

# **The State of India's Children\***

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It has been suggested that the first question the Indian Prime Minister should ask his ministers is not “how is the economy growing?”, but rather “how are children growing?”. The ministers, however, would probably rather answer the former, for the state of Indian children is nothing short of a humanitarian emergency. Few countries, in fact, have worse indicators of child development, and progress in this field has been excruciatingly slow. This crisis casts a deep shadow on India's progress in other fields. This paper presents a brief update on this issue, with special focus on children under the age of six years.

## **1. Stumbling from the Start**

The average Indian child gets a rather poor start in life. Even before birth, he or she is heading for disaster due to poor ante-natal care and maternal undernutrition. About one third of expectant mothers in India are deprived of tetanus vaccination, an important defence against infection at birth. Similarly, about one fourth of pregnant women do not have a single ante-natal check-up, and a majority of deliveries take place without the assistance of any health professional (Table 1). Worse, the average Indian mother is frail and anaemic. This is likely to result in low birth-weight, a major cause of child undernutrition.

After birth, life continues to be precarious. About one third of all new-born babies in India weigh less than the acceptable minimum of 2.5 kilograms. Undernutrition levels keep increasing during the first two years of life, largely due to poor breastfeeding and faulty weaning. About half of all children below three years of age are undernourished, more than half are deprived of full immunization, and a large majority suffer from anaemia (Table 2). Illness is also widespread, with a fifth of all children suffering from diarrhoea and almost a third suffering from fever. A substantial proportion of Indian children (about one tenth) never reach the age of five.

As children grow up, poor nutrition and ill health affects their learning abilities and preparedness for schooling. In 1998-9, almost one third of all children in the 15-19 age group

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\* This note is based on our respective contributions to the Focus On Children Under Six (FOCUS) Report. The findings of the third National Family Health Survey (“NFHS-3”, conducted in 2005-6) are in the process of being released, and available findings have been included in this note. Where NFHS-3 results are not available, we have used the second National Family Health Survey (“NFHS-2”, conducted in 1998-9).

had failed to complete Class 5, and one half had not completed Class 8. By the time Indian children are supposed to complete upper-primary school, many of them have actually been pushed into the labour force and are further ruining their health by working long hours in harsh conditions.

In short, millions of Indian children are condemned to stumble right from the start. During the first six years of life, and especially the first two, they sink in a dreadful trap of undernutrition, ill health and poor learning abilities. This burden is very difficult to overcome in later years.

## **2. Slow Progress**

Another disturbing aspect of the situation of children in India is that the rate of improvement over time is very slow. Extreme forms of hunger and undernutrition, such as marasmus and kwashiorkor, have sharply declined over the years. But the general progress of nutrition indicators (such as the heights and weights of Indian children) is sluggish. The findings of the third National Family Health Survey (“NFHS-3”), which are in process of being released, are quite alarming in this regard. For instance, as Table 2 shows, the proportion of undernourished children, based on standard weight-for-age criteria, was virtually the same in 2005-6 as in 1998-9: in both years, nearly half of all Indian children were underweight. Even the decline of stunting in that period, from 45 per cent to 38 per cent, is far from impressive - about one percentage point per year. If the incidence of stunting continues to decline at this rate, it will take another twenty-five years or so for India to reach levels similar to those of China today.

Health-related indicators from the third National Family Health Survey are no less disturbing. For instance, they suggest that child immunization rates were much the same in 2005-6 as in 1998-9 (Table 2). The incidence of anaemia among children was also similar in both years; in fact, it was a little *higher* in 2005-6, according to the available NFHS-3 data. While some other indicators have improved, the general pace of change is excruciatingly slow – much slower, for instance, than in neighbouring Bangladesh (see below).

Similar concerns arise if we look at mortality indicators. In India as in most other countries, the infant mortality rate has steadily declined during the last fifty years or so: from about 150 per 1,000 live births in the late 1950s to 60 per 1,000 or so today. However, the decline of infant mortality slowed down significantly in the nineties, compared with earlier decades. The rate of decline seems to have picked up again during the last few years, but

nevertheless, the overall progress made since 1990 is quite limited in comparison with many other countries.

This slow progress in the field of child health and nutrition is all the more striking as the Indian economy is one of the fastest-growing in the world. During the last fifteen years, India's GDP has been growing at about 6 per cent per year on average, and per-capita income has more than doubled. Few countries have had it so good as far as economic growth is concerned. Yet the progress of child development indicators has been much slower in India than in many countries with comparable or even much lower rates of economic growth.

### **3. India and South Asia**

When India is compared with other countries, the comparison is usually made with “big” countries – say China or the United States. The focus also tends to be on relatively advanced countries, and on how India fares in comparison: whether, say, its army can withstand China's, or whether democracy is more developed in India than in the United States. Except for the occasional comparison with Pakistan, India's immediate neighbours in South Asia are usually ignored. They do not seem to be considered worthy of comparison with India, perhaps because they are too small, or because they are assumed to be relatively backward. After all, isn't India an emerging “superpower”?

Yet there is a great deal to learn from looking around us within South Asia, especially in matters of nutrition and health. Far from being “backward” in comparison with India, other South Asian countries are generally doing better than India in this field. The point is conveyed in Table 3. It is disturbing to find that India has the lowest child immunization rates in South Asia. For instance, the proportion of children without BCG vaccine in India is twice as high as in Nepal, more than five times as high as in Bangladesh, and almost thirty times as high as in Sri Lanka! Turning to child undernutrition, India emerges in a poor light again, with only Nepal doing worse. And despite its sophisticated medical system and vast army of doctors, India has not been able to achieve higher rates of child survival than any of its neighbours except Pakistan. Almost any “summary index” of these child development indicators would place India at the bottom of this list of countries.

Some aspects of this picture are relatively well known. For instance, Sri Lanka's outstanding achievements in the field of child health have been widely noted. In spite of being almost as poor as India in terms of per-capita income, Sri Lanka has an infant mortality rate of only 12 per 1,000 – less than one fifth of India's (about 62 per 1,000). Similarly, child immunization is virtually universal in Sri Lanka, in sharp contrast with India where this is still a distant goal (Table 3). What is less well known is that Sri Lanka's success in this field

is largely based on public intervention. Free and universal provision of essential services, especially in health and education, became an important feature of social policy in Sri Lanka at an early stage of development. For instance, most children in Sri Lanka have been integrated in a common schooling system of reasonable quality, under government auspices. In fact, private schools have been banned since the 1960s, up to the secondary level. Indian readers may also be surprised to hear that in Sri Lanka “few people live more than 1.4 km away from the nearest health centre” (Oxfam International, 2006). The fact that Sri Lankan children are doing so well in comparison with their Indian siblings is no accident – it reflects highly divergent levels of public commitment to the well-being of children in these two countries.

No less interesting is the contrast between Bangladesh and India. In spite of being poorer (much poorer) than India, Bangladesh has better indicators of child development in many respects, as Tables 3 and 4 illustrate. The contrast in immunization rates is particularly sharp: the proportion of children without vaccination is two to five times as high in India as in Bangladesh, depending on which vaccine one looks at. Similarly, infant and child mortality rates are significantly lower in Bangladesh than in India.

This pattern is a relatively recent development: it is during the last fifteen years or so that Bangladesh has “overtaken” India in this field. While Bangladesh had a much higher infant mortality rate than India in 1990 (91 and 80 per 1,000 live births, respectively), today the positions are reversed: 56 per 1,000 in Bangladesh compared with 62 per 1,000 in India. India has been neatly leap-frogged, that too during a period when economic growth was much faster in India than in Bangladesh.

It is also worth noting that the contrast between India and other South Asian countries would probably be even sharper if we were to focus on deprived regions or communities of each country, instead of national averages. This is because the internal inequalities are typically larger in India. Other South Asian countries tend to be less “heterogeneous”, not only in terms of regional differences but also in terms of socio-economic inequalities. It is doubtful whether any country in South Asia (other than India) has substantial pockets where children live in such dreadful conditions as, say, among the Musahars of Bihar or the Sahariyas of Madhya Pradesh. And it is worth remembering that Musahars alone represent a population of about 2.5 million – more than the entire population of Bhutan, or for that matter of 45 of the 177 countries listed in the latest Human Development Report.

In short, we would do well to take more interest in our neighbours. South Asia is a useful “lens” through which India can look at itself more realistically, tone down its

superpower aspirations and acknowledge its awful treatment of children. There are also many positive lessons to learn from the recent achievements and initiatives of other South Asian countries. As India races for higher international status, catching up with Bangladesh in matters of child development would be a good start.

#### 4. Regional Contrasts

National averages often hide major disparities between regions and socio-economic groups. This is particularly the case in a country like India, which is so large and so diverse. To illustrate, consider immunization rates, as reported in the second National Family Health Survey (1998-9).<sup>1</sup> For a child born in Tamil Nadu, the chance of being fully immunized by age one is around 90 per cent (and even higher among privileged Tamil families). But the chance of being fully immunized is only 42 per cent for the average Indian child, and drops further to 26 per cent for the average “scheduled tribe” child, and a shocking 11 per cent for the average Bihari child. When different sources of disadvantage (relating for instance to class, caste and gender) are combined, immunization rates dip to abysmally low levels. For instance, among “scheduled tribe” children in Bihar, only 4 per cent are fully immunized, and 38 per cent have not been immunized at all. Startling disparities can also be observed in terms of other aspects of child development.

The regional disparities are further explored in Table 5, also based on NFHS-2 data. The table focuses on four crucial aspects of the well-being of children: Survival, Immunization, Nutrition and Schooling (their SINS, so to speak). For each of these, a standard indicator has been chosen (other indicators could have been used, but the choice does not matter much for our purposes). Each indicator is measured in percentage terms, and can be roughly interpreted as the “probability” that an average child in the relevant state achieves a particular goal: survival until age five, full immunization, adequate nourishment, and school participation, respectively. In the last column, we present a simple “summary index” of child development, based on these four indicators. This index is not very mysterious: it is just an unweighted average of the four indicators. To stress the vital importance of the achievements reflected in this index, we call it the “Achievements of Babies and Children” (ABC) index.<sup>2</sup>

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<sup>1</sup> This survey is almost ten years old, but as mentioned earlier, immunization rates were much the same seven years later, at the time of the third National Family Health Survey (2005-6). The NFHS-2 figures are being used here because the corresponding figures from NFHS-3 are not available at the time of writing.

<sup>2</sup> We are grateful to Dr. Vandana Prasad for the inspiration behind this name and acronym.

In interpreting this index, it is useful to remember that we are focusing here on very basic achievements of Indian children, as the acronym indicates. Ideally, we would like every child (or almost every child) to survive until age five, be fully immunized, be well nourished, and go to school. In that case, the ABC index would be close to 100 per cent – full marks. As Table 5 shows, however, this ideal situation is nowhere near being realized in any Indian state, even Kerala – the trail-blazer in this field. At the bottom of the scale, the ABC index is barely 50 per cent for the states formerly known (somewhat unkindly) as “BIMARU” states – Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. Roughly speaking, this corresponds to a situation where the average child in these states achieves only half of the four elementary goals captured in Table 5.

It is not surprising to find Kerala at the top of this ranking, since Kerala is well known for its achievements in the fields of health and education, which have a long history. However, it is interesting to note that Kerala is no longer “way ahead” of all other states, as it used to be. Further, the states that are “catching up” with Kerala do not seem to be doing it on the basis of economic growth alone. If the achievements of babies and children were driven by economic success, we would expect Punjab and Haryana (India’s most prosperous states) to be ahead of other states. But in fact, Punjab and Haryana rank fourth and sixth, respectively, in terms of the ABC index. Both have been overtaken by Tamil Nadu and Himachal Pradesh, which are now quite close to Kerala as far as child development is concerned.

There is an important pointer here to the role of public action in this field. Indeed, both Tamil Nadu and Himachal Pradesh have made serious efforts to ensure that all citizens have access to basic health, nutrition and education services. In Himachal Pradesh, for instance, a “schooling revolution” of sorts has taken place during the last few decades (PROBE Team, 1999). Widely considered as an educationally “backward” state not so long ago, Himachal Pradesh has rapidly caught up with Kerala, based on active state promotion of elementary education. In 1998-9, school attendance rates in the 6-14 age group were as high as 99 and 97 per cent for boys and girls, respectively, compared with 97 per cent in both cases for Kerala. This schooling revolution, together with related social initiatives, has not only led to a dramatic increase in education levels but also paved the way for rapid advances in other fields, including health and nutrition. Himachal Pradesh’s high ABC index is one manifestation of this general pattern of accelerated social progress based on public intervention.

Similar remarks apply to Tamil Nadu. Though Tamil Nadu has not been as successful as Himachal Pradesh in the field of elementary education, it has an outstanding record of active state involvement in the provision of health and nutrition services. For instance, it was

the first state to introduce cooked mid-day meals in primary schools, way back in 1982 – almost twenty years before the Supreme Court nudged other states in the same direction. Tamil Nadu is also far ahead of most other states (with the possible exception of Kerala) in terms of the reach and quality of the Integrated Child Development Services (ICDS), the only national programme that addresses the needs of children under six. Here again, it is not an accident that Tamil children are doing relatively well, and nor is it due primarily to economic growth. Rather, it reflects active state intervention and public involvement in the field of child development.<sup>3</sup>

At the other end of the scale, the dismal levels of child development in Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh reflect a long history of public apathy towards the well-being of children in these states. In some of these states, or their “offshoots” (Chhattisgarh, Jharkhand and Uttaranchal), there have been positive signs of change in recent years. For instance, Chhattisgarh launched an innovative community health programme (the “Mitanin” programme) in 2001-2, and recent data from the Sample Registration System as well as from the third National Family Health Survey suggest that this programme may be having a significant impact on child health, as Table 6 illustrates. However, the general level of attention to children’s well-being in these states remains abysmally low.

### **Concluding Remark**

In this note, we have presented a brief update on the state of Indian children, with special focus on “children under six”. In particular, we have examined recent trends in child development indicators, how India fares in this field vis-à-vis other South Asian countries, and the comparative achievements of children in different Indian states. From these different angles, one overarching hint emerges again and again: economic growth is not a dependable means of achieving rapid improvements in child development.<sup>4</sup> The contrast between runaway economic growth and the sluggish improvement of child development indicators in recent years is particularly telling in this respect.

This point would hardly need to be made were it not for the fact that economic growth continues to be seen in influential quarters as the golden gate to human development. This outlook is evident, for instance, in the Finance Minister’s latest Budget Speech. While the speech endorsed the 11<sup>th</sup> Plan’s “declared goal” of “faster and more inclusive growth”, the fine print made it clear that “faster” was the priority. Human development is essentially treated as a by-product, and is even invoked at the end of the speech to justify the single-

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<sup>3</sup> For further discussion, see the Focus On Children Under Six (FOCUS) Report, Chapter 7.

<sup>4</sup> The international evidence presented in Haddad et al (2002) is also relevant in this context.

minded focus on faster economic growth: “Our human and gender development indices are low not because of high growth but because growth is not high enough”. This odd statement trivialises any possible dissent with the growth-centred strategy by equating such dissent with the foolish claim that India’s human development indicators are low “because of high growth”. The concluding sentence of the speech drives the last nail in the coffin of the critics by quoting Nobel Laureate Mohammad Yunus to the effect that there is “no other trick” than faster growth to achieve rapid poverty reduction.

Recent experience suggests otherwise, at least in the field of child development. This is not to say that the “other tricks” are obvious or straightforward. Putting in place effective child development services is a major challenge, which calls for sustained attention to a range of financial, logistic, administrative and political issues.<sup>5</sup> But the first step is to acknowledge the limitations of “unaimed growth” as a way of protecting children from malnutrition, ill health and premature death.

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<sup>5</sup> Some of these issues have been discussed in a series of documents prepared in the context of the preparation of the 11<sup>th</sup> Plan. See e.g. Government of India (2004, 2006a, 2006b, 2007a, 2007b, 2007c) and Gupta et al (2007); also Drèze (2006) and the studies cited there.



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**TABLE 1**  
**India: Maternal Health and Related Indicators**

	1998-99 (NFHS-2)	2005-6 (NFHS-3)
<b>Proportion (%) of mothers who had:<sup>a</sup></b>		
No tetanus immunization during pregnancy	33	n/a
No antenatal checkup	34	23
No iron or folic supplement	42	n/a
No assistance from health professional at delivery	58	52
<b>Proportion (%) of adult women with:</b>		
Anaemia	52	58
Body mass index (BMI) below 18.5	36	33

<sup>a</sup> Data pertain to births during three years preceding the survey.

Source: National Family Health Survey 1998-99 (“NFHS-2”) and National Family Health Survey 2005-6 (“NFHS-3”) data presented in International Institute for Population Sciences (2000, 2006); also available at [www.nfhsindia.org](http://www.nfhsindia.org). The figures apply to ever-married women in the age group of 15-49 years.

**TABLE 2**  
**The State of India's Children**

<b>Proportion (%) of young children with the following characteristics:</b>	<b>1998-9 (NFHS-2)</b>	<b>2005-6 (NFHS-3)</b>
<b>Low birth-weight</b>	<b>(about 30)</b>	
<b><u>Not</u> breastfed within an hour of birth</b>	<b>84</b>	<b>77</b>
<b>Undernourished<sup>a</sup></b>	<b>47</b>	<b>46</b>
<b>Stunted<sup>a</sup></b>	<b>45</b>	<b>38</b>
<b>Wasted<sup>a</sup></b>	<b>16</b>	<b>19</b>
<b>Not fully vaccinated<sup>b</sup></b>	<b>58</b>	<b>56</b>
<b>Not vaccinated at all<sup>b</sup></b>	<b>14</b>	<b>n/a</b>
<b>Birth was not preceded by any antenatal checkup</b>	<b>34</b>	<b>23</b>
<b>Suffer from anaemia</b>	<b>74</b>	<b>79</b>
<b>Suffer from the following during the last two weeks:</b>		
<b>Fever</b>	<b>30</b>	<b>n/a</b>
<b>Diarrhoea</b>	<b>19</b>	<b>n/a</b>
<b>Acute respiratory infection</b>	<b>19</b>	<b>n/a</b>

<sup>a</sup> Based on standard anthropometric indicators: weight-for-age for “undernourished”, height-for-age for “stunted”, weight-for-height for “wasted”.

<sup>b</sup> Age 12-23 months.

Source: National Family Health Survey (see Table 1). Unless stated otherwise, the reference group consists of children aged below 3 years (excluding children aged below 6 months if appropriate). For “low birth-weight”, the estimate is from Human Development Report 2006.

**TABLE 3**  
**Child Deprivation in India and South Asia, 2004**

	Bangladesh	Bhutan	India	Nepal	Pakistan	Sri Lanka
<b>Immunization</b> (% of children under 3 years who have <u>not</u> received the stated vaccine)						
BCG	5	8	<u>27</u>	15	20	1
DTP3	15	11	<u>36</u>	20	35	3
MCV	23	13	<u>44</u>	27	33	4
Pol3	15	10	30	20	<u>35</u>	3
<b>Child undernutrition</b> (% of children with the stated condition)						
Underweight	48	19	47	<u>48</u>	38	29
Stunting	43	40	46	<u>51</u>	37	14
Wasting	13	3	<u>16</u>	10	13	14
<b>Infant and child mortality</b> (per 1,000 live births)						
Infant mortality rate	56	67	62	59	<u>80</u>	12
Under-five mortality rate	77	80	85	76	<u>101</u>	14

Source: UNICEF (2006), *State of the World's Children*. In each row, the “worst” figure is underlined.

**TABLE 4**

**India and Bangladesh:  
Children's Well-being and Related Indicators, 2004**

	<b>India</b>	<b>Bangladesh</b>
<b>Infant mortality rate</b> (per 1,000 live births)	<b>62</b>	<b>56</b>
<b>Proportion (%) of one-year-olds immunized</b>		
<b>BCG</b>	<b>73</b>	<b>95</b>
<b>Measles</b>	<b>56</b>	<b>77</b>
<b>Proportion (%) of undernourished children, 1995-2003<sup>a</sup></b>		
<b>Based on weight-for-age</b>	<b>49</b>	<b>48</b>
<b>Based on height-for-age</b>	<b>45</b>	<b>43</b>
<b>Estimated maternal mortality rate, 2000</b> (per 100,000 live births)	<b>540</b>	<b>380</b>
<b>Net primary enrolment ratio (female)</b> (%)	<b>87</b>	<b>95</b>
<b>GDP per capita</b> (PPP US\$)	<b>3,139</b>	<b>1,870</b>

<sup>a</sup> Data refer to the most recent year for which estimates are available during this period.

Source: Human Development Report 2006. Unless stated otherwise, the reference year is 2004.

**TABLE 5**  
**Regional Contrasts in Child Development, 1998-9**

State	Selected Child Development Indicators <sup>a</sup>				“Achievements of Babies and Children” (ABC) index
	Survival (% of children who survive to age 5)	Immunization (% of children who are fully immunized)	Nutrition (% of children who are <i>not</i> underweight)	Schooling (% of children who attend school)	
Kerala	98.1	80	73	97	87.0
Tamil Nadu	93.7	89	63	92	84.4
Himachal P.	95.8	83	56	98	83.2
Punjab	92.8	72	71	91	81.7
Maharashtra	94.2	78	50	93	78.8
Haryana	92.3	63	65	89	77.3
Jammu &K.	92.0	57	66	84	74.8
Karnataka	93.0	60	56	80	72.3
Andhra P.	91.6	59	62	76	72.2
Gujarat	91.5	53	55	78	69.4
West Bengal	93.2	44	51	87	68.8
INDIA	90.5	42	53	79	66.1
Orissa	89.6	44	46	79	64.7
Assam	91.1	17	64	77	62.3
Uttar P. <sup>b</sup>	87.8	21	48	77	58.5
Rajasthan	88.5	17	49	76	57.6
Madhya P. <sup>b</sup>	86.2	22	45	76	57.3
Bihar <sup>b</sup>	89.5	11	46	63	52.4

<sup>a</sup> Age groups: “12-23 months” for immunization; “below 3 years” for nutrition; “6-14 years” for schooling.

<sup>b</sup> Undivided (e.g. including Jharkhand, in the case of “Bihar”).

Note: The “ABC Index” is an unweighted average of the four indicators (for further discussion, see text). States are ranked in descending order of this Index.

**Table 6**  
**Progress of Health Indicators: Chhattisgarh and India**

	Chhattisgarh			India		
	1998-9	2005-6	Change <sup>a</sup>	1998-9	2005-6	Change <sup>a</sup>
<b>POSITIVE INDICATORS</b>						
Proportion (%) of mothers who had at least 3 ante-natal care visits for their last birth	33	55	+22	44	51	+7
Proportion (%) of births assisted by health personnel	32	44	+12	42	48	+6
Proportion (%) of children below 3 years who were breastfed within an hour of birth	14	25	+11	16	23	+7
Proportion (%) of children aged 12-23 months who are fully immunized	22	49	+27	42	44	+2
Proportion (%) of children with diarrhoea in last 2 weeks who received ORS	30	42	+12	27	26	-1
<b>NEGATIVE INDICATORS</b>						
Proportion (%) of children below 3 years who are underweight	61	52	-9	47	46	-1
Infant mortality rate <sup>b</sup> (per 1,000 live births)	81 (79)	71 (60)	-10 (-19)	68 (68)	57 (58)	-11 (-10)

<sup>a</sup> Percentage points.

<sup>b</sup> In brackets, the Sample Registration System (SRS) estimates for 2000 and 2004-5, respectively (the 2004-5 is an unweighed average of the 2004 and 2005 estimates). The state of Chhattisgarh was formed in 2000, and SRS estimates for earlier years are not available.

Source: National Family Health Survey (International Institute for Population Sciences, 2000, 2006).



## Map 1

