Article

C H I L D W E L F A R E*

By

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"Somehow the fact that ultimately everything depends on the human factor gets rather lost in our thinking of plans and schemes of material development in terms of factories, machinery and general schemes .... Ultimately, of course it is the human being that counts and if the human being counts well, he counts much more as a child than as a grown up".

Jawaharlal Nehru

Child care programmes are not new to plantations. Ad-hoc programmes have been in vogue since creches are mandatory. Today, the concept of child care has undergone fundamental changes in concept and it is necessary to review the growth of child care programmes, and its future role, to have a better perspective of money spent on these programmes.

DEVELOPMENT OF CHILD CARE PROGRAMMES:

For centuries human attitudes towards children have been to treat them as dependants and family possessions.

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* The information in the paper has been extracted from various books, periodicals, magazines and Government of India publications.

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The family system was marriage and procreations. This became more important than care of the child. Universal parental love was taken for granted. This is more true in old societies and developing countries.

The experience of economically advanced countries show that they could progress not because they emphasised material goods, but they placed a premium on human factors in economic growth. Prof. J.K. Galbraith in his book "Man and Capital" says "The fact that this is the age of ascendant man, not triumphant machine, has practical consequences. If machines are the decisive thing then the social arrangements by which we increase our physical plant and equipment will be of first importance. But, if it is men that count, then our first concern must be with the arrangements for conserving and developing personal talents, for it will be these on which progress will depend. Should it happen moreover, that our societies succeeded in supplying itself with machines and failed in providing itself with adequately trained manpower there would be cause for concern. There is such cause for that is precisely our situation".

India's economic plans began to build up the infrastructure for a scientific state with little emphasis on manpower needs for such a state. It is worthwhile quoting from A Souvy's book from "Malthus to Mao Tse Tung". "The apparent over population of an economically under developed country, leads to the thinking that there is a surplus of men but, it is the qualified work that matters. If the men are unemployed it is because they do not know how to work usefully, how to tame nature and transform its products".

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Making a man is a long process, its success rests on the inputs in the early formative years of the child. Maria Montessori revolutionised thinking about child care with proof that the first 6 years of human life are the ones of most rapid growth and capacity to absorb. Habits value systems and discipline are implanted into the human child at this age. Few people realise how critical this is in the development of character. What is once learnt is not readily unlearnt (e.g., Indians are grossly careless of their own environment. These habits are engendered in the young child. If cleaner habits are to be inculcated in the future generation, it has to start in childwood.). The greatest mistake we make is linking care of the child to charity and welfare and not to economic growth of the country.

CHILD CARE OVER THE YEARS:

The earliest known services to needy children began with orphanages. Britain in the middle ages looked upon the poor as bad human material. And hence, the growth of legislations that govern Child Care Programmes had their genesis in this concept. It is only in 1968, that Britain sanctioned money for pre-school education in Urban centres.

France assumed responsibility for children as early as 1874 and progressed towards comprehensive child care over the years. USA the late entrant started programmes, with an objective of giving coloured children a head start through their primary education programme known as "Head

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start programmes" from 1964. It is in the communist countries that child welfare assumed a new perspective. Marxists thought embodied the realisation that capital formation in economic terms meant the preparation of human capital as a major component. Isarel is the other non-communist country which adopted this policy in a bid to set up a modern state within one generation. China has placed great emphasis on Child Care by reviving activities familiar to the child and inculcating the concept that even a child is and should be a productive member of society.

CHILD CARE IN INDIA:

India is faced with 17th century problems of Europe and England without time as an advantage. The idea of a whole child is of very recent origin. Our concepts and thoughts have been influenced by western thinking. However, as early as 1874, the first centre for pre-school children was established in Lucknow. In the field of education we had Tagore in Bengal and Annie Basant in South India. The first children's organisation was established in 1920 in Bombay. Various voluntary organisations established centres for children in various parts of the country. In 1956, the Government recognised the work done by voluntary organisations. In 1958, the Planning Commission recognised the need for child welfare programmes. However, it is only in 1974, the Parliament approved India's first child welfare policy. The Parliament stated, children are a nation's supremely important asset and that their programmes must find a prominent place in our national plans for the

development of human resources. The premise was that the investment in a child represented investment in human capital.

CHILDREN LEARN WHAT THEY LIVE.

- If a child lives with criticism he learns to condemn.
- If a child lives with hostility he learns to fight.
- If a child lives with redicule he learns to be shy.
- If a child lives with shame he learns to feel guilty.
- If a child lives with tolerance he learns to be patient.
- If a child lives with encouragement he learns confidence.
- If a child lives with praise he learns to appreciate.
- If a child lives with fairness he learns justice.
- If a child lives with security he learns to have faith.
- If a child lives with approval he learns to like himself.
- If a child lives with acceptance and friendship he learns to find love in the world.

Dorothy Law Holtz.

REQUIREMENTS OF A CHILD:

Health and nutrition has to be an important component in child care programmes. However, education and play must secure equal importance in the formative years if our aim is to prepare them for future responsible citizenship. It is only by transforming the human being in these formative years that social transformation can be brought about. The education in this period should be deliberately designed to give children new habits of both behaviour and thought.

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Child Care Programmes should have the following inputs:-

- Child Health,
- Nutrition,
- Education and
- Welfare.

DEMOGRAPHIC PROFILE OF THE CHILD IN INDIA:

According to the 1971 census, children 0-14 years form 42 per cent of the population. The registered infant mortality rate in 1970 is given as 113/1000 live births(1). However, the estimated infant mortality rate given by Doctor Shanthi Ghosh for 1978 is 122/1000 live births. 40 per cent of the children born do not reach age 5 (Shanthi Ghosh). It is estimated that 75 per cent of the child population can be classified as not healthy (2) due to major and minor illness. High morbidity is largely attributed to unfavourable sanitary conditions, weaning is another critical period in the life of the Indian child. 56 per cent of illness seen in the health centres are related to intestinal infections, respiratory complaints and nutritional disorders(3). Where death does not result, it is obvious that enormous human suffering is entitled besides loss of growth, health, efficiency and wastages of human resources. Though a child

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(1) Infant mortality, Population growth and Family Planning in India - S.Chandraseker.

(2) Perspectives on the child in India, Central Institute of Research and Training in public co-operation.

(3) -do- -do- -do-

born in India today has a better chance of survival, the fact cannot be glossed over that infant mortality rates are high. Mortality rate in India does not even compare very well with countries like Sri Lanka, Malaysia or Taiwan (4).

CHILD HEALTH:

The Indian Council of Medical Research (ICMR) Survey points out that the one year old Indian child starts with the deficit of 1.6 cms. in height (2.3%) and by five years of age, the deficit increases to 8 cms. (5.5%)(5). The deficit in body weight is much more marked. This, in spite of the fact the unborn Indian baby weighs the same as the unborn western child up to 33 weeks of gestation (Doctor Shanthi Ghosh). At the heart of the problem of the young child is the problem of the mother.

NUTRITION:

In the field of study covering 1400 pre-school children it was found that 32 per cent of the children belonging to the birth order 4 and above exhibited various

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(4) Perspectives on the child in India - Central Institute of Research and Training in public co-operation.

(5) N.V. Patkhe & H.D. Kulkarni, Growth and Development of pre-school children in report of the Seminar on the Pre-school Child, Madras, ICCW, 1973.

signs of malnutrition while only 17 per cent of children of earlier birth orders showed such symptoms. The heights and weights of pre-school children showed negative correlation with family size. 67 per cent of all nutritional deficiencies were encountered in children of birth orders 4 and above (6). This implies that even under the current economic and living condition mere limitation of the family can bring down incidents of malnutrition in pre-school children by 60 per cent (7). 40 per cent of physical growth and 80 per cent of mental growth takes place in the first 6 years of life. A countrywide survey of children 1-5 years done by ICMR reveals that 92 per cent suffer from malnutrition (8). The 1972 survey by ICMR reports that 60 per cent of the children suffer from nutritional anaemia. Nutritional dwarfism is a common feature of the child population in this country.

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(6) C. Gopalan, Nutritional Status, Needs & Services. Reports of the seminar on the pre-school child, New Delhi, ICCW 1973.

(7) -do- -do- -do-

(8) Malnutrition among pre-school children, Indian Express, November 2nd, 1974.

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The Balwadi teacher is to prepare the child through constructive play and liase with the community with the child as the central figure.

The Anganwadi concept started with the "Meadow school concept". This was to provide constructive occupation for children during the mothers' working hours. It envisaged setting up of open spaces under the tree. The Anganwadi teacher has a condensed training programme in comparison to the Balasevika training programme. The idea is to take a woman from the village and give her just sufficient training to look after the children. The Balasevika has 9 months training after S.S.L.C. while an Anganwadi teacher is less qualified and undergoes training for 3 months. Another important development is the mobile creche for construction workers' children.

MOTHER AND CHILD A FACT SHEET:

A. Infant Mortality Rate - The average world-wide infant mortality rate is 83/1000 live births. In developing countries it ranges between 42/1000 live births to 200/1000 live births. In India it is stated to be 122/1000 live births in 1978. Kerala has the lowest infant mortality rate at 52/1000 live births. 30 per cent of infants die within a week of birth, 20 per cent between one week to one month, 27 per cent one week to 6 months, 40 per cent do not reach age 5. The goal set for 2000 AD. is less than 50/1000 live births by all countries. Nutritional deficiencies with low birth weights accounts for 57 per cent of all infant deaths.

The terms used in mortality among children:

Perinatal mortality - The period from 28th week of pregnancy to the 7th day of life.

Neo-natal mortality early - The first 7 days of life.

Neo-natal period late - Upto 28 days of life.

Post neo-natal period - From the 28th day of life to the end of the year.

Infant mortality - Deaths during the first 12 months of life.

Childhood mortality - Deaths occurring from age 1 to 4.

The last two are commonly used as an indication of the health of the children and as a guage of social development, 60 to 80 per cent childhood deaths occur between the ages of 1 month and 1 year.

These are mainly due to diarrhoeas, respiratory infection etc. Nutritional deficiencies are a major contributoring cause. The more malnutrition and anaemia in the mother, the more uncertain the future of the child. The greater the number of the children the more serious is the risk to the mother and the child. Post neo-natal mortality increases steadily with birth order. Childhood mortality (age 1 to 4) account for 33 per cent of all deaths while in developed countries it accounts for less than 1 per cent.

B. Weight at Births - Birth weight is the indicator of health. 70 per cent of all deaths in the neo-natal period were among babies with weight of less than 2500 gms. Factors influencing birth weight are the health, size, nutritional status of the mother, obstetrical history, birth order of the child, and interval between births. In developing countries 25 to 45 per cent of all babies born are underweight and they are born full term to undernourished mothers. In India, studies have shown that the weight of the foetus is the same as that of the American foetus upto 33 weeks of gestation. However, the American baby weighs 3300 gms. at birth while the Indian baby has the following weights:

Rural	...	2500 gms.
Urban	...	2800 gms.
Well to do Indian.		3100 gms.

Low birth weight is a very important cause of infant deaths. It affects developmemt of a child, growth and possibly even brain development. Studies in South India have shown that treatment of anaemic mothers with Iron Folic Acid tablets in the last 6 weeks of pregnancy increased birth weights of children.

C. Height as an indicator - Height as well as weight is a reliable indicator. Shortness in any child population is less likely related to genetic factors than to malnutrition and infection. With the exception of a few ethnic groups, there is evidence showing that all children have a similar growth potential.

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Fact sheet about plantations: /**/

The information given here is for the Comprehensive Labour Welfare Scheme estates only as information from other estates are not available. The population covered is 2,02,616 in 1979. Crude birth rate in 1970 when the programme was started was 41.7/1000 population and has come down to 27.7/1000 population in 1979. The infant mortality rate was 118/1000 live births in 1970 and has come down to 63.7/1000 live births in 1979. 50 per cent of all deaths among infants took place in the first week of life with prematurity accounting for 80 per cent. Details are not available on whether prematurity was by term or by weight. However, it would be fair to presume that 70 per cent of prematurity reported must be by weight. On the CLWS estates children 0-14 were 42 per cent of the population. However, in 1979, the child population 0-14 accounted for 37 per cent of the population.

Nutritional status of children by weight for age:

	1974	1979
Normal.	27%	35%
1st degree.	46%	40%
2nd degree.	16%	23%
3rd degree.	10%	2%

/**/ Information given in the fact sheets is extracted from "A Healthy Child a sure future" - "World Health Day, 1979" WHO, Delhi.

An analysis of the nutritional standards of 10,000 children showed that children 1-5 had a higher weight and height compared to South Indian children's height and weight as reported by Dr.Gopalan in his survey of 1976. However, height and weights of children below one year was found to be much less. The average birth weight was found to be 2500 gms. This was based on an analysis of 3500 births.

Birth orders:

In 1975-76 only 51.1 per cent of the births were among women with 3 or less than 3 children. In 1979, 75 per cent of the births were among women with 3 or less than 3 children. In 1973, 53.1 per cent of births were among women below 29 years of age while in 1979, women below 29 accounted for 81.1 per cent of deliveries.

Maternal deaths:

The data in this has been disappointing. However, in 1979, 3.4/1000 deliveries took place. 90 per cent of the deaths took place in the lines and the balance 10 per cent reached the hospitals late.

Institutional deliveries:

In 1973, less than 42 per cent of the deliveries took place in hospitals. In 1979, this has increased to 70 per cent.

Ante-natal Care:

In 1973, only 27 per cent of pregnant mothers examined. In 1979, 98 per cent have alteast 2 examinations before deliveries. However, the problem of ante-natal care in the last 6 weeks of pregnancy after the woman goes on maternity leave is still poor This is the most vulnerable period in the pregnant women's life. Just covering the woman with iron folic acid tablets in the last 6 weeks of pregnancy can increase the birth weights of children considerably, thereby, reducing infant mortality rate to a large extent.

Creche in the plantations:

All estates have a creche per division provided, there are 50 women workers employed. Till 1973, there was very little thinking on the role of a creche in plantations. Earlier older illiterate women were employed as creche attendants with a view that the old woman would be a mother substitute. However, in the caste conflict society the creches were not used the workers preferred to bring female relatives to lookafter the children in the homes. Today, changes have taken place and old creche attendants are being replaced by young trained women. The replacement per-force has to be a gradual process. Significantly, the health of the child and nutritional inputs for the child has received great attention which is obvious from the analysis of the nutitional status and immunisation status of the children in the plantations. The concent of the whole child and the child as a focal point for changes in society has yet to be developed. This is mainly because

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firm links has yet to be established between the community and the creche. This requires thinking and reorganisation in the functioning of the creche. It also requires additional inputs in terms of psychological and social inputs required for the total development of the child.

RECOMMENDATIONS:

It is suggested the creche should be envisaged as a place where development of the human resources starts. The activities should be designed to form the core of the human development. This requires development of activities that will inculcate good habits, creative thinking, team work discipline and cooperation. This can be achieved by making sure that children can play freely, participate in organised games, indulge in creative art like painting, drawing etc and actively participate in gardening to maintain the agricultural background of the children. It has been shown that children who have played at gardening have maintained their interest in agriculture even after the formal education in the system. There is need to make the creche/and the home. The role envisaged is that of educating the family on nutrition, personal hygiene, environmental hygiene and making the mother a participant in the growth of the child. /attendant the link between the child in the creche

For these, there is need to ensure that all children attend the creche. The creche attendants need to be trained for the role. However, the health department has to energise its activities to make the creche the centre of maternal child health programmes. They also need to develop the logistics of constructive supportive services.

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