

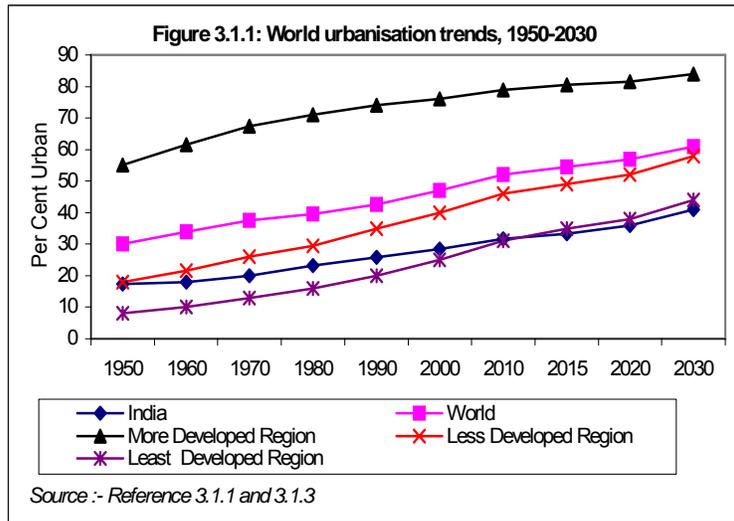
3. SOCIAL TRANSITION

India, the second most populous country in the world, has no more than 2.5% of global land but is the home of 1/6th of the world's population. Being a developing country with high population density, India invested in human development and improvement in quality of life of its citizens; to achieve rapid social transition efforts were focused on interventions to improve per capita income, availability of food, clothing, education, employment and health care. India's policies and programmes aimed at promotion of both equity and excellence. Urbanization, improvement in water supply and sanitation and investment in all tiers of education have led social transition and resulted in human capital formation. Transition in each of these aspects has occurred at different rates; there are large inter state variations in the progress achieved in these aspects. While most of the aspects ongoing social transition is beneficial there are some adverse effects such as problems of urban slum dwellers and the worsening of gender bias and consequent adverse sex ratio.

The benefits of national economic progress reach different segments of the population through different channels at different rates. The needs of people above the poverty line and an improvement in their standards of living can be achieved through optimum utilisation of existing market mechanism; governmental programmes are aimed to improve access to available facilities or fully meet the essential needs of the population with poor purchasing power. The Eleventh Plan has focused on inclusive growth; accelerating the progress in all these efforts to improve quality of life and reducing inter state variations in quality of life.

3.1 Urbanization

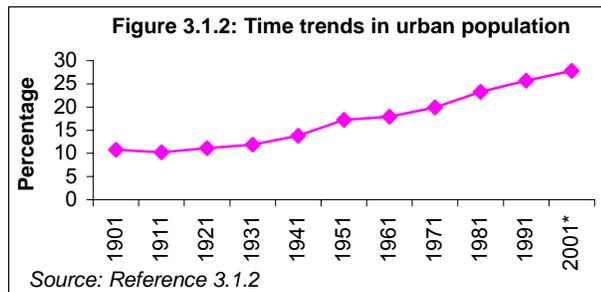
The proportion of people in developing countries who live in cities has almost doubled since 1960 (from less than 22 per cent to more than 40 per cent), while in more developed regions the urban share has grown from 61 per cent to 76 per cent. Urbanization is projected to continue well into the twenty first century. By 2030, it is expected that nearly 5 billion (61 per cent) of the world's 8.1 billion people will live in cities. India shares this global trend toward urbanization (Figure 3.1.1).

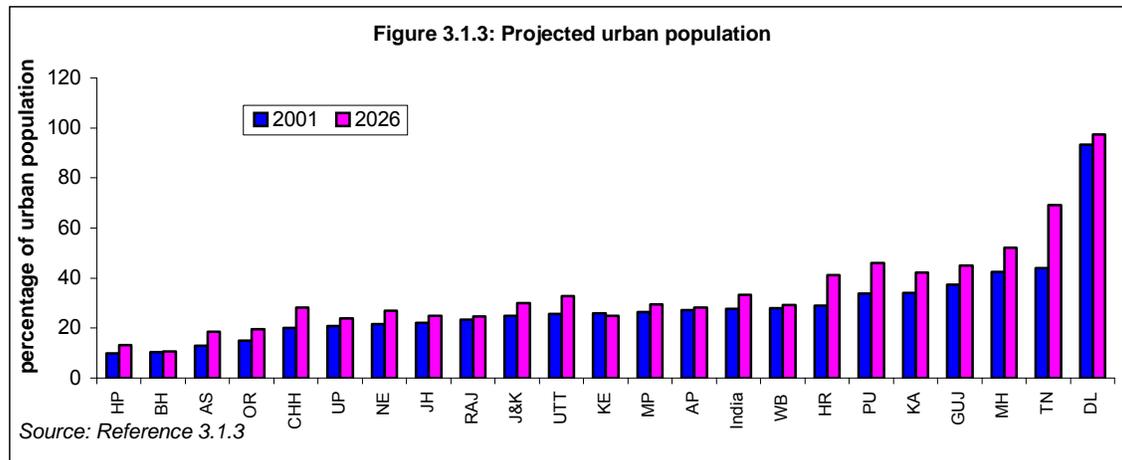


Globally, the number of cities with 10 million or more inhabitants is increasing rapidly, and most of these new "megacities" are in developing regions. In 1960, only New York and Tokyo had more than 10 million people. By 1999, the number of megacities had grown to 17 (13 in developing countries). It is projected that there will be 26 megacities by 2015, (18 in Asia; of these five in India); more than 10 per cent of the world's population will live in these cities (1.7% in 1950).

Like all the developing countries India too had undergone progressive urbanization. Decadal increase in urban population as proportion of the total population of India during the last century is shown in Figure 3.1.2. India's urban population has doubled from 109 million to 218 million during the last two decades.

Percentage of urban population in 2001 in different states and the projected urban population percentage by 2026 are shown in Figure 3.1.3 and India's million plus cities are given in Annexure 3.1.1. There are large interstate differences in proportion of urban population. Delhi has almost all population residing in urban area. Maharashtra, Tamil Nadu, Gujarat, Punjab and Karnataka are some of the states with over 35 % of the population are living in urban areas. Among the smaller states Mizoram has high urban population. At the other end of the





spectrum are states like Himachal, Bihar, Assam and Orissa, which have only about 10% of the population, are living in urban areas. In all states there will be increase in urban population over the next two decades but the large interstate differences in %urban population will continue to exist even in 2026. State-wise proportion of population expected to live in urban areas by 2026 is depicted in Figure 3.1.3. It is observed that by 2026, 98 percent of Delhi's population would be living in urban areas, which is highest among the states, included for projecting the population by component method. In contrast only 11 percent of the population of Bihar would be expected to live in urban areas in 2026.

Like many other demographic changes, urbanization has both positive and negative effects. One of the major problems associated with urbanization is the inability of the existing infrastructure and services to cope with needs of the rapidly expanding population especially poor migrants. Urban population growth has outpaced the development of basic minimum services; housing, water supply, sewerage and solid waste disposal are far from adequate; increasing waste generation at home, offices and industries, coupled with poor waste disposal facilities result in rapid environmental deterioration. Increasing automobiles add to air pollution. All these have adverse effect on ecology and health. Health and nutritional status of the urban slum population especially the recent migrants are worse than the rural population. Poverty persists in urban and peri-urban areas; awareness about the glaring inequities in close urban setting may lead to social unrest.

Rapid economic growth will inevitably lead to an increase in urbanisation as cities provide large economies of agglomeration for individual activity. As urban infrastructure is inadequate and of poor quality in the urban population is not able to fully benefit from these large economies. Poor urban infrastructure inflicts a severe hardship on people. Congested roads, poor public transport, inadequate availability of water, improper treatment of sewage, uncollected solid waste and inadequate housing that forces more than 50% of our population in some metropolis to live in slums, all these severely compromise the quality of life and well being of urban population. Urban poor urgently need sectoral policies aimed

at improving livelihood support and increasing employment and a strategy for providing essential services education, health and other basic public facilities. Inadequate access essential facilities deny urban poor the opportunity to share fully in the benefits of growth. Curtails the quality of human resource development and consequently limit the growth process itself.

In order to cope with this massive problem due rapid urban growth, the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) was launched in 2005. The mission envisages providing focused attention to integrated development of infrastructural services in 63 selected cities to secure effective linkages between asset creation and asset management, to ensure adequate investment of funds to fulfill deficiencies, to scale up delivery of civic amenities on universal access to urban poor and to encourage planned development of cities.

But urbanisation also provides new opportunities. Cities and towns have become the engines of social change and rapid economic development. Urbanisation is associated with improved access to education, employment and health care. These can result in increase in age at marriage, create demand for maternal and child health and nutrition higher contraceptive use, and fewer unwanted pregnancies, smaller better nourished healthier families. As people have moved towards and into cities, information has flowed outward. Better communication and transportation now link urban and rural areas both economically and socially creating an urban-rural continuum of communities with improvement in some aspects of lifestyle of both. The ever increasing reach of telephone net works and mass media result in communication of information, new ideas and points of reference; available options are becoming more widely recognized, appreciated and sought. The country has to fully utilise the opportunities provided by the ongoing process of urbanization to improve the quality of the citizens.

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India's million plus cities, 2001

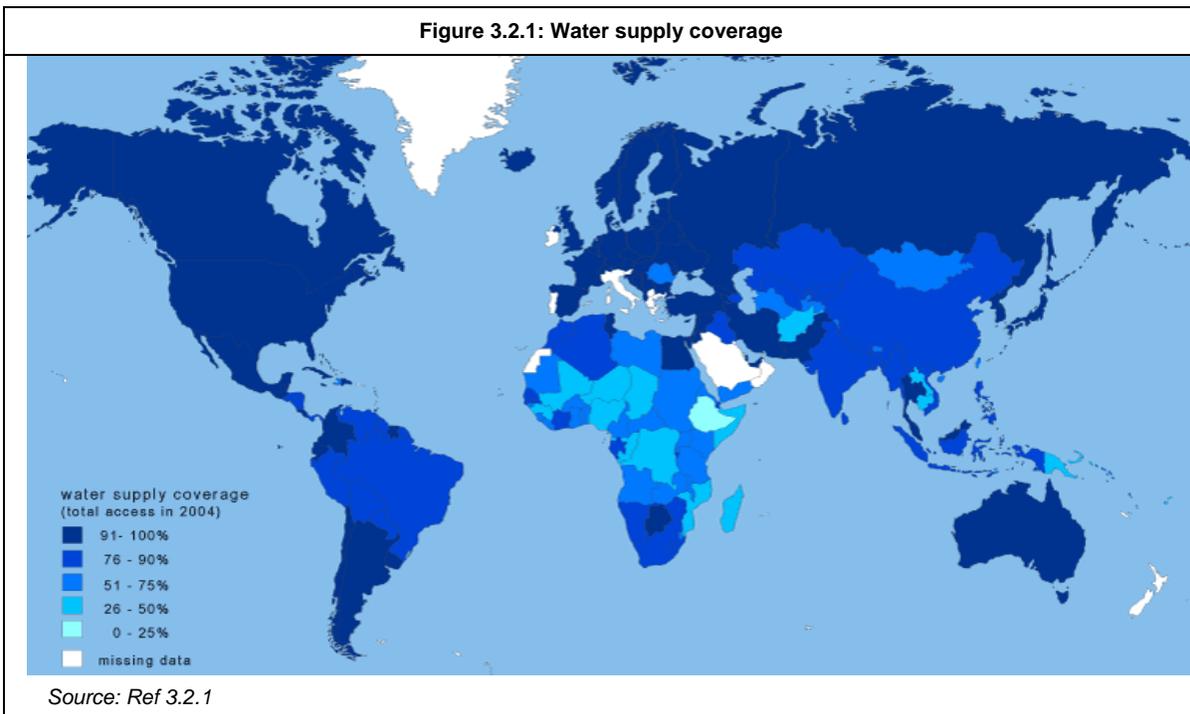


3.2 Water supply

Relationship between water supply and nutrition is two fold: water is the essential and often limiting factor for improving agricultural productivity; access to safe drinking water is a critical determinant for reduction in water borne infections and improvement in health and nutritional status. In many parts of developed and developing world, water demand substantially exceeds sustainable water supply. It is estimated that currently 430 million (8% of the global population) is living in countries affected by water stress; by 2020 about one fourth of the global population may be facing chronic and recurring shortage of fresh water (Figure 3.2.1). In India, water withdrawal is estimated to be the twice the rate of aquifer recharge; as a result water tables are falling by one to three meters every year; tapping deeper aquifers have resulted in larger population groups being exposed to health hazards such as high fluoride or arsenic content in drinking water. At the other end of the spectrum, excessive use of water has led to water logging and increasing salinity in some parts of the country. Eventually, both lack of water and water logging could have adverse impact on India's food production. There is very little arable agricultural land, which remains unexploited, and in many areas, agricultural technology improvement may not be able to ensure further increase in yield per hectare. Research efforts are therefore focusing on biotechnology for improving development of food grains strains that would tolerate salinity and those which would require less water. Simultaneously, a movement towards making water harvesting, storage and need based use part of every citizens life should be taken up.

Drinking water is less than one percent of the total water demand and should have the first priority among all uses of water. Provision of clean drinking water,

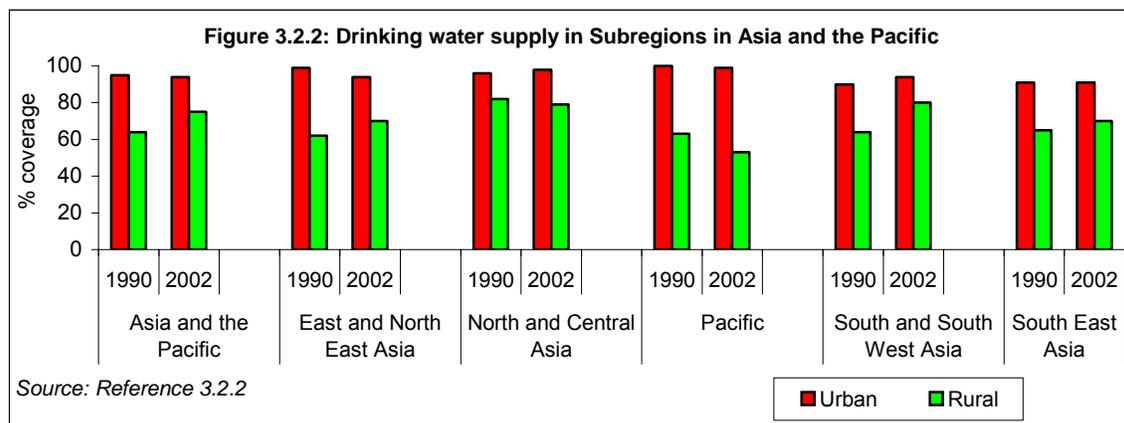
Figure 3.2.1: Water supply coverage



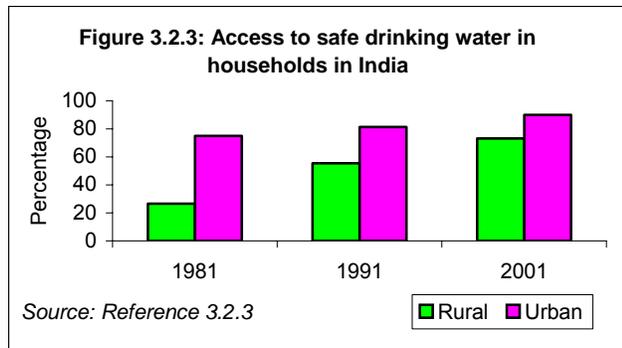
sanitation and a clean environment are vital for reducing morbidity, improving health and nutritional status of the population. Recognizing the link between healthy environment and sanitation, the Millennium Development Goals (MDGs) stipulate, halving, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. Access to safe drinking water is the key element for prevention of water borne infection, which is a major factor responsible for undernutrition especially in young children. Global position regarding access to safe drinking water is shown in Figure 3.2.1. While all the developed countries have achieved universal access to safe drinking water, the populous developing countries have not been able to ensure this to substantial proportion of their population. In all the countries of the world access to safe drinking water is higher in urban as compared to rural areas.

Progress towards universal access to safe drinking water in urban and rural areas in India and some of the neighboring countries is shown in Figure 3.2.2 and Figure 3.2.3. Most of the Asian countries had ensured that their urban population had access to safe drinking water by 1990. Over the last decade there has been some improvement in rural people getting safe drinking water; but even in 2002 nearly one fourth of the rural population lacked access to safe drinking water.

Prior to India's independence water supply and sanitation were part of the responsibility of the public health engineering section of the department of health. However, realizing the magnitude of the task of providing access to safe drinking water to the growing population these two services were made a part of the urban and rural development departments. Special focus was given to improving rural water supply during the last three decades. Government of India's major intervention in water sector started in 1972-73 through Accelerated Rural Water Supply Programme (ARWSP) for assisting States/UTs to accelerate the coverage of drinking water supply. In 1986, the entire programme was given a mission approach with the launch of the Technology Mission on Drinking Water and Related Water Management. This Technology Mission was later renamed as Rajiv Gandhi National Drinking Water Mission (RGNDWM) in 1991-92. In 2002-03 the Swajaldhara programme was launched.



Census figures show that there has been considerable improvement in rural water supply position in the last two decades (Figure 3.2.3). As on 1.4.2007, Department of Rural Development has reported that out of a total of 15,07,349 rural habitations in the country, 74.39%(11,21,366 habitations) are fully covered, and 14.64%

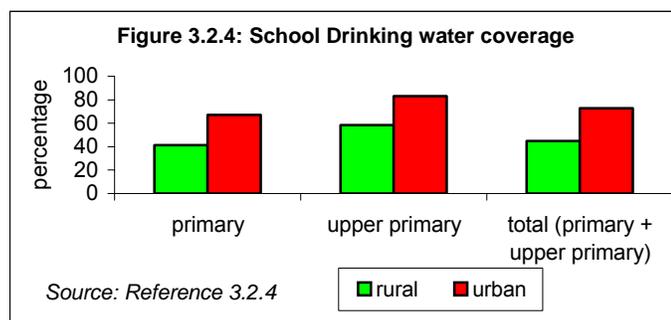


(2,20,165 habitations) are partially covered. The 10th Plan target of providing potable drinking water to all villages has clearly not been achieved; 55067 uncovered habitations will be covered in 4 years (2005-09) under Bharat Nirman Yojana). Rural Water Supply is, beset with the problem of sustainability, maintenance and water quality. Out of the 14.22 lakh habitations in the country, although more than 95% coverage was achieved prior to Bharat Nirman, about 2.8 lakh habitations have slipped back from either fully covered to partially covered category. Another 2.17 lakh habitations have problems with the quality of water, with about 60,000 habitations facing the serious problems of salinity or arsenic and fluoride contamination. Present estimates shows that out of the 2.17 lakh water quality affected habitation as on 1.4.05, about 70,000 habitations have been addressed. Under Bharat Nirman, it is proposed to tackle the habitations that have slipped back or have problems with water quality.

Although on 31.3.2004, about 91% of the urban population has got access to water supply facilities; access does not ensure adequacy and equitable distribution. Average access to drinking water is highest in class I towns (73%), followed by class II towns (63%), class III towns (61%) and other towns (58%). Poor people in slums and squatter settlements are poor. As water supply is not round the clock there is lot of wastage of water; taps are left open kept open; often-stored water is not fully used.

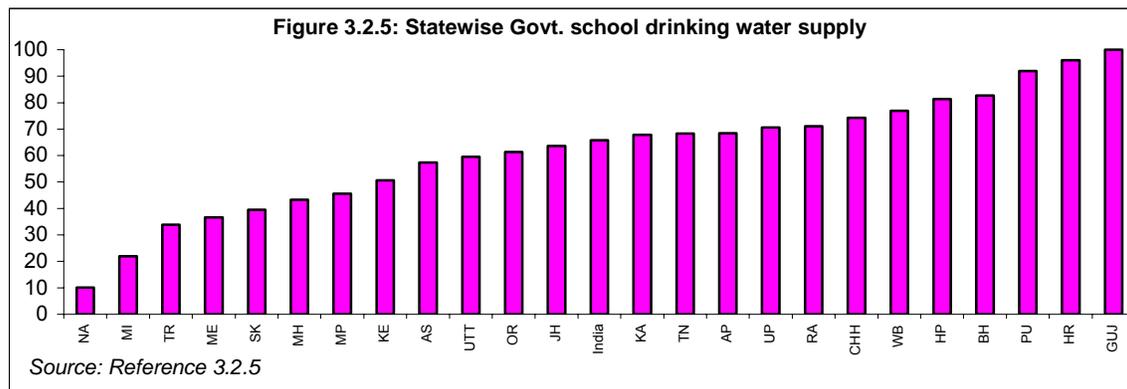
There are substantial inter state and inter district variations in the access to safe drinking water. District wise information on access to safe drinking water provided by Census India is widely used for decentralized district based planning and monitoring of the progress in access to safe drinking water (Annexure 3.2.1)

Special efforts are being made to provide access to safe drinking water to schools, anganwadis and hospitals where vulnerable segments of population such as children and mothers assemble; this will enable the institutions to maintain appropriate standards



of hygiene and also enable these institutions to provide health education in the right ambience. The efforts are more successful in upper primary schools than in primary schools (Figure 3.2.4). There are considerable interstate differences in access to safe drinking water to school children (Figure 3.2.5). While almost all schools in Gujarat, Punjab and Haryana have access to safe drinking water; Maharashtra, MP and Kerala lag behind.

The problems of sustainability of water availability, maintenance of supply system and dealing with the issue of water quality are the major challenges. The conjunctive use of groundwater, surface water and roof top rainwater harvesting systems have to encourage as means of improving sustainability and drinking water security. Where groundwater quality and availability, is unsatisfactory surface water sources need to be developed. Restoration and building of tanks and other water bodies along with rainwater harvesting structures for recharge and for direct collection at community and household levels constitute an attractive option. There is a huge growing gap between the demand and supply of water in urban areas, due to increasing population. There should efforts to tackle both supply and demand side problems. Recycling and reuse of water, reducing the water demand through rainwater harvesting, using water efficient household equipments including flushing cisterns would go a long way in conserving water and reducing ever growing urban demand for water.

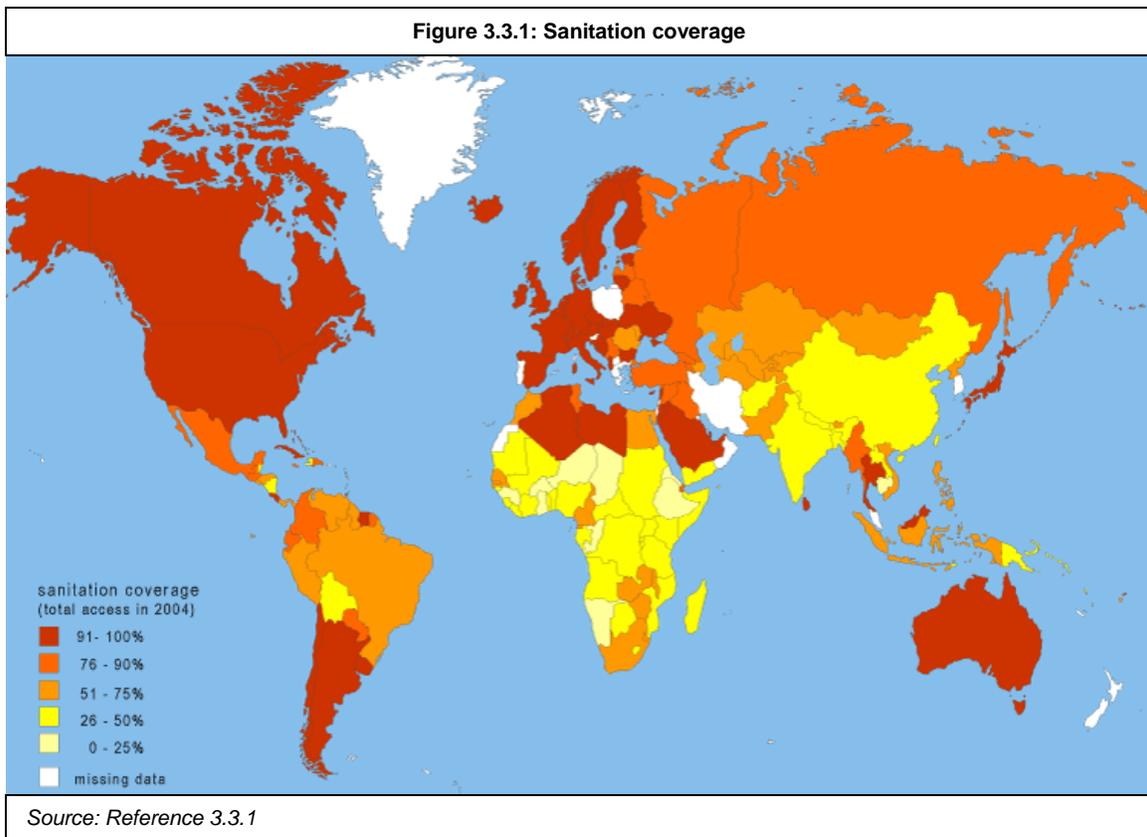


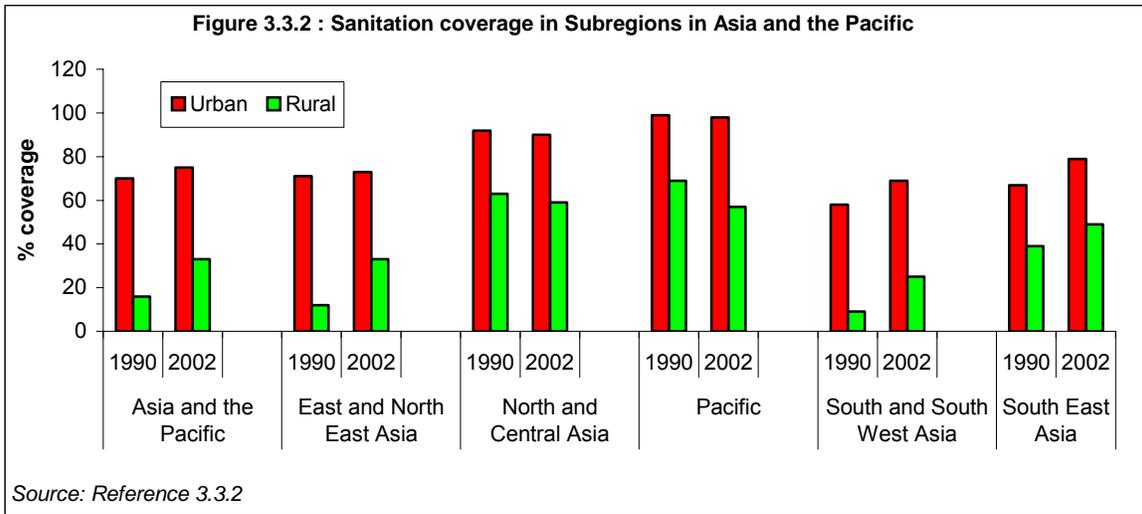
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3.3 Sanitation

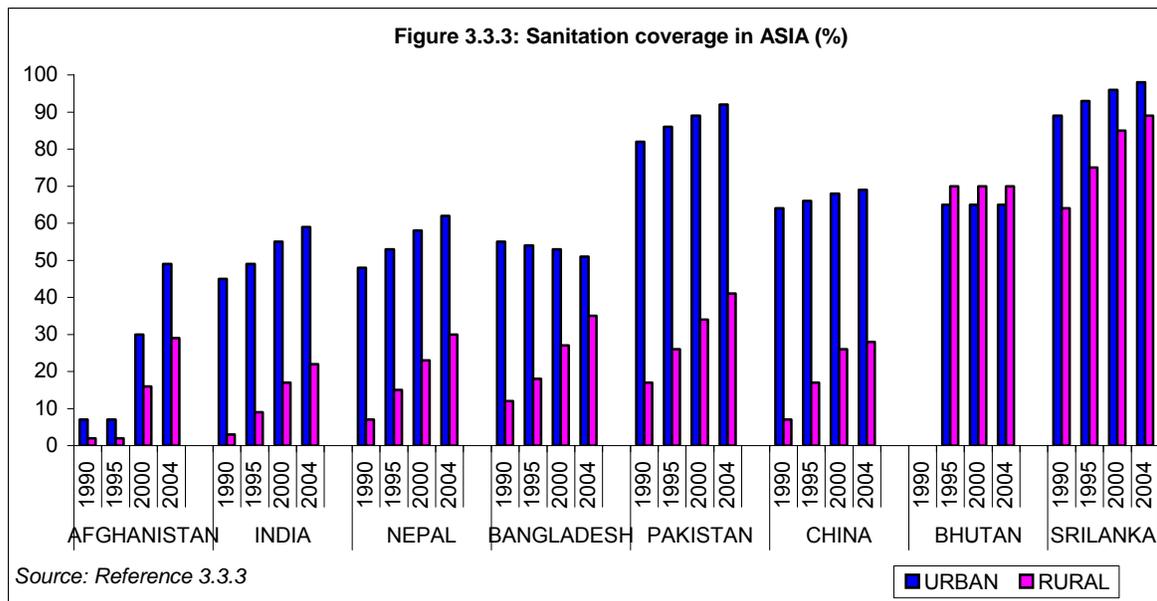
Sanitation covers the whole range of activities including human waste disposal, liquid and solid wastes from household and industrial waste. Lack of drains and the presence of ditches create unsanitary conditions, which contaminate water, breed mosquitoes and cause water-borne diseases. Sanitation is to be seen as a need, as basic as drinking water or food. A sanitary toilet within or near home provides privacy and improves environmental sanitation. Provision of clean drinking water sanitary toilets is critical for reducing water borne infections. While majority of the developed countries have achieved universal access to toilets, developing countries lag behind (Figure 3.3.1); as a result prevalence of water borne diseases in these countries continue to be high with all the attendant adverse effects on health and nutritional status of vulnerable population especially children.

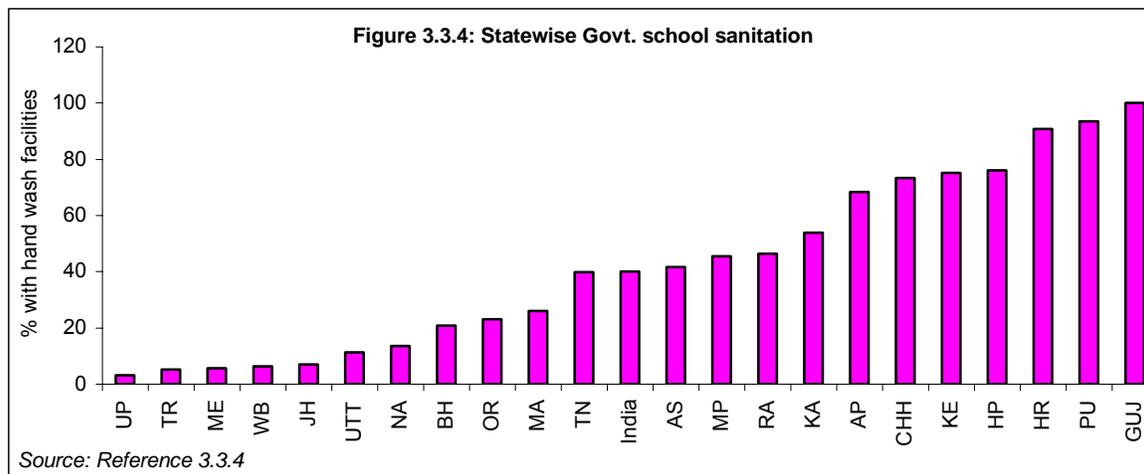




In developing countries sanitation coverage is higher among urban areas as compared to rural areas. Progress in terms of improvement in sanitation coverage in Asian region and in some of the neighboring countries in Asia is shown in Figure 3.3.2 and Figure 3.3.3. There has been progressive improvement in access to sanitary toilets over the last two decades both in urban and rural areas but the gap between urban and rural areas persists. Among the neighboring countries, Sri Lanka has been most successful in providing access to sanitary toilets to urban and rural population.

Rural sanitation coverage was only 1% in the 1980s. With the launch of the Central Rural Sanitation Programme in 1986, the coverage improved to 4% in 1988 and then to 22% in 2001. The programme was modified as Total Sanitation Campaign in 1999 changing the earlier supply driven, high subsidy and departmentally executed programme to a low subsidy, demand driven one, with

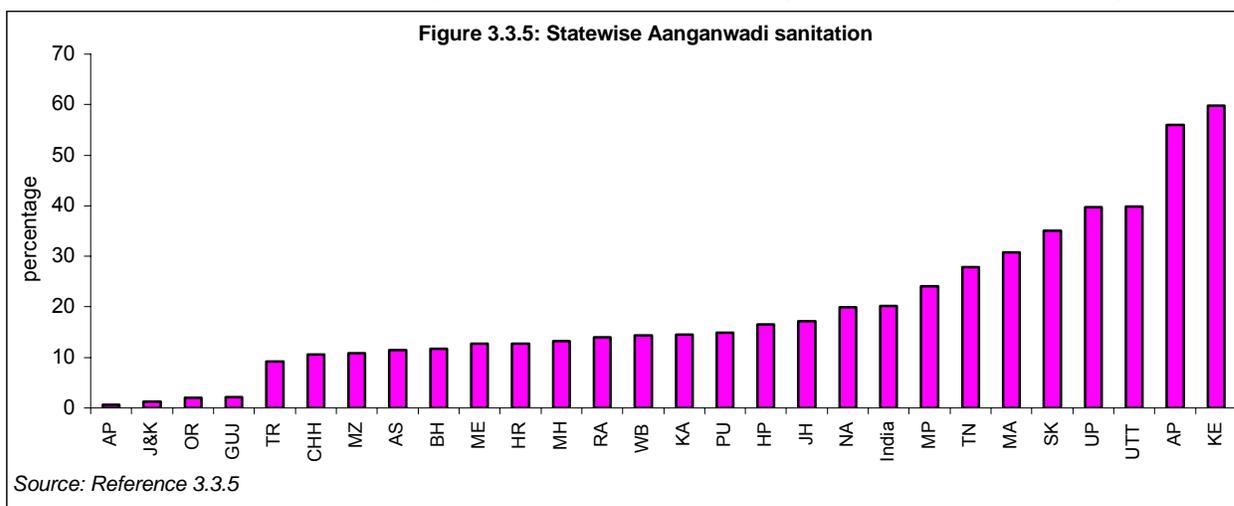


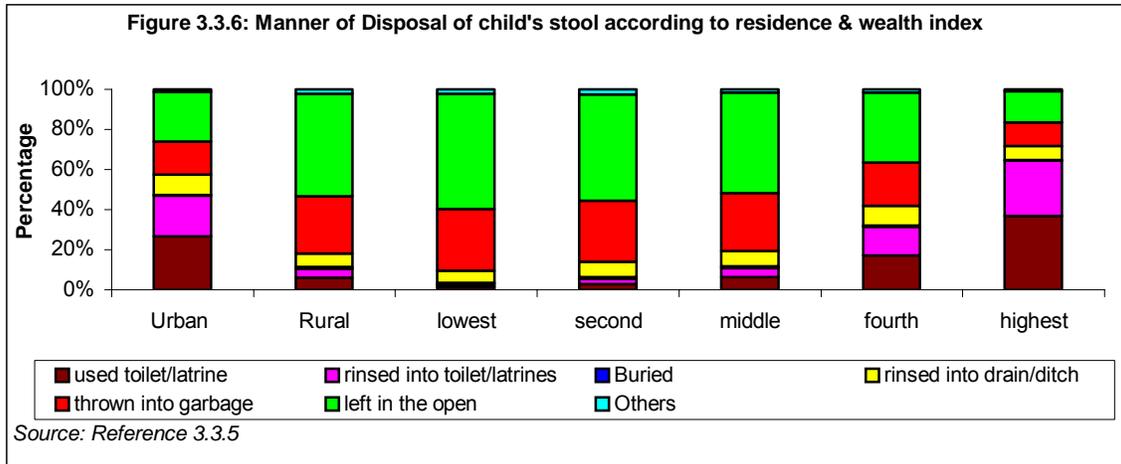


emphasis on hygiene education. Census 2001 indicates that of the 200 million dwelling units across the country, only some 40 million dwelling units have a toilet inside the house. Only 61 per cent households in urban areas and 17 per cent households in rural areas have access to improved sanitation; about 63% of the urban population has access to sewerage and sanitation facilities. However, adequacy, equitable distribution and per-capita provision of these basic services may not be as per prescribed norms in most of the cities. The poor, particularly those living in slums and squatter settlements, do not have access to these basic facilities.

During the Tenth Five Year Plan period an attempt was made to provide toilet facilities in schools and anganwadi's on priority basis. Data on the coverage levels as of 2003 is given in Figure 3.3.4 and Figure 3.3.5. Data indicate that while Kerala, and Andhra have fared well in improving toilet facilities in anganwadis, Gujarat, Punjab and Haryana were providing better toilet facilities in schools.

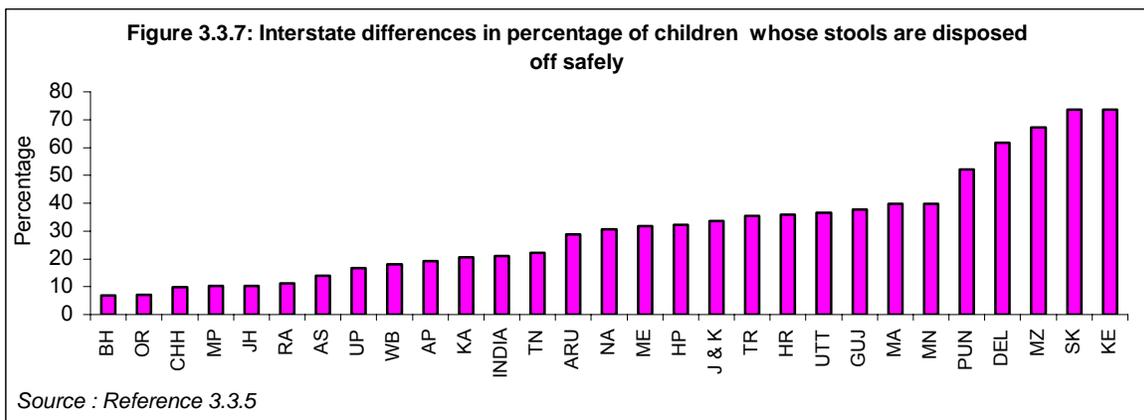
In view of the importance of sanitary disposal of the human excreta, the National Family Health Survey obtained information on the disposal of child's stools from each of the households surveyed. Data from the survey confirmed that sanitary





disposal of human excreta was better in urban as compared to rural areas. There was a socioeconomic gradient in the safe disposal of child's stools with the poor having the least access to safe disposal methods (Figure 3.3.6). There are large interstate differences in the safe disposal of the children's stools. In Kerala, Sikkim, Mizoram, Delhi and Punjab majority of the households disposed the child's stools safely; at the other end of the spectrum are states like Bihar, Orissa, MP and Rajasthan where only about one tenth of the households had access to safe methods of disposal of the child's stools (Figure 3.3.7).

In order to rapidly achieve universal access to sanitary toilets, Govt of India has initiated the Total Sanitation Campaign. TSC programme is being implemented in 578 districts of 30 States/UTs with support from the Central Government and the respective State/UT Governments. Against a target of 10.85 crore individual household toilets, the toilets reported completed is about 2.89 crore up to Jan 2007. In addition, about 3.12 lakh school toilets, 8900 sanitary complex for women and 99150 balwadi toilets have been constructed. The Eleventh Five Year Plan has set the target of completing 7.29 crore individual toilets for achieving universal sanitation coverage in rural areas. In order to achieve 100 per cent coverage of clean water and sanitation in rural areas, rural sanitation programme are being linked with the National Rural Health Mission.



The strategies include:

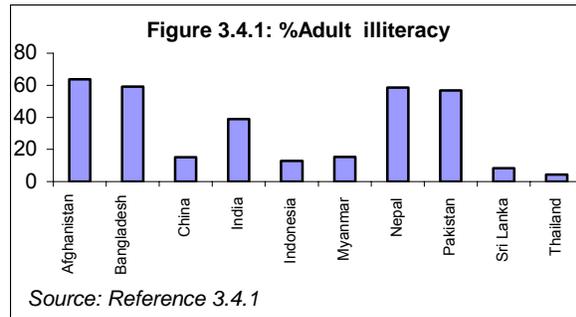
- convergence of health care, hygiene, sanitation and drinking water at the village level
- participation of stake holders at all levels, from planning, design and location to
- implementation and management of the projects
- institution water quality monitoring and surveillance systems by involving PRIs,
- community, NGOs and other civil society organizations
- increased attention to IEC campaign

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3.4 Education

The role of education in accelerating social and economic development and improving the quality of life of the citizens is well recognized. Education opens up opportunities, empowers people with skills and knowledge, gives them access to productive employment, enhances efficiency and improves overall quality of life. India, the second most populous country in the world realized the importance of education in human resource development and invested heavily in education right from the time of Independence. Since independence the country has witnessed substantial improvement both access to education and in the quality of education. However, the national goals of universal elementary education and total eradication of illiteracy still continues to elude us. Adult literacy rates in India and some of its neighboring countries are shown in Figure 3.4.1. In Afghanistan 63.75% of the adults are illiterates; illiteracy rates in Bangladesh, Nepal and Pakistan are high. China Sri Lanka and Thailand have nearly eliminated illiteracy. Even in the current decade about a third of the Indians are illiterate.

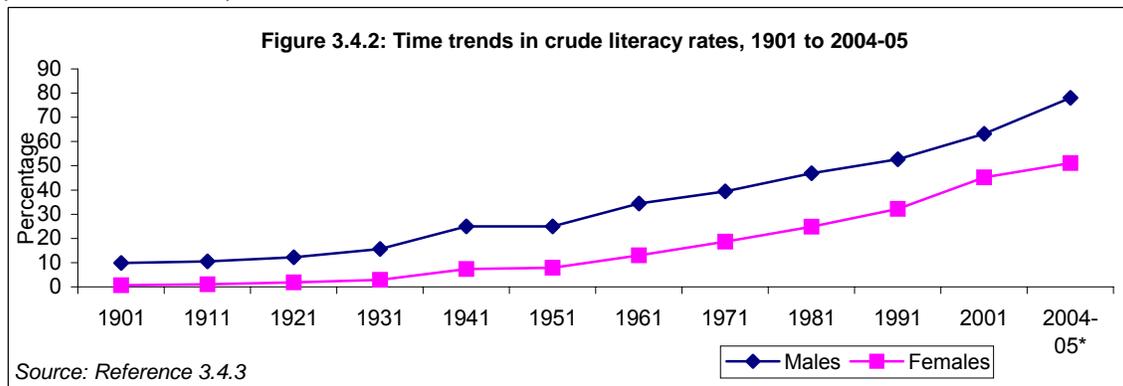


Year	Persons	Males (M)	Females (F)	MF gap
1951	18.33	27.16	8.86	18.30
1961	28.30	40.40	15.35	25.05
1971	34.45	45.96	21.97	23.98
1981	43.57	56.38	29.76	26.62
1991	52.21	64.13	39.29	24.84
2001	65.38	75.85	54.16	21.70

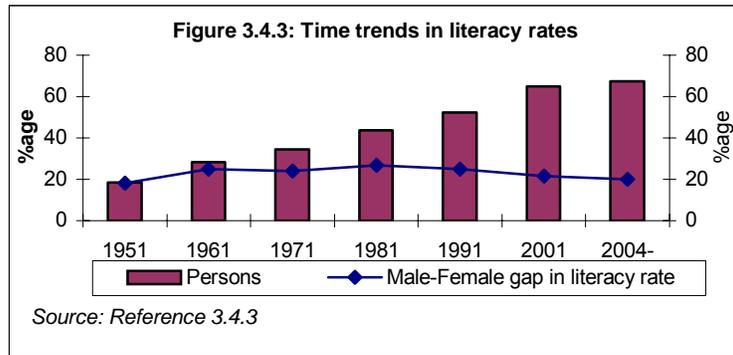
Source: Reference 3.4.2

Literacy rates in India

Time trends in literacy rates over the last five decades computed from the census are given in Figure 3.4.2, Figure 3.4.3, Table 3.4.1 and Annexure 3.4.1. 1961 and 1971 censuses relate to the population aged five years and above while those for the 1981, 1991 and 2001 censuses relate to the population seven years and above. There has been a progressive increase in literacy rates over the last five decades but inspite of the efforts universal literacy continues to be elusive. The gap in literacy rates between men and women has not decreased substantially (Annexure 3.4.2).



Literacy rates are lower in rural areas. There are substantial interstate differences in literacy Kerala and northeastern states like Mizoram and Meghalaya have high literacy rates with very little urban rural or gender disparity in literacy rates.



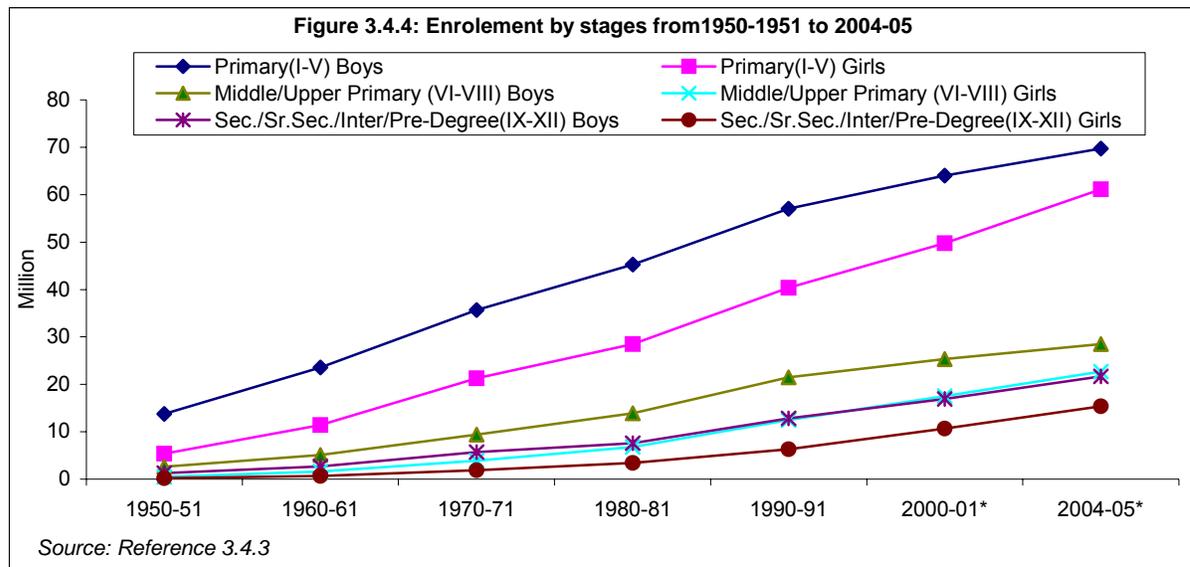
In spite of substantial progress over the last three decades literacy rates especially in rural areas, among women and those belonging to scheduled caste and tribes are lower in states like Rajasthan, Madhya Pradesh and UP.

School education

Time trends in over all enrolment and girls enrolment as % of over all enrolment in primary, upper primary and secondary schools over the last five decades is shown in Figure 3.4.4 and Figure 3.4.5. There has been a steep increase in primary school enrolment and girls' form nearly 50% of the enrolled children. However the enrolment in upper primary and secondary schools is considerably lower; though there has been improvement in the girls attending higher classes, the gender gaps persist.

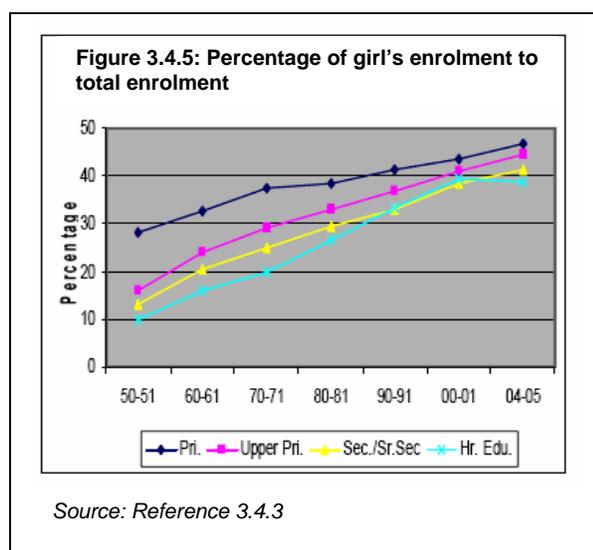
Universal of Elementary Education

Elementary education i.e. classes IV-VIII consisting of primary (I-V) and upper primary (VI-VIII) is the foundation of the pyramid in the education system. A broad objective of the National Policy on Education (NPE), 1986 modified in 1992 has been that education should play a positive and interventionist role in correcting social and regional imbalances, empowering women and in securing



rightful place for the disadvantaged and the minorities. The National Policy of Education had indicated three thrust areas in elementary education:

- Universal access enrolment;
- Universal retention of children upto 14 years of age; and
- A substantial improvement in the quality of education to enable all children to achieve essential levels of learning.



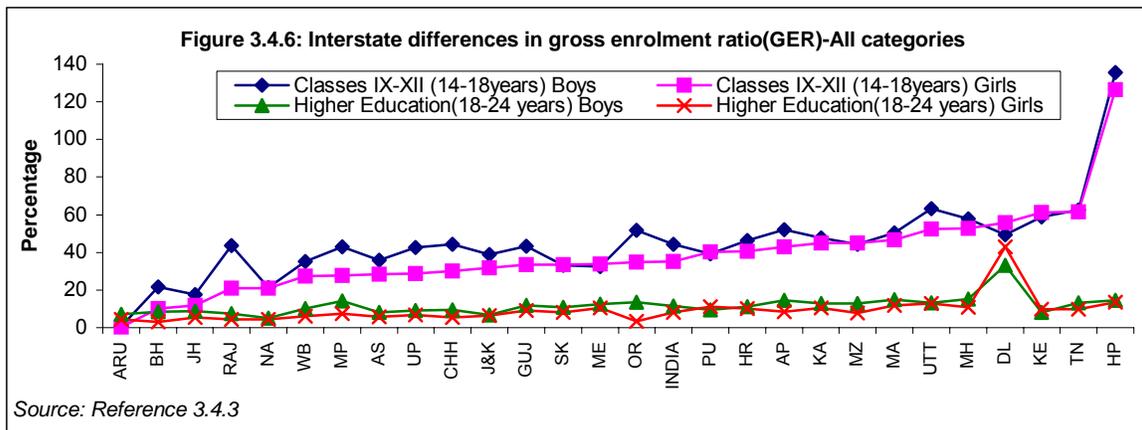
The 86th Constitutional Amendment Act 2002 made education a Fundamental Right for children in the age group of 6-14 years by providing that “the State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine”. Unlike the other rungs of educational institutions elementary educational institutions are predominantly run by the government or is government aided. Therefore government has to play the critical role in ensuring that the right for education is translated into reality. Sarva Shiksha Abhiyan which is the flagship programme of the Ministry of Human Resource Development (MHRD) Government of India for primary education and Mid Day Meal programme are interventions to ensure that the objectives do get achieved within the time frame.

Sarva Shiksha Abhiyan (SSA)

SSA, the principal programme for UEE, is the culmination of all previous endeavors and experiences in implementing various education programmes. Implemented in partnership with the States, SSA addresses the needs of 194 million children in the age group of 6-14 years. Under the SSA the Ministry of HRD has reported that the total enrolment at elementary education level increased from 131 million in 2001-02 to 182 million in 2004-05. This included enrolment of over 25 million out-of-school children. Enrolment in primary, and upper primary schools in 2002 and 2005 is shown. State/UTs have reported a significant reduction in the number of out of school children; and as on March 31, 2006, there were only 70.5 lakh children in the 6-14 age group who were not enrolled in a school. There has been substantial increase in the gross enrolment ratio

Stage	Gross Enrolment Ratio				% Point increase
	01-02	02-03	03-04	04-05	
Primary (I-V)					
Boys	105.3	97.5	100.6	110.7	5.4
Girls	86.9	93.1	95.6	104.7	17.8
All	96.3	95.3	98.2	107.8	11.3
Upper primary (VI-VIII)					
Boys	67.8	65.3	66.8	74.3	6.5
Girls	52.1	56.2	57.6	65.1	13
All	60.2	61	62.4	69.9	9.7
Elementary (I-VIII)					
Boys	90.7	85.4	87.9	96.9	6.2
Girls	73.6	79.3	81.4	89.9	16.3
All	82.4	82.5	84.8	93.5	11.1

Source: Reference 3.4.3

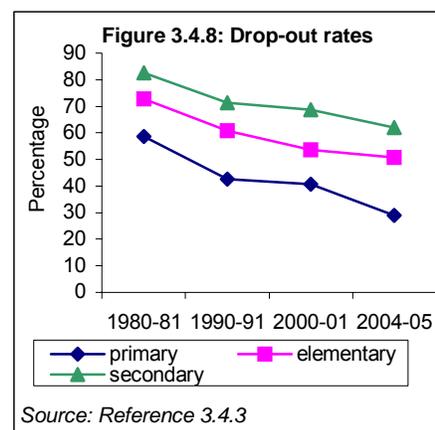
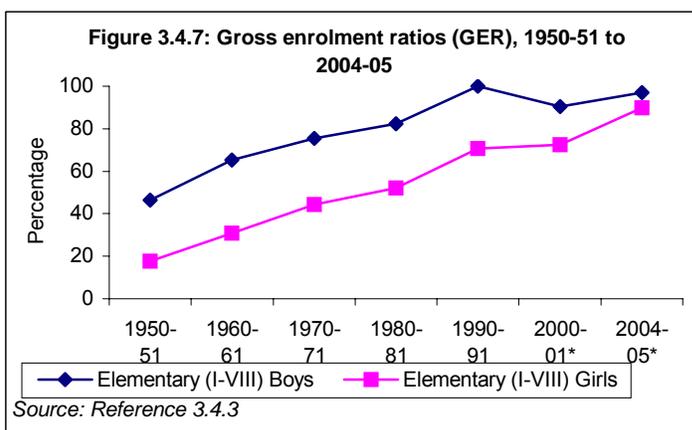


(GER) at the primary and upper primary school levels. There are huge interstate variations in GER (Figure 3.4.6, Table 3.4.2 and Figure 3.4.7).

It is increasingly realized that retaining the disadvantaged children enrolled in schools is a far more challenging task than enrolling them into educational system. Time trends in drop out rates in primary, elementary and secondary schools in the last two decades are shown in Figure 3.4.8. Drop out rates in primary schools have come down substantially over the last five decades but the drop out rates in elementary and secondary schools still continue to be very high. Around 22% children dropout in classes I and II. Several factors, apart from their adverse socio-economic conditions are responsible for this. Drop out rates are higher among girls and among SC and ST (Table 3.4.3).

Some of the major achievements during the Tenth Plan period in the quest for universalisation of elementary education are:

- Reduction in the number of out of school children: from about 320 lakh in 2002-03 to 70.5 lakh in March 2006.
- Decline in gender and social gaps:
 - ✓ The gender gap at the primary stage reduced from 5.5 % in 2002-03 to 4.2% in 2005-06.



- ✓ At the upper primary stage this gap reduced from 10.7% to 8.8%
- ✓ The GPI at the primary stage in 2005 was 0.95 and 0.88 for the upper primary stage.
- ✓ The share of SC students in total enrolment was 20.72% at the primary stage and 19.42% at the upper primary stage.
- ✓ For ST students, share in total enrolment was 11.75% at the primary stage in 2005-06 and 9.28% at the upper primary stage.

Table 3.4.3: Dropout rates by social composition 2004-05						
Categories	Primary (I-V)			Elementary (I-VIII)		
	Boys	Girls	Total	Boys	Girls	Total
SC's	32.7	36.1	34.2	55.2	60	57.3
ST's	42.6	42	42.3	65	67.1	65.9
All	31.8	25.4	29	50.5	51.3	50.8

Source: Reference 3.4.3

Table 3.4.4: Learning achievements at elementary level (percentage)				
Stages of education	Maths	Lang.	EVS / science	Social Science
At end of class III	58.25	63.12	-	-
Class V	46.51	58.57	50.30	-
Class VII	29.87	53.00	35.98	32.96
Class VIII	38.47	52.45	40.54	45.00

Source: Reference 3.4.4

- Reduction in dropout rates:
 - ✓ gross dropout rate declined from 39.03% in 2001-02 to 28.49% in 2004-05.
 - ✓ For girls, the decline in dropout rate has been from 39.88% to 24.82%

Quality and equity are two major issues yet to be addressed satisfactorily under UEE. The results of learning achievement surveys conducted by NCERT (Table 3.4.4) highlight poor quality of learning

Eleventh plan targets for elementary education

- Universal enrolment of 6-14 age group children including the hard to reach segments.
- Substantial improvement in quality and standards improved through a range of coherent, integrated and comprehensive strategies with the ultimate objective to achieve standards of KVs under the CBSE pattern.
- All gender, social and regional gaps in enrolments to be eliminated by 2011-12.
- One year pre-schools education for children entering primary school.
- Dropout at primary level to be eliminated and the dropout rate at the elementary level to be reduced from over 50% to 20% by 2011-12.
- Universal coverage of ICT at upper primary schools by 2011-12.
- Significant improvement in learning conditions with emphasis on learning basic skills, verbal and quantitative.

Mid-Day Meal (MDM) Scheme

MDM scheme aims at promoting school enrolment, reduction in drop out rates, preventing classroom hunger, instilling educational values and fostering social

and gender equity. Under the last revised scheme (June, 2006), cooked midday meal with a energy content of 450 calories, 12 grams protein and vegetable 50 g is to be served to children 12 crore children studying in over 9.50 lakh schools at primary level in government, government-aided, and local body schools; and in Education Guarantee Scheme (EGS) /Alternative & Innovative Education (AIE) Centres. The Scheme is being implemented by all States/UTs. The number of children covered under the programme has risen from 3.34 crore in 3.22 lakh schools in 1995 to 12 crore in 9.5 lakh primary schools/EGS centres in 2006-07.

A review of MDM indicates absence of proper management structure in many States. Even the reported average number of school days on which meals are provided varied widely. NUEPA reports 209 days per annum, while MHRD reports 230 days at the national level .On the whole, despite the prevalence of good practices, a systematic supervision and monitoring of the programme and transparency in implementation are lacking in most of the states. Notwithstanding these shortcomings, MDM appears to have had a positive impact on school attendance.

Unlike the other rungs of the educational pyramid primary and upper primary schools are predominantly funded by the government or get government aid. During the Eleventh Plan the scheme has been extended to upper primary schools in 3479 EBBs from 1st October, 2007 to cover 17 million additional children and will be extended to all upper primary schools from April, 2008 to cover 54 million children. Thus, MDMS will cover about 18 crore children by 2008-09. The nutritional value of meals for upper primary children will be fixed at 700 calories derived from 150 gm of cereals and 20 gm of protein from pulses and 75 grams of vegetables. MDMS will be universalized at elementary level by 2008-09.

Secondary education

Over years there has been an increase in enrolment in secondary education. But there are huge urban rural, interstate and gender disparities in secondary education. It is increasingly realised that a person with a mere 8 years of schooling will be as not be able to thrive in modern industry and services. There is a need to aim at a progressive rise in the minimum level of education towards high school level or Class X. The demand for secondary education will expand significantly as SSA reaches its goal of universal and complete elementary education. The needed expansion of secondary education will require not only public but also private effort. At present, private aided and unaided schools account for 58% of the total number of secondary schools. The striking feature is that their proportion is actually increasing at a faster pace than public funded schools. During the Eleventh Plan strategies for secondary schooling will emphasize the primacy of public responsibility for providing secondary schooling and also allow scope for private schools to expand if they complement the public effort.

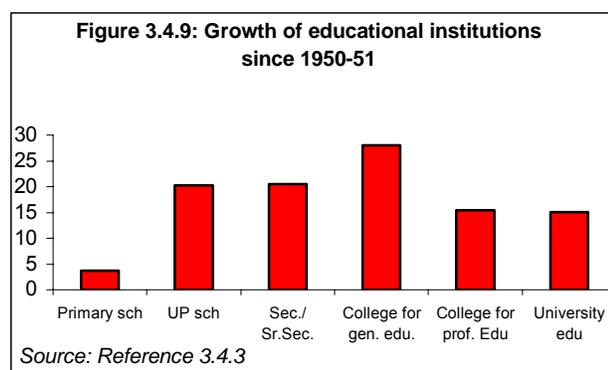
Vocational training

India has historically lagged behind in the area of technical/vocational training and even today enrolment rates in ITIs and other vocational institutes, including nursing and computer training schools, is only about a third of that in higher education. This is quite the opposite of other Asian countries. Technical and vocational training have to be substantially expanded not only in terms of the persons they train but also in the number of different skills and trades they teach. The quality and range of their training should keep pace with the changing needs of the economy. Data collected in 60th round of NSS shows that only 3% of the rural youth (15-29 years) and 6 per cent of the urban youth have gone through a formal course of vocational training of any kind. Most of them have acquired the skills they have from taking up or changing employment. Therefore, the principal planning issue will be how to expand vocational training from the present capacity of a mere 2 to 3 million to 15 million new entrants to the labor force. More importantly, the scope and content of the training they provide must be made relevant to the needs of industry and available jobs by involving industries and industrial associations in running them. The number of skills for which training is provided must be increased hundred fold from the current 40.

Higher education

India invested in building up educational institutions at all levels right from 1951. During the period 1950-51 and 2004-05, the number of Primary Schools increased by 3.66 times, while the Upper Primary Schools and Secondary/Hr. Secondary Schools increased by more than 20 times each. The number of Colleges for general education and professional education increased by about 28 and 15 times respectively while the number of Universities increased by 15 times during the period. India has a well developed higher education system but only about 8% of the relevant age group go to university; in many developing countries 20 and 25% of the age group go to colleges. (Figure 3.4.9)

At the time of independence, the number of universities was no more than 20, of colleges around 500 and the total enrolment was less than 1.0 lakh. By the end of the X Plan, the Indian higher education system has grown into one of the largest in the world with 378 universities, 18,064 colleges, a faculty strength of 4.92 lakh and an estimated enrolment of 140 lakh students. The higher education institutions include 23 Central Universities, 216 State Universities, 110 Deemed Universities, 11 Private Universities and 33

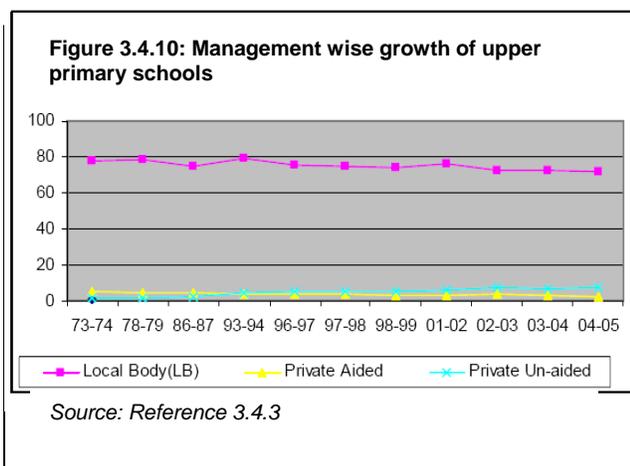


Institutions of National Importance established through Central legislation and another 5 institutions established through state legislations. There has been an impressive growth in the area of higher education with an increase in annual student enrolment from 7.26 million in 1997-98 to 10.48 million in 2004-05. Enrolment of women students rose from 2.45 million in 1997-98 to 4.04 million in 2004-05, constituting 40.4 per cent of the total enrolment NSSO survey (55th Round 1999-00) showed that, there were inequalities in enrolment in higher education across various social groups in rural and urban areas, and also in terms of gender. Women belonging to SCs and STs and those living in rural areas are the most disadvantaged.

The investment made in higher education in the 1950s and 1960s has given the country a strong knowledge base in many fields and contributed significantly to economic and social development. The country is currently reaping the benefits of these investments in terms of GDP growth mainly due to manufacturing service sector growth. Despite the expansion the higher education system is unable to provide adequate number of qualified and skilled persons needed for rapidly expanding manufacturing and service sectors. Clearly there is a need undertake major expansion. While some of the institutions of higher education compare well in terms of quality with the best in the world, the average standard is much lower. Even the high quality institutions are finding it difficult to get faculty of suitable quality because of the enormous increase in opportunities in the private sector for many of the skills most in demand. Over decades there has been a change in investments in educational institutions. Earlier majority of the educational institutions at all levels were funded by the government; a small proportion were funded by not for profit educational foundations. Currently majority of the primary and upper primary schools are still under local body management; but there has been increase in high schools and colleges funded by the private sector (Figure 3.4.10).

Education in the Eleventh Plan

The Eleventh Plan places the highest priority on education as a central instrument for achieving rapid and inclusive growth. It presents a comprehensive strategy for strengthening the education sector covering all segments of the education pyramid. It aims to achieve universal elementary education. In view of the demands of rapidly changing technology and the growth of knowledge economy, a mere eight years of elementary education would be inadequate for children to acquire necessary skills

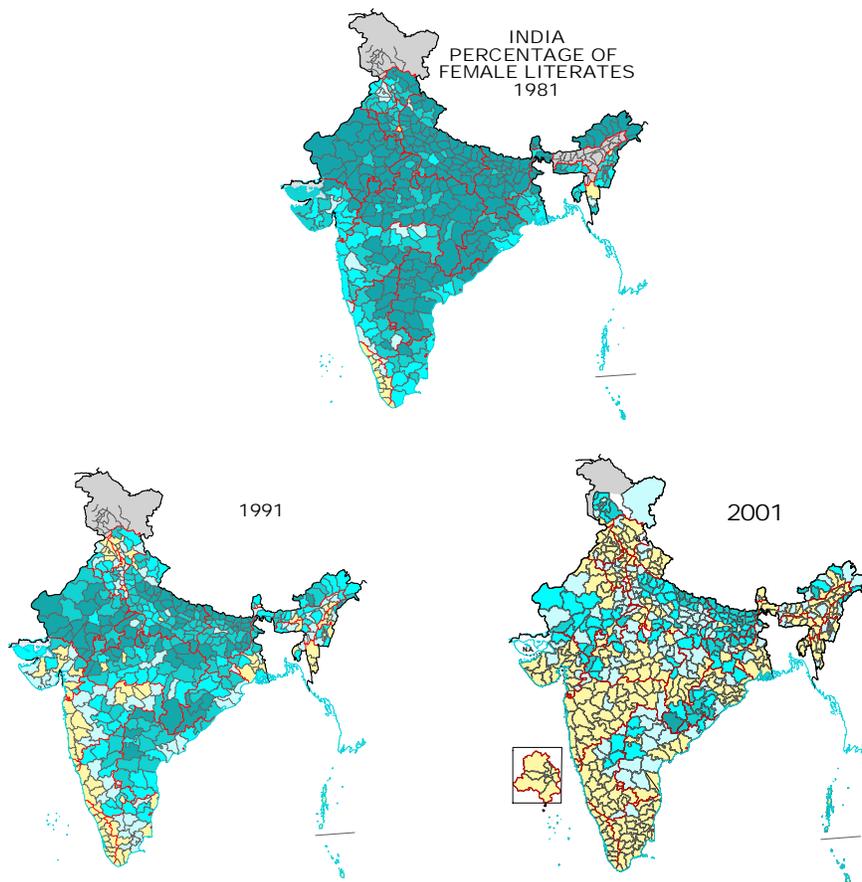


to compete in the job market. Therefore, a Mission for Secondary education is essential to consolidate the gains of Sarva Siksha Abhyan and to move forward in establishing a knowledge society. The Eleventh plan will also have to address major challenges including bridging regional, social and gender gaps at all levels of education. Due attention will also be paid to higher education so that the manpower for growing knowledge, service and manufacturing sectors is provided.

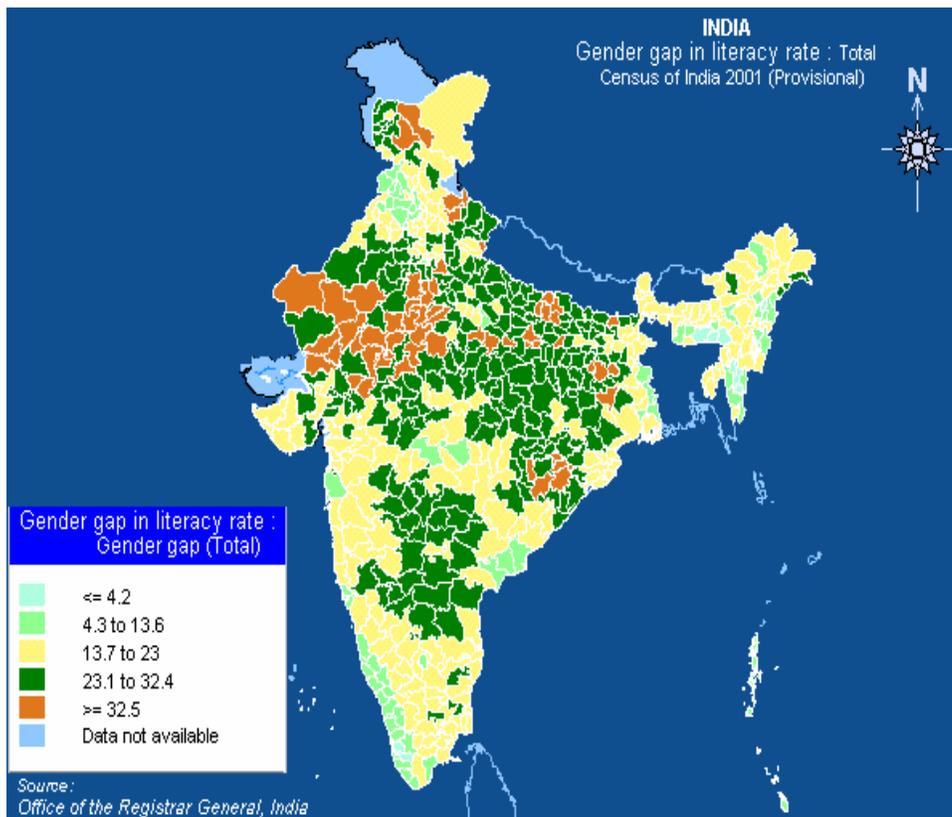
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- 3.4.3 **Approach paper to the Eleventh Five year Plan**

Decadal changes in female literacy

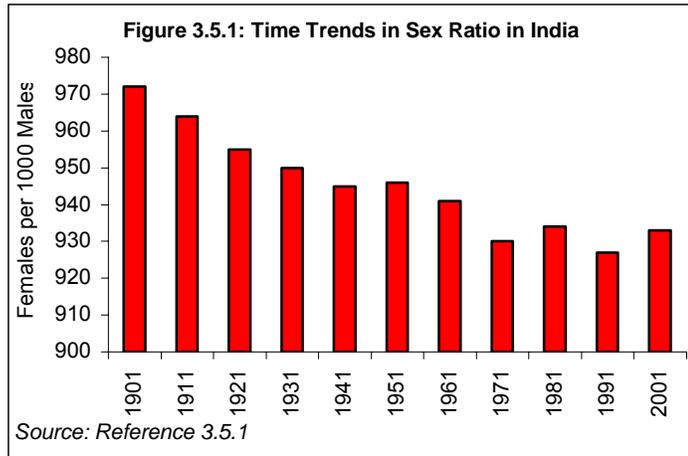


Gender gap in literacy rate



3.5 Sex ratio

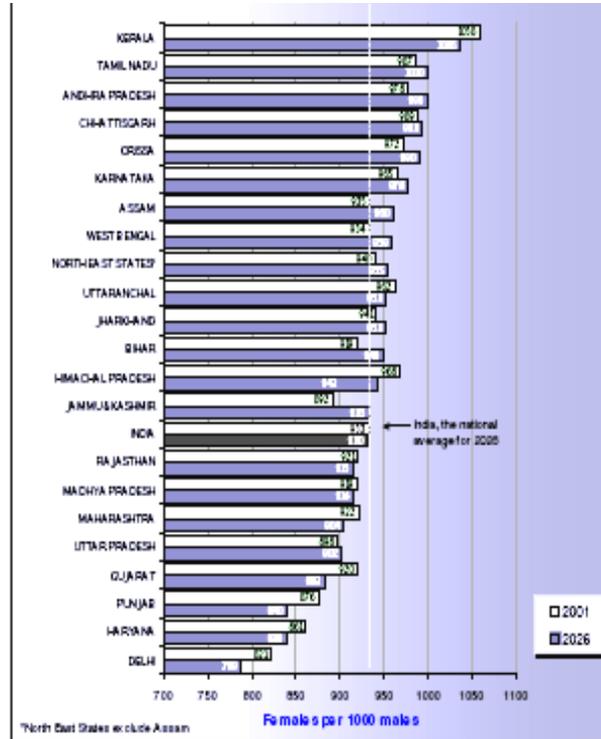
Sex Ratio (defined as the number of females per thousand males) is an important social indicator to measure the extent of prevailing equity between males and females in a society. Census 2001 recorded that sex ratio for India as a whole, was 933. Over the last century there has been decline in the sex ratio (Figure 3.5.1). Among the



states, Kerala has registered the highest sex ratio (1058) and Haryana the lowest (861). There is a decline in the sex ratio between 1991-2001 in Himachal Pradesh, Punjab, Haryana, Gujarat, Sikkim, Maharashtra and Goa. District map of India for sex ratio in 2001 is shown in Annexure 3.5.1. Districts with sex ratio less than 900 are shown in Annexure 3.5.2. District wise decadal changes in sex ratio in India is shown in Annexure 3.5.3. The reasons for the continued decline in

sex ratio is as yet not clearly identified. However, it is well recognized that the adverse sex ratio is a reflection of gender disparities, which have to be combated. Projected sex ratio for 2026 indicate that in some of the northern states, the ratio will decrease in 2026. Lowest sex ratio of 789 is expected to be in Delhi in 2026, followed by 839 and 840 in Haryana and Punjab respectively. In the southern and eastern states except Kerala, the situation would be reverse. In Kerala, where there are excess females than males in Census 2001, the trend would remain the same in 2026. Tamil Nadu is the other state, where the number of females is expected to be equal to the number of males in 2026 (Figure 3.5.2).

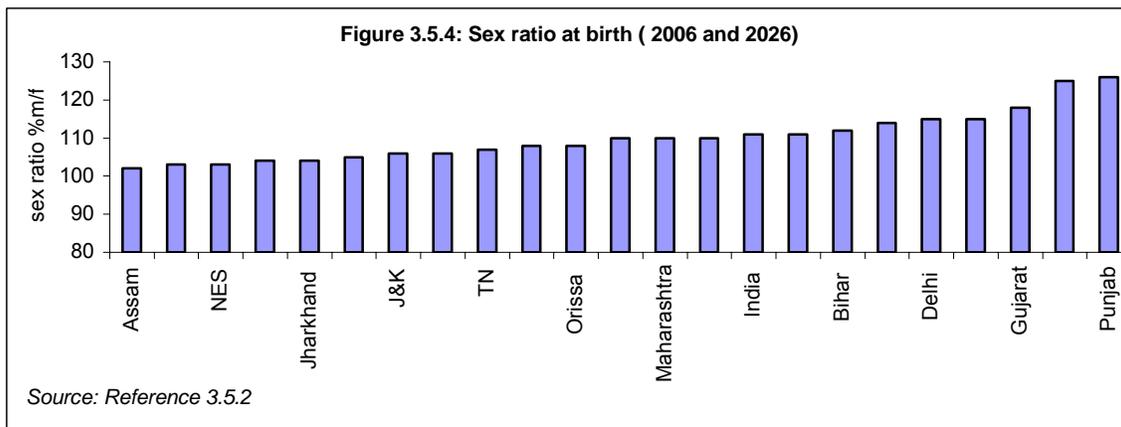
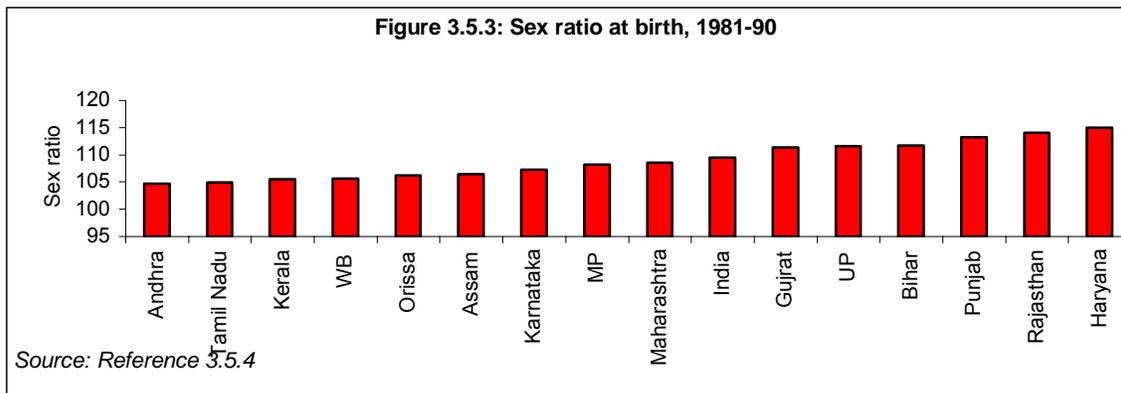
Figure 3.5.2: Projected sex ratio during 2001-2026, India and selected states



Source: Reference 3.5.2

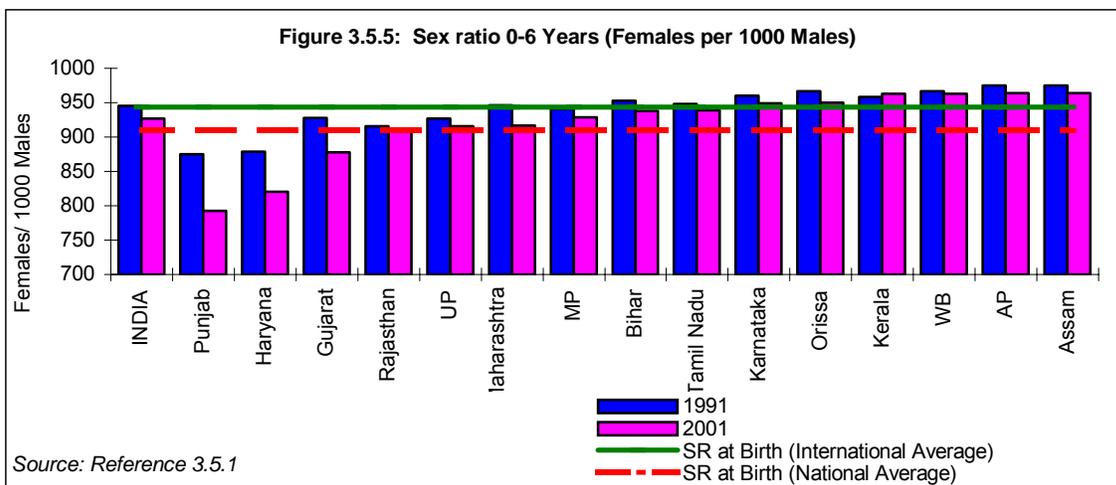
Sex ratio at birth

Computed sex ratio at birth



(defined as number of boys /100 girls) in India and different states of India in 1981-90 (Figure 3.5.3), for 2006 and 2026 (Figure 3.5.4); Sex ratio state wise in 1982,1991 and 1999 from SRS is shown in Annexure 3.5.4

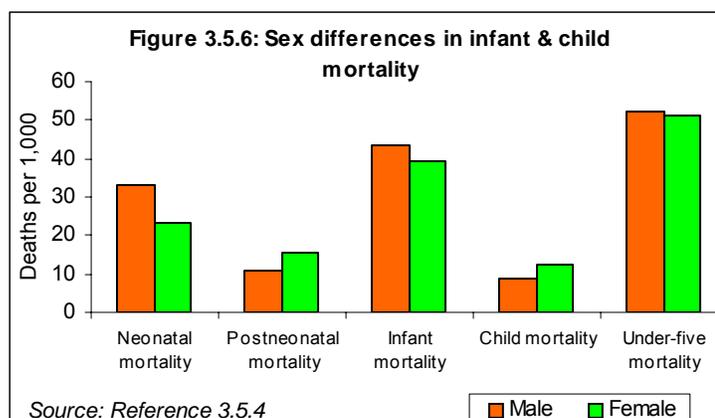
The global figures for sex ratio at birth are 106. However in India the national sex ratio at birth is 111 ratio at birth and the projections indicate that they will remain at the same level. The available data is based on sample registration and not on universal registration of births as all births are not registered in the country. There are huge interstate differences in sex ratio at birth; Assam, Northeastern states,



Andhra and West Bengal are some of the states with sex ratio lower than 106; at the other end of the spectrum are Haryana, Punjab, Gujarat, Rajasthan, Bihar and UP where sex ratio at birth are reported to be over 110. There are inter district variations in sex ratio at birth (Annexure 3.5.5). The reasons for such high variation in sex ratio at birth between states is not clear; however it is possible that in some of these states status of women is low and female foeticide or infanticide is atleast in part responsible for the observed distortion in sex ratio in these states.

Child sex ratio

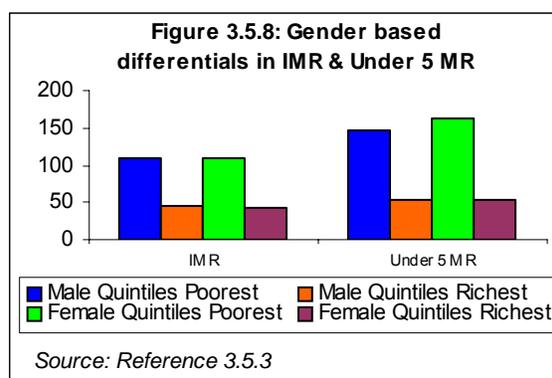
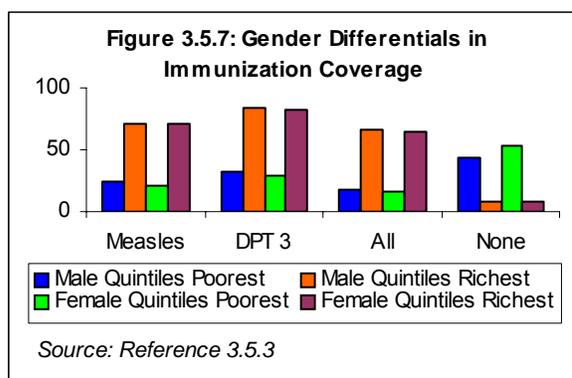
The sex ratio in the age group 0-6 years is an important indicator of the future trends of the sex composition of population in the country. Census of India, 2001 reported a child sex ratio for the country as a whole as 927 girls per thousand boys, which is lower than 945 recorded at



the 1991 Census (Annexure 3.5.6). District map of child sex ratio (urban rural and over all) from census 2001 is given in Annexures 3.5.7, 3.5.8 and 3.5.9. The child sex ratio in certain states like Himachal Pradesh, Punjab, Haryana, Gujarat and union territories of Delhi and Chandigarh are inordinately low and a cause of serious concern (Figure 3.5.5). Even within the same state there are substantial inter *tehsil* variations in child sex ratio (Annexure 3.5.10, 3.5.11 & 3.5.12). There had been speculation as to whether female infanticide, sex determination tests and selective female foeticide are, at least in part responsible for this. The Government of India has enacted a legislation banning the prenatal sex determination and selective abortion while female infanticide is a cognizable offence. However, unless there is a change in social attitudes, these legislations cannot achieve the desired change. Intensive community education efforts to combat these practices, especially in pockets from where female infanticide and foeticide have been reported, are being taken up.

Gender differences in mortality and access to services

Data from NFHS-3 regarding mortality rates in relation to gender is indicated in



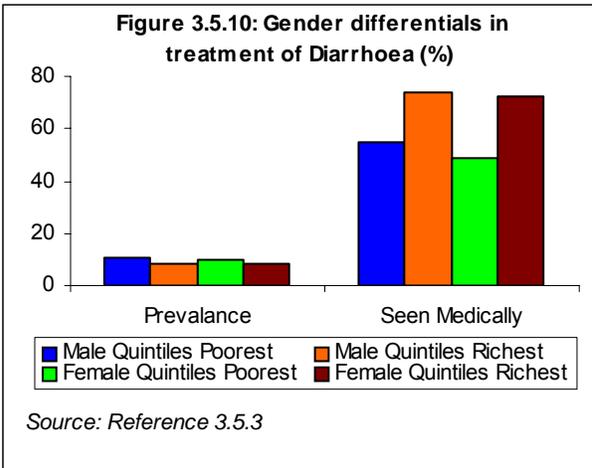
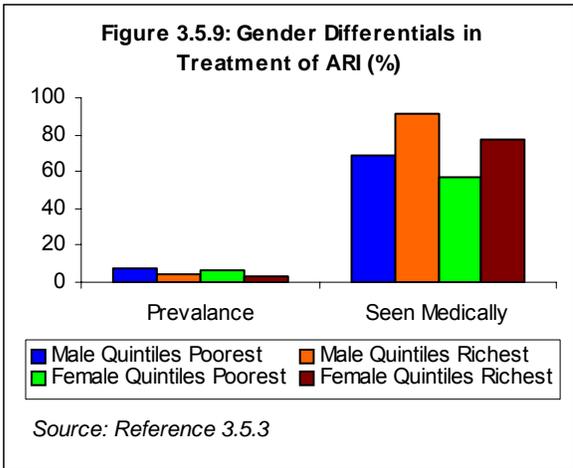
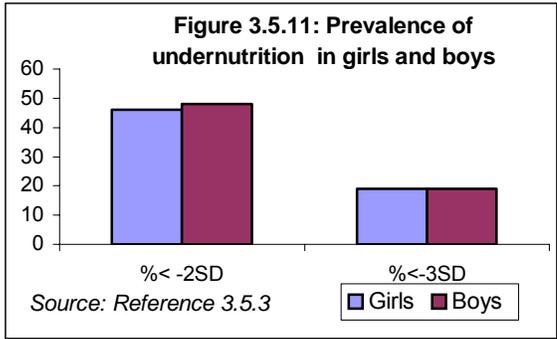
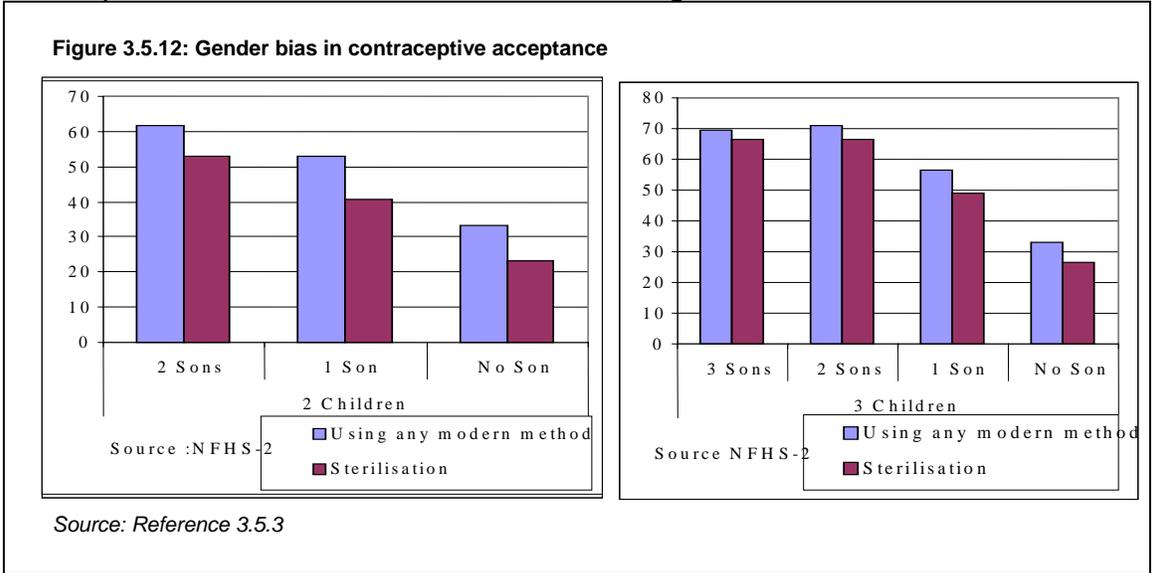


Figure 3.5.6. U5MR in girls is higher than that of the boys consistently though the difference is small. Data from NFHS indicate that the gender differential in mortality is more in the poorest quintiles. Access to prophylactic services like immunization is lower among girl from poorest quintiles. Data from NFHS2 suggest that poorer segments of population do not seek health care for sick girls as often as they would for boys (Figure 3.5.7-10).

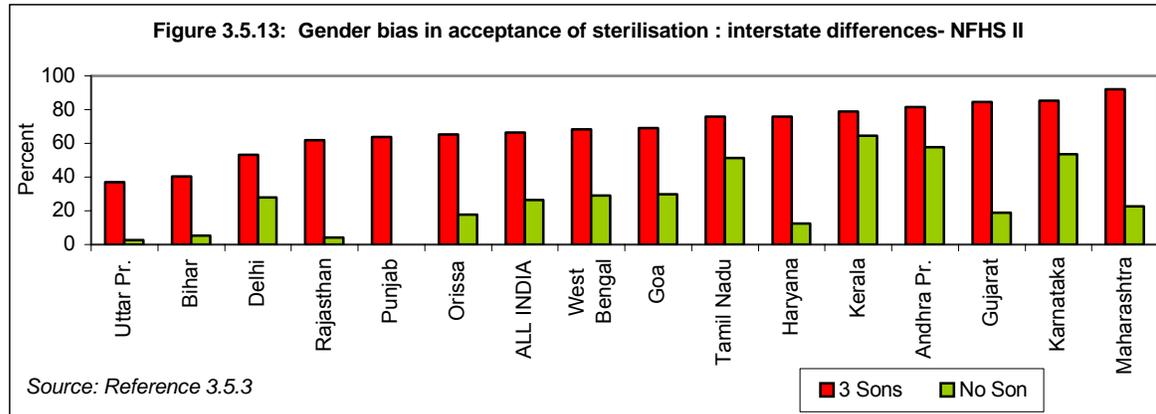


Contrary to the popular belief there is not much difference in the prevalence of under-nutrition between the girls and boys. Similar trend has been reported by NNMB for the last three decades (Figure 3.5.11).

It is important to understand whether there is gender bias in the mindset of the



population, and if so whether there are interstate differences in the bias, so that appropriate interventions for mind set and behavioral modifications can be attempted. In order to find this out, data from NFHS-2 on acceptance of contraception by families, which had two or three children, was analysed and the results are in Figures 3.5.12. It is obvious that there are huge differences in



acceptance of contraception between families with two or more sons as compared to those with no sons. This reluctance to accept terminal methods of contraception with no sons exists in all states; the magnitude of the difference in % of women undergoing sterilization with three sons and no sons is lowest in Kerala, relatively low in Karnataka, Andhra, and Tamil Nadu. The difference is very high in Punjab, Rajasthan, UP, Bihar, Haryana and Gujarat. The fact that the family does not want to accept permanent methods of contraception if they have no sons clearly indicates that they do not feel that the family is complete if they do not have a son. It is interesting that most of the states with high % differences in acceptance of contraception with no sons are also the states with adverse child sex ratio (Figure 3.5.13).

It is essential that the efforts for appropriate communications for behavioral change are taken up with utmost vigor so that the problem of gender bias with all its adverse implications can be minimized.

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