
UNIT 1 PROFILE OF CHILDREN IN INDIA

Structure

- 1.0 Objectives
- 1.1 Introduction
- 1.2 Demography
- 1.3 Education and Literacy
- 1.4 Health and Nutrition
- 1.5 Let Us Sum Up
- 1.6 Further Readings and References

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 billion 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 Malaysia (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

In spite 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 Uttarakhand	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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