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India's Human Development in the 2000s: Towards Social Inclusion

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This note summarizes the conceptual framework and the main findings of the *India Human Development Report 2011: Towards Social Inclusion* (IHDR 2011). Section 1 presents the conceptual framework of the Report, which is situated firmly within the human capability approach. Sections 2-4 examine the main findings. Section 2 analyzes changes in the Human Development Index (HDI), Health and Education indices for the states of India. Section 3 discusses the findings in regard to social indicators for Scheduled Castes (SCs) and Scheduled Tribes (STs) (although the IHDR 2011 examines state-wise indicators for all social groups). Section 4 summarizes the findings for the largest minority, Muslims (although IHDR examines state-wise indicators for major religious communities).

1. The Conceptual Framework

The analysis of *India Human Development Report 2011: Towards Social Inclusion* is based on a conceptual framework around a feedback loop model which states that human development outcomes feedback as inputs into the development process. These feedback loops operate both at the micro (individual) as well as macro (societal) levels.[1] Interventions to promote human capital formation (through investments in health and education) are key requirements for economic growth to be more successful in reducing income poverty.

Table 1 illustrates how feedback loops operate at the micro level. It shows how various indicators act both as inputs and outcomes in the human development process. The rows represent the inputs and the columns represent human development outcomes or outputs. While the shaded cells show the relationship between an input and the output variable, and the arrows depict the feedback effects from the development outcomes to the inputs. For instance, education makes an individual more aware of healthy and hygienic practices. Education therefore can serve as an input towards better health and nutritional status which feeds back into better learning ability. Similarly,

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1 The conceptual framework is utilized across the report for each dimension of human development. The narrative can be better appreciated if read throughout the Report. Oommen (*EPW*, February 18, 2012, Vol. XLVII, No.7) notes: 'The authors sum up the [feedback loop] model in a triangle'. Unfortunately, Oommen does not read the full text of the conceptual framework (found in the first few pages of Overview of the IHDR, which is also used across the chapters of the report). The fact is that the triangle merely summarises one of two synergies in the conceptual framework – the macro one. He ignores the feedback loop on the very next page – the micro level synergy. Oommen also alleges that IHDR 2011 does not refer to the first National Human Development Report 2011, unfortunately which is not the case as seen in chapter 2 of IHDR 2011.

educated parents understand the importance of family planning and reduced family size in turn feeds back into better health (both for the mother and the child) and education for all children in the family.

Table 1: Feedback Loops in the Human Development Process – at the micro level

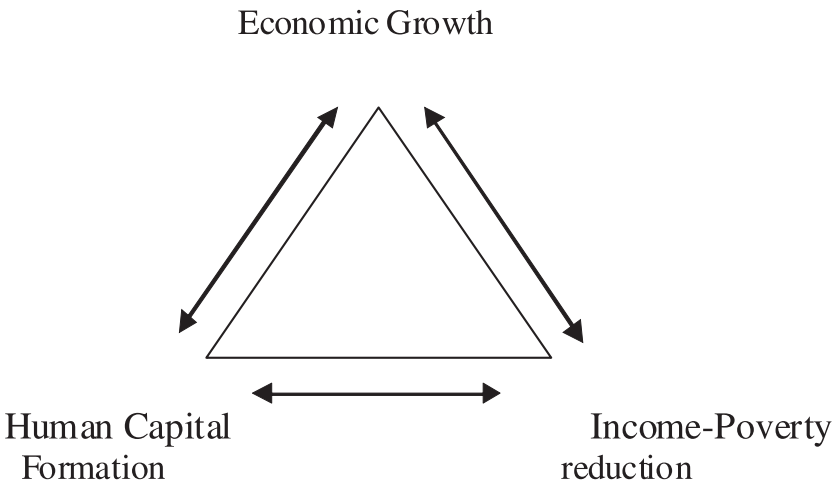
Social services inputs/processes	Human development outcomes/outputs				
	Knowledge	Family size	Health status	Nutritional status	Healthy livingconditions
Education		↲	↲	↲	↲
Family Planning	↲				
Health		↲	↲	↲	↲
Nutrition	↲	↲	↲		
Water and Sanitation					

Source: Mehrotra and Delamonica (2007)

Feedback loops at the micro (individual/household) level (Synergy 1) then feed back into a synergistic relation at the macro level (Synergy 2) (for an elaboration of this theoretical framework, see chapters 2,3 and 11 of Mehrotra and Delamonica (2007). Without the feedback loops being triggered as demonstrated in Table 1, human capital accumulation will not occur. Investments in health and education lead to human capital formation, addressing multiple dimensions, as illustrated through the feedback loops at the micro level. For instance, investments in reproductive and child healthcare programmes result in improvements in maternal health care and family planning. Proper spacing between children not only results in better health of the mother but also healthier children. Fewer number of children also means that all of them get adequate food and schooling opportunities. An educated mother would ensure education for her girl child as well. Healthier children often perform better in school and are also expected to have improved earning ability. Thus, improved human capital formation, for both men and women, ensures an educated workforce that can engage in economic activities and earn better livelihoods. This in turn translates into improved economic growth and a reduction in income poverty. Figure 1 shows how economic growth, human capital formation, and income poverty reduction are synergistically related such that, the impact of intervention in any one is enhanced by investments in any other (Synergy 2).[2]

2 Oommen suggests that 'the assumed nexus between economic growth and income poverty reduction is a questionable one'. IHDR 2011 argues that economic growth is a necessary condition for the reduction of income poverty, but not a sufficient one. Investment in human capital is required if the income poor are to take advantage of economic growth – that is precisely the point of the conceptual framework at the macro-level.

Figure 1: Feedback loops at the Macro-economic level



These synergistic relations have been witnessed in the past decade in terms of improved literacy levels, rising life expectancies, rising wages and reduction in poverty from 45 per cent in 1993-94, to 37 per cent in 2004-5 and to 30 per cent in 2009-10.[3]

In the context of feedback loops, *IHDR 2011* assesses the performance across multiple dimensions of human development across states and across all social and religious groups. The main thrust of this report is to analyze whether certain sections of society which suffer from multiple deprivations have started to share the benefits of development. It is here that India's unique socially stratified society deserves a mention. The historically marginalized sections of society are largely concentrated in precisely those states that appear at the bottom end in human development rankings. Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, and Uttar Pradesh together account for 47 per cent of all Scheduled Castes (SCs), 52 per cent of all Scheduled Tribes (STs) and 43 per cent of Muslims in the country. In addition, SCs and STs account for over 40 per cent of the state's population in Chhattisgarh, Jharkhand, Madhya Pradesh and Orissa, while it is 32 per cent in case of Rajasthan and 26 per cent in Uttar Pradesh and 20 per cent in Bihar (largely due to the SC population in the last two). Compared to these, SCs account for 20 per cent, STs 9 per cent, and Muslims 13 per cent of the country's population (NSS 2007-08).

The analysis is thus spread across eight chapters that examine the multiple dimensions of development – employment, poverty, nutrition, health, education, support infrastructure (like housing, access to electricity, telephony and road connectivity), and disability and child labour; in addition to the usual practice of constructing a human development index (HDI) for states.

3 Incidence of poverty based on Tendulkar poverty line estimates.

2. The Human Development Index of States

The HDI is a composite index, consisting of three indicators – consumption expenditure (as a proxy for income), education and health. The income index is calculated using real per capita consumption expenditure[4] adjusted for inequality. Life expectancy at birth is used to construct the health index. And the education index is constructed as a weighted average of literacy seven years and above and mean years of schooling adjusted for out of school children.[5]

IHDR 2011 estimates HDI for the beginning of the decade, and for the year 2007-8.[6] The top five ranks in HDI in both years are captured by the states of Kerala, Delhi, Himachal Pradesh, Goa and Punjab. States that perform better on health and education outcomes are also the states with higher HDI and thus higher per capita income which gets reflected through improved human functionings. However, at the other end of the spectrum are states like Chhattisgarh, Orissa, Bihar, Madhya Pradesh, Jharkhand, Uttar Pradesh and Rajasthan. These states have over time shown tremendous improvement in HDI and its component indices over time thus leading, to a convergence in HDI across states.[7] The coefficient of variation of the HDI for states in 2000 was 0.313, which had fallen sharply to 0.235 in 2008.

India's HDI has registered an improvement of 21 per cent over the eight year period 1999-2000 to 2007-8. This improvement is largely driven by achievements in the education sector – as the education index improved by 28.5 per cent. The pace of improvement in the health sector was lower (13 per cent). Also, because the income index is constructed using monthly per capita consumption expenditure from National Sample Survey, which is lower than both consumption estimates by National Accounts and income, the income index computed using the Net Domestic Product per capita results in an increase in HDI of over 30 per cent and not 21 per cent over the 8 year period. It however, needs to be qualified here that the arguments of *IHDR 2011* are not merely based on these percentage changes, but on the analysis across each individual dimension of human development.

Recently, an issue was raised whether the low income states' HDI is actually converging with that of India's HDI. Chakraborty (2012) argues that HDI of Bihar (a low per capita income state) increased by 0.075 points while the national average increased by 0.080 – so, he concludes, *IHDR 2011* argument does not hold. But is it not commendable that despite low base the improvement for Bihar is of the similar order as that for all India? What is significant is that absolute improvements in health and education indices for low PCI

4 It is because of lack of state wise compiled and comparable data on income per capita that the Income index is computed with monthly per capita consumption expenditure as a proxy for income, which is the main reason why the India HDR 2011estimate of HDI is different from the global HDR 2011.

5 Global HDRs use mean years of schooling and expected years of schooling to construct the education index.

6 Education in India: Participation and Expenditure, National Sample Survey 64th Round, 2007-8, the latest that was available.

7 Gini coefficient and Coefficient of variation of HDI across states have both declined over the period 1999-2000 and 2007-8.

states like Chhattisgarh, Jharkhand, Madhya Pradesh and Orissa have been better than for all India, with their gaps with all India average narrowing over time.[8]

For six of the low HDI states – Bihar, Andhra Pradesh, Chhattisgarh, Madhya Pradesh, Orissa and Assam – the improvement in HDI (in absolute terms) is considerably above the national average. If we look at absolute changes in HDI alone over the decade, our conclusion that the poorer states are catching up with the national average is strengthened. For instance, in case of Uttarakhand, the increase in HDI has been the maximum (0.151 points) between 1999-2000 and 2007-8 compared to the national average of 0.080 points. Other relatively poorer states that have seen an improvement in HDI greater than the all India average are Assam (0.108 points), Jharkhand (0.108 points), Madhya Pradesh (0.090), and Orissa (0.087). Chhattisgarh with an improvement of 0.080 points has performed as well as the national average in terms of HDI. However, among the relatively poorer states, Bihar (0.075 points), Uttar Pradesh (0.064 points) compared to the national average (Table 2).

However, the relative improvement (i.e, percentage change) in HDI is greater in Bihar than for the national average. In fact, as Table 2 shows, the percentage change in HDI is greater for the majority of low PCI states than the HDI's improvement for India as a whole.

Table 2: Human Development Index, 1999-2000 and 2007-8

State	HDI 2007-08	HDI 1999-00	change in HDI	% change
Uttarakhand	0.49	0.339	0.151	44.54
Kerala	0.79	0.677	0.113	16.69
Assam	0.444	0.336	0.108	32.14
Jharkhand	0.376	0.268	0.108	40.30
Andhra Pradesh	0.473	0.368	0.105	28.53
NE (excl Assam)	0.573	0.473	0.100	21.14
Madhya Pradesh	0.375	0.285	0.090	31.58
Tamil Nadu	0.57	0.48	0.090	18.75
Karnataka	0.519	0.432	0.087	20.14
Orissa	0.362	0.275	0.087	31.64
All India	0.467	0.387	0.080	20.72
(Contd.)				
Chhattisgarh	0.358	0.278	0.080	28.78

(contd.)

8 Chakraborty (2012) not only selectively bases his criticism of IHDR 2011 merely on a reading of chapter 2 (on the HDI), but goes further by merely citing selectively the case of Bihar, while ignoring the absolute improvements faster than the national mean for the majority of the remaining low per capita income states.

(contd.)

Bihar	0.367	0.292	0.075	25.68
Himachal Pradesh	0.652	0.581	0.071	12.22
Maharashtra	0.572	0.501	0.071	14.17
West Bengal	0.492	0.422	0.070	16.59
Jammu and Kashmir	0.529	0.465	0.064	13.76
Uttar Pradesh	0.38	0.316	0.064	20.25
Punjab	0.605	0.543	0.062	11.42
Gujarat	0.527	0.466	0.061	13.09
Haryana	0.552	0.501	0.051	10.18
Rajasthan	0.434	0.387	0.047	12.14
Goa	0.617	0.595	0.022	3.70
Delhi	0.75	0.783	-0.033	-4.21

However, the real issue lies elsewhere. Everyone knows that HDI is an extremely crude indicator. As chief economist of the Global Human Development Reports, the team leader of *IHDR 2011* recalls Mahbub ul Haq telling Amartya Sen that: 'construct for me an index which is as crude as gross national product per capita.' Both Amartya Sen and Mahbub ul Haq were clear that they were constructing a crude index , but a simple one, but which at least had the saving grace of being multi-dimensional (incomes, health, education), rather than merely using income as a means of assessing the welfare of human beings. It is remarkable that some academics fail to understand the main argument of the India Human Development Report, which is clearly elaborated in 8 chapters, and which goes well beyond using HDI as a means of assessing human well-being.

Using HDI alone as a measure of the improvement in the human development levels of Indian states would understate the complexity of the notion of human development, amounting to a crudely reductionist approach. The welfare of human beings and the expansion of human capabilities is what is the goal of development: that is essence of the capability approach. Individual human functionings matter, i.e. the probability of my dying prematurely, the probability of my remaining illiterate or even merely with primary education, the probability of my remaining undernourished are central to the realization of my human potential. Every chapter in the Report clearly demonstrates that for important indicators of human functioning not only were the states of India converging but the Scheduled Castes, Scheduled Tribes and Muslims - the most marginalized of Indian society – found their indicators converging with the national average (on which more later).[9]

9 Oommen (2012) suggests that 'it is naïve to consider social inclusion or inclusive growth as a binary model, as between those who are included and those who are not.' We do not deny that the terms of inclusion are very important. However, at the same time, it would be impossible to argue that the historically disadvantaged groups are experiencing social inclusion if their human development outcome indicators were actually diverging from the rest of society. The IHDR provides the empirical foundations for the claim that, by and large, social indicators of the SCs, STs and Muslims, are converging with the national mean.

Tables 3 and 4 show that this trend of convergence is also evident in case of health and education indices. Chhattisgarh (0.075 points), Uttar Pradesh (0.075), Orissa (0.074), Madhya Pradesh and Rajasthan (0.067 points each) have seen an improvement in the health index greater than the national average of 0.066 points over 2000 and 2008. Jharkhand's improvement in health index was of the same magnitude as for all India. Among the relatively poorer states, it is Bihar where the improvement in health index is lower than the national average (0.058 points). However the gap with the national average in case of Bihar has fallen over time.

Table 3: Health index, 2000 and 2008

State	Health Index 2008	Health Index 2000	change in Health index	% change
Goa	0.650	0.363	0.287	78.899
NE (Excl Assam)	0.663	0.567	0.097	17.059
Chhattisgarh	0.417	0.341	0.075	22.065
Uttar Pradesh	0.473	0.398	0.075	18.802
Orissa	0.450	0.376	0.074	19.618
Jammu and Kashmir	0.530	0.457	0.073	15.997
Gujarat	0.633	0.562	0.071	12.659
Assam	0.407	0.339	0.067	19.846
Madhya Pradesh	0.430	0.363	0.067	18.532
Rajasthan	0.587	0.520	0.067	12.922
All India	0.563	0.497	0.066	13.346
Jharkhand	0.500	0.434	0.066	15.114
Uttarakhand	0.530	0.465	0.065	13.884
Karnataka	0.627	0.567	0.060	10.560
Andhra Pradesh	0.580	0.521	0.059	11.359
Bihar	0.563	0.506	0.058	11.412
Haryana	0.627	0.576	0.051	8.803
Tamil Nadu	0.637	0.586	0.050	8.581
West Bengal	0.650	0.600	0.050	8.312
Maharashtra	0.650	0.601	0.049	8.146
Himachal Pradesh	0.717	0.681	0.036	5.271
Punjab	0.667	0.632	0.035	5.481
Kerala	0.817	0.782	0.034	4.372
Delhi	0.763	0.735	0.029	3.891

Table 4 shows that the relatively poorer (with low PCI) states (which are also educationally backward) like Uttarakhand (0.267 points), Jharkhand (0.213), Chhattisgarh (0.161), Madhya Pradesh (0.157), Bihar (0.137), and Orissa (0.126) have seen improvements in the education

index higher than the national average (0.126 points) between 1999-2000 and 2007-8. These states have also managed to narrow the gaps with the all India education index and have seen percentage improvements higher than the national average. However, among the poorer states, Uttar Pradesh (0.121) and Rajasthan (0.114) have seen improvements in absolute value of their education index lower than the national average. But, due to their relatively low base, the pace of improvement in terms of percentage change even in their case is greater than the national average.

Table 4: Education index, 1999-2000 and 2007-08

State	Education Index 2007-08	Education Index 1999-00	change in Education Index	% change
Uttarakhand	0.638	0.371	0.267	71.99
Jharkhand	0.485	0.271	0.213	78.59
Andhra Pradesh	0.553	0.385	0.168	43.60
Chhattisgarh	0.526	0.365	0.161	44.03
Madhya Pradesh	0.522	0.365	0.157	43.04
Tamil Nadu	0.719	0.570	0.149	26.18
Bihar	0.409	0.271	0.137	50.65
Karnataka	0.605	0.468	0.136	29.11
NE (Excl. Assam)	0.670	0.535	0.135	25.28
Kerala	0.924	0.789	0.135	17.06
Orissa	0.499	0.372	0.126	33.93
All India	0.568	0.442	0.126	28.51
Uttar Pradesh	0.492	0.371	0.121	32.55
West Bengal	0.575	0.455	0.120	26.32
Assam	0.636	0.516	0.120	23.17
Rajasthan	0.462	0.348	0.114	32.65
Punjab	0.654	0.542	0.112	20.70
Himachal Pradesh	0.747	0.636	0.112	17.58
Haryana	0.622	0.512	0.110	21.55
Maharashtra	0.715	0.606	0.108	17.89
Jammu and Kashmir	0.597	0.507	0.090	17.65
Gujarat	0.577	0.512	0.065	12.73
Goa	0.758	0.751	0.007	0.95
Delhi	0.809	0.816	-0.007	-0.86

3. The SCs' and STs' human well-being indicators are converging with the nation

One of the main findings of *IHDR 2011* is that for most human development indicators, there is convergence (though with important exceptions) with the national average for Scheduled Castes (SCs), Scheduled Tribes (STs) and Muslims (Figures 2-7). SCs, STs and Muslims are converging with the all India average for most health, education and income indicators like infant mortality rate (IMR), under five mortality rate, total fertility rate, contraception prevalence rate, child immunization rate, literacy rate and unemployment rate, while, nutrition and sanitation are two major exceptions where these groups are diverging from the national average.

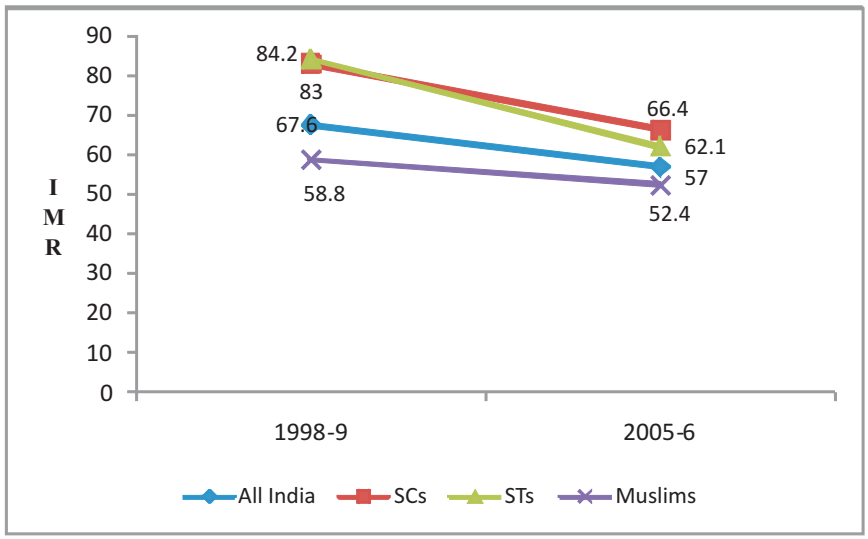
Infant mortality rate (i.e. the probability of an infant surviving after its first birthday) is a very important health outcome indicator (as it determines and is highly correlated with life expectancy). Sen (1995) considers that mortality rates are better indicators for assessing overall well-being and inequality than income estimates. He argues that mortality information reflect the nature of social and economic inequalities, including gender bias and racial disparities which can be seen through differential mortality rates.

SRS estimates show that over the last decade (2000 to 2009), IMR has witnessed a dramatic fall both in rural as well urban areas. It was 68 per 1000 live births in 2000, which dropped to 50 in 2009. The greatest improvement was seen in states of Orissa (from 95 in 2000 to 65 in 2009), Jharkhand (from 70 in 2000 to 44 in 2009), Chhattisgarh (from 79 in 2000 to 54 in 2009), Tamil Nadu (from 51 in 2000 to 28 in 2009), followed by Madhya Pradesh (from 87 in 2000 to 67 in 2009), Rajasthan (from 79 in 2000 to 59 in 2009), and Uttar Pradesh (from 83 in 2000 to 63 in 2009). Thus, the relatively poorer states witnessed improvements in IMR over 20 points compared to all India decline in IMR by 18 points thus suggesting convergence over time.

Moreover, the rural urban has also narrowed over time due to faster improvements in rural areas. In 2000, IMR in rural areas was 74 per 1000 live births which fell to 55 in 2000, compared to a decline from 44 per 1000 live births in 2000 to 34 in 2009 in case of urban India respectively. Most of the poorer States was where there was a sharp reduction in rural-urban gap – Andhra Pradesh, Arunachal Pradesh, Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Orissa and Uttarakhand.

Estimates for IMR across social and religious groups are available from National Family Health Surveys (NFHS). IMR across social and religious groups shows that a higher number of Muslim infants compared to national average (in 2005-06) lived beyond age one. Even SCs and STs are converging with the all India average of IMR over time. In fact, fall in IMR has been the sharpest in case of STs for which IMR declined by 22 points from 84 per 1000 live births in 1998-99 to 62 per 1000 in 2005-06 compared to a fall from 67.6 to 57 per 1000 live births in case of all India (Figure 2).

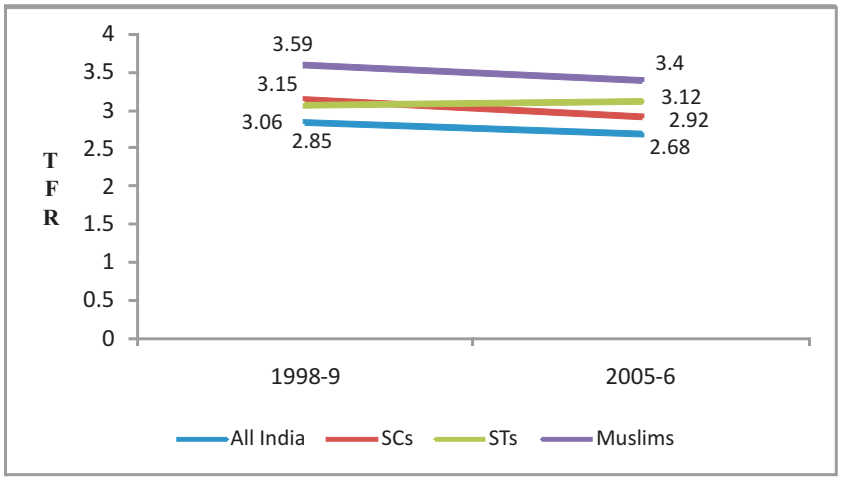
Figure 2: Infant Mortality Rate: SCs, STs and Muslims converging with all India average



Total Fertility rate and prevalence of contraception are important indicators that reflect the state of public health systems (PHCs, Sub-Centres, District hospitals) in the country. More importantly, from the perspective of human well-being, these indicators reflect the degree of autonomy women enjoy in the household's decision-making, and how much time/energy women will have to perform tasks other than just child-rearing.

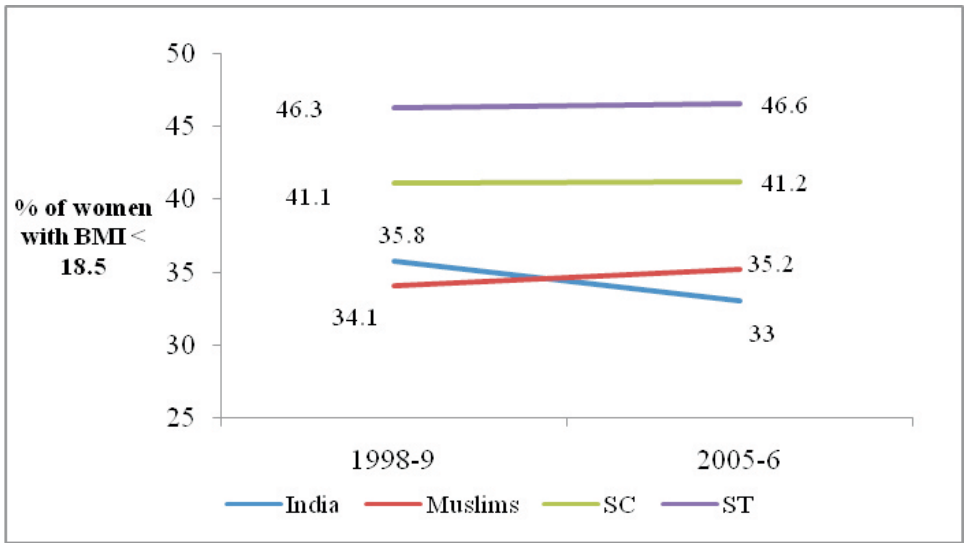
Nine major states – Andhra Pradesh, Delhi, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, and West Bengal - have achieved the replacement level of TFR (2.1) by 2009, but the poorer states like Bihar, Chhattisgarh, Madhya Pradesh, Rajasthan and Uttar Pradesh are way behind with TFR of over 3. Unless the public health system in the latter states improves, the population growth rate cannot be reduced. While TFR has been converging in case of SCs and Muslims, ST TFR has marginally increased from 1998-99 to 2005-06. This is surprising because the contraception prevalence rates for all groups – SCs, STs and Muslims - are converging with the national average and have resulted in a decline in TFR for SCs and Muslims. The decline in TFR has been the highest in case of SCs (Figure 3).

Figure 3: Total Fertility Rate: SCs and Muslims are converging with the national average



Body Mass Index (BMI) less than 18.5 shows malnutrition among women. From 1998-99 to 2005-06, while the percentage of Indian women with BMI< 18.5 declined from 36 per cent to 33 per cent, percentage of SC and ST women with BMI< 18.5 remained unchanged over the same period – 41 per cent and 46 per cent respectively. And, infact incidence of malnutrition among Muslim women increased from 34 per cent in 1998-99 to 35 per cent in 2005-6. Thus, all these groups showed divergence from the all India average of incidence of female malnutrition (Figure 4). This is also true in case of percentage of women with anaemia. Over half of Indian women suffer from anaemia, and there is an increasing trend of anaemia among SC, ST and Muslim women.

Figure 4: SCs, STs and Muslims diverging from national average of women with BMI <18.5

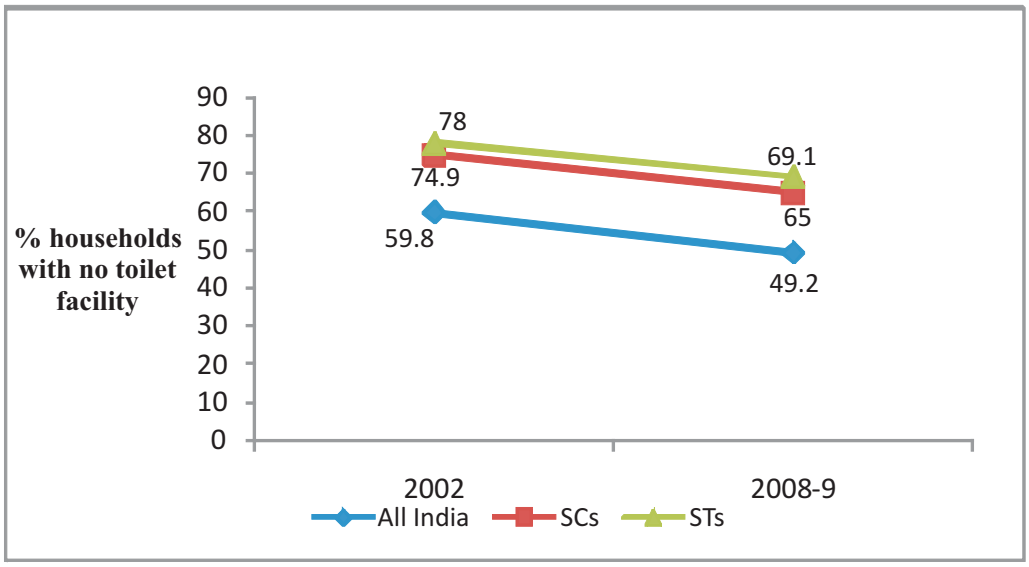


Poor nutritional outcomes are often a result of constant exposure to water borne diseases which are due to lack of proper sanitation facilities and open defecation. Out of the 1.1 billion people in the world practicing open defecation, 638 million or 58 per cent live in India (WHO and UNICEF 2010). Despite an increase in the number of toilets being constructed, open defecation remains one of the largest threats to health and nutritional status, in addition to the safety of women and girls. There are also concerns regarding the actual use of toilets built through the subsidy programme being often used for storage, bathing and washing purposes. Even if a single household is defecating in the open, that household can be a source of diarrhea for all households.

Our analysis of the NSS data for *IHDR 2011* shows that about half of Indian households lacked access to sanitation facilities in 2008-9. In Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan and Uttarakhand over 60 per cent of households were without toilets. The situation is more dismal in rural areas, particularly in these states, where more than 75 per cent households do not have toilet facilities (*IHDR 2011*). This also gets reflected in the poor access to sanitation facilities in case of SC and ST households. Compared to 49 per cent Indian households, as much as 65 per cent SC and 69 per cent

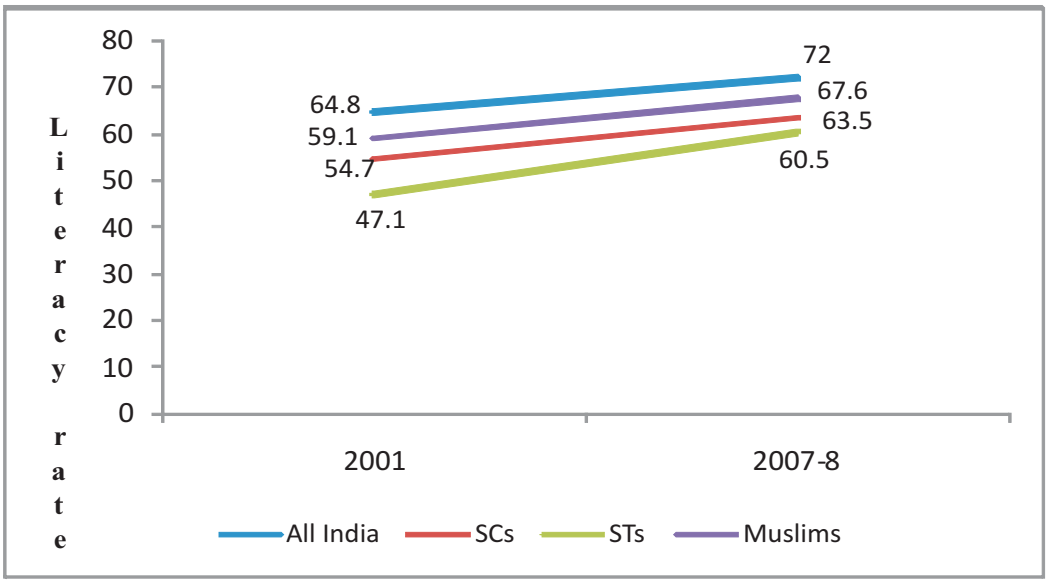
ST households lack toilet facilities and are even diverging from the national average over time (Figure 5).

Figure 5: Sanitation: SCs and STs are diverging from the national average



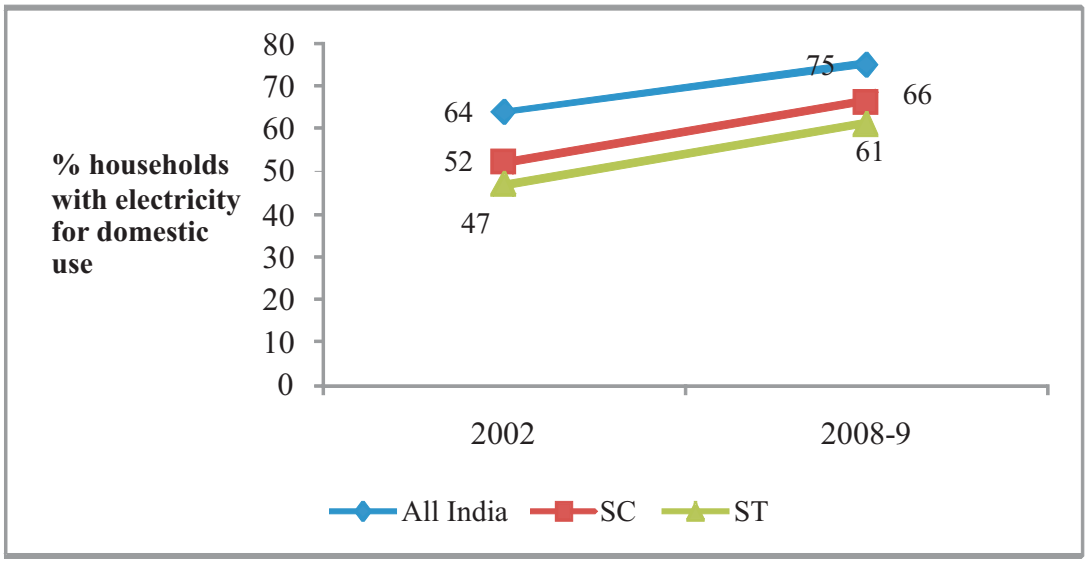
We had seen earlier that improvements in HDI have been largely guided by improvements on the education front. With an all round increase in literacy across the country, there is a decline in the inter-state variation in literacy rates both in rural as well as urban India, showing that the poorer and the educationally backward states are catching up with the national average. The rate of increase in literacy was higher in rural areas implying that even the rural and urban India are also converging. Even the SCs, STs and Muslims are catching up with the all India literacy rate with the sharpest increase in case of STs. STs have witnessed an increase in literacy rate by 13 percentage points from 2001-2007-08 compared to 7 percentage points increase for all India (Figure 6).

Figure 6: Literacy rate: SCs, STs and Muslims are converging with the national average



Determinants like housing conditions, access to electricity, telephony and road connectivity are crucial inputs in the development process. Supporting human development, infrastructure is a source of positive externalities and stimulant to economic growth. There have been improvements in housing conditions over the past decade. Two third of Indians now reside in pucca houses compared to less than 50 per cent at the beginning of the decade. However, compared to an all India average of 66 per cent, 58 per cent of SC and 38 per cent of ST households reside in pucca houses (NSS 2008-09) with their gap with the national average widening over time. As per NSS estimates, in case of households with electricity connection for domestic use, there has been an overall increase in India from 64 per cent in 2002 to 75 per cent in 2008-09. Even the poorer states have seen a huge increase in the percentage of households with electricity for domestic use in rural areas, but the coverage still remains low (like Bihar 25 per cent, Jharkhand 43 per cent, Orissa 45 per cent, and Uttar Pradesh 38 per cent) (*IHDR 2011*). However, the SCs and STs with improvements higher than the all India average are converging with respect to households with access to electricity (Figure 7).

Figure 7: Access to electricity: SCs and STs are converging with the all India average



To summarise, but for nutrition, sanitation and pucca houses, for all other indicators the SCs and STs are converging with the national average. This clearly demonstrates that government policies in regard to SC-ST access to these three services need to be more carefully designed.

4. The Muslims' Social indicators are also converging

The Prime Minister's High Level Committee - Sachar Committee on Status of Muslim Community in India - had carried out an analysis of the social, economic and educational status of Muslims in India and had come to the conclusion that for most social indicators Muslims were doing much worse than the rest of the population of the country. *IHDR 2011* has undertaken the analysis to examine how the Muslim community's socio-economic indicators have evolved over this past decade.

Table 5 shows a series of indicators found in the Sachar Committee Report which have been re-examined by the *IHDR 2011* based on data for the 2000s. In fact most of the indicators for which end-point data is presented in *IHDR 2011* are for the end of the 2000s, i.e. its data at least covers a 10 year period beyond what was captured in the Sachar Committee report.

The average for Muslim underweight children (48.3 per cent) as per NFHS 2 (1998-99) and as reported in the Sachar Committee was worse than the all India average (47 per cent). However, over 8 years after 1999, there was a drop in the percentage of Muslim underweight children by 6.5 percentage points compared 4.5 percentage points drop in the national average by 2005-6. As a result, Muslim average for underweight children was better than the national average in 2005-6.

Similarly, in terms of literacy rates, Muslims are improving faster than the all India average with the gaps narrowing over time. For instance, the difference between national average and Muslim average for literacy rate in rural areas was 6 percentage points and in urban areas 10 percentage points in 2001. Both of these have fallen to 3.5 percentage points and 8.5 percentage points respectively (although Muslims still continue to have lower literacy rates compared to the national average in 2007-8) (Table 5).

Table 5: Comparing results: Sachar Committee 2006 versus IHDR 2011

	Sachar Committee			IHDR 2011		
Indicator	Year	Muslims	All	Year	Muslims	All
			Health and Nutrition			
IMR	1992-93 (NFHS-1)	77	86	1998-9	58.8	67.6
	1998-99 (NFHS-2)	59	67.6	2005-6	52.4	57
U5MR	1992-93 (NFHS-1)	106	119	1998-9	82.7	94.9
	1998-99 (NFHS-2)	83	94.9	2005-6	70	74.3
Contraceptive Prevalence Rate	1998-99 (NFHS-2)	37	48.2	2005-6	45.7	56.3
Total fertility rate	1998-99 (NFHS-2)	3.59	2.85	2005-6	3.4	2.7
underweight children	1998-99 (NFHS-2)	48.3	47	2005-6	41.8	42.5
stunted children	1998-99 (NFHS-2)	47	40	2005-6	50.3	44.9
Institutional delivery	1998-99	31.5	33.6	2005-6	33	38.6
Education						
Literacy(R)	2001 Census	53	59	2007-8	63.5	67
Literacy(U)	2001 Census	69	79	2007-8	75.1	84.3
Infrastructure						
Pucca House (R)	1998-99	23	20	2008-9	49.8	55.4
Pucca House (U)	1998-99	63	65	2008-9	90.1	91.7

Thus, the main conclusions to be drawn from Table 5 are that gaps between the Muslim and national average for most human development outcomes are narrowing, thus reflecting improving conditions of Muslims. Muslims fare better than SCs and STs for most social indicators. However, except for child mortality indicators (IMR and U5MR), access to toilets and percentage of underweight children absolute levels for most other indicators for Muslims are still lower compared to the national average.

Table 6 summarizes indicators across the report for which convergence and divergence is witnessed between the marginalized communities on the one hand, and the country as a whole. The table shows that for a majority of output/outcome indicators of income,

Table 6: Convergence for most human development indicators for SCs, STs and Muslims

Indicators	Convergence	Divergence
	Income and Employment	
Per capita consumption expenditure	SCs	STs, Muslims
Unemployment rate	SCs, Muslims	STs
Child labour rate	SCs, STs, Muslims	
	Health and Nutrition	
Female malnutrition (Body Mass Index <18.5)		SCs, STs, OBCs, Muslims
Women with amaemia		SCs, STs, OBCs, Muslims
Infant Mortality Rate	SCs, STs, OBCs, Muslims	
Under five mortality rate	SCs, STs, Muslims	
Total fertility rate	SC, Muslims	STs, OBCs
Contraception Prevalence rate	SCs, STs, Muslims	
Child immunization	STs, Muslims	SCs
	Sanitation	
Toilet facility	OBCs	SCs, STs
	Education	
Literacy	SCs, STs, Muslims	
	Support Infrastructure	
Pucca houses	OBCs	STs
Electricity for domestic use	SCs, STs, OBCs	

employment, health, education and support infrastructure, the SCs, STs and Muslims are converging with the rest of the nation. However, as noted earlier, there are notable exceptions, especially in respect of nutrition. Moreover, the situation in regard to safe sanitation is appalling across the board in the majority of states. The IHDR 2011, therefore, undertakes a serious, disaggregated level analysis of a very large set of indicators and is unhesitating in its criticisms of our failures in human development outcomes – while recognizing that there is empirical evidence of achievement on many dimensions.

As discussed earlier, the historically excluded sections of the society are particularly concentrated in those states that appear at the lower end in human development rankings. As we have argued above and in *IHDR 2011* these very states have been showing relatively faster rates of improvements over time, thus reducing inter-state variations in HDI and other indicators. But all this is not to detract from the fact of the still continuing low absolute values of various social indicators of these groups and intra state variations for various socio-religious groups. The pace of convergence can improve if the low absolute levels for SCs, STs and Muslims are duly addressed.

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