



# Campaign Issues in Child Health

Towards the National Health Assembly II  
Booklet - 4



National Coordination Committee,  
Jan Swasthya Abhiyan



## **Campaign Issues in Child Health**

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



## NATIONAL COORDINATION COMMITTEE MEMBERS

- \* All India People's Science Network (AIPSN)
- \* All India Drug Action Network (AIDAN)
- \* Asian Community Health Action Network (ACHAN)
- \* All India Democratic Women's Association (AIDWA)
- \* Association for India's Development (AID India)
- \* Bharat Gyan Vigyan Samiti (BGVS)
- \* Breastfeeding Promotion Network of India (BPNI)
- \* Catholic Health Association of India (CHAI)
- \* Centre for Community Health and Social Medicine , JNU
- \* Centre for Health Enquiry into Health and Allied Themes (CEHAT)
- \* Christian Medical Association of India (CMAI)
- \* Society for Community Health Awareness, Research and Action (SOCHARA)
- \* Forum for Creche and Child Care Services (FORCES)
- \* Federation of Medical Representative Associations of India (FMRAI)
- \* Joint Women's Programme (JWP)
- \* Medico Friends Circle (MFC)
- \* National Alliance of People's Movements (NAPM)
- \* National Federation of Indian Women (NFIW)
- \* National Association of Women's Organizations (NAWO)
- \* Ramakrishna Mission (RK)
- \* Voluntary Health Association of India (VHAI)

### **Participating organisations**

Over 1000 organisations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Abhiyan campaign as participating organisations.



## About the Jan Swasthya Abhiyan

In 1978 at Alma Ata, the governments of the world came together to sign the Alma Ata Declaration that promised "Health for All by 2000". However this promise was never taken very seriously and was subsequently marginalised in health policy discussions.

As the year 2000 approached it appeared that "Health for All by 2000" was quietly being forgotten by governments around the world. To remind people of this forgotten commitment the First People's Health Assembly was organised in Savar, Bangladesh in December 2000. The People's Health Assembly was a coming together of people's movements and other non-government civil society organisations all over the world to reiterate the pledge for Health for All and to make governments take this promise seriously. The assembly also aimed to build global solidarity, and to bring together people's movements and organisations working to advance the people's health in the context of policies of globalisation.

The national networks and organisations that had come together to organize the National Health Assembly, decided to continue and develop this movement in the form of the Jan Swasthya Abhiyan (People's Health Movement). Jan Swasthya Abhiyan forms the Indian regional circle of the global People's Health Movement.

Despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people worldwide. Enduring poverty with all its facets and in addition, resurgence of communicable diseases including the HIV/AIDS epidemic, and weakening of public health systems is leading to reversal of previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under threat.

These trends are to a large extent the result of the inequitable structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, unfair world trade arrangements and uncontrolled financial speculation - all part of the rapid movement towards inequitable globalisation. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Within the health sector, failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis. These deficiencies include:

- A retreat from the goal of comprehensive national health and drug policies as part of overall social policy.
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society.

- A failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread and usually inequitable policies of privatisation of health services.
- A narrow, top-down, technology-oriented view of health and increasingly viewing health care as a commodity rather than as a human right.
- It is with this perspective that the organisations constituting the Jan Swasthya Abhiyan have come together to launch a movement, emerging from the Peoples Health Assembly process. Some objectives that this coalition set for itself (which are set out in detail in the Peoples Health Charter) can be listed briefly as below:
- The Jan Swasthya Abhiyan aims to draw public attention to the adverse impact of the policies of iniquitous globalisation on the health of Indian people, especially on the health of the poor.
- The Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 A.D.' pledge. This historic commitment needs to be renewed and taken forward, with the slogan 'Health for All - Now!' and in the form of the campaign to establish the Right to Health and Health Care as basic human rights. Health and equitable development need to be reestablished as priorities in local, national, international policy-making, with Primary Health Care as a major strategy for achieving these priorities.
- In India, globalisation's thrust for privatisation and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialise medical care. Irrational, unethical and exploitative medical practices are flourishing and growing. The Jan Swasthya Abhiyan expresses the need to confront such commercialisation, while establishing minimum standards and rational treatment guidelines for health care.
- In the Indian context, top down, bureaucratic, fragmented techno-centric approaches to health care have created considerable wastage of scarce resources and have failed to deliver significant health improvements. The Jan Swasthya Abhiyan seeks to emphasize the urgent need to promote decentralisation of health care and build up integrated, comprehensive and participatory approaches to health care that places "Peoples Health in Peoples Hands".

The Jan Swasthya Abhiyan seeks to network with all those interested in promoting peoples' health. It seeks to unleash a wide variety of people's initiatives that would help the poor and the marginalised to organise and access better health care, while contributing to building long-term and sustainable solutions to health problems

The Jan Swasthya Abhiyan is being coordinated by National Coordination Committee consisting of 21 major all India networks of peoples movements and NGOs. This is the third book in a six booklet series brought out by the NCC for the NHA II.



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

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## Towards the National Health Assembly II

*The health and survival of children is a key index of the level of development of any society. Unfortunately, India's track record on this front continues to be dismal and is a true reflection of a failure to achieve economic and social growth of a kind that benefits the majority.*

## Section I

# Globalisation, Determinants & Status of Child Health

The socio economic determinants of child health are complex and numerous. However, the two most important determinants of child mortality, predictably, are poverty and gender with all their consequences on nutrition, access to health care, environment and education. Other social determinants like caste, religion, and culture also play a significant role. The status of, and access to health and childcare services of adequate quality is a critical factor.

Our IMR and U5MR are even higher than that of Bangladesh and malnutrition figures are higher than those in the poorest sub Saharan countries.



## Poverty

India is seeing an era of unprecedented economic growth as measured by standard economic indices. Yet, improvements in all child mortality indices are showing clear stagnation over the last many years. In decade 1971 -81 IMR had declined by 29 points and in 1981-91 the IMR fall was by 30 per 1000. But in the years of the so-called structural adjustment and reforms- from 1991 to 2001 this rate of decline plummeted to less than half - only 14 per 1000. Thus, infant and child mortality, malnutrition rates

Two-thirds of all child deaths occur in 13 countries. Of these, only two, Bangladesh and Indonesia, are on track for the MDG target. Another four, China, India, Niger and Pakistan; will achieve the goal between 2015 and 2040.

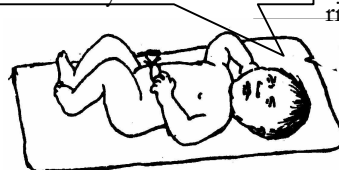
*Human Development Report 2005*



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etc. illuminate the situation of poverty and inequity in a way that rising sensex figures cannot compensate for. This 'poverty' can be

Out of 1000 children who are born like me - 30% have low birth weight, 58 will die before their first birthday and another 85 before they are five.



further deconstructed to relate directly to food security, access to health care facilities, education of parents and access to 'correct' information (as against media messages that are guided by markets), rights as workers (specially right to maternity leave and compensation, control over working hours and leave, exploitative wage conditions, lack of child care services on

worksites), displacement, dispossession and migration leading to urban habitats that are short on space, materials, safety and sanitation . National Family Health Survey II confirms that in household with low standard of living the neo-natal mortality is two times, the post-neonatal mortality is three times and 1-4 year child mortality is five times that of households with high standard of living. These differences are more obvious in urban than in rural areas.

Also, measurements of poverty have become another area requiring constant struggle- just to ensure that the poor are counted.

Infant Mortality			
Rates	Total	Rural	Urban
1971	129	138	82
1981	110	119	63
1981	80	-	-
1991	80	87	53
2001	66	72	42
2004	58	64	40

### **Campaign Issues in Child Health**

Increasingly, the designation of BPL (Below Poverty Line) is becoming the pre requisite to extract entitlements from the State such as that of free health care services, food subsidies such as the PDS and access to various welfare schemes even for children. This leaves out the majority of poor children and does not even target those in extreme poverty effectively.

### **Gender**

Where the issue of gender and the status of women are concerned, women are the bearers and main caregivers of all children male or

We girls are particularly vulnerable to malnutrition due to general discrimination in terms of food allocation within the family, additional responsibilities, and later and lesser access to medical treatment.

In addition, as we grow older, proneness to anemia due to menstruation, an inadequate appreciation of adolescent food requirement, and early marriage and early motherhood continue our chronic malnutrition and poor health

female. Thus it is self evident that the health that they maintain, the power they wield, the decisions they are able to take, the support they receive as child care-givers while balancing onerous roles as workers and home makers, their self esteem and values, all impact all children. Still, the impact on the girl child is even greater because patriarchy is transmitted from woman to woman and social conditioning created at the earliest of ages. Whether it be the deafening silence that surrounds the birth of the girl child, the delays in getting to health care services, the discrimination in feeding, the early induction into housework and care of younger siblings or the curtailment of education, the girl child is disempowered in



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these early years and prepared to be a 'woman' in a 'man's' world. (Statistics show no major gender differences in breast-feeding and only small differences in malnutrition figures. However, child mortality is distinctly higher in girls. The fact that is more so in relatively richer states like Punjab, which are also facing falling sex ratios, testifies to the association between the gender inequity situation and high child mortality).

Being the main care-giver for children, the woman's own health and well being pertains directly to the health of the newborn as well as her ability to give care in the vital initial years of life when the child is most vulnerable and sets the foundations for her entire future in terms of growth and development. The 'care-giver' role is so steeped in invisibility, so poorly understood and so much taken for granted that interventions to provide support are largely missing even as huge bodies of work now exist to show the relationships of women's work, time, energy and power to the health of children. It is this combination of factors that disempowers women that gives rise to the so called South Asian Enigma, where poorer populations of non South Asian countries show a better status of child nutrition than South Asian countries with relation to what can be expected in co relation to their respective GDPs. It is to be noted that the mortality figures, however, are better in the South Asian countries and this has been attributed to a somewhat better situation of health care services.

More specifically, the health of the woman before and during pregnancy relates directly to the birth weight of the children she bears. The prevalence of low birth weight in India is close to 30%, and this in turn, has a direct bearing on neonatal morbidity and mortality as well as adult chronic diseases like heart disease and diabetes.

It is well established that exclusive breast feeding for a period of 6 months contributes significantly to the normal growth and development of the newborn and also prevents malnutrition and killer diseases like diarrhea and pneumonia. However, this requires continuous proximity between mother and child for that period and much expenditure of time and effort on the part of the mother. In

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the absence of support within the home or by systems such as maternity entitlements and crèches on worksites, this becomes untenable. Though the woman does not have to be the main caregiver for the next and critical phase of 6 months to 3 years, she usually is. Again, economic and other compulsions take precedence of the time and energy she is able to commit to childcare. Healthcare seeking behaviour is also conditioned by economics and her decision making power. Of course, culture and tradition have a close connection with child care

*I am also lucky my dai was trained and told me to breast feed my baby. About 33% babies get adequate , complimentary feed.*



practices which cannot be denied, but our collective experience suggests that the practical difficulties and struggles of daily life are over riding and that there is a significant underestimation of how much time, trouble and expense needs to go into child caring for the maintenance of her health. [As an example, a newborn would feed for a cumulative four hours in a day. This is over and above the time taken to bathe, clean and other wise interact with the baby. A one year old should be fed about five times a day with appropriate food and given about two milk feeds as well. This time expenditure must be seen in juxtaposition to what we know about the daily schedules of poor women who spend up to 18 hours a day in housework and wage work. ] Women have been seen going back to work within a few days to few weeks after delivery since no paid leave is forthcoming in casual work. Babies are often left in the care of older siblings often with an unsterile bottle full of diluted milk for the day.

All the factors related to gender are further exacerbated in the situation of early marriage and motherhood resulting in much higher

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infant mortalities in children born to mothers younger than 20 years. Short birth intervals and higher birth orders (excluding first- born children) also contribute significantly to higher child mortalities.

In this connection another policy impediment (like the definition of poverty as BPL) to improvements in child mortality is the Two Child Norm. As part of coercive population policies, this is also a



major limiting factor in the access of entitlements as reflected in the fact that maternity entitlements and many subsidised services are only available for the first two children as though subsequent pregnancies and children do not contribute to reduction of maternal or child deaths and as if

punishing the mother and child for going beyond the ceiling of two children by subjecting them to greater risks will achieve any results. Even the Janani Suraksha Yojna was limited by two-child norm till it was removed as a result of public pressure.

### **Women's Education**

Women's literacy levels are known to be one of the most important (if not the most important!) determinants with a positive correlation with child survival and often quoted as one of the key factors in the relative success of states like Kerala in this regard.

*Our literacy level has a clear positive correlation with child survival*



The NFHS II confirms that all components of child mortality are

### **Campaign Issues in Child Health**

observed to decline with increasing maternal education. All child mortality rates are higher amongst illiterate mothers compared to mothers who had completed high school education. There is almost a linear relationship between years of schooling and child mortality. The infant mortality rate for children of illiterate mothers is one and a half times the rate for children of mothers who are literate, and is two and a half times the rate for children whose mothers have at least completed high school.

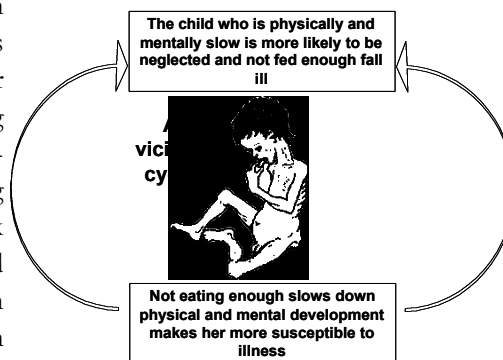
## **Nutrition**

### **A: Infant and Young Child Feeding (IYCF); Malnutrition**

The roots of child morbidity and mortality lie in determinants described above. However, it cannot be overemphasised that a major underlying factor to disease and death amongst children is the situation of chronic hunger and malnutrition. In fact, poverty and gender work largely through the creation of malnutrition as far as impact on child mortality is concerned.

As described, about one third of our children are born already compromised with low birth weight. This combined with poor breast-feeding practices and complementary feeding practices due to lack of support and information, results in one in two children being malnourished and stunted. The resulting vulnerability to disease further reinforces malnutrition, which in turn creates further vulnerability to disease setting up a vicious cycle leading ultimately to death in many cases.

Predictive studies show that more than 50% of deaths amongst



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One third of children like me are born with Low Birth Rate and 50% of us die due to malnutrition.



children have malnutrition as an underlying factor. More specifically, studies predict that not breast-feeding can increase the risk of death up to 6 times from diarrhea and up to 2.4 times from pneumonia in babies less than 6 months and two fold in babies aged 6 - 23 months!<sup>1</sup>

In 2003, The Lancet published a child survival series, which showed proven and practical intervention for preventing or treating main cause of death among children younger than five. According to this analysis, breastfeeding was identified as the single most effective preventive intervention, which could prevent 13 per cent to 16 per cent of all childhood deaths. Adequate complementary feeding between six months to 24 months could

### **National Guidelines on Infant & Young Child Feeding, 2004 set following norms of infant feeding**

- *Initiation of Breastfeeding within one hour*
- *Exclusive breastfeeding for first six months*
- *Introduction of complementary foods at 6 months*
- *Continued breast-feeding for at least 2 years*

prevent an additional six per cent of deaths. If we adjust for the fact that most children, who die, do so in the first month, the percentage of 6 to 24 months old children whose deaths could have been prevented through adequate complementary feeding is even higher.



In a study of over 10,000 babies from rural Ghana, it was shown that promotion of early initiation of breastfeeding has the potential

<sup>1</sup> WHO Collaborative Study Team, Lancet 2000 and Arifeen et al., Pediatrics 2001

### **Campaign Issues in Child Health**

to make a major contribution to the achievement of the child survival millennium development goal; 16% of neonatal deaths could be saved if all infants were breastfed from day 1 and 22% if breastfeeding started within the first hour. Therefore, the various components of child nutrition and possible interventions in the same need to be well understood.<sup>2</sup>

#### **Maternity Benefit Act, 1961**

- ‡ *Maternity leave of twelve weeks.*
- ‡ *Payment of maternity benefit at the rate of the average daily wage*
- ‡ *2 nursing breaks till the child attains the age of 15 months*



In India initiation of breastfeeding within one hour is only 15.8% (according to NFHS-II), it does not even match percentage of institutional deliveries, which is close to 34%. Only 20 percent of infants, six months old, are exclusively breastfed. Just about 33 percent get adequate complementary feeding at 6-9 months.<sup>3</sup>

Support to poor pregnant and lactating women in terms of maternity entitlements and leave is not available to over 93% women who work in the informal sector and a report card on IYCF in India shows this to be one of the weakest areas requiring intervention.

### **B: Campaign Issues in Supplementary Nutrition**

The supplementary nutrition programme for children is run mostly through the ICDS and the MDMs. Two main issues of discussion and debate in recent times have been how to reach the SNP to children under three who may not come to the centre every day, and the role and form of micronutrients within the SNP.

**SNP to Under Threes** - most would agree that forcing very

<sup>2</sup> Global strategy for Infant and Young Child Feeding

<sup>3</sup> <http://www.appartoolkit.com/India.php>



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small children who are not requiring to attend preschool to come to the centre every day is not reasonable. ICDS programmes tend to provide Take Home Rations (THRs) for such children as well as for



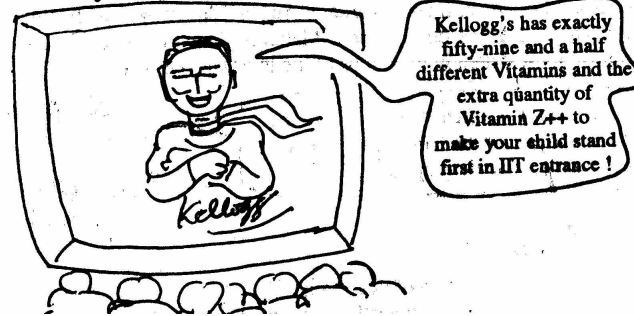
pregnant women. If these THRs are given in the form of uncooked grains or dalia, the concern is that it goes into the family pot and is not earmarked for the child. However, if some kind of 'special' food is provided by way of a 'baby mix' or pre processed food, it may reinforce the notion that babies cannot be given modified home food as well as promote the role

of manufactures and the corporate sector. It is largely agreed that whatever be the THR, it should be procured locally and should be accompanied by nutrition counseling to the family. If any food processing is to be done, it should be such as can be done by women's groups etc locally (such as pounding, roasting, sprouting).

**Micronutrients** - it is well recognised that malnourished children suffer form a variety of micronutrient deficiencies that must be made up for optimal growth and development. Over 75% of our children suffer from iron deficiency anemia. Two national programmes of vitamin A and iron supplementation pertain to this. Unfortunately, they have been fraught with problems. Vitamin A is notoriously short in supply and iron was never provided in a manner (syrup or drops) so that it could be given to very small children. Many experiments have been tried in the name of micronutrient supplementation and food fortification, which the government seems desirous of replicating and universalising (micronutrient candy, double fortified salt, fortified flour etc.) the issues if concerns are as stated above for processed food. It is felt that a combination of adequate, good quality food which has variety of vegetables as well as sufficiency of protein can be combined with the national programmes for Vitamin A and Iron

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### **Deficiency of Micro-Nutrients**



supplementation for good effect rather than spending a lot of money on various more expensive and medical forms of supplementation.

### **C: Diseases Leading to Deaths in Children**

More than 50% of these deaths are attributed to diarrhea, acute respiratory illness, malaria, or measles, conditions that are either preventable or treatable with low-cost interventions.

**1. Diarrhea:** diarrhea accounts for about one fifth of child deaths in India. Its socio - medical determinants include malnutrition (poor breast feeding and weaning practices with little support), lack of safe water, lack of sanitation, lack of information about correct home management of diarrhea with oral re-hydration and continued feeding, lack of access to health care services including pediatricians and antibiotics for dysentery. 90% of diarrhea deaths are said to be preventable.

***Do you know*** - 1 tbsp per day cooked green leafy vegetables g is sufficient for Vitamin A requirements of a 6 month old & 30gm / day enough for 1 yr old's requirement of Vitamin A and most requirements of iron and Vitamin C

**2. Pneumonia:** another fifth of under 5-child mortality is contributed by pneumonia. Its socio-medical determinants include

## Towards the National Health Assembly II

*Our greatest killers are Diarrhoea. Dysentery, Measles and Respiratory Tract infections & many of us also die of TB and Malaria- all of which are preventable*



malnutrition (poor breast feeding and weaning practices with little support), lack of information amongst care taker to be able to recognise the illness and seek care, lack

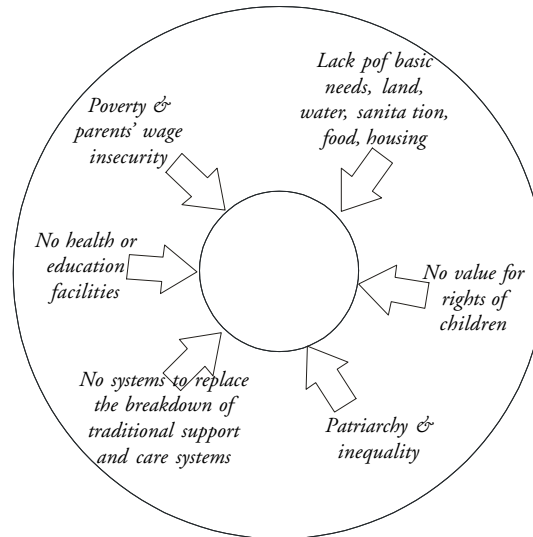
of immunisation and lack of access to health care services for correct management with antibiotics. About 65% of deaths from pneumonia are considered preventable.

**3. Measles:** measles contributes a mortality of 1% with similar determinants. However, the main point about measles deaths is that they are almost 100% preventable by immunisation. Thus, the measles case rate is a clear indictment of lack of access to and outreach by health care services in any system. The other issue of significance is that malnutrition contributes significantly to deaths due to measles and in turn, measles is a significant cause of malnutrition. The risk of death from measles is estimated to be 300 times higher in a grade III malnourished child as compared to a normal child.

**4. Diseases in the neonatal period:** apart from premature births and birth injury, sepsis remains a major cause of death amongst neonates. This is related to unsafe delivery, incorrect breast-feeding practices and failure of early recognition and management. Breast-feeding counseling, good quality institutional delivery and adequate neonatal care services can prevent many neonatal deaths.

### **Campaign Issues in Child Health**

The basic issues in child health



### **State of Health Care Services for Children**

It becomes self evident from the discussion above that health care services play a major potential role in keeping children well and being able to prevent children from dying. From adequate antenatal care, to facilities for safe delivery, immunisation, regular growth monitoring, effective health education of care takers, management of common childhood diseases, facilities for care of Grade III and Grade IV malnutrition and intensive care for the sick child, the health care delivery system needs to address promotion of child health and management of sick children. It also needs to be emphasised that mere access to any sort of care does not suffice. At each level of care provision - habitation, primary health center, referral level etc, their needs to be care of adequate quality of care with referral linkages to the next higher level.

### **Other Services**

As mentioned above, systems for food security such as the PDS,



### **Towards the National Health Assembly II**

integrated systems of care such as the ICDS and creches, systems for access to safe water and sanitation, all have a major role in being able to prevent child mortality.

### **Caste, Culture, Religion, Conflict**

Culture plays a significant role in all aspects of childcare and is often overlooked when interventions are being designed to the detriment of their effectiveness. Its impact is most obvious in health and nutrition related practices around childbirth, infant and young child feeding and use of indigenous forms of medicine. In families that have access, TV watching and its positive and negative impact on socialisation of children is an issue that deserves more attention than it has hitherto merited.

Caste is one of the determinants of poverty and lack of 'power' and children below 3 years of age in scheduled tribes and scheduled castes are twice as likely to be malnourished than children in other groups.

Tribes partake of all the problems mentioned above as well as geographical isolation with its consequences further lack of access to services. Also culturally determined dietary and life style practices of tribal communities are forced to change due to depleting natural resource base and the dietary and other primitive health advice that they are prescribed by the health system is completely insensitive to matching it with their natural and cultural environment.

Communal strife has affected the lives of thousands of Indian children leaving many killed, orphaned, disabled and severely traumatised. The Gujarat riots of 2002, for example, left hundreds of children orphaned and thousands of children destabilised.

Regional insurgency also creates an atmosphere of violence and insecurity in which children survive (or don't!). The situation in Jammu and Kashmir and the North East in particular bear testimony to this in the numbers of children killed or orphaned during skirmishes where the violence may often be inflicted by agencies of the State.

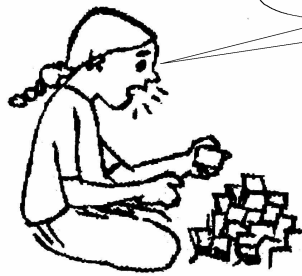
### **Campaign Issues in Child Health**

The conflict situation in Dantewada, (an area of very high malnutrition), which is pushing tens of thousands of families into protection/refugee camps and disrupting the social fabric not to speak of all service delivery is another ongoing example of how conflicts take a heavy toll on child lives. Post traumatic stress must be identified and managed correctly and with skill in such situations of trauma and conflict rather than leaving children to cope with it alone and being labeled 'withdrawn' or 'slow' as a consequence.

### **Child Health and Schooling**

Increasingly more parents have been recognising the need for education. Various state governments recognising people's

*The process of education should cater to essential needs of children and done within a healthy environment.*



aspirations have taken necessary steps in universalising education through various state and central schemes. Ensuring 'Education for All' especially the girl child would bring huge dividends on the economic and development fronts.

It is important to note if the process of ensuring education is child friendly and done within a healthy environment.

Special learning disabilities or dyslexia are common (5-20%) in children and a curriculum that does not recognise such learning needs tends to induce a lot of stress on such children, the teachers and the parents. Many progressive education boards like the Indian School Certificate (ISC) and boards of Tamil Nadu have recognised this fact and exempted mathematics and languages as compulsory subjects at the class X level. A little has been done in elementary schools where education is seen as more a drill to learn by rote than learning for an

### **Towards the National Health Assembly II**

understanding and ensuring creativity.

Even in rural areas, quality education is sought, most parents send their children to 'convent' schools that lack the basic amenities like ventilation, light and playground. Such mushrooming schools lack basic safety norms (as seen in the fire out-break at Tamil Nadu).

The need of the hour is to

develop minimum

standards for schools

to ensure a healthy

environ-ment. An

important issue for the

health of children is that

they must not be made to carry

heavy bags! Bag should not weigh more

than 10 per cent of the body weight of the child.

They should be hung on both tl

"trolley" bags should be used if

The Mid Day Meal Scheme is an important component of using the school to improve the health of children, especially in combination with the school health scheme

Another urban pheno-

mushrooming nursery schools

and crèches. These schools are

meant to prepare the child for

their first entrance exam! These

three year olds are made to

memorise songs, poems and able

to write. The whole issue of entrance exams for tiny tots smacks of

insensitivity and causes a lot of stress on children and parents. Such

entrance tests need to be banned or an alternative form of selection

chosen. We could advocate for inclusion of health promoting

behaviour messages to be included in the school curriculum, but

insist that no examination be held on the subject, instead have project

based work, where children can enumerate /survey their village or

conduct health education camps to the elders in their village. There is

nothing better than a child advocate for healthy behaviour!!



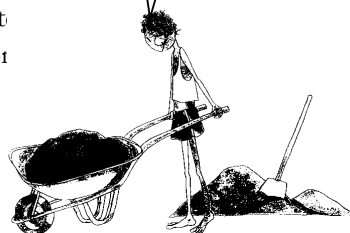
## Campaign Issues in Child Health

### **Child Labour**

India has the largest number of child labourers in the world.

According to the Census of India 2001, 1.25 crore children in the age group of 5-14 years are engaged in different occupations. Many more who work in the unorganised sector and in the small-scale household units, never get enumerated labour. There is no information on less than 5 years who may be Children working in brick kilns, stone quarries, mines, carpet and zari industry are known to suffer from silicosis, respiratory problems, backaches, weak eye-sight and other occupation related diseases.

1.25 crore children are engaged in different hazardous occupations



The 86th Constitutional amendment Act 2002 has provided for free and compulsory education for all children in the age group of six to fourteen years as a Fundamental Right under Article 21A of the Constitution. However, the existence of child labour is a direct contradiction to this fundamental right to free and compulsory education. How can a child avail his/her fundamental right to education, if s/he is simultaneously asked to earn a living?

Our country has the largest number of child labour in the world. This is in contradiction to the fundamental right to free and compulsory education enshrined in the 86th amendment act 2002 of our Constitution.



The Child Labour (Prohibition & Regulation) Act, 1986 is highly inadequate and yet there has been no move to amend it. The fallacious



### **Towards the National Health Assembly II**

distinction between hazardous and non-hazardous occupations continues to exist in law. As a result, children in occupations such as domestic work, in hotels and dhabas, tailoring and sweatshops, wherein they fall prey to exploitation and abuse remain unprotected. Just like agriculture, domestic work, too, is not part of the list of prohibited occupations under the Child Labour (Prohibition and Regulation Act). The Common Minimum Programme of the UPA government too makes this fallacious distinction between hazardous and non-hazardous work.

### **HIV/AIDS and Children**

According to UNAIDS, 120,000 Indian children were living with the

The most common cause of HIV infection among children is the mother to child transmission and with 1.36 million women infected, the infection among children are growing higher.

An estimated 14 million of children like us (under the age of 15) have lost one or both parents to HIV-AIDS.

virus in 2004. The National AIDS Control Organisation (NACO) estimated

that around 60,000 new infections occurred last year. The 2001 Declaration on HIV/AIDS included commitments to implement by 2005 strategies for special assistance for children orphaned by, and vulnerable to, HIV/AIDS, reduce the number of infections passed from mother to child by 20 per cent, and roll out treatment and care. The most common cause of infection among children is the Mother-to-child transmission (MTCT) and, with 1.36 million women infected, the infection



### **Campaign Issues in Child Health**

among children can go higher, unless effective programmes are put in place. Other than MTCT, sexual contact, including sexual abuse; blood transfusion; and unsterilised syringes, including injectable drug use are also sources of infection among children. Besides, millions of children are becoming orphans deprived of parent care and protection due to untimely death of their parents. There are no authenticated statistics on these orphaned children. The AIDS control programme and policy of the government is not touching this crucial point.

We face discrimination.  
There are no care  
arrangement for children  
orphaned by AIDS



According to an unofficial and unpublished estimate of UNAIDS and the Asian Development Bank, India has around 1-1.2 million AIDS orphans. In such situation, when HIV is infecting and killing most of the middle-aged generation, the very young are ending up looking after the ailing parents and family. So, the children become more vulnerable and there are greater chances of them being pushed into hazardous forms of labour and prostitution. Some 70 per cent of people living with HIV/AIDS in India said they faced discrimination, mostly within their families and in healthcare settings, according to findings from International Labour Organisation (ILO) research. As a result, HIV/AIDS infected and affected children are widely denied education or health care.

We have no access to  
medical and institu-  
tional care!



Discrimination against people living with HIV/AIDS hits children even in orphanages, in their neighborhood and in their homes. In a situation like this when there

### **Towards the National Health Assembly II**

are no separate care arrangement for the children orphaned by AIDS it becomes more difficult to provide them access to medical and institutional care. Street children, children of sex workers and other marginalised groups face additional forms of discrimination. Public hospitals refuse to treat them and public hotels refuse to keep the children of sex workers. Although children are considered a priority category for distribution of free ARV, till recently there was no pediatric ARV formulation for young children under the Government rollout plan, making their access to ARV a distant dream.

As of April, only 1,215 of the NACO-estimated 39,000 children who need ARVs were receiving them, a document prepared by the International Treatment Preparedness Coalition (ITPC) said. Less than three per cent of an estimated 189,000 HIV positive women in antenatal clinics received ARVs last year.

### **Child Sexual Abuse**

Child sexual abuse cuts across gender, class, caste or ethnicity and happens to both urban and rural children. While girls are more vulnerable to being sexually abused, against popular belief, boys too

A glance at the National Crime Record shows that there has been a constant rise in the number of child rape cases since 2002. In 2002 the total number of child rape case was 2532, which rose to 2949 in 2003 and further to 3542 in 2004. Clearly, child sexual abuse or sexual assault is not just rape. Indeed rape is just one form of child sexual abuse.

are victims. Children with mental and physical disabilities are indeed at greater risk of abuse due to their vulnerability.

Contrary to popular belief that the threat of sexual abuse is always from outsiders, the abuser in almost 90 per cent cases is someone the child knows and trusts. He may be a member of the family-father, uncle, cousin older siblings or servants, driver's gardeners, family friends or neighbours.

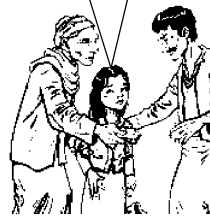
### **Campaign Issues in Child Health**

World Health Organisation (WHO) estimates that globally, 8 per cent of boys and 25% of girls below age 18 suffer sexual abuse of some kind every year. India has the dubious distinction of having the world's largest number of sexually abused children with a child below 16 years raped every 155th minute, a child below 10 every 13th hour, and one in every 10 children sexually abused at any point in time. However, this is only the tip of the iceberg as child sexual abuse cases remain unreported or underreported.

### **Child Trafficking**

Every year, 44,476 children are reported missing in India of whom 11,008 children remain untraced. A recent report, Action Research on Trafficking in Women and Children in India, 2002-2003, indicates that many of the missing persons are not really missing but are instead trafficked.

HELP ME! Every year 44,476 child like me are missing in India!



### **Forms and Purposes of Child Trafficking**

- **Labour** - bonded labour, domestic work, agriculture labour, construction work, carpet/garment industry, diamond cutting, shrimp cultivation etc
- **Sexual Exploitation**- forced prostitution, socially and religiously sanctified forms of prostitution, sex tourism and pornography.
- **Illegal Activities**- begging, organ trade, drug peddling and smuggling
- **Entertainment and sports** - Camel jockeys and circus
- **Adoption**- This is a much needed social service, but in the hands of unscrupulous elements becomes a growing form of child trafficking

### **Towards the National Health Assembly II**

According to ILO estimates, 15 percent of the country's estimated 2.3 million prostitutes are children. While some may be children of sex workers, who have been also sucked into the trade, needless to say most of them are also trafficked.

Trafficking of children, as is the case with all other social problems, cannot be addressed in isolation. It is intrinsically linked to all other problems such as illiteracy, homelessness, and greater influence of the market - all of which creates greater demand. The lack of stringent laws and even weaker implementation of the existing ones only makes it easier for traffickers to continue functioning, as does the lack of an inter-related approach on child trafficking.

### **Children without Adult Protection**

This is another growing problem. One major contributor to this is the disaster situation, which suddenly leaves behind a number of family-deprived children, a situation that has been consistently repeating itself, but for which no policy framework is still in place.

Other than these fractured families, poverty and alcohol related brutalisation of family relationships, and abandoned children make

"Every child has  
right to a caring  
family"



large contributions to this pool. In the absence of any policy of reaching out to these children, the city streets and the public transport systems become host to multitudes of children denied any form of adult protection. Forced into precocious maturity, addicted to drugs and crime, brutalised by the very systems that should protect them, those who do survive emerge with scars that not only affect them-but affect all of society as well. Girls seldom survive at all and sexual abuse of both sexes is the rule, not the exception.

Even where the situation has not assumed the large proportions that

### **Campaign Issues in Child Health**

it has assumed in the metropolis, any modern society which has a vision of itself has modern must undertake this task- at least as part of building into society values of compassion and caring in a crudely commercial world. There are in India many examples of excellent work done in this area. What is needed is to extend this to make it the rule, and part of the social security and welfare structure of governance.

Thus, it is clear that while the immediate cause of mortality in childhood is usually disease, the underlying factors point to serious issues of socio economic inequity. It is also clear that many of these factors are amenable to interventions that are known to be effective and neither too expensive nor too difficult to deploy. In such circumstances, it is unforgivable that the current state of childhood mortality be allowed to linger and treated as 'business as usual'. This area of concern should, instead, be declared a 'state of emergency' and tackled with focus and urgency.

What has been the State's response to child healthcare in terms of policies, schemes, programmes and budget?



What has been the State's response to this emergency in terms of policies, programmes, schemes and budgets? The following section looks at some significant gains and challenges in these areas.

**Section II**

## **Significant Schemes & Programmes**

Currently, the only government scheme that engages with the issue ECCD including IYCF is the ICDS. Linkage with the health care and immunisation services is an essential aspect of maintaining child nutrition and preventing malnutrition. It is expected that the ASHA, a volunteer accredited social and health activist identified per 1000 population in the 18 EAG states under the National Rural Health Mission (NRHM) will also play a big role in IYCF and child health by dint of her impact at the level of the household. Other supportive schemes are the MDMS and the School Health Scheme.

### **Children and the Union Budget 2006-2007**

The share of children in the Union Budget 2006-07 is 4.91 per cent (approximately) as against 3.86 per cent in 2005-06.

Out of this allocation for children the share for Child Education is 71.06%. the percent share of the child budget for health is 11.32% which has gone down from 17.28% in 2004-2005. Child health gets about 25% of the health and family welfare budget. The budget for child development is 16.9% and that for child protection a meager 0.7%. The maternity benefits scheme got no allocation last year at all. This year it has been subsumed in the **Janani Suraksha Yojana** under NRHM.

On October 26, 2005 the Government of India announced that it would henceforth undertake Child Budgeting. This, however, found no mention in the Finance Minister's speech.

## **The ICDS<sup>4</sup>**

The integrated child development services scheme is envisaged to promote all aspects of child growth, health and development in a comprehensive and integrated manner as the name suggests.

Currently, the main issue with respect to the ICDS is to be able to universalise it with quality so that it is able to fulfill its mandate.

On 28 November 2001, the Supreme Court directed the government to universalise ICDS. Further orders to this effect were issued on 29 April 2004 and 7 October 2004.

## **Services Provided Under ICDS**

As its name indicates, the ICDS programme seeks to provide a package of “integrated services” to children under six. The main services are as follows:

### **Nutrition**

1. **Supplementary Nutrition (SNP):** The nutrition component varies from state to state but usually consists of a hot meal cooked at the Anganwadi, containing a varied combination of pulses, cereals, oil, vegetable, sugar, iodised salt, etc.
2. **Growth Monitoring and Promotion:** Children below the age of three years are weighed once a month, to keep a check on their health and nutrition status. Elder children are weighed once a quarter. The details are updated regularly and maintained as growth charts to detect growth faltering.
3. **Nutrition and Health Education:** The aim of NHE is to build the capacity of women aged 15-45 years to look after their own health and nutrition needs, as well as those of their children and families. NHE is imparted through counseling

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<sup>4</sup> Most of this section has been lifted or adapted from the primer on ICDS (created by the Right to Food Campaign which should be referred to as an excellent document for detailed information about the ICDS and the current challenges before it as an intervention in child nutrition.



## **Towards the National Health Assembly II**

sessions, home visits and demonstrations. It covers issues such as infant feeding practices, family planning, sanitation, utilisation of health services, etc.

### **Health**

1. **Immunisation:** Children under the age of six are immunised against polio, DPT, measles, and tuberculosis, while pregnant women are immunised against tetanus. This is a joint responsibility of ICDS and the Health Department. The main role of the Anganwadi worker is to assist health staff (such as the “auxiliary nurse midwife” or ANM) to maintain records, motivate the parents, and organise immunisation sessions.

2. **Health Services:** A range of health services are *supposed* to be provided through the Anganwadi Worker including health checkups of children under six, ante-natal care of expectant mothers, post-natal care of nursing mothers, recording of weight, management of under nutrition, and treatment of minor ailments.

Today 4 crore children are covered under supplementary nutrition component of ICDS program which is only one quarter of all children below the age of six.



3. **Referral Services:** This service attempts to link sick or undernourished children, those with disabilities and other children requiring medical attention with the Public Health Care System. Cases like these are referred by the Anganwadi worker to the medical officers of the Primary Health Centres (PHCs).

### **Pre-School Education**

The aim of PSE is to provide a learning environment to children aged 3-6 years, and early care and stimulation for children under the age of three. PSE is imparted through the medium of “play” to promote the social, emotional, cognitive, physical and aesthetic development of the child as well as

### **Campaign Issues in Child Health**

prepare him or her for primary school

Today, about 4 crore children are covered under the "supplementary nutrition" component of the Anganwadi programme. This is barely one quarter of all children below the age of six. In other words, the coverage of ICDS is very far from universal. To cover all rural settlements the Supreme Court has ordered the government to increase the number of Anganwadis to 14 lakhs. The National Advisory Council has made similar recommendations. In addition, about 3 lakh Anganwadis are required in urban areas, based on existing norms. So far, the government has not accepted these figures. It claims that the number of Anganwadis required is much lower and has sanctioned an additional 1.88 lakh Anganwadis, in response to requirements submitted by State Governments based on existing norms.

In terms of improvement in quality, of services provided under ICDS, the following issues need to be addressed urgently:

1. **Low budgets:** Low commitment to children under six has led to low allocation of funds for ICDS. The total allocation for ICDS by the Central Government for 2004-5 was a mere Rs 1,600 crores - less than one tenth of one per cent of India's GDP. By contrast, in the same year, the Central Government spent Rs.77, 000 crores on defence. Although the budget allocation for 2005-6 has been increased to Rs 3,000 crore, this is far from adequate to improve quality and move rapidly towards universalisation. The expenditure per child needs to be doubled, at the very least, to achieve minimum quality standards. And of course the budget needs to be doubled again, if not tripled, to achieve "universal coverage" of all children. Not only is the overall budget low, the item-wise breakdown also shows glaring inadequacies. For example, each Anganwadi receives a mere Rs. 150 per month for "rent". Getting proper space for an Anganwadi within this budget is almost impossible, particularly in urban areas. Similarly, the standard expenditure norm for "supplementary nutrition" in

### **Towards the National Health Assembly II**

2004-5 was as low as Rs 0.95 per child per day, to be contributed by the State Government. The norm has been doubled by the Central Government, in response to Supreme Court orders, but the money allocated continues to be inadequate to cover basic items like fuel and vegetables.

- 2 Staffing gaps, poor infrastructure and crushing workload of the Anganwadi worker:** Because ICDS is not a priority, State Governments often fail to appoint Anganwadi workers, supervisors and other essential staff. Many Anganwadis are non-functional or poorly supervised due to shortage of essential staff. Similarly, lack of basic infrastructure (from room space to drinking water and teaching aids) is a major problem in many Anganwadis.

We Anganwadi workers have a whole day's work with very low monthly honararium and they expect us to perform 100 different tasks.

They must be mad! But we are not - we know what we should do and we'll do that!

The Anganwadi worker is the most important human factor in the programme - the person who relates to the children and the families. Her confidence, her skills and her motivation are most important. But little attention has been given to this.

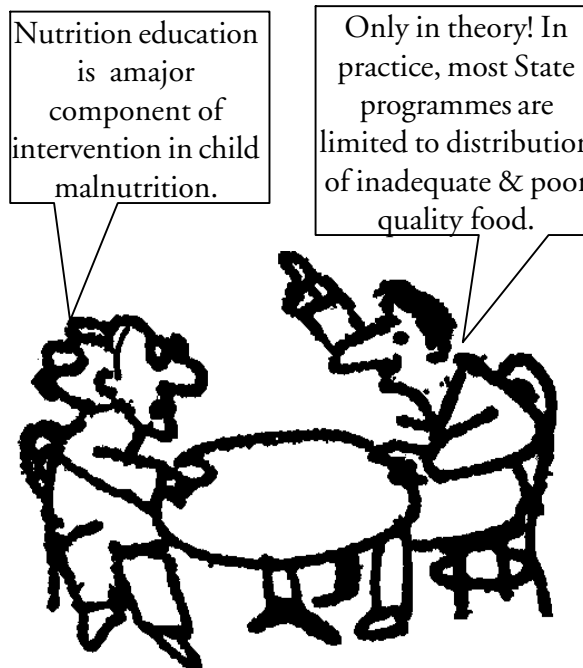


The Anganwadi worker has been given countless responsibilities. Apart from children's health, nutrition and pre-school education, she is supposed to reach out to pregnant and nursing mothers, make home visits, provide nutrition counseling, help with immunisation campaigns, attend Self-Help Group meetings, carry out surveys, keep numerous

### **Campaign Issues in Child Health**

registers, and so on. In addition she is frequently mobilised by other government departments for special duties, such as storing grain for other programmes or meeting targets for setting up Self Help Groups. These further cuts down her time for the children. To make things worse, the training of Anganwadi workers is very limited, and their wages (called an "honorarium") are very low. This affects the status of the Anganwadi worker in the village. She seldom gets the respect due to her, and this undermines her efficiency and her morale. The same holds true for the Anganwadi helper.

3. **Erratic or Defective food supply:** This is a big problem in many states. If there is no food at the Anganwadi, or if the food is tasteless and monotonous, few children attend and no activity can take place. Unfortunately, food supply is often erratic. In some states, food supplies are disrupted for months at a time for trivial reasons, such as delays in sanctioning funds



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or administrative bottlenecks. Irresponsibility and corruption on the part of food supply contractors is also common. However, the Supreme Court has banned the use of contractors for procuring and distributing food for the ICDS. Even where food supplies is regular, there is much carelessness in food storage, and the quality of food is poor in many cases. There are, of course, major variations in all these respects between different states. Some states such as Tamil Nadu have been able to ensure regular food supply and adequate quality standards.

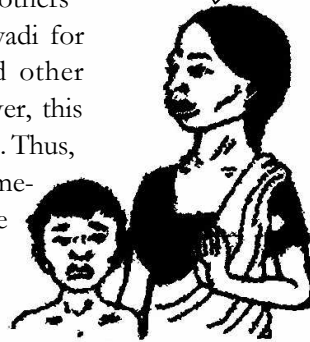
- 4. Poor coordination between health services and ICDS staff:** Health services provided at the Anganwadi tend to be quite popular. Unfortunately, they are often hampered by lack of coordination between the ANM and the Anganwadi worker as well as by a lack of basic medicines. For instance, recent surveys show that many Anganwadis have no medical kit. Even Oral Rehydration Solution (ORS) and other basic items are often lacking.
- 5. Neglect of the pre-school component of ICDS:** Some states, like Kerala and Tamil Nadu, have made great strides with "pre-school education" (PSE). But in most places, this component of the ICDS programme has been grossly neglected. More emphasis has been placed on distribution of food, and to some extent on immunisation. Children need a good learning environment and plenty of activities for proper growth and development. Also, a failure to acknowledge the programme as the sole preschool programme run by the government contributes to the lack of priority, budgets etc it is given.
- 6. Poor outreach to the "under threes":** Children under the age of three should receive the highest priority in the ICDS programme. In practice, they are virtually excluded. The designers of the programme apparently assumed that the family can look after young children without any special

### **Campaign Issues in Child Health**

assistance. This assumption shows little understanding of the lives of women, especially working women. Poor outreach to children under three is a critical gap in the conception of ICDS.

Regular supplementary nutrition is essential for a healthy child.

One way of reaching children under three is for mothers to bring them to the Anganwadi for supplementary nutrition and other services. In most cases however, this does not happen on a daily basis. Thus, in many Anganwadis, take-home-food (THF) is given out once or twice a fortnight for the pregnant women and children under three. This may consist



of food grain like dalia, or special ready-to eat food for the under threes. One problem with the THF approach is that the food may be added to the common family pot and shared by all family members - not just the young child. This is perhaps less likely with certain kinds of "ready to eat" food such as baby-mix that are seen as "baby foods". However, baby food is unlikely to be manufactured locally and shifts procurement in favour of companies and contractors. It also creates the impression that "normal" food is not good enough for the very young child. Clearly, different solutions are needed for different situations, but experience suggests that a combination of nutritious THFs based on local food, together with good nutrition counseling, works relatively well. Depending on the context, this could include local food grains or items such as dalia, laddus etc.

The location of the Anganwadi and its timings are also critical for women to be able to bring or leave their young children at the centre. A full day crèche facility is crucial for the care of

### **Towards the National Health Assembly II**

We need an Anganwadi cum crèche center for care of our children



children of women working away from home. There are limited provisions for some Anganwadis to be converted to "Anganwadi cum crèche" centres. However, this requires not only more infrastructure but also special training and a larger number of workers and should not be undertaken without due preparation.

### **The NRHM and Potential Role of ASHA**

As the ICDS seems to be concentrating on tackling malnutrition, the main thrust of the NRHM also seems limited to preventing child mortality and especially neonatal mortality. However, as with the ICDS, components of the NRHM such as the ASHA offer potential space for (Early Childhood Care and Development) ECCD. How well it is utilised again depends on the influence the 'ECCD lobby' is able to exert.

Previous experience with the issue of infant and young child feeding has clearly brought to the fore the need for support and information to women on these and other parenting issues. Strategies of using a community health worker to bridge these gaps as well as

### **Campaign Issues in Child Health**

facilitate services have been found to be very useful in many small experiments throughout the years, and recently tried at a state level scale in Chattisgarh through a cadre of mitanins or 'health friends'. The ASHA programme attempts to replicate this strategy in 18 of the poorest states of the country. Her roles include the following<sup>5</sup>:

- ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.
- She will counsel women on birth preparedness, breast feeding and complementary feeding, immunisation, contraception and prevention of common infections including RTIs/STIs and care of the young child. She will also act as a health advisor for a whole range of common-acute and chronic ailments.
- ASHA will mobilise the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as immunisation, ANC check-up, ICDS, sanitation and other services being provided by the government.
- She will work with local health committees and panchayats to develop a comprehensive village health plan.
- She will escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre-identified health facility i.e. PHC /FRU.
- ASHA will First Contact Care for all common, minor ailments such as diarrhea, fevers, and first aid for minor injuries. She



<sup>5</sup> NRHM documents



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will be a provider of DOTS. She will also act as a depot holder for essential provisions being made available to every habitation like ORS, IFA, chloroquine, DDK (disposable delivery kits), oral pills & Condoms, etc. A drug kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group.

### **Opportunities for Child Care & Reduction of Child mortality**

ASHA can potentially meet every family with a newborn within the first day, if not within the first hour and support the mother to establish exclusive breastfeeding. This single measure would create a significant reduction in mortality as evidenced earlier.

ASHAs can potentially meet every family with a newborn repeatedly in the first week to ensure that the key steps to newborn care- keeping the baby warm, ensuring weighing of the newborn and referring the severely low birth weight child and the sick neonate to appropriate care, as well as adequate feeding of the mother. These

### **Challenges**

1. Can the selection of the ASHA be leveraged in favour of ECCD by ensuring that already ECCD experienced workers are given preference?
2. Can training of the ASHA be leveraged in favour of ECCD?
3. Ensure that adequate supervision and support exists to reduce chances of failure as has happened with other community health worker programmes.
4. Ensure that ASHA does not become a via media to provide sub standard curative services
5. Ensure that ASHA does not become a vehicle merely to achieve sterilization targets.

### **Campaign Issues in Child Health**

steps done by a trained volunteer can make a difference even under given social and economic circumstance.

Every family can potentially access ASHAs where there is a child with diarrheas, fever or coughs and cold within the first day of the illness. ASHA would be able to help the family make an informed choice between management with home remedies or seeking appropriate medical care. This support would save the poor family needless expense for trivial illness while helping them access timely institutional care for life threatening illness. To some extent she would be able to contribute to saving lives by her own curative interventions also.

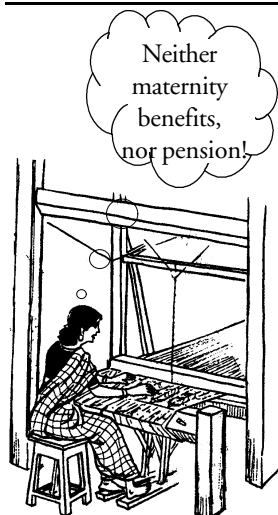
ASHA can potentially reach out to every family with an infant in the first year and in a substantial part of them prevent the slip into malnutrition by appropriate counseling on exclusive breastfeeding and later on adequacy of complementary feeding possibilities within the families' social, economic and cultural contexts.

It needs to be noted that this prompt and appropriate and persistent attention needed in the situations described above can be achieved only by a person who is resident in the very habitation as the family needing care - thus ruling out the ANM, and in most habitations the AWW as well as the provider of this care. These are measures that assist the poor family cope with their poverty and assist the poor woman in her most immediate and overpowering felt need - safeguarding the life of their child. Moreover these changes are wrought not by individual counseling alone, but by such counseling happening in a setting of social mobilisation to effect change in their own lives. And where successful it would lead to increased self-confidence and confidence in collective community action.

Such social mobilisation therefore provides a context and a possibility when catalyzed by interactions with other community based organisations and with movements and peoples movements of moving on to address issues of access to institutional care and to the other social determinants of their predicament.

## **Towards the National Health Assembly II**

### **Maternity Protection: Laws and Schemes**



Currently, the only law that pertains to maternity protection is the Maternity Benefits Act (1961), which not only leaves out the majority of workingwomen who work in the informal sector but also does not fulfill the requirements of providing support to exclusive breast feeding for six months. The main scheme for the support of the poorest of poor women, the National Maternity Benefits Scheme (NMBS) offers Rs.500 to BPL women for the birth of her first two children.

### **The Crèche Schemes for Working and Ailing Mothers**

Over 90 million women work in the unorganised or informal sector with an estimated 50 million children. Of these, a large number are in situations of migration.



Over 90 million women work in the unorganised or informal sector with an estimated 50 million children. Of these, a large number are in situations of migration. The Central Sector scheme of assistance to voluntary organisations for running creches/day care centers for working/ailing women was started in 1975 in pursuance of the priority objectives of the National Policy for Children adopted in 1974. This scheme aimed to provide day care services for the children (0-5 years) have mainly casual, migrant, agricultural and construction labourers. The children of mothers unable to care for the children due to sickness or suffering from communicable diseases were also covered under the scheme. Only those children whose parents' total monthly income do not exceed Rs.1,800/- were covered under the scheme. The services available to the children include sleeping and day-care facilities, supplementary nutrition,

### **Campaign Issues in Child Health**

immunisation, medicine, recreation and medical check-up. It should be noted that pre school education does not figure in the list of services!!

The Central Social Welfare Department was implementing the scheme all over the country and it supported about 12,470 crèche units providing services to around 3.11 lakh beneficiaries. This figure had been static since 1994.

The **National Crèche Fund** was set up in 1994 to meet the growing requirement of working mothers for opening more crèche centers. A corpus fund of Rs 19.90 crore was made available out of the Social Safety Net Adjustment Credit from the World Bank.

However, the **Rajiv Gandhi National Creche Scheme** was announced in Nov 2005 for the children of working mothers - by merging the existing two schemes viz. **National Creche Fund Scheme**, with the **Scheme for Assistance to Voluntary Organisation** for running Creches for the children of Working/ailing women and liquidating the corpus of Rs.19.90 crore effective from Jan 2006. This promises revision of the financial norms for the crèches covered under both the schemes for the remaining two years of the Xth Five Year Plan with effect from January 1, 2006 and opening of 14,719 new crèches under the new scheme during remaining period of X Five Year Plan. These crèches will be allocated amongst the existing implementing agencies, namely, Central Social Welfare Board, Indian Council for Child welfare and Bhartiya Adimjati Sevak Sangh.

The services available to the children include day care facilities, supplementary nutrition, immunisation, medicine, recreation & medical check-ups. It should be noted that pre-school education does not figure in this list of services!!



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However, it also enhances the eligibility under the scheme from Rs.1800/- per month per family to Rs.12,000/- per month per family and introduces collection of user charges by organisations implementing the Scheme at the rate of Rs.20/- per child from BPL families and Rs.60/- from other families per month.

The Employment Guarantee Scheme recognises the need for crèches on worksites and allows for a woman to be paid her EG wage for the care of five or more children on a worksite. However, the implementation of this service will need much more than its existence in the rulebook.

The delays and low priority given to improvements of schemes for the protection of children of working mothers of poorer sections is a matter of deep concern as also the disregard for implementation of crèches at worksites across the country. This is a huge gap area of action though policy documents like the National Plan of Action 2005 clearly articulate the need for crèches. Campaigns, awareness, advocacy for the young child's care and development needs is an urgent requirement to both activate crèches as part of ICDS, and also across Employment Guarantee sites, worksites, working places, plantations and in community spaces. The need and scope is enormous. (Estimated requirement is 8 lakh crèches).

### **School Health and the Mid Day Meal Schemes<sup>6</sup>**

The near-universal coverage of midday meals is a victory of sorts as it reflects organised public pressure, with a little help from the Supreme Court. However, the quality of midday meals is still quite low in most states: the content of the meal is inadequate, health safeguards are lacking and social discrimination is common. Thus, the next challenge is to achieve a radical improvement in the quality of midday meals. A well run "school health scheme" can be of great value to support child health and nutrition. This should include growth monitoring, micronutrient supplementation (e.g. iron tablets),

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<sup>6</sup> Adapted from the mid day meal primer, right to food campaign, which should be referred to for further details.

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immunisation, deworming as well as dealing with common ailments and conducting dental or eye checkups. It is also essential to ensure freely available potable water and accessibility to clean functional toilets for the students. Currently the school health scheme is poorly functional if at all.

A well run school health scheme can be a great value to support childhealth and nutrition

### **Health Care Services for the Sick Child**

The Health Sub-Center and its service delivery: The central child related service provided



by the health sub-center and its main functionary the ANM is immunisation and vitamin A supplementation. Other aspects of child health are so overcome by this central necessity that unless the poor family makes an effort to access her there would be no opportunity for her to provide any other service and even where they do access - she is seldom equipped with the drugs, especially in pediatric formulations, or the supplies or the skills to provide such services.

To some extent her role in antenatal care and in assistance at childbirth also contributes to child health. But the former service lacks quality even where access is there and the latter lacks access and quality. Even in immunisation alarmingly immunisation rates have been going down. Part of the reason is the way routine immunisation has had to make away for the efforts of repeated mass pulse polio administration. Also as immunisation can be seen to be contributing to child health only for protection against measles and to some extent against neonatal tetanus as part of antenatal care. The perceived value of this service is probably declining. Also the problems of exclusion of vulnerable sections - especially urban slums, tribal communities

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etc appear to be on the increase. These problems affect even micronutrient delivery - and vitamin A coverage remain low while pediatric iron and deworming is almost off the list of services insisted on. Even on grade III and IV malnutrition the health system cannot even see a role itself in its management.

Health sub centers and ANM provide immunisation and Vitamin A supplementation. Antenatal care and assistance at childbirth contributes to child health.

### **The Primary Health care Centers**

These are potentially the nearest sites of medical care for the sick child. Though it is not equipped for hospitalisation it is expected to provide for 24-hour institutional delivery and therefore for a fair degree of emergency neonatal care that needs to go along with it. Unfortunately while there is considerable insistence of achieving the institutional delivery goal there is not adequate recognition of this as the site of neonatal institutional care.



Further the system is implicitly willing to concede now that primary health care for the sick child has been deficient. As part of correcting this deficiency a new package called the Integrated Management of Neonatal and Child Illness (IMNCI) is being rolled out. Integrated Management of Neonatal and Child Illness is an effort to reduce the management of common child illnesses to a set of algorithms and then rigorously build the skills for such algorithm-based management in its medical and paramedical staff. If IMNCI goes along with all the other improvements needed to make a primary health centre or sub-center functional as a site of quality medical care - then it would certainly make a difference. This basic set of instructions on child care is now also being introduced into medical education- whose gaps were in the first place responsible for the failure of the PHC to deliver appropriate medical care to the sick child. The IMNCI

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is not magic remedy in itself, it is not even a new remedy, but in the sense that it is a conscious effort to close such a huge gap in child health care services it is long overdue and therefore welcome. However, seeing it through into effective implementation is going to require informed public participation also in the process.

The IMNCI should also be seen only as one step in the process of developing standard treatment protocols to rationalise and improve the quality of care for all illness.

#### **The Community Health Center:**

This 30 bedded referral hospital is to be equipped with a pediatrician and all the equipment needed to provide hospitalised care to the sick neonate and sick child. Such an emergency neonatal and child care center is a concomitant of the provision of emergency obstetric care at this level and indeed much of the benefits of the latter would be lost without the former. Thus for every maternal death due to problems in labour there are three child deaths!! However fragmented planning of the top-down variety is yet to give these two dimensions equal emphasis - probably because even the thrust to emergency obstetric care at this level is far from delivering results.

CHCs should be equipped with emergency neonatal care through IMNCI



The critical gap in this has always been the availability of specialist skills. The specialisation courses that create a pediatrician are set at an advanced tertiary care level and leave the specialist dissatisfied professionally and economically at the secondary care level. On the other hand the undergraduate medical programme does not provide the necessary skills to manage secondary levels of specialist care - whether in anesthesia or obstetrics or pediatrics - all of which needs to go together.

But this does not stop professional bodies, which are often only safeguarding privilege in the name of quality, of obstructing ef





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to raise skill levels in the MBBS doctor. Or even to meaningfully expand access to specialist education or to providing specialists for secondary care levels. The way forward in this may be to train medical officers for desired skill sets and support them to initiate care in this level.

Of course this too can proceed only with all the systemic corrections needed to make the health system and the CHC functional. If we note that the number of CHCs established in only one third what is required and the number of them, which are functional, are first referral units (which is similar to the concept of the secondary level of care or first level of hospital care) not even one in twenty - there is clearly a long road ahead.

The immediate alternative to be considered is to ensure that the public system can insist on free care by private sector hospitals or care with reimbursement by the state wherever other hospitals by public system undertakings or mission hospitals or not for profit hospitals for emergency referrals from the CHCs.

### **The District Hospitals**

These are necessarily sites of secondary and where possible tertiary care for the care of the sick child. Yet few of them can provide round the clock emergency neonatal services or are equipped with pediatric intensive care units. These need to be seen as essential components of child health care services. Also some of these centers would also need to be developed as centers for periodic skill upgradation of all paramedical and medical staff so that the skills needed in the CHCs and PHCs and health sub-centers are available.

Referral Transport mechanisms need to be made available for transporting the sick child.

### **The Sick Severely Malnourished Child**

One of the areas that the health system is in denial of, and which needs to be made their responsibility is the sick and severely malnourished child. Almost all grade III and IV children are sick or



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so recurrently sick that institutional care is needed. All of them on diagnosis of severe malnutrition need to come under medical supervision- and this cannot be left to the private market, partly because they cannot afford it and partly because the private market is thoroughly irrational in addressing it. Earlier there was a system of nutrition rehabilitation centers that was started and given up without adequate discussions. As child malnutrition reaches alarming proportions there is need to rethink these issues.

### **Services for Differently Abled Children**

All field workers dealing with children need to be trained in early detection and management of developmental disorders and disability. Institutional support services hardly exist outside of the major cities. All district hospitals must have a Child Development Clinic.

## **Section III**

# **Recommendations**

*Various groups and campaigns that are members and partners of JSA have been working on these issues for a number of years. The following campaign issues and recommendations on child health emerge as being those that demand focus in the current context.*

### **Infant and Young Child Feeding (IYCF)<sup>1</sup>**

1. Mainstreaming of IYCF in all child health programs by providing IYCF counseling as "service" and ensuring health workers "duty" for its delivery like immunization.
2. Capacity/ability of the community health workers to provide IYCF counseling on Breastfeeding, Complementary feeding and HIV & breastfeeding.
3. Strong political will to focus on these issues could be possible by making an Infant Nutrition & Survival Authority with committed resources

### **Maternity Entitlements<sup>2</sup>:**

1. All women who become mothers, including adoptive mothers, shall be entitled to maternity support services, with priority to the poorest.
2. Support to breast-feeding and nutrition counseling including support to breast-feeding in the first hour by ensuring the presence of a trained health worker must be included.
3. Financial support shall be sufficient to allow for at least six

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<sup>1</sup> Courtesy BPNI

<sup>2</sup> Courtesy Tamil Nadu FORCES

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months or 180 days withdrawal from work from the date of child birth, and an additional period of two weeks shall be made available according to need for the last period of pregnancy, to be termed as pregnancy leave.

All pregnant women like me should be entitled to maternity support services-support to breast-feeding and nutrition counseling, adequate financial support and pregnancy leave

4. The rate at which such support shall be calculated shall be equivalent to the prevailing daily (or monthly) wages or earnings of the woman in the concerned occupation, and in the case of non-employed, to the lowest prevailing minimum wage, and these shall be regularly revised as and when the wages are revised.
5. For women working in the organised sector, the Maternity Benefits Act, 1961 with full employer liability and with amendments to bring it in line with the rest of this Charter, shall be applicable to all Governmental, semi-and quasi-Governmental establishments, and autonomous corporations with more than 50% Government equity, and shall be strictly implemented.
6. For all women working in the private or non-governmental organized sector, and in all establishments employing at least 10 persons, the Employees State Insurance Act, with shared liability, shall be mandatory, and ESI shall be appropriately expanded, amended and brought in line with the rest of this Charter, and strictly implemented.



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7. For women working in the unorganized sector, maternity entitlements shall be provided whenever possible on the basis of the industry or occupation concerned (as in the case of bidi workers, construction workers, and others recognized as such through special laws or schemes) with shared liability of employers, workers and State, and with tripartite structures representing the three to oversee participatory procedures for implementation, monitoring and grievance redressal.

What about us who are not employed! We demand maternity entitlements under the National Maternal Assistance Scheme, without any discrimination.



8. For all other women in the unorganized sector where occupation-wise implementation may not be feasible, and for self-employed, maternity entitlements with shared liability of employers, workers and State shall be provided for in a similar way on a regional or district basis, through tripartite structures, representing the State, the employers and the women through women's organizations, cooperatives unions, social workers...and other such structures recognized as representing women.
9. For all other women who are non-employed, unpaid family workers or household workers, the National Maternal Assistance scheme shall be provided with full State liability on the basis of the lowest prevailing minimum wage. There

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shall be no discrimination on grounds of age, marital status; number of children or any other basis, but poverty may be the criterion for priority.

10. Umbrella legislation of an enabling kind for all of the above, incorporating the changes and amendments, and harmonizing the various structures and procedures to avoid duplication, shall be developed, but its absence or delay should not prevent the immediate implementation of all of the above.

### **Integrated Child Development Services Scheme<sup>3</sup>**

*The universalization of Integrated Child Development Services Scheme (ICDS) is urgently required to protect the rights of children under six. Universalization means that the full range of ICDS services should reach every child under six, every pregnant or lactating mother, and every adolescent girl. It also requires a radical improvement in the quality of these services. Thus, our demand is not just universalization but "universalization with quality".*

1. In the process of universalizing ICDS, priority should be given to marginalized communities. In particular, SC/ST hamlets should get priority in the creation of new Anganwadi Centers (AWCs).
2. The population norms for placement of AWCs should be revised. The revised norms should ensure that every child under-six is within convenient reach of an AWC.
3. The physical infrastructure of AWCs should be racially upgraded. In particular, all AWCs should have their own pacca building, attractively designed and with adequate space.

<sup>3</sup> Recommendations on ICDS and MDMS courtesy the Right to Food Campaign, Report on the Children's Right to Food Convention, Hyderabad, April 2006

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All of them should have basic facilities including storage arrangements, drinking water, cooking utensils, toys, child-friendly toilets, etc. AWCs should also receive untied grants for improving the services in response to local requirements.

4. Training programmes for AWWs also need radical improvement. They should include special training on childcare for children under three, nutrition counseling, and pre-school education.
5. Each AWC should have two Anganwadi Workers (AWWs) and one Anganwadi Helper (AWH) at the very least. One Anganwadi Worker should be in charge of looking after children below the age of three - the most vulnerable and neglected age group.
6. The concerns and difficulties of Anganwadi Workers, particularly regarding excessive work burden, inadequate and delayed remuneration, and poor working conditions, need to be addressed. Their status as regular skilled salaried workers needs to be established as part of the process of institutionalizing ICDS itself. Anganwadi Helpers must receive the statutory minimum wage at the very least.
7. For children in the age group of 3-6 years, supplementary nutrition should be provided in the form of a cooked, nutritious meal at the AWCs, using locally procured food. For children below the age of three, nutritious take-home

Children need nutritious food in order to be healthy without which they suffer from diseases & die because of hunger. When these basic needs are met, children are able to grow and develop.



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rations (THR) based on locally procured food may be provided. Supplementary nutrition should always be combined with extensive nutrition counseling and home-based interventions for both growth and development, particularly for children under 3.

8. Wherever required, day care services should be provided. The requisite resources, infrastructure, staff, space, training etc., should be available for this purpose. The timings of Anganwadi Centres should be sensitive to the needs of working mothers.
9. The process of "community participation" in ICDS needs to be defined and planned, and should involve all sections of the population. Untied grants should be provided to each Anganwadi Centre to encourage community innovation and quality improvements. Budget provisions for community awareness are also required.
10. Special provisions should be made for differently-abled children. Also, surveys of children under six conducted by AWWs should include a survey of children with special needs.
11. Special provisions should also be made for other marginalized groups of children, such as street children and children of migrant families.
12. ICDS also needs to respond to disaster situations (floods, earthquakes, conflict, etc.) by opening emergency centres in the area as soon as possible.
13. There should be no privatization of any ICDS services. Moves towards privatization, such as the introduction of user fees in ICDS, or privatization in the name of community participation, should be resisted. The ICDS should be funded entirely from government funds raised without recourse to loans or grants from agencies such as the World Bank.
14. All ICDS-related information should be in the public domain. The provisions of the Right to Information Act, including



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- pro-active disclosure of essential information, should be implemented in letter and spirit in the context of ICDS. All AWCs should be sign-posted and the details of ICDS entitlements and services should be painted on the walls.
15. The universalization of ICDS (with quality) should be built into the 11th Five Year Plan, with a specific time frame and the requisite Budget allocations.
  16. Supreme Court orders on ICDS in the "right to food" case (PUCL vs Union of India and Others, Civil Writ Petition 196 of 2001) should be immediately implemented in letter and spirit, especially orders relating to universalization with priority to SC/ST hamlets and urban slum.

### **Mid Day Meals**

1. Budget allocations for mid-day meals should be raised.
2. Proper infrastructure for mid-day meals should be mandatory, including cooking sheds, storage space, drinking water, ventilation, utensils, etc.
3. Responsibility for the management of mid-day meals should not be assigned to teachers, to avoid disruption of classroom activities.
4. There should be no privatization of mid-day meals in any form.
5. Serious action should be taken in the event of any form of social discrimination in mid-day meals, such as discrimination against Dalit children or Dalit cooks.
6. Priority should be given to disadvantaged communities (especially Dalits and Adivasis) in the appointment of cooks and helpers. All cooks and helpers should be paid no less than the statutory minimum wage.
7. Mid-day meals should be extended to school vacations and out-of-school children (including street children, migrant children and drop-outs).

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8. Community participation in the monitoring of mid-day meals should be strengthened, particularly to prevent corruption and ensure quality.
9. The NREGS should cover the building of kitchen sheds and employment of cooks.

### **Child Health in Schools**

1. School Health Scheme to be universalised
2. School bags not to be more than 10% of child's weight and a strict government order to be passed for the same.
3. Regulation of private schools (including preschools) for minimum services and standards including safety.
4. Improving the quality of Mid Day Meals and ensuring universalization of the scheme.

### **Child Labour<sup>4</sup>:**

1. An equal opportunity to participate in the economic growth of the nation should be given to all children. This can be ensured only through equal and compulsory education
2. Recognizing the contradiction between the existence of child labour and the constitutional guarantee of fundamental right to education for all children all forms of child labour should be prohibited and every child should be in school.

There should be a move to amend the fallacious distinction between hazardous and non-hazardous labour as mentioned in the Child Labour (Prohibition & Regulation) Act, 1986. All forms of labour, which keeps a child away from school or denies him/her the right to childhood, should be considered as hazardous



<sup>4</sup> Recommendations on child labour, trafficking, child sexual abuse, HIV/AIDS, child protection and child budgets courtesy HAQ team

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### **3. Improve law enforcement**

#### **Child Trafficking:**

1. A comprehensive definition of trafficking, which includes all forms and purpose of trafficking is required. Ensure that the necessary legislation is in place to punish traffickers. All activities related to trafficking including instigating, aiding, abetting, attempting and conspiring to traffic must be made answerable under criminal law. In addition all perpetrators involved in trafficking must be prosecuted.
2. Labour Laws are relevant because traffickers often lure their victims with false promises of employment. Strong labour laws have the potential to discourage trafficking for child labour.
3. Adoption laws should be strengthened in order to eliminate the loopholes that facilitate trafficking in children for purpose of adoption.
4. To check trafficking for and through marriage it is important to ensure compulsory registration of marriage.
5. Improve law enforcement

15% of our country's estimated 2.3 million sex workers are children. Children like me are unaware of dangers of trafficking and exploitation. So, there is an urgent need to strengthen laws and their implementation with an inter-related approach on child trafficking

#### **Child Sexual Abuse**

1. While the law to protect children from child sexual abuse and punish the abuser remains inadequate, societal attitudes continue to be an even bigger impediment. The laws dealing with sexual offences as they are today do not address child

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sexual abuse. Only rape and sodomy can lead to criminal conviction. There is an appeal to bring in a more comprehensive legislation to address child sexual abuse in all its forms.

2. Improve law enforcement

### **Children without Adult Protection**

1. Half way homes for street children linked to processes of returning them to their homes or finding foster families or education and vocational opportunities for them.
2. Policy for protection for children orphaned by disasters.
3. Homes for children without adult protection and need to have special kind of public participation built into them.

### **HIV/AIDS**

1. There is need to control HIV/AIDS infection, stigma, discrimination and denial of services to children infected and affected with HIV/AIDS as soon as possible.
2. NACO needs to review its programme from a children's perspective and utilize the fund in a better manner instead of going for 'low cost care and support programme'.

### **Health Care Services**

1. Strengthen and support a community health worker programme for community level care provision - by a volunteer selected and supported in every habitation.
2. Standard treatment protocols for both paramedical and medical staff for management of the sick child.
3. Staffing gaps in pediatricians, ANMs and AWWs to be filled with priority and urgency.
4. Pediatric formulations of entire formulary to be made available.

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5. Special focus on the severely malnourished and on the sick malnourished child.
6. Vitamin A supplies need to be ensured and maintained.
7. Immunization drives such as pulse polio must be organized carefully to ensure that routine immunization is not being neglected.
8. Measles coverage must be achieved to 100% on a priority basis.
9. The school health scheme needs to be made mandatory for all private and public schools and should include annual general health checks, vision and dental checks, immunization and deworming, iron supplementation and adolescent health counseling
10. Services for early detection and management of disability and developmental disorders, institutional support services at least at state level, Child Development Centres at district level.

Strengthen the provision of appropriate childcare in the health sub-center and 24-hour quality care for the sick child in the primary health center with emergency transport connectivity with higher centers.

Make provision for effective secondary care- hospitalized institutional care for the sick child at the one lakh population level



Establish Pediatric and Neonatal emergency care units at the district hospital.

## **Child Budget**

Children constitute more than 40 per cent of our population. There are a number of laws, policies, programmes and schemes to address their needs. A new programme is launched almost every year, but still there are no visible changes. Time and again we are told, "The situation is grave-but the resources are limited..." A sharp increase in the allocation on child budget is required in order to ensure that the rights of the children are fully protected and promoted. Also the impact of budgetary allocation on children should be measured and the information thus gathered should be widely disseminated.