

Rajasthan and MDGs
Status and Progress
The Half Way Mark (2007)

A snapshot

In September 2000, the world leaders representing 189 countries adopted the United Nations Millennium Declaration, calling for stronger global efforts to reduce poverty, improve health, and promote peace, human rights and environmental sustainability. The UN Secretary-General at the behest of the UN General Assembly prepared a road map for achieving the commitments made in the Declaration-resulting in the Millennium Development Goals (MDGs). The Goals reflect key aims of various UN development conferences in the 1990s. They also built on the International Development Goals created by the Organisation for Economic Co-operation and Development (OECD) in 1996. The Millennium Development Goals include all but one of the OECD International Development Goals. The Goals are now widely accepted as a framework for measuring development progress. Bilateral and multilateral institutions, including the World Bank, have made the MDGs a central focus of their development assistance.

The overall aim of the MDGs is to reverse the spread of poverty and disease by 2015. The eight goals are backed by a plan of action that sets out 18 quantifiable targets. Each target is using specified indicators. Three goals and four targets are directly related to health. The focus of the health-related Goals, as of the MDGs in general, is on poor tropic countries where 99 percent of world-wide maternal deaths occur.

Rajasthan and MDGs

Objectives

The main objectives of the report are to look into the state of progress that has been made in attaining the MDGs, thereby bringing out constraints and future concerns. Specifically it

attempts: (i) to assess and analyse the progress towards MDGs using selected indicators to judge the progress and; (ii) to identify and analyse the key indicators which require urgent policy attention.

The report relies on secondary source produced by the State Government, websites, civil society assessments and academic literature. Interaction with people is also reflected in the report. Rajasthan report reflects the current situation largely. Some data formats are not availability. The state departments also do have information that really reflects the indicators. Time was another constraint that limited the in-depth review of few variables. The literature on Rajasthan was used.

Goal 1: Eradicate Extreme Poverty and Hunger

A secure, stable and sustainable livelihood that provides employment and helps grow and live with dignity is crucial for human development. If people have secure livelihoods, then they can have access to facilities like education, health care and safe habitats. In this situation, people reduce their dependence on natural resources.

The economy of Rajasthan is primarily agriculture based and it provides livelihood to 77 percent of the rural population. The growth rate of state income has been fluctuating over the years since the formation of the state in 2000. The per capita income at 1999-2000 prices was Rs.9721 in 1999-2000 that went up to Rs.11378 in 2005-06.

The contribution of agriculture and related activities to GSDP has been fluctuating with the lowest share accruing in 2002-03 and reaching 25.2 percent in 2005-06. Industry sector has not observed major swings either way. Service sector has become the major contributor to state income in 2005-06.

State being primarily rural, 52.57 farmers are marginal and small farmers with another 39.52 percent semi-medium and medium farmers and 7.91 percent large farmers.

The rural poverty line in 2004-05 was defined as Rs.374.57 and urban as Rs.559.63 (Rs. per capita per month). Overall, the number of population below poverty line in Rajasthan in 2004-05 as per MRP consumption (mixed recall period) were 107.18 lakh or 17.5 percent. The corresponding figures for rural areas are 66.69 lakh or 14.3 percent. In urban areas, the number of poor people are 40.50 lakh or 28.1 percent. Rural poverty situation is significantly better than urban poverty.

The number of population below poverty line in Rajasthan in 2004-05 as per the URP consumption (uniform recall period consumption) were 134.89 lakh or 22.1 percent. The corresponding figures for rural areas are 87.38 lakh or 18.7 percent. In urban areas, the number of poor people are 47.51 lakh or 32.9 percent. Rural poverty situation is significantly better than urban poverty.

The monthly per capita expenditure of 26.5 percent in rural Rajasthan is below Rs.410 and only 9.5 percent have MPCE of Rs.890 or more. On the other hand, in urban Rajasthan, the corresponding proportions are 46.0 percent and 7.4 percent. It is observed that only 3.4 percent in rural Rajasthan have MPCE of Rs.270 or less while this percentage is 10.4 in urban Rajasthan. This would reflect in nutrition intake of the urban population.

As per the NSSO survey on level and pattern of consumer expenditure for the year 2004-2005 reports that 17 percent of villagers were living below the MPCE level of Rs.365 or Rs.12 per day and 3 percent are living below the MPCE of Rs.270 or Rs.9 per day. In urban areas, 36 percent of urban dwellers live below the MPCE of Rs.580 or Rs.19 per day and 10 percent live below the MPCE of Rs.395 or Rs.13 per day.

Almost 95.7 percent villagers and 95.9 percent urban dwellers live on Rs.38.50 per day that is less than a dollar a day. The average MPCE in rural areas is Rs.590.83 with a Lorenz ratio of 0.248 while urban MPCE is Rs.964.02 with Lorenz ratio of 0.367.

In rural Rajasthan, the percentage of households where all the members got enough food everyday throughout the year improved from 98.5 percent to 99.7 percent during the period from 1993 to 2000.

In urban Rajasthan, the percentage of households where all the members got enough food everyday throughout the year marginally improved from 99.2 percent to 99.8 percent during the period from 1993 to 2000.

Overall, the perception of the people in Rajasthan in 1999-2000 was that they were generally getting enough food everyday throughout the year, in both rural and urban areas.

The NFHS-2 reported that in 1998-99, 36.1 percent of ever married women were with Body Mass Index (BMI) of below normal and this percentage did go down to 33.6 percent, which is still high by 2005-2006 (NFHS-3). The rural situation (36.5%) is worse than urban situation (25.6%).

Among women, as per the NFHS-3, education plays an important role in improving the nutritional status. 35.5 percent of women having BMI of below normal had no education as against 18.9 percent women with 10 years complete or above education. The impact of education is visible only after 8-9 years of education.

In case of men, as per the NFHS- 3, 33.8 percent ever married men had BMI of below normal; rural 38.6 percent and urban 22.8 percent. Education is important here too. 39.1 percent of men having BMI of below normal had no education as against 18.9 percent men with 10 years complete or above education. Only 7.1 percent ever-married women were over-weight or obese. The deterioration is observed in this indicator as per the NFHS-3.

Obesity is mainly an urban problem- 22.1 percent compared to only 5.8 percent rural area. In case of men, 8.4 percent were over-weight or obese. The regional proportions were 19.3 percent urban and 3.7 percent rural.

Higher the education higher is the chance of obesity in both rural and urban areas and more so among women- 25.4 percent women and 18.7 percent men with 10 years complete or above education are obese compared to 7.4 and 3.0 percent with no education.

Goal 2: Achieve universal primary education

This goal calls for universal primary education by 2015 children everywhere, boys and girls alike, to be able to complete a full course of primary schooling. The suggested indicators are net enrolment ratio in primary education, proportion of pupils starting grade 1 who reach grade 5, and literacy rate of 15-24 years olds.

In 2005-06 as per the state government education department there were 34751 pre-primary/ primary schools, 28414 upper primary schools and 10144 secondary/ senior secondary schools. In 2005 as per the DISE data there were 61545 primary only schools, 26507 primary with upper primary schools, 4237 primary with upper primary and secondary/ higher secondary schools, 608 upper primary schools, 4307 upper primary with secondary/ higher secondary schools. In all there were 97204 schools.

Rajasthan had 10176 upper primary schools in 1993 and this number increased to 23181, a 127.8 percent improvement. The increase in rural upper primary schools has been significant compared to urban schools. This number increase is due primarily to up-gradation of primary schools in upper primary schools. The fillip is more in rural areas. Here, *Sarva Shiksha Abhiyan* (SSA) is quite sizeable. The number of rural upper primary schools is much higher than urban upper primary schools. The increase in secondary schools in urban areas has been greater than rural areas. The reverse is the situation in case of senior secondary schools. All this indicates that rural schools have spread in Rajasthan during this period and this should reflect in children going to schools.

In 2005-06, in Rajasthan, there were 13.57 lakh boys and 12.21 lakh girls enrolled in class I giving a gender ratio of 0.90. One observed continuous decline in enrolment from class I onwards till class VIII in case of both boys and girls but decline is sharper for girls. This affects

the gender ratio. From a gender ratio of 0.91 in class II, the gender ratio falls to 0.57 in class VIII. This means that gender differences widens as one move towards the high schooling. Table also shows that the gender ratio falls significantly in case of scheduled caste category of students and also in case of scheduled tribe students. The general category students have a high gender ratio of 0.72 in class VIII compared to 0.50 and 0.52 in case of scheduled caste and scheduled tribe students respectively. This should be a cause of concern to all.

In rural Rajasthan, 69.6 percent of children aged 3-5 are either in *Anganwadi* or school and this percentage varies between 90.0 percent in Ganganagar and 55.3 percent in Sikar district in 2006. With regards to children aged 6-14 years, 10.9 percent are out of school and 25.2 percent are in private schools. The percentage of out of school children is the highest in Bikaner (25.6%) and lowest proportion in Hanumangarh (3.8%). There are 14 districts (of 31) where proportion of out of school children is higher than the state average. Privatisation of schooling appears to be significant in quite a few districts meaning that 18 districts (of 31 districts) have 20 or more percent children are in private schools (highest percentage being in Jhunjhunu-45.6%), and 25 districts have 10 or more percent of children in private schools in rural Rajasthan. Only Jaisalmer district has 2.0 percent children in private schools.

What are children's achievements? 54.4 percent children of class 1-2 can read and 47.8 percent can recognise numbers or more. There are wide inter-district variations. In case of children in class 3-5 who can read class 1 text or more, the percentage is 63.0 and those who can do subtraction or more, the percentage is 63.0 too. There are quite a few districts where the proportion of children performing these tasks is below the state proportion. Overall, the performance is not good. This is the result of teacher absenteeism, irregular class attendance, poor teaching aids and quality of teachers, high teacher pupil ratio, etc.

On the learning achievements, there is high percentage of children who cannot read. 36.5 percent of children cannot read level 1 (ability to read a small paragraph with short sentences of std 1 level difficulty) and 51.4 percent children cannot read level 2 (ability to read a story text with some long sentences of std 2 level difficulty) in age group of 7-14. ASER 2005 finds that

performance in private schools is relatively better, compared to government schools in rural Rajasthan in case of reading and solving written numerical sums.

Performance of top five and bottom five districts in Rajasthan based on percentage of all children in Standard V who cannot read level 2 are:

	Top 5		Bottom 5
Churu	19.8%	Sirohi	77.8%
Barmer	20.2%	Dungarpur	61.3%
Sikar	21.2%	Ajmer	58.2%
Jalore	26.7%	Jhalawar	57.1%
Ganganagar	27.9%	Jaipur	54.6%

Source: ASER 2005.

The Seventh All India Educational Survey on Rajasthan reports a drop- out rate that varies between 10-15 percent and repetition rate varying between 10-15 percent (average 10.86%). All this is despite *Sarva Siksha Abhiyan* (SSA) programme in place and other innovative schemes being implemented. Rajasthan has repetition rate (cohort 2003-04) of 20.25 percent in class I, 14.14 percent in class II, 7.94 percent class III, 4.21 percent in class IV, 3.08 percent in class V and 9.28 percent in class VI. The average rate for all these classes is 11.93. This means that without improving promotion rate in class I efforts being made through SSA initiatives in attaining goal of universal primary enrolment is not likely to be realised.

In class I roughly 52 percent of boys and 48 percent girls get promoted. The repetition rate of girls, however, continuously declines after class I, but significantly after class V. The promotion rate of boys goes down significantly in the upper primary school where girls perform much better. The major reasons for repetition are long absenteeism, failures, and re-admissions. The drop out rates in Rajasthan at primary level is the highest in class I (24.97%) and followed by class V (15.6%), class II (12.03%), class III (10.21%) and class IV (4.74%).

On survival rate, about 50.85 children (boys and girls in both rural and urban areas) out of 100 reached class V in 2005. More boys (55.28) survived up to class V compared to their girl counterparts (45.9). The gap is not much. Only 27.86 children out of 100 reached class VIII in

2005 and this number was 34.2 for boys and 20.79 for girls. Here the gap is more than that was in class V.

In Rajasthan, never enrolled children in schools are 5.9 percent in age group of 6-14 years and the dropout percentage is 4.5. It is as high as 12.5 percent for girls aged 11-14 years. The dropout rate is higher among girls in 11-14 age groups (ASER 2005).

In Rajasthan, the number of schools marginally increased from 73061 in 2002-03 to 73708 in 2003-04, and further to 74719 in 2004-05. The number of students covered improved from 7177718 in 2002-03 to 7678153 in 2003-04 and fell to 7662192 in 2004-05. It is found that coverage of scheduled caste students has gone down in 2004-05 from the previous years, though increased coverage of scheduled tribe students is observed. Some of the problems cited in case of this scheme are deficiencies in terms of nutritional content of the food served to children, difficulties in implementing the programme in those schools, which are served by one or two teachers. This is coupled by caste prejudices. However all is not well with mid-day meal scheme. There are complaints of corruption, poor quality grains being used and food cooked in unhygienic conditions.

Goal 3: Promote Gender Equality and Empower Women

This goal calls for elimination of gender disparity in primary and secondary education by 2005 and in all levels of education no later than 2015. The suggested indicators are ratio of girls to boys in primary, secondary and tertiary education, ratio of literate women to men aged 15-24 years, share of women in wage employment in the non-agricultural sector, and proportion of seats held by women in national parliament (local levels).

Overall literacy rates in 2001 were 76.20 percent and male literacy rates were higher at 86.45 percent compared to female literacy rate of 64.67 percent. Gender differences have reduced, but still significant across districts. The female literacy rates have improved tremendously during the decade of nineties. Dholpur, Jalore and Rajsamand districts have observed widening gender differences, however.

The largest category facing discrimination, though they can scarcely be considered a 'group' since they constitute half the population, are women. Females even from birth can be excluded from health services in countries/ regions that show a strong preference for sons.

The situation in Rajasthan reveals that women constitute 47.96 percent of total population. In rural areas, the female population was 48.21 percent and it was lower at 47.09 percent in urban areas. Women constituted 67 percent of all women workers are cultivators in Rajasthan in 2001. The share of women in other economic activities is: 16.19 percent agricultural labourers, 2.85 percent household industry and 13.96 percent other workers. This shows that women are concentrated in agriculture and allied activities only (83.19%). Thus, it is still a long way before gender parity in the labour is achieved.

It may also be noted that in many activities women's work is not considered as a work. At the district level, it is observed that the highest percent of female workers in agriculture and allied activities is in Banswara (93.01%) and the least is proportion is recorded in Dholpur at 44.77 percent. In 18 of the 32 districts the percentage of female workers in agriculture and allied activities is higher than the state average, which means that in 18 districts women in agriculture and allied activities constitute more than 83 percent.

With regards to work participation rate, in 2001, the average male work participation rate was 49.95 compared to 33.49 percent for females. There are wide variations in female work participation rate across districts. The maximum rate was observed in Chittorgarh (46.23) and the lowest in Kota (19.41).

Crime rate in Rajasthan as per NHRC annual reports are: 16689 in 2003, 17486 in 2004 and 14964 in 2005. Crime against women accounted for 8.62 percent of total IPC crimes. On an average, 3 women are raped and 4 murders are committed daily. In comparison to 2003 in 2004, there was an increase of 1368 cases of crime against women. Although there was a decrease in cases of dowry deaths and rapes but all other crimes increased.

The violent crime includes rapes, murders, culpable homicides and dowry deaths. Women are often beaten up and murdered. Harassment is on an increase though rape cases are fewer now. Many do not get reported also.

NFHS-2 (1998-99) found that in Rajasthan there is widespread acceptance among ever-married women that the beating of wives by husbands is justified under some circumstances. Almost half the ever-married women (51%) accept at least one of six reasons as a justification for a husband beating his wife. 10.9 percent of ever-married women in Rajasthan have experienced beating or physical mistreatment since age 15, and 12.3 percent experienced such violence in the last 12 months preceding the survey.

Most of these women have been beaten or physically mistreated by their husbands. The battering is more in families with low standard of living index (14.9% low status; 11.3% medium status; and 6.8% high status). It is irrespective of whether the women had children or not (the proportion of wife battering is more in case of only daughters in the family), no religious or caste or regional differences, but recently married are experiencing less this situation.

Education helps in reducing incidence of violence against ever-married women as NFHS-2 reports that only 4.6 percent affirmed wife beating who are high school complete and above as against 12.1 percent of illiterate women. Family violence is more committed by the husband on his wife than in-laws or other persons. The incidence of wife beating is relative more in case of nuclear families.

NFHS-3 reports for the year 2005-2006, 46.3 percent of ever-married women experienced spousal violence. It was relatively less in urban areas (45.5% women reporting) compared to rural areas (46.6% women reporting). Further, NFHS-3 reports that only 20.7 percent affirmed wife beating who are high school complete and above as against 50.4 percent of illiterate women. This indicates that woman's education help in reducing spousal violence. NFHS-2 does report higher incidence of wife beating among scheduled tribes followed by scheduled castes, OBC and others. Rich women experience less spousal violence. Those who are working for cash experience more violence.

The issue of gender representation have been centre stage since the *Panchayati Raj* institutions and urban local bodies were given constitutional protection of one-third representation to women under the 73rd and the 74th amendments to the constitution. There are 41722 women office bearers and members of the *Panchayati Raj* bodies as on 1.4.2004 in Rajasthan and majority were *Gram Panchayat* members (39450 or 94.6%) followed by 1908 (4.6%) intermediate *Panchayat* members and 364 (0.8%) district *Panchayat* members.

The women representation in the *Lok Sabha* is three and three in *Rajya Sabha* from Rajasthan.

Women's traditional in Indian society had limited role in household decision making. Education and socio-economic status of the family does make difference in involvement of women in decision-making. There, there are rural-urban differences. As per NFHS-2 data for the year 1998-99 reveals that 13.3 percent of ever-married women aged 15 plus reported no involvement in any decision-making at home.

Younger women (29.1% aged 15-19), urban located (12.4%), high school plus educated (12.6%), Hindu (13.1%) and high status (15.9%) were never involved in decision-making compared to other categories. And what are these issues/activities where ever-married women are involved in decision-making- what to cook (66.3%), own health care (16.5%), purchasing of jewellery (6.1%) and staying with her parents/ siblings (8.4%). In all this more years the women is married greater is her involvement as she is further into her cycle- young wife, mother or may be mother-in law).

Women's earning capacity also furthers the cause of participation in decision-making. The corresponding proportions in rural areas are: what to cook (61.1%), own health care (23.4%), purchasing of jewellery (9.8%) and staying with her parents/ siblings (12.9%). In urban areas the percentages were: what to cook (67.9%), own health care (14.3%), purchasing of jewellery (5.0%) and staying with her parents/ siblings (7.0%).

On the question as to how the money she earns will be used, 42.8 percent responded that they make the decision: 60.5 percent rural and 35.7 percent urban. This gives a fairly good idea on involvement in decision making of married women.

As per the NFHS-3 for 2005-2006, 40.2 percent women usually participate in household decisions. This proportion is lower in rural areas compared to urban areas and more among high school plus educated. Education and economic capacity do play a positive role.

Goal 4: Reduce Child Mortality

This goal target reducing under-five infant and child mortality rates by two-thirds between 1990 and 2015. The suggested indicators are under-five mortality rate, infant mortality rate and proportion of one year-old children, immunised against measles. State has major role to play in tackling infant mortality. The evidence is that if the state is broken, the market does not solve the problem.

In 2004, percentage of infant deaths to total deaths in Rajasthan was 27.8 and the rural percentage was 31.2 compared with urban percentage of 16.0. Also the infant mortality rate (infants deaths in less than one year) in 2004 was 67 and varied from 74 in rural areas to 42 in urban areas. The gender dimension is that in 2004, 66 male infants died compared with 69 female infants. A similar trend is visible in both rural and urban areas though infant mortality is much higher in rural areas of both male and female infants.

Sample Registration System data shows that in 1992-94, the average infant mortality rate was 85.3 that came down to 73.3 in 2002-04. In rural areas the decline during the period was from 89.7 to 77.7 compared with decline from 60.3 to 50.0 in urban areas.

Percent of deaths to children below age five to total deaths in Rajasthan as per SRS 2004 was 35.2 (India 24.4) and it varied from 38.6 in rural Rajasthan (India 26.5) to 23.2 in urban Rajasthan (India 16.5). This situation is only better than Madhya Pradesh among all major states.

The death rates for children below age 5 were estimated at 21.0 (India 17.0) in Rajasthan in 2004 that is fairly high. The male children have slightly lower death rates of 20.8 (India 16.6)

compared with female children deaths of 21.3 (India 17.5). In rural Rajasthan, the rate is 23.1 across the board (4th highest amongst all states) when at the national level the estimates are 19.1. The male children deaths were 18.7 and 19.6 respectively at the national level when the corresponding rates were 22.2 and 24.1 respectively in Rajasthan. The urban Rajasthan rates are almost half that of rural rates (13.8, 15.7 and 11.7 total, male and female respectively). Here again, the rates at all India level are lower than that for Rajasthan (10.1, 9.8 and 10.5 total, male and female respectively). This means Rajasthan still has to traverse a long way to fulfil the MDG on infant mortality and more so in rural areas. The health and population policies have apparently little impact in Rajasthan.

In 1998-99, number of infant deaths per 1000 live births declined from 97 during 1984-88 to 80 during 1994-98. The rural infant mortality rate declined from 102 during 1984-88 to 83 during 1994-98, a decline of 19 percent while the urban infant mortality rate declined by 12 percent from 82 to 70 during the same period.

All indicators except post neonatal and infant mortality rates have declined 15 years prior 1998-99. But no significant change occurred between 1992-93 and 1998-99. The infant mortality rate of 80 for the period 0-4 years before 1998-99 increased from the infant mortality rate of 73, 0-4 years before 1992-93. The under-five mortality rate of 114.9 for the period 0-4 before NFHS-2 (1998-99) is somewhat lower than the under-five mortality rate of 13134.5 the period 0-4 years before 1992-93. Rural areas lag far behind in any improvement that has occurred over time.

Overall, it is clear that infant and child mortality in Rajasthan remains high. With 1 in every 12 children born during the five years before NFHS- 2 dying within the first year of life, and 1 in every 9 children dying before reaching age five, it is clear that child survival programmes in Rajasthan require intensification. State has major role to play in tackling infant mortality. State has major role to play in tackling infant mortality. The evidence is that if the state is broken, the market does not solve the problem. The remoteness of habitations further complicated the situation. It is the poor who suffer the most by private service failures.

The infant and under- five mortality rates are higher in rural areas compared with urban areas. It is also significant in South- Eastern region of Rajasthan.

In case of educated mothers, the infant and under-five mortality rates are lower compared with illiterate mothers. Hindu children have higher infant and under-five mortality rates as against Muslim children.

Scheduled tribe children have the highest under-five mortality rate among all social groups. So is the case with children in low-income status families, having higher infant and under-five mortality rates. Child survival programmes might usefully focus on specific groups of children with particularly high infant and child mortality rates, such children belong to the scheduled tribes and castes, whose mothers are illiterate, children living in rural areas, and children from households with a low to medium standard of living.

Reduce Child Malnutrition by Two-thirds during 1990-2015

Nutrition of the child is important for his survival and for this mother's health also has to be good.

Although breastfeeding is universal in Rajasthan, most children do not begin breastfeeding immediately after birth (13.3% in the first hour after birth).

As per NFHS-2 in 1998-99, 51 percent of children under age three years in Rajasthan are underweight (too thin for age), 52 percent are stunted (too short for age), 12 percent are wasted (too thin for height). In the year 2005-2006 (NFHS-3), the corresponding percentages are 44, 34 and 20 percent are underweight, stunted and wasted respectively. This shows an improvement in nutritional level in 2005-2006 over 1998-99.

The most important indicator influencing child's nutrition status is mother's body mass index. In Rajasthan, female children are much more likely to be under nourished than male children according to all three measures. Children of under nourished mothers and children born less than

two years after a previous birth are also more likely than other children to be under nourished according to most indicators.

Children from families with low standard of living, belonging to scheduled castes or tribes and having illiterate mothers are more likely to be under nourished.

82.3 percent children age 6-35 months were anaemic in 1998-99 and this proportion improved to 79.6 percent in 2005-2006. Female children are slightly more likely to be anaemic. The anaemic tendencies are more among rural children, but proportion is also high. Also illiterate mothers are more likely to have anaemic children compared more educated mothers.

The tendency to being anaemic child reduces with improvement in household standard of living, though the differences are not much. Children of anaemic mothers are more likely to be anaemic themselves than are other children.

Immunisation of children is an important component of child survival programmes in India. In Rajasthan, 17.3 percent of children age 12-23 months are fully vaccinated as per NFHS-2 down from 21.1 percent as per the NFHS-1 and this, however, proportion improved to 26.5 percent in 2005-2006 (NFHS-3). The improvement in full vaccination in rural is from 11.0 percent to 22.1 percent during the same period while the improvement in urban areas is from 27.4 to 44.3 percent. This status is result of limited reach of the measles vaccine and the third dose of the DPT vaccine.

Only 27.1 percent of children age 12-23 months received measles vaccine in 1998-99 and in 2005-2006 the percentage was 42.7 percent, a much-improved situation. 26.1 percent children age 12-23 received DPT vaccinations in 1998-99 and the proportion went up to 38.7 percent in 2005-2006.

The effect of Pulse Polio Immunisation Campaign is somewhat visible. In 1998-99, only 44.6 percent children age 12-23 had got three doses of polio vaccine, but in 2005-2006 the percentage

went up to 65.2 percent. This is far from what is targeted. However, urban coverage is better compared to rural coverage. Thus, stress is required for greater rural coverage in a mission mode.

Child under five years should receive oral doses of vitamin A every six months starting at age nine months. Only 13.2 percent of children aged 12-35 months have received any vitamin A supplementation in 2005-06 in the six months preceding the survey.

In 2005-2006, only 11.7 percent rural children received a dose of vitamin A in the six months preceding the survey and urban areas performed better than rural areas with 19.0 percent children receiving the dose of vitamin A.

As per NFHS-2, 26.0 percent of children under age three were ill with fever during two weeks preceding the survey and 61.0 percent children who were ill with acute respiratory infection (ARI) were taken to a health facility. This proportion was 68.9 percent in 2005-2006. It could mean that health facility availability has improved over the period or more children were affected by ARI.

In 1998-99, 58.2 percent of children who were taken ill with diarrhoea in the last two weeks were taken to a health facility and this percentage was 56.6 in 2005-2006. Rural areas still suffer from lack of facilities as the numbers show.

Goal 5: Improving Maternal Health

This goal aims at reducing maternal mortality ratio by three-quarters between 1990- 2015 and the suggested indicators are maternal mortality ratio and proportion of births attended by skilled health personnel.

NFHS-2 shows that mothers in Rajasthan received antenatal check-ups for only 47.5 percent births during the three years preceding the survey (1998-99), up from 32 percent in 1992-93 (NFHS-1). Mothers received antenatal check-ups from doctors for 27 percent births, from other health professionals (ANM/ nurses/midwives/ LHVs and others) for 12 percent births, and check-ups exclusively at home from a health worker for 9 percent of births.

The likelihood that mothers received antenatal check-ups does vary by age but does go down steadily with birth-order. By caste/ tribe, the likelihood of having received any antenatal check-up, as well as the likelihood of having received an antenatal check-up from a doctor, are lowest for births to scheduled caste mothers and the highest for births to mothers who do not belong to a scheduled caste, scheduled tribe or an other backward class. The status of household in a society appears to be vital.

Rural women use antenatal services less than urban women may be because they are engaged in low paid jobs and taking leave affects their income. The economic status of the household also determines utilisation of ANC services. It is invariably illiterate poor young women who do not register for antenatal care and also had three or more children.

Among births to mothers living in households with a low standard of living, 35 percent received antenatal check-ups and 15.4 percent received antenatal check-ups from doctors. By comparison, among births to mothers living in households with a high standard of living, 74 percent received antenatal check-ups and 54 percent received check-ups from doctors.

Education of the mother is an important social variable that has positive bearing on utilisation of maternal and child services. The proportion of pregnant mothers receiving antenatal check-up increases sharply with mother's education and that too from a doctor. 19 percent of births to illiterate mothers received antenatal check-ups from a doctor compared to 80 percent births to mothers who have at least completed high school. Conversely, the percentage of births for which mothers received home visits only from a health worker declines with mother's education from 10 percent for births to illiterate mothers to 0.4 percent for births to mothers who have completed at least high school.

Muslim mothers received an antenatal check-up for 54 percent of births compared to Hindu mothers who received an antenatal check-up for 46 percent of births. In brief, women in Rajasthan did not receive an antenatal check-up for almost half the births in the three years preceding the survey (1998-99).

Women not receiving antenatal check-ups tend disproportionately to be women of high parity, women from scheduled castes and tribes, illiterate women, women from the western region and poor women.

Evidence also exist that women undergoing six plus delivery utilised antenatal care the least. Awareness regarding antenatal care and the need for trained birth assistance is greater among women with educated spouses.

Access to health care facilities in terms of distance and who provided health care also influence utilisation of services. This suggests improving the coverage of antenatal programmes requires special efforts to reach high-parity women and women who are socio-economically disadvantaged and also young.

As per the SRS report 2004, 17.3 percent of live births received medical attention at time of delivery in government hospitals and the proportion was 38.9 percent in urban areas compared to 11.7 percent in rural areas. Another 5.6 percent live births received medical attention in private hospitals at time of delivery with urban proportion being 10.8 percent and rural only 4.3 percent. Qualified professionals providing medical attention to mothers at the time of delivery for was 28.2 percent and 31.6 percent in urban areas and 27.3 percent in rural areas. The concern is that untrained functionaries handle still 48.9 percent mothers at the time of delivery of live births. The rural proportion is higher at 56.7 percent compared with much lower proportion of 18.7 percent in urban areas. This data says that there is no excuse for not having a government hospital service and trained professionals in rural areas.

Reduction of maternal mortality is an important MDG. In Rajasthan, the information provided by NFHS-2 (1998-99) show that 52 percent of births received two doses of TT injections, while 39 percent received IFA tablets/syrup. The utilisation of ANC services for the last birth in Rajasthan is 47 percent and this relatively inadequate utilisation is attributed to inadequate outreach services.

38.5 percent women did not receive prenatal care from anyone and 10 percent did receive it at home from health workers while another 37 percent received it from a doctor. Those who did not receive antenatal check-ups at home or at health facility did not consider it necessary are 69 percent. Costs account for 6.4 percent of cases and distance and lack of transport account for 3.5

percent of cases that did not avail the antenatal check-ups while 8 percent cited reasons as customary or family did not allow. The results also reveal that urban women are more likely than rural women to say that antenatal check-ups were not necessary or customary, and rural women were more likely than urban women to cite costs, transport, or distance as reasons. These results reinforce the fact those women and their families' needs to be informed about the benefits of ANC services. As about one-fourth of the reasons reported deal with problems of accessibility, quality, and cost of services, utilisation of antenatal care services could also be increased by lowering direct and indirect costs, improving quality and making services more accessible.

53 percent women did not receive any antenatal check-up in Rajasthan. It is also reported that 19 percent of women in Rajasthan received first antenatal check-up in the first trimester of pregnancy and 16 percent during second trimester and 12 percent during third trimester. The first antenatal check-up should take place at the latest during the second trimester of pregnancy.

Check-ups during first trimester were much more common in urban areas (40%) than in rural areas (14%). So the effort should be to see that more women receive first antenatal check-ups in first trimester. It is also necessary because the effectiveness of antenatal check-ups in ensuring safe motherhood depends largely on tests and advises received during the check-ups.

As per the NFHS-2, 61 percent women had abdominal examination, 45 percent had their blood pressure checked up, 51 percent had their blood tests and 43 percent urine tests conducted while only 17 percent had internal examination and 10 percent had height measurement done. The type of advice received for the last birth showed that dietary advice was given more often than other advice. 21 percent women received advice on the danger signs of pregnancy. Similar is the proportion is in case of advice on delivery care, new born care of family planning. In India, it is mandatory that a pregnant woman should receive two doses of tetanus toxoid injections. In Rajasthan, coverage of TT is less than the antenatal check-ups.

Place of residence is an important indicator of accessibility as health institutions/ facilities are located more in urban areas than rural areas. Cultural taboos in rural areas coupled with lack of

knowledge among pregnant mothers are also the reasons for low utilisation of ANC. In Rajasthan, urban women have more ANC check-ups compared to their rural counterparts.

More women belong to other caste have gone for more number of ANC check-ups than their scheduled castes and tribes counterparts. Women from lower economic strata went for less than three ANC check-ups compared with women from higher economic strata. ANC check-ups are more among younger women *vis-à-vis* older women.

In Rajasthan, non-working women are more likely to go for ANC check-ups than working-women. Also literate women go in for more ANC check-ups than the illiterate women and so is the case with those women who are exposed to media.

Education of the spouse is also important as in Rajasthan, women with more educated husbands are more likely to have more number of ANC check-ups compared to illiterate husbands. This is also natural as educated husband must be engaged in better job, so higher income and so could afford visits to a medical institution. This situation also happens with nucleation of family structure more, where the role of the spouse in decision-making for pre-natal care becomes important. The birth order is negatively associated with number antenatal check-ups. Women with lower birth order seem to go for three or more ANC check-ups than women with higher order of birth. This could be because of perceived complication at birth being more at lower birth order compared with higher birth order.

NFHS-2 reported that only 8.7 percent women reported spacing as unmet need for family planning and this percentage was 7.3 percent in NFHS-3. The corresponding percentages for limiting were 8.9 and 7.4 percent respectively. There is still need for strengthening outreach services to reduce fertility which 3.21 in 2005-2006, though slightly lower from 3.78 in 1998-99. It would also help reduction in mortality between mother and children.

Goal 6: Combat HIV/AIDS, malaria and other diseases

Delivery care is important for reducing maternal mortality rate. NFHS-2 reports that in Rajasthan, 21.5 percent births took place in health facilities (12% in NFHS-1), a figure much lower than the national level (34%). This percentage rose to 32.2 percent in 2005-06. Also, more deliveries take place in the care of health professional in urban areas (77.0%) in comparison with rural areas (34.6%) as per the NFHS-3.

As per the NFHS-2, utilisation of hospitals or health professionals is greater among women from other caste (27.9% from other caste and 14.2% from SC and 15.8% from ST). 45.6 percent women from higher economic strata utilised hospital services or assistance of health professional during delivery than 11.3 percent women from lower economic strata. 23.5 percent women in Rajasthan utilised health care facilities for delivery were aged 20 or less while only 21.2 percent did so in the age group of 20-34.

More literate women utilised delivery care (76.6%) compared to illiterate women (14.2%). Similarly, women whose spouses have high school and above education are more likely to have utilised more delivery care facilities compared those with spouses with up to middle level education and illiterate spouses. Relatively more not- working- women would utilise delivery care compared to working- women.

Younger women delivering in hospitals etc. as noticed above. It is also the case with women exposed to media using delivery- care services and lower birth order (below 3). Women with 4 or more ANC check-ups used more delivery care (58.7%) *vis-à-vis* women with less than 1 ANC check-up (17.4%).

As per the NFHS-3 32.2 percent ever-married women had delivery in a hospital or other institution. The urban areas outscore rural areas in this regard (significant proportion in urban areas-67.7% and only 23.3% in rural areas). It is further observed that in 43.2 percent delivery cases, a doctor/ nurse/ LHV/ ANM/ other health personnel assisted. This proportion was 35.8

percent in 1998-99. There are wide rural-urban differences (47.6% urban against 14.8% rural) pointing to the fact that rural health infrastructure is still poor.

Women with at least 3 antenatal care visits for their last birth constituted 41.2 percent as per the NFHS-3 and it is a significant improvement over 1998-99. Also, 74.7 percent women in urban areas had at least 3 antenatal care visits for their last birth compared to 32.5 percent rural women. IFA consumption is still low as only 12.8 percent women reportedly consumed IFA for 90 days or more when they were pregnant with their last child. Here, again women in urban areas fare better than their rural counterparts. Besides, women who received postnatal care from a doctor/ nurse/ LHV/ ANM/ other health personnel within 2 days of delivery for their last birth constituted only 28.9 percent with 56.8 percent urban women and only 21.7 percent rural women. It is noticed that hospital care is still a distance dream for a rural woman and even in urban areas not all women avail the facilities available. Rural-urban disparities are very wide in Rajasthan.

Education of the women does come out to be an important factor along with the wealth of the family in procuring and availing health facilities.

As regards the nutrition level of ever-married women, 33.6 percent had a BMI of below normal in 2005-2006, which is an improvement over 1998-99 (36.1%). NFHS-3 reports that 25.6 percent of urban women reportedly had BMI of below normal compared to 36.5 percent rural women. It also noticed that a greater proportion of rural women are anaemic (54.9% against 48.0% urban women), but a lower percentage of rural pregnant women age 15-49 are anaemic (60.1% against 64.5%). These percentages are very high indeed.

Rural women are hardly obese as reflected by the percentage (5.8%) compared to urban women (22.18%). Overall, the obesity has gone up as is reflected by the percentage of women who are obese. There is no doubt an improvement in 2005-2006 over 1998-99 in case all the indicators of nutrition level of ever-married women, the still miles to go before Rajasthan relax.

Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

This goal calls for halting by 2015 and begun to reverse the spread of HIV/ AIDS. The suggested indicator are HIV prevalence among pregnant women aged 15-24 years, condom use rate of the contraceptive prevalence rate (condom use at last high risk sex; percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS; and contraception prevalence rate) and ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years.

As per the NFHS-2 for the year 1998-99, only 20.8 percent ever-married adults women aged 15-49 ever had heard of AIDS and this percentage went up to 33.8 in 2005-2006 (NFHS-3). The rural and urban proportions are 19.3 and 73.0 percent respectively in 2005-06. Thus, awareness building among women had improved significantly, but still especially in rural areas lot needs to be done. As regards, ever-married adults men aged 15-49, the NFHS-3 reports that 74.2 percent of them have heard about AIDS and this proportion is 96.5 percent in urban areas compared to 64.5 percent in rural areas.

Against this at the All India level, as per the NFHS-2 for the year 1998-99, 40.3 percent ever-married adults women aged 15-49 ever had heard of AIDS and this percentage went up to 57.0 in 2005-2006 (NFHS-3). In rural India, the corresponding proportions were 30 and 46 percent compared to 70 and 81 percent in urban India. Thus awareness building among women had improved significantly, but still especially in rural areas lot needs to be done.

As regards, ever-married adult men aged 15-49, the NFHS-3 reports that 80 percent of them have heard about AIDS and this proportion is 94 percent in urban areas compared to 73 percent in rural areas. This shows that men urban areas of Rajasthan are equally better aware of AIDS compared to urban men at the all India level. It may be pointed out here that in 2005-06, 27.3 percent women knew that consistent condom use can reduce the chances of getting HIV/AIDS and the 61.6 percent urban and 14.7 percent rural women knew about it. As regards, men, 63.2 percent knew that consistent condom use can reduce the chances of getting HIV/AIDS and 88.6 percent urban men and 52.0 percent rural men knew about it. In 1992-93, 2.4 couples were using condoms and this percentage went up to 3.1 in 1998-99 and further to 5.3 percent in 2005-06.

Thus, there is a vast gap between usage of condoms and knowledge about aids. This may be because official figures on AIDS report only 1153 cases when all India figures are 117716 in 2005.

Goal 7: Ensure Environmental Sustainability

This goal has target No. 9, which states that, the principles of sustainable development are integrated into policies and programmes and reverse the loss of environment resources.

In 2005, Rajasthan had a forest cover of 2660816 hectares, which was 2353360 hectares in 1991. This is an increase of 13 percent during the last 15 odd years. Southern Rajasthan has largely the forest cover. In 1998, the forest cover was 32488.1 sq.km and 36.5 percent of it was reserved forest and 54.3 percent was protected area. The unclassified area was 9.2 percent. The rural population of this area is largely tribal and dependence on forests is sizeable.

Goal 7 has a target No.10 that requires halving by 2015 the proportion of people without sustainable access to safe drinking water and sanitation.

In 2001, Rajasthan had 9342294 households with drinking water source and 32.92 percent had drinking water source within the premises while another 43.28 percent had a source near the premises and the remaining 23.82 percent had a source that was away from the living space. In rural areas, of the 87156703 such households, only 19.83 percent had drinking water source within the premises while 51.60 percent had a source near the premises and the remaining 28.57 percent had a source that was away from the living space. In urban areas, of the 2185591 such households, 75.79 percent had drinking water source within the premises while 16.03 percent had a source near the premises and the remaining 8.18 percent had a source that was away from the living space.

Rajasthan, in 2001, had only 35.27 percent households had tapped water supply and this percentage was only 21.57 percent in rural areas compared to 80.12 percent in urban areas. Nearly 26.35 percent households in Rajasthan depend on hand pumps for water supply and this percentage is 31.26 percent in rural areas and 10.29 percent households in urban areas. Wells are

still in currency in Rajasthan as 24 percent of households depend on wells for drinking water supply. This proportion is 30 percent in rural areas and only 4 percent in urban areas. Just 7.86 percent households still rely on tanks, ponds, lakes, river, canal, spring and other sources with 9.51 percent such households in rural areas compared to only 2.41 percent urban households. This reveals that rural areas still has a long way to go get potable drinking water in Rajasthan.

The 2005-2006 National Family Health Survey (NFHS-3) reports that 66.1 percent of households have electricity- 95.7 percent urban and 54.0 percent rural. A low percentage of households in Rajasthan have piped drinking water (45.4%) and this proportion is 85.1 percent in urban areas and 29.1 percent in rural areas. Toilet facilities are also meagre as only 30.8 percent households have access to a toilet facility and this proportion is 85.3 percent in urban areas and only 8.4 percent in rural Rajasthan. Except for provisioning of electricity, toilet and possession of a television, in all other indicators Rajasthan is ahead of the national averages. In urban areas, it is ahead in all indicators while in rural areas it is behind in all except drinking water, pucca, vehicle and television possession. This shows that Rajasthan has made quite good performance in making basic facilities available to its population.

Goal 7 also requires by 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

Rajasthan in 2001 had slum population of 12.94 lakh in 26 towns with 76.69 lakh population. There was 132.14 lakh urban population in Rajasthan. This means that slum population constituted 16.9 percent of population of cities reporting slums and 9.8 percent of all urban population. It is quite surprising that literacy rate of slum population in 2001 was 65.6 percent when male literacy rate was 77.8 percent and female literate rate of 51.9 percent. The gender difference recorded was 25.9 percent. At the national level, 640 town/ cities had 4.26 crore slum population that constituted 15.0 percent of urban population and 23.1 percent of population of cities reporting slum population. Scheduled tribes constituted only 4.1 percent of slum population in Rajasthan and merely 2.4 percent at the all India level. 27.0 percent slum population is scheduled caste in Rajasthan and 17.4 percent at the all India level. The literacy rates at all India level are higher at aggregate level, for males and females compared to

Rajasthan. The gender differential is also lower at the all India level at 16.4 percent. In 2001, Rajasthan had slum population of 3.0 percent of the total population lived in slums. At the all India level, total slum population is 4 percent. The sex ratio among the slum population in 2001 was higher at 902 compared to non-slum sex ratio of 886.

There are cities/towns in Rajasthan like Kishangarh that have 37.4 percent population living in slums followed by 36.7 percent in Sardarshahar and 29.9 percent in Baran. The least slum population is in Nawalgarh- 0.4 percent. There are 12 towns of the 26 towns in Rajasthan that have higher proportion of slum population compared to the state slum population. These data indicate extent of problem that Rajasthan has to tackle in coming years to improve the lot of slum dwellers. The problem of housing, water and sanitation are prime problems that would require serious interventions when there is high slum when almost three-fourth of a population lives in slums.

On improvement if any occurred during last 5 years in all facilities in these slums, we observe that 33 percent notified slums reported had a road within the slum (one percent in case of non-notified slum), 33 percent had improved water supply, 33 percent improved electricity, streetlight and drainage, 100 percent improvement in latrines, 33 percent in garbage disposal. The improvement was little poor in all the facilities in case of non-notified slums. There was improvement only in approach road to slum (25% slums), water supply (4%), electricity (2%), streetlight (4%), latrine (100%), drainage (70%) and garbage disposal only 2 percent. Whatever improvement took place in facilities was due to government. There was no notified slum reporting deterioration of facilities during last 5 years, however, 33 percent notified slums reported deterioration in sewerage. This does imply that government did not take care of facilities in the non-notified slums and there was no private intervention too.

The problem of slums further gets complex as most have high density. For instance, 53 percent slums are located on an area of below 2 hectares.

Future Course

There is no doubt that Rajasthan has made progress on the MDGs. However, picture is not very rosy on all counts.

Rajasthan did well during the early nineties, but growth rate of income has slowed down. Agriculture is facing new environmental threats and farmers' income is now more dependent on market forces. Agriculture stabilisation is required as still three-fourth of people is dependent on it.

However, poverty situation has improved over the years. People do not go hungry in rural areas also. Urban poverty would require more attention now than it got earlier. Consumption pattern has seen a change in Rajasthan and compared to Madhya Pradesh and Chhattisgarh, it is better placed. Livelihood diversification is required. Employment schemes have played a vital role in Rajasthan, but non-farm sector growth is must.

Efforts would be require on a mission mode to achieve enrolment goals. There is no doubt that infrastructure in terms of schools have increased especially in rural areas, but grey areas are reducing drop-out rate, increasing retention rate, reducing repetition rate and increasing enrolment. Girl child requires special attention as after class II it becomes difficult for them.

There are wide gender differences after first two years in school. This requires added attention. Would more schools help or more exclusive girl schools would help is a moot question. Would composition of school teachers require a re-look as more male teacher dominated schools deter girls from coming to such schools.

Attendance also required to be increased. We have failed to make school teaching interesting and creative. Games are missing from schools especially rural schools. Libraries are lacking in schools.

Learning achievements are also very poor at the primary level. Greater efforts are required here too.

Health sector is lagging behind on many counts in Rajasthan. Fertility rates are still high. Infant mortality rates are high

Nutrition situation is not really good. Accessibility to health facilities is poor. More needs to be done. Still large proportions of births take place without trained medical staff. The number of staff has to be increased. Rural areas deserve better attention. Funds also have to be found. Let people run and manage health facilities created by the states. The partnership has to be built. The role of PRIs should increase in health sector.

South-Eastern and Western Rajasthan deserves special attention on certain counts as many indicators in these two regions are far behind the state averages.

Female work participation rate has to go up and diversification of female work that gives higher wages is must to achieve MDG goals.

Rajasthan has miles to go before it can rest and get out of BIMARU tag.