CHILD MORTALITY IN RURAL INDIA pdf

1: Statistics | India | UNICEF

The authors focus on infant and child mortality in rural areas of India. They construct a flexible duration model framework that allows for frailty at multiple levels and interactions between the.

Faix Received Aug 13; Accepted Sep This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. This article has been cited by other articles in PMC. Abstract The neonatal mortality rate in India is amongst the highest in the world and skewed towards rural areas. Nonavailability of trained manpower along with poor healthcare infrastructure is one of the major hurdles in ensuring quality neonatal care. We reviewed case studies and relevant literature from low and middle income countries and documented alternative strategies that have proved to be favourable in improving neonatal health. The authors reiterate the fact that recruiting and retaining trained manpower in rural areas by all means is essential to improve the quality of neonatal care services. Besides this, other strategies such as training of local rural healthcare providers and traditional midwives, promoting home-based newborn care, and creating community awareness and mobilization also hold enough potential to influence the neonatal health positively and efforts should be made to implement them on a larger scale. The above proposed strategy is likely to reduce morbidity among neonatal survivors as well. The Scale of the Problem of Neonatal Deaths in India Globally four million deaths occur every year in the first month of life [1]. In India alone, around one million babies die each year before they complete their first month of life, contributing to one-fourth of the global burden [1 , 3]. The neonatal mortality rate in India was 32 per live births in the year , a high rate that has not declined much in the last decade [4 , 5]. The common causes of neonatal deaths in India include infections, birth asphyxia, and prematurity which contribute to Despite the recognition of neonatal survival as a key to child survival, poor progress in neonatal survival in India poses concern regarding attainment of the fourth Millennium Development Goal MDG target, that is, to reduce under-5 child mortality by two-thirds by Healthcare Scenario in Rural India 2. Rural Health Infrastructure Despite having a comparatively higher neonatal mortality rate, rural India is tackling with the problem of ill equipped public health facilities. The numbers of existing peripheral health facilities fall short of what has been recommended by the government of India. The healthcare in rural areas has been developed as a three-tier structure based on predetermined population norms. The subcenter is the most peripheral institution and the first contact point between the primary healthcare system and the community. Primary Health Centers PHCs comprise the second tier in rural healthcare structure envisaged to provide integrated curative and preventive healthcare to the rural population. Community Health Centers CHCs form the uppermost tier and their function is mainly to provide specialized obstetric and child care. As per the district level health survey DLHS-3 , newborn care equipment was available in only These findings underscore the critical condition of the public health facilities that are meant to cater to the health problems of the newborns in rural India. Status of Trained Healthcare Personnel Rural public health facilities across the country are having a difficult time attracting, retaining, and ensuring regular presence of highly trained medical personnel especially the gynecologists and pediatricians that are epochal in ensuring and promoting newborn health. Statistics for suggest a shortfall of The condition of community health centers supposed to provide specialized medical care is even more appalling. As compared to requirements for an existing infrastructure, there was a shortfall of Similarly, in case of health worker male , there was a shortfall of In case of health assistant female , the shortfall was The lack of qualified child care specialists results in a majority of rural households receiving care for their ill babies from private providers, many of whom are less than fully qualified. Key Initiatives to Improve Neonatal Health by the Government of India The Government of India has launched various initiatives envisaging a high priority action with regard to neonatal health. They are further expected to mobilize the community and help them in accessing healthcare services. Under the Reproductive and Child Health program RCH-II , the quality and reach of antenatal care is planned to be expanded and home-based newborn care using integrated management of neonatal and childhood illness IMNCI protocols is envisaged. The IMNCI strategy encompasses a range of interventions to

prevent and manage the commonest major childhood and neonatal illnesses that cause death, that is, acute respiratory infections, diarrhoea, measles, malaria, and malnutrition [16]. The IMNCI package is planned to be implemented at the level of household and subcentres through ANMs and primary health centres through medical officers, nurses, and lady health visitors. Till October , it has been implemented in districts across the country [17]. Facility-based care of neonates F-IMNCI is proposed through strengthening of infrastructure, provision of extra nurses, and skills upgradation of physicians and nurses [18]. These units have been established at district hospitals and are expected to have a minimum of 12 to 16 beds manned by 3 physicians, 10 nurses, and 4 support staff. A total of SNCUs have been established till the year [17]. A total of New Born Care Corners NBCCs , which are special corners within the labour room where resuscitation, infection control, and early breast feeding can be commenced, have been set up, as of [17]. Janani Shishu Suraksha Karyakram JSSK was launched on 1 June, with the aim to promote institutional delivery, eliminate out-of-pocket expenses, and facilitate prompt referral through free transport [21]. A program on basic newborn care and resuscitation, named Navjaat Shishu Suraksha Karyakram NSSK , is being launched to address important interventions at the time of birth that is, prevention of hypothermia and infections, early initiation of breastfeeding, and basic newborn resuscitation [22]. The objective is to have one person trained in basic newborn care and resuscitation at every delivery. Neonatal health is seemingly one of the priority issues in the agenda of the government which gets reflected in the various programs devised and implemented. Immediate Challenges The main obstacles to improving newborn survival are that many babies are born at home without being attended by skilled personnel, faulty home-based newborn care practices are widespread, lack of awareness among care givers limits care-seeking for neonatal illness and even if that is taken care of, lack of trained health workforce adds to the problem. This deficiency in skilled manpower undermines the initiatives by the government to improve neonatal health. Another set of dilemma exists in bringing the neonates and the health system closer to each other. There are broadly two ways of doing so, either bring the health system closer to the neonate or bring the neonate closer to the health system. Both of these are feasible and hold the promise to yield positive results but the real challenge lies in their reproduction and sustainment at the national level. Recruiting and Retaining Doctors in Rural Areas In order to ensure the availability of trained medical personnel in rural areas, we first need to understand the reasons behind the observed shortage. Recruiting trained doctors by all means is one of the essential components towards providing quality maternal and neonatal care services. A recent report documents that out of the paediatricians including both postgraduates and diploma holders that are produced annually in India, only around half of them i. Similar is the scenario for gynaecologists and obstetricians. The predominant reasons for preference to work in urban areas include adequate infrastructural facilities, high salary, and a decent standard of living [24 , 25]. Further, in the recent years, there has been substantial emigration of trained doctors to developed countries, much of it coming from lower and middle income countries [26 â€” 28]. Among the developing countries, India is the biggest exporter of trained physicians with India-trained physicians accounting for about Although the recipient nations and the physicians that emigrate benefit from this migration, the home country loses its important health potentialities. There is no clear-cut solution to the problem of lack of doctors in rural setup. The provision of better financial incentives oriented specifically to doctors working in the rural areas might be crucial to attract and retain more doctors in these areas. Thus, the experience with paying direct financial incentives, such as rural allowances, has been variable and usually depends on the affordability of resources but this should not undermine the potential it might offer to increase the influx of doctors in rural areas. Other key initiatives could include establishing rural doctor networks, mentorship programmes, and giving rural practitioners preference in admissions in specialty programs. Exposure to rural areas as part of the training of medical graduates, so they can understand the working conditions and acquire rural clinical skills, is essential and has the potential to yield positive results. This has been documented in Thailand where a majority of graduates continued in rural practice after completing a compulsory rural residency [34]. To prevent brain drain, international scholar exchange programmes could be thought of as an option besides improving healthcare infrastructure and creating an enabling work environment. Promoting Healthy Domiciliary Newborn Care Practices through Community Mobilization Poor domiciliary care practices have often been

implicated in causing neonatal illness. Several cultural beliefs and traditions that exist in different communities influence care practices. Realizing the presence of such traditions in the community and formulating intensive information, education, and communication IEC campaigns to address these is required. Further, approaches to improve newborn survival should focus on community mobilization as well. There is a need to develop programs where there is a collective involvement of the communities in order to identify problems and their solutions. Several such programs have been implemented in other parts of the globe and have yielded positive results. As a result of the intervention, neonatal mortality decreased from per live births to 40 per live births. In eastern India, the Ekjut trial â€" evaluated the impact of community mobilization on birth outcomes in three districts of Jharkhand and Orissa. These studies offer evidence to encourage community involvement and leverage the community resources to bring about improvements in neonatal health. Programs should be designed to acknowledge and maximize these linkages and resources. Further, there is a need to make an effort to integrate community mobilization with health system strengthening. Home-based newborn care could be explicated as a family as well as community oriented services that involve community mobilization and the empowerment of care givers to demand quality services for their sick newborns [42]. HBNC mainly aims at reducing the neonatal deaths by preventing or treating morbidities such as infections, asphyxia or hypothermia which largely form the preventable causes of mortality. Further, Bhutta et al. The most convincing example was set out by Bang et al. They were also trained to manage neonatal sepsis by providing parenteral antibiotic treatment to sick neonates. In another example from Sirur, a periurban area near Pune, Maharashtra, India, forty female village health workers were trained to serve a population of 47, The village worker identified high-risk cases that required treatment by herself and the nurse, under the supervision of the field medical officer. She also made 3 home visits: Other successful examples include trials of home-based care in North India, Bangladesh, Pakistan, and Nepal [46 â€" 49]. In addition to creating awareness among community members and care givers in the family through information, education, and communication IEC activities, a prerequisite for implementation of home-based care is the development of simple and easily comprehensible standard management guidelines. Further, it would be a challenging task to upscale the home care newborn package to the most vulnerable states such as Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Orissa, and Rajasthan with a high neonatal mortality rate [6]. The lack of a trained personnel predisposes the newborn to a variety of birth related complications mainly birth asphyxia, birth injuries, and infections. Moreover, most of the neonatal deaths occur in the first week of life with a majority of them dying on the first day of birth, thus reflecting the poor intrapartum care that the mother receives [1 , 50 , 51]. They can be a vital link between women and the health system, giving advice, encouraging women to go to the clinic to deliver, and accompanying mothers to provide moral support. One such successful case study is from Indonesia [52 , 53]. In , nearly half of all newborn deaths in the Cirebon district of Indonesia were due to birth asphyxia. In Zambia, midwife training programs significantly decreased the seven-day neonatal death rate in community health clinics [54]. The midwives were given training in essential newborn care ENC and in neonatal resuscitation. After training, the all-cause, 7-day neonatal mortality rate decreased from The perinatal mortality rate decreased from Similar examples providing evidence for up scaling of trained midwives in order to lower down the neonatal mortality can be drawn from Sri Lanka, Thailand, Malaysia, and Pakistan [55 â€" 59]. Focus on Socioeconomic Development Infant mortality rates reflecting neonatal mortality as well are one of the most important indicators of the differentials in health and socioeconomic condition in a community. A substantial progress in lowering down the high burden of neonatal mortality is unlikely unless ways can be found to enhance the economic wellbeing of the lower socioeconomic groups. In a study done in rural Haryana to document the determinants of neonatal deaths, it was found that the occurrence of deaths was a multifactorial process with involvement of factors at community level, family level socioeconomic , and biological level and that the socioeconomic determinants explained a large proportion of neonatal deaths [62].

CHILD MORTALITY IN RURAL INDIA pdf

2: High Neonatal Mortality Rates in Rural India: What Options to Explore?

This paper focuses on infant and child mortality in rural areas of India. We construct a flexible duration model, which allows for frailty at multiple levels and interactions between the child's age and individual, socioeconomic, and environmental characteristics. The model is estimated using the.

Nearly 20 fewer children per 1, live births are dying in India now, before reaching 28 days of life, than they did two decades ago. As far as post-neonatal deaths are concerned, India is now losing 15 fewer lives per 1, live births than it did in Among children aged years, nearly 30 fewer children are dying now than 20 years back. Scientists predicted that about 7. The deaths this year would include 3. The global decline during the past 20 years is 2. Murray and colleagues assessed information from countries from to In , 12 countries had an under-5 mortality rate of more than deaths per 1, live births. Today, no country has an under-5 mortality rate that high, according to IHME estimates. Against a neonatal rate of The bad news is that Delhi has the highest infant mortality rate IMR among all the metros and at the current sluggish pace at which the figure is being reduced the capital would achieve its goal of reaching an IMR of 15 only in From an IMRâ€”a measure of how many die within the first year for every 1, live birthsâ€”of 33 in , Delhi has progressed at a crawl to touch the current IMR of The Delhi Human Development Report DHDR pointed out that much larger states like Maharashtra and Tamil Nadu had achieved IMRs of 25 and 22 respectively despite having substantial rural populations, higher levels of poverty and a less intensive network of public health infrastructure. Segregating infant deaths shows that most happen in the early neonatal period up to seven days after birth. The report argued for urgent efforts to ensure improved coverage of maternal and child health services in Delhi. Part of the answer can be found in a recent survey report put out by the Census office. The key reasons for MMR include not getting proper treatment and child-birth related complications. They are sup posed to get at least one checkup every three months three in all , one tetanus injection and iron supplement for at least days. On both these counts, there has been some improvement in all states since when a baseline survey was done. But, at this rate it will take years to bring it to acceptable levels. This is despite a huge immunization programme conducted by the government. Iron supplementation is a necessity because nearly half the new borns in our country suffer from anemia, as do their mothers. The numbers are staggering: The states covered in the survey are: Tamil Nadu, Delhi and Maharashtra have improved on their already superior health outcomes while poorer performing states like Uttar Pradesh, Assam and Madhya Pradesh have slid, a study has found. Lowering of infant mortality rate is a priority of the National Rural Health Mission and part of the UN millennium development goals that India has committed to. In India, IMR has declined from 57 per 1, live births in to 42 per 1, live births in None of the poorly performing states were able to achieve a rate of decline close to what the best performing states have achieved. The interstate inequity grew between and , despite NRHM providing additional funding to such states. Improving healthcare is insufficient to address the structural causes of high infant mortality. Marked improvement in most states Subodh Varma Bihar, Gujarat, Rajasthan lag in curbing infant deaths The steady decline in infant deaths in Indian states appears to be faltering in some while progressing well in others, according to fresh data for released by the Census office based on an annual sample survey. Some of the more back ward states like Assam, Jharkhand and Chhattisgarh did well in bringing down infant deaths, but Gujarat, MP, Odisha, Rajasthan and Uttarakhand showed an alarming slowdown. Most such deaths occur in the absence of well-equipped delivery rooms and doctors or when mother and child are weak. Out of the 36 states and union territories, information for only 23 has been put out. Left out are all southern states and some others like Maharashtra and West Bengal. Rohit Bharadwaj, Deputy Registrar General, told TOI that data for all states is yet to come in, ascribing the delay to preoccupation with a baseline survey released recently. Parsing the rural-urban and male-female data confirms that there is something going wrong in many states. For instance, Rajasthan and Bihar show an increase in infant mortality in rural areas, while Gujarat and Madhya Pradesh show no change over the previous year. Gujarat, Jharkhand and Rajasthan show a worrying increase in female infant mortality in rural areas. In urban areas, Bihar and Gujarat show increase in infant death rates, while female infant deaths increased in UP.

Among the smaller states, infant mortality has increased in Manipur. In Meghalaya, female infant mortality has increased. Nagaland, Sikkim and Tripura show healthy declines in infant death rates. The predominantly urban union territory of Chandigarh has shown an increase in infant deaths, driven by a rise in female infant mortality. Delhi, also largely urban, has shown a decline. An all-India picture will emerge only after the system data for other states is released, which Bharadwaj assured would happen in the coming weeks. The latest birth and death registration data shows that the number of neonatal deaths -children dying within 29 days -has nearly doubled in the last 10 years from 3, in to 5, in The number of infant deaths children who die before turning a year old in the capital has also gone up from 4, to 8, over the last decade. This data was released in the annual report prepared by the directorate of economics and statistics of Delhi government on registration of births and deaths in The data shows infant deaths were caused by hypoxia, birth asphyxia and other respiratory conditions Slow fetal growth, fetal mal nutrition and immaturity was the third-most common cause of infant deaths 7. Of these infant deaths, 8, were institutional and 83 non-institutional. The infant mortality rate per thousand live births in is Public health officials have are shocked at the neonatal and infant mortality rate. Maternity centres and some government-run health institutions, experts said, lack facilities for caesarean-section delivery. He also blamed poor nutrition of mothers for the high infant mortality rate. Doctors said that public sector hospitals are overburdened and the private sector is unaffordable for most people. Social activists working for the rights of women and the girl child point towards the need for focussed measures to build awareness against sex determination tests and crackdown on ultrasound clinics offering such facilities illegally. IMR highest ever, Delhi More infants died within month of birth last year December 17, Number of children admitted to hospitals, mortality and maternal deaths- Year- wise The number of children dying in Delhi within 29 days of their birth has gone up in the past one year -from in to 1, in Latest statistics released by Delhi government show maternal mortality , an indicator of public health system, has witnessed a sharp increase during the same period. According to government data, total 2,30, deliveries 1,96, at public hospitals and 34, at private hospitals were conducted in Experts say many neonatal deaths are still not reported. He added that poor infrastructure and human resources at SNCUs is also to blame. Experts say premature births contribute the highest to neonatal deaths. Infection is the second leading cause, followed by asphyxia shortness of breath and diarrhoea. Data also shows an increase in the number of children between years being detected with protein energy malnutrition and low weight. There is bad news for the government on family planning front too. Except for Insertion of Intrauterine Contraceptive Device IUCD , the usage of all other contraceptive methods has witnessed a significant decline in the last one year. This includes condoms, oral pills and sterilization of both men and women. The Economic Survey Report shows that 22 out of every 1, children born in Delhi in the latest available data died within a year of birth. In Kerala, the IMR was less than 12 per 1, births, or one in The number of children dying within 29 days of birth in Delhi--called neonatal mortality rate NMR --was 15 per 1, births in Experts said conditions arising in the period immediately before and after birth cause the maximum infant deaths, followed by hypoxia, birth asphyxia and other respiratory conditions. He said the number of nurses is also not adequate. It reduced to 13 per 1, in and but has been on the rise ever since. Dr Sidharth Ramji, who heads the neonatology unit at Lok Nayak Hospital, said public sector hospitals are overburdened and the private sector is unaffordable for most people. Dr Ramji added that none of the CATS ambulances run by the state have incubators which are a must to transport critically-ill newborns. To put it in perspective, if India, with a current IMR of 41 could get it down to 6, around seven lakh children would be saved each year. Kerala had been strugg ling over the past decade to bring down the IMR to a single digit from 12 where it has been stuck since , according to the Sample Registration Survey SRS conducted by the office of the registrar of census. Kerala continues to be way ahead of other Indian states on this measure, the closest big state to it being Ta mil Nadu with an IMR of Paediatricians and public health experts in Kerala, however, are more sceptical than overjoyed at the new numbers. While many are willing to believe that the IMR has dipped below 10 in recent years, a dramatic fall to six is something they are skeptical about. Most of these deaths are due to prematurity, low birth weight and asphyxia at birth. The Navjaat Sishu Suraksha Karyakram of the central government has helped train nurses in all government hospitals and even private hospitals in basic newborn care and resuscitation. Dr Nair feels these efforts could have led to a steady

decline to a single digit, most probably around 8 or 9 rather than a sudden fall from 12 to 6. To bring down IMR from such a low level of 12, high technology capital intensive interventions are needed. Kusnopur is a hamlet in the area and it is a transformed place. As are some other villages in this mineral-rich district. Indkata, Dengsorgi and Landupoda are also in the grip of a quiet â€" and happy â€" revolution. Fewer newborn babies are dying. How has this happened? Through an extraordinary training project for local tribal women. Aantri Koda, 28, of Balundi village, was one of the early trainees. She recounts how hard it was: However, my sister in law persuaded him to let me join, citing her own suffering during pregnancy. Mother-of-two Kulsum Sundi, 33, recalls the gram pradhan opposing volunteers who wanted to assist her when she was pregnant. By now, it has 20, trained women, spread across more than a thousand villages in nine districts of Jharkhand and Orissa. Data from health department shows 62 out of 1, children born in Gorakhpur die before turning one. Against this, 48 out of 1, die in UP and 40 out of 1, in India.

CHILD MORTALITY IN RURAL INDIA pdf

3: Child mortality in rural India (English) | The World Bank

Note: Citations are based on reference standards. However, formatting rules can vary widely between applications and fields of interest or study. The specific requirements or preferences of your reviewing publisher, classroom teacher, institution or organization should be applied.

Children from the poorest communities are three times more likely to die before they reach the age of 5 than those from high income groups, Save the Children said today. In a new global report titled A Fair Chance at Life, the organisation said reductions in child mortality in India and elsewhere in the world appeared to focus on children from better-off communities leaving children from the most disadvantaged backgrounds behind. Support a charity like Save the Children to contribute your bit. Child mortality is often described as the best barometer of social and economic progress. Despite being one of the fastest growing economies, there has been no visible pattern between per capita income growth and the rate of reduction of child mortality rates. The rate of decline between and among the lowest income quintile is Donate money to Save the Children to support their work to bring down the high incidence of preventable child deaths in India. Of the 26 million children born in India every year, approximately 1. The under 5 mortality rate in Kerala is 14 deaths per live births. This stands at a sharp contrast to Madhya Pradesh at 92 per or 91 per for Uttar Pradesh. By demonstrating political will and the right policies, MDG4 can be achieved in India. When people donate to charity for children, great impact is made on the ground. The good schemes in place need to be matched by effective implementation. And there is enough experience in India proving that low-cost interventions can make the difference between life and death for a child. This is the highest number anywhere in the world. The annual rate of decline in child mortality between and has been 2. The required rate of decline from to per year has gone up to 6. One-third of all malnourished children live in India. More than two-thirds of infants die in the very first month. Ninety per cent of these deaths are due to easily preventable causes like pneumonia and diarrhoea. For instance, the under-five mortality rate in Madhya Pradesh is 92 per live births, in Kerala it is only 14 per Low cost interventions could reduce neonatal mortality by up to 70 per cent if provided universally.

CHILD MORTALITY IN RURAL INDIA pdf

4: Female foeticide in India - Wikipedia

The neonatal mortality rate in India is amongst the highest in the world and skewed towards rural areas. Nonavailability of trained manpower along with poor healthcare infrastructure is one of the major hurdles in ensuring quality neonatal care. We reviewed case studies and relevant literature from.

Legitimacy Stakeholder Engagement Fair There is evidence of collaboration between several parties in the creation of the programmes to reduce child mortality. The focus states are the key stakeholders in the partnership and NIPI works as a catalyst to help them innovate and find new ways of delivering health services. Promise Renewed" in In the case of diarrhoeal diseases, for example, the message of correct management simply has not reached its audience in a consistent and sufficient way. Various ministries have implemented child-centric policies and programmes to address the issues related to child health. However, there is evidence of a good use of data to establish the priorities for different policies targeting infant mortality. Knowing that low birth weight is a key predictor of malnutrition and a determinant metric of child mortality, efforts have been made to collect representative estimates of birth weights at the national level, from institutional and community deliveries, but the findings vary greatly. The NFHS found that small birth size â€" a proxy for birth weight â€" carries a risk of infant death 2. Low birth weight has also been identified as a factor in the retardation of motor, adaptive, social and language development, as well as in the susceptibility of adults to diseases. This effect was much less marked beyond the neonatal period. However, there is evidence of several initiatives to support child development, as well as funding for health being increased at the time the MDGs were launched. There have been several programmes implemented in India support the comprehensive development of children and improve child conditions in the country: In , the allocation for child development was increased to 0. The increase was due to the focus on meeting the challenges of the From the sixth plan onwards, health policies have focused more on improving health infrastructure in rural areas. In some places we have strong advocacy as we have strong civil society, as in Kerala and Tamil Nadu. Whereas in other states the management is weak and technical skills are inadequate. These two factors can increase inequity. So the potential benefits of having a decentralised system are not always realised. The SRS was started in a few states in and extended to all states in , tracking births through continuous enumeration and biannual surveys. Its registration and survey results are matched and verified in the field to minimise duplication and omission. However, it has still shown some inaccuracies: On the other hand, the coordination of such initiatives at the local level has not been wholly successful. It partnered with three NGOs in efforts to improve the quality of healthcare that pregnant women in India receive through the private sector. Save the Children is working with the MoHFW to support the global Every Newborn Action Plan, and has actively participated in the development of newborn healthcare policies. While these have brought benefits, they need better coordination and implementation at the federal, state and local level, and the services provided locally needs to be of better quality.

5: Demographics of India - Wikipedia

UNICEF is committed to doing all it can to achieve the Sustainable Development Goals (SDGs), in partnership with governments, civil society, business, academia and the United Nations family - and especially children and young people.

These scholars [9] claim that both the sex ratio at birth and the population sex ratio are remarkably constant in human populations. Significant deviations in birth sex ratios from the normal range can only be explained by manipulation, that is sex-selective abortion. Sen pointed to research that had shown that if men and women receive similar nutritional and medical attention and good health care then females have better survival rates, and it is the male which is the genetically fragile sex. Most families find greater utility in having a son so the curves are higher up on the y axis. When having a female becomes more expensive due to dowry prices, lack of financial return in the future, educational and health expenses then the budget curve has to swing inward on the x axis. Even though the budget stays the same, it is relatively more expensive to have a girl than to have a boy. The substitution effect shows that people move from point A on the first indifference curve to point B on the second indifference curve. They move from an already low number of females due to social reasons to even fewer daughters than before due to the added financial liability of daughters being more expensive. The number of males grows and the contrasting increase and decrease in quantities results in a high sex ratio. This is based on the unitary model of the household where the household is seen as a single decision making entity under the same budget constraint. This is not to say that all households follow this model, but enough of them do that it results in a high sex ratio. The data suggests the existence of high sex ratios before and after the arrival of ultrasound-based prenatal care and sex screening technologies in India. Female foeticide has been linked to the arrival, in the early s, of affordable ultrasound technology and its widespread adoption in India. Obstetric ultrasonography , either transvaginally or transabdominally, checks for various markers of fetal sex. It can be performed at or after week 12 of pregnancy. One group estimates more than 10 million female foetuses may have been illegally aborted in India since s, and , girls were being lost annually due to female foeticide. Culture is favored by some researchers, [19] while some favor disparate gender-biased access to resources. Generally, male babies were preferred because they provided manual labor and success the family lineage. The selective abortion of female fetuses is most common in areas where cultural norms value male children over female children for a variety of social and economic reasons. Female foeticide then, is a continuation in a different form, of a practice of female infanticide or withholding of postnatal health care for girls in certain households. As MacPherson notes, there can be significant differences in gender violence and access to food, healthcare, immunizations between male and female children. This leads to high infant and childhood mortality among girls, which causes changes in sex ratio. Specifically, poorer families are sometimes forced to ration food, with daughters typically receiving less priority than sons Klasen and Wink However, globally, resources are not always allocated equitably. Thus, some scholars argue that disparities in access to resources such as healthcare, education, and nutrition play at least a small role in the high sex ratios seen in some parts of the world. The majority of men do not find any benefit from these goods and are less likely to invest in them. In Rajasthan, where women complain more often about drinking water, women politicians invest more in water and less in roads. It is often found in "socially stratified, monogamous societies that are economically complex and where women have a relatively small productive role". The outcome is pareto optimal and reaches equilibrium when no one can be better off with any other partner or choosing not to marry. However, if both partners do not share an equal distribution of the returns then there must be a transfer of funds between them in order to reach efficiency. Therefore, women and their families have to compete for men and pay a dowry as a transaction payment to make up for the lack of productive inputs they bring into a marriage. The power hierarchy and financial obligation created through this system help perpetuate acts like female foeticide and a high son preference. Additionally, the technological progress leading to sex selective abortions lowers the cost of discrimination and many people think that it is better to pay a " rupees now abortion instead of 50, rupees in the future dowry. In India, there is a very limited social

security system so parents look to their sons to ensure their futures and care for them in old age. Additionally, they do not contribute economically to the family wealth and are costly because of the dowry system. This also ties to the fact that it is easier for men in India to get high paying jobs and provide financially for their families. Consequences of a declining sex ratio in Indian states[edit] Census sex ratio map for the states and Union Territories of India, boys per girls in 0 to 1 age group.

6: Child mortality in rural India is alarming - www.enganchecubano.com India News

Maternal Health and Child Mortality in Rural India ASARC WP /12 3 Another attribute of mother in determining child mortality is age of mother at the time of.

7: Centre for Public Impact

Child Mortality in India Thursday 6 September New Delhi, September 6: Children from the poorest communities are three times more likely to die before they reach the age of 5 than those from high income groups, Save the Children said today.

8: Save the Children India | Child Mortality in India

In the s, India had the highest infant mortality rate in the world. In , the Indian government introduced the Reproductive and Child Health (RCH) programme to reduce infant, child and maternal mortality. Three years later, India signed the Millennium Declaration adopted at the UN General.

9: Fighting maternal mortality in rural India | India | UNICEF

The mortality rate for neonatal infections in Central India () was nearly four times higher than in South India () and mortality rates for birth asphyxia and birth trauma was highest in Central India () and lowest in the South ().

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