward as identified by the Department of Education. A Pre-Project Survey and setting up a Monitoring and Evaluation Mechanism with support from World Bank is being undertaken. The Scheme has been included in the Eleventh Plan (MWCD 2007-08)

Effective Implementation of the Pre-Conceptional and Pre-Natal Diagnostic Techniques Act: The Ministry of Women and Child Development has given a number of suggestions for effective implementation of the Pre-Conceptional and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 by strengthening monitoring mechanisms through multiple memberships including NGOs in the National Inspection and Monitoring Committee, de-linking medical professionals from Appropriate Authorities, suspension of errant clinics/doctors, system of incentives/decoy operations etc.

Awareness Generation on Female Foeticide: In order to combat female foeticide, a massive nationwide sensitization and advocacy campaign with specific focus on the importance of the girl child is being undertaken. As this requires multi-sectoral approach, MWCD has taken the lead in collaborating with Ministries such as Ministry of Defence (NCC, Army Wives Association etc), Ministry of Youth and Sports (NYKS and NSS), Ministry of Panchayati Raj and Ministry of Health and International Organizations to draw up a Plan of Action. The grassroot functionaries such as Anganwadi Workers (AWW), Auxiliary Nurse and Mid Wife (ANM), ASHA Worker, Panchayati Raj Institutions have been advised and sensitized to keep track of pregnant mothers and take note of female births and tracking the progress of girl child. (MWCD 2007-08)

Ladli Scheme: The Government launched the ladli scheme under which the Government as part of the scheme will make a payment of Rs.6,000 if the girl child is born in a hospital or nursing home in Delhi and will provide a cash payment of Rs.5,000 each on admission of the child to Class I, VI, IX, X and XII. The aim of this scheme is to combat female foeticide and to facilitate birth of more girl children. It seeks to benefit maximum number of girl children and ensure that she is seen as an asset to the family and an economically self-reliant individual. It is also to enhance the social status of the girl child by promoting their education and protecting them from discrimination and deprivation. It will also help in increasing enrollment of girls in schools and overcome the problem of dropouts. The scheme also fulfills dreams of families whereby their daughters would be educated. The girl child should be born in Delhi on or after January 1, 2008 and the annual income of the parents of the girl child should not exceed Rs one lakh (TOI March 8, 2008; May 2, 2008).

The Haryana government claims that the state's lopsided sex ratio has improved marginally after it introduced the 'Ladli' scheme of financial assistance for girls in 2005. The sex ratio of 819 girls per 1,000 males in the 0-6 years age group has now improved to 823 girls per 1,000 males, according to the statistics of 2005. Under the 'Ladli' scheme, parents having a second girl child are given a financial assistance of Rs.5,000 per year up to five years of the birth of the girl. The amount is invested in savings schemes and a matured amount of nearly Rs. 87,000 would be paid to the girl when she attains 18 years of age. Buoyed by the success of the scheme, the state government has set a target of making the benefits of the scheme reach 85,000 girls in the next five years. So far, 5,642 girls have benefited under the scheme since it was introduced on August 20, 2005. The scheme was introduced as one of the measures to combat female foeticide and check the declining sex

ratio in Haryana. 65 percent of Haryana's population comprise of women and children in the 0-6 years age group (The Sunday July 30, 2006).

The Ladli Social Security Pension Scheme: This scheme is a unique initiative taken by the Haryana Government to improve the socio-economic status of women and check the declining sex ratio. The scheme had specially been introduced for families that had only daughters and suffered from feelings of insecurity that they would be left alone in life after the marriage of their daughters. Only such parents, one or both of whom belonged to Haryana, could benefit from this scheme. They should also not have their own son or any adopted son. A monthly pension of Rs. 300 is being given under this scheme to the registered families from the 55th to 60th birthday of the mother or father, after which they would become eligible for old age allowance. In case the mother or the father died during this period, the living spouse would get the pension till the age of 60 (The Hindu January 7, 2007).

Dhan Laxmi: The Central Government launched 'Dhan Laxmi' like the ladli scheme, a conditional cash transfer scheme for the girl child in view of the falling sex ratio and also to stop female foeticide. The objective of the scheme is to provide financial incentives for families to encourage them for better upbringing of the girl child and to educate her. The scheme also seeks to change the attitude of the family towards the girl who from now would look upon the girl as an asset rather than a liability since her birth would facilitate the family with cash inflow. As per the unique scheme, the family of the girl child will be provided a significant amount of money if the child fulfills certain conditions like registration of birth of the girl, following total immunization schedule, school enrollment and delaying of marriage until the age of 18 years. The centre also plans that an insurance cover of Rs.1 lakh will be provided to the girl child at birth. Overall, a cash package of Rs. 2 lakh will be provided to the girl's family, preferably to the mother, through the scheme. Firstly the scheme will be started on a priority basis in eleven educationally most backward blocks of Andhra Pradesh, Chhattisgarh, Orissa, Jharkhand, Bihar, Uttar Pradesh and Punjab. It will cover both those living below and above the poverty line. An estimated amount of Rs.10 crore has been earmarked for 2008-09 to facilitate benefits to around 1, 01,970 girl children.

Kishori Shakti Yojana (KSY) seeks to empower adolescent girls, so that they are able to take charge of their lives. It is viewed as a holistic initiative for the development of adolescent girls. The programme through its interventions aims at bringing about a difference in the lives of the adolescent girls. It seeks to provide them with an opportunity to realize their full potential.

This scheme is a redesign of the already existing Adolescent Girls (AG) Scheme being implemented as a component under the centrally sponsored Integrated Child Development Services (ICDS) Scheme. The new scheme dramatically extends the coverage of the earlier scheme with significant content enrichment, strengthens the training component, particularly in skill development, aspects aimed at empowerment and enhanced self-perception. It also fosters convergence with other sectoral programmes, addressing the interrelated needs of adolescent girls and women.

Adolescent Girl Scheme

ICDS, with its opportunities for early childhood development, seeks to reduce both socio-economic and gender inequalities. In order to better address concerns for women and the girl child, it was necessary to design interventions for adolescent girls. This is aimed at breaking the inter-generational life cycle of nutritional disadvantage, and providing a supportive environment for self-development. For the first time in India, a special intervention has been devised for adolescent girls, using the ICDS infrastructure. This intervention focuses on school drop-outs, girls

in the age group of 11-18 years, with a view to meet their needs of self development, nutrition, health, education, literacy, recreation and skill formation. Special emphasis is also placed on reducing nutritional anaemia among this group. This scheme has been sanctioned in 507 blocks covering all States and UTs. "State parties recognize that every child has the inherent right to life. State parties shall ensure, to the maximum extent possible, the survival and development of the child" (Article 6 of the UN Convention on the Rights of the Child). Government of India acceded to this convention in December 1992.

Check Your Progress II

Note: Use the space provided for your answer.

1) What are the programmes for the welfare and development of the girl child? Examine their effectiveness.

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2.6 LET US SUM UP

In this unit we have reviewed the situation of the girl child in India. The girl child is the most disadvantaged in terms of educational indicators of enrollment, retention and drop-out. The health profile of girls shows that due to female foeticide and infanticide the girl child is either not born or dies much earlier in life. If she continues to live, discrimination in nutrition and health services affect her well-being. The extremely low sex ratio in the age-group of 0-6 years is the result of such a situation. Policies have been formulated that recognize her marginalization and various efforts are being made to enhance her life status. But there is a long way to go still.

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UNIT 3   CHILDREN IN CRITICAL CIRCUMSTANCES

Structure

3.0   OBJECTIVES

Children are the most precious wealth of a nation. Childhood is the most crucial period in a person's life because growth and development attain maximum level during this period. A worldwide study on children shows that a large number of children live in a very unhealthy and intimidating environment (both biological and psychological arenas) affecting their overall psychosocial development. Children living in critical circumstances undergo various types of trauma in life. This unit concentrate on understanding the situations of such children.

After studying this unit, you should be able to:

● identify the children living in critical circumstances;

● analyze the difficulties faced by the children in critical circumstances; and

● recognize the living condition and deprivation of rights of these children.

3.1   INTRODUCTION

In spite of persistent efforts on the part of the government, voluntary organizations and international organizations, a large segment of children have remained out of the ambit of programmes and services. These are children in critical circumstances whose quality of life requires serious attention and special measures for the protection of their rights. The term "children in critical circumstances" is an umbrella term which refers to many groups of children in situations of need. Statistics do not exist for many of these groups of children. However, with erosion in values and disorganization of the family due to urbanization and industrialization, the magnitude of the problem is increasing.

In an effort to understand the most vulnerable group of population i.e children in critical circumstances, it has been observed that in the last few years there has been an increase in the number of children under this category. These children are seen in every nook and corner of the city. Though during childhood days, children

are supposed to be primarily engaged in playing, schooling, friendship, fun etc., this group of children could not get access to those rights that they are supposed to enjoy.

3.2 STREET CHILDREN

One of the major consequences of the process of urbanization and industrialization is growing population of urban poor in the cities which do not have access to the basic amenities of life. They are constantly involved in the struggle for survival. These are the people who migrate from the rural areas in large numbers and settle down in slums, shanty towns, or squat wherever there is vacant land available. Some of them cannot even get this and lead a life on city streets, pavements, public places, parks, etc. looking daily for a place to spend the night. A more serious and vulnerable group of the urban poor that is growing rapidly in the big cities is the street children and working children, with a home or without a home. Many of them may be just runaways, as a result of broken homes, lured by city life and have no other alternative than to stay on the streets temporarily (Vanitha, 2009).

The phenomenon of "street children" is universal. With increasing awareness among governmental and international agencies, "street children" are seen as a vulnerable group worthy of special interest, attention and intervention.

The term **"Street Children"** may suggest children such as those popularly known as 'rag pickers' in India, 'parking boys' in Kenya, 'Peggy boys' in the Philippines, 'pivetes' in Brazil, 'pajaro frutero' in Peru and 'homeless youth' or 'runaways' in some developed countries (Agrawal, 1999).

A street child is one who

- lives on the streets, waste land, or public space most of the time,

- works in the streets on jobs of low status and low income,

- lives in the exposed conditions of the street,

- has no or little parental supervision or other social protection,

- has either continuous, intermittent or no family contact at all,

- is vulnerable to the hazards of urbanization and urban living conditions.

DEFINITION OF STREET CHILDREN

'Street Children' is a term which often highlights a certain set of working and living conditions rather than personal or social characteristics of individual children themselves. Accordingly "a street child is any minor for whom the street has become his or her habitual abode, and who is without adequate occupation". In this context three categories of children are identified.

i) **The children on the street:** Largest of the three categories, it consists primarily of working children who still have family connections of a more or less regular nature. Their focus of life is still the home.

ii) **The children of the street:** The group is smaller but more complex. Children in this group see the street as their home and it is there they seek shelter, food and a sense of family among companions. Family ties exist but are remote and they visit home frequently.

iii) **Abandoned children:** This group may appear to form a part of the second group and in daily activities are practically indistinguishable. However by

virtue of having severed all ties with a biological family they are entirely on their own, not just for material, but also for psychological survival.

FACTORS RESPONSIBLE FOR CHILDREN LIVING ON THE STREET

Children may end up on the streets for several basic reasons. They may have no choice - they are abandoned, orphaned, or disowned by their parents. Secondly, they may choose to live in the streets because of mistreatment or neglect or because their homes do not or cannot provide them with basic necessities. Many children also work in the streets because their earnings are needed by their families.

Socio-Structural Causes: The phenomenon of street children is a by-product of industrialization and urbanization. Uprooted from the only place they knew and could call their home, migrated people (men, women and children alike) take to the streets as their refuge. In such circumstances there is little that they can do for their children who wander on the streets while they work until late hours to make ends meet. Some children are fortunate to have a 'home' that they can retire to at the end of the day; while many others have no other choice but to seek shelter on the pavements, in public places and so on.

Economic Causes: The economic compulsions are often more visible and apparent than many other compulsions like geographic, social, cultural and political which can force a child to be on street. Many a time the earnings of the parents are insufficient to secure even the family's most basic needs. Consequently the children have to be sent to work to supplement the family's income. Since these children are young, uneducated and unskilled they work largely in the unorganized sector and frequently end up in trades such as shoe-shining, rag-picking and so on.

School Dropout: The dropout rate in India is quite high (36%-52%). Many street children are school dropouts. Many children (especially girls) are forced to drop-out from school in order to work with their parents or to look after their younger siblings while their parents are at work. Children may escape to the cities in the hope that they may be able to procure an education or work for themselves.

Natural Calamities: Natural calamities like floods, droughts, earthquakes etc. often leave families displaced and torn apart (physically, socially, economically and culturally). Above that the relief operations from various sources not only arrive long after the disaster but are also woefully inadequate compelling children orphaned by these calamities to take to the streets merely to survive.

Cruelty and Abuse: Many parents today still use the traditionally upheld methods of disciplining children by hitting them with belts, canes, sticks and so on. Thus, to escape such cruelty and abuse, children often run away from homes and take to the streets. The young, gentle mind of a child is not designed to cope with such severe trauma and pain and when the situation becomes unbearable, the only escape the child knows is physical escape from the home - the source of the pain and torture.

Neglect: With both parents at work, the children go unattended for hours. In many cases, older siblings have to look after the younger ones. Neglected and deprived, the children feel not only insecure, but also unjustly treated. Thus, in a state of rejection and hurt, they may turn hostile and run away from home in search of other places where they can belong and feel loved.

Broken Homes: Children living with a single parent or a stepfather or stepmother, or children who are orphans, are most prone to emotional trauma and often suffer from feelings of rejection and insecurity that may drive them out in search of a place where they may be better accepted and loved.

Peer Group Influence: Peer group has a lot of influence on the young minds of children. Some children find themselves on the streets as a result of their peers

encouraging them to leave the conflict-ridden homes they live in. This may be done by the peers glorifying the idea of city life, or of independent life out of the home. Thus a few children leave their homes for street life by coming under the influence of their peers.

Influence of Media (films and television)

The media today also plays quite a significant role in encouraging children to leave home. They over emphasize 'city life' as being 'exciting', 'adventurous', and 'totally filled with fun' and at the same time fail to realistically present the disadvantages of the same. As a result, children do not think twice about leaving their homes for the cities. While their illusions are shattered when they actually land in the cities and face the harsh realities of life giving up their pride and returning home make them stay on in the city in an attempt to prove themselves right.

DIFFICULTIES AND PROBLEMS FACED ON THE STREET

Street children live in an environment devoid of the affection, love, care and comfort of a family life. Early in life, these children learn to make their own decisions since there is no one to help them or guide them. They are physically and emotionally worn down by the need to fend for themselves and make a living at such a young age.

The main problems that street children have to face come under three main categories:

i) **Physical Problems**

Lack of Adequate Nutrition: Even though many street children get some amount of food to eat, they do not get nutritious or balanced diets which manifests itself in the form of anemia, vitamin deficiencies and other forms of malnutrition.

Homelessness: The children who choose the streets as their home face the most acute problems related to shelter. They are vulnerable to all ranges of adverse conditions. These children do not suffer merely from physical homelessness, but also from a psychological homelessness since they have 'nowhere to belong'. The homes they leave behind no longer remain their havens while the streets provide no comfort.

Health Problems: Street children continuously face physical and mental strain. All street children suffer from severe malnutrition and various kinds of deficiencies. The consumption of tobacco, alcohol or drugs retards their growth at an early age.

Due to exposure to dust and other pollutant, they suffer from bronchitis, asthma and even severe tuberculosis. Because of the unhygienic conditions in which they live, they are prone to skin diseases such as scabies, ulcers and rashes. They also encounter sexual and reproductive health problems such as STDs, HIV / AIDS, unwanted pregnancies, unsafe abortions, etc. The lack of opportunity to ever visit a doctor further compounds all these health problems.

ii) **Psychological Problems**

A Stressful Past: The past plays a crucial role in predisposing street children to become more vulnerable to emotional, social, and psychological disorders in the future. Those situations and events that lead children to take to the streets may have an on-going impact on their well-being and may deprive them of emotional, economic, and other kinds of support for many successive years.

A Transitory Lifestyle: Street children frequently move from place to place. Though in a majority of instances they do this by choice, at other times, they are

forced to keep moving in order to hide from the police, welfare authorities, and gangsters. This ambiguous lifestyle results in problems of social isolation and loneliness and leads to difficulties in developing emotional attachments to other human beings.

Substance Abuse: Many street children resort to substance abuse (such as alcohol and drugs) in an attempt to escape from the overwhelming pressure of their traumatic past and their daily problems. Substance abuse can lead to medical problems due to overdoses, an increase in the probability of accidents, violence and unprotected sex.

Unlearning of Learned Behaviour: The children who leave home and begin to live, the streets soon realize that the values their family taught them (such as honesty, integrity, etc.) are not conducive to their survival on the streets. At times they are forced to steal food and money because they have none of their own. They have to swallow their pride in order to beg for food or money. They learn to let go of their shame when they have no clothes or when they have only an undergarment to wear.

iii) **Social Problems**

Deprivation of Needs and Lack of Resources and Opportunities: Socio-culturally, the street children lack opportunities for healthy recreation and lack social acceptance. They frequently go hungry, wear torn, tattered and dirty clothes or sometimes, no clothes at all. They have no permanent place to stay, no educational facilities, no facilities for hygiene and in brief, no facilities at all. They are exploited and abused, their basic needs of security and happiness are not met.

Exploitation: Children on the street have to work to survive. Frequently, they are forced to work for 10-12 hours a day for very meagre payment or in exchange for just one square meal a day. They are also abused and harassed - either physically or sexually by persons in authority. Besides the police, the street children are frequently taken advantage of by the underworld gangsters or by older street boys who bully them and use them to achieve their own ends. If the children do not oblige, they are threatened, beaten and sometimes, in extreme cases, may even be killed.

Stigmatization: The general misconception is that street children are addicts, uncontrollable and violent, have no emotions or moral values who are out to cause trouble. As a result of these misconceptions, people tend to be unsympathetic and indifferent to the actual plight of street children. This lack of social acceptance is what pushes them away from mainstream society and forces them to survive on the fringes of the social system.

3.3 RAG PICKERS

'Rag Pickers' are a significant part of our society. Most of these rag pickers are young children. As they have no source of income of their own and are often orphans or street dwellers, rag picking seems to be their favourite pastime and their main source of income as well. But it is not as simple as just finding the stuff and selling it to the 'kabaadi walla' shops.

Rag pickers are those who pick scraps or waste items from the city dumps, garbage bins, road sides and drains. Hanging a jute or plastic bag on their shoulder, they go around in certain pockets in the busy city areas from early morning to mid night to collect such materials. They walk around barefoot and without gloves to handle the garbage and search for recyclable items like iron, bottles, electric bulbs,

polythene bags, plastic materials, tin etc. The working condition is hazardous and unhygienic.

Background of the Child Ragpickers

Many children begin working as ragpickers at a young age even before they are five years old. The majority of the ragpickers are between 8 and 10 years of age. Most of them never attend school and do not have any formal education. Their families are generally in need of extra incomes which they earn through their children.

There are two categories of child ragpickers:

Street pickers mostly boys, are extremely mobile and therefore it is difficult to gain access to them. What they usually need is a shelter or reintegration with their families. In most cases, the children work for a middleman who takes the major share of the sales and pays only a small amount to the children.

On the other hand, the Dump pickers often live with their families, in a relatively more stable environment. They usually work with their parents in or around the dumping ground.

ISSUES RELATED TO RAG PICKERS

Social: Most of the rag-pickers are extremely poor, illiterate, and belong to rural immigrant families. Many commence their profession at the young age of five to eight years. Most of them never attend any school or have any formal education. Most of their families are in need of extra incomes from these young children. As earning members of the family they do not heed much to the advice of family elders.

Long working hours: Normally children work in one shift only but some of the children are collecting rags two to three times in a day. Those who are involved in collection of empty bottles work late in the night.

Hazardous work conditions: Ragpicking is probably one of the most dangerous and dehumanizing of activities. Child ragpickers are working in filthy environments, under extreme weather conditions and have to search through hazardous waste without gloves or shoes. They often eat the filthy food remnants they find in the garbage bins or in the dumping ground. The children run the risk to come upon needles, syringes, used condoms, saline bottles, soiled gloves and other hospital wastes as well as harmful plastic and iron items. Often these rag pickers go down drains and nallahs in search of the precious wastes and are subjected to chemical poisons and infections.

Health: Rag pickers tend to suffer from many diseases, such as respiratory problems, worms, anaemia, fever and other problems which include cuts, rashes and dog bite. Because of malnutrition they suffer from retarded growth and anaemia. The rag pickers are very susceptible to diseases like tuberculosis and cancer due to their exposure to hazardous materials. They commence chewing and smoking tobacco quite early in life and soon they become addicted to alcoholic beverages and then they switch to hard liquors. They even do not refrain from taking the drugs.

Education issues: A large majority of the child ragpickers are out of school children, despite the presence of schools in their neighbourhood. Most of the children are withdrawn from school at an early age. The boys often work in their parents' business while the girls are made to take up the household responsibility.

State of the legislation: Several Indian states are enforcing anti-begging laws and hence the traditional beggars have opted for "rag-picking". In 2001, waste-picking

was included among the hazardous occupations banned under the Child Labour (Prohibition and Regulation) Act, 1986. But apart from this very brief mention, ragpicking is ignored in legislation regarding child labour. Contrary to most child labourers, ragpickers are self-employed or working with their parents and therefore not answerable to any employer.

3.4 CHILD LABOURERS

Child labour continues to be a global phenomenon – no country or region is immune to this problem. It is commonly understood to be the result of economic deprivation and widespread illiteracy. It is one of the major problems which India is facing though there are clear provisions in our Constitution to safeguard the interests of children by ensuring that they are not forced to work for a living. It is very unfortunate that the problem of child labour exists to a large extent in our country.

Categories of Child Labourers

International law categorized child labour into three categories These are as follows:

i)   The unconditional worst forms of child labour, which are internationally defined as slavery, trafficking, debt bondage and other forms of forced labour, forced recruitment of children for use in armed conflict, prostitution and pornography and illicit activities.

ii) Labour performed by a child who is under the minimum age specified for that kind of work (as defined by national legislation, in accordance with accepted international standards), and that is thus likely to impede the child's education and full development.

iii) Labour that jeopardizes the physical, mental, or moral well being of a child either because of its nature or because of conditions in which it is carried out, known as hazardous work.

Extent of Child Labour

According to the International Labour Organization (ILO) almost one billion children are working for their survival. The largest numbers – 127 million -of working children age 14 and under are in the Asia Pacific region. Roughly 2.5 million children are economically active in the developed economies, 2.4 million in the transition countries, over 17 million in Latin America and the Caribbean, 48 million in Sub-Saharan Africa and more than 13 million in the Middle East and North Africa. In India as per the Census 2001, there are 1.2 crore economically active children in the age group of 5-14 years. The number was 1.13 crore in the 1991 Census (ILO Report, 2002).

The United Nation Children's Fund (UNICEF) estimates that in India there are more than 35 million child labourers, accounting for 14 percent of children in the 5-14 years age group. As per the census 2001, there are 1.26 crore economically active children in the age group of 5-14 years.

Causes of Child Labour

Some common causes of child labour are poverty, parental illiteracy, social apathy, ignorance, lack of education and exposure, exploitation of cheap and unorganized labour.

Family Tradition: The family practice to inculcate traditional skills in children also pulls little ones inexorably into the trap of child labour, as they never get the opportunity to learn anything else.

Lack of Education: Absence of compulsory education at the primary level, non-availability and non-accessibility of schools, boring and unpractical school curriculum and cheap child labour are some other factors which encourage the phenomenon of child labour.

Economic Conditions

Poverty and over population have been identified as the two main causes of child labour. Monetary constraints and the need for food, shelter and clothing drives parents to send their children into the trap of premature labour. Over population in some regions creates paucity of resources. Thus, when there are limited means and more mouths to feed, children are driven to commercial activities and development needs are not provided for.

Illiteracy and Ignorance of Parents: Illiterate and ignorant parents do not understand the need for wholesome proper physical, cognitive and emotional development of their child. They are themselves uneducated and unexposed, so they do not realize the importance of education for their children, thus pushing their children into child labour.

Adult unemployment: Adults often find it difficult to find jobs because factory owners find it more beneficial to employ children at cheap rates. Adult exploitation of children is seen in many places. Elders relax at home and live on the labour of their helpless children.

Urbanization: The industrial revolution has also had a negative effect by giving rise to circumstances which encourage child labour. Sometimes multinationals prefer to employ child workers in the developing countries. This is so because they can be recruited for less pay and more work can be extracted from them. Since there is no organized union working for them, they do not demand better wages or improved working conditions.

Governmental Initiatives

The Constitution of India, which came into force in January 1950, contains provisions for survival, development and protection of children. According to Article 24, no child below the age of fourteen years shall be employed to work in any factory or mine or engaged in any other hazardous employment. In Directive Principles of State Policy, Article 39 directs that the tender age of children are not abused and not forced by economic necessity to enter a vocation unsuited to their age or strength; that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood be protected against exploitation and against moral and material abandonment.

Government of India has enacted many laws before and after independence on the basis of various reports regarding position and condition of child labour in different sectors.

The Government of India is determined to eradicate child labour in the country. The world's largest child labour elimination program is being implemented at the grass roots level in India, with primary education targeted for nearly 250 million. In this a large number of non-governmental and voluntary organizations are involved. Special investigation cells have been set up in States to enforce existing laws banning employment of children in hazardous industries.

The need of the hour is to attract public attention to involve everybody in this fight against child labour. We should not forget that a child is an invaluable asset of any society and has a definite role to play in the development of the nation. We need to get down to action creating a new world for the children for whom we are responsible.

3.5 HIV/AIDS AND CHILDREN

There is a growing concern for children living with HIV today. Without treatment, thousands die as a result of AIDS. In addition, millions more children who are not infected with HIV are indirectly affected by the epidemic, as a result of the death and suffering that AIDS causes in their families and their communities. Till very recently, attention had centred mainly around two groups of children - infected children (those who are HIV positive), and affected children (those who have a sero-positive family)

Profile of Children and HIV/AIDS in India

In relative terms, the overall HIV prevalence rate in India is still low. There is, however, no cause for complacency. India's socio-cultural environment makes all children vulnerable to the infection. There are numerous risk factors intricately linked to social and cultural aspects of life that directly, and indirectly, facilitate HIV transmission among children. These include migration, increasing urbanization, poverty, illiteracy, displacement of people, the subordinate status of women, changing family patterns, growing consumerism, uncensored media exposure, unsafe sexual practices, irregularities in blood supply services, child abuse and child sexual abuse. Around 90% of all children living with HIV acquired the infection from their mothers during pregnancy, birth or breastfeeding. (Joshi, and Rao, 1999)

Impact of HIV/AIDS on Children

Social: Children may leave school either to earn or to perform household and/or care giving roles if there is no other support. If the community becomes aware of the family's HIV status the children face social prejudice and exclusion. Friends visit less often and children may be harassed at, or denied access to, school.

Children who lose a parent to HIV/AIDS are also at risk of losing their property rights, and their rights to inheritance. The resulting poverty and isolation can create a vicious circle, placing these children, especially the girls, at greater risk of contracting HIV themselves (UNAIDS 1999). Following the passing away of both parents, the extended family usually serves as the social security system. These families may lack the resources to care for them, and hence, such children may be the first to be denied education, adequate nutrition, health care, etc. (UNICEF 1999).

Economic: HIV/ AIDS irrevocably changes the world for children. The onset of the symptomatic phase implies a change in family roles and relationships and in the family economy. Household resources dwindle due to medical expenses, and the parents' inability to work. Parents may be laid off due to their HIV status.

Health: HIV infection turns more quickly into full-blown AIDS in children. Moreover, in developing countries like India many common, inexpensive antibiotics and other medications are not available. Health services are difficult to access. Clinical guidelines for pediatric AIDS are less clear than those for adults. Children's nutrition, education, health and other needs are compromised. Discrimination in accessing health care is also common. The fact that all children born to positive mothers do not necessarily contract HIV is often ignored. Thus, children are at greater risk of dying of preventable diseases and infections because every illness is attributed to AIDS, and medical assistance thought to be of no use. Sero-positive children undergo considerable 'physical suffering as the infection plays out its course.

Psychological: The psychological distress HIV causes is compounded by children having to watch their parent(s) suffer over an extended period of time. Parental reluctance to disclose their diagnosis and its fatal nature, add to their child's

confusion. Finally, the death of a parent is a very painful event. These various experiences cause emotional turmoil in the child that could leave long-term scars. If a child in the family is infected, parents may shield healthy siblings from finding out, though the latter witness their sibling growing inexplicably weaker. Children, aware of the illness of a sibling, may be aware that they are also losing one or both parents. Behavioural and emotional disturbances in healthy siblings are possible (King, 1993).

3.6 CHILDREN OF SEX WORKERS (CSWs)

While several categories of children are in the grip of social and physical disadvantages, the children of commercial sex workers (CSWs) have not only been marginalized, but receive scant attention as well. Children of sex workers are the main victims of the institution of prostitution as they are discriminated against, socially isolated and deprived of normal life for no fault for theirs. They remain deprived of basic opportunities, a conducive environment and conditions necessary for the overall physical and psychological development.

Social institutions of education and marriage slam the doors on their face. Besides, they are caught up in an ever tightening grip of the vicious cycle of commercial sex. Children of sex workers are at-risk and most often require special services, they experience problems which call for both intervention and prevention measures. These children have a difficult time being successful in the schools. Some grow up with special needs, often requiring the services of specifically trained professionals while the cost of specialized staff, facilities, equipment and materials is expensive and thus often inaccessible. To have a physically and emotionally healthy generation, these children need a better environment to grow and become responsible citizens.

ISSUES OF CHILDREN OF SEX WORKERS

Living Conditions: Besides being born with the stigma of illegitimacy, children of sex workers grew up in red light areas, where primps, brothel keepers, 'hafta' and anti-social elements existed all around. These children live in small dingy, ill ventilated rooms, lacking toilet facilities, have insufficient water for bathing and move around in inadequate clothes, and frequent the unclean bye lanes in the area. Thus they live in a world that is virtually closed; with few, or no avenues for escape or change. They normally sleep on the pavements, where they are constantly exposed to fights, brawls and abusive language. In fact, these children are denied their rights to education, health, social support, and development (Garhia, 1999).

Children as Security: One might wonder why a prostitute would want to bring up a child in the exploitative environment that traps her. They perceive the child as the only human being in the world with whom they can share trust and love. The desire to have children comes from their need for love and affection. Barred forever from normal, mainstream family life, sex workers create their own families by keeping at least one of their pregnancies and raising their offspring themselves (Patkar, 1992). However, the child is also seen as a source of economic security in later years. In some cases, the woman may chose to give birth to a child to retain some emotional hold on the father.

Cramped Conditions: The paucity of space in brothels often compels sex workers and their children to live in one room, which, in many cases, is also the one used by them for entertaining clients. The smaller children of sex workers are made to sleep below their mothers' beds and are treated with contempt by brothel keepers, since they take up a lot of their mother's time. Children sharing sleeping quarters with their mothers, are silent spectators, not just to their mothers' sexual activities, but also to the abuse they face at the hands of clients or brothel-keepers.

Neglect: The children are often neglected, and many small children are even drugged during their mother's working hours. They are fed only when the mother is free, so they either go hungry or fend for themselves. Older children, if any, end up taking care of the younger ones (Pande, 1996). Their plight becomes worse during the monsoons. Outdoors, the children of sex workers wander around dirty lanes half-naked, often unbathed because of water shortages in the area. The mothers may have no time to attend to their children's hygiene needs.

Social Environment: The older children, who loiter on the streets, are isolated from mainstream society, and constantly exposed to pimps, corrupt policemen, alcoholics, drug peddlers, drug addicts and all types of customers. In the absence of normal family socialisation and due to lack of constructive activity, these children often start bootlegging or running errands for their mother's customers. Later on, they could be dragged into pimping and procuring. For girls especially, there is the pressure to conform to the family tradition in order to earn a livelihood.

Physical Health: Due to poor environmental conditions, lack of adequate nutrition, medical advice and treatment, the children frequently suffer from fevers, colds, dysentery, diarrhoea, ulcers, scabies, tuberculosis, and anaemia, much of which goes untreated. Most children suffer from various infectious diseases and most contract venereal diseases, due to sexual abuse. Despite their desire to look after them, mothers find it difficult to take them to hospital when required. They rely instead on private doctors in the red-light area, many of whom are quacks.

Education: A large number of children of sex workers drop out of school at the secondary stage, either because they are embarrassed over their family situation or because of the lack of financial means to continue. The children also face the problem of lack of place to study at home and the academically weak students are often unable to get remedial tuition because of financial constraints (Menon, 2010). Problems arise in class V to VIII phase as students get more curious and have enough information to ask intrusive questions. This often leads to humiliation and psychological inadequacy amongst the children from red light areas as friends start avoiding or ostracizing them once the truth comes out. Children coming from other backgrounds do not mingle sufficiently with the kids from places like red light area.

Stigma: The societal rejection experienced by sex workers, applies in equal measure to the children of sex workers, too. At school, they discover that they are not 'socially acceptable'. Other children sooner or later learn of their background and begin to shun them.

No options/lack of Alternatives: The children of Sex Workers face a major conflict in their lives. They develop an acceptance of what goes on in the area, but this is pitted against their desire to run away from it all. However, given their isolation and lack of alternatives, the strong likelihood is that sons of sex workers will get drawn into the underworld, and daughters into prostitution (Ghosh, 1996)

3.7 CHILDREN AFFECTED BY RIOTS

A Chronicle of Riots in India

There have been communal riots in India practically in every region between religious groups, linguistic groups, castes and tribes. The first inter-religious riot in India, which can be authenticated by records, took place in 1730 in Ahmedabad, in the modern state of Gujarat (Saxena, 1984).

The loss during such riots is both overwhelming and irreparable. Nevertheless, in the adult preoccupation with citing death tolls, estimating loss to property and

processing compensation claims, we tend to overlook the grave disruption and psychological harm that communal violence causes to children; bringing their childhood to an abrupt, tragic and often, gory halt.

For much too long we have taken communal riots 'in our stride'; many of us have even started believing that they are another unavoidable reality of our times. At the same time, it is only natural for battle lines to silently form in the little minds and hearts of children who have personally witnessed or experienced brutality, violence and loss. Neglecting their needs can spell disaster for a nation that prides itself on pluralism and tolerance.

Effects of Riots on Children

Displacement: In almost all instances of riots children get displaced. They lose their homes, parents, siblings and friends.

Physical Health Problems: Since 1989, scores of children have been maimed or killed in the Kashmir Valley. However, there is no reliable data on the actual numbers of such children. In Gujarat, the picture is similar. The violence has left many children physically wounded, and in some cases, with permanent disabilities:

The report by Medico Friend Circle (MFC), describes the poor hygiene and health facilities at relief camps, which led to outbreaks of measles, chicken pox, typhoid and bronchopneumonia. Thousands of children were affected by diarrhoea and respiratory infections.

Psychological Health: According to Dr. R. Srinivas Murthy, in all disasters and conflicts, children are most deeply affected. Dr. Murthy, who visited some relief camps in Gujarat, found the children in a state of shock. He found that the trauma seen in children who survived the riots in Gujarat was similar to the trauma children suffered after the Bhopal gas tragedy, the Uttarkashi earthquake and the earthquake in the state" (Kakodkar, 2002).

It is seen that children who suffered physical and sexual violence, or had the misfortune of seeing their family members and neighbours being killed, raped or burnt, experienced Post Traumatic Stress Disorder (PTSD).

Children living in areas where regular armed attacks by insurgents and militants (and actions by security forces) take place, suffer from stress, depression and poor health. Consequently, everything builds up inside them and manifests in behavioural disorders, irritability, and so on. Many child specialists noticed an increase in the incidence of nail biting, aggression, bedwetting and nightmares.

Social Problems: Since 1989, a number of children in Jammu and Kashmir have been orphaned. However, it is difficult to find reliable data on the numbers of such children. According to one source, there are an estimated 1 00,000 children orphaned by the crisis - many of them forced to fend for themselves as child labourers (BBC, 2000).

Children lose out on other fronts as well: their avenues of advancement are blocked, access to health care compromised and their mobility severely curtailed. Besides losing out on education, girls have been pushed by anxious parents into early marriage, afraid they would be preyed upon by multiple armed groups who are increasingly unaccountable, especially in the border areas.

Loss of innocence, faith and trust: Children who have lived through communal riots have their innocence prematurely snatched from them. Many children in riot-torn areas are familiar with rape and other atrocities.

An erosion of children's faith in the police has been documented by Chakmak, a monthly children's magazine published by Eklavya, an NGO working in Madhya

Pradesh. The editorial team of Chakmak decided to record the views of children after the communal riots broke out in December 1992. Some children expressed a subtle lack of faith in and even anger towards the keepers of law and order - the police. There were others, who felt that the presence of the police bred fear and tension in them, rather than a sense of security. Many of them felt disturbed seeing policemen roughing up people - guilty and innocent.

3.8 CHILDREN AFFECTED BY NATURAL DISASTERS

Natural disasters disrupt everything that makes up society-family and community life, livelihoods, and even belief systems. When a natural disaster strikes, children are the worst affected in many ways. They are exposed to traumatic scenes of devastation, both at home and outside. Many lose parents and siblings; others suffer serious injuries and loss of limbs. Losing their homes, schools and friends, often in a matter of seconds, leaves them traumatized, for life.

Caring for children is a big responsibility under "normal" conditions. However, when something out of our control happens, such as a nature- or weather-related disaster, caring for children becomes an even greater responsibility. Severe weather and related emergencies are scary as they happen suddenly with little time to react. They often leave behind a great deal of destruction to land, homes, and people's lives. For those who survive a disaster, life may never be the same. The impact of disasters can be long-lasting-months or years. While there is nothing that can be done to stop mother nature, there are ways to prepare ahead of time.

The Indian sub-continent is one of the major arenas of disasters-both natural and man-made. Its unique geo-climatic conditions and diverse natural features make this region among the most vulnerable to many types of natural disasters, particularly drought, floods, cyclones, earthquakes and landslides.

India is also becoming increasingly vulnerable to man- made disasters or policy disasters, i.e. disasters induced as a result of irrational policies such as large-scale displacement of people due to development projects, etc. These could be referred to as 'man - made' disasters. The frequency of all categories of disasters-epidemics, road accidents, drought, industrial accidents and floods is escalating, resulting in a multi-fold increase in injuries, disabilities, disease, destitution, and death.

Impact of Natural Disasters on Children

Physical Health

Natural disasters of various kinds result in a broad spectrum of health hazards. Water - borne diseases (including diarrhoea and dysentery), vector -borne diseases (including malaria), hepatitis, respiratory infections, snake bite infections, and conjunctivitis are very common in disaster - hit areas. Improper nutrition in the wake of a disaster leads to malnutrition. Micronutrient deficiencies are common which contribute to lowering of immunity and resistance to infections. During earthquakes, fractures account for a majority of all physical trauma cases. Lacerations are common in cyclones. A very high proportion of survivors, including children, is left disabled. Children are often the most affected and the inaccessible and disrupted services make the situation of children even more precarious. In the aftermath of disaster, vaccination and immunization often get disrupted. Children's injuries go untreated for months. Those suffering from viral and other fevers also receive no medical help for days together. Despite a long history of natural disasters, diarrhoeal diseases continue to be a major cause of morbidity and mortality among children.

Emotional and Psychological Health

The trauma faced by the children after a natural disaster is multi-dimensional. A disaster for a child implies sudden encounters with death and destruction, threats to one's own life or the lives of loved ones, and the shock of wide-scaled deaths. Adults tend to overlook the trauma a child can suffer as a consequence of a natural disaster, because children often lack the ability to verbalize their experiences and feelings. Children's outward behaviour in the aftermath of a disaster may not reflect their inner emotional turmoil. Some may exhibit the range of maladaptive responses, including fearfulness, sleeplessness, sadness and aggression. Some exhibit regressive behaviour and become clingy and whiny, while others report nightmares, changes in appetite, withdrawal from activities, lack of concentration or refusal to attend school, and academic decline.

Disruption of Routines and Security Nets

Life for children may not return to normal quickly after a disaster. There are changes in living conditions that disrupt day-to-day activities. This can lead to strained and tense relationships within family and between friends. This disruption in relationships, roles, and routines can make life unfamiliar or unpredictable, which can be unsettling and sometimes frightening for children. With progressive economic deterioration, children are increasingly expected to bring in some income to contribute to the family's day-to-day expenses and survival.

Social Fallouts of a Disaster

Children are always vulnerable; but their vulnerability is heightened when ever disaster strikes. This is particularly true in the Indian context, where there already exists acute poverty, illiteracy, malnutrition and gender insensitivity. In the aftermath of a disaster, children exhibit various types of maladaptive behaviour patterns, and there is a marked increase in the prevalence of juvenile delinquency even in children below 10 years of age.

Children orphaned or separated from their families are "cannon fodder" for child traffickers. Many child victims of disasters end up being sold into prostitution or are traded by adults who take advantage of their vulnerability. Middlemen and pimps visit disaster struck areas to procure children with the intention of selling them into prostitution or bondage.

With schools destroyed, study materials gone and teachers missing, thousands of children set out to work. Their work brings much needed income to their impoverished households. Unfortunately, the long-term impact of temporary disruptions in schooling are seldom acknowledged by policy makers. The fact is that by the time the educational system is brought back on track, many children may have dropped out permanently, or drifted into vagrancy, prostitution, wage labour and begging.

3.9 LET US SUM UP

During childhood days, children are supposed to be primarily engaged in exploring, learning new things, playing, friendship and fun. However, children in critical circumstances spend most of their time in difficult situations. Some of them do not even have shelter. Even if some do, they are in the most dilapidated condition, not suitable for living at all.

There is an increase in the number of children under this category. These children are seen practically in every city. This unit we described the various critical situations the children can be in and the impact such circumstances can have on their growth and development.

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UNIT 4   SITUATION OF ADOLESCENTS

Structure

4.0   OBJECTIVES

The aim of this unit is to provide you with an understanding of the needs of adolescents and addressing certain critical areas in the development of adolescents to ensure holistic growth.

Adolescents today form a critical mass of human capital. They have and continue to contribute immensely to the social and economic development of the nation. The potential in each young mind still needs to be tapped to ensure that they live up to their true potential and become real leaders. In order to help them achieve this, we must all play our role in ensuring that they are given the necessary tools to make their lives more meaningful-physically, mentally and emotionally.

After studying this Unit, you would be able to:

● define adolescence;

● explain the process of Growing Up;

● describe important features of understanding the self; and

● discuss the influence of peer pressure, interpersonal relationships and socialization of the adolescence.

4.1   INTRODUCTION

Throughout adolescence, young people have to cope with dramatic emotional, physical, cognitive, and social changes. It is a time when young people are beginning to search for an identity that is separate from the family, are questioning existing family values and their role in the family and society, are adapting to and coping with bodily changes, and are wanting greater freedom to make personal choices. Adolescents also begin to explore more intimate relationships with people other than their family members and seek greater acceptance from their peers.

This desperate need for positive reinforcement of the self, including the need for a satisfactory body image directly impacts an adolescent's sense of worth and his or her interaction with the world. The process from early to late adolescence and finally to adulthood, is marked by an increasing awareness of the individual as an essential part of a family, neighbourhood, community, society, nation and the world community.

4.2 UNDERSTANDING ADOLESCENTS

Definition of Adolescents

Adolescence can be defined as the state between attainment of puberty until maturity. The period between 10 to 20 years of age is called adolescence according to WHO. There is no fixed period since there are both biological and cultural variations. Often the ages between 10-13 years are referred to as the pre-adolescence years. The word is derived from the Latin word adolescere, which means to grow. Adolescence is a time of moving from the immaturity of childhood into the maturity of adulthood. There is no single event or boundary line that denotes the end of childhood or the beginning of adolescence. Rather, experts think of the passage from childhood into and through adolescence as composed of a set of transitions that unfold gradually and that touch upon many aspects of the individual's behaviour, development, and relationships. These transitions are biological, cognitive, social, and emotional.

History of Adolescence

Adolescence emerged as a concept in the 1890s, when psychologists began investigating the abilities, behaviours, problems, and attitudes of young people between the onset of puberty and marriage. G. Stanley Hall, a pioneer in the study of children and their learning processes, is credited with giving adolescence its first full definition in his text Adolescence: Its Psychology and Its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education, published in 1904. Hall thought that the stresses and misbehaviour of young people were normal to their particular time of life, because he believed human development recapitulated that of human society. For Hall, just as the human race had evolved from "savagery" to "civilization," so too did each individual develop from a primitive to an advanced condition. Adolescence corresponded to, or recapitulated, the period of pre-history when upheaval characterized society and logical thinking began to replace instinct.

Hall identified adolescence as a period of emotional upheaval, inconsistent behaviour, and vulnerability to deviant and criminal activity caused by psychosexual conflicts.

Adolescence as a Universal Concept

Few societies agree on the boundaries of adolescence because most societies define adolescence in terms of both age and life circumstance, and thus, the meaning of the terms adolescent, youth, and young person vary across countries.

At the beginning of the twenty-first century, multiple models of American adolescence brought into question whether or not the historical concept had as much uniformity as some twentieth-century experts implied it had. Certainly almost all adolescents, regardless of race or class, undergo similar biological changes, though characteristics may vary. But the social and psychological parameters appeared to have become increasingly complex and diverse. Although the most common images of adolescents set them inside the youth-oriented consumer culture of clothes, music, and movies, the darker side of growing up had captured increasing attention. Poverty, sexual abuse, substance abuse, learning disabilities, depression, eating disorders, and violence had come to characterize youthful experiences as much as the qualities of fun-and freedom-seeking depicted by the media and marketers. Popular theory still accepted that almost all adolescents confront similar psychological challenges of stress and anxiety, but the processes involved in growing up display complexities that confound attempts to characterize them. The trend of young people assuming adult sexual, family, social, and economic behaviour and

their attendant problems blurred many of the qualities that previously gave adolescence its distinctiveness.

Process of Growing Up

Adolescence is the time between the beginning of sexual maturation (puberty) and adulthood. It is a time of psychological maturation, during which a person becomes "adult-like" in behaviour.

The adolescent experiences not only physical growth and change but also emotional, cognitive, social, and mental change and growth.

Physical changes

The physical changes of puberty are triggered by hormones, chemical substances in the body that act on specific organs and tissues. In boys a major change occurring during puberty is the increased production of testosterone, a male sex hormone, while girls experience increased production of the female hormone oestrogen. In both sexes, a rise in growth hormone produces the adolescent growth spurt, the pronounced increase in height and weight that marks the first half of puberty.

Perhaps the most dramatic changes of puberty involve sexuality. Internally, through the development of primary sexual characteristics, adolescents become capable of sexual reproduction. Externally, as secondary sexual characteristics appear, girls and boys begin to look like mature women and men. In boys primary and secondary sexual characteristics usually emerge in a predictable order, with rapid growth of the testes and scrotum, accompanied by the appearance of pubic hair. About a year later, when the growth spurt begins, the penis also grows larger, and pubic hair becomes coarser, thicker, and darker. Later still comes the growth of facial and body hair, and a gradual lowering of the voice. Around mid-adolescence internal changes begin making a boy capable of producing and ejaculating sperm.

In girls, sexual characteristics develop in a less regular sequence. Usually, the first sign of puberty is a slight elevation of the breasts, but sometimes this is preceded by the appearance of pubic hair. Pubic hair changes from sparse and downy to denser and coarser. Concurrent with these changes is further breast development. In teenage girls, internal sexual changes include maturation of the uterus, vagina, and other parts of the reproductive system. Menarche, the first menstrual period, happens relatively late in puberty. Regular ovulation and the ability to carry a baby to full term usually follow menarche by several years.

Cognitive changes

A second element of the passage through adolescence is a cognitive transition. Compared to children, adolescents think in ways that are more advanced, more efficient, and generally more complex. This is evident in five distinct areas of cognition.

First, during adolescence individuals become better able than children to think about what is possible, instead of limiting their thought to what is real. Whereas children's thinking is oriented to the here and now (i.e., to things and events that they can observe directly), adolescents are able to consider what they observe against a backdrop of what is possible-they can think hypothetically.

Second, during the passage into adolescence, individuals become better able to think about abstract ideas. The adolescent's greater facility with abstract thinking also permits the application of advanced reasoning and logical processes to social and ideological matters. This is clearly seen in the adolescent's increased facility and interest in thinking about interpersonal relationships, politics, philosophy, religion, and morality-topics that involve such abstract concepts as friendship, faith, democracy, fairness, and honesty.

Third, during adolescence individuals begin thinking more often about the process of thinking itself, or metacognition. As a result, adolescents may display increased introspection and self-consciousness. Although improvements in metacognitive abilities provide important intellectual advantages, one potentially negative by-product of these advances is the tendency for adolescents to develop a sort of egocentrism, or intense preoccupation with the self. Acute adolescent egocentrism sometimes leads adolescents to believe that others are constantly watching and evaluating them. Psychologists refer to this as the imaginary audience.

A fourth change in cognition is that thinking tends to become multidimensional, rather than limited to a single issue. Whereas children tend to think about things one aspect at a time, adolescents describe themselves and others in more differentiated and complicated terms and find it easier to look at problems from multiple perspectives. Being able to understand that people's personalities are not one-sided, or that social situations can have different interpretations, depending on one's point of view, permits the adolescent to have far more sophisticated and complicated relationships with other people.

Finally, adolescents are more likely than children to see things as relative, rather than absolute. They are more likely to question others' assertions and less likely to accept "facts" as absolute truths. This increase in relativism can be particularly exasperating to parents, who may feel that their adolescent children question everything just for the sake of argument.

Emotional changes

Adolescence is also a period of emotional transition, marked by changes in the way individuals view themselves and in their capacity to function independently. As adolescents mature intellectually and undergo cognitive changes, they come to perceive themselves in more sophisticated and differentiated ways. Compared with children, who tend to describe themselves in relatively simple, concrete terms, adolescents are more likely to employ complex, abstract, and psychological self-characterizations. As individuals' self-conceptions become more abstract and as they become more able to see themselves in psychological terms, they become more interested in understanding their own personalities and why they behave the way they do.

For most adolescents, establishing a sense of autonomy, or independence, is as important a part of the emotional transition out of childhood as is establishing a sense of identity. During adolescence, there is a movement away from the dependency typical of childhood toward the autonomy typical of adulthood. Being independent, however, means more than merely feeling independent. It also means being able to make decisions and to select a sensible course of action. This is an especially important capability in contemporary society, where many adolescents are forced to become independent decision makers at an early age. In general, researchers find that decision-making abilities improve over the course of the adolescent years, with gains continuing well into the later years of high school.

Susceptibility to the influence of parents and peers changes during adolescence. In general, during childhood, boys and girls are highly oriented toward their parents and less so toward their peers; peer pressure during the early elementary school years is not especially strong. As they approach adolescence, however, children become somewhat less oriented toward their parents and more oriented toward their peers, and peer pressure begins to escalate. During early adolescence, conformity to parents continues to decline and conformity to peers and peer pressure continues to rise. It is not until middle adolescence that genuine behavioural independence emerges, when conformity to parents as well as peers declines.

Social changes

One of the most noteworthy aspects of the social transition into adolescence is the increase in the amount of time individuals spend with their peers. Although relations with age-mates exist well before adolescence, during the teenage years they change in significance and structure. During adolescence, peer groups function much more often without adult supervision than they do during childhood, and more often involve friends of the opposite sex.

The importance of peers during early adolescence coincides with changes in individuals' needs for intimacy. As children begin to share secrets with their friends, loyalty and commitment develop. During adolescence, the search for intimacy intensifies, and self-disclosure between best friends becomes an important pastime. Teenagers, especially girls, spend a good deal of time discussing their innermost thoughts and feelings, trying to understand one another. The discovery that they tend to think and feel the same as someone else becomes another important basis of friendship.

One of the most important social transitions that take place in adolescence concerns the emergence of sexual and romantic relationships. Most adolescents' first experience with sex falls into the category of "autoerotic behaviour," sexual behaviour that is experienced alone. The most common autoerotic activities reported by adolescents are erotic fantasies and masturbation.

Adolescent Health and Development

As children mature into adults, they must acquire a range of interrelated knowledge and skills that will allow them to lead fulfilled and productive lives. These skills are critical to helping young people stay healthy, learn, obtain a job or livelihood, and participate fully in society. Young people account for 15% of the disease and injury burden worldwide, and more than 1 million die each year, mainly from preventable causes (WHO, 1999). Nonetheless, roughly 70% of premature deaths among adults can be linked to behaviour that was initiated during adolescence, for example, tobacco use, poor eating habits, and risky sex (WHO, 2001a).

In particular, adolescents are affected by the following serious health challenges (WHO):

- One in every five people in the world is an adolescent, and 85% of them live in developing countries. Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behaviours that began in youth, including tobacco use, a lack of physical activity, unprotected sex or exposure to violence. Promoting healthy practices during adolescence and efforts that better protect this age group from risks will ensure longer, more productive lives for many.

- About 16 million girls aged 15 to 19 years give birth every year - roughly 11% of all births worldwide. The vast majority of births to adolescents occur in developing countries. The risk of dying from pregnancy-related causes is much higher for adolescents than for older women. Laws and community actions that support a minimum age for marriage, as well as better access to contraception, can decrease too-early pregnancies.

- Many boys and girls in developing countries enter adolescence undernourished, making them more vulnerable to disease and early death. Conversely, overweight and obesity – another form of malnutrition with serious health consequences – is increasing among other young people in both low- and high-income countries. Adequate nutrition and healthy eating and physical exercise habits at this age are foundations for good health in adulthood.

- The vast majority of tobacco users worldwide begin during adolescence. Today more than 150 million adolescents use tobacco, and this number is increasing globally. Bans on tobacco advertising, raising the prices of tobacco products, and laws that prohibit smoking in public places reduce the number of people who start using tobacco products. They furthermore lower the amount of tobacco consumed by smokers and increase the numbers of young people who quit smoking.

- Harmful drinking among young people is an increasing concern in many countries. It reduces self-control and increases risky behaviours. Harmful drinking is a primary cause of injuries (including those due to road traffic accidents), violence (especially domestic violence), and premature deaths. Regulating access to alcohol is an effective strategy to reduce harmful use by young people.

- Violence – including rape, family abuse and war – is among the top ten causes of death among adolescents globally. For every death resulting from violence, there are an estimated 20 to 40 more non-fatal injuries requiring hospital treatment. Many survivors are left with significant physical and psychological problems.

Check Your Progress I

Note: Use the space provided for your answer.

1) Define Adolescent?

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2) Explain the changes that occur during puberty?

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4.3 UNDERSTANDING SELF

Development of Identity

The process of developing an identity begins with the infant's discovery of self, continues throughout childhood, and becomes the focus of adolescence. Erik Erikson, a pioneer in the field of personality development, identified the goal of adolescence as achieving a coherent identity and avoiding identity confusion. Identity is multidimensional and may include physical and sexual identity, occupational goals, religious beliefs, and ethnic background. Adolescents explore these dimensions, and usually make commitments to aspects of their identity as they move into early adulthood. Periodically, adults may re-evaluate and alter certain aspects of their identity as life circumstances change.

Identity development begins with children's awareness that they are separate and unique individuals. The first indications of this awareness are evident in infancy

when children begin to recognize themselves. During childhood, self-awareness grows and changes. Between ages six and twelve, children begin to include less concrete aspects of the self in their descriptions. The emergence of abstract reasoning abilities allows adolescents to think about the future and experiment with different identities.

The physical changes associated with puberty initiate adolescents' exploration of their physical and sexual identity. For females, an important component of their identity and worth is related to their physical appearance. The changes in the male body may not be as important as their timing. Early maturing males have advantages in athletics, hold more leadership roles in school, and are viewed more positively by peers and adults. The effects of timing for females are not as clear and may be less important in their development.

The two major processes involved in identity development are:

1) The exploration of alternative beliefs in various domains (e.g., leisure, gender roles, sexuality, religion) - Exploration of alternative beliefs refers to the process of encountering and examining beliefs or values that differ from those with which one was raised or that are dominant within their society.

2) Commitment to personally chosen identity, beliefs, and values regarding these domains – these multiple identities (beliefs/values in these different domains) must be incorporated and organized into some meaningful, coherent identity in a minimally contradictory manner.

Identity development is ultimately the result of a lifelong journey. The person that an individual ultimately becomes is unique. However, the process by which identity develops is similar among individuals. Although identity development is most often associated with adolescence, each developmental stage offers opportunities for re-evaluation and modification.

Self Esteem

What is Self-Esteem? Esteem is a word associated with someone or something that is important and valued. Self-esteem is how you estimate yourself, your strengths and weaknesses, how much you value yourself and your achievements, how you think others see you, and your purpose in life. Low self-esteem can mean helplessness, depression, loneliness and insecurity. A positive self-esteem helps people feel worthy of being loved and accepted and equips them to cope with life's daily challenges. Therefore, building a positive self-esteem and self-confidence is key to living a more fulfilled and happy life.

Self-Esteem and Adolescents

Self-esteem is very crucial during adolescence because several children fall prey to low self-esteem. Though an individual's self-esteem develops through out adulthood, the essence of ones self-esteem is formed during adolescence. Therefore, it is important to further develop a teenager's self-esteem during this period. As children get older, they can play a more active role in developing their self-esteem. Daily activities, opportunities to take responsibility and make one's own decisions, certain achievements in school and college, all contribute in making young people feel proud of who they are and respect themselves more. Having good self-esteem also helps young people make correct choices and decisions about their own safety, health, education, and interpersonal relationships.

Adolescents with low self-esteem are very critical of themselves, feel negative and have little confidence. Lack of support and encouragement from parents and teachers, poor performance in school or college activities, peer pressure, unsatisfactory friendships and a poor body image, can all contribute to a teenager

feeling neglected, and worthless. These feelings can also lead to depression and a concomitant host of problems including drug and alcohol abuse, eating disorders, suicidal tendency and others. Therefore, a positive self-esteem is indispensable to normal and healthy adolescent development.

What Determines Self-Esteem?

Something experienced as a part of, or background to, all of the individual's thoughts, feelings and actions determines the self-esteem of an individual. The other factors that determine self-esteem is one's own body image, peer group influence (what peers think of you), one's own self confidence, surrounding environment (family and relatives) and their affirmations.

The Four Conditions for Developing a Healthy Self-Esteem

Self-esteem develops when the primary needs of life have been appropriately satisfied. Social scientists have found that self-esteem can be gained when people experience positive feelings within four distinct conditions. These are:

a) **Connectiveness**

Connectiveness is the feeling people have when they can gain satisfaction from associations. Connectiveness is about:

*   Identifying with a group of people;

*   Feeling connected to our past or heritage;

*   Feeling that we belong to something or someone;

*   Feeling good about our relations or what we belong to;

*   Knowing that the people or things we are related to is appreciated by others; and

*   Feeling that we are important to others.

b) **Uniqueness**

Uniqueness is the special sense of the self that individuals feel when they can acknowledge and respect qualities or attributes that make them special and different, and when they receive respect and approval from others for these qualities. Uniqueness is about:

*   Knowing that there is something special about oneself, in spite of recognizing the fact that human beings have several similar qualities;

*   Being aware that others think we are special;

*   Respecting our self as an individual;

*   Enjoying the feeling of being different, without having to make others uncomfortable.

c) **Power**

The feeling of power within an individual comes from having the resources, opportunity and capability to influence the circumstances of one's own life in important ways. Power is about:

*   Feeling that we are in charge of our own life;

*   Being able to use the skills we have in situations which require those skills, the most;

*   Feeling that we can make decisions, and solve most problems we might have.

d) Role Models

Role models are reference points that provide people with human, philosophical, and operational examples. They help them establish meaningful values, goals, ideals and personal standards.

Role models are about:

● Knowing people worth emulating;

● Feeling confident of distinguishing right from wrong, and good from bad;

● Having values and beliefs, which consistently guide and direct adolescents;

● Feeling that there is something that the adolescent is working toward, and knowing, more or less, where she/he is headed;

● Being able to make sense of what is going on in their lives and around them.

All four of the above mentioned conditions should be present continuously for a high sense of self-esteem to be developed and maintained. No one condition is more important than another. If any one condition is not adequately provided for, there is a decrease or distortion of self-esteem.

Enhancing Self-Esteem

Having low self-esteem can cause hindrances in the process of growing up. As one gets older and is faced with having to make tough decisions, especially under peer pressure, the more self-esteem one has the better decisions one can make. It is important that an individual understands and knows his or her worth.

There are ways in which one can boost and improve your self-esteem and have greater faith in oneself. Most often the best way is to try talking to a trusted adult or a family member. It is likely that they will make the adolescent feel important and make aware of their strengths and come up with some good ideas for building their self-esteem.

Values and Beliefs

Values are ideals that guide or qualify our personal conduct and interaction with others. They give significance to our lives which are reflected through the priorities we choose and act on consistently and repeatedly. Values are those things that really matter to each of us, they are the ideas and beliefs we hold as special. They are also defined as beliefs of a person or social group in which they have an emotional investment either for or against something. Values are subjective reactions to the world around us. They guide and mould our options and behaviour. Values play an important role in forming people's beliefs and life goals. All people behave in accordance with a set of values in virtually everything that they do. Therefore, a person's values are highly relevant to the process of knowing themselves, in choosing career or making important decisions.

Values have certain important characteristics. First, values are developed early in life and are very resistant to change. Values develop out of the adolescent's direct experiences with people who are important to them, particularly their parents. Values also arise not only from what people tell them, but also from how they behave towards others and the adolescents. Second, values, like morals, help to distinguish what is right from what is wrong and provide guidance on how to conduct life in a meaningful way.

Values are also determined by an individual's own perception and interpretation and can be classified into the following sub-categories:

- **Personal values**

Personal values are principles that define a person as an individual. Personal values, such as honesty, reliability, and trust, determine how an individual can face the world and relate with people.

- **Family values**

Family values are principles, beliefs that we have learned from our parents, grandparents and other family members. The family plays a significant role in shaping, influencing and inculcating many of our values.

- **Cultural values**

Cultural values signify the practice of one's own faith and customs. They are principles that sustain connections with our cultural roots. They help us feel connected to a larger community of people with similar backgrounds.

- **Social values**

Social values are principles that indicate how we relate meaningfully to others in social situations, including those involving family, friends, and co-workers.

- **Work values**

Work values are principles that guide our behaviour in professional contexts. They define how we work and how we relate to our co-workers, bosses, and clients. They also reveal our potential for advancement.

A **belief** can be defined as the psychological state in which an individual is convinced of the truth or validity of a proposition or premise (argument). A belief does not necessarily confer the ability to adequately prove one's main contention to other people, who may disagree.

Different people have different values. It is important to make decisions and live life according to personal values. The family is one of the most important and powerful sources of messages about values. People learn their families' values and, if they have children, they are likely to pass on some of those same values. In a nutshell, values play a major role in making decisions.

Goals and Setting up Goals

A goal can be defined as a target, a dream in action, with a purpose. Goals can help enable us to live our wishes and desires and help us in fulfilling our purpose in life.

Setting of goals is a powerful process for thinking about your ideal future, and for motivating yourself to turn this vision of the future into a reality. The process of setting goals helps you choose where you want to go in life. By knowing precisely what you want to achieve, you know where you have to concentrate your efforts. You will also quickly spot the distractions that would otherwise lure you from your course. In addition, properly set goals can be incredibly motivating, and as you get into the habit of setting and achieving goals, you will find that your self-confidence builds fast.

Importance of Goals in our Lives:

Goal Planning is an Important Method of:

- Deciding what is important for us to achieve in our life;

- Separating what is important from what is irrelevant, or a distraction;

- Motivating ourselves;

- Building our self-confidence, based on successful achievement of goals.

Setting Goals

Setting and realizing goals create a positive energy and motivate us to strive ahead even when obstacles arise. Goals help us in keeping ourselves motivated by providing guidance and directions in difficult and confusing moments of our lives. By setting goals, we can plan and dream to take on ambitious activities by taking steps, which make our goals more realistic and realizable. We are able to set ourselves up for success because we are able to make what we want obtainable. And each time we accomplish a small goal, we experience success, which is highly motivating.

Achieving Goals

When you have achieved a goal, take the time to enjoy the satisfaction of having done so. Absorb the implications of the goal achievement, and observe the progress you have made towards other goals. If the goal was a significant one, reward yourself appropriately. All of this helps you build self-confidence.

Conflict Resolution and Problem Solving

Adolescents need to develop healthy interpersonal relationships, with peers, family and community. Adolescents learn to manage conflict resolution; coping with anger; reaching an agreement through problem solving; articulating reasons and managing stress in relationship; work, health; managing school, home, neighbourhood or workplace activities.

What is Conflict Resolution?

The term "conflict resolution" refers to a range of processes aimed at alleviating or eliminating sources of conflict. The term "conflict resolution" is sometimes used interchangeably with the term dispute resolution or alternative dispute resolution. Processes of conflict resolution generally include negotiation, mediation and diplomacy. The processes of arbitration, litigation, and formal complaint processes such as ombudsman processes, are usually described with the term dispute resolution, although some refer to them as "conflict resolution."

Too often, minor disagreements lead to serious violence among adolescents. Conflicts and disagreements are a part of life, but they do not have to end in violence. Fights can only happen among equals. When you keep people either above or below you, then there is no fight. When people are above you, you respect them. When they are below you, you love them and feel compassionate. Either submission or compassion will take you out of a fight in no time.

The source of conflict is the notion of "mine" and "yours" and many people create conflict in order to get attention. Self-knowledge eases the sense of limited belongingness and resolves this conflict.

Resolving Conflict

There are many tools available to persons in conflict. How and when they are used depends on several factors (such as the specific issues at stake in the conflict and the cultural context of the disputants). The tools available include negotiation, mediation, community building, advocacy, diplomacy, activism, non-violence, critical pedagogy, prayer and counselling and stress management.

What is Problem Solving?

Problem solving is part of thinking. Considered the most complex of all intellectual functions, problem solving has been defined as higher-order cognitive process that requires the modulation and control of more routine or fundamental skills (Goldstein & Levin, 1987). It occurs if an organism or an artificial intelligence system does not know how to proceed from a given state to a desired goal state. It is part of the larger problem process that includes problem finding and problem shaping.

Understanding Stages of Problem Solving

1) Understand and explore the problem;

2) Find a strategy;

3) Use the strategy to solve the problem;

4) Look back and reflect on the solution.

The Four Stages of Problem Solving helps to resolve problems for adolescents within relationships or at work. There are several ways of responding to a problem and there are things people say or do that trigger defensiveness, resistance, and resentment. Such responses are more likely to thwart the other person's problem solving efficiency, and increase the emotional distance between people.
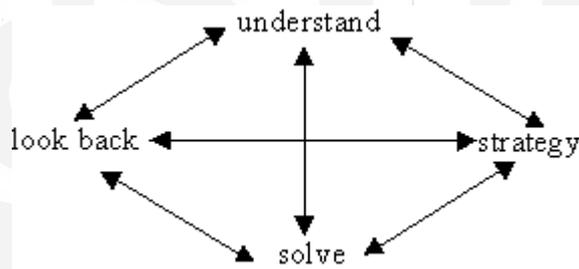
There is no chance of being able to solve a problem unless you are can first understand it. This process requires not only knowing what you have to find but also the key pieces of information that somehow need to be put together to obtain the answer.

Check Your Progress II

Note: Use the space provided for your answer.

1) What determines self esteem?

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2) What is problem solving?

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4.4 THE WORLD AROUND ADOLESCENT

Peer Pressure

Who is a Peer?

"Peers" are people of the same age and social group may be friends, schoolmates and maybe co-workers. Everyone needs to belong - to feel connected with others and be with others who share attitudes, interests, and circumstances that resemble their own. People choose friends or peers who accept and like them and see them in a favourable light.

Peer Group and Adolescents

Adolescents want to spend a lot more time with their friends, and less time with their family. This makes them more susceptible to the influences of their peers. Adolescents practice risk-taking behaviours as they are trying to find their own identity and become more independent. This makes them very vulnerable to experimenting or becoming addicted to using drugs, smoking and drinking, especially if there is peer pressure to do so.

Why do adolescents give in to Peer Pressure?

Like adults, adolescents are also influenced by their peer group. This is normal behaviour and is modeled for them by the adults around them almost every minute of every day. We all conform to the social standards set by our peer groups and our teenagers observe it. That said, teenagers will tend to follow their peers in behaviours that are not considered appropriate or where they will leave their common sense behind. Part of the reason is the "newly found" importance of friendships, as young people are just getting used to their friends having any say in what they do. In addition, the "everyone is doing it" factor can make an adolescent feel compelled to comply.

"Peer Pressure" means a push coming from the people adolescents tend to associate with such as classmates and friends.

How Does Peer Pressure Affect the Adolescents?

Peer pressure may be a positive influence and help to challenge or motivate adolescents to do their best. Peer pressure may also result in doing activities that may not fit with the adolescents' sense of what is right and wrong.

Peer pressure may influence them in a number of ways, including:

- Fashion choice;
- Alcohol and drug use;
- Decision to have a boyfriend/girlfriend;
- Choice of friends;
- Academic performance;
- Having attractive possessions; and
- Portraying a higher standard of living.

Types of Peer Pressure

Whether the influence of peers is positive or negative is of critical importance in youth.

Positive Peer Pressure: The ability to develop healthy friendships and peer relationships depends on a youth's self-identity, self-esteem, and self-reliance. At

its best, peer pressure can mobilize the youths' energy, motivate them for success, and encourage youth to conform to healthy behaviour. Peers can and do act as positive role models. Peers can and do demonstrate appropriate social behaviours. Peers often listen to, accept, and understand the frustrations, challenges, and concerns associated with being a youth.

Negative Peer Pressure: The need for acceptance, approval, and belonging is vital during adolescence. Adolescents who feel isolated or rejected by their peers or in their family are more likely to engage in risky behaviours in order to fit in with a group. In such situations, peer pressure can impair good judgment and fuel risk-taking behaviour, drawing a youngster away from the family and its positive influences and luring her/him into dangerous activities.

A powerful negative peer influence can motivate a teen to make choices and engage in behaviour that his or her values might otherwise not permit. Some adolescents will risk being grounded, losing their parents' trust or putting their or other's lives at risk just to try and fit in or feel like they have a group of friends they can identify with and who accept them.

Interpersonal Relationships

An interpersonal relationship is an association between two or more people. This association may be based on emotions like love and liking, regular business interactions, or some other type of social commitment. Interpersonal relationships take place in a great variety of contexts, such as family, friends, marriage, acquaintances, work, clubs, neighbourhoods, and churches. They may be regulated by law, custom, or mutual agreement, and are the basis of social groups and society as a whole. Although humans are fundamentally social creatures, interpersonal relationships are not always healthy.

All relationships involve some level of interdependence. People in a relationship tend to influence each other, share their thoughts and feelings, and engage in activities together. Because of this interdependence, anything that changes or impacts one member of the relationship will have some level of impact on the other member. Interpersonal relationship skills help us to relate in positive ways with our family members and others. This may mean being able to make and keep friendly relationships as well as being able to end relationships constructively.

Developing Interpersonal Relationship Skills

Interpersonal relationships are dynamic systems that change continuously during their existence. They tend to grow and improve gradually, as people get to know each other and become closer emotionally, or they gradually deteriorate as people drift apart and form new relationships with others. One of the most influential models of relationship development was proposed by psychologist, George Levinger. This model was formulated to describe heterosexual, adult romantic relationships, but it has been applied to other kinds of interpersonal relations as well. According to the model, the natural development of a relationship follows five stages:

1) **Acquaintance** – Becoming acquainted depends on previous relationships, physical proximity, first impressions, and a variety of other factors. If two people begin to like each other, continued interactions may lead to the next stage, but acquaintance can continue indefinitely.

2) **Buildup** – During this stage, people begin to trust and care about each other. The need for compatibility and such filtering agents as common background and goals will influence whether or not interaction continues.

3) **Continuation** – This stage follows a mutual commitment to a long-term friendship, romantic relationship, or marriage. It is generally a long, relatively

stable period. Nevertheless, continued growth and development will occur during this time. Mutual trust is important for sustaining the relationship.

4) **Deterioration** – Not all relationships deteriorate, but those that do tend to show signs of trouble. Boredom, resentment, and dissatisfaction may occur, and individuals may communicate less and avoid self-disclosure. Loss of trust and betrayals may take place as the downward spiral continues.

5) **Termination** – The final stage marks the end of the relationship, either by death in the case of a healthy relationship, or by separation.

Enhancing Interpersonal relationship

To understand what a relationship is, how to bring one about, how to enhance one, and why relationships are diminished and lost, one must understand the power of a person's needs.

Needs affect opinions, attitudes, and viewpoints. Generally we are more aware of unfulfilled needs than the ones that are consistently met. Fundamental life needs in particular are so commonly accepted that we usually overlook them. No one is aware of the air breathed, the ground walked on, the water they drank, and yet these are the needs we miss most when gone.

A good relationship is a mutual filling of needs. A good interpersonal relationship is about discovering and recognize needs. Needs in myself as well as needs in others." It is sometimes easier to recognize another person's needs; our own needs are often hidden by fear, guilt, and programming. The way to recognize needs in other people is by their response to you.

Socialization of the Adolescent

The term socialization is used by sociologists, social psychologists and educationists to refer to the process of learning one's culture and how to live within it. For the individual it provides the resources necessary for acting and participating within their society. For the society, inducting all individual members into its moral norms, attitudes, values, motives, social roles, language and symbols is the "means by which social and cultural continuity are attained".

A sociologist may distinguish five kinds of socialization:

● **Primary socialization:** primary socialization is the process whereby people learn the attitudes, values, and actions appropriate to individuals as members of a particular culture. For example, if a child saw their parent expressing a discriminatory opinion about a minority group, then that child may think this behaviour is acceptable and could continue to have this opinion about minority groups.

● **Secondary socialization:** secondary socialization refers to the process of learning what is appropriate behaviour as a member of a smaller group within the larger society. It is usually associated with teenagers and adults, and involves smaller changes than those occurring in primary socialization e.g. entering a new profession, relocating to a new environment or society.

● **Developmental socialization:** developmental socialization is the process of learning behaviour in a social institution or developing social skills.

● **Anticipatory socialization:** anticipatory socialization refers to the processes of socialization in which a person "rehearses" for future positions, occupations, and social relationships.

● **Re-socialization**: re-socialization refers to the process of discarding former behaviour patterns and accepting new ones as part of a transition in one's life.

Social norms, attitudes and practices

Socialization occurs throughout the human life cycle, Norms, beliefs, attitudes and practices have a major role to play in bringing about social change and socialization. A norm, or social norm, is a rule that is socially enforced and generally accepted by the society. Social sanctioning is what distinguishes norms from other cultural products or social constructions such as meaning and values. Every society has a set of norms: a code of conduct about what is acceptable behaviour. Norms reflect the society's values, beliefs, attitudes and behaviours and may be explicit or implicit. Responding to social norms may not necessarily mean conforming to them, but understanding them and then asserting one's own rights and responsibilities.

Acting upon social norms will help the youth to understand the implications of both, conforming to them and deviating from them.

An attitude is a hypothetical construct that represents an individual's like or dislike pertaining to an idea or towards a person, behaviour or event. Attitudes can express positive, negative or neutral views.

Practices are related to customs and influence our response to different situations and/or events. They generally refer to religious and spiritual practices. Practices exist in all traditions and cultures.

Check Your Progress III

Note: Use the space provided for your answer.

1) Why do adolescents give in to Peer Pressure?

    ....
    ....
    ....
    ....

2) Why is socialization for adolescent is important?

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    ....

4.5 LET US SUM UP

In this unit, we have focused on understanding who is an adolescent, history of adolescence, and the process of growing up, what are the changes that occur during adolescence, adolescent health and development. This unit will provide an insight into adolescent life and the process of growing up into adulthood, and also about the adolescent's journey of self-discovery and understanding self for development of healthy and responsible young adult.

We have also explored the world of adolescence with relation to family, community, peers and their influence, increasing awareness of the individual as an essential part of a family, neighbourhood, community, society, nation and the world community. It also explains the importance of socialization and the adolescent's vision about life, and role of culture, tradition and value systems. Deepening their

roots gives them a sense of responsibility and ownership, while a broader vision, gives a sense of relaxation. A broader vision and deeper roots really mean responsibility with ease, calmness and equanimity.

4.6 FURTHER READINGS AND REFERENCES

Author: Peggy Mohan, Publisher: Voluntary Health Association of India, Year 1997/ N Delhi.

Title: Life skills for Youth, A manual Publisher: Partners in Development Initiatives, Year: 2007/n Delhi.

Title: International Planned Parenthood Association (1985): Growing up in a changing world, Part one, Youth Organisation and Family Life Education: An Introduction, London, IPPF.

Title: Family Life Education:- Teaching Adults to Communicate with Youth by (Family Health International).

Links and Reference material

1) http://www.selfgrowth.com/articles/Goldman4.html

2) http://social.jrank.org/pages/322/Identity-Development.html

3) Life skills for youth- A manual by (Partners in Development Initiatives)

4) Family Life Education:-Teaching Adults to Communicate with Youth by (Family Health International)

5) Advocates for Youth's popular family life education program, Life Planning Education

6) www.who.int/child-adolescent-health

7) www.adolescenthealth.org/