

**From the Womb to Primary School:  
Challenges, Policies and Prospects for the  
Young Child in India**

**Vimala Ramachandran**  
**August 2018**

Ramachandran, V., 2018. From the Womb to Primary School: Challenges, Policies and Prospects for the Young Child in India. Technical Background Paper for the Report, 2020, Mobile Creches, New Delhi.

## TABLE OF CONTENTS

<b>Introduction:</b>	<b>2</b>
Diagram 1: ICD Conceptual framework 1	3
<b>The uneven situation of the children in the states of India:</b>	<b>4</b>
Table 1: Sex Ratio at birth (females per 1000 males)	6
<b>Health status of children under six:</b>	<b>7</b>
Table 2: Definitions	8
Infant Mortality over the last three decades:	8
Table 3: Infant Mortality	10
Table 4: Key child indicators NFHS 1 to 4	11
Table 5: Under Five Mortality	12
Chart 1: Infant mortality rates by wealth, NFHS 3 2005-06	12
Chart 2: Child mortality rates by Sex, NFHS 3 2005-06	13
Chart 3: Perinatal mortality rate by residence, NFHS 3 2005-06	13
Nutrition:	14
Table 6: States by % Stunting, (NFHS 4)	15
Table 7: Nutritional status of children by education, poverty and social group	16
Burden of communicable diseases	18
Immunization:	18
Table 8: Status of immunization by vaccine, NFHS 1 to 4	18
The dire situation among Scheduled Tribe children:	20
Summing up the picture from data sources:	21
Table 9: Overview of child health, NFHS	21
Table 10: Literacy Rate of General, SC and ST (1961-2011) (India)	23
Table 11: Basic child health indicators by state	25
<b>The ambiguous situation of early childhood education:</b>	<b>27</b>
Table 12: Participation in pre-school education by gender, wealth and location 2013-14	27
Recent efforts to turn the spotlight on pre-school education	29
<b>Rights and entitlements of Children under six:</b>	<b>30</b>
The Constitution of India (GOI, 1949):	31
Post-Independence policies and legal provisions:	32
National Policy for Children 2013	34
Illustrative List of Preventive and Public Health Interventions for children under six Funded and Provided by Government	34
<b>Key issues confronting children</b>	<b>36</b>
<b>Recommendations:</b>	<b>38</b>
<b>References:</b>	<b>41</b>

<sup>1</sup> Sincere thanks to Dr. Narendra Gupta of Prayas Chittorgarh for reviewing the draft – especially the health / nutrition section of this paper.

## Introduction:

The status of a young child in India is a sensitive indicator of the overall development of our society. Any society that does not pay attention to the health and overall wellbeing of children, is a society that does not care about its people – especially the most vulnerable. It is not easy to paint a comprehensive picture of the young child in India without a broad conceptual framework that enable us to not only identify the key dimensions of well-being of children. As spelt out in the ICD framework (Table 1) given below – the various dimensions of a child's life are intertwined with the mother (and her health and well-being), with the larger environment in which the child lives and grows and the availability of nutrition, a safe and violence-free environment, a caring care giver (adult) and most importantly early introduction to pre-school education.

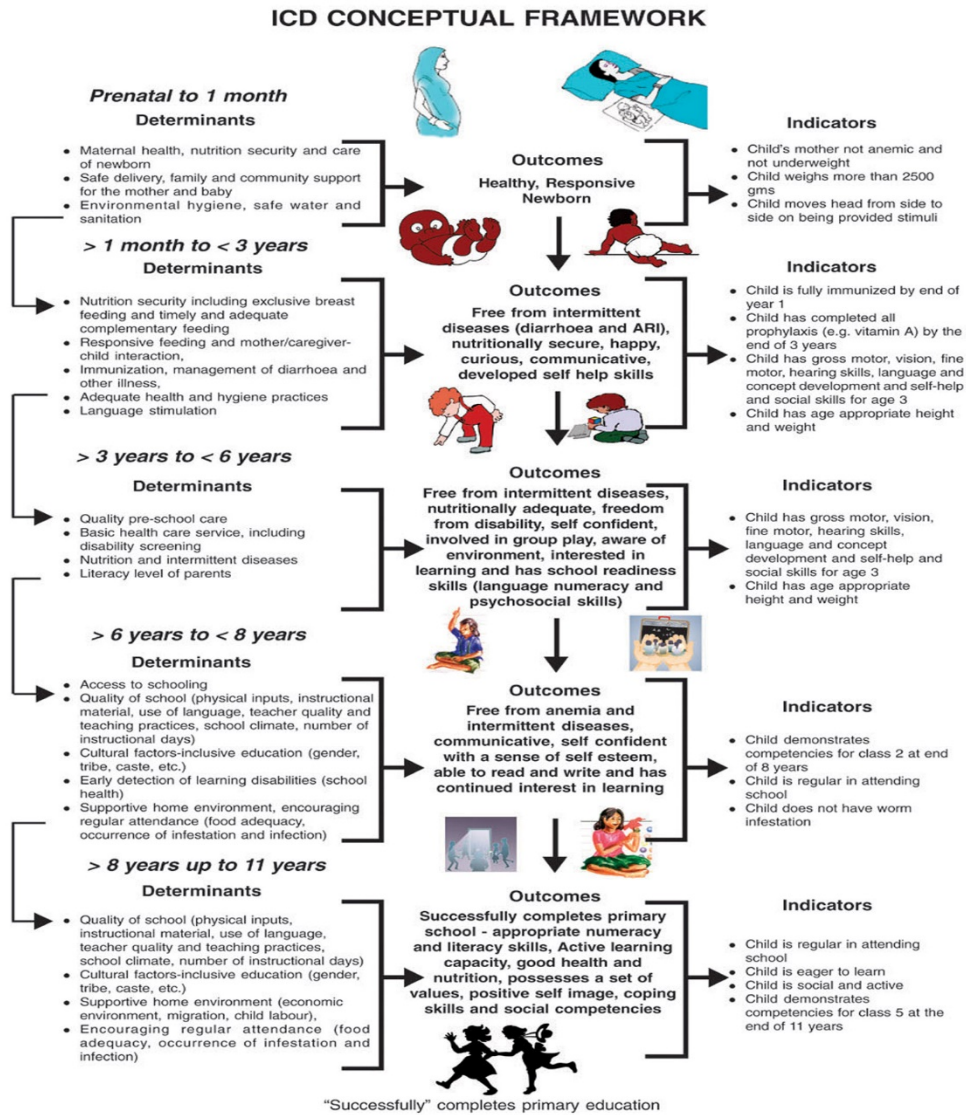
Children do not only need food to survive and grow, they need intellectual stimulation, emotional security and physical care. Equally the child should be free from violence and abuse at home, in the community and in child care / pre-school spaces. It is important to see the child as a composite whole – not a disjointed sum divided across different sectors like health, nutrition, education and so on. The framework (given in Table 1 below) identifies constant determining factors and developmental milestones across different stages: (i) adequate nutrition and balanced diet, (ii) protection from illness and timely medical care, (iii) hygienic living conditions and clean drinking water, (iv) safe environment – free from violence, abuse, bondage, hazardous work, full-time work and trafficking - and (v) love, affection and mental and physical stimulation for all children. Other frameworks (notably UNICEF<sup>2</sup>) detail each dimension of the child separately. This ICD framework is among the more holistic ones. “The strength of the framework lies in its ability to integrate the physical and psychosocial development of children with the social, political, and economic dimensions of health, nutrition, and education, view child development as a continuous and a cumulative process, and finally put forth a holistic understanding of what is desirable and necessary for developing as well as evaluating a child-centred social policy”. (Page 12, Vimala Ramachandran et al, World Bank. 2004)

This paper starts with a review of a range of health indicators (using Census data, the findings of NFHS 1 to 4 and SRS data of the Government of India). This is followed by a discussion on the availability, accessibility and affordability of pre-school education and early childhood care and stimulation. The paper then discussed the evolution of government policies towards the young child and concludes by highlighting key issues and challenges that we – as a country and as a society – face in India today.

---

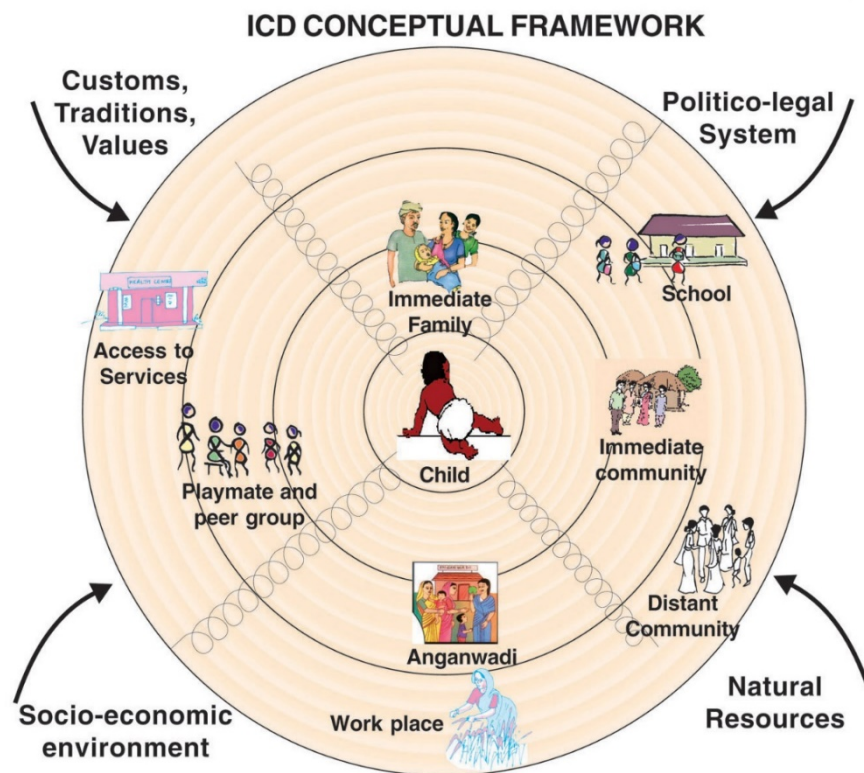
<sup>2</sup> UNICEF 2009: [https://www.unicef.org/tfymacedonia/MK\\_Pub\\_ELDS\\_ENG.pdf](https://www.unicef.org/tfymacedonia/MK_Pub_ELDS_ENG.pdf)

Diagram 1: ICD Conceptual framework 1



Source: Conceptual Framework, New Concept Information System, New Delhi 2003

Diagram 2 1: ICD Conceptual framework 2



Source: Conceptual Framework, New Concept Information System, New Delhi 2003

## The uneven situation of the children in the states of India:

According to Census 2011, the total number of children in the age-group 0-6 years is reported as 158.79 million which is down by 3.1% compared to the child population in 2001 of the order of 163.84 million. The share of children (0-6 years) to the total population is 13.1% in 2011 whereas the corresponding figures for male children and female children are 13.3% and 12.9%. It is indeed noteworthy that twenty States and Union Territories have over one million children in the age group 0-6 years - Uttar Pradesh (29.7 million), Bihar (18.6 million), Maharashtra (12.8 million), Madhya Pradesh (10.5 million) and Rajasthan (10.5 million) constitute 52% Children in the age group of 0-6 year. Equally the decadal decline in population was more for female children (3.8%) than male children (2.4%) in the age group 0-6 years. (Source MOSPI, GOI. 2012 pp 24-25)

The development discourse in India is full of insightful analysis of the historical, geographical, political, economic, social and governance related factors that have led to uneven development across different regions and communities of India. Starting from Amartya Sen's 1992 paper "Inequality re-examined"<sup>3</sup>, almost all

<sup>3</sup> Sen, A. (1992b), Inequality Re-examined, Oxford: Clarendon Press

development economists have tried to grapple with this issue<sup>4</sup>. As we cannot go into this debate in this paper, it is worthwhile keeping in mind that unevenness in economic development, geographical characteristics, political and social culture and ethos have a bearing on children.

Three successive Census (1991, 2001 and 2011) have highlighted the issue of adverse child sex ratio with significant between the north and some north-western states and the southern and eastern states of India. Interestingly however, urban-rural differences are skewed in favour of rural areas, with child sex ratio in rural areas being 919 and in urban areas 902. This is a telling statement on Indian society – higher years of education of men and women and relatively better economic status does not improve the chances of girl children. According to Census 2011 rural child sex ratio is higher as compared to urban areas in 26 states. The Census commissioner reports *“In rural India, there are 74 districts with CSR < 850 in 2011, whereas, there were 54 districts in this group in 2001. In 38 districts, the decline in CSR has been more than 50 points. In 51 districts, there is increase in CSR with 20 or points”*. (pp 30, MOSPI, GOI. 2012)

Another sensitive indicator is the sex ratio at birth<sup>5</sup>. If we compare the period 2000-2005 period to 2005-10 – we see a silver lining. From a dip of 892 to 880 in 2000 to 2005; there is some improvement to 892 to 905 in 2005 to 2010 and this seems to have gone down up to 906 in 2014 (S. Irudaya Rajan et al, 2017, EPW pp15). This data is collected through the Sample Registration System – which records all birth and deaths. How many children who are born actually survive? S. Irudaya Rajan cautions us that the data from different sources (Census, NFHS, SRS and Civil Registration) may not always match – however the broad trend across different data sources seem to be similar. He also points out the registration of births is below 80% in states like Uttar Pradesh and Bihar while in Tamil Nadu 100% of births are registered. Notwithstanding these caveats – most commentators agree that there are significant differences across states. He opines *“between 2011 and 2014 several states—even if we focus only on those states that have an (estimated) birth registration rate of more than 80% have witnessed a sharp decline in SRB. For instance, Gujarat, Himachal Pradesh, Karnataka, West Bengal and Tamil Nadu have recorded a decline in SRB in the post-Census 2011 period. While not unusual, the source-dependent difference in SRB for Tamil Nadu, for example, is perturbing. According to the CRS, Tamil Nadu has experienced a decline in SRB from 905 to 834 between 2011 and 2014 on a 100% birth registration rate between 2011 and 2014. However, other sources such as the SRS peg Tamil Nadu’s SRB at 929 in 2007–09 and at 921 in 2012–14 in contrast to the NFHS figures of 896 in 2004–05 and 954 in 2015–16.”* (S. Irudaya Rajan et al, 2017, pp 15)

---

<sup>4</sup> See J Nathan for a good summary of this issue - [https://organizations.bloomu.edu/qasi/pdf\\_documents/2015\\_Proceedings\\_pdfs/NATHANGASI\\_2015\\_Proceedings\\_India's\\_Uneven\\_Development\\_8\\_27\\_2015.pdf](https://organizations.bloomu.edu/qasi/pdf_documents/2015_Proceedings_pdfs/NATHANGASI_2015_Proceedings_India's_Uneven_Development_8_27_2015.pdf)

<sup>5</sup> Sex Ratio at birth denotes the number of female live births to 1000 male live births

**Table 1: Sex Ratio at birth (females per 1000 males)**

**Table 1: Sex Ratio at Birth (Females per 1,000 Males) for India and Major States Based on Census, SRS, CRS and NFHS**

India and Major States	Census <sup>1</sup>		National Family Health Survey <sup>2</sup>		Sample Registration System <sup>3</sup>			Civil Registration System <sup>4</sup>				Level of Registration of Births <sup>4</sup> %			
	2001 (2)	2011 (3)	2005–06 (4)	2015–16 (5)	2010–12 (6)	2011–13 (7)	2012–14 (8)	2011 (9)	2012 (10)	2013 (11)	2014 (12)	2011 (13)	2012 (14)	2013 (15)	2014 (16)
India	905	899	920	na	908	909	906	909	908	898	887	83.6	84.4	85.6	88.8
Andhra Pradesh	951	924	876	914	914	916	919	983	985	954	955	79.8	74.8	98.5	100
Assam	948	930	1033	929	922	920	918	920	872	909	902	85.8	87.6	97.7	100
Bihar	917	892	893	934	909	911	907	na	na	924	868	59.8	74.7	57.4	64.2
Chhattisgarh	928	948	972	977	979	970	973	915	895	925	934	55.1	74.2	87.8	100
Delhi	852	869	848	n.a	884	887	876	893	886	895	896	100	100	100	100
Gujarat	834	868	906	907	909	911	907	901	902	901	886	100	100	100	95
Haryana	786	824	762	836	857	864	866	833	832	840	843	100	100	100	100
Himachal Pradesh	845	948	901	na	939	943	938	918	916	906	896	100	100	100	93.1
Jammu and Kashmir	951	774	912	na	895	902	899	913	n.a	923	914	69.9	69.8	71.8	75.5
Jharkhand	907	903	1,102	na	918	913	910	n.a	847	885	886	60.7	61.9	77.7	82
Karnataka	936	922	922	910	950	958	950	983	971	943	926	98.9	100	96	97.8
Kerala	969	977	902	na	966	966	974	939	955	942	948	100	100	100	100
Madhya Pradesh	903	908	960	927	921	920	927	897	912	904	908	86.5	87.2	84.1	82.6
Maharashtra	877	862	867	924	896	902	896	861	894	901	911	100	100	100	100
Odisha	928	910	963	933	948	956	953	902	896	886	880	95.6	96.4	93.9	98.5
Punjab	787	843	734	860	863	867	870	852	844	876	880	100	100	100	100
Rajasthan	864	899	847	887	893	893	893	911	861	859	799	96.7	98	98.4	98.2
Tamil Nadu	935	934	896	954	928	927	921	905	904	853	834	100	100	100	100
Uttar Pradesh	901	890	949	na	874	878	869	na	930	883	881	64.9	57.5	68.6	68.3
West Bengal	975	937	976	960	944	943	952	924	926	913	897	100	100	92.8	92.5

Both SRS and CRS provide SRB whereas NFHS provides SRB for children born in the last five years. The census data refers to at ages 0 and 1 combined. Sources: (1) Office of the Registrar General (2012, 2014, 2016b). (2) Kishor and Gupta (2009); IIPS (2007, 2016).

Source: S Irudaya Rajan et al, 2017 (p 15)

A recent publication on this subject argues “A critical indicator of gender equality is the sex ratio at birth (SRB). Nature (biology) suggests that without intervention, the SRB approximates to a universal constant of 105, i.e. that for each 100 girls born, 105 boys are born. However, despite rapid economic growth in the last thirty years, the sex ratio at birth in India has not evolved as per “normal” expectations. Before the late-1990s, the SRB was close to 111. But this rose to a peak of 113.6 in 2004. Fertility declines and availability of new sex determination technologies were felt to be at the heart of the increases in the sex ratio imbalance. Post 2004, a fast decline has been seen with SRB reducing to 110 in 2012—a significant improvement but well above the “norm” of 105.” (Ravinder Kaur et al, UNFPA, 2016 pp 2-3)

National or even state-wise data do not reveal the real picture. The economically better off and better educated middle classes in rural and urban areas are known to practice female infanticide and sex selective abortion. It was argued that the landed rural middle class did this to prevent depletion of wealth (Ravinder Kaur et al, 2016). It was also believed that non-land-owning communities – especially SC and ST did not resort to these practices. This is because land ownership / property has been seen as an essential dimension of unequal status of boys and girls in the family. Equally, among communities where human labour is the source of livelihood – the contribution of

women and men to household survival is almost equal. This is (perhaps) one of the reasons why bride price used to be common some communities. However, from 2001 Census the evidence shows that this trend does not hold and that SC communities – especially in urban areas are also resorting to sex selective abortion. Son preference is catching on among SC, ST and OBC communities. Ravinder Kaur et al argue *“Hence, while caste patterns might have been somewhat distinctive in an earlier period, there is much greater heterogeneity currently in the behaviour of caste groups vis-à-vis gender discrimination...”* (Ravinder Kaur et al, 2016 pp 8) Equally, regional differences evident in the 1980s and 1990s may not be comparable to the decades of 2000.

At one level, it seems as if the economic situation of people is changing rapidly. It is also believed that poverty levels are coming down slowly (this is a highly contested domain), educational levels are going up with many more young people completing at least 8 years of elementary education. Yet, son preference remains and is rapidly spreading to communities and areas where son preference was not so evident (especially ST communities). Experts argue whether higher levels of education, more wealth exerts a negative or positive influence on son preference – the jury is still out as most experts believe that the situation on the ground is rapidly changing and give the huge diversity across regions, communities and economic wealth quartiles – it is difficult to conclusively say what the national trend is<sup>6</sup>.

Therefore, when we try to capture the profile of children in India – from sex ratio at birth to child sex ratio – regional, caste and economic differences need to be factored in. As this paper will argue later, the changing landscape affects children right from the time they are born. Starting with breastfeeding, immunisation, health care, nutrition to preschool education – communities and parents make choices. These choices could adversely affect some children – especially girls and children born with disabilities.

## **Health status of children under six:**

For seven decades now, since independence one of the most distressing issues that we confront on a daily basis has to do with the physical wellbeing of our children. Starting with infant and child mortality, malnutrition, stunting and wasting to chronic illness – the conscience of our people seems to have been numbed. While almost all studies agree that mortality rate among neonates, infants and children has been

---

<sup>6</sup> Concluding an exhaustive literature review, Ravinder Kaur et al summarize: “There are, thus, two contradictory conclusions about the relationship between SRB and prosperity (or higher-class status). First, an optimist view that prosperity leads to an improvement in the SRB; the second, an opposite pessimistic view. The reasoning behind the optimistic view is supported by the observation that as people become richer and more educated, their ideas and perceptions of the value of girls and boys begins to shift towards becoming more gender equal. The implicit assumption made in the optimist view is that with a rise in prosperity, there is a rise in educational attainment as well. However, the pessimistic view is that sex selection will rise as socio-economic circumstances improve. A likely explanation for this phenomenon is that as the poor begin to move up the economic ladder, they tend to shape the composition of a smaller family through recently acquired means and access to sex selection technology, preferring more sons. (Ravinder Kaur et al, UNFPA, 2016 pp 11)

coming down – the sad reality is that it is still unacceptably high. A child born in a remote rural area or an urban slum does not have the same chance of survival as a child born in a rich household. Needless to say, the picture varies across different states in India, across rural and urban areas, across economic groups, social groups (caste / religious groups, gender differentials and across household educational levels. At the outset it is important to underscore the point that neonatal, infant and child death are preventable – as has been shown across the world. Equally, the issue is not only related to health care services – overall wellbeing and nutrition of mothers, infant and child feeding practices, safe drinking water, sanitation and other environmental factors matter as much as the availability of emergency medical care. Infants and small children are vulnerable and persistent neglect or recurrent illnesses can lead to death.

Experts and community workers argue that the first 1000 days of a child is critical. The first 270 days in the womb of the mother demands focused attention to nutrition and overall wellbeing of the mother. The remaining 730 days demand focused and targeted strategies to ensure timely immunisation, proper feeding (from breast feeding to supplementary feeding), stimulation and early childhood care and education. By the time a child is 3 years, her brain development occurs at a very fast pace. Poor nutrition at this stage can harm the long-term cognitive ability (Source: Dr. Narendra Gupta, Prayas Chittorgarh – email communication 21 March 2018).

**Table 2: Definitions**

- Neonatal mortality: The probability of dying in the first month of life
- Post neonatal mortality: The probability of dying after the first month of life but before the first birthday
- Infant mortality (1q0): The probability of dying before the first birthday
- Child mortality (4q1): The probability of dying between the first and fifth birthdays
- Under-five mortality (5q0): The probability of dying before the fifth birthday

Source: NFHS 3, Volume 1, pp 179

## **Infant Mortality over the last three decades:**

About 70% of the infant deaths occur in the first 28 days of birth. Therefore, neonatal and perinatal deaths which contribute more than half of the under five deaths is very important period for child survival. Within the neonatal period, 30% deaths are attributed to pre-term birth followed by respiratory distress syndromes. Pre-term birth is intricately linked with the nutrition status and health of mother. In India, with 23% women lesser than the lowest range of normal body mass index and 53% women of reproductive age group anaemic, it is bound to have preterm babies. Globally, there

are 16% of the all babies born are low birth weight. This could be higher in India because of the socio-economic factors. With total number of 26.90 million children born every year in India an estimated 4.8 million children are born low birth weight and just less than half are prone to infection and premature death within first month of their lives. Around six hundred thousand children die within 28 days of their births in India. Children born with congenital heart defects and other forms of disability is another important aspect to be looked into. The prevalence of birth defects in India range from 61 – 70 per 1000 live births. This is essential because *'Indian people are living in the midst of risk factors for birth defects, e.g., universality of marriage, high fertility, large number of unplanned pregnancies, poor coverage of antenatal care, poor maternal nutritional status, high consanguineous marriages rate, and high carrier rate for hemoglobinopathies'*. (Source Dr. Narender Gupta – email communication, quoting Rinku Sharma 2013, 125–129). This makes the scenario quite challenging for India which continues to contribute highest number of neonatal, infant and under five deaths in the world. It will however be not appropriate to paint the entire country by one brush as India is a country of many countries because of its huge size and population and wide diversity exists between its different states many of which are bigger than most countries of the world. The southern states of the country - Kerala, Tamilnadu, Karnataka, Andhra Pradesh, Telengana have neonatal and infant mortality rates equivalent to developed countries and have completed epidemiological transition or very near to it. This indicates there is marked reduction in diseases that affect children's health the most - communicable, maternal, neonatal and nutritional diseases in these states. (ICMR 2016) while other states – Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh Odisha, Rajasthan, Uttar Pradesh, Uttarakhand, Assam and Meghalaya are still struggling to achieve it or to move in that direction. Perusal of SRS data (which is most often used by the government as a reliable source for IMR) reveals that during the period 1991 to 2013, the infant mortality rate (per thousand live births) was declined by 50 percent. In 1994 IMR was 74 (Rural 80 and Urban 52), by 2004 it had come down to 58 (rural 64 and urban 40) and by 2013 it had further come down to 40 (rural 44 and urban 27) (Table 1.2.7 National Health Profile (GOI) 2015 - <http://www.indiaenvironmentportal.org.in/files/file/NHP-2015.pdf> ).

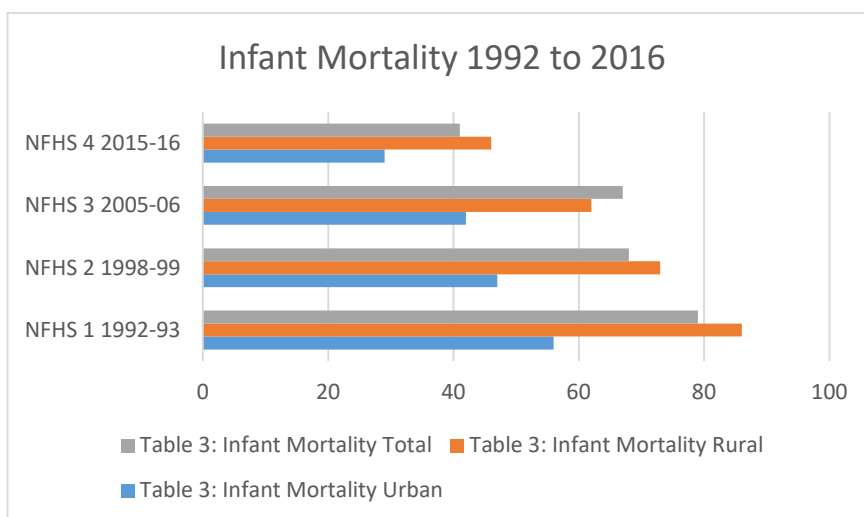
If we compare the decrease between neonatal and post neo natal mortality rates, neonatal mortality rates decreased by 45 per cent whereas post neonatal mortality rates declined by 58.6 per cent during the same period. It is also observed that post neo natal mortality rates declined more rapidly than neonatal mortality rate between 2001 and 2013.

Successive NFHS surveys have also estimated infant mortality rates<sup>7</sup>. For the period 0-4 years before the survey, NFHS-1 and NFHS-2 recorded infant mortality rates of 79 and 68, respectively. Comparison of these estimates with the NFHS-3 estimate of 57

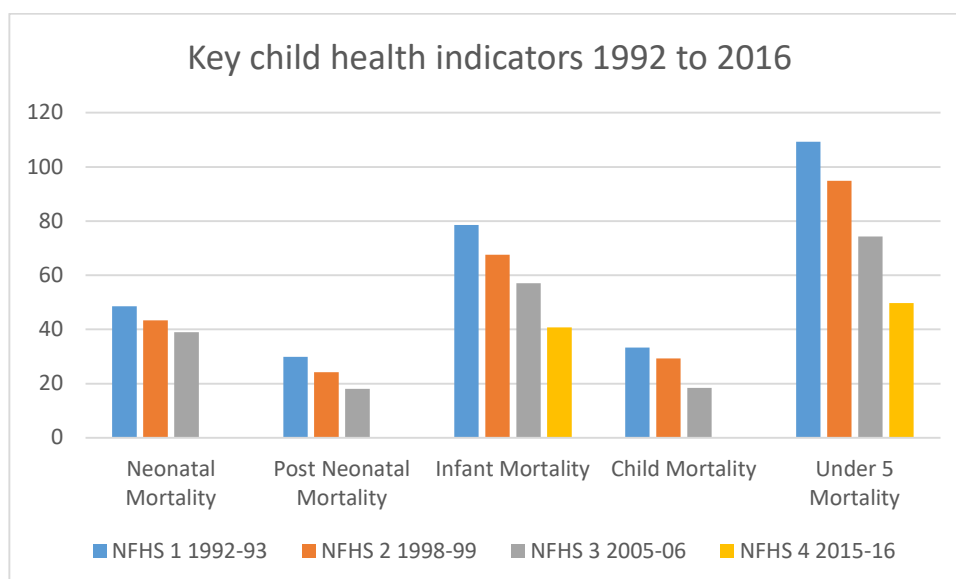
---

<sup>7</sup> Three National Family Health Surveys (NFHS) were conducted during 1992-93, 1998-99, 2005-06. Some information has recently become available from NFHS-4 (2015-16).

indicates that the infant mortality rate declined by 22 deaths per 1,000 live births in approximately 13 years. This implies an average reduction of 1.7 infant deaths per year. Neonatal mortality has declined from 49 for the period 1988-92 to 39 for the period 2001-2005 and the post neo natal mortality declined from 30 to 18 between the same time period. It is observed that the decline was more in the post neonatal (12) and child mortality (15) as compared to neonatal mortality (10).



	Urban	Rural	Total
NFHS 1 1992-93	56	86	79
NFHS 2 1998-99	47	73	68
NFHS 3 2005-06	42	62	67
NFHS 4 2015-16	29	46	41



	Neonatal Mortality	Post Neonatal Mortality	Infant Mortality	Child Mortality	Under 5 Mortality	Percentage children Under 5: Stunted (low weight for age)	Percentage children Under 5 Underweight (low weight for age)
NFHS 1 1992-93	48.6	29.9	78.5	33.3	109.3	na	na
NFHS 2 1998-99	43.4	24.2	67.6	29.3	94.9	na	na
NFHS 3 2005-06	39.0	18.0	57.0	18.4	74.3	48	43
NFHS 4 2015-16	29.5	11.3	40.7	9.4	49.7	38	36

Infant and child mortality rates in India not only vary by state, but within each state they also vary by gender, location (rural, urban), by social group (SC, ST, OBC etc.) and by wealth quintile – as evident in the NFHS based graphs (Source: NFHS India, 2015). It is therefore important to take a nuanced view of the situation in India – the reasons contributing to different child health indicators could be different across locations, communities and income quintiles.

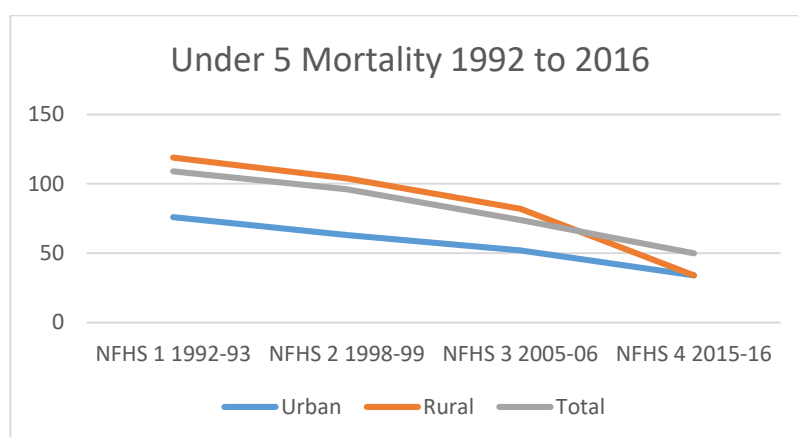
For example, in 2015-16 the under-five mortality rate was 56 deaths per 1,000 live births in rural India while it was 34 in urban India. Uttar Pradesh recorded the highest under-five mortality at 78 per 1,000 live birth while in Kerala it was only 7. The under-five mortality for scheduled castes was 56 per 1,000 live births and scheduled tribe 57 per 1,000 live birth. Similarly, under five mortality rates also declines with increasing household wealth – from 72 per 1,000 live births for the lowest wealth quintile to 23 deaths per 1,000 for the highest quintile.

One of the most difficult issues facing researchers, administrators and activists is to isolate the key factors that either improve or worsen key child health indicators. Often, we are asked why is UP so different from Kerala? One could identify key issues that seem to make a huge difference to child health:

- i. Health, nutrition and education of the mother seems to make a huge difference. In several states in India women's access to nutritious food, timely health care and education up to or beyond secondary school has been an accepted social norm. A number of historical factors contributed to changes in different parts of the country.
- ii. Access to safe drinking water, proper sanitation and related social/community hygiene is known to reduce children's exposure to communicable diseases. On this score too, states across the country differ and social/community level awareness about these issues seem to be high.
- iii. Levels of abject poverty is known to exert a huge influence on child health indicators. Inequality in wealth is often compounded by lack of access to government food security schemes and programme. In many of the poor performing states, the functioning of the PDS system or the ICDS centre or any

other pro-poor programmes pushes the very poor and marginalised into greater and greater distress.

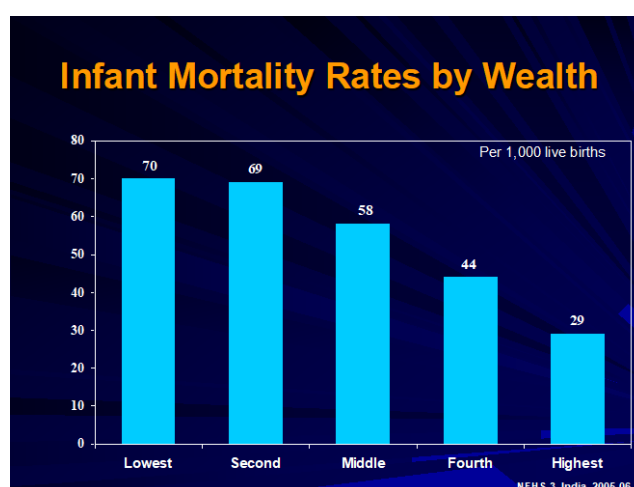
- iv. Gender relations and gender issues differ across different states of India. And within the same area, it could be different for different social groups / castes or religions. For a long time it was believed that son preference and neglect of girl child was more prevalent among the landed communities and among the rich. However, as discussed in the preceding sections of this paper, son preference seems to be catching on even in areas and communities that were known for greater gender equality.



**Table 5: Under Five Mortality**

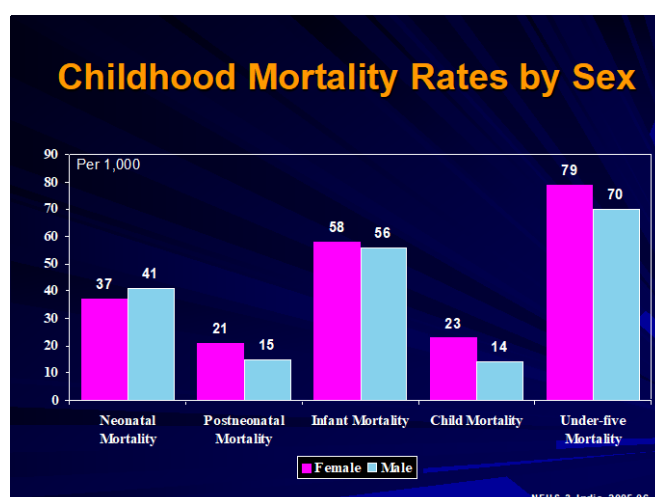
	Urban	Rural	Total
NFHS 1 1992-93	76	119	109
NFHS 2 1998-99	63	104	96
NFHS 3 2005-06	52	82	74
NFHS 4 2015-16	34	34	50

**Chart 1: Infant mortality rates by wealth, NFHS 3 2005-06**



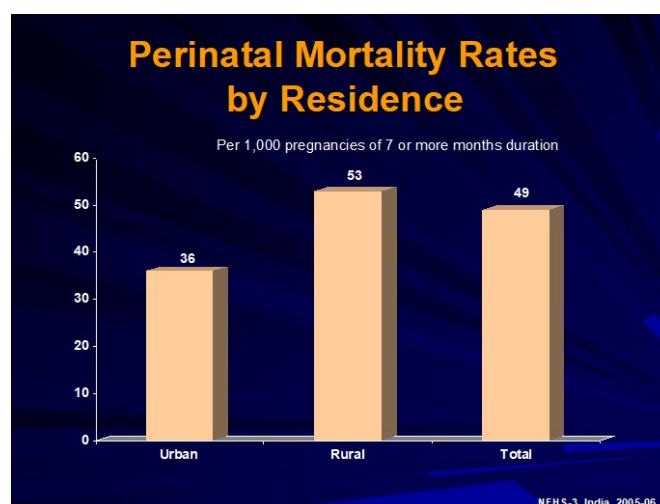
Source: IIPS and MOHFW, PowerPoint, 2010

Chart 2: Child mortality rates by Sex, NFHS 3 2005-06



Source: IIPS and MOHFW, PowerPoint, 2010

Chart 3: Perinatal mortality rate by residence, NFHS 3 2005-06

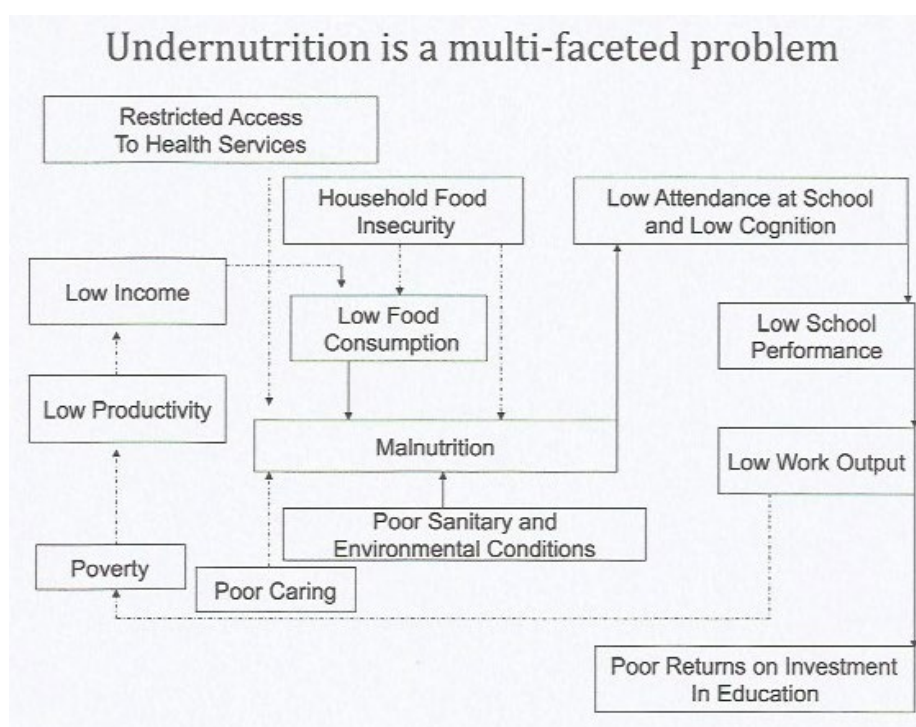


Source: IIPS and MOHFW, PowerPoint, 2010

Another significant dimension is that infant and child mortality rates decrease steadily with an increase in mother's schooling. Infant mortality has come down significantly – especially among children whose mothers have some schooling as compared to those with no schooling. For example, if we take NFHS 3 data – IMR was 70 for children whose mothers have no schooling, compared to 50 for children whose mothers have 5-7 years of schooling and 26 for children whose mothers have 12 or more years of schooling. As a result, Mother's schooling has a greater effect on the mortality of older children. During the neonatal period, children of mothers with 12 or more years of school have a mortality rate that is 43 percent as high as the rate for children of mothers with no education. That percentage decreases to 26 percent during the post neonatal period and 15 percent during the age interval 1-4 years. Among the largest

religious groups, Hindus have the highest rate of infant mortality (59), followed by Buddhists/Neo-Buddhists (53), Muslims (52), Sikhs (46), and Christians (42). Christians and Sikhs have relatively low mortality rates at all ages under five years. Although scheduled tribes have a lower infant mortality rate (62) than scheduled castes (66), the under-five mortality rate is higher among scheduled tribes (96) than among scheduled castes (88). Other Backward Classes (OBCs) have lower mortality than scheduled castes or scheduled tribes but have higher mortality than other castes at all childhood ages. Overall, the under-five mortality rate is 23 percent higher among OBCs than among the population in the general category. (Page 183 (Vol 2 NFHS 3 National Report))

## Nutrition:



Source: Ministry of Women and Child Development, 2011 (Page 12)

Researchers have argued that malnutrition and Infection are the two most important factors that affect the growth of children. In most cases of childhood infections, the cause can be traced to insufficient food intake or absorption, which makes children susceptible to infections. Malnutrition remains a big issue across the country. "More than 26,000 children under the age of 5 die around the world each day mostly conditions due to preventable causes. Nearly all of them live in developing countries or, more precisely in 60 developing countries" (Anuradha R et al. 2015). After all, childhood is not only a period of rapid growth and development, it is a phase in life when chronic malnutrition can affect the future of the child. While presenting the status of children we use several anthropometric indices to estimate the prevalence

of under-nutrition – for example, height-for-age, weight-for-age and weight-for-height. They capture the cumulative effect of under-nutrition during the life of the child. It has also been established that the risk of mortality is inversely related to children's height-for-age and weight-for-height.

Recent data from ICDS and NFHS 4 reiterates the grim situation that we face in India today. The hard reality is 19.8 million children below age 6 in India are undernourished (ICDS 2015) and only 9.6% of children between 6-23 months in the country receive an adequate diet (NFHS 4, 2015-16). If that is not enough to convince our administrators and political leadership – NFHS 4 reveals that 38% (1 in 3) of children between 0-5 years are stunted in the country, 21% (1 in 5) of the children in the country suffer from wasting, 36% of children under 5 years of age are underweight in India, 58% of children between 6 months – 5 years were found to be anaemic in the country and the Total Immunisation coverage in the country stood at 62% in 2015-16.

<b>Table 6: States by % Stunting, (NFHS 4)</b>		
<b>Category A &gt;38 %</b>	<b>Category B &lt; 38%, &gt;30%</b>	<b>Category C &lt; 30%</b>
Bihar 48.3	Chhattisgarh 37.6	Sikkim 29.6
Uttar Pradesh 46.3	Assam: 36.4	Arunachal Pradesh 29.4
Jharkhand 45.3	Karnataka 36.2	Manipur 28.9
Meghalaya 43.8	Maharashtra 34.4	Telangana 28.9
Madhya Pradesh 42.0	Odisha 34.1	Nagaland 28.6
Rajasthan 39.1	Haryana 34.0	Mizoram 28
Gujarat 38.5	Uttarakhand 33.5	Jammu and Kashmir 27.4
	West Bengal 32.5	Tamil Nadu 27.1
	Delhi NCR 32.3	Himachal Pradesh 26.3
	Andhra Pradesh 31.5	Punjab 25.7
		Tripura 24.3
		Puducherry 21.1
		Goa 20.1
		Kerala 19.7

Source: Venkatesh Ramani. 2017

Equally significant is that India is a country of huge inequalities and diversities. For example, in 2005-06 IMR was highest in Uttar Pradesh (73) and lowest in Kerala and Goa (15). With respect to under-five mortality, Uttar Pradesh also has the highest rate (96) and Kerala has the lowest rate (16). Aside from Uttar Pradesh, high levels of infant and child mortality are found in Chhattisgarh and Madhya Pradesh in the central region, Assam and Arunachal Pradesh in the North-eastern region, Jharkhand, Orissa, and Bihar in the eastern region, and Rajasthan in the northern region. In contrast, all states in the southern and western regions have lower levels of infant and child mortality. Three states in the North-eastern region that have lower than average

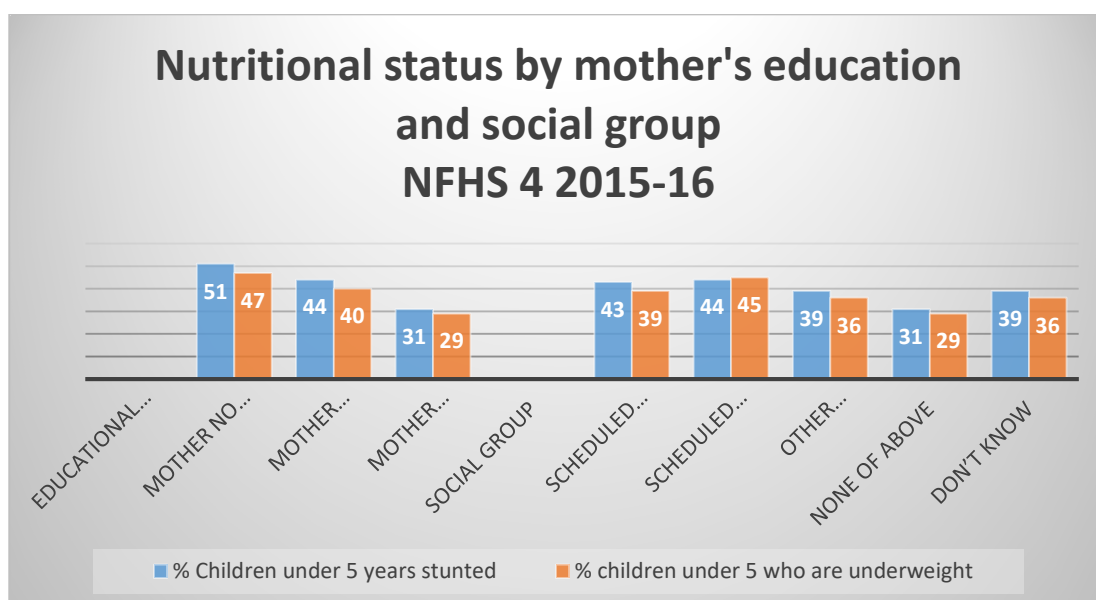
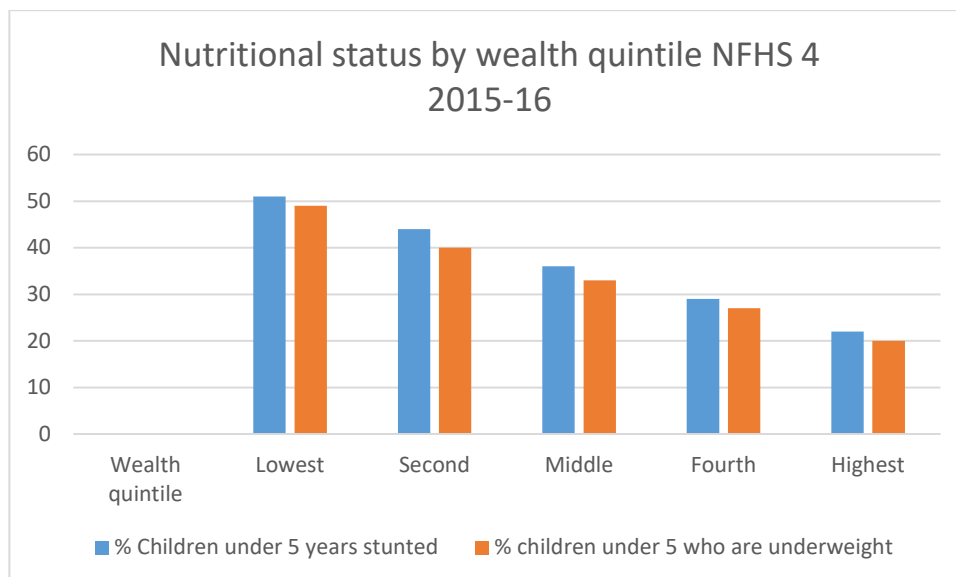
reported levels of neonatal mortality have higher than average rates of post neonatal and child mortality (Arunachal Pradesh, Meghalaya, and Nagaland). The picture seems to have changed lightly in 2013 - Madhya Pradesh and Assam recorded the highest Infant mortality rate of 54 (MP: M 52, F 55; Assam M 53, F 55). The other states with an IMR more than 50 are Odisha and Uttar Pradesh. The states with IMR between 45 and 50 are Chhattisgarh, Meghalaya and Rajasthan (National Health Profile (GOI) 2015, Table 1.27)

Anaemia prevalence is also a sensitive indicator of nutritional status of children. It is indeed worrying that anaemia prevalence among children of (6-59 months) is more than 70 percent in Bihar, Madhya Pradesh, Uttar Pradesh, Haryana, Chhattisgarh, Andhra Pradesh, Karnataka and Jharkhand. Anaemia prevalence among children of (6-59 months) is less than 50 percent in Goa, Manipur, Mizoram, and Kerala. For the remaining States, the anaemia prevalence is in the range of 50% - 70%. Anaemia prevalence among male and female children (6-59 months) the percentage of children with any anaemia was reported as 69% and 69.9% respectively, severe anaemia was reported for 3.2 % male children and 2.7% female children. About 76.4% of children (6-59 months) in the lowest wealth index are suffering from anaemia whereas 56.2% children of the highest wealth index are suffering from anaemia (MOSPI, 2015, pp 11)

**Table 7: Nutritional status of children by education, poverty and social group**

NFHS 4	% Children under 5 years stunted	% children under 5 who are underweight
<b>Educational status</b>		
Mother no education	51	47
Mother primary complete	44	40
Mother secondary complete	31	29
<b>Social group</b>		
Scheduled Caste	43	39
Scheduled Tribe	44	45
Other backward classes	39	36
None of above	31	29
Don't know	39	36
<b>Wealth quintile</b>		
Lowest	51	49
Second	44	40
Middle	36	33
Fourth	29	27
Highest	22	20

Source: NFHS 4, National Report Vol. 1, 2015-16



Notwithstanding huge regional differences, there is one thread that runs across all states and all communities in India – that is poverty. Quantitative data available through sample surveys that factor in the economic status of the sample population and a range of qualitative studies done over the last three decades reveal the one-to-one correlation between poverty and child health. Using the Tendulkar methodology, the National Health Profile (2015) of the government estimated the percentage of people living below the poverty line. Across all the states, rural poverty was far more severe than urban. For example, in Madhya Pradesh 21% urban and 35.7% rural people are below poverty line and the corresponding figures for other states which show consistently poor child health indicators are: Assam 38.9 (R) and 28.3 (U); Chhattisgarh 44.6 (R) 24.8 (U), Uttar Pradesh 30.4 (R) 26.1 (U).

## Burden of communicable diseases

Another cross-cutting issue that affects children living in diverse poverty situation in almost all states of the country is the burden of communicable diseases. Malaria has remained a huge issue across India, alongside other mosquito borne diseases like Dengue, Chikungunya and Encephalitis. Infants and small children are also more vulnerable to respiratory infections, diarrhoeal diseases, measles, meningitis and other viral diseases. Poor sanitation, poor nutrition, non-availability of safe drinking water and overall environmental hygiene all exacerbate the situation. It is indeed shocking that four states of India share the maximum burden of Encephalitis namely Uttar Pradesh, Bihar, West Bengal and Assam. The situation in Uttar Pradesh is most alarming – accounting for a very high number of encephalitis related deaths among children. In the last decade the dire situation of child death in Gorakhpur has received a lot of media attention (Source: NPH 2015, Table 3.1.4, pp 98-99).

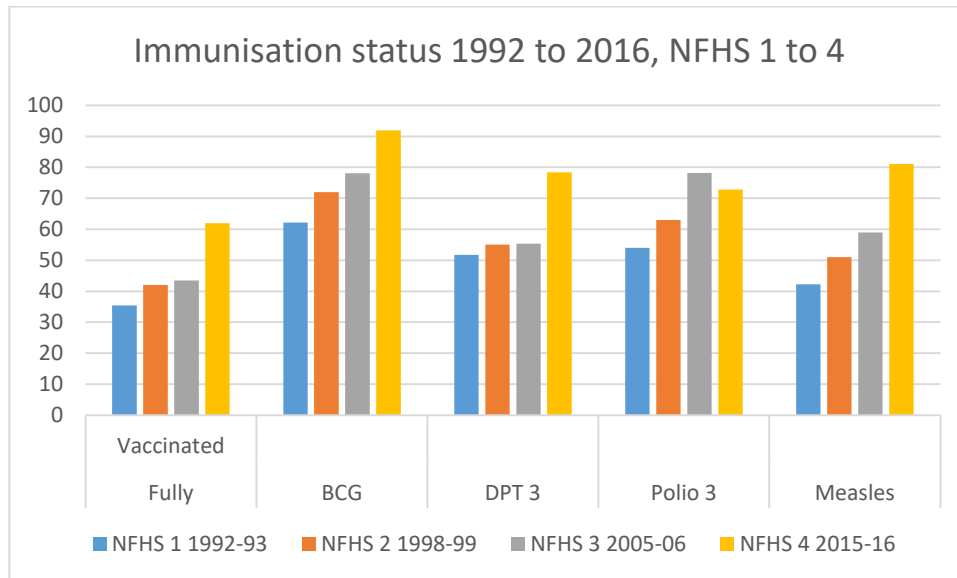
Cholera is another deadly communicable disease that has affected child health. The prevalence of Cholera in 2014 was recorded in Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Punjab, Rajasthan, Uttar Pradesh and West Bengal (Table 3.1.6, pp 103, NHP 2015)

One of the most disturbing child health data pertains to do with cases of Tetanus Neonatal (Table 3.1.10 pp 114, NHP 2015). Notwithstanding several decades of safe-delivery programmes and a number of GOI sponsored maternal and child health initiatives and campaigns – the very fact that children still get Tetanus Neonatal is indeed a huge blot of the country's health care system. In 2013 cases were reported in Bihar (113), Odisha (82), Madhya Pradesh (62), Haryana (35), Uttar Pradesh (36), West Bengal 88 and Delhi (19). Equally alarming is the reported cases of Diphtheria – Assam (1450), Bihar (167), Gujarat (48), Haryana (104), J & K (234), Jharkhand (47), Madhya Pradesh (44), Maharashtra (188), Rajasthan (857), Uttar Pradesh (49), West Bengal (631) and Delhi (181) (Table 3.1.12, pp 118, NHP, 2015) Similar data is also report for Whooping Cough and Measles. All these are vaccine preventable diseases – and the prevalence of so many cases points to the state of the vaccination programme in India.

## Immunization:

**Table 8: Status of immunization by vaccine, NFHS 1 to 4**

	Fully Vaccinated	BCG	DPT 3	Polio 3	Measles
NFHS 1 1992-93	35.4	62.2	51.7	54	42.2
NFHS 2 1998-99	42	72	55	63	51
NFHS 3 2005-06	43.5	78.1	55.3	78.2	59
NFHS 4 2015-16	62	91.9	78.4	72.8	81.1



What is noteworthy in NFHS 4 is that urban-rural differences in immunization coverage is not very stark. For example, in NFHS 4 the percentage of children fully immunized is 63.9 in urban areas and 61.3 in rural areas. What is more interesting is that most of the children received the immunization in public-health facilities – with the percentage of rural children receiving vaccination in public health facility (82.1 urban, 94.2 rural areas) is more than urban areas. This clearly shows that – when there is political and administrative resolve – the public health facility is able to provide the necessary services.

As discussed earlier – vaccination coverage ranges from 21 percent in Nagaland to 81 percent in Tamil Nadu (NFHS 3). According to the government Tamil Nadu, Goa, Kerala and Himachal Pradesh stand out in full immunization coverage as about three-fourths or more of children in each of these states are fully immunized. The states where coverage still remains a concern are Uttar Pradesh (23 percent), Rajasthan (27 percent), Assam (31 percent), Bihar (33 percent), Jharkhand (34 percent), and Madhya Pradesh (40 percent) stand out as having a much lower percentage of children fully vaccinated than the national average of 44 percent. Whichever indicator we choose, many of the high poverty states are also those with poor child health indicators, poor vaccination coverage and also very poor human development indicators. On the other hand, there are some states which report not only better immunization coverage but also consistently record better child health indicators. For example, Tamil Nadu, Himachal Pradesh, Goa, Kerala and Sikkim the coverage for BCG and at least the first doses of DPT and polio is generally in excess of 90 percent and in some cases, nearly universal. In Tamil Nadu and Goa, measles coverage is also above 90 percent.

## The dire situation among Scheduled Tribe children:

National averages hide the huge differences across regions, locations, communities and economic groups. Among the communities that are in a dire situation with respect to children are the Scheduled Tribe, followed by Scheduled Caste and then the backward classes and Muslims. For example, NFHS 3 revealed that the under 5 mortalities among ST is 95.7 while it is 74.3 in the general population, similarly only 31.3 per cent of ST children received all vaccinations in 2005-06 as compared to 43.5 per cent of all communities (NFHS 4 data on SC and ST has not yet been released). As argued by Dr. H Sudarshan *"Immunisation coverage of tribal children is also poorer than other children and hence contributes to increased burden of infectious diseases as well as stunting and wasting among these children. Only one-third of tribal children received full primary immunization; worse still, they found that an alarming 1 in 8 (12%) tribal child did not receive immunization at all (national – 5%, rural – 7%) as per the NFHS-3 data. In general, immunisation coverage of tribal children is lower than the national and rural Indian averages. There appears to be little improvement in this trend from the 80s till mid 2000s. ... Inadequate immunisation coverage of tribal children could be related to difficulties in availability, procurement, storage, maintenance of cold chain of vaccines and accessibility of the target population, but also because of poor management, agenda-setting and prioritisation of tribal health problems within district and state administration. Coverage of Vitamin A supplementation too was poor; only 15% of the tribal children received Vitamin A in the 6 months in one."* (p19-21, H Sudarshan and Tanya Seshadri, 2015)

It is now widely accepted that childhood under-nutrition is higher among tribal children at the national and the rural figures. According to NFHS 3 data, 57% of tribal children are underweight (rural 50%, national 39%), 55% stunted (rural 50%, national 45%), 29% wasted (rural 25%, national 19%) and 78% anaemic (rural 71%, national 67%). Dr. H Sudarshan argues that the causes for the poor nutritional status are related to lack of access to appropriate quantity and quality of food due to poverty, lack of livelihood security and secure land tenure for agriculture or harvesting non-timber forest products, as the case may be locally. The hard reality is that the reasons for this situation not only go beyond the purview of health services delivery but is the cumulative impact of the failure of convergence of services of various schemes and departments. When each department or scheme works in silos – it cannot have the expected impact. For example, Dr Sudarshan point out *"the anganwadi centres established under the Integrated Child Development Services (ICDS) have a significant limitation; they do not cater to the nutritional needs of children between 6 months to 2 years of age. The tribal children of this age group are particularly vulnerable due to lack of food, income and livelihood security for their households."* (pp 21-22 H Sudarshan and Tanya Seshadri, 2015)

Another extremely disturbing trend highlighted by the High-Level Committee of the Ministry of Tribal Affairs (GOI) reveals that the mortality rates among Tribal communities increase with age among tribal children with the under-five mortality being three

times that of neonatal mortality and is nearly double that among non-tribal children. For example, taking India as a whole (using NFHD 3 data) the Neo Natal mortality among ST was 39.9 (while it was 34.5 among all other communities); the Infant Mortality was 62.1 (others 48.9) and under-five mortality was 95.7 (others 59.2). Dr. Sudarshan argues that the specific situation in tribal areas need focused attention and that children under six in almost all tribal areas, and in particular the Schedule V areas need tailor made health, nutrition and pre-school education programmes. The current practice of all-India programmes designed as one shoe fits all have not worked and will not work for the tribal groups of India.

## Summing up the picture from data sources:

The current situation of young children in India is not very encouraging. The most recent NFHS 4 (which is universally accepted as being a very reliable source of health data) reveals that we do have a long way to go before we can even hope to ensure that all our children under the age of six are able to go through the first six years without any major illness or trauma.

**Table 9: Overview of child health, NFHS**

	NFHS 4			NFHS 3
	Urban	Rural	Total	Total
<b>Child Immunizations and Vitamin A Supplementation</b>				
Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%)	63.9	61.3	62.0	43.5
Children age 12-23 months who have received BCG (%)	93.2	91.4	91.9	78.2
Children age 12-23 months who have received 3 doses of polio vaccine (%)	73.4	72.6	72.8	78.2
Children age 12-23 months who have received 3 doses of DPT vaccine (%)	80.2	77.7	78.4	55.3
Children age 12-23 months who have received measles vaccine (%)	83.2	80.3	81.1	58.8
Children age 12-23 months who have received 3 doses of Hepatitis B vaccine (%)	63.3	62.5	62.8	na
Children age 9-59 months who received a vitamin A dose in last 6 months (%)	62.9	59.1	60.2	16.5
Children age 12-23 months who received most of the vaccinations in public health facility (%)	82.1	94.2	90.7	82.0
Children age 12-23 months who received most of the vaccinations in private health facility (%)	16.7	3.4	7.2	10.5
<b>Treatment of Childhood Diseases (children under age 5 years)</b>				
Prevalence of diarrhoea (reported) in the last 2 weeks preceding the survey (%)	8.2	9.6	9.2	9.0
Children with diarrhoea in the last 2 weeks who received oral rehydration salts, ORS (%)	58.5	47.9	50.6	26.0
Children with diarrhoea in the last 2 weeks who received zinc (%)	23.7	19.1	20.3	na

Children with diarrhoea in the last 2 weeks taken to a health facility (%)	74.1	65.8	67.9	61.3
Prevalence of symptoms of acute respiratory infection (ARI) in the last 2 weeks preceding the survey (%)	2.3	2.9	2.7	5.8
Children with fever or symptoms of ARI in the last 2 weeks preceding the survey taken to a health facility (%)	80.0	70.8	73.2	69.6
<b>Child Feeding Practices and Nutritional Status of Children</b>				
Children under age 3 years breastfed within one hour of birth <sup>9</sup> (%)	42.8	41.1	41.6	23.4
Children under age 6 months exclusively breastfed (%)	52.1	56.0	54.9	46.4
Children age 6-8 months receiving solid or semi-solid food and breastmilk (%)	50.1	39.9	42.7	52.6
Breastfeeding children age 6-23 months receiving an adequate diet (%)	10.1	8.2	8.7	na
Non-breastfeeding children age 6-23 months receiving an adequate diet (%)	16.9	12.7	14.3	na
Total children age 6-23 months receiving an adequate diet (%)	11.6	8.8	9.6	na
Children under 5 years who are stunted (height-for-age) (%)	31.0	41.2	38.4	48.0
Children under 5 years who are wasted (weight-for-height) (%)	20.0	21.5	21.0	19.8
Children under 5 years who are severely wasted (weight-for-height) (%)	7.5	7.4	7.5	6.4
Children under 5 years who are underweight (weight-for-age) (%)	29.1	38.3	35.7	42.5

We seem to be doing quite well when it comes to disease management – like diarrhoea or life-threatening illnesses. However, prevention and continuous care and support remains a huge weakness in India. In the 1960s, 1970s and 1980s it used to be argued that when literacy level goes up, mothers would become more aware of good child health and nutrition practices and that with higher levels of education in the general population the families of children would also become far more sensitive to women and children's health. The last decade has seen a huge increase – not only in literacy rates, but in elementary school completion rates. Female literacy rates have gone up significantly - with impressive improvements in female literacy rates among socially disadvantaged groups like Scheduled Caste and Scheduled Tribe. The young mothers and fathers of today are definitely better educated and informed than their own parents. Yet, if we are to compare ourselves with other countries (that are similar to us) – we find that India is lagging behind.

**Table 10: Literacy Rate of General, SC and ST (1961-2011) (India)**

Year	All Social Groups			SC			ST		
	M	F	Total	M	F	Total	M	F	Total
1961	40.4	15.4	28.3	17.0	3.3	10.3	13.8	3.2	8.5
1971	46.0	22.0	34.5	22.4	6.4	14.7	17.6	4.9	11.3
1981	56.4	29.8	43.6	31.1	10.9	21.4	24.5	8.0	16.4
1991	64.1	39.3	52.2	49.9	23.8	37.4	40.7	18.2	29.6
2001	75.2	53.7	64.8	66.6	41.9	54.7	59.2	34.8	47.1
2011	80.9	64.6	73.0	75.2	56.5	66.1	68.5	49.4	59.0

Source: Registrar General of India, Census of India Various Years

During the period 1999-2000 and 2014-15 the number of primary schools increased from 6,42,000 to 8,47,000; upper primary schools increased from 1,98,000 to 4,25,000. The National Sample Survey Organisation of Government of India conducts a comprehensive survey every few years. The most recent NSSO round (71<sup>st</sup> Round of NSSO 2016) that covered education access revealed that nearly 67% of rural households and 83% of urban households reported upper primary schools within 1 km from the house while only 37% of rural households compared to 73% of urban households reported secondary schools within such a distance. This means that the supply bottleneck is far more adverse in rural areas than in urban areas. Equally, the more economically disadvantaged locations with poor infrastructure have poorer access than the relative forward and better resourced areas (Vimala Ramachandran, 2018 pp 57)

With significant improvements in school participation rates, improvement in infrastructure (like roads, transport, electricity supply, water etc) – it is a big question as to why the overall health and well-being of children under six remains poor. At one level Indian government likes to project itself as a super power and has consistently maintained that poverty levels are coming down, educational levels are going up and overall infrastructure situation has improved.

International data from the SOWC 2017 reveal that India has certainly made considerable progress in the last 20 years and that most of the indicators are almost close to the world average (as evident in Table 9 below). Yet, we still have a long way to go...

This clearly shows that literacy alone cannot make a difference nor will years of schooling by itself make a difference. The coming together of enhancement of the overall literacy / educational level of people needs to go hand in hand with improvement in three critical inter-connected services: (i) food security at home (not only MDM and supplementary nutrition), (ii) safe drinking water and proper sanitation and (iii) reliable health care services.

Experience across the world has shown that a holistic approach to development – where education, overall living environment, access clean drinking water, proper sanitation and a reliable primary health care service can indeed make a difference. The rapid progress made by China on a range of child development indicators could be attributed to a multi-pronged approach. Similarly, it is believed that Bangladesh has also adopted a more holistic strategy to not only child development but also towards health and well-being of women. Similarly, the impressive improvement in the overall child health indicators in Malaysia, Bhutan, Lao PDR, Vietnam and several countries in South East Asia show that what works is a multipronged approach. Working through vertical schemes in some sectors alone in silos cannot make a difference.

Table 11: Basic child health indicators by state

Countries and areas	Under-5 mortality rate		Under-5 mortality rate by sex 2016		Infant mortality rate (under 1)		Neonatal mortality rate	Total adult literacy rate (%)	Primary school net enrolment ratio (%)
	1990	2016	male	female	1990	2016			
							2011-16	2011-2016	
Afghanistan	177	70	74	66	120	53	40	32	-
Bangladesh	144	34	37	32	100	28	20	73	91
Bhutan	128	32	36	29	90	27	18	57	86
Brazil	64	15	16	14	53	14	8	92	93
Cambodia	116	31	34	27	85	26	16	74	95
China	54	10	11	9	42	9	5	95	-
Ghana	127	59	64	53	80	41	27	71	87
India	126	43	42	44	88	35	25	69	92
Indonesia	84	26	29	23	62	22	14	95	90
Lao People's Democratic Republic	162	64	70	58	111	49	29	58	93
Malaysia	17	8	9	8	14	7	4	93	98
Mexico	46	15	16	13	37	13	8	94	95
Nepal	141	35	37	32	98	28	21	60	97
Pakistan	139	79	82	75	106	64	46	57	74
South Africa	57	43	48	39	45	34	12	94	83
Sri Lanka	21	9	10	9	18	8	5	91	99
Turkmenistan	86	51	60	42	70	43	22	-	-
Viet Nam	51	22	25	18	37	17	12	94	98
East Asia and Pacific	57	16	18	15	43	14	8	-	94
Europe and Central Asia	31	10	11	9	25	8	5	-	96
Eastern Europe and Central Asia	47	14	16	13	38	13	7	98	94
Western Europe	11	4	4	4	9	3	2	-	98
Latin America and Caribbean	55	18	19	16	44	15	9	94	93
Middle East and North Africa	66	24	26	22	50	20	14	78	94
North America	11	6	7	6	9	6	4	-	94
South Asia	129	48	48	48	92	39	28	68	90
Sub-Saharan Africa	181	78	84	73	108	53	28	65	80
Eastern and Southern Africa	164	61	66	56	101	43	25	75	82
West and Central Africa	199	95	101	89	116	63	31	-	-
Least developed countries	176	68	73	63	109	48	26	63	81
<b>World</b>	<b>93</b>	<b>41</b>	<b>43</b>	<b>39</b>	<b>65</b>	<b>31</b>	<b>19</b>	<b>78</b>	<b>90</b>

## The ambiguous situation of early childhood education:

Census 2011 was an eye opener on another important issue that concerns children under six. Out of 158.7 million children under six years, around 76.5 million children (48%) reported to be accessing the ICDS programme, which is supposed to include early childhood education. The Census also reveals that the remaining 30 to 40 million children – probably belonging to the most disadvantaged and the very poor do not access these services. A recent rapid survey commissioned by the Ministry of Women and Child Development revealed rural-urban differences, social category differences and wealth index differences in participation in government ICDS/Anganwadi centre and in private pre-school education centres. A significant percentage of children from lowest wealth index attend Anganwadi Centres while the situation is just the opposite for the highest wealth index. In India close to 27 per cent of children of 3 to 6 years do not attend any preschool facility and just 58 per cent of enrolled attend regularly. The largest provider of pre-school education is the ICDS programme followed by the private sector.

**Table 12: Participation in pre-school education by gender, wealth and location 2013-14**

Per cent of children 3-6 years currently attending pre-school education (PSE) at	Residence			Gender		Social Category				Wealth Index	
	Total	Rural	Urban	Male	Female	SC	ST	OB C	Other	WI-Lowest	WI-Highest
Anganwadi Centre	37.9	45.1	21.6	36.6	39.3	41.6	50.9	34.8	33.9	51.4	15.4
Privately run institution	30.7	22	50.3	31.7	29.6	25	17.3	32.1	32.1	8.6	61.5
Not attending	26.9	28	24.5	27.3	26.6	29.1	27.3	28.3	22.9	34.7	19.9
Per cent of children 3-6 years currently attending pre-school education (PSE) in AWC for 16 or more days in the month prior to the survey	58.1	58.6	55.5	57.2	58.9	57.2	58	58.4	58.9	56.6	56.6

Source: Ministry of Women and Child Development, 2015 (RSOC) p 4

A modest proportion of government primary schools (15.5%) have a pre-school section and the Gross Enrolment Ratio in pre-school (attached to primary schools) is only 12.91 per cent (Source: UNESCO 2017). According to the UDISE data of 2014-15 "around 15.5% of government schools nationally have a pre-primary section, catering to about 30.2 lakh students, with an average enrolment of 22 students. In 12 states and UTs in the country, more than 50% of government primary schools have an attached PPS. Nationally, there are 86,319 teachers in pre-primary sections in

government schools. Significantly, 65% of schools having PPS do not have a teacher. In sum, DISE 2014-15 data reveals that national provision of government PPS is low, with only a few states having large programmes. Government pre-school sections in these states are characterized by low enrolments and fewer teachers relative to private schools." (Central Square Foundation 2016) Equally significant is that a large number of children from 4 to 6 years attend government primary schools – this is evident in the high Gross Enrolment Ratios at primary. In comparison 43.26 per cent of private primary schools have a pre-school section. Whichever way we look at the scenario – the sad reality is that just over 30 lakhs of children (in 2014-15) attend a formal pre-school centre or section in primary schools' while the Anganwadi centres cater to 3.7 Crores of children. Among the states that have shown resolve to attach preschool section to primary schools are Delhi, Chandigarh, Haryana, West Bengal and Kerala.

One of the persisting critiques of the ICDS programme (since the 1980s) is that it has not been able to focus on pre-school education. A single Anganwadi worker with one helper is expected to manage supplementary nutrition, immunisation, health check-up, referral services and the care of pregnant women. In recent years the programme has also included some interventions for adolescent girls. As a result, the pre-school education component receives low priority. Equally, specialised training to enable Anganwadi workers to acquire pre-school education skills is also weak. Many of the workers do not have the basic qualifications required for them to become trained pre-school teachers. The recent CECED, ASER and UNICEF study confirmed the mounting evidence on dysfunctional pre-school education in ICDS. The study noted "With some exceptions, Anganwadis generally act as a place where children come primarily to collect their mid-day meal and spend some time when parents are away at work. There is generally no planned ECE activity and children can be found playing among themselves while the Anganwadi worker does her own administrative work. When some activity takes place, it is invariably recitation of poems or rhymes or learning of letters or numbers. Although there are play materials appropriate for children available, they are not available in appropriate numbers. The material is rarely taken out for children as the worker fears it will get damaged..." (Pp 52, CECED ASER and UNICEF, 2017).

In recent years, especially after RTE excluded pre-school education from the ambit of the constitutional amendment – there have been many efforts to convince the government to take the issue seriously and sort out the seeming turf battle between two ministries. Both ministries of the government talk about the importance of pre-school education in their respective policies and annual reports – however, when it comes to budget allocations, it appears that the DWCD that managed the ICDS programme may not let go of 3-6 years (and associated budget provisions) and MHRD is wary of taking on additional responsibilities. As this is an inter-ministerial issue – this could be resolved by the PM or any other neutral body like the Niti Ayog. We are informed that the new education policy – which may be announced in 2018 is

contemplating opening pre-school classes in all government primary schools<sup>8</sup>. However, there is no firm information on this and as far as the government is concerned the jury is still out – should pre-school education continue to be piggybacked to ICDS or should it be transferred to primary schools.

#### Recent efforts to turn the spotlight on pre-school education

- The Right to Free and Compulsory Education Act, 2009 recommends (in section 11) that there is a need to prepare children for elementary education and therefore the appropriate Government may make necessary arrangements for pre-primary education.
- The Ministry of Human Resource Development (MHRD), India, had, in response to demand from the states, set up a sub-committee of the Central Advisory Board of Education to examine the feasibility of extending the Right to Education (RTE, 2009) to children below 6 years.
- The 12th Five Year Plan for Elementary Education has as a target, “Providing at least one year of well-supported/well-resourced pre-school education in primary schools to all children, particularly those in educationally backward blocks”
- The Law Commission Report on Early Childhood Education, August 2015, recommends that the government provide free pre-school education for all children aged 3-6 years, and that further, pre-school centres should be established in all government and aided schools in a phased manner.
- The 22nd Joint Review Mission (JRM) of the Sarva Shiksha Abhiyan (SSA) in December 2015 endorses the suggestion that all states introduce pre-school sections in all primary school to cater to 4-6-year-olds
- Source: Central Square Foundation, 2016

Like in almost all aspects of the lives of children in India, “Gender differences in the participation trajectories of school going children in India have been amply documented over the years, with larger proportions of boys than girls attending private institutions. These trends are visible in the case of preschool aged children as well, confirming that gender discrimination begins very early in a child’s life...” (CECED, ASER & UNICEF. 2017 pp 40) Similar other characteristics like mother’s education and family income are important positive triggers. As a result, it is the poor and families where the mother is not literate or barely literate, that seem to be disadvantaged. Another concern highlighted by the CECED, ASER and UNICEF study is the location of the centres, cleanliness and safety. A snapshot from the study reveals serious issues on all the three aspects: “most Anganwadis in the three states were

---

<sup>8</sup> Discussions with NUEPA faculty and RTE Forum in April 2018 on the future of pre-school education in the new education policy in the pipeline. The argument put forth is that it is an inter-ministerial issue – one that can either be resolved by the PMO or the Niti Ayog. The draft policy with MHRD includes one chapter on pre-school education. However, this is yet to be made public.

*found to have limited infrastructure. Typically, Anganwadis were running from rented accommodation, while others operated from primary school campuses or in a separate room allocated on the outskirts of the village. Some differences were evident across states. A higher proportion of Anganwadis in Rajasthan had their own buildings, which were built on the outskirts of the village on Panchayat land, although these centres were not necessarily located in safe surroundings. Inadequacy of space was found to be a major limitation; almost 50 per cent of these centres did not have enough space for children and the Anganwadi worker to move around freely, let alone conduct group activities. About 54 per cent of Anganwadis did not have proper seating facilities, with children observed sitting on torn mats or on a bare floor. Basic amenities such as toilets were rarely available, and in most cases, children were observed to be using open spaces." (CECED, ASER and UNICEF 2017, pp 45)*

The pre-school education scenario is fairly grim – to begin with (as argued in the policy brief prepared by CECED et al in 2017) there is no consolidated data available to enable an accurate assessment of the extent of provisions for ECE across the country. We still do not know what the GER for pre-school education is – the figures vary from 12 % (DISE – covering children attending PSE in primary schools) to 55% (UNESCO). There are wide regional and state-wise differences. States like Nagaland, Assam and Meghalaya in the Northeast; Haryana, Jammu and Kashmir and Chandigarh in the North have some visible resolve to provide pre-school education – with many of them encouraging a pre-primary section in regular primary schools. Another serious concern is the availability of pre-service education for pre-school education teachers. The importance of trained pre-school teachers is yet to be accepted and it is commonly belied that any one (preferably female) can become a pre-school teacher. For several decades now, experts have argued for a 2-year teacher education programme – but such training facilities are just not available in adequate numbers. We in India are far away from ensuring universal access to preschool education and given the nature of the debate between different ministries – it looks like this turf war may not be resolved any time soon.

## **Rights and entitlements of Children under six:**

A quick perusal of Government of India's official documents like the Twelfth Plan raises an alarm – the document lists the issues that frame the rights of children in India – apart from the health and nutritional issues discussed in the preceding section of this paper the government lists the following as major issues of concerns:

- i. Wide social and economic disparities exacerbate not only the physical wellbeing of children (health and nutrition) but influences the ability of the children to education – from pre-school to secondary. The poorer the child the lesser are her chances of accessing pre-school education, the greater the chances of dropping out from formal school.

- ii. The situation of children living in 'insecure environment' may exacerbate vulnerabilities. In particular, the Twelfth plan mentions exposure to violence in areas that are known to be affected by conflict (left-wing extremism, terrorism).
- iii. Children of new migrants and urban poor communities face multiple deprivations – from being denied an identity, sexual abuse and violence, exposure to substance abuse and exposure to other forms of addiction at an early age.
- iv. Children of working mothers – especially those engaged in construction, domestic labour, other forms of daily wage labour, sex work and so on – are particularly vulnerable to neglect and exposure to violence at an early stage in their lives. This not only affects their physical health but may scar them emotionally and psychologically.
- v. Children of parents affected by HIV/AIDS and children who are themselves affected by HIV/AIDS face many more challenges in society and their ability to go to child care centres or pre-schools is also highly compromised.

How has the government and our society responded to the challenges faced by children? A brief history of government policies for the young child reveals a disturbing trend – same recommendations are repeated policy after policy – with little evidence by way of concrete implementation.

### **The Constitution of India (GOI, 1949):**

- i. Article 15(3) empowers the government to promote and practice positive discrimination / affirmative action in favour of socially and economically disadvantaged or vulnerable communities. This should ideally include children under six. However, in reality this has not resulted in proactive policies to improve the lives of children from vulnerable communities, regions and situations.
- ii. Articles 21 (protection of life and personal liberty), Article 21 A (Free and compulsory education; subsequently amended in 2009 under Right to Education Act), Article 23 (Prohibition of traffic in human beings and forced labour) – all apply to children as much as it to adults.
- iii. While free and compulsory education was introduced as a fundamental right (it was in the directive principles) in 2009, the right to pre-school education was left in the directive principles. In 1949 Article 45 (a non-justiciable provision) read "The state shall endeavour to provide ECCE for all children until they complete

the age of six.” –and this remains the case today. Just a promise that cannot be enforced in the court of law.

- iv. Article 39 (e and f) recognises the rights of children and their protection against all forms of abuse and exploitation.
- v. Article 45 asks the state to endeavour to provide early childhood care and education to all children until the age of six. This was placed in the Directive Principle and was not a justiciable right.
- vi. Article 47 said that the state with work towards raising the live of nutrition and living standards of all people – including children under six.

### Post-Independence policies and legal provisions<sup>9</sup>:

- o **National Policy for children 1974:** The policy states “it shall be the policy of the State to provide adequate services to children, both before and after birth and through the period of growth to ensure their full physical, mental and social development. The State shall progressively increase the scope of such services so that within a reasonable time all children in the country enjoy optimum conditions for their balanced growth.” (FOCUS 2006). It was under the aegis of this policy that the ICDS programme was introduced in 1975.
- o **National Policy on education 1986:** which recognised pre-school education as a “feeder and support programme for primary education and a support service for working women” (MHRD, GOI 1986)
- o **National Nutrition Policy 1993:** recognised that children below six years as high-risk group that must be given priority;
- o India ratified the **Convention on the Rights of Children in 1992** that sought to protect / safeguard the rights of children.
- o **National Plan of Action on Nutrition (NPAN) 1995:** This updated the monitorable targets, strategies and interventions using WHO child health standards for assessing and reviewing programmes (Source: 12<sup>th</sup> Plan working group report. 2011)
- o **National Charter for Children 2003:** “to secure for every child its inherent right to be a child and enjoy a healthy and happy childhood, to address the root causes that negate the healthy growth and development of children, and to

---

<sup>9</sup> Source Venita Kaul and Deepa Sankar, 2009, Ministry of Women and Child Development GOI Working Group Reports for the 12<sup>th</sup> Five Year Plan

awaken the conscience of the community in the wider societal context to protect children from all forms of abuse, while strengthening the family, society and the Nation" (quoted from National Policy for Children 2013, DWCD, GOI)

- **The National Plan of Action for Children 2005** also spelt out two years of pre-school education and ECCE as significant for holistic development of children. *The main provisions of this Act area:*
  - *To regard the child as an asset and person with human rights*
  - *To address issues of discrimination emanating from biases of gender, class, caste, race, religion and legal status in order to ensure equality*
  - *To accord utmost priority to the most disadvantaged, poorest of the poor and the least served child in all policy and programme interventions*
  - *To recognise the diverse stages and settings of childhood and address the needs of each, providing all children the entitlement that fulfil their rights and meet the needs of each situation.*
- **Commission for the Protection of Child Rights Act 2005:** this act provided for the creation of child rights commissions at the state and national level to provide speedy trial in offences against children or to protect children from the violation of any of their rights.
- **Juvenile Justice (care and protection of children) Act 200, and Amended in 2006:** spelt out a number of measures to protect children in including issues of adoption, foster care, sponsorship etc.
- **Protection of Children from sexual offences Bill. 2011:** this bill was drafted to protect children on an urgent basis.
- **Amendment of the Juvenile Justice Act and Central Model Rules Under the Act. 2011.**
- **National Policy for Children 2013:** this essentially reaffirmed "affirm the Government's commitment to the rights-based approach in addressing the continuing and emerging challenges in the situation of children, the Government of India hereby adopts this Resolution on the National Policy for Children, 2013.
- **National Early Childhood Care and Education (ECCE) Policy in 2013** followed by National Curriculum Framework and Quality Standards in 2014. The policy also recommends institutionalization of a regulatory and accreditation framework for quality, particularly for the private sector.
- **National Nutrition Strategy (NNS) 2017:** Introduced to work in a targeted manner to reduce child malnutrition in India. This strategy is expected to focus on those states, districts and specific pockets of poor nutrition. The NITI Aayog and the MWCD are going to use a new Nutrition Monitoring System (NMS) to

- identify states/districts/blocks that are performing well and those that are lagging for focused intervention.

### **National Policy for Children 2013**

#### 2. Preamble

##### 2.1 Recognising that:

- a child is any person below the age of eighteen years;
- childhood is an integral part of life with a value of its own;
- children are not a homogenous group and their different needs need different responses, especially the multi-dimensional vulnerabilities experienced by children in different circumstances;
- a long term, sustainable, multi-sectoral, integrated and inclusive approach is necessary for the overall and harmonious development and protection of
- children;

##### 2.2 Reaffirming that:

- every child is unique and a supremely important national asset;
- special measures and affirmative action are required to diminish or eliminate conditions that cause discrimination,
- all children have the right to grow in a family environment, in an atmosphere of happiness, love and understanding;
- families are to be supported by a strong social safety net in caring for and
- nurturing their children;

Source: National Policy for Children 2013, DWCD, GOI

### **Illustrative List of Preventive and Public Health Interventions for children Provided by Government**

1. Full Immunisation among children under three years of age, and pregnant women
2. Full antenatal, natal and post-natal care
3. Skilled birth attendance with a facility for meeting need for emergency obstetric care
4. Iron and Folic acid supplementation for children, adolescent girls and pregnant women
5. Regular treatment of intestinal worms, especially in children and reproductive age women
6. Universal use of iodine and iron fortified salt
7. Preventive and promotive health educational services, including information on hygiene, hand-washing, dental hygiene,
8. Use of potable drinking water, avoidance of tobacco, alcohol, high calorie diet and obesity, need for regular physical
9. Advice on initiation of breastfeeding within one hour of birth and exclusively up to six months of age, and complimentary feeding thereafter, adolescent sexual health, awareness about
10. Home based new-born care, and encouragement for exclusive breastfeeding till six months of age
11. Community based care for sick children, with referral of cases requiring higher levels of care
12. HIV testing and counselling during antenatal care
13. Free drugs to pregnant HIV positive mothers to prevent mother to child transmission of HIV
14. Management of diarrhoea, especially in children, using Oral Rehydration Solution (ORS)
15. Patient transport systems including emergency response ambulance services of the 'dial 108' model

Source: Planning Commission GOI, 2013 (pp 14)

If we are to go by what is said in the Constitution of India or subsequent policy documents and acts of the parliament – it looks almost as if the child in India is protected from almost every kind of mal-treatment, abuse, poverty, deprivation and identity. This is a unique feature of India, we (as a country) are amazingly good at drafting policies. We reiterate the same basic issues in every policy, we reemphasize them in almost every government sponsored programme and we reaffirm our commitment in the parliament and in the state legislatures. However, as evident in the preceding section on the status of children under six – on almost every single count we seem to be faring quite poorly. Starting from survival of our children to nutrition, health, pre-school education, protection and safety – on almost all counts we are far behind most other countries in the world.

While this paper is not dealing with programmes and project of the government – the story is not very dissimilar. Notwithstanding several decades of the world's most ambitious child health and nutrition programme – ICDS – the nutritional situation, immunisation record and most importantly pre-school education is in a sorry state. Successive Five-Year plan working groups and mid-term appraisals point to both data gaps to ascertain the impact of government policies and programmes and also absence of ground level monitoring processes that could enable to government to realise its own goals. For example, the mid-term appraisal of the 11<sup>th</sup> Plan stated: *“The Mid-term Appraisal has found glaring gaps and inconsistencies on nutritional against the promise made in the eleventh Five Year Plan. While examining the interventions for better nutritional status, the Mid-term Appraisal referring to different surveys and reports indicate that the progress in addressing undermatron has been almost negligible...”* (pp 33, MWCD, WGREP Nutrition. 2011) Similar observations have been made by the working group on Child Rights (2011). Similarly, recent reports on increasing incidence of child abuse, especially of infants and small children, has been alarming. The 2016 report brought out by Save The Children reveals *“The number of cases registered for child abuse raised from 8,904 in the year 2014 to 14,913 in the year 2015, under the POSCO Act. Sexual offences and kidnapping account for 81% of the crimes against minors... Uttar Pradesh led the highest number of child abuse cases (3,078) followed by Madhya Pradesh (1,687 cases), Tamil Nadu (1,544 cases), Karnataka (1,480 cases) and Gujarat (1,416 cases)”*<sup>10</sup>

A ten-year old study commissioned by Ministry of Women and Child Development, GOI (2007) was a grim reminder of the vulnerability of infants and small children. Similarly, successive NFHS, NSSO and other sample surveys periodically remind us that all is not well and that children under six continue to be vulnerable. Sometimes it feels like nothing much has changed on the ground in the last several decades – this is particularly so for the very poor, the marginalised rural and urban communities and children living in areas of conflict, strife and natural disasters.

---

<sup>10</sup> Source: Save the Children: <https://www.savethechildren.in/resource-centre/articles/recent-statistics-of-child-abuse> accessed on 29 April 2018

## Key issues confronting children

The key issues that face infants and children in India have been repeated ad nauseum in government policy documents, periodic working group and commission reports and the larger child development community.

Let us start with what every child can – by right – expect from the government and from society. The entitlement can be broadly categorised as follows (this categorisation has been adapted from the SDGs):

1. Every child in India survives and thrives:
  - a. Every pregnant mother is healthy, gets nutritious food and supported
  - b. Gradual and consistent reduction in neo natal and child mortality
  - c. All births attended by skilled health personnel
  - d. Timely and complete immunisation of all children
  - e. Proper nutrition at all stages of the life of a child – breastfeeding, supplementary nutrition, access to clean and safe water and availability of adequate nutritious food.
2. Every child lives in a safe and clean environment:
  - a. Access to water, sanitation and other hygiene services
  - b. Access to safe place to live, proximity to mother / care giver
  - c. Availability of shelter
3. Every child is protected from violence, exploitation and harmful practices
  - a. The birth of every child is registered and her well being tracked
  - b. Every child is protected from violence in the home, in the community and institutions that the child accesses.
4. Every child has a fair chance in life
  - a. Protection of children from the harsh impact of poverty
  - b. Every child has access to basic services – health care, supplementary nutrition and emotional wellbeing
5. Every child has an opportunity to learn, grow and develop
  - a. Every child has a chance to access pre-school education / care

If we take this as the basic minimum entitlement of every single child up to the age of sex – the sad reality is that millions of our children do not really get a fair change. Starting from the issue of mortality to nutrition and to safety and security – the data presented in the preceding sections clearly demonstrates that we are nowhere near achieving the SDGs goals – that the Government of India has not only signed but has wholeheartedly accepted in front of the international community. If this is the situation, what then are the key issues that frame children under six in India?

1. Lack of real political and administrative intention / will to implement government's own stated policies and programmes. Since 1950, when we formally adopted the Constitution of India – it was quite evident that issues of mortality, poor nutrition, poor health care services and non-existent pre-school education affects the very poor in rural and urban areas far more than the better off. Equally, tribal areas, remote desert and mountainous regions were known to have poor accessibility, poor infrastructure and extremely poor outreach services. Despite knowledge of prevailing inequalities, the government did not initiate any specific scheme or programme to alleviate the dire situation of children across the country. It is indeed ironic that a scheme like the ICDS was not even conceived in the first three decades after India attained Independence. Perhaps the leaders thought that economic development and increasing incomes would automatically improve the situation of children in India.
2. While India has shown time and again that it can deliver limited services in a mission and time-bound manner (like eradication of polio in recent times through pulse polio campaign) – continuous and consistent service delivery has plagued our system. As a result, routine services are put on the back burner while specific vertical missions for a specific issue takes precedence.
3. Inability to ensure ground level convergence of health, education, nutrition, water and sanitation and pre-school education services has seriously impaired programmes meant for children. Notwithstanding the rhetoric of early childhood education, the pre-school education component of ICDS has been a non-starter. The government has resisted efforts to transfer it to the education department – which could easily add a pre-primary section in existing schools and ensure mid-day meal for all enrolled children. However, notwithstanding recommendations from several stakeholders – this remains a non-starter.
4. The impact of poverty on the health and well-being of infants and small children is well known – yet the ability of the very poor and marginalised (especially those belonging to the most disadvantaged social groups) to access public services (rations, health care, nutrition supplement) remains tardy. While some regions of the country and some states seem to handle this better than others, the lack of attention to detail in programme

implementation has affected the poorer states like Madhya Pradesh, Uttar Pradesh, Bihar, Jharkhand, Odisha and so on.

5. Persistent discrimination against girls – from birth to pre-school – is symptomatic of a society that prefers sons over daughters. Patriarchal mindset remains deep-rooted leading to neglect of girls. Declining sex ratio at birth and child sex ratio is a result of this. Whether we like it or not, the reality is that laws alone cannot change the mindset of people. Nothing short of a social reform movement could bring about change in entrenched prejudices and practices. Laws and strict enforcement of the letter of the law is indeed important. To some extent this was possible due to three inter connected trends – enforcement of law against child marriage, girls and women's education and social reform movements – big and small in different parts of the country.
6. An overwhelming majority of poor rural and urban women are engaged in paid and unpaid work. While the ICDS centre, MNREGA worksites and factories (covered under the Factories Act of 1948, Mines Act of 1952, Plantation Act of 1951, Inter-State Migrant Workman Act 1979 and NREGA 2005) are expected to provide day care services – the fifty years of Mobile Creche's experience has shown that these legal provisions are rarely adhered to. It is a common sight to see young babies left alone near construction sites, in rural roads related work, near factories. Stakeholders like MC argue that there is no will on the part of the government to ensure day care services are provided.
7. The preschool education conundrum needs to be addressed urgently – as of now it has fallen between two stools – the Ministry of Women and Child Development and the Ministry of Human Resource Development. There is a need to take a holistic view and address teacher training, curriculum, classroom management and seemingly overemphasis on learning alphabets and numbers. At the same time the health, nutrition and safety issues need to be kept in focus.

## **Recommendations:**

### **What could be done by the central government?**

- i. Transfer pre-school education to schools and make it an integral part of the education continuum. Ensure the ICDS programme focuses on health and nutrition in a concerted manner. While the ICDS centre could provide all health/nutrition services from 0 to 4 or 5 years; the children who transfer to the pre-school around age 4 or 5 need to be followed up by the ICDS centre on a regular basis through height / weight measurement and referrals.

- ii. Extend the mid-day meal to pre-schools and make sure both government and private pre-schools and primary schools provide breakfast (as soon as the child arrives) and mid-day meal. Ensuring that they are freshly cooked and served is important.
- iii. Design and develop a school health programme where children are checked regularly and malnourished children and those with other health issues are enrolled in special health / nutrition programme.
- iv. Educate people through the radio and television about the serious long-term effects of poor nutrition. This needs to be a national programme along the lines of the extremely successful polio programmes of yesteryears.
- v. Re-design and overhaul the ICDS programme with higher financial resources and community-based structures to monitor and support them. Most state government do not have the financial resources to embellish and overhaul this important programme.
- vi. Enact a legislation (one that is justiciable in a court of law) to ensure child care centres / Creches are provided in all work places, public work / construction sites across the country.

### **What can be done at the state level?**

Given the wide regional differences in India – it would be foolhardy to suggest one template for such a diverse and unequal country. However initiating processes of change needs to start with the state government and move on right up to local self-government institutions. Among the strategies that could make a difference are the following:

- i. Transferring the responsibility of managing and supervising the ICDS centres to the Panchayat – with a provision for tailor made inputs to respond to local situations / needs could be a good starting point. Alongside the Panchayat, each ICDS centre could have a mother's committee that regularly checks on the functioning of the centre and report to the Panchayat. A public display of the timings, activities and nutrition programme right outside the ICDS centre could make it more transparent. Tweaking the ICDS centre to the specific needs of a locality / village / ward is essential. To this end, the Panchayat should have discretionary funds to embellish whatever is needed.
- ii. A door-to-door campaign is urgently required to understand and mitigate poor nutrition / malnutrition in India. Using / reviving locally available food sources to enhance the nutritional quality of food, regular feeding of babies from the time they are weaned and enhancing and improving the food intake of mothers is

important. Like the pulse polio campaign that reached every household in India – we need a locally designed nutrition education programme. Such a campaign has to be designed for each state and within the state each region to ensure the local specificities are addressed. The cumulative burden of poor nutrition and frequent childhood illnesses on the overall health and development needs to be an integral part of any mass campaign.

- iii. Nutrition education has to continue through the elementary school – so that children become the vehicles of behavioural change and social change. Every school should have posters and specific activities around the issue of child health and nutrition.
- iv. The national sanitation programme (Swachh Bharat) needs to include the importance of hygiene and improve water handling / storage practices. Stopping open defecation is just the first step – the sanitation programme needs to go deeper into everyday practices of communities that lead to the spread of infectious diseases.

## References:

1. Augsburg, Britta and Paul Andres Rodriguez-Lesmes. 2018. Sanitation and child health in India. World Development. 107(2018) pp 22-39
2. CECED, ASER and UNICEF. 2017. The India Early Childhood Education Impact Study. New Delhi
3. CECED, World Bank, Care and AUD. 2017. Early Childhood Education in India: A Snapshot. New Delhi
4. Central Bureau of Health Intelligence, MOHFW, GOI. 2015. National Health Profile 2015. New Delhi
5. Central Square Foundation. 2016. Pre-primary sections in government schools: current landscape and recommendations. New Delhi
6. Citizen's initiative for the Rights of Children Under Six. 2006. Focus on Children under six. New Delhi
7. Gupta, Arun, Biraj Patnaik, Devika Singh, Dipa Sinha, Jean Dreze, Radha Holla, Samir Garg, T Sundaraman, Vandana Prasad and Veena Shatrugna. 2007. Strategies for Children under six – A framework for the 11<sup>th</sup> Plan. Planning Commission, GOI. New Delhi
8. Gupta, Ashima. 2016. State-wise Malnutrition Analysis in India: Findings from NFHS III. International Journal of Science and Research. Volume 5, Issue 4, April 2016 pp 482-484
9. ICMR. 2016. India Health of Nation's States: The Indian State Level Disease Burden Initiative. New Delhi 2016
10. International Institute of Population Studies. 2017. National Family Health Survey (NFHS 4) – India Report. New Delhi
11. Kaul, Venita and Deepa Sankar. 2009. Early Childhood Care and Education in India – Mid Decade Assessment. NUEPA, New Delhi
12. Kaur, Ravinder Surjit S Bhalla, Manoj K Agarwal and Prashanti Ramakrishnan. 2016. Sex ratio at birth: The role of gender, class and education. UNFPA, New Delhi
13. MHRD, GOI. 1986. National Policy on Education and Programme of Action (1992). New Delhi
14. Ministry of Health and Family Welfare, GOI. 2017. NFHS 4: State Fact Sheets. New Delhi
15. Ministry of Statistics and Programme Implementation, GOI. 2015. Children in India: A Statistical Appraisal. New Delhi.
16. Ministry of Statistics and Programme Implementation, NSSO, GOI. 2014. Nutrition Intake in India: NSS 68<sup>th</sup> Round, Report Number 560. New Delhi
17. Ministry of Statistics and Programme Implementation, Registrar General of India, GOI. Census 2011. New Delhi
18. Ministry of Women and Child Development, GOI. 2007. Study on Child Abuse in India. New Delhi.
19. Ministry of Women and Child Development, GOI. 2007. The Girl Child in the Eleventh Five Year Plan (2007-12) – Sub Group Report. New Delhi
20. Ministry of Women and Child Development, GOI. 2011. Report of the Working Group on Child Rights for the 12<sup>th</sup> Five Year Plan (2012-17). New Delhi
21. Ministry of Women and Child Development, GOI. 2011. Report of the Working Group on Nutrition for the 12<sup>th</sup> Five Year Plan (2012-2017). New Delhi
22. Ministry of Women and Child Development, GOI. 2015. Rapid Survey 2014-15: India Fact Sheet. New Delhi
23. MOHFW, GOI. National Family Health Survey 3 (2005-06) State Factsheets and National Fact Sheet. New Delhi
24. MOHFW, GOI. National Family Health Survey 4 (2015-16) State Factsheets and National Fact Sheet. New Delhi.
25. MOHFW, GOI. SRS Statistical Report: Detailed Tables 2015. New Delhi
26. New Concept Information System, 2003. Conceptual framework for Child Development
27. NIPCCD. 2014. An analysis of levels and trends in infant and child mortality rates in India. New Delhi
28. PHFI and UK Aid. 2015. India Health Report – Nutrition. New Delhi
29. Planning Commission, GOI. 2013. Twelfth Five Year Plan (2012-2017) Volume III, Social Sectors. New Delhi
30. R, Anuradha, Ranjit Sivanandam, Sam Dashni Salome, Roniya Francis, Roopa D, Sakti Sampavi, Saby S R and Ranjit Prasad. 2014. Nutritional Status of Children Aged 3-6 Years in Rural Areas of Tamilnadu. Journal of Clinical and Diagnostic Research. Vol 8 (10) JC01-JC04. 2014
31. Rajan, S. Irudaya, Sharada Srinivasan And Arjun S Bedi. 2017. Update on Trends in Sex Ratio at Birth In India. Economic and Political Weekly. Vol 52. No 11, 18 March 2017. Pp 14-16
32. Ramachandran, Vimala and ERU Team. 2004. Snakes and Ladders. World Bank. New Delhi
33. Ramani, Venkatesh. 2017. Child Malnutrition: Using data more effectively. India Development Review (idronline.org)
34. Raykar, N, Mazumdar M, Laxminarayan R and Menon.P. 2015. India Health Report: Nutrition 2015. Public Health Foundation of India. New Delhi.
35. Sharma, Rinku. 2013. Birth defects in India: Hidden truth, need urgent attention. Indian Journal of Human Genetics. April-June 19(2) pp 125-129.
36. UNICEF. 2011. Situation of Children in India – A profile. New Delhi.
37. UNICEF. 2018. Progress for every child in the SDG era. New York.