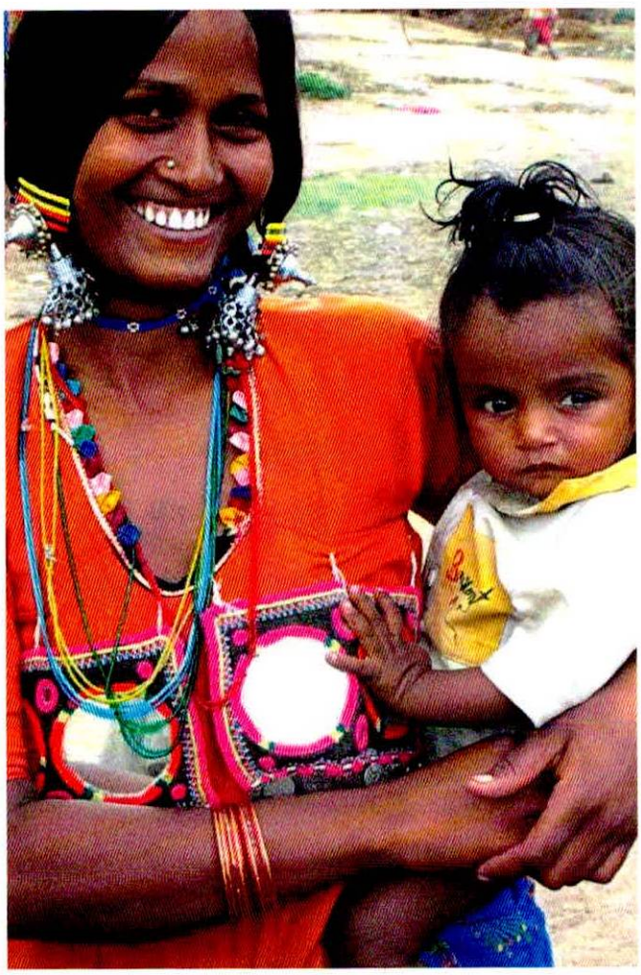
The Young Child in Karnataka

A STATUS REPORT



Karnataka FORCES
SUTRADHAR, Bangalore, 2004

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Abbreviations and Acronyms

ANM	Auxiliary Nurse Midwife
ANC/PNC	Antenatal care/Prenatal care
ARI	Acute Respiratory Infection
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCG	Bacillus Calmette-Guerin
BPL	Below Poverty Line
CDPO	Child Development Project Officer
CSSM	Child Survival and Safe Motherhood
CSWB	Central Social Welfare Board
DIET	District Institutes of Education and Training
DOE	Department of Education
DPEP	District Primary Education Program
DPT	Diphtheria, Pertussis and Tetanus
DSERT	Department of State Education, Research and Training
DWCD	Department of Women and Child Development
ECCE	Early Childhood Care and Education
ECD	Early Childhood Education
ECE	Early Childhood Education
ESI	Employee State Insurance
FORCES	Forum for Crèche and Childcare Services
GDP	Gross Domestic Product
GNP	Gross National Income
GOI	Government of India
GOK	Government of Karnataka
IAPE	Indian Association for Preschool Education
ICDS	Integrated Child Development Services
IEC	Information, Education, Communication
IIPS	International Institute for Population Studies
ILO	International Labour Organisation
IMR	Infant Mortality Rate
KSSCW	Karnataka State Council for Child Welfare
KSSWAB	Karnataka State Social Welfare Advisory Board
LBW	Low Birth Weight
MBA	Maternity Benefit Act
MCH	Maternal and Child Health
MHRD	Ministry of Human Resource Development
MMR	Maternal Mortality Rate
NCAER	National Council for Applied Economic Research
NCERT	National Council for Educational Research and Training
NCF	National Crèche Fund
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NIPCCD	National Institute of Public Cooperation and Child Development

NMR	Neonatal Mortality Rate
NPE	National Policy of Education
NSSO	National Sample Survey Organisation
ORT	Oral Rehydration Therapy
PEM	Protein Energy Malnutrition
PHC	Primary Health Center
PIL	Public Interest Litigation
PMGY	Pradhan Mantri Gramodaya Yojana
PNDT	Prenatal Diagnostic Techniques
PSE	Preschool Education
RCH	Reproductive and Child Health
SC	Scheduled Caste
SNP	Supplementary Nutrition Provision
SSA	Sarva Shiksha Abhiyan
ST	Scheduled Tribe
TBA	Traditional Birth Attendant
U5MR	Under Five Mortality Rate
UN	United Nations
UNICEF	United Nations Children's Fund
VEC	Village Education Committee
WHO	World Health Organisation

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1. Introduction

The "Status Report on the Young Child" was commissioned by Karnataka FORCES in 2003-2004. Karnataka FORCES is one of nine state chapters of a national advocacy network, FORCES - Forum for Crèche and Childcare Services. This network is unique in its work of advocating for early childhood care and development services, for underprivileged children below six years.

These children typically belong to families mired in poverty, for whom government services are the only option. As service providers, the government is unparalleled in its outreach and potential of impact. It is a challenge for the government to ensure the delivery of quality services at such a large scale; and a responsibility to wisely spend the financial sums that are involved.

In this context; as an institution of civil society, a national level NGO network can bring to bear its collective wisdom and diversity in strengthening the effectiveness of government programmes and policies. FORCES members, including NGOs such as Mobile Crèches and SEWA, have drawn on their field practice and research, and played a key role in influencing policy formulation in early childhood care and development.

Through this status report, Karnataka FORCES has attempted to understand the structures and possibilities offered by different policies and programmes, and their actual impact at ground level. We anticipated that this exercise would illuminate areas for change and spawn ideas for action.

The document attempts to synthesise and analyse available secondary information. This has been a challenge, as government data lies scattered and is not always available in the public domain. We hope that this report will provide the larger backdrop and reference point against which our future advocacy initiatives, research studies, and community programmes can be positioned.

We welcome your feedback in refining our perspective, and your support towards our endeavour.

2. The importance of early childhood care and development

There are many arguments in favour of improved childcare services for young children.

1. The most compelling argument is from the perspective of **human development and cognition,** which recognises that 75 per cent of brain development occurs by the age of six years. There are critical "windows of opportunity" in the early years, when the child is most receptive to care and stimulation. Children who do not receive adequate healthcare and food at this stage fall into a cycle of malnutrition and illness. When this is coupled by a lack of adequate stimulation, the young child is liable to have cognitive disadvantages that are not easily compensated for in adulthood.
2. From a **rights perspective**; maternal and childcare services are a step towards ensuring the rights of both women and children. They are of particular benefit to the vast numbers of women working in the unorganised labour sector.
3. Early childhood care also makes sound financial sense in **economic terms**. Young children who receive good nutrition, healthcare and preschool education are more likely to go to primary school; and to complete schooling. They are more likely to be healthy and productive adults.
4. One of the most common forms of child labour is sibling care, which becomes the burden of the young girl child. Childcare services ensure **gender justice**; by making it possible for girls to be free to attend school. Educated women, in turn, are better able to meet the family's needs of health care, nutrition, and infant stimulation.
5. In terms of **scale**, children under six years constitute 12 per cent of the population. This is no small size, and is particularly significant, as young, vulnerable children are a group least able to stand up for their needs or rights.

3. The status report: key issues

We looked at key issues and programmes that relate to the young child in Karnataka. A set of eight themes were chosen for their significance:

1. **Facts and figures on the young child**: This introductory paper provides an overview on the status of children with respect to key indices, with inter-district variations.
2. **Sex selective foeticide:** The falling child sex ratio in the state reveals that this needs to be an area of urgent attention. Foeticide is one of the most casually administered, violent forms of discrimination against one half of our children – our girls.
3. **Maternity provisions** embrace issues of maternal health and entitlements, and relate directly to the start that a child gets. They are of particular significance for the large number of women who work in the harsh, fragile, and unrecognised labour economy. Almost a third of families are headed by women, for whom maternal and childcare services are a crucial social support.

4. **Crèches** support working women and young children at their most vulnerable stage. They are of particular significance in the context of migration and urbanisation; where traditional extended family support may not exist. They also free girls from sibling care; allowing greater access to girls' schooling.
5. **Anganwadis** as part of the Integrated Child Development Scheme (ICDS) are the main, the largest, and the most holistic service for the young child. They serve both mother and child; meeting the triple needs of food, health care and preschool education.
6. **Preschool education:** This paper explores services in early childhood education; and comments on the growing, unregulated private sector that steps in when government services are inadequate.
7. **Health:** Too many of our young children are malnourished and anaemic. This paper comments on the larger public health delivery system that must work in tandem with the ICDS to provide essential healthcare – to our young children as well as their mothers; who are often still in their teens themselves.
8. **Disability:** A poorly functioning health care system puts all children at risk for disability. This paper highlights the many preventable disabilities and the need for early detection and treatment.

4. The framework and methodology

In each of these papers, we first trace international and national perspectives, and see how the child has been viewed through time. Government policies and programmes are formulated in keeping with these perspectives, sometimes with targets of coverage and time, and fiscal commitments and responsibilities of centre and state. In this document, government provisions and schemes are outlined in detail, to understand problems that may exist in the way schemes are formulated. We also attempt to understand problems in accessing or providing services, the quality of services provided, and the impact on indicators of children's well-being.

Data on the provision of services is inadequately recorded. It is therefore not possible to infer a causal link between policy, programme, delivery and outcome. At best; shifts and trends in key indices provide a sense of the shifting status of children. An attempt has been made to correlate data where possible, so that coverage and impact can be inferred and assessed. Wherever possible, disaggregated data by district, gender and social stratum has been obtained.

Each paper concludes with a summary of issues of concern, and priority areas of action.

Scope and limitations

This status report is based on secondary data, largely compiled from Bangalore. It does not include data from the centre or the districts. The data is mostly from government sources, as these remain the only large scale source of information. The insights and work of NGOs has been included to understand how they perceive gaps in the system, and how they have tried to respond to these lacunae.

There are undoubtedly omissions and repetitions in the papers. Some overlap is deliberate; so that each paper provides an adequate overview of the issue and can be read independently of the other.

5. The young child and the state

	Laws
1961	• Maternity Benefit Act
1992	• The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation, Prevention and Misuse) Act
1994	• The Prenatal Diagnostic Techniques (Regulation, Prevention and Misuse) Act
1996	• The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act
	Policies
1974	• National Policy for Children
1983/rev. 2002	• National Health Policy
1986/rev. 1992	• National Policy on Education
1993	• National Nutrition Policy
2000	• National Population Policy
2002	• National Policy and Charter for Children
	Schemes/programmes
1975	• Integrated Child Development Services
1992	• National Plan of Action for Children
1994	• National Crèche Funds Scheme
1997	• Reproductive and Child Health Programme
2000	• Sarva Shiksha Abhiyan

Over the years, the state's approach has changed from a welfare to a development model, and concomitantly children's issues have moved from a needs-based approach to a **rights approach**. This was first seen in the National Policy for Children, 1974, and stated more explicitly in the National Policy and Charter for Children, 2002. These shifts have manifested themselves in development discourse: maternity "benefits" are now seen as maternity "entitlements". The Persons with Disability Act, 1995, and the Prenatal Diagnostics Techniques (PNDT) Act, 1996, were based on a rights approach.

This paradigm shift can be attributed to a concern for child rights at the global level during the last decade. The Convention on the Rights of the Child (CRC) came into force from 1990, and was ratified by India in 1992. The convention broadly covers areas of survival, protection, development and participation, which every signatory nation is obligated to ensure for its children. Along with its commitment to the CRC, the state has enacted various laws, policies, schemes and programmes to address the needs of children. The table above lists the main laws and programmes relevant to children under six years.

The world over, the young child has been seen as the primary responsibility of the family, not the state. This still holds true for children under three years; whose needs are distinct from those of the 3-6 years age group. The fact that existing childcare services address the needs of **only a fifth of young children** speaks for itself.

When we review recent policies in different sectors; there still seems to be a long way to go, both at the centre and the state, in explicitly accounting for the needs and rights of young children. In key sectors such as **health, education and labour**; all of which have a direct bearing on the young child, this is quite apparent:

- The revised National Health Policy, 2002, does not make *any* direct references to child health indicators or programmes.
- The 86th amendment to the constitution recognises the fundamental right to education for children between 6-14 years. For children under six years, the state will continue to "endeavour to provide" early childhood care and development.
- The sum of Rs 500 currently provided under the Maternity Benefits Act at childbirth is appallingly small, and has not been raised despite a petition by FORCES to the Second Labour Commission.

The following indicators make it clear how ineffective our provisions for addressing children's needs are. At first glance, indices for Karnataka appear to be better than the national indices. However, the national indices are a blurred composite that reflect the poor performance of many northern states. Compared to the neighbouring southern states, as well as in absolute terms, Karnataka has a long way to go.

Indicators	**India**	**Karnataka**
Total child population (under six years)	15,78,63,145	68,26,168
Infant Mortality Rate (1999)	70	57.7
Sex ratio (2001)	933	964
Children under 3 years with anaemia (1999)	74.3%	70.6%
Coverage of immunisation (1999)	42%	60%
Underweight children under 3 years age (NFHS-2)	47%	43.9%
Anganwadi centres providing services (March 2002)	4, 27,862	39,878
ICDS beneficiaries of preschool education (under six years)	1,66,55,533	12,85,812

Source: The Indian Child: A Profile, MHRD, 2002

The Karnataka State Programme of Action for the Child, 1994, laid out a five-year plan of action for 1995-2000. It spelt out many targets, strategies and indicators for early childhood education, daycare, health and nutrition. However, the current indices of child development reflect that these objectives have not been met. In many areas, such as immunisation or peri-natal mortality, the trends show a decline.

The State Plan of Action needs to be reviewed and debated more widely in the public domain. The next Programme of Action was formulated in late 2003, but issues related to Early Childhood Care and Development have not received a special focus in this.

The section below presents some thoughts and concerns raised in the course of compiling the status report.

5. Data on the young child

For the government to effectively plan, implement and revise programmes in a logical way, collating data on the number of children requiring services as well as data on the actual delivery of services is of paramount importance. However, researchers across all the themes found it extremely difficult to obtain and analyse data related to children. **This suggests the disturbing fact that data is evidently not feeding the government's planning process.**

Firstly; **data on children under six years is not recorded as such**, a reflection on the overall importance accorded to them. Census data on young children is computed by deducting them from the whole population, as a "residual category of non-literate persons". Government surveys such as the census are carried out every ten years and may not enumerate the under six years age group accurately, as children may have transited out of that age bracket during that period. Demographics between the decades use smaller samples and do not sufficiently capture the large **inter-district variations** that exist.

A review of secondary literature often yielded **conflicting data.** Much of the available information is dated. The latest publication on the "Indian Child", 2002, released by the Ministry of Human Resource Development; lacks data on essential services such as crèches for the young child.

On visiting government offices, it was found that **data was unrecorded or partially recorded**. This again reflects the secondary status of women and children. For example, no records were available on the number of statutory crèches run in compliance of the Plantations Act and the Mines Act. Under the Maternity Benefits Act (MBA), the Labour Department keeps track of the number of "Shops and Establishments" it inspects, but not the number of beneficiaries! As it has no targets for inspecting these establishments, and 22 different services to inspect, recording the number of women who have availed of maternity benefits is not their priority.

There is often **no parity in the indicators** being used to record schemes for a similar service. For example, the Employee State Insurance (ESI) Act records the number of payments and amount of disbursals vis-a vis maternity entitlements, but not the number of beneficiaries. How then can one compare the MBA and ESI Acts, or **assess their coverage** as a percentage of pregnant women availing of their entitlements?

In a system where record-keeping is over-emphasised, such as the ICDS, we know that the records maintained are not always accurate. For example, the anganwadi worker or helper simply does not understand the complicated growth chart and its significance; and pencils in figures because she is expected to do so. Perhaps a simpler measure or tool can be devised for this purpose. Similarly, an immunisation schedule may require three doses, but this is not always taken into account when recording immunisation coverage. What this suggests is a need to look into both the **validity and reliability of data**, as well as the need for greater **training of childcare functionaries in recording data**.

6. Coverage: access and quality issues

The terms used by the government in relation to coverage, particularly the ICDS, can be easily misunderstood. For instance, the government claims that there is "**universal coverage**" of ICDS in Karnataka. In government terms, this means that there is one project (comprising about 125-150 anganwadis) in every block. This does not at all imply that every child under six years has access to an ICDS centre. Access needs to be spelt out by every possible indicator for a functional and effective anganwadi centre.

This includes infrastructure, services, personnel, quality, inclusion of vulnerable children, proximity to residence, etc. The criteria for starting an ICDS centre also need to be relaxed; so that the most marginalised children – of small tribal and rural hamlets as well as unrecognised urban slums – have a basic start to life. Ensuring universalisation also requires that an anganwadi be made accessible to **children with disabilities** – if this is an objective in elementary schools under the government scheme of Sarva Shiksha Abhiyan (SSA); the same needs to apply to anganwadis too. If an anganwadi is to be accessible to **girl children** and **young children**; it needs to expand its services to become an anganwadi-cum crèche. This has been planned but not implemented.

ICDS was universalised in 1993 in Karnataka. However the **intended target** is that only 40 per cent of the centres in rural/urban areas should provide supplementary nutrition; and only 50 per cent should provide preschool education. Such poor targets reflect poor concerns and imply even poorer implementation; and are particularly disturbing given the young child's needs for both nutrition and stimulation. In services such as immunisation where the ICDS intends to provide 100 per cent coverage, the NFHS-2 survey shows that only 60 per cent children are immunised in Karnataka.

An assessment of **coverage vis-à-vis the targets** set by the government also points to large gaps. For instance, the centre was able to set up only 659 anganwadi-cum-crèches versus its own target of 1,00,000 crèches aimed to be set up by year 2000. The total number of crèches as per the last available data of '96-'97 was only about 20,000.

This implies a service to less than 1 per cent of children under six years. In Karnataka there are no anganwadi-cum-crèche at all.

This gross failure on the part of the government to meet its planned targets – manifested in the poor nutritional and health status of the young child in Karnataka – needs to be highlighted through various kinds of advocacy measures.

7. Service delivery

The government sector

In a country as vast as ours; and riddled with an ever-shifting political climate, there is an **inevitable and large time lag** between the promulgation of a central act and the actual enactment of structures and schemes for implementation at the state level. Changes at ground level lie beyond that, and require the coming together of a multitude of factors: political will, social acceptance, community awareness, advocacy by pressure groups, etc. This process of social change takes decades. Though the Persons with Disability Act, 1995, mandates that anganwadis should be accessible to children with disability, in 2004 the FORCES study revealed that they were rarely seen at anganwadis. The PNDT Act was passed in 1996, but in Karnataka, as of 2004, we are yet to see "appropriate authorities at the sub-district level" to monitor the implementation of the PNDT Act.

Faulty schemes, with inadequate funds, staff and training, result in poor quality of maternal and childcare services. In the case of crèches, it appears that there are **too many schemes** for the same purpose. Each scheme offers different wages to the crèche worker, resulting in problems at the ground level. The comparative benefits of a single, well-funded, easy to administer scheme versus "diverse and flexible" schemes needs to be carried out.

The **childcare functionary** in the key scheme for young children, the ICDS, is treated as little more than an *ayah*. She is expected to take on far too many tasks at far too little compensation. This is self-defeating and causes the entire scheme to fail in its objectives, and is a gross waste of large public expenditure with dubious outcomes.

In actual practice; grant-in-aid schemes have often remained **static**, eg in the case of the central crèche scheme it has not been revised in 20 years, and remains at Rs1.05 per child per day. Does the **underutilisation of this scheme** imply that it should remain static or even be reduced, or does it suggest that the amount should be reviewed and realistically enhanced in keeping with rising costs? It is therefore no surprise to learn that for the last 10 years no new crèches have been sanctioned under this scheme, despite an increasing and evident need.

Undoubtedly, lengthy **bureaucratic** procedures limit the ability or desire of poor, working family to avail of any scheme, particularly when the benefits are too paltry compared to the efforts made to avail of them. It is difficult for poor women to easily prove their eligibility for maternity assistance, that too for meagre Rs 500.

Similarly, disabled children need to traverse long distances to acquire a disability certificate. Thus social benefits are not availed of by the people they are designed for.

It is evident that many schemes are not **gender-just**. While international treaties speak of parenthood and equal responsibilities, why are statutory crèches determined only by the number of women employees?

It is evident that check-and balance mechanisms need to be instituted for government services to improve. The most powerful lobby for the improvement of services would be from the people benefiting from the services. In the case of the young child, the anganwadi centre remains the key service provider. For the ICDS system, the government has instituted the Balavikasa Samithi, a body with representation of parents, anganwadi workers, panchayat members, etc. This body has the potential to serve as a **mechanism for dialogue and accountability**, but in actual practice, neither are parents aware of the Samithi, nor are anganwadis taking a lead in activating it.

The private sector

The private sector includes the for-profit sector; as well as the small, not-for profit sector of voluntary agencies. In the current scenario, there are also examples of newer forms of partnerships between the government and private sector, and the institution of subsidised, rather than free social services.
In the case of health, preschool education, and day care; there is an increasing expansion of private services due to the failure of the government system. A large, private pre-school sector caters to the needs and aspirations of working families, but is **unregulated** and comes under no scrutiny regarding the quality of services offered. There are also newer partnerships instituted by the government; such as the **health insurance scheme** in Karnataka, where the poor are required to contribute an amount for availing of the services of private health care providers.

In the case of welfare measures such as maternity benefits and crèches, the government has placed the onus on the private employer. However, given the large and surplus pool of labour, employers governed by a for-profit ideology do not feel compelled to institute **welfare practices**. Under such circumstances, they avail of inherent loopholes in the systems set up by the government. The ESI benefit for maternal health is often not dispensed – either by employing fewer women, or by paying them a wage that will not necessitate that dispensation. Similarly, there is no recorded data of statutory crèches set up in plantations or mines of Karnataka.

Should any of these benefits not be provided, there are few **grievance mechanisms** available to the poor for redressal. More often than not, employees would be nervous of jeopardising their job security. Since employers are not held accountable due to a **lack of punitive measures**, they are unlikely to provide the dispensation or service.

There also appears to be **devolution of responsibility to voluntary agencies**. While there are many grant-in-aid schemes available for NGOs to run crèches, it is ironic that the government of Karnataka has not converted even a single anganwadi to an anganwadi-cum-crèche even though a 25 per cent conversion was called for.

8. Budgets for children

As we know, children constitute a third of our population, and children under six years make up 12 per cent of the population. The HAQ report on union budgets for children reveals that out of every 100 rupees, only 1.20 rupees was spent on children (in the years 1990-1999). One can extrapolate that only a sliver of the total union budget is spent on the child under six years. Budgetary analysis is significant as it is one of the most direct manifestations of the state's intent and concern for children. The **decrease** in budgetary allocations for **critical social sectors such as health** also has a direct impact on children.

In Karnataka, it has been difficult to get a clear sense of spending on the young child as a fraction of the overall budgetary outlay. There are innumerable schemes; and a lack of clear trends in planned, revised and actual expenditure makes it difficult for us to draw any conclusions. Yearly variations in these figures are due to many extrinsic factors; from political shifts to elections and drought. It is also difficult to disaggregate spending in schemes that often address both women and children's needs (eg the Reproductive and Child Health programme).

Analysis and advocacy in budgets needs to be at three levels: demand for **greater allocations** where required, such as for health; **optimal usage** of a scheme such as ICDS; and an understanding of the **causes for under-utilisation,** eg creches.

If we were to prioritise for greater allocations and better usage; we would request that money be primarily spent to strengthen the ICDS in its universalisation and functioning in all senses. Basic infrastructure with safe drinking water must be available. A well-balanced, hot cooked meal must be in place in all projects, including Bangalore (urban). Immunisation as per the required schedules must be delivered. Large numbers of children in the state are malnourished and anaemic, and this must be our first concern.

9. Suggestions and strategies for change

9.1 Advocacy

Public Interest Litigations and public hearings

There is no doubt that campaigns for change need to be grounded in good field surveys. One example is the Right to Food Campaign, which carried out surveys of the nutritional status of children across several states of India. This was followed by a PIL filed in the Supreme Court. *Jan sunwais* or public hearings on health are now being organised across the country. These provide a forum for collective representation and systemic change.

The scale of such single-issue surveys, combined with strategies of legal recourse, media coverage, as well as community mobilization, appear to be effective in seeking enduring and systemic, large-scale change.

Media advocacy at the regional level

The issues that concern the child often involve change in mindsets and perspectives. Mass media can play a useful role in creating a climate of social change. Issues of sex selective abortion, gender discrimination, breastfeeding, and negative attitudes towards disability can be countered by the consistent use of regional media that create spaces for alternate discourse. Tamil Nadu FORCES has used media in various ways: from spots on television on different aspects related to the young child; to the imaginative "cradle campaign" where cradles were hung in the hard-nosed Labour Department to draw attention to the needs of the young child.

Community mobilisation and education

In the context of the young child, working with the community in their role as caregivers is particularly significant. For children under three years, parents are the primary caregivers for breastfeeding, bathing, feeding, infant stimulation; and various forms of psycho-social stimulation that pave the way for health, language and cognition.

An informed community is also one that can play a role in demanding that government services work. They can participate in local structures of self-governance; ensuring that the ICDS centre is given the support, financial and otherwise, that it may need. NGOs such as Samuha have begun to redefine their role: from childcare service providers to facilitators in the creation of informed communities.

9.2 Need for research, documentation and alternate data

The status report reveals that government data on young children is evidently lacking. This underscores the imperative for NGOs to collate alternate data as a tool for advocacy. As NGOs often work at a small scale and research skills are not always available, such studies need to be thought through well in terms of the ease of undertaking them and the possible impact they could have.

- There are benefits to participating in **nationwide surveys**, so that the advantages of tool design, analysis and advocacy efforts can be widely shared. As FORCES we need to partner with other alliances and identify a few core areas where such data can be well utilised and its impact multiplied. One such nationwide study could be the functioning of the ICDS system.
- **Easy-to-administer surveys** that provide local, **quantitative** data for advocacy can also be taken up; for eg, the enumeration of the number of crèches or private preschools; the number of disabled children and younger children at anganwadis; the number of women who have availed of maternity benefits in a given area.

- Smaller **qualitative studies** are also required. These may throw light on disturbing **trends**, eg the casual use of oxytocin to hasten childbirth; childhood illness patterns; or the quality of preschool education in anganwadis. An intent may be to use these findings to design context-specific **tools for community advocacy** eg documenting caregiving practices, both good and bad, for designing a parent education programme.

9.3 Registration and accreditation of the private preschool sector

There is evidently a need for a check-and-balance mechanism to be instituted for the growing, unregulated private pre-school sector. Just as the state requires elementary schools to be registered, preschools that serve vulnerable children also need to be brought into the ambit of concern. The state and other concerned organisations should play a role in spelling out norms for a safe and functioning early learning centre.

As an NGO network, Maharashtra FORCES has played in role in joining hands with the government in lobbying for the setting up of an accreditation system. Karnataka FORCES too could take this up.

9.4 Convergence

The young child cannot continue to only be the responsibility of the Department of Women and Child Development. The recent Common Minimum Programme (CMP) of the government, May 2004, commits to the **universalisation of ICDS in every settlement**. For children of primary and secondary schools, the CMP speaks of the National Commission for Education and the mid-day meal scheme. Yet education and nutrition are most vital to the young child, and the ICDS as it stands needs to improve in both these areas.

The **continuity and convergence** between different sectors and departments that is required at all levels – both policy and field – can be addressed only by a **National Commission for Children.** Such a Commission was proposed in 1999; but the bill is yet to be submitted to Parliament by the Department of Women and Child Development. FORCES must partner with organisations such as CRY-Child Relief and You, to hasten this process.

The two most important partnerships that would allow for systemic coherence are:

- Between the Department of Women and Child Development and Department of Education; to ensure improved preschool education and nutrition. Under the Sarva Shiksha Abhiyan (SSA) scheme of the Department of Education, fiscal provisions for universalising anganwadis have been made, but there is no other provision for preschool education.
- Between the ICDS and the PHC, to ensure improved healthcare.

10. Concluding thoughts

This report has helped us in putting together a snapshot of key concerns in relation to the young child. It has suggested areas for further enquiry and action. It has ratified our belief in focusing on the ICDS as the most important area of concern. Looking at the young child holistically, we realise that piecemeal sops and schemes do not help: a more systemic approach is required. It is time to review entire schemes and acts that have failed to impact the young child, particularly for crèches and maternity entitlements.
A summary of the **themes and priority areas for future advocacy** is presented below.

Issue	Problem/manifestation	Action points
Sex Selective Abortion	Decreasing child sex ratio shows gender discrimination	• Set up a Karnataka CASA (Campaign against sex selective abortion) • Sensitisation of doctors, and raids against errant practitioners • Set up `Appropriate authorities' at sub-district level
Maternity Entitlements	No social security for poor working women at crucial time of childbirth	• Raise amount of benefit • Institute penalty procedures for non-compliance (in the organised sector) • Institute welfare funds for workers in the main unorganised sector vocations • Make benefits available to underage mothers and adoptive mothers
Crèches	Not enough crèches for working mothers	• Convert AWC to AWC-cum-Crèche • Extend timings • Enhance the grants-in-aid scheme amount
ICDS	Key service provider for young children has inadequate service delivery	• Ensure minimum infrastructure at anganwadi • Helpers: improve selection, training and job responsibility • Improve linkage with primary school
Preschool Education	AWW and helper spend very little time on preschool education	• State to target for universal preschool education at every Anganwadi • Improve quality of preschool education in AWC using resources of Dept of Education
Health	• 75% children are anaemic • 48% rural children are malnourished • Perinatal deaths on the rise; 42% deaths due to prematurity • Immunisation coverage decreasing	• ICDS centre to improve in nutrition, hygiene, and immunisation • Advocate for increasing the age of marriage, and better prenatal care for women
Disability	• With inadequate health care, all children are at risk of being disabled • Children with disability are not visible at AWCs	• Ensure access and inclusion of disabled at AWC



Facts and figures: the young child in Karnataka

Archana Mehendale

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1. Introduction

Children, by and large, are an ignored sub-group of our society. The young child population is even less visible within this sub-group. One of the main reasons for this lack of acknowledgement is the lack of recognition of young children as separate entities. Since they are highly dependent on their families for meeting their basic needs, they are often treated as attributes of their families.

But the young child population is not a homogenous sub-group. Its members range from babies who are completely dependent on their families for their nourishment, care and survival, to children who leave their families during most of the day and go to school or work. Each phase of early childhood offers unique needs and problems which the immediate family, society and the state are expected to address. In the Indian context, early childhood is celebrated within the private sphere but lies almost unattended to in the public sphere.

To a large extent, **government indifference is due to the lack of sufficient data and understanding about the issues of early childhood**. Available statistical data is restricted to highlighting a few key vital health indicators. As a result, even the policies and programmes are addressed largely to ensuring health standards among young children. Apart from this, children below the age of six years do not receive adequate attention of planners and policy makers.

A review of existing official data on the young child indicates the following:

1. Data about this group is insufficient. Data on the overall status of the young child is lacking and statistics are restricted to a few key demographic indicators.
2. The young child is almost treated as a **residual category**. One of the senior officers from the Directorate for Census Operations explained it to this researcher. The Census is supposed to compute the number of literate persons. Since a literate person is defined as a person above seven years of age, the census authorities have to take away the category of 0-6 years from the population. Whatever data is thus made available for young children is because they were left out from the entire population to facilitate computation of other key demographic indicators.
3. Data collection does not happen frequently. Even a period of five to ten years between surveys leaves the young child at a disadvantage since s/he happen to be in this category only for six years.
4. Policy making is restricted to issues where data is available, and correspondingly, data collection happens only within areas of policy concern. Thus, there is no official data on certain areas such as play or child abuse which actually happen to be very important for the young child's overall growth and development.

The purpose of this paper is to collate data from all official sources and contribute towards an understanding of the nature and characteristics of young children in Karnataka. In doing so, it seeks to identify problems and specific trends on various dimensions of early childhood.

The paper draws upon official data in the form of Census reports, National Family Health Surveys, and government publications. Certain statistical tables have been additionally computed using data from various sources. Descriptive statistics are used to analyse and present the broad trends and patterns.

This paper presents a demographic profile of the young child population in Karnataka by elaborating on their size and characteristics, their health and nutrition, education and other demographic indicators.

2. Size and characteristics of the young child population

Typically, demographers depict the characteristics of a population with the help of a pyramid. The base of the pyramid indicates the percentage of the youngest in the population and the top peak indicates the percentage of the oldest in the population. In most developed countries with the reduction in fertility rates, the pyramid is slowly shrinking at the bottom and bulging on the top. Increased longevity amongst the population also contributes to this demographic change. Indian demographers have indicated since the past several years that the population pyramid in our country is also narrowing at the base. This is because the percentage of the young child population throughout the country is slowly declining. In India, the proportion of children in the age group 0-6 decreased from 18% in 1991 to 15% in 2001. A fairly strong positive correlation is now established between the percentage of child population in 0-6 years and the level of fertility. In 1991, only four states/UTs had child population (0-6 years) below 14% but by 2001, 16 states had a child population below 14%. This indicates a widespread lowering in fertility rates across many states in the country.

As per Census 2001, there are 15,78,63,145 children between 0-6 years in India. Karnataka has 68,26,168 young children, comprising 4.32% of the total child population in 0-6 age group in India. Of this, 47,12,109 children (69.03%) are in rural areas and 21,14,059 children (30.97%) are in urban areas. **Thus, we see that the young child population is predominantly rural in the context of Karnataka.**

Of the entire child population in Karnataka, 35,01,499 are boys and 33,24,669 are girls.

Table 1: Number of children in under 6 years age group by social groups

	Scheduled Castes			**Scheduled Tribes**		
	Total	**Rural**	**Urban**	**Total**	**Rural**	**Urban**
State	14,23,576	11,21,505	3,02,071	3,62,101	31,3,634	48,467
Boy	7,24,113	5,69,565	1,54,548	1,83,767	1,58,983	24,784
Girl	6,99,463	5,51,940	1,47,523	1,78,334	1,54,651	23,683
India	2,71,26,742	2,23,75,066	47,51,676	1,36,72,709	1,27,65,258	9,07,451

In terms of social groups, Table 1 shows that 17,85,677 children belong to Scheduled Castes (SCs) and Scheduled Tribes (STs). Of this 79.72% belong to the SC communities and the remaining 20.27% belong to the ST communities. Young children from SC communities in Karnataka comprise 5.25 per cent of the overall SC young child population in India. The young child ST population in Karnataka is only 2.6% of the total young child ST population of India. The table also shows that a majority of young children from SC and ST communities live in the rural areas. It also indicates that there are more young boys than young girls in the SC and ST communities in Karnataka.

Table 2: Percentage of child population (under 6 years) by residence and sex (2001)

State/District	Persons			Males			Females		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Karnataka	12.94	13.54	11.8	13.04	13.69	11.8	12.85	13.38	11.79
Belgaum	14.28	14.89	12.36	14.54	15.18	12.54	14.00	14.58	12.17
Bagalkot	15.40	16.16	13.55	15.7	16.43	13.95	15.09	15.89	13.14
Bijapur	15.07	15.42	13.83	14.89	15.12	14.07	15.26	15.73	13.58
Gulbarga	16.30	17.02	14.35	16.52	17.31	14.44	16.07	16.73	14.25
Bidar	15.62	15.76	15.13	15.47	15.58	15.10	15.78	15.96	15.16
Raichur	16.22	16.98	14.01	16.37	17.19	14.03	16.07	16.77	13.99
Koppal	16.64	17.09	14.41	17.02	17.53	14.47	16.25	16.63	14.35
Gadag	13.65	14.02	12.95	13.77	14.17	13.02	13.52	13.87	12.87
Dharwad	12.93	14.04	12.02	12.96	14.03	12.07	12.90	14.04	11.97
Uttar Kannada	12.52	12.94	11.48	12.68	13.10	11.63	12.37	12.79	11.32
Haveri	13.49	13.50	13.45	13.36	13.33	13.47	13.62	13.67	13.43
Bellary	14.87	15.94	12.88	15.03	16.13	12.99	14.71	15.74	12.76
Chitradurga	12.53	12.75	11.53	12.58	12.82	11.52	12.47	12.67	11.54
Davangere	12.68	12.95	12.04	12.69	12.97	12.03	12.67	12.93	12.05
Shimoga	12.12	12.58	11.27	12.24	12.74	11.30	12.01	12.42	11.23
Udupi	9.80	10.06	8.70	10.67	11.06	9.03	9.04	9.18	8.39
Chikmagalur	11.50	11.63	10.99	11.62	11.77	11.00	11.39	11.49	10.97
Tumkur	11.30	11.35	11.07	11.38	11.47	11.00	11.21	11.23	11.15
Kolar	12.60	12.81	11.99	12.57	12.73	12.06	12.64	12.89	11.90
Bangalore	11.17	12.40	11.00	10.97	12.11	10.82	11.39	12.73	11.21
Bangalore Rural	11.39	11.19	12.15	11.46	11.26	12.21	11.32	11.11	12.09
Mandya	10.88	10.84	11.11	11.15	11.16	11.10	10.60	10.51	11.12
Hassan	11.18	11.25	10.89	11.42	11.51	11.03	10.95	10.99	10.74
Dakshina Kannada	11.25	11.79	10.37	11.65	12.30	10.62	10.85	11.30	10.13
Kodagu	12.25	12.38	11.47	12.37	12.55	11.28	12.13	12.20	11.67
Mysore	11.63	12.31	10.46	11.60	12.24	10.50	11.66	12.38	10.42
Chamrajnagar	11.19	11.24	10.91	11.25	11.30	10.99	11.13	11.18	10.83

The total percentage of the young child population, i.e. children below six years is 12.94% in Karnataka. A district-wise study shows that the young child population is not evenly spread across the state (see Table 2). Certain districts have a very high percentage while in other districts, the young child population is dwindling.

Among the districts, Koppal has 16.64% of its entire population in the age group of 0-6 years. This is the highest proportion among all the districts and much higher than the state where the young child population is 12.74% of the total population. Koppal district with 17.09% of its rural population in 0-6 years age group tops the rural child population. The lowest percentage of rural child population is in Udupi (10.06%). In urban areas, Bidar has the highest percentage (15.13%) of child population and the lowest is 8.70% in Udupi. In the state as a whole, 11.80% of the total urban population is in the age group 0-6 years. Thus, we see that the percentage of young child population is higher in rural areas than in the urban areas, among boys as well as girls.

Table 3: Distribution of 175 talukas by child population size

Population range	Number of talukas in each range
Upto 9999	7
10,000-19,999	24
20,000-29,999	48
30,000-39,999	42
40,000-49,999	22
50,000-99,999	28
1,00,000 and above	4

Among the 175 talukas in the state, Bangalore North and South talukas in Bangalore district, Mysore taluka in Mysore district and Mangalore taluka in Dakshina Kannada district are the most populous talukas for the 0-6 years child population. Sringeri and Gudibanda talukas have the lowest child population for 0-6 years. Table 3 above shows that half the talukas in Karnataka have a child population within 20,000 to 40,000 range. Knowing the most frequently appearing value of child population at the taluka level is important for planning services for the young child at the local, decentralised level.

Table 4: Percentage distribution of child population over the decades

	1961			1971			1981			1991		
Ages	M	F	T	M	F	T	M	F	T	M	F	T
0-4	14.5	15.0	14.7	14.2	14.6	14.4	12.3	12.6	12.4	11.4	11.4	11.4
5-9	14.9	15.7	15.3	14.6	15.1	14.7	13.8	14.2	14.0	12.4	12.9	12.7

There is a gradual decline in the proportion of children of the age group of 0-4 years and 5-9 years from 1961 to 1991. This indicates that the number of young children in our population is reducing slowly, a phenomenon noted across the country as we have seen earlier. Table 4 shows this decline in terms of the sex differentials.

There has been a significant reduction in the percentage of girls over the decades. The percentage of girls under-4 yrs has been consistently reducing in relation to boys in same age group. In 1961, girls were 15 % and boys were 14.5 % of the total female and male population respectively. By 1991, the percentage of girls had reduced and was equal to that of boys: 11.4%. The reduction of girls is not as drastic for children of 5-9 years. The adverse adult sex ratio (964 females per 1000 males, Census 2001), shows there are fewer women than men in the state. A reducing proportion of girls from a reducing population of women indicates increasing adversities against girls. **This alarming trend of the declining proportion of girls indicates widespread gender discrimination.**

According to 2001 census, the child sex ratio was 949 in Karnataka, 954 in rural areas, and 939 in urban areas. Table 5 shows district-wise child sex ratios and sex ratios for the total population.

Table 5: District wise sex ratios for 2001-Karnataka

District	Sex Ratio of Total Population			Child (under 6 yrs) Sex Ratio		
	Total	Rural	Urban	Total	Rural	Urban
Belgaum	959	962	948	924	924	921
Bagalkot	977	982	966	939	949	910
Bijapur	948	948	948	971	986	914
Gulbarga	964	976	932	937	943	920
Bidar	948	957	919	967	980	923
Raichur	980	991	949	962	967	946
Koppal	982	985	971	938	934	963
Gadag	968	969	967	951	948	957
Dharwad	948	945	950	944	945	943
Uttar Kannada	970	970	969	946	947	943
Haveri	942	941	945	961	966	942
Bellary	969	977	955	949	954	937
Chitradurga	955	956	948	946	945	949
Davangere	951	956	939	949	953	940
Shimoga	977	982	967	959	958	961
Udupi	1127	1149	1038	955	953	964
Chikmagalur	984	990	958	964	966	956
Tumkur	966	974	937	952	953	949
Kolar	970	971	966	976	983	953
Bangalore	906	911	905	940	957	937
Bangalore (Rural)	953	957	938	941	945	928
Mandya	985	989	966	937	931	968
Hassan	1005	1014	962	964	969	937
Dakshina Kannada	1023	1034	1005	952	949	958
Kodagu	996	1003	952	977	976	986
Mysore	965	965	965	970	976	958
Chamarajnagar	968	969	966	957	958	952

Among the districts in the State, Kodagu district has the highest child sex ratio of 977 whereas Belgaum with a ratio of 924 has the lowest child sex ratio. Among the rural population, Bijapur with 986 has the highest and Belgaum with 924 has the lowest child sex ratio. Among the urban population, the highest child sex ratio is 986 in Kodagu and the lowest is 910 in Bagalkot. **It is important to note that in all districts except Bidar, Bangalore, Bijapur, Haveri, Kolar and Mysore, the total child sex ratio is consistently lower than the total sex ratio of the general population.**

3. Birth registration

Civil Registration of births is compulsory under the Births and Deaths Registration Act. The Convention on Rights of the Child recognises every child's right to name and nationality. Registration of children is important for various reasons. Firstly, it establishes the age of the child which is required for school admissions and for availing of various health, nutrition and social welfare services. Registration of the child after birth is not common and almost half of the births in India were not registered in 1995.

Table 6: Percentage of birth registration

Year	Karnataka	Total
1995	85.0	55.0
1998	102.7	NA

The above table shows how **Karnataka has made a big leap in birth registration from 85% in 1995 to 102.7% in 1998.** This is way ahead of the national figure for 1995 which is just over fifty percent. However, the registration percentage exceeding hundred is indicative of over-registration of some kind or lack of proper documentation.

4. Health indicators

Given the phase of development of the young child, health indicators are key to understanding the characteristics of needs and problems at this stage. Reading data collected right from the birth of the child (or even pre-natal data) is important to understand the broad conditions of child health and well-being.

4.1. Antenatal care

Antenatal care is extremely critical for ensuring the birth of a healthy baby as well as a healthy post-partum recovery of the mother. The NFHS survey reveals that **the percentage of mothers who received antenatal care in Karnataka increased from 83.4 per cent in 1992-93 to 86.3 per cent in 1998-99.** Although this is definitely a large coverage, it is important to understand the quality of these services and the reasons why the remaining 13% per cent mothers do not have access to these services. Data on these issues is not readily available and this remains an area for further study.

4.2. Place of delivery

One of the main reasons for maternal and neonatal deaths is complications arising during the birth process. When deliveries take place at home, with the assistance of untrained personnel, in an unhygienic manner, the risks to both the mother and the baby are very high. Thus, the percentage of deliveries taking place in institutions (such as hospitals, primary health centres) indicates the extent to which mothers and new-born babies are exposed to such risks. Data for Karnataka is dismal in this regard.

Table 7: Percentage of institutional deliveries for 1996-97

District	Percentage of Institutional deliveries
Bangalore	89.3
Bangalore Rural	48.9
Belgaum	40.8
Bellary	27.5
Bidar	11.4
Bijapur	22.2
Chikmagalur	53.7
Chitradurga	37.5
Dakshina Kannada	77.0
Dharwad	39.8
Gulbarga	12.7
Hassan	45.6
Kodagu	76.0
Kolar	36.1
Mandya	48.8
Mysore	51.4
Raichur	11.9
Shimoga	45.0
Tumkur	41.1
Uttar Kannada	72.2
State	41.8

Institutional deliveries are far lower than deliveries attended by traditional birth attendants or other persons. **Only 42% of all deliveries in the entire State take place in institutions.** Districts like Raichur, Gulbarga and Bidar have only 11-13% deliveries conducted in institutions. The percentage of institutional deliveries is high in Bangalore (89.3%), Dakshina Kannada (77%), Kodagu (76%) and Uttar Kannada (72%) where people in general have better access to health facilities. These are also districts where the status of women's health is relatively high.

Table 8: Place of delivery and attendant at birth (1992-93)

	Institutional Deliveries			Home Deliveries			Other
	Total	Govt.	Private	Total	Qualified	TBA*	
Karnataka	37.6	21.7	15.9	62.4	13.8	21.8	26.8
India	25.6	15.7	10.9	74.4	9.1	35.1	30.2

**TBA is Traditional Birth Attendant*

Data available for 1992-93 for Karnataka and the country as a whole present a different picture. The figures show that the situation in Karnataka is better than the rest of the country. In 1992-93, only 25.6% of deliveries in India took place in institutions, while this percentage was 37.6 for Karnataka. Table 8 shows that the number of home deliveries in India (74.4%) was higher than the number of home deliveries for Karnataka (62.4%). The number of deliveries carried out by traditional birth attendants as against qualified persons was higher for the country as a whole (35.1%) than the figures for Karnataka (21.8%). This data reveals that safe deliveries conducted in Karnataka, although more than those noted for the country as a whole, are still few in an absolute sense since a majority of mothers and new-born babies continue to be exposed to risks.

Table 9: Institutional and safe deliveries

	NFHS-1 (1992-93)	NFHS-2 (1998-99)
Percentage of Institutional Deliveries	37.5	51.1
Percentage of Safe Deliveries	50.9	59.2

The National Family Health Survey data also reveals that the percentage of institutional deliveries and safe deliveries has gone up over the years. Table 9 shows that the percentage of institutional deliveries increased from 37.5 per cent in 1992-93 to 51.1 per cent in 1998-99. Percentage of safe deliveries which are conducted by qualified birth attendants increased from 50.9 per cent to 59.2 per cent. Despite this increase, **the risks of delivery remain fairly large because about half of the deliveries in Karnataka still take place at home and in an unsafe manner.**

4.3. Breastfeeding

The importance of breast-feeding for the first six months of life is well established. Breast-feeding offers babies essential nutrients which help their overall growth and build their immune system. It is also considered to be safe and hygienic. The first milk, known as the 'colostrum' contains a unique combination of nutrients which provides the new-born baby all the vital elements for growth. The practice of breast-feeding, including nursing the baby with 'colostrum', is not very common in Karnataka. In 1998-99, only 18.5% of the mothers in Karnataka could start breast-feeding within an hour of birth while 41.5% could start breast-feeding within a day of birth.

Table 10: Initiation of breastfeeding and feeding of colostrum (in percentages) 1998-99

	Percentage started breastfeeding within one hour of birth	Percentage started breastfeeding within one day of birth*	Percentage whose mother squeezed and discarded the first milk from breast
Karnataka	18.5	41.5	61.4
India	15.8	37.1	62.8

* Includes children who started breastfeeding within one hour of birth
Source: NFHS-2

Table 10 shows that the percentage of mothers breast-feeding in India is lower than those breast-feeding in Karnataka. The highly rich 'colostrum' is squeezed out and discarded by most mothers (61.4% for Karnataka and 62.8% for India) indicating prevalent misconceptions regarding its use and a lack of awareness about its nutritional importance.

5. Mortality

Data on mortality is useful for identifying priorities for health action as well as for resource allocation. This data is subject to certain limitations; namely, incomplete reporting of deaths, lack of accuracy in recording age and cause of death, lack of uniformity and standardised methods in collecting data. The various parameters used to understand mortality are crude death rates and age-specific death rates. For understanding childhood mortality; indicators such as pre-natal mortality rates, neonatal mortality rates, post-neonatal mortality rates, infant mortality rates, child mortality rates and under-five mortality rates are used. Let us look at each of these in detail.

Crude Death Rate: Crude Death Rate (CDR) is the simplest measure of mortality. It is defined as the number of deaths (from all causes) per 1000 estimated mid-year population in one year in a given place. The NFHS calculates death rates on the basis of the average annual number of deaths occurring to usual residents of the household during the two year period preceding the survey; i.e. 1991-92 for NFHS-1 and 1997-98 for NFHS-2. The Sample Registration System calculates death rates on the basis of deaths to the usual resident population in that year, i.e. 1997.

Table 11: Crude death rates in Karnataka

	NFHS-1 1991-92			NFHS-2 1997-98			SRS 1997		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Crude Death Rate	8.3	6.6	7.5	8.7	7.0	7.9	8.1	7.0	7.6

For the entire state of Karnataka, the CDR was marginally higher in 1997-98 than it was in 1991-92 according to the NFHS data. According to NFHS-2, in most countries, male death rates are higher than female death rates at nearly all ages. South Asia is an exception with higher death rates for females over much of the age span. But in Karnataka, according to NFHS-1, NFHS-2 and SRS, the CDR for males is higher than CDR for females.

Age Specific Death Rates: Age Specific Death Rates are calculated as the number of deaths of persons in the given age group divided by the mid year population of persons in that age group and is expressed as a rate per 1000.

Table 12: Age specific death rates in Karnataka

	NFHS-1 1991-92			NFHS-2 1997-98			SRS 1997		
Age	Male	Female	Total	Male	Female	Total	Male	Female	Total
< 5 years	16.3	10.9	13.7	11.3	13.2	12.2	15.6	17.2	16.4
5-14	1	1.1	1	1.4	0.6	1.0	1.5	1.0	1.2

The Age Specific Death Rates for Karnataka show that there is a greater inconsistency in data from National Family Health Surveys and Sample Registration System for the younger age group (< 5 years) than for the higher age group (5-14 years).

- Below 5 years: The death rates among children below five years was higher for boys than for the girls during 1991-92. But after 1997, both NFHS-2 and SRS data indicates a reversed situation wherein the death rates are higher for girls than boys.
- Between 5-14 years: Within the age group of 5-14 years, a reverse trend is observed. While the number of deaths among girls was slightly more than that among boys in 1991-92, the post-1997 period shows an entirely different picture. The number of deaths among boys show an increase since 1991-92 and are also more than the deaths among girls.

In Karnataka, as of 1997, both the NFHS-2 and SRS surveys show that the death rates are higher for girls than for boys below five years and higher for males than for females at all other ages. But in contrast to Karnataka, the NFHS-2 data indicates that the female mortality is higher than male mortality in every age group less than 30 years for the country as a whole.

5.1. Mortality indicators

Specific childhood mortality indicators are helpful in strategising for child health care policies. It is customary to consider mortality in and around infancy at different stages of growth from both the analytical and programmatic point of view. The specific mortality indicators are as follows.

Peri-natal mortality rate: The peri-natal mortality rate is the number of deaths occurring from 28 weeks of gestation to seven days after birth per 1000 live births in the same year. It includes still-births as well as foetal deaths towards the end of gestation when the foetus weighs more than a 1000 grams. It is a sensitive index reflecting standards of health care prior to and during pregnancy and child birth. **The peri-natal deaths in Karnataka increased from 43.2 deaths per 1000 live births in 1981 to 47.8 deaths to 1000 live births in 1994.** This indicates falling levels of health care, particularly ante-natal and post-natal services available and utilised.

Neonatal mortality rate: The Neo-natal Mortality Rate (NMR) is calculated as the number of deaths occurring during the neonatal period i.e. birth to 28 days of life in a given year per 1000 live births in that year. The NMR gives the probability of dying in the first month of life or 28 days of life. These deaths are determined by endogenous factors such as gestational age, ante-natal care available, birth weight of the baby and so on. The risk at birth is the highest during the first 24 to 48 hours of life. Two important aspects related to neonatal deaths are; firstly, a majority of deaths that occur during the first year, occur during this neo-natal period and hence neonatal mortality is the highest contributor of infant mortality. **During 1996, 74.5% of all infant deaths in Karnataka occurred during the neonatal period while 64.6% of all infant deaths in India took place during the neo-natal period.** Secondly, the NMR is greater for boys than for girls throughout the world because new born boys are biologically more fragile than girls. In Karnataka, the NFHS-2 found that the NMR for boys is 53.4 per 1000 live births and that for girls is 34.8 per 1000 live births.

Table 13: Neo-natal mortality rate in Karnataka

Year	Urban	Rural	Total
1994-98	32.1	39.3	37.1
1989-93	38.7	56.2	50.8
1973-88	42.2	42.6	42.5

The neonatal mortality is 22% higher in rural areas than in urban areas. While the rural-urban difference in NMR was minimal between 1973-88, the difference increased significantly during 1989-93. Between 1994-98, the difference was reduced but persisted with 32.1 neonatal deaths per 1000 live births in urban areas and 39.3 neo-natal deaths per 1000 live births in rural areas.

Post Neo-natal Mortality Rate: The Post Neo-natal Mortality Rate (PNMR) refers to deaths occurring from 28 days to under one year. It is defined as the ratio of post neo-natal deaths in a given year to the total number of live births in the same year, usually expressed as a rate per 1000. The PNMR indicates the probability of dying after the first month of life but before the first birthday. The post neo-natal deaths are caused by exogenous factors, namely the environmental and social factors. During this period, girls die more frequently than boys, indicating a neglect of the female child. According to the NFHS-2, the PNMR among boys was 16.5 deaths per 1000 live births and that for girls was 19.3 deaths per 1000 live births.

Table 14: Post neo-natal mortality rate in Karnataka

Year	Urban	Rural	Total
1994-98	8.1	17.2	14.4
1989-93	8.9	26.3	21.0
1973-88	17.6	32.3	27.7

The rural and urban difference in PNMR is striking. Between 1989-93, the rural PNMR was more than thrice the urban PNMR. In 1994-98, the rural PNMR was over twice as much as the urban PNMR indicating poor post-natal care services available and utilised in the rural areas. The urban PNMR has not reduced much between the decade of 1989 and 1998.

It may be noted that the Neo-natal Mortality Rate has been more than twice the level of the Post Neo-natal Mortality Rate in Karnataka.

Infant Mortality Rate: The Infant Mortality Rate (IMR) is one of the most critical indicators of the health and development status of any given society. The IMR is the ratio of infant deaths registered in a given year to the total number of live births registered in the same year, usually expressed as a rate per 1000 live births. It indicates the probability of dying before the first birthday. As per NFHS-2 (1998-99), the national infant mortality rate was 68 deaths per 1000 live births.

In Karnataka, the National Family Health Survey-2 (1998-99) data reveals that the **Infant Mortality Rates (IMR) declined from 70 deaths per 1000 live births during 1984-88 to 52 deaths per 1000 live births during 1994-98 – an average decline of nearly two infant deaths per 1000 live births per year.** In recent years the IMR in Karnataka has been declining twice as fast as in India as a whole. Despite this decline, one in every 19 children born during the five years before NFHS-2 died within the first year of life and one in every 14 died before reaching five years.

Sex differentials in IMR: In Karnataka, the IMR was 70.1 deaths per 1000 live births among boys and 54.1 deaths per 1000 live births among girls. Higher IMR among boys than girls is a result of higher neo-natal mortality rates among boys and the fact that over 74% of all infant deaths occur during the neonatal period.

There are wide inter-district variations with respect to the IMR in Karnataka. Table 15 presents these variations along with sex differentials and changes in the IMR over the decade. The male infant mortality rate for the state has been consistently higher than that of females in 1981 as well as 1991. Districts such as Bellary (79) and Bijapur (75) have higher rates than the state average of 73 infant deaths per 1000 live births.

Table 15: District wise infant mortality rates for 1981 and 1991

State/ District	1981			1991		
	Male	Female	Total	Male	Female	Total
Bangalore	65	55	60	51	49	50
Bangalore Rural	65	55	60	51	49	50
Belgaum	72	63	67	48	54	50
Bellary	100	82	92	84	73	79
Bidar	86	75	81	67	73	66
Bijapur	104	95	100	80	69	75
Chikmagalur	84	69	77	56	55	55
Chitradurga	79	64	71	51	52	51
Dakshina Kannada	69	40	55	20	30	29
Dharwad	84	86	85	74	75	74
Gulbarga	87	73	80	59	59	59
Hassan	89	55	83	73	44	61
Kodagu	57	57	57	43	42	41
Kolar	71	66	69	54	57	56
Mandya	93	75	84	76	59	67
Mysore	80	74	77	57	58	57
Raichur	73	62	67	58	52	59
Shimoga	93	76	90	81	73	69
Tumkur	72	92	83	66	60	64
Uttara Kannada	81	73	77	50	49	49
State	87	74	81	74	72	73

The lowest infant mortality rate (29) is found in Dakshina Kannada, where the female IMR (30) is higher than the male IMR (20) for the year 1991. Other districts where the female IMR is higher than the male IMR are Belgaum and Bidar (with a difference of six points each), Kolar (with a difference of three points) and Chitradurga, Dharwad and Mysore (with a difference of one point each).

The male infant mortality rate ranges from a high of 84 in Bellary to a low of 20 in Dakshina Kannada. The female infant mortality rate ranges from a high of 75 in Dharwad to a low of 30 in Dakshina Kannada. Some districts have been able to improve their infant mortality rates significantly from 1981. **Dakshina Kannada is the only district which has been able to almost halve its IMR during the ten years.**

Data from other states show that the female IMR average in Karnataka is higher than in other states like Kerala, Gujarat, Haryana, Punjab, Maharashtra, West Bengal and Tamil Nadu. However, the overall female IMR for India is higher than that of Karnataka. The difference between rural and urban areas with respect to infant mortality rates is significant.

Rural-Urban Differentials in IMR:

Table 16: Infant mortality rate, 1999 and 2000

	Karnataka			India
	Total	Male	Female	Total
Total IMR (1999)	57.7	58.6	56.7	70.0
Rural	69.4	73.4	65.1	75.4
Urban	24.5	18.5	31.5	43.8
Total IMR (2000)	57.0	-	-	68.0
Rural	68.0	-	-	74.0
Urban	24.0	-	-	43.0

Source: India, Registrar General (2001) Sample Registration System Bulletin, April 2001, New Delhi. Page 1.

Table 16 shows that the **rural IMR during 1999 and 2000 for Karnataka was more than double of the urban IMR.** The national figures also indicate a rural-urban difference in IMR during 1999 and 2000, but this difference is less than half. This suggests that **the rural-urban differentials in Karnataka for infant mortality are larger than those seen for the country as a whole.** According to NFHS surveys, the IMR in Karnataka decreased by 33% in urban areas and by 25% in rural areas between 1984-88 to 1994-98.

When the rural-urban differentials are studied along with sex differentials, the picture with respect to Karnataka in comparison with the national status is interesting.

Table 17: Estimated infant mortality rate by sex and rural-urban status, 1999

	Karnataka	India
Total	57.7	70.0
Male	58.6	69.8
Female	56.7	70.8
Rural	69.4	75.4
Male	73.4	75.6
Female	65.1	75.2
Urban	24.5	43.8
Male	18.5	47.4
Female	31.5	39.7

Source: India, Registrar General (2001) Sample Registration System Bulletin, April 2001, New Delhi. Page 1-6.

Table 17 shows data for 1999. The situation with respect to the infant mortality rate is better in Karnataka (57.7) than that for the country (70). In Karnataka as a whole, we find the male IMR (58.6) is higher than female IMR (56.7) unlike the national trend of female IMR being higher than the male IMR. The rural IMR (68) continues to be more than double of the urban IMR (24). The rural areas also show a corresponding trend with the male IMR (73.4) being higher than the female IMR (65.1). This trend is reversed in urban areas where the female IMR (31.5) is much higher than the male IMR (18.5).

The national data presents a mixed picture. The overall picture shows that female IMR (70.8) is marginally higher than male IMR (69.8), and the rates are almost comparable in rural areas. In the urban areas, the male IMR (47.4) is higher than the female IMR (39.7).

The differential between the urban male IMR in Karnataka and the urban male IMR in India is very high. The urban male IMR in Karnataka (18.5) is less than half of the urban male IMR (47.4) for the country. This differential is the least among the rural males in Karnataka and India. The IMR for rural males in Karnataka is 73.4 and that of rural males in India is 75.6. This table shows that the situation with respect to IMR is better among girls in rural areas and boys in urban areas. Although the conditions are better in Karnataka than in India as a whole, the rural-urban difference is more pronounced in Karnataka than in the country.

Factors contributing to IMR: In Karnataka, the NFHS-2 states that **the IMR declines sharply with increasing education among mothers** from a high of 76 deaths per 1000 live births for illiterate mothers to a low of 38 deaths per 1000 live births for mothers who have at least completed high school education. The survey data also shows that the IMR is 32% higher among Hindu children than among Muslim children in Karnataka. Children from the scheduled caste and scheduled tribe families have higher mortality rates than children belonging to other backward castes and other castes.

Causes of Infant Deaths: When one looks at the causes of infant deaths, the data available for 1997 indicates that a majority of deaths (42.4%) in Karnataka are due to pre-maturity among babies. Respiratory infections of new-borns cause 18.7% of infant deaths. It should be a matter of grave concern that over one-fourth of all the infant deaths in Karnataka occur due to 'other causes'. Congenital malformations and diarrhoea among new borns claim 4% of deaths each.

When compared to the national figures, pre-maturity as a cause of death is not as highly prevalent in the country as it is in the state. But pneumonia among infants, which causes 14.5% of all infant deaths in India; anaemia which causes 2.9% of all infant deaths in India; typhoid and paratyphoid as well as bronchitis and asthma which cause one per cent of all infant deaths each in India have not been observed to cause infant deaths in Karnataka.

When one examines the situation in rural Karnataka for the year 1996, the causes of death range from pre-maturity (45.8%) to neonatal tetanus and bronchial asthma (claiming one per cent of infant lives each). Acute Respiratory Infections were seen to cause 23.2% infant deaths in rural Karnataka. Over 18% of infant deaths were caused by 'other causes', a matter that deserves further elaboration and study.

Table 18: Percentage distribution of infant deaths by major cause groups for 1997

Cause	**Rural Karnataka** (1996)	**Karnataka**	**India**
Pre-maturity	45.8	42.4	29.9
Pneumonia	-	-	14.5
Respiratory Infection of new born	23.2	18.7	11.0
Congenital malformation	4.9	4.0	3.1
Anaemia	1.0	0	2.9
Diarrhoea of new born	3	4.0	2.9
Birth Injury	2.9	3.0	1.9
Tetanus Neonatorum	0.5	2.5	1.6
Typhoid and Para-typhoid	-	0	1.0
Bronchitis and Asthma	0.5	0	1.0
Other Causes	18.2	25.3	30.2

Source: India. Registrar General, Vital Statistics Division, (2000), Survey Causes of Death (Rural): Annual Report 1997, New Delhi. Page 28.

A considerably large proportion of infant deaths due to pre-maturity may be linked to poor antenatal care and an early age of marriage among girls in Karnataka. The NFHS-2 survey indicates that **the age at first cohabitation with the husband was 17.4 years for women in the age group of 20-49 years**. The age at which women start child bearing is the median age at first birth for any group of women and is defined as the age by which half of all women in the group have had a first birth.

The NFHS-2 shows that the median age at first birth is 19 years in Karnataka among women in the 25-49 years age group. It is particularly low among illiterate, Muslim, Scheduled Castes and Scheduled Tribes. In rural areas, the median age at first birth is 18.3 years; and in urban areas, it is 20.2 years.

Child Mortality Rate: Child Mortality Rate (CMR) is also sometimes referred to as the child death rate. It is the number of deaths of children between one to four years per 1000 children in the same age group in a given year. It excludes infant mortality and is expressed as a rate per thousand. **CMR is a more refined indicator of deaths due to exogenous factors since it excludes the infant mortality rate and particularly the neo-natal mortality rate.**

Table 19: Child mortality in Karnataka

Year	Urban	Rural	Total
1994-98	9.0	23.9	19.3
1989-93	15.0	30.1	25.3
1973-88	12.3	54.0	40.4

Source: NFHS-2

Although the CMR has reduced over a period of time, the urban CMR is less than half of the rural CMR. The male CMR was 21.1 deaths while the female CMR was 23.8 according to the NFHS-2 survey (1998-99). This confirms that girls are more likely to die due to neglect and discrimination than boys. The Child Mortality Rate is also found to be 41% higher among Hindu than Muslim children in Karnataka.

Under-Five Mortality Rate: The Under-Five Mortality Rate (U5MR) is the probability of a new born dying before the fifth birthday. It is expressed as a rate per 1000 live births. The Under Five Mortality Rate is an important comprehensive indicator of children's health. In Karnataka, as per the NFHS-2, the male U5MR was 89.7 and the female U5MR was 76.6 deaths per 1000 live births. This means that the probability of boys dying before their fifth birthday is higher than the probability of girls dying before their fifth birthdays, primarily because boys are more likely to die around their infancy and these deaths are also included while computing the U5MR.

We know that death rates are higher for girls than for boys below five years, not only in Karnataka but also for the country as a whole. However, the U5MR is higher for boys than for girls in Karnataka, contrary to the national figures. This inconsistency may be due to medical and nutritional neglect of the girl child in the early years of life. NFHS surveys have shown that girls are less likely to receive medical attention and treatment than boys and that they are more likely to be deprived of basic nutrition and care.

Rural-Urban Differentials: **Overall the Under Five Mortality Rate is 62% higher in rural areas than in urban areas.** The decline in this rate has also been faster in rural areas (37%) than in urban areas (32%).

Table 20: Under five mortality rate in Karnataka

Year	Urban	Rural	Total
1994-98	48.8	79.0	69.8
1989-93	61.8	110.1	95.2
1973-88	71.4	124.9	107.7

Inter-District variations in U5MR: Data for 1981 and 1991 show that the total U5MR for Karnataka decreased from 142 in 1981, to 90 in 1991. Table 21 shows the inter-district variations in the Under Five Mortality Rates (U5MR) in Karnataka.

Table 21: Under Five Mortality Rates for Karnataka

Districts	1981			1991		
	Males	Females	Total	Males	Females	Total
Bangalore	109	100	105	66	69	67
Bangalore Rural	-	-	105	66	69	67
Belgaum	135	141	138	67	70	69
Bellary	179	183	181	118	121	119
Bidar	144	144	144	84	86	85
Bijapur	164	166	165	88	89	88
Chikmagalur	152	136	144	77	73	75
Chitradurga	160	162	161	102	108	104
Dakshina Kannada	90	83	86	45	47	46
Dharwad	166	170	168	94	97	95
Gulbarga	158	168	163	81	91	86
Hassan	144	122	133	80	76	78
Kodagu	134	128	131	72	59	66
Kolar	139	129	134	101	99	100
Mandya	132	126	129	86	85	84
Mysore	138	132	135	97	86	89
Raichur	183	184	184	79	84	80
Shimoga	147	133	140	93	85	88
Tumkur	142	148	145	99	108	102
Uttar Kannada	120	113	117	70	69	69
State	143	140	142	91	88	90

In 1991, four districts had a total U5MR of 100 and more. These districts were Bellary (119), Chitradurga (104), Tumkur (102) and Kolar (100). The lowest total U5MR in 1991 was seen in Dakshina Kannada (46), which was almost half of the total rate for the state (90).

The sex differentials for U5MR in the state present an interesting picture. In both the years, the male U5MR was higher than the female U5MR in Karnataka. In 1991, the three districts with a total U5MR of over 100 had a higher female U5MR than the male U5MR. The districts were Bellary (118 male U5MR and 121 female U5MR), Chitradurga (102 male U5MR and 108 female U5MR), and Tumkur (99 male U5MR and 108 female U5MR). The same districts had higher female U5MR than the male U5MR in 1981 also. But in Dakshina Kannada which has the lowest total U5MR, female U5MR (47) is higher than the male U5MR (45) in 1991. In Bangalore and Dakshina Kannada, the female U5MR was lower than the male U5MR in 1981, but this was reversed in 1991, when the female U5MR became higher than the male U5MR.

5.2. Health goals of the state

The Karnataka State Plan of Action (1992) had laid down goals for child health to be attained by the year 2000. One of the major goals was reduction of Infant Mortality Rate to less than 50 and Child Mortality Rate (for ages one to four years) to less than ten per thousand live births. The NFHS survey data shows that although the IMR dropped from 65.4 in 1992-93 to 51.5 in 1998-99, it was still well above the target of 'IMR less than 50'. The child mortality rates also dropped from 23.5 in 1992-93 to 18.9 (1998-99), but they were nowhere close to the target of attaining the 'Less than ten Child Mortality Rate'. The efforts of the government in this regard need to be critically reviewed and scaled up in order to attain the same goals in the next few years.

6. Nutrition

Basic nutrition is an important factor for maintaining health. However, the nutritional status of children in Karnataka is very poor. Right from infancy, we find that children receive less nutrition than what is required. Data published by the Department of Women and Child Development, Government of India, 2003, shows that 22% per cent of all babies born in Karnataka are below normal birth weight with some rural and urban variations. The same data indicates that 38.4% of infants aged 6-9 months in Karnataka received timely complementary feeding in 1999, while 33.5% of babies in India received these feedings.

As per Gomez Classification, **47.6 per cent children from one to five years in rural Karnataka were malnourished in 2002.** Over 48 per cent of rural boys and over 46 per cent of rural girls in Karnataka were malnourished.

Table 22: Nutritional status of children in Karnataka and India

Indicator	Karnataka	India
Underweight	43.9	47.0
Stunted	36.6	45.5
Wasted	20.0	15.5

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As per the NFHS survey (1998-99) data shown in Table 22, almost 44 per cent of children below three years are underweight compared to 47 per cent in the country as a whole *(see box for definitions)*. The percentage children stunted in Karnataka (36.6%) is lower than that in India (45.5%). **But when we study the percentage of children wasted, the situation in Karnataka is worse (20%) than that in the country (15.5%).**

Definition of Nutritional Parameters

Underweight prevalence Proportion of under-fives who fall below minus two and minus three standard deviation from median weight for age of NCHS/WHO reference population.

Stunting prevalence Proportion of under-fives who fall below minus two and below minus three standard deviations from median height for age of NCHS/WHO reference population.

Wasting prevalence Proportion of under-fives who fall below minus two and below minus three standard deviations from median weight for height of NCHS/WHO reference population.

Anaemia in children is a major nutritional concern. In 1999, the percentage of children below three years with anaemia was 70.6 for Karnataka and 74.3 for India. Although the state figures are slightly lower than the national figures on anaemia, **the fact that almost three-fourths of children under three suffer from anaemia should be seen as a situation demanding urgent action from the state**. The NFHS-2 data shows that 42.4 per cent of women suffer from anaemia in Karnataka.

7. Immunisation

Immunisation of children against preventable diseases is one of the most important strategies for ensuring child health. The government has a goal of universalising immunisation against diseases such as tuberculosis, diphteria, pertussis, tetanus, measles and polio. Children who are immunised against all these diseases are considered to be fully immunised. The NFHS data shows that the percentage of children fully immunised increased from 52.2% in 1992-93 to 60% in 1998-99. These figures are, however, far lower than the intended target of universal coverage.

Table 23: Immunisation coverage in Karnataka

	NFHS 1 (1992-93)	NFHS 2 (1998-99)
Percentage of children fully immunised	52.2	60.0
Percentage of children given BCG vaccination	81.7	84.8
Percentage of children given DPT (3) vaccination	70.7	75.2
Percentage of children given polio (3) vaccination	71.4	78.3
Percentage of children given measles vaccination	54.9	67.3

The table shows that immunisation against tuberculosis (with BCG vaccine) is the highest. Its coverage was 81.7% in 1992-93 which increased to 84.8% in 1998-99. This high coverage may be due to the fact that this vaccine is usually given to children a few days after birth at the place of birth itself. Since about half of the deliveries take place at home, the high coverage of BCG vaccination indicates that immunisation drives and outreach services have an important role to play in this regard. The percentage of children vaccinated against diphteria, pertussis and tetanus (by three shots of DPT vaccine) increased from 70.7% in 1992-93 to 75.2% in 1998-99. Vaccination against polio (by three doses of oral polio drops) covered 78.3% children in 1998-99 as against 71.4% children in 1992-93. The NFHS data also shows that the immunisation coverage is lowest for measles (by measles vaccine) and only 67.3% of all children in Karnataka were administered this vaccine by 1998-99. Thus, the state authorities have a long way to go before they can declare that every child in the state is protected from major preventable diseases.

8. Children living in slums

The conditions under which children grow up in urban slums typify utter marginalisation. Some may argue that the 'urban advantage' enjoyed by them improves their quality of life. While the fact that urban areas have more facilities and opportunities on the whole cannot be disregarded, the question of their accessibility, quality, distribution and ownership merits closer scrutiny. Various studies have pointed out that inadequate provision of basic services for the urban poor in India remains a fundamental problem that has compounded their daily struggles.

The 2001 Census shows that there are over 1,80,000 children (between 0-6 years) living in slums across the state. Of this, over 92,000 (51.4%) are boys and over 87,000 (48.5%) are girls.

Table 24: Child population (0-6 years) living in slums by districts, 2001

District	Total	Boys	Girls
Karnataka	1,80,157	92,613	87,544
Belgaum	4,147	2,129	2,045
Bagalkot	4,041	2,155	1,886
Bijapur	4,890	2,507	2,383
Gulbarga	4,200	2,155	2,045
Bidar	5,942	3,092	2,850
Raichur	7,453	3,916	3,537
Koppal	7,148	3,680	3,468
Gadag	1,372	709	663
Dharwad	15,746	8,203	7,543
Uttar Kannada	676	350	326
Haveri	1,591	794	797
Bellary	20,475	10,620	9,055
Chitradurga	3,489	1,722	1,717
Davangere	11,948	6,149	5,799
Shimoga	7,947	4,057	3,890
Udupi	-	-	-
Chikmagalur	1,382	732	650
Tumkur	1,774	929	845
Kolar	7,222	3,647	3,575
Bangalore	47,751	24,469	23,282
Bangalore Rural	3,050	1,596	1,454
Mandya	2,085	1,022	1,063
Hassan	4,985	2,548	2,437
Dakshina Kannada	194	113	81
Kodagu	-	-	-
Mysore	10,622	5,269	5,353
Chamarajnagar	-	-	-

The highest proportion of these children come from Bangalore (26.5%) which has over 47,000 children living in slums. This is followed by Bellary (11.36%) which has over 20,000 children living in slums. The census does not show any child residing in slums in districts such as Udupi, Kodagu and Chamarajnagar. This perhaps indicates an absence of slums in these districts. In all districts except Mysore, Haveri and Mandya, there are more boys living in slums than girls.

9. Education/economic activity

Pre-school education for children is an important area which remains outside the mandate of the state government. Given the importance of early education and a growth of early learning centres, particularly in urban areas, many parents send their young children to school. But as we shall see in the following data, this trend is largely restricted to the urban areas. The 1991 Census data shows the trends in schooling among young children in Karnataka.

Table 25: Percentage of children going to school in urban and rural Karnataka, 1991

Age Group	Urban Karnataka			Rural Karnataka		
	Total	Male	Female	Total	Male	Female
0-4 years	2.04	2.08	1.99	0.38	0.37	0.38
5 years	18.5	19.31	17.66	3.68	4.03	3.31
6 years	40.1	41.08	39.23	22.35	24.66	20.01

Source: Census, 1991

It is seen that **a small percentage (2.04%) of urban children between 0-4 years went to pre-school**. About 2.08 percent of all urban boys and 1.99 percent of all urban girls in this age group attended pre-school. In the rural areas, however, the percentage of children in this age group attending school was minuscule. Less than half a per cent of rural children, both boys and girls, attended pre-school.

At five years of age, the data shows greater school attendance among children. In urban areas, 18.5% of five-year olds attended pre-school. Over 19% of all boys and over 17% of girls attended pre-school in urban areas. In comparison with urban areas, pre-school attendance among five-year olds in rural areas was extremely low. Of all the five-year olds in rural Karnataka, 3.68% children went to pre-school. Over 4% of all the boys and over 3% of all girls of this age attended pre-schools.

The percentage of children going to pre-schools shows an increase among six-year olds. In urban Karnataka, about 40% of all children; 41% of all boys, and 39% of all girls attended pre-schools. In rural areas also, a significant increase is evident in pre-school attendance among six-year olds; with over 22% of all children: 24% of all boys and 20% of all girls attending pre-schools.

These figures highlight three important trends. Firstly, **the percentage of children attending pre-schools is extremely low in Karnataka.** The absence of pre-school education from the government's mandate for providing education for all could be responsible for this scenario. The small section of children who are found attending pre-schools would most likely come from urban, middle and upper class families sending children to privately run pre-schools.

With government formal schooling beginning at six years, the data shows an increase in school attendance at that age. Secondly, the percentage of girls attending schools is lower than that of boys for all age groups, in urban as well as rural Karnataka. **The disparity between sexes in education is seen to begin at this early stage.** Thirdly, **the difference in school attendance between rural and urban areas is more stark than the sex differentials at all ages**. Even among six year olds, the percentage of rural children - total, boys and girls - attending school is half of those in urban areas.

Public perceptions about child labour may not always include the realities of the very young working child. The Census 1991 provides absolute numbers of children employed even at an early age.

Table 26: Number of children working by age, school attendance and economic activity (1991)

	Attending School					
Place/Age	**Main Workers**			**Marginal Workers**		
	Total	Male	Female	Total	Male	Female
Karnataka						
5 years	10	10	0	0	0	0
6 years	70	50	20	80	40	40
Rural						
5 years	10	10	0	0	0	0
6 years	60	40	20	60	30	30
Urban						
5 years	0	0	0	0	0	0
6 years	10	10	0	20	10	10
	Not Attending School					
Karnataka						
5 years	2160	1250	910	740	270	470
6 years	2100	1350	750	980	340	640
Rural						
5 years	1810	1080	730	690	250	440
6 years	1860	1160	700	940	330	610
Urban						
5 years	350	170	180	50	20	30
6 years	240	190	50	40	10	30

Table 26 indicates that there were 80 children below six years who along with attending school worked as main workers (worked more than 183 days in a year), and another 80 worked as marginal workers (worked for less than 183 days in a year). A majority of these children came from rural areas. Among children below six years who did not attend school, more than 4,000 children worked as main workers and around 1,700 worked as marginal workers. A majority of these children also came from rural areas.

This data brings out the following issues. Firstly, young child workers are often not recognised as workers and their specific problems therefore go unattended. Even after we discount under-reporting that commonly occurs during working children's census, the fact that there are several children reported to be employed is a cause of concern. Secondly, the proportion of young children joining the workforce is higher in rural areas than in the urban areas. This corresponds with the data on poor pre-school attendance among children in rural areas which was presented above. Thirdly, the percentage of children (among those attending school and not attending school) working as main workers is more than that of children working as marginal workers. **This shows that for a majority of very young workers, employment is not just seasonal or for a short duration, but an activity which takes up the entire time of the child.**

ICDS coverage: Since 1979, the government has been implementing the centrally sponsored Integrated Child Development Scheme (ICDS) in parts of Karnataka. By March 2002, there were 39,878 ICDS anganwadi centres providing services to underprivileged children from urban, rural and tribal parts of Karnataka. These constituted 9.32 percent of the entire 4,27,862 anganwadi centres functioning in the country.

Table 27: ICDS beneficiaries (0-6 years) central sector projects on March 2002

Service	Karnataka	Males	Females	Total
Supplementary Nutrition	24,76,278	-	-	3,15,03,764
Pre-school Education	12,85,812	6,57,940	6,27,872	1,66,55,533

Table 27 shows the number of children benefited by the ICDS programme by March 2002. In Karnataka, supplementary nutrition under the programme was provided to 24,76,278 children between 0-6 years in Karnataka. Pre-school education was provided to 12,85,812 children. In Karnataka, 51.1% of children in pre-school were boys and the rest were girls.

10. Concluding summary

Young children in Karnataka, like elsewhere in the country, receive very little government attention. At times, this lack of attention borders on government apathy towards this sub-group of children. Problems such as insufficient data and official data treating children as a residual category contribute to a vicious cycle where policies for children do not get formulated because of lack of data and data gets generated in the established policy domains. This paper highlighted the key demographic characteristics of this group of children.

While the fertility rates are decreasing, over 12% of Karnataka's population is below six years of age. A majority of this population is rural. Even among the SC and ST communities, the proportion of young children living in rural areas is higher than those living in urban areas. The paper also highlighted a significant reduction in the percentage of young girls in the female population. The child sex ratio for Karnataka (949 girls per 1000 boys in 2001) also confirms this widespread discrimination against the girl child.

Most of the data for the young child is available with respect to health indicators, an area where most policies and programmes for early childhood operate. Young children are put at risk right from birth. Half of the deliveries take place in non-institutional and unsafe surroundings. Only half of the babies receive breast-feeding and a large proportion are deprived of the rich first milk called the 'colostrum'. Wide scale efforts to raise awareness about the importance of breast-feeding and the nutritional values of colostrum need to be undertaken. In addition, the state needs to provide work environments that are conducive to breast feeding.

The infant mortality rate for the state has been on a decline, but the rate is significantly higher in rural areas compared to the urban areas. The Under-Five Mortality Rate is higher among boys than among girls but the post neonatal mortality and child mortality rates are higher among girls than among boys.

There are wide-scale inter-district variations as well as variations in rural-urban areas with respect to health conditions. A majority of infants are known to die due to pre-maturity, a condition which can be averted with adequate ante-natal care and increase in the age of marriage. Anaemia and underweight children are a major source of concern in Karnataka. Despite the campaigns for universal immunisation, only 60% of all children below six years were vaccinated against the six major preventable diseases. Given these problems, the state needs to re-energise its preventive medicine programmes, particularly immunisation, management of acute respiratory diseases, diarrhoea and supplementary nutrition.

The paper also presented a lack of pre-schools, especially in rural areas, and the induction of young children as main and marginal workers. The existing policy framework enunciates universalisation of education and an elimination of child labour; however, the state has not been successful in preventing child labour at a very young age and ensuring that all children have access to pre-schools.

While this data should help in identifying issues for change and lobbying with the government thereafter, concerted effort must also go into identification of crucial areas where data collection needs to be initiated. Absence of data has been an excuse for governmental inaction on certain policy areas such as early childhood care and education. This gap needs to be plugged in order to re-present the problems of the young child and re- orient the existing policies for their overall growth and development.

Facts and Figures related to the Young Child in Karnataka
At a Glance...

- *The young child population (0-6 years) in Karnataka is 12.94% as per the 2001 Census.*
- *The child sex ratio is 949 girls per 1000 boys as per 2001 Census.*
- *Of all infant deaths in Karnataka, 74.5% occur during the neonatal period, i.e. between birth and 28 days of life. The neonatal mortality rate for boys is 53.4 deaths per 1000 live births and for girls is 34.8 deaths per 1000 live births as per NFHS-2.*
- *The IMR for Karnataka is 52 deaths per 1000 live births as per NFHS-2. The rural IMR was more than double the urban IMR during 1999-2000 in Karnataka.*
- *The Under Five Mortality Rate is 70 deaths per 1000 live births (NFHS-2)*
- *Forty two per cent of child deaths in Karnataka are due to pre-maturity.*
- *Half of all deliveries take place in non-institutional and unsafe surroundings.*
- *Only half of the babies receive breast milk and around 60% children are deprived of 'colostrum'.*
- *Only 60% of all children below six years are vaccinated against six major preventable diseases as per NFHS-2.*
- *In 2003, 22% babies born in Karnataka were below normal birth weight.*
- *About 44% of all children in Karnataka are underweight.*
- *Almost three-fourth of all children under three suffer from anaemia*
- *The percentage of children attending pre-schools is extremely low in Karnataka. The disparity between sexes in education is seen to begin at this early stage. But the rural-urban differences in pre-school attendance are more stark than the sex differentials at all ages.*

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Sex selection and sex determination: law and reality

Archana Mehendale

In the Indian context, some medical practitioners have abused these techniques by using them to detect the sex of the foetus followed by abortion of the female foetus, making quick profits from this practice. Advertisements blatantly suggest that couples could pay Rs. 500 (for sex determination tests) now, and save Rs.5 lakhs (on dowry) later!

The nature of technology is changing, and invasive techniques such as amniocentesis and chorionic villus biopsy are getting replaced by non-invasive techniques such as ultrasonography. Portable ultrasound machines can be easily carried to remote villages in mobile clinics and can even be used by semi-skilled practitioners.

South India did not have sex determination clinics until the late '80s, unlike the northern and western regions of the country. Since then, there has been a definite shift with the proliferation of these clinics and a falling child sex ratio. This paper attempts to document this situation in the context of Karnataka and the implementation of the Prenatal Diagnostics Techniques Act, 1994.

2. The situation in Karnataka

The decreasing number of girls in the overall population is the result of a number of factors. A strong son preference, the neglect of the girl child resulting in higher mortality at a young age, a male bias in the enumeration of population, female infanticide, and female foeticide are some of the key determinants of an adverse sex ratio among children.

In the context of a declining fertility rate; a preference for a male child; an easy availability of new sex determination and sex selection technology; and a strong patriarchal bias which blames the woman for producing a female child; many women are forced to find out the sex of the foetus and terminate it if it is female. In the absence of adequate abortion facilities; women resort to unauthorised practitioners or even quacks, thereby putting their health to grave risk.

These factors are examined in the context of Karnataka.

2.1. Fertility decisions and son preference

The National Family Health Survey-2 (1998-99) indicates that fertility levels are declining in Karnataka. For women between the age of 15 - 44 years, the Total Fertility Rate declined from 2.82 (1990-92) to 2.12 (1996-98). The decline of 0.7 children for urban areas and 0.9 children for rural areas indicates that the absolute level of fertility fell somewhat more rapidly in rural areas than in urban areas.

Box 1: Total Fertility Rate

Total Fertility Rate is defined as the average number of children a woman would have if she were to pass through her reproductive years bearing children at the same rate at which women in each age group of the population are now bearing children.

Families in India are known to prefer sons to daughters because of various social, economic and cultural reasons. With respect to the prevailing son preference, the results of the National Family Health Survey-1 (1992-93) and National Family Health Survey-2 (1998-99) reveal that the preference for sons, although still significant, has weakened in Karnataka.

In 1995, data for the state revealed that among married women who wished for another child (irrespective of earlier pregnancies), 44% wanted a son whereas only 16% wanted a daughter. Almost 33% indicated no preference and 8% left it to God. The same data also revealed that the preference for sons was particularly strong in rural areas where 48% wanted a son, compared to urban areas where 34% wanted a son. In 1998-99 the NFHS-2 survey results showed that 37% of women who wanted another child said that they wanted the next child to be a boy; 16% said that they wanted a girl and the rest said that the sex of the child was either up to God (9%) or did not matter (39%).

The NFHS-1 and NFHS-2 survey data for the state also shows that the proportion of women who desire a son decreases substantially with the number of living children. In 1995, women who did not have any living children were more likely to desire a son (30%) than a daughter (only 5%). The desire to stop child bearing generally increased with the number of living sons and also with the number of living daughters. However, the desire to stop was more prevalent among women with two or more sons than among women with two or more daughters. In 1998-99, 31% of women with no living sons wanted no more children, compared to 90% of women with two living sons. 13% of women wanted more sons than daughters, but only 2% wanted more daughters than sons. On an average, women in Karnataka considered a family with one son and one daughter to be ideal (IIPS and ORC Macro, 2001: 63-65).

Compared to Karnataka, the preference for sons is found to be stronger in other states, particularly the northern states of the country. Although on a decline, this preference for sons has been consistent over the years in Karnataka. Field activists claim that women worry that their husbands might get re-married, or throw them out if they give birth to a female child. The women also feel that they have suffered and do not want to subject their daughters to the same kind of suffering.

2.2. Sex ratio

The sex ratio for the total population indicates the number of women per 1000 men in the population. It is affected by factors like migration. The child sex ratio indicates the number of girls per 1000 boys in the 0-6 years age group. An adverse sex ratio is considered to reflect the poor status of women and of social development.

2.2.1. Sex ratio for the total population

According to the 2001 Census, the sex ratio of the total population for Karnataka was 964, for the rural population was 976, and for the urban population was 940 females per males. The male bias in the urban population is often due to the migration of men to cities from villages in search of work, and does not necessarily reflect a better health status among women in rural areas as compared to women in urban areas. It is seen that in three districts and 25 talukas the sex ratio is positive; indicating the presence of 1000 or more females per 1000 males. These districts are Udupi (1127), Hassan (1005) and Dakshina Kannada (1023).

2.2.2. Child sex ratio

According to the 2001 census, the child sex ratio was 949 girls per 1000 boys for Karnataka, 954 girls per 1000 boys in rural areas, and 939 girls per 1000 boys in urban areas.

The table below presents the sex ratio for the total population and the child sex ratio for the census years 1991 and 2001.

Table 1: Sex ratios for 1991 and 2001 for Karnataka

Census year	**Total population sex ratio**			**Child (0-6 years) sex ratio**		
	Total	Rural	Urban	Total	Rural	Urban
1991	960	973	930	960	963	951
2001	964	976	940	949	954	939

This table reveals that while the overall sex ratio has registered an increase, the child sex ratio has registered a considerable decrease between 1991 and 2001. This is equally true in the context of both rural and urban areas, although the decrease in the urban areas is more rapid than that in rural areas. The child sex ratio in rural areas is better than that in urban areas. This could be due to the easy availability of sex determination technology and abortion facilities in urban areas compared to those available in rural areas.

Inter-district and intra-district variation in child sex ratios

- Among the districts, Kodagu has the highest child sex ratio of 977, and Belgaum the lowest at 924.
- Among the urban population, Kodagu has the highest child sex ratio at 986, and Bagalkot the lowest at 910.
- Among the rural population, Bijapur has the highest child sex ratio at 986, and Belgaum the lowest at 924.

Table 2: District wise sex ratios for 2001-Karnataka

District	Sex ratio of total population			Child (0-6 years) sex ratio		
	Total	Rural	Urban	Total	Rural	Urban
Belgaum	959	962	948	924	924	921
Bagalkot	977	982	966	939	949	910
Bijapur	948	948	948	971	986	914
Gulbarga	964	976	932	937	943	920
Bidar	948	957	919	967	980	923
Raichur	980	991	949	962	967	946
Koppal	982	985	971	938	934	963
Gadag	968	969	967	951	948	957
Dharwad	948	945	950	944	945	943
Uttar Kannada	970	970	969	946	947	943
Haveri	942	941	945	961	966	942
Bellary	969	977	955	949	954	937
Chitradurga	955	956	948	946	945	949
Davangere	951	956	939	949	953	940
Shimoga	977	982	967	959	958	961
Udupi	1127	1149	1038	955	953	964
Chikmagalur	984	990	958	964	966	956
Tumkur	966	974	937	952	953	949
Kolar	970	971	966	976	983	953
Bangalore	906	911	905	940	957	937
Bangalore (Rural)	953	957	938	941	945	928
Mandya	985	989	966	937	931	968
Hassan	1005	1014	962	964	969	937
Dakshina Kannada	1023	1034	1005	952	949	958
Kodagu	996	1003	952	977	976	986
Mysore	965	965	965	970	976	958
Chamarajnagar	968	969	966	957	958	952

Except for Bidar, Bangalore, Bijapur, Haveri, Kolar and Mysore, the total child sex ratio in all districts is **consistently lower than the total sex ratio of the general population of Karnataka,** which is 964 females per 1000 males.

Taluka level variations in Child Sex Ratio: When one examines the child sex ratio for the various talukas in Karnataka, it is seen that there are two talukas below 900 (Chikodi in Belgaum with 879 and Siddapur in Uttar Kannada with 896 girls per 1000 boys). Seven talukas have a positive child sex ratio, i.e. more than 1000 girls per 1000 boys, the highest being 1182 in Indi taluka of Bijapur, followed by 1149 in Malur taluka of Kolar.

Table 3: Child sex ratio (0-6 years) for talukas in Karnataka, 2001

Sex ratio	Number of talukas
1000 and above	7
Between 975-999	12
Between 950-974	73
Between 925-949	67
Between 900-924	13
Less than 900	2

There are intra-district variations in the child sex ratio as per the 2001 census figures. For instance; in Bijapur district, the child sex ratio ranged from 915 in Bijapur taluka to 1182 in Indi taluka; in Koppal district, it ranged from 900 in Gangawati taluka to 964 in Koppal taluka; in Uttara Kannada district, it ranged from 896 in Siddapur taluka to 974 in Supa taluka.

Declining proportion of young girls

If one examines the young child (0-6 years) population over the last decade in Karnataka, it is clear that although there is an absolute increase in the number of both boys and girls from 1991 to 2001, their proportion to the total population reflects the following picture:

1. The proportion of young children within the total population is decreasing, which is the result of declining fertility rates.
2. In 1991, the proportion of young girls in the total population was higher than the proportion of young boys; but in 2001, the proportion of girls was lower than that of young boys.

Table 4: Proportion of child population in Karnataka

Total 0-6 years Population (Absolute)	**1991**	**2001**
Children	150,421,175	157,863,145
Boys	77,322,151	81,911,041
Girls	73,099,024	75,952,104
Percentage of the total population		
Children	17.94	15.42
Boys	17.77	15.47
Girls	18.12	15.36

While some research studies report an increasing practice of female foeticide as the cause for an adverse sex ratio, others argue that the preferential treatment given to boys in the intra-household allocations and neglect of young girls in terms of health care, nutrition and related needs are equally significant reasons for this distortion (See discussion in Dreze and Sen, 1995: 143-144).

Although it is assumed that the deliberate girl child neglect often spares the first child, research points out **that the proportion of families aborting the female foetuses in the first pregnancy has been increasing over the past five years** (George, S. et al, 1992). This is despite a decline in preference for sons as reflected in the National Family Health Surveys. This inconsistency in data can be a result of methodological limitations of inquiry into culturally deep-rooted problems. In other words, women may be 'compelled' to say they do not prefer sons since these are more politically correct and 'expected' responses. Thus, the declining son preference in Karnataka has not translated into child sex ratios favouring girls.

2.3. Reasons for abortions

Repeated and late mid-trimester abortions are hazardous for women. Data on abortions in Karnataka reveals that the percentage of cases where reasons for carrying out an abortion was not available has increased significantly in a short period of time. From 1997-98 to 1999-2000, the percentage of such cases has gone up from 1.60 to 20.79 per cent. In fact, this category of 'reasons' is the second highest in 1999-2000, after 'failure of any contraceptive device' which is the most commonly stated reason.

Table 5: Reasons for accepting Medical Termination of Pregnancy, Karnataka

Reasons	**1997-98**	**1999-2000**
Danger to the life of pregnant woman	9.71	13.14
Grave injury to the physical health of pregnant woman	17.06	17.53
Injury to the mental health of pregnant woman	12.76	11.12
Pregnancy caused by rape	4.51	0.82
Substantial risk that if the child was born it would suffer from physical abnormalities to be seriously handicapped	12.99	12.78
Failure of any contraceptive device	41.37	23.02
Not available	1.60	20.79
Total	**100**	**100**

Such a high rate of cases where the reasons for abortion are not documented raises questions on the possible use of sex determination followed by female foeticide. The fact that a pregnant woman can find ways to terminate her pregnancy legally after illegally determining the sex of the foetus should be a matter of legal concern.

3. The legal framework on the issue

1978 Given the rapid advancement in medical technology on the one hand, and the persistent bias against the girl child on the other, the Government of Maharashtra issued a directive in 1978 which banned the use of amniocentesis in government hospitals and laboratories.

1988 The State passed the first law in the country to prevent sex determination tests, The Maharashtra Regulation of Pre-Natal Diagnostic Techniques Act, 1988. This law was meant to curb the practice of sex selective abortion.

1994 In 1994, Parliament enacted the Pre-Natal Diagnostic Techniques Act (hereinafter referred to as the PNDT Act), which came into force from 1996.

2003 The PNDT Act was amended in 2003 to address inadequacies and administrative difficulties. The amended law is intended to enlarge the coverage by including other discriminatory practices such as sex selection, both before and after conception, which was not covered under the earlier enactment.

3.1. A question of discrimination

Arguments on sex selective abortions can spill into the contentious area of the right to life of the foetus. It is important to remember that the issue here is not concerning the foetal right to life but that of discrimination against the female foetus. While women can legally abort their foetus on certain grounds as per the Medical Termination of Pregnancy (MTP) Act, 1971, determining the sex of the foetus is made a legal offence.

Box 2: Grounds for termination of pregnancy

On health grounds-if it involves a risk to the life of the pregnant woman or if it involves grave injury to her physical or mental health as in the case of pregnancy on account of failure of contraception, or pregnancy due to rape.

On eugenic grounds- if there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Section 3 (i) and (ii) of the MTP Act

The underlying logic of this is that if sex detection is not permitted, those carrying out abortions would not be doing so in order to get rid of the female foetus but for other genuine reasons laid down in the MTP Act. Thus, discrimination against the girl child will not begin in the womb and she would have an equal right to be born alive. In other words, the objective is to prevent discriminatory abortions on grounds of sex by putting an end to sex detection technologies and practices.

3.2. The legal provisions

The PNDT Act with the recent amendments is now titled the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994. It aims 'to provide for the prohibition of sex selection, before and after conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and for the prevention of their misuse for sex determination leading to female foeticide and for matters connected therewith or incidental thereto'. The amendment thus brings in the entire range of technology and practices pertaining to sex selection even before conception. This enlargement was particularly required in the context of newly emerging technologies which give couples an option on the sex of their baby.

3.2.1. Registration of genetic centres

The Act requires that all genetic counselling centres, laboratories and clinics be registered; whether government-run, private, voluntary, honorary, part-time, contractual or consultative. Registration should be accompanied by an affidavit undertaking that the body shall not conduct any test or procedure for selection of sex before or after conception, or for detection of the sex of the foetus except for certain diseases, nor shall the sex of the foetus be disclosed to anybody. They are also required to prominently display a notice indicating that they do not conduct any technique, test or procedure for the detection of the sex of the foetus or for selection of sex before or after conception.

The Appropriate Authorities under the Act are required to inspect these centres/clinics and ensure that they have adequate space, required equipment and are staffed by qualified personnel. If the authorities are satisfied with the inspection, the application is placed before the Advisory Committee for scrutiny and for final decision on the registration.

Box 3: Authorities under the PNDT Act

Appropriate Authority: Appropriate Authorities are statutory bodies appointed by the Central Government for carrying out central functions and the State Government for carrying out functions at the state level. At the state level, the Appropriate Authority is a multi-member team comprising of an officer of or above the rank of the Joint Director of Health and Family Welfare as the Chairperson, an eminent woman representing women's organisation and an officer of Law Department of the State or the Union Territory concerned.

Advisory Committee: Advisory Committees are statutory bodies constituted by the Central Government for functioning at the central level and by the State Government for functioning at the state level. The Committee consists of three medical experts from amongst gynaecologists, obstetricians, paediatricians and medical geneticists; one legal expert; one officer to represent the department dealing with information and publicity of the state government; three eminent social workers of whom not less than one shall be from amongst representatives of women's organisations.

Supervisory Board: The Board is a statutory body meant to monitor the implementation of the Act and oversee the performance of the Appropriate Authorities and Advisory Committees under the Act. The Central Government constitutes a Central Supervisory Board and the State Government constitutes the State Supervisory Board. At the state level, this Board consists of the Minister in charge of Health and Family Welfare in the State, who is also the ex-officio Chairperson; the Secretary in charge of the Department of Health and Family Welfare as the ex-officio Vice- Chairperson; Secretaries or Commissioners in charge of Departments of Women and Child Development, Social Welfare, Law and Indian System of Medicines and Homeopathy; Director of Health and Family Welfare or Indian System of Medicines and Homeopathy of the state government; three women members of Legislative Assembly or Legislative Council; ten members appointed by the state government out of which two each shall be from the following categories [a] eminent social scientists and legal experts [b] eminent women activists from non-governmental organisations or otherwise [c] eminent gynaecologists and obstetricians or experts of *stri-roga* or *prasuti tantra* [d] eminent paediatricians or medical geneticists [e] eminent radiologists or sonologists; and an officer not below the rank of Joint Director in charge of Family Welfare who is the ex-officio Member-Secretary.

3.2.2. Prohibitions under the act

The Act prohibits sex selection before or after conception and the misuse of pre-natal diagnostic techniques for determining the sex of the foetus. It recognises certain offences which are as follows:

- Issuing, publishing, distributing, communicating or causing to be issued, published, distributed or communicated any advertisement, in any form, including advertising on the internet, regarding the facilities of pre-natal determination of sex or sex selection before conception.
- Opening any centre having ultrasound or imaging machine or scanner or any technology capable of undertaking determination of sex of foetus or sex selection without due registration.
- Conducting or causing to be conducted a pre-natal diagnostic technique for the purpose of determining the sex of the foetus.
- Offering services for conducting or aiding another person to carry out any pre-natal diagnostic technique at any place other than a registered place.
- Seeking or encouraging any pre-natal diagnostic technique to be carried out except for purposes specified in the Act.
- Seeking or encouraging the conduct of any sex selection technique.
- Conducting or aiding sex selection before or after conception, by whatever means.
- Communicating the sex of the foetus to any person in any manner.
- Selling, distributing, supplying, renting, allowing or authorising the use of any ultrasound machine or imaging machine or scanner or any other equipment capable of detecting the sex of the foetus whether on payment or otherwise to any centre or person not registered under the Act.

Box 4: Conduct of Pre-natal Diagnostic Techniques

Pre-natal diagnostic techniques may be used for detecting:

- chromosomal abnormalities;
- genetic metabolic diseases;
- haemoglobinopathies;
- sex-linked genetic diseases;
- congenital anomalies;
- other abnormalities or diseases as specified by the Central Supervisory Board.

Section 4 (1) and Section 4 (2) of the Act

The offences under this Act are cognisable and non-bailable. Besides the Appropriate Authority, and officers authorised in this behalf by the Government, any person or organisation can make a complaint under this Act by first giving a notice of at least fifteen days to the Appropriate Authority of the alleged offence and his/her intention to make a complaint in the court. The offences under this Act are tried only in a court of the Metropolitan Magistrate or a Judicial Magistrate of the First Class.

3.2.3. Structures for implementation

The Act stipulates the formation of a **Central Supervisory Board** at the national level to:

1. advise the central government on policy matters
2. review and monitor the implementation of the Act
3. create public awareness on the issue and oversee the performance of Appropriate Authorities and Advisory bodies constituted under the Act.

The **State Supervisory Boards** carry out similar functions at the state level.

The Board has also laid down a **Code of Conduct** to be followed by all persons working at any of the facilities that use pre-natal diagnostic techniques. This Code requires such personnel to refrain from conducting, associating, helping in carrying out procedures for sex detection or selection, before or after conception, except for purposes specified in the Act. It also requires such personnel to ensure that no provision of the Act is violated and that they help law enforcing agencies to book violators.

Recent amendments call for **one or more multi-member Appropriate Authorities** for each State. This body should:

1. grant, suspend or cancel registration
2. enforce the standards for the clinic as prescribed
3. investigate into complaints, take appropriate action *suo moto* or on complaints
4. recommend modifications in the rules
5. create public awareness about the issue.

The Appropriate Authorities have the powers to summon any person in possession of any information related to the violation, produce any document or material object, issue search warrants for any place. They are also expected to provide quarterly reports on clinics/laboratories surveyed, registered, action taken on complaints, etc.

The Act also provides for **Advisory Committees** at the Central and State level to aid and advise the Appropriate Authority.

3.3. Enforcing the act

3.3.1. The Supreme Court Order in CEHAT and others versus Union of India and others

Although the PNDT Act was enacted in 1994 and brought into operation in 1996, its enforcement was not satisfactory. A Public Interest Litigation was filed by two NGOs CEHAT and MASUM, and activist Dr. Sabu George. Some of the landmarks in the case are as follows:

4 May 2001: The Supreme Court asked the Central and the State governments to effectively implement the Act by appointing an Appropriate Authority at district and sub-district levels in all the States and Union Territories.

11 December 2001: The Supreme Court asked all States to furnish district-wise information about the implementation of the Act. It stated that information about buyers of ultrasound machines may be obtained from manufacturers, importers, suppliers, etc. of such machines. The help of the Indian Medical Association, Indian Radiologists Association, and the Federation of Obstetrics and Gynaecologists Societies of India for identifying users of ultrasound machine was sought.

29 Jan 2002: The Supreme Court directed companies to supply information on how many machines they have sold to various clinics in the last five years; their names, addresses and also their service contracts. Some of the manufacturers listed were: Wipro GE Medical Systems, L&T, Seimens, GE. A list of over 11,000 buyers of ultrasound machines received from manufacturers and suppliers was forwarded to the states for follow-up.

3.3.2. Implementation in Karnataka

3.3.2.1. Government Action

The Supreme Court while hearing the PIL also observed an utter slackness by the administration in implementing the Act. As per the Supreme Court order dated September 19, 2001, Karnataka had not issued a notification for appointing Appropriate Authorities at the sub-district level and had not constituted these bodies at the sub-district level. Thereafter, one of the areas of work undertaken by the state government was the setting up of district wise bodies for the implementation of the Act. At present, the District Health Officers are the Appropriate Authorities at both the district and sub-district level.

There are District Advisory Committees and the District Health Officer is the Chairperson of the Committee. Meetings of these Committees are expected to be held regularly, every two months. However, district-wise data shows that not all districts have been regular in this regard.

Table 6: Frequency of District Advisory Committee Meetings in 2003

Frequency of meetings	Number of Districts	Districts
Every 2 months	9	Bangalore Urban, Kolar, Shimoga, Tumkur, Mysore, Dharwad, Haveri, Bidar, Raichur
Every 3 months	13	Bangalore Rural, Davangere, Mandya, Dakshina Kannada, Chikmagalur, Hassan, Bagalkot, Bijapur, Gadag, Uttar Kannada, Gulbarga, Koppal, Bellary
> 3 months	2	Udupi, Belgaum

Note: The frequency has been calculated on the basis of duration between meetings held during 2003.
Source: Directorate of Health and Family Welfare, Government of Karnataka, *PNDT Act 1994 District-wise Report as on 30 June 2003.*

The table above shows that a majority of the District Advisory Committees in the State have not met regularly as per the Act. The districts of Chitradurga, Chamarajanagar and Kodagu have had meetings only once during 2003.

The State Advisory Board has been constituted by the Government. Information, Education and Communication (IEC) activities have been undertaken such as hoardings, slides in cinema halls, posters, etc.

Another area where the state government has focussed its efforts since the Supreme Court directive is the registration of genetic clinics, genetic counselling centres and genetic laboratories. In 2002, available data showed that 1090 centres were registered in the state. By June 2003, 1475 ultrasound machines have been registered in the state after 1500 ultrasound machines were found through the survey conducted by the District Appropriate Authorities.

Table 7: District-wise status of registration of ultrasound machines in 2003

District	No. of Ultrasound machines as per the District Appropriate Authority survey	Registration Granted	Registration under Process
Bangalore Urban	490	480	10
Bangalore Rural	32	32	--
Chitradurga	16	16	--
Davangere	29	29	--
Kolar	33	33	--
Shimoga	48	48	--
Tumkur	37	36	1
Mysore	76	76	--
Mandya	24	24	--
Dakshina Kannada	72	71	1
Chikmagalur	25	25	--
Chamarajnagar	13	13	--
Kodagu	13	13	--
Hassan	33	33	--
Udupi	52	50	2 (1 rejected)
Belgaum	118	115	(3 rejected)
Bagalkot	51	51	--
Bijapur	27	23	4
Dharwad	67	67	--
Gadag	23	23	--
Haveri	13	13	--
Uttar Kannada	41	41	--
Gulbarga	49	45	2
Koppal	11	11	--
Bidar	26	26	--
Raichur	32	32	--
Bellary	49	49	--
Total	**1500**	**1475**	**20**

Source: Directorate of Health and Family Welfare, Government of Karnataka, *PNDT Act 1994 District-wise Report as on 30 June 2003.*

After Bangalore Urban, Belgaum has the highest number of ultrasound machines in the state, and this is particularly a matter of concern since the child sex ratio in Belgaum is 924. One of its talukas, Chikodi, has the worst child sex ratio (879) in the state.

There have been very few rejections of registration. One of the registrations was rejected since the doctor was an Ayurvedic practitioner. The mobile scanning units are also required to be registered, but this process has not been completed.

In 2002, the Appropriate Authorities had sealed and seized five machines, and five cases were filed in the court for various violations under the PNDT Act. By June 2003, official data indicates that 22 cases were filed in Bangalore Urban district, six in Belgaum, four in Dharwad and two in Gulbarga. Among these, the two clinics of Gulbarga had not applied for registration and they had obtained an interim order of status quo from the Court of the Civil Judge, Gulbarga. The Appropriate Authority filed objections in the Court and the case is still pending. However, most cases are filed with respect to non-registration. Booking cases against doctors for sex determination or sex selection has not happened, primarily because of lack of evidence. Using decoys is one way of catching the violators red-handed and the government is seriously looking at this possibility.

Box 5: Use of decoys for enforcing the PNDT Act

Using decoys is perhaps the most effective means to book cases against errant doctors and other practitioners. Recently, Vimochana, a Bangalore based women's organisation, sent decoys to well-known doctors and hospitals who were suspected of conducting sex determination tests. One woman met a doctor seeking advice on how to conceive a male child. This kind of counselling is not permissible under the PNDT Act. The transaction was video recorded by the woman decoy. In another case, a pregnant woman volunteered to visit a sonologist as a decoy. She carried a video camera for recording the transactions. The sonologist was caught on tape revealing the sex of the foetus. Throughout this operation, the decoys were extremely careful and did not let out their real identity. For several weeks after gathering this hard evidence, Vimochana prepared a strategy to get the doctors booked under the law. It informed the police as well as the Appropriate Authority about the evidence but did not reveal the identity of the doctors concerned. The organisation did not want the word to leak out and reach the concerned doctors, lest it lead them to abscond, distort other evidence or evade the law. It worked with the media so that they gave adequate coverage to the cases. On the selected day (both cases were pursued separately), it released the evidence and immediately got the Appropriate Authority to raid the premises and file cases against the two doctors. This was the first instance of using decoys in the city of Bangalore and a significant one since it helped to reinforce the rule of law among the medical community.

3.3.2.2. Medical Ethics and Practice

The medical community plays a very critical role in the declining sex ratios on account of sex selective abortions. From presenting sex-selection as a possibility to the pregnant woman to asking her to undergo sonography, even when it is not required; from detecting the sex of the foetus to helping her undergo an abortion; medical practitioners are involved, either discreetly or openly. In Karnataka, one does not come across blatant advertising of ultrasound clinics which is prohibited by law. According to health activists, the penetration of ultrasound clinics is so deep that women in even remote villages have addresses of sonologists in their traditional pouches used for money and betel nuts.

Mobile vans with ultrasound clinics have been found visiting villages. This has become an extremely profitable venture and even untrained practitioners are known to perform ultrasonography.

Sonologists are known to communicate the sex of the foetus by various means. The sex of the foetus is conveyed to the pregnant woman and/or her family by drawing a leaf or a flower, or asking for *laddoo* or *barfi*, or by using a specific colour of ink for writing. These signs are usually recognised by persons accessing the sonologist.

In the absence of adequate facilities for safe abortion, women visit quacks to get rid of their female foetus. In some cases, abortions are carried out clandestinely by doctors even after 20 weeks of pregnancy. There is no way of knowing the exact number of abortions carried out in any given health centre, government or otherwise; or how many female foetuses were aborted, because the records are often inaccurate and unreliable. Moreover, the law does not oblige the doctors to record the sex of aborted foetuses.

Doctors at times use the law for vested interests and for settling personal scores against their peers or even patients. Some complaints have been filed for such reasons. For instance, doctors may falsely accuse their fellow practitioners for illegally practising sex selective abortions. But such cases are rare. The government is unable to take action unless there is concrete evidence and this often requires leads to work on. But the nexus between medical practitioners as a community and that between medical practitioners and their patients is difficult to confront and becomes one of the main obstacles in the implementation of the Act.

The members of the Federation of Obstetrics and Gynaecologist Societies of India (FOGSI) have taken an oath that they would not practice sex determination and anyone doing so would be removed from the primary membership of FOGSI. The Medical Council of India has warned doctors of de-registration if they are found defaulting. The Indian Medical Association had circulated an appeal to its members which stated that of nearly 20,000 ultrasound machines, only 1% were registered until a few years ago. It therefore requested every hospital, nursing home or clinic to ensure that [a] pre-natal sex determination by ultrasound, chorionic villi biopsy, amniocentesis and sex selection by X-Y chromosome separation are not practised in their premises; [b] no second trimester pregnancy termination should be done for indications other than genetic malformations, pregnancy following rape or grave risk to the life of the mother. Yet the medical community needs to be sensitised in this regard and must begin to view this as a problem of medical ethics and not simply that of law.

3.3.2.3. The role of the media

The media, particularly the vernacular media, has not given adequate coverage to issues involved in sex determination and sex selection and their social implications. With recent amendments to the law and Supreme Court orders in this regard, the obligation on the media to take a responsible position on this issue has been reinforced.

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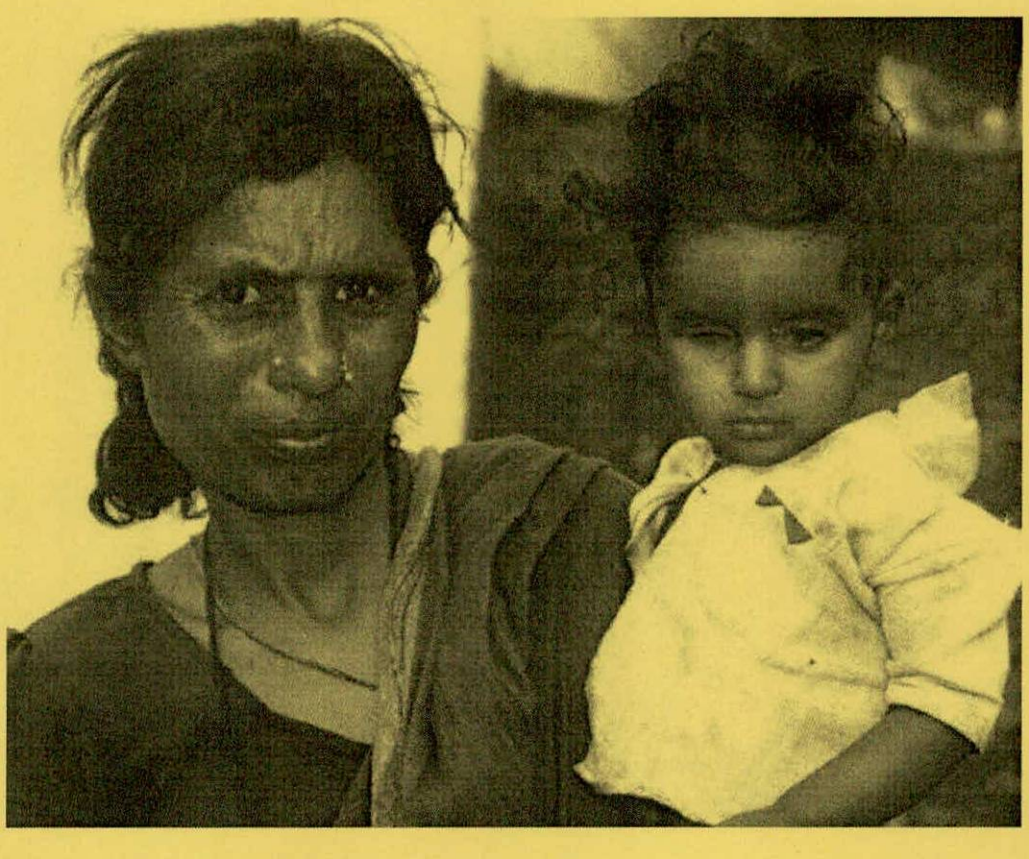
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Maternity provisions: entitlements, benefits and healthcare

Vinalini Mathrani

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1. Introduction

The status of the young underprivileged child (under 6 years) is influenced by the continuous interplay of multiple interrelated variables. One of these variables is the nature of maternity provisions available in the country. This area needs to be approached in the context of the mother and the child as it concerns both equally.

The title of this paper defines the scope, which has been kept broad deliberately. The term maternity provisions, includes entitlements, benefits and services. In the current scenario, maternity entitlements are restricted to working women and specifically only to women within the organised sector. If women in the organised sector are denied their entitlements, they have the right to legal recourse. For women in the unorganised sector and for women who are not designated as workers by the government (i.e., women from the care economy) maternity benefits and maternal health care services are available. These benefits and services are dispensed subject to the availability of funds and the political will of the issuing authority to dispense these services. If women are denied these, they do not have the right to go to court.

The mandate of this study is women belonging to the lower socio-economic category (within organised and unorganised sectors and even outside the working category), hence the need for comprehensive coverage. This paper presents a picture of the nature of all maternity provisions available to women in Karnataka and the extent to which these have been accessed. Maternity provisions necessarily include related issues of infant health and crèches but these aspects are being examined in other papers.

2. The need for maternity provisions

Pregnancy is a period demanding a support system that ensures additional dietary allowances, systematic antenatal care, absence of stress and a positive attitude from the family and society. It is well established that the good health of the mother has a direct bearing on that of the infant. It ensures the availability of nutrients to the foetus, a full-term well developed baby at birth, a risk-free delivery and breast milk of good quality and adequate quantity during lactation (NIN, 1982). Pregnant women rarely get the necessary care, attention, diet or rest, which affects their own and the nutritional and health status of the children they deliver. A mother's health is closely linked to the child's welfare, and maternity provisions are the lifeline to ensure proper survival and development of the child.

Women, especially poor women, perform multiple roles as workers, homemakers, child bearers and care givers. The reproductive period of women's lives is also the time they are likely to be the most productive as workers and under most pressure as homemakers. In the absence of adequate provisions for maternity leave; a woman worker often leaves her job to have a child. Poor health, additional medical expenses and the loss of employment, make her vulnerable during the period of childbirth, plunging her into an economic crisis of borrowing at high interest rates, which has social and emotional ramifications.

The repeated neglect of a woman's health during pregnancy and childbirth results in high mortality rates, anaemia and low birth weight of the new born (Shram Shakti, 1988). The period of maternity is probably best dealt with through various supportive arrangements to enable the woman to carry out her reproductive and productive roles. Therefore, all maternity provisions need to be examined in this context (Swaminathan, 2001).

3. What are maternity provisions?

> All working women (paid or unpaid) whether located in the organised or unorganised sector should be entitled to twelve weeks leave with full pay of which six weeks can be taken prior to delivery. They should be assured job security during this period. They should be entitled to medical maternity benefits i.e., cost of antenatal, postnatal care and cost of delivery (along with cost of associated complications) should be covered. All lactating mothers should have access to crèche facilities, which will enable them to breastfeed their babies. Additionally, poor women subsisting below the poverty line and those not designated as workers (women working in the care economy), should be entitled to cash compensation to tide them through this period. FORCES, 2001

It needs to be reiterated that this definition remains restricted to the rhetorical realm. It is anticipated that over time rhetoric will translate into reality. Also, **what constitutes maternity provisions varies, depending upon where women are located in the socio-economic and occupational ladder.** The different entitlements and services available to different categories of women are described in the paper. Prior to looking at what is happening in the country, it is useful to examine provisions in the international context.

4. The international context

In the international context, the main convention covering maternity provisions is the International Labour Organisation's (ILO) Maternity Entitlement Convention, 2000. The Convention includes the following provisions:

a) Maternity benefits should be available to all women workers whether full time or part time or employed in atypical dependent forms of work.
b) Leave should be granted for a period of up to 14 weeks with a minimum of six weeks as compulsory in the postnatal period and cash benefits should include not less than two-thirds of a woman's insured earnings. It should cover prenatal, postnatal and hospitalisation care where necessary.
c) Employment security should include protection from dismissal. The woman should have the right to the same job. No dismissal should take place if the woman is pregnant or ill. In the case of dismissal, the burden of proof should lie with the employer.
d) Maternity entitlements should not be a source of discrimination in employment (FORCES, 2001).

India is yet to agree to all these provisions.

5. The national context: a historical overview

BOX 1

Provisions	Context and key features
1940-1965 Article 42 of the Directive Principles The 11th Schedule of the 73rd and 74th Amendment. Employees State Insurance Act (ESI) 1948 and Maternity Benefit Act (MBA), 1961.	• Article 42 in the Constitution of India provides a comprehensive understanding of women and children's rights. It requires that the states should provide just and humane conditions of work and maternity relief. • The 11th Schedule places 'women and child development' among the 29 subjects which are to be the responsibility of local state governments while labour legislation is a central responsibility (MSSRF, 1993). These two large statements of intent were narrowly interpreted only in the context of 'labour' or workers; hence **maternity provisions formed a part of labour legislation and policy.** Even in the international context, the ILO dealt with maternity provisions. These did not feature in policies for women or children. • The ESI and the MBA were modeled along acts prevailing in the erstwhile colonial societies, which were on the brink of industrialisation. It was assumed that women were employed only in the formal sector. It needs mention that the term 'benefits' was in currency at this stage because under these two acts, women were treated as beneficiaries rather than as persons asserting their rights. Technically, these are the only two acts, which can feature in the realm of entitlements as women can take legal recourse if the provisions are not adhered to. **The notion of the informal sector did not feature in the minds of the Indian policy makers even though it existed in real terms.**
1965-1970 Beedi and Cigar Workers Act, 1966	• The Beedi and Cigar Workers Act brought some awareness regarding the role and magnitude of the informal sector and the large presence of women within it. Till date, laws and schemes in the informal sector have been slow in coming and inadequately implemented.

1970-1980 Integrated Child Development Scheme (ICDS) and the Maternal Child Health Programme. National Policy on Children (1974)	• The seventies saw the burgeoning of anti-poverty schemes, which embodied a welfare approach towards women. These programmes did not recognise that 'mothers' are 'women' and a number of them are also 'workers'. Hence the emphasis is on health i.e., ante and postnatal care (ANC, PNC), safe childbirth and breastfeeding rather than on support services and day care. • This policy emphasised the responsibility of the state to provide adequate services to children, both before and after birth to ensure their full physical, mental and social development. **However specific acts were not promulgated towards attaining this goal.**
1980-1990 Different schemes in different states (e.g., National Maternity Assistance Programme) Maternity and Child Care Code (MCCC) Maternity Fund	• In the eighties, many of the states adopted schemes to offer minimal assistance to women at childbirth. These schemes are intended for the poor, destitute and indigent i.e., these recognise women's poverty rather than their double roles or their need for support services. • This code was first put forward in Shram Shakti (1988), the Report on the National Committee on Women in the Unorganised Sector. It was the first official recognition that the needs of women and young children are intimately interlinked and need to be considered together. • The MCCC deals with the totality of a woman's reproductive function, from pregnancy till the child is able to go to school. This speaks of the woman's right to health care, wage protection and adequate working conditions during maternity**. The MCC Code has not yet been translated into a concrete programme for action.** • From the non-governmental sector (NGO) Mina Swaminathan proposed a maternity fund as an alternative to the MCCC. Every woman should be able to draw upon this fund regardless of income, number of children or any other consideration. If she is working her income should be protected to enable her to withdraw temporarily, partially or wholly from the workforce, in the interest of childcare (Swaminathan, 2001). **These recommendations remain restricted to paper.**

1990-2000 The World Summit for Children, 1990. Convention of the Rights of the Child (CRC) 1992.	• India was a signatory at this summit. For the first time in history, 71 heads of state met at the United Nations Headquarters in New York. They declared their determination to protect the physical and mental development of children throughout the world. The summit goals included: halving the 1990 maternal mortality rate; reducing child mortality for children under 5 years by one-third; and halving severe and moderate malnutrition among children under 5 years. • The Convention looks upon children not merely as extensions or dependents of adults but as human beings and rights holders who can play an active part in the enjoyment of their rights. Owing to their vulnerable position, they need protection. But they also have their strengths and, if allowed and encouraged, are able to participate in decisions that concern them. The first three key principles of the Convention directly relate to maternity provisions: the right to survival, development and protection. The Convention views parents as primary carers and protectors who must be supported in doing the best for their children. (Thukral, 2002).

Subsequent sections of this paper examine the entitlements, benefits and services and the manner in which these have been implemented in Karnataka. Prior to that, the stance within the Non-Governmental Organisation (NGO) sector is presented, as it has a key role to play in lobbying for change.

6. The NGO sector stance

FORCES (Forum for Crèche and Childcare Services), an informal national level advocacy network committed to securing the rights of the underprivileged child (0-6 years) has played a key role in this area. It focuses on the rights of both women (with their multiple roles) and children. The mother and child are regarded as a **dyad** who need to be together continuously during the first few months of life, for both nourishment and for psychosocial reasons. FORCES is responsible for mooting a shift from the term **benefits** to the notion of **entitlements** wherein, all women should have the right to avail of maternity provisions rather than feel that they are receiving these in the form of largesse on the part of the dispensing body.

Women's organisations and the women's movement have taken little interest in this subject. This can be attributed to two primary reasons. Firstly, they feel that they are still dealing with larger issues of bonded labour and minimum wages. Until these are addressed, it is premature to lobby for maternity entitlements. Secondly, they have entered the area of reproductive issues as they have fought for the right to abortion and the right to exercise reproductive choices but most groups feel that lobbying for maternity entitlements amounts to 'glorification of motherhood' rather than ensuring women equal rights (perscom. Mina Swaminathan, October 2003).

This historical overview and the NGO stance constitute the backdrop for examining the reality on the ground. The national and state maternal health status is a valuable starting point for examining reality.

7. National and state level statistics on maternal health

Maternal health care is only one aspect of maternity provisions. However, in real terms it is only maternal health care that is getting addressed as maternity provisions for a majority of women from the lower socio-economic category.

7.1 The all-India picture

In a patriarchal society, women subsist within the constraints of their poor nutritional and health status, the low educational status of young girls, early marriage, early motherhood, multiple pregnancies and closer spacing of children.

- The maternal mortality rate (MMR) was 540/100,000 in the two year period preceding the National Family Health Survey II, 1998-99 (IIPS and ORC Macro, 2000)
- The Indian MMR is 50 times higher than developed countries and six times higher than Sri Lanka.
- Anaemia, haemorrhage, eclampsia, obstructed labour and infection account for 80 per cent of maternal deaths in India (HDR, 1999).
- 75 per cent of pregnant women are anaemic. This increases maternal mortality risk, foetal growth retardation, pre and perinatal morbidity, low birth weight babies (LBW-one third of the children in India are LBW), child growth failure, poor physical and mental development, even infant mortality (Shiva, 2002).
- 75 per cent of children between 6-35 months are anaemic in India. Micronutrient deficiency (silent hunger) is most devastating in pregnant women and pre-school children (Vir, 1995).

BOX 2: Maternal healthcare indicators
(NFHS II, 1997-98, India, IIPS and ORC Macro, 2000).

Antenatal care (ANC): A minimum of four visits are recommended by WHO	• 65 per cent of the women who gave birth in the two years preceding the survey received one antenatal checkup. • 44 per cent received three or more antenatal checkups. • 33 per cent received antenatal care in the first trimester.
Iron and folic acid tablet dispensation.	• 58 per cent women received iron and folic acid for more than three months.
Tetanus toxoid (TT) injections: Two doses are recommended	• 67 per cent received two or more TT injections.
Place of delivery and type of assistance	• 33 per cent women delivered babies in a medical institution. • The rest of the babies were delivered at home (either in the natal or marital home). • Health professionals assisted 42 per cent of the births. • 35 per cent of the births were attended by trained or untrained dais. • 23 per cent of the births were attended by friends and relatives.
Postnatal care: Three PNC visits are recommended	• 17 per cent women who had non-institutional deliveries received postnatal care within two months of delivery. • 14 per cent of the women who had non-institutional deliveries received postnatal care within two days of birth.

7.2 The Karnataka situation

The situation in Karnataka is an improvement on the average national data.

- NFHS II does not present data on maternal mortality. However, Sample Registration Survey 1998 places this figure at 198/100,000 while according to UNESCO it is 450. The former figure is significantly lower than the national average of 540/100,000. Even the latter is lower but only by 90 (GOK, 2001).
- 42 per cent women are anaemic and 18 per cent pregnant women are anaemic (IIPS and ORC Macro, 2000).
- 71 per cent children between 6-35 months are anaemic. This can be attributed to the mother's poor nutritional status to some extent (IIPS and ORC Macro, 2000).

BOX 3: Maternal healthcare indicators
(NFHS-II, 1997-98, Karnataka, IIPS and ORC Macro, 2000).

Antenatal care (ANC)	• 86.3 per cent of the women who gave birth in the four years preceding the survey received one antenatal checkup. • 71.4 per cent received three or more antenatal checkups. • 52.7 per cent received antenatal care in the first trimester.
Iron and folic acid tablet dispensation.	• 74.2 per cent women received iron and folic acid for more than three months.
Tetanus toxoid (TT) injections.	• 74.9 per cent received two or more TT injections.
Place of delivery and type of assistance	• 51.1 per cent women delivered babies in a medical institution. • The rest of the babies were delivered at home. • 59.1 per cent of the births were assisted by health professionals • The rest of the births were attended by trained or untrained dais.
Postnatal care (PNC)	• 35.3 per cent women who had non-institutional deliveries received postnatal care within two months of delivery. • 3.6 per cent of the women who had non-institutional deliveries received postnatal care within two days of birth.
Breastfeeding	• 18. 5 per cent of the babies were breastfed within one hour of birth. • 41.5 were breastfed within one day of birth. • 61.4 per cent mothers removed the colostrum.

On all counts, women in Karnataka fare better than the average Indian except with regard to early PNC.

Maternity provisions are available only to women above the age of 18; therefore it is also relevant to look at the age of marriage. According to NFHS I:

- At the age of 15-19, 38 per cent of women are married. This figure stands at 43 per cent in rural areas and 27 per cent in urban areas.
- Child bearing in Karnataka is concentrated in the age group 15-29 where four-fifths of the births occur.
- 23 per cent of the births are in the age group of 15-19. Slightly more than one-fifth of all women aged 15-19 and 72 per cent of ever married women aged 13-19 have begun childbearing.

This data indicates that there is a significant proportion of underage women who need maternity provisions (ISEC and IIPS, 1995).

Despite the advantage women in Karnataka have over the average Indian woman, it is clear that there is scope for improvement. This is possible only if the state assumes certain responsibilities and there is community participation. At this juncture, it becomes relevant to examine the specific provisions devised by the government and to see how these have been implemented in Karnataka.

8. Maternity provisions for working women: entitlements and benefits

Three types of statutes prevail which address the needs of women within the workplace. (Details on and implications of all legal terms (e.g., statutes) are provided in Annexure 1.)

8.1 The penalty-entitlement model: provisions for women in the organised sector

The first set of statutes enable the promulgation of acts, which feature within the entitlement-penalty model. These statutes specify who the beneficiary is, the statutory benefit and the penalty for non-observance. Any amendments in these acts require the sanction of the legislature (Dhanda, 2001). The provisions of the **Maternity Benefit Act (MBA), 1961 and the Employees State Insurance Act (ESI) 1948** have been formulated in non-negotiable terms. Both these acts apply only to women who work within the organised sector.

BOX 4: The Maternity Benefits Act, 1961

- The MBA applies to all workers in regular employment in factories, commercial establishments, plantations, mines, circuses and every shop and establishment in which 10 or more persons are or were employed on any day in the preceding 12 months.
- Every woman employee who has worked for a period of 80 continuous days in one year is eligible to be covered under the Act.
- A commercial establishment is a premises where any trade or business or profession is carried out. In legal terms, contract work is also included in this definition. Unfortunately, this Act is implemented only in the organised sector.
- The salient features of the Act include:
    1. Protection from dismissal during pregnancy.
    2. 12 weeks paid leave of which six weeks may be taken in the period preceding childbirth if the mother so desires.
    3. The employer will not compel the woman to engage in any arduous work during pregnancy, or give notice for discharge or dismissal during this period.
    4. Two nursing breaks of 15 minutes each, once the mother goes back to work.
    5. To obtain the benefit, the woman has to give notice in Form D and the employer is obliged to pay the amount and grant leave to the concerned applicant.
    6. Any employer who infringes the provisions of the statute can be punished with imprisonment for a period of not less than three months and with a fine of not less than Rs. 2,000. An Inspector under this statute (from the Labour Commissioner's office) can initiate action for contravention (Dhanda, 2001). (Annexure 2 contains additional details on the Act.)

Implementation of the MBA, 1961 in Karnataka.

This data has been obtained from the State Labour Commissioner's Office. It indicates the extent to which the MBA has been implemented.

Table 1: Shops and Establishments

Year	No. of Units Inspected	No. of Violations
1998	13	Nil
1999	37	Nil
2000	201	Nil
2001	95	Nil
2002	149	Nil

Data compiled in this manner throws very little light on the actual situation on the ground. It does not indicate how many women have received the benefit. It is also not clear how many inspections are mandatory. (The staff maintains that they have 22 issues to be inspected. Maternity benefits are one of the less important issues; hence a specific number of inspections are not prescribed.) It is unlikely that there are no violations.

Table 2:Tea, coffee and rubber plantations

Year	Number of applications and number of claims processed
1998	742
1999	625
2000	509
2001	445

Data for 2002 is still being compiled. This data does not indicate whether all plantations have been covered or how many women got pregnant. According to this data, all claims of all the women who applied have been accepted and the money has been disbursed. However, a declining trend in the number of claims is evident.

Table 3: Factories

	Particulars	Year			
		1998	1999	2000	2001
1.	Number of applications and number of claims processed	229	296	251	77
2.	Inspections by the officers during the year	5201	5951	5766	5398

The data for 2002 is yet to be compiled. This data pertains to women working in factories. This table indicates that all women who have applied for the benefit have received it. It is unlikely that only 77 women needed the benefit in 2001 as opposed to 296 women in 1999. The number of mandatory inspections is not indicated or available. Apparently there are no prescribed targets. This data needs a context to engage in any detailed analysis. However the small number of claims is a cause for concern.

Maternity provisions are also provided for women in the organised sector under the ESI Act, 1948.

BOX 5: The Employees State Insurance (ESI) Act, 1948

- This Act only applies to non-seasonal factories using power and employing 10 or more persons; and also to factories not using power and some other establishments employing 20 or more persons.
- The ESI facilities are usually available in areas of industrial concentration. The medical facilities are set up only if there are at least 1000 workers in the vicinity to make this an economically viable proposition.
- The categories of women to which the provisions of the ESI schemes apply are excluded from the purview of the MBA. Women drawing wages above the wage ceiling under the ESI Act are entitled to the benefits under the MBA. The provisions in the ESI Act are more comprehensive than those under the MBA as they include medical care and pre and postnatal care.

Key features

1) The Act applies to employees whose earn less than Rs. 6,500 per month.
2) Both the employer and the employee contribute an amount to the ESI Corporation. The employee contribution is 1.75 per cent of her salary/per annum and the employer contribution is 4.75 per cent of the salary. The contributions are remitted every six months to the ESI/SBI account. If the deposits are made regularly, the ESI staff does not go on inspections. Usually inspections are made once in two years.
3) In the case of non-adherence, the woman has the right to either file a complaint directly or she can register the complaint through an office bearer of the registered trade union of which the woman is a member, a voluntary organisation registered under the Societies Registration Act or an Inspector.
4) The woman has to apply to the ESI Corporation to avail of the benefit. State governments administer the Act.
5) An insured woman is entitled to maternity benefit in the form of periodical payments in the case of confinement, miscarriage or sickness arising out of pregnancy. Payments are made for actual absence up to 12 weeks on average daily wages (minimum wage or Rs. 10). Women are also entitled to medical care and where medical facilities are not available, they are paid a sum of Rs. 250 for the purpose.

Implementation of the ESI in Karnataka,

Approximately 20,000 employers are covered by the ESI (perscom. Mr. Hegde, Deputy Director ESI, October 2003). According to Mr. Hegde, 25 per cent of the employers are defaulters. The question of the employee defaulting does not arise as the employer is supposed to deduct the contribution at source.

Table 4: ESI disbursals for maternity benefits

Year	Number of payments	Amount in rupees
1999	25,304	2,51,64,250
2000	28,444	3,13,60,834
2001	26,177	3,57,15,960
2003	24,856	3,86,76,642

This table throws light on the number of payments made to women who are availing of the benefit. Usually two payments are made per woman but this figure can vary. It is therefore not possible to extrapolate how many women have received the benefit. It is evident that over time there is an increase in the quantum paid to the women, which is reassuring.

It needs to be reiterated that **only these two Acts feature in the realm of entitlements as women have the right to legal recourse if they are denied any of the provisions described above.** In real terms these continue to remain benefits, as most women do not have the wherewithal to assert their rights. Moreover, if they feel that their jobs are in jeopardy, they would rather forgo these.

8.2 Maternity protection through welfare funds

The second set of statutes provides maternity protection to vulnerable working groups through the setting up of Welfare Funds.

- The Welfare Fund statutes indicate how to set up the funds and provide the structures for their administration.
- These schemes can be altered on the basis of experience without going back to the legislature. These include the Beedi and Cigar Workers Welfare Fund, 1966; Working Journalists and other Newspaper Employees and Miscellaneous Provsions Act, 1955, etc.
- To avail of benefits the employees have to be registered as workers with a specified statutory authority. Under the Building and other Construction Workers Act, 1996, every registered building worker should receive the benefits provided by its Fund. The other mode of establishing worker status is through identity cards issued by the employer. The worker can also obtain the worker status certificate from a state functionary (village officer, executive officer of the panchayat, municipal commissioner or corporation commissioner of the area).
- In the case of non-adherence under these statutes, there is no provision for the woman to file a complaint directly. She has to register the complaint through an office bearer of the registered trade union of which the woman is a member, a voluntary organisation registered under the Societies Registration Act or an Inspector.
- The Welfare Fund statutes do not just provide benefits to vulnerable population but also accord the government an opportunity to distribute these.

In Karnataka, none of the welfare funds has any provision for maternity benefits.

8.3 Maternity protection for women in the unorganised sector

A third variety of statutes are those, which enjoin the state to launch schemes to address the needs of people in the unorganised sector (Tamil Nadu Workers Act, 1982).

- The statute only identifies the need. Once the need is recognised, the scheme has to be devised for its realisation i.e., the formulation of the scheme becomes a statutory obligation.
- The actual entitlements and procedure for obtaining these are provided in the scheme. In these statutes, the funding source is not mentioned and these schemes do not have the force of law and thus benefits accruing cannot be claimed as entitlements or be contested in court.
- The government can alter the schemes without legislation.
- The content of the schemes can vary from state to state and allow for greater location specificity. This aspect assumes relevance only if the local population is aware of its rights and people's groups maintain pressure on the government to ensure that benefits are provided.

The Karnataka government has not devised any maternity benefit schemes under the third set of statutes.

In 2003, a bill for workers in the unorganised sector (Unorganised Workers Act) was placed before the Karnataka state legislative assembly. This will cover 70 categories of unorganised workers. Provision of maternity benefits will be addressed in this bill. How the benefits will reach this category of workers needs to be examined when the bill is passed and converted into an act. The process of passing the bill is still underway. In neighbouring Tamil Nadu, an Unorganised Workers Sector Bill was formulated in 2003 as an outcome of the Second National Labour Commission's recommendation. This bill classifies 37 crore workers in the unorganised sector into 122 categories. It can serve a valuable reference source.

The major gain of statutory schemes over non-statutory ones is that they introduce a modicum of non-negotiability. Whilst the content of the scheme can change, the scheme itself cannot be withdrawn.

8.4 Issues related to maternity provisions for working women

NGOs including FORCES members from all over the country have analysed the provisions in detail. As the second and third statutes are not being implemented in Karnataka, issues pertaining to these are not being presented.

1) To obtain maternity benefits/entitlements, a person has to first establish the **status of the worker**. This depends upon how the term worker is defined under the statute. The statutory procedures are geared to weed out wrongful claimants. There is no urgency to ensure that rightful claimants get their just due. The burden of proving such a status always resides with the person seeking the benefit. This is not easy given the woman's lower socio-economic and sometimes non-literate status.

   The MBA and the ESI Acts only apply to **workers in the organised sector where only 10 per cent women work.** Even within the organised sector, a very tiny group avails of the MBA. A national study by Niru Chaddha shows that only 0.25 per cent of women who are entitled actually avail of maternity benefits. Here the term worker tends to exclude contract labourers though in real terms they may actually be entitled.

2) Further, the **functional efficacy** of the MBA and ESI depends on the existence of **efficient inspectorate and diligent prosecution.** If there are inadequacies on this score, then guaranteeing that the benefits reach the women cannot be ensured. For questioning violations, the woman has to first be aware of her rights. She then has to know who is the Appropriate Authority to be contacted in the case of violation.

   For the MBA, the woman needs to inform the State Labour Commissioner's office. These officers are not always responsive. Lengthy court procedures are not a viable option for women from the lower socio-economic category. A real consequence of the inability to question violations has led many women to leave their jobs when they are pregnant or they have not been hired to avoid providing maternity benefits during and after pregnancy. As the MBA is an employer liability scheme, it has often worked adversely for the employment of women. Employers would rather not employ women than ensure that they receive their entitlements.

   An important mechanism for ensuring observance of statutory requirements under the ESI is registration or licensing. All factories can function only if they have the relevant license. Licenses can be revoked if the ESI Act is infringed. This clause is relevant only if the factory inspectors choose to take their role in this regard seriously.

3) With regard to the **amount of benefit** provided by the **ESI and MBA Acts**, it is **inadequate** as women are not able to cover the cost of extra nutrition required during pregnancy. According to Brinda Karat (AIDWA) food entitlements should be an important component of maternity benefits (FORCES, 2001).
4) Often the factory owners and contractors find it easy to avoid the ESI scheme by employing 9 rather than 10 women. Also a number of factories owners pay their employees Rs. 6,501/- per month to avoid implementing this scheme.
5) Currently no maternity leave is granted if the child is adopted. Maternity leave should be granted if the child is less than six months old. The **scope of the acts needs to be extended to include adopted infants.**
6) The two-child norm population policy has an intimate relationship with this area. The recent pronouncement of the government restricting all maternity benefits to only two children seems to be in contradiction to the policy flowing from the CRC, since it discriminates against a group of children. Such a unilateral decision on the part of the government without the usual consultation any other institutional forums has disturbing implications and can be contested on constitutional grounds.

9. Maternity provisions for women outside the workplace

In addition to these statutory workplace related schemes, different states have different schemes, which address the needs of women outside the workplace.

The National Maternity Assistance Scheme (1995) has been introduced under the National Social Assistance Programme (NSAP) to provide financial assistance (a one-time payment of Rs. 500) to women below the poverty line (BPL). The government of Karnataka is also implementing the National Maternity Assistance Scheme for pregnant women who are above the age of 19 and belong to BPL families (Annexure 3).

Implementation of the National Maternity Scheme in Karnataka
This data is currently maintained by the Women's Welfare Department. They only have data for 2001 and 2002.

Table 5: National Maternity Scheme in Karnataka

Year	Number of women who received the benefit	Total number of pregnant BPL women	Percentage of women who have received the benefit
2001	46,941	2,15,337	22
2002	59,059		

Despite the fact that over time more women are receiving the benefit, this table establishes that this scheme has an inadequate outreach (22 per cent in 2001). (The total number of pregnant BPL women is a proxy figure as it has been computed by using the WHO formula: total BPL population multiplied by17.3 (Crude Birth Rate) divided by 1000. Total BPL population has not been compiled for 2002.

FORCES groups have undertaken sample studies in four locations: Delhi (sample size 152), Orissa (181), Bihar (57) and Uttar Pradesh (53). Their study reveals that this scheme is poorly implemented in all states. Surprisingly Bihar fares the best with a 44 per cent implementation rate. Delhi (21.7 per cent) and Uttar Pradesh (20.7 per cent), implementation figures resemble Karnataka (22 per cent). Orissa is the lowest with 9.4 per cent. These figures are actually not comparable due to variation in sample size but this gives an indicative picture.

The state figure in Karnataka of 22 % hides inter-district variations. Data from a few select districts has been presented to reveal the variation. As the BPL population has not been compiled for 2002, 2001 data has been used which will only be an underestimate.

Table 6: District wise figures of national maternity scheme in Karnataka

Name of district	Number of women who received the benefit in 2002	Total number of pregnant BPL women in 2001	Percentage of women who have received the benefit
Raichur	1,490	1,767	84
Mysore	5644	10,878	52
Tumkur	5,909	12372	47.7
Bellary	3,347	10,571	31.6
Kodagu	522	1,672	31
Koppal	1,258	7,175	17.5
Bagalkot	867	5,574	15
Bijapur	990	9,700	10

It is evident that the poorer districts (Bijapur, Bagalkot, Koppal) suffer from inadequate implementation of this scheme. BPL women in the richer districts (Mysore and Kodagu) seem to fare better. It is difficult to explain the wide variation in implementation between Raichur (84 per cent) and Koppal (17.5 per cent). These are neighbouring districts with a similar socio-economic profile. On the whole, the scheme is inadequately implemented.

9.1 Issues related to maternity provisions for women outside the workplace

- Minimal provisions are available to women outside the workplace, that too only for BPL women. Women who subsist even slightly above the poverty line are not entitled.
- The benefit of a fixed sum of Rs. 500, as a one-time payment, does not sustain the mother or the child in real terms.
- The money can be obtained only if the woman fills up form M.B-1 and submits it to the anganwadi worker within six months from the date of conception. If she fails to do so, she forfeits even this minimal benefit. Given these women's lack of awareness and non-literate status, this condition is often not fulfilled.
- The woman should have lived in the concerned district for three years prior to the application. Inter-district marriages are not uncommon, and most women conceive soon after their marriages. This eliminates a large number of women. Many women go to their natal homes for delivery, hence forgo this benefit.

10. Maternal health services

In addition to the provisions described above, the government also has the responsibility of providing women with maternal health services. It focuses on maternal health through two schemes: Integrated Child Development Services (ICDS) Scheme and the Reproductive Child Health (RCH) programme.

10.1 The Integrated Child Development Scheme (ICDS)

The Department of Women and Child Development implements this scheme. It is a centrally sponsored scheme, which has been in operation since 1975. This scheme has the most extensive and comprehensive network of childcare services in any developing country and reaches about 15 per cent of all children in the age group 0-6 and two-fifths of those most in need. The scheme is executed through local anganwadi centres. This programme provides support to the woman during pregnancy and lactation (Annexure 4). (Details on the ICDS are available in another paper.).

Implementation of the ICDS in Karnataka

In Karnataka, the ICDS department has data pertaining to nutrition for pregnant and nursing women for the years 2002 and 2003.

Table 7: Percentage of mothers receiving supplementary nutrition through ICDS

Year	Supplementary nutrition to pregnant women	To nursing mothers
2002	93.27 per cent	93.21 per cent
2003	93.88 per cent	92.32 per cent

A district wise break up is attached to Annexure 4. No significant trends are evident across districts. In fact in some areas, the achievements exceed the targets. These figures indicate that almost all pregnant and nursing mothers who avail of the ICDS are adequately nourished. This data however does not indicate the quality of the nutrition and whether the women actually consume the supplements. Karnataka FORCES undertook a small study of some anganwadi centres in September 2003. This indicated that women only get bread in the Bangalore (urban). According to the staff of Belaku Trust (an NGO working on reproductive and child health), the health services dispensed by the rural anganwadis in their area, Bangalore (rural), are also inadequate.

10.2 The Reproductive and Child Health (RCH) programme

Maternal health for the lower socio-economic category has been subsumed in the government's population control and family planning efforts. Family planning and immunisation programmes were amongst the earliest health programmes initiated in the 1960s. Sterilisation was the focus of the National Family Planning Programme. In 1979, the Family Planning Programme was renamed as Family Welfare Prgramme and initiatives were taken to improve the health and nutritional status of women and children. The National Health Policy of 1983 stressed on maternal and child health (MCH). The MCH programme of the 80s was renamed as the Child Survival and Safe Motherhood (CSSM) programme in 1992. As reproductive health care became the focus post-ICPD (International Conference on Population and Development, Cairo, 1994), CSSM was brought under the umbrella of the present Reproductive and Child Health (RCH) programme of the Ministry of Health and Family Welfare (Shiva, 2002).

The RCH is a composite programme, incorporating inputs from the Government of India (GOI), funding from the World Bank and the European Commission. Under the RCH programme women should be able to go through pregnancy and childbirth safely and the outcome of pregnancies should be successful in terms of maternal and infant survival. It was anticipated that this approach would provide beneficiaries with need-based, client-centred, demand-driven, high quality and integrated RCH services. This programme is being projected as a target free one but in reality the staff are compelled to direct their efforts at reaching pre-set targets.

Table 8: Implementation data under the RCH

	Year	Expected level of acceptance	Antenatal registration	%	High risk Identified & referred	%	T.T to P W	%	IFA to P W	%	ANC with 3 completed visits by HAF
1	1997-98	12,07,900	11,89,282	98.46	58,679	4.93	12,23,188	101.27	11,62,165	96.21	10,41,324
2	1998-99	12,31,200	11,42,155	92.77	62,932	5.51	11,57,490	94.01	6,93,789	56.35	9,30,270
3	1999-00	12,93,000	12,75,161	98.62	1,19,444	9.37	12,10,883	93.65	12,79,809	98.98	10,80,854
4	2000-01	12,32,000	12,37,252	100.43	1,25,909	10.18	11,94,472	96.95	13,78,752	111.91	9,31,784

	Year	Total Deliveries	Deliveries conducted by								Total Live Births
			Institution.	%	HAF / LHV	%	Trained dai	%	Untrained dai	%	
1	1997-98	8,76,894	3,80,939	43.44	2,37,264	27.06	2,21,939	25.31	36,752	4.19	8,60,828
2	1998-99	8,08,361	3,68,141	45.54	2,12,456	26.64	1,98,810	24.59	25,971	3.21	7,92,606
3	1999-00	9,05,394	4,26,994	47.16	2,35,198	25.98	2,22,271	24.55	20,931	2.31	8,52,563
4	2000-01	9,11,376	4,61,472	50.63	2,20,131	24.15	2,11,192	23.17	18,724	2.05	8,70,352

	Infants Birth Wt. Recorded	LBW Babies less than 2.5 kg	Infant Deaths	Maternal Deaths	IFA for Children below 5 years		
					Below 5 years		
					Expected	Total	%
1	6,19,227	62,299	16,163	1,050	24,07,920	11,52,085	47.85
2	6,40,520	40,890	16,249	1,112	25,62,000	9,44,415	36.86
3	7,73,961	48,261	16,027	1,180	26,95,000	11,07,196	41.08
4	7,89,954	43,174	16,340	1,177	27,27,000	13,46,133	49.36

T.T. to PW: Tetanus Toxoid to Pregnant Women.
HAF/LHV: Health Assistant Female/Lady Health Visitor
IFA: Iron and Folic Acid
ANC: Antenatal Care
LBW: Low Birth Weight

- This table reveals that the antenatal registration ranges from 92 to over 100 per cent. RCH staff attributed the data exceeding 100 per cent to the fact that sometimes the targets set for the scheme are based on guesstimates. These guesstimates may be lower than the actual number of pregnant women. It is not clear whether all the components of ANC are being provided.
- Five to ten per cent deliveries are identified as high risk.
- This data shows that almost all women get their tetanus toxoid doses.
- In the case of iron and folic acid dispensation a sudden dip is noted in 1998-99, which the authorities could not explain.
- This table reveals that half the babies are delivered in hospitals. The Health Assistant Female and the Lady Health Visitor attend one-fourth of the deliveries. One-fourth of the babies are delivered by trained dais and the rest have untrained dais attending.
- The number of low birth babies shows a steady decrease over time from 10 to 5.4 per cent of the babies being born with a birth weight of less than 2.5 kg. The maternal mortality rate shows an increasing trend from 119/100,000 in 1997-98 to 255/100,000 in 2000-01. This however, is still lower than the figure projected by UNESCO (450/100,000).

10.3 Issues related to maternal health services

With regard to the facilities created for maternal health care for poor urban and rural women, both the **ICDS** and the **RCH** are dogged by problems associated with most large government programmes.

- These schemes do not specifically recognise or cater to work done by women or their needs or responsibilities as mothers. The timings or location of the centres are not geared to the convenience of working women of any category, to seasonal changes in their work schedules, migration patterns or any other work related factors.
- The anganwadi worker expends a lot of energy helping the ANM meet her targets in the ostensibly target-free RCH programme. This coupled with other administrative responsibilities leaves her with very little time to implement the ICDS.
- Moreover, culturally the rural population is uncomfortable with handouts. The women feel that they are being reduced to beggars rather than getting what is their entitlement because of the manner in which the programmes are implemented.
- The anganwadi worker gives little or no advice on breastfeeding. As a result, breastfeeding is delayed; and poor quality and unhygienic supplementary feeding begins very early. The end result is that malnutrition starts between one and four months and peak malnutrition sets in by one to two years.
- NGOs (Mahila Samakhya and Belaku Trust) working on maternal and child health are of the view that this data does not reflect ground realities in terms of access to maternal health care and outcomes described above.

Sections 6-12 establish that there are a series of issues arising, which pertain both to inherent problems within the acts and schemes; and there are problems emerging from the manner in which these provisions are dispensed. Further, most of the data on implementation cannot be interpreted in real terms, as it does not provide the context for understanding it. It is against this backdrop, groups working on maternity provisions have put a series of suggestions forth.

11. Reflections and suggestions

FORCES has been a pioneering network in contributing to thought in this realm.
At a **broad and theoretical level,** FORCES has made the following suggestions.

1) At the very outset, there is a basic question as to whether maternity and childcare should be considered a part of labour legislation or should be treated as social welfare. From the perspective of women's multiple roles, an integrated approach would be considered most productive. While the positive features of the laws acquired after long years of struggle should be preserved, it must be accepted that present labour legislation needs to be more mother and child friendly. At the same time, where laws are inadequate either in scope or nature, maternity and childcare should be considered a national and state responsibility not only left to the employers, especially as the employer-employee relationship is often not clearly established in the unorganised sector.
2) Women located within the economically productive economy have to constantly prove their status to obtain benefits. This indicates the need for law reform at two levels. One level would require the ideology (i.e., a philosophy of largesse and a psychology of suspicion) of existing statutory regimes to be examined. The other would need changes to be introduced in the substantive provisions. The present statutory suspicion should be replaced with a statutory recognition of the dignity of claimants. Statutory duties should be placed upon state officials wherein they seek out claimants and inform them of their entitlements and provide them the same. Failure to fulfill these duties should invite penalty. The statutes should also provide that whenever the authorities do not accept a claim they should be obliged to supply reasons for the same.
3) Majority of the provisions are relevant only to women within the workplace. Therefore it is important to **sensitise** people and the government **regarding women's unpaid work**. The government has taken the first step by including the care economy in the Economic Survey of 2000-2001. Women in the unorganised sector and women in the care economy need maximum support.

In **concrete terms**, FORCES also submitted a memorandum to the Second Labour Commission (instituted by the government in 2000). The members suggested that:

a) the GOI should ratify the ILO Maternity Convention 2000.
b) a six-month leave period should be provided to enable exclusive breastfeeding in view of the WHO recommendation.
c) the concept of maternity entitlement should be enlarged to include childcare and the two should be given the same status in law and policy. The health and the well being of the mother and infant require cash support as well as crèches and childcare services on work sites and labour camps.
d) institutions should be set up cover smaller establishments.
e) welfare funds can be an important model for providing social security to workers in the unorganised sector. Welfare Funds can be set up for each of the major sectors (agriculture, building and industry, handlooms and power looms, railway porters, etc.). With regard to the minor sectors, it may not be practical to set up a Welfare Fund for each. It would be necessary to bring them under an umbrella type of legislation with a common Welfare Fund.

12. Response of the Second Labour Commission

The Commission has responded to these demands by suggesting two broad approaches – through **occupation-based welfare boards** and through **area-based schemes**. Both should be schemes that follow the insurance model, i.e., these should be contributory in nature and tripartite in structure. Contributions should come from employers; employees; and supplementary funding should come through tax or cess. It also indicated alternative ways of identifying beneficiaries and getting workers contributions through identity cards. For example, in Tamil Nadu and Kerala, the Construction Workers Welfare Board provides entitlements.

- The government should set up **welfare boards** at the district and state level. FORCES has recommended that these Boards have to be welfare boards and different networks will have to campaign for setting these up where they do not exist. It is not possible to have a single national policy (Swaminthan, 2002).
- The **area-based schemes** will cover workers who do not fall easily into any of the occupational categories. Such schemes could also cater to the self-employed, casual labourers, migrants and those situations where employers are not readily identifiable. It emphasises that when offering membership to all adult workers in a given geographical area, regardless of the nature of work, special focus should be on the inclusion of women as workers and women should not be treated merely as members of a family unit.

In addition, **a third level** has been identified by the Commission for below poverty line women who are not in a position to make any contribution for various reasons and for whom social assistance is to be provided wholly at government expense. This has been articulated as **Social Assistance Scheme**, which was proposed first by Mina Swaminathan. Women should be able to avail of benefits irrespective of whether they can contribute or not. Cash is the minimum benefit that all women should get. The responsibility of implementation should lie with the state. This proposed scheme is yet to be codified.

It should be accessed through multiple channels and agencies like the panchayat office, post offices, banks, health centres, ICDS centres, government departments and banks. The sources of funding should be the employees and the government at the central, state, district (or municipal) and local (ward or panchayat) level. The China and Thailand module can be followed where the community sponsors one worker for every 100 families to ensure the proper delivery of benefits. The scheme should also provide for the setting up of a Monitoring and Grievance Committee with representatives from workers, employers and local authorities.

The desire to devise provisions for women in the unorganised and care sector indicates that this is a concern area. The details of these provisions are yet to be worked out. At this stage, it needs to be reiterated that accessing maternity benefits for women in the organised sector has been problematic. It likely that these problems will be exacerbated for women outside the organised sector. Further, all the **recommendations of the Second Labour Commission and FORCES prevail at the level of discussions. These suggestions have not yet been translated into concrete policies or schemes till date.**

13. Summary and conclusions

1. This paper establishes that in India, there is no uniform notion or absolute description of what constitutes maternity provisions. Maternity provisions vary depending upon where women are located in the socio-economic and occupational ladder. It is ironic that women in the organised sector who are at the top of the ladder receive the most protection.
2. Maternity provisions for women in the international context (as recommended by the ILO) are much more comprehensive than what is prescribed by the Indian government.
3. The historical overview to this area indicates that considerable thought has been devoted to this realm. It also reflects that the government has interpreted larger commitments in narrow terms. Maternity provisions are seen largely in the context of working women. It becomes evident that there were no provisions for women outside the organised sector till 1965. Till date, these women receive virtually no protection during the period of child bearing and rearing in the early years.
4. Despite the critical nature of this issue, the NGO sector has not given it the importance it merits. Apart from FORCES members, few NGOs are working actively in this area.

5. National and state maternal health statistics indicate that women in Karnataka fare better than the average Indian woman. Despite this, there is scope for improvement in Karnataka. It also evident that maternity provisions are not available to some key groups of women (e.g., underage mothers) in Karnataka.
6. There are multiple issues, which need to be addressed for both the organised and the unorganised sector. Women are subsisting within a context of discrimination. With regard to maternity provisions for women within the workplace, in Karnataka only the organised sector has been acknowledged. For these women, legally the provisions do constitute entitlements. However, the manner in which these are designed and implemented; the awareness levels of women; the compulsions guiding women's lives; political will (or the lack of it) of dispensing authorities tend to reduce these entitlements to benefits.
7. Maternity provisions for women outside the workplace are available only to BPL women in Karnataka indicating a minimal outreach. Thus women in the unorganised sector and outside the worker category are highly neglected.
8. These two groups receive some redressal through the two schemes (ICDS and RCH), which extend maternal health care services. The two schemes, which have a limited mandate, appear to be efficiently implemented but NGOs working in the field maintained that these do not have the required impact in reality. A juxtaposition of the RCH data (1997-98) and the NFHS II (1997-98) data reveals some inconsistencies. The validity of the former becomes questionable.
9. This chapter clearly establishes that all data on implementation is collated in a format that obfuscates reality. Interpretation becomes problematic as it lacks contextual underpinnings. Therefore, it is not possible to effectively assess the impact of acts and schemes. Lobbying for change and planning for the future becomes difficult.
10. One of the challenges facing groups working in this area is to collate and compile contextual information, as this will act as a powerful instrument for advocacy.
11. The FORCES network members have played a crucial role in directing the government's attention to lacunae in this area.
12. The Second Labour Commission has responded to the issues raised by FORCES but the response remains at the discussion level. No changes have been introduced on the ground.
13. It is evident that unless a multi-pronged approach is brought into play, it is unlikely that any real change will be effected. The formulation of laws, policies and schemes addresses only one dimension of the problem. The conversion of maternity benefits into maternity entitlements will arise only when there is a penalty associated with non-adherence and when women are sufficiently empowered and aware of their rights to make these demands.

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ANNEXURE 1: Glossary of legal terms

Statutes: A law always exists in a written form, called a statute or an Act. Individuals and the government have to comply with these acts.

Rules: Statutes or Acts describe the main components of the law. Detailed aspects like procedures are written in Rules. The Maternity Benefit Act, applicable to the whole country, lays down general aspects. Different states make their own Rules. Karnataka's rules on maternity benefit are the Maternity Benefit Karnataka Rules.

Orders: Many decisions are taken in the day-to-day functioning of government. The executive has to make orders for taking these decisions. Orders are generally made from one official to another, or from an official to a department. Orders must also be in accordance with the law, in writing. There are different types of orders. Some are made for the internal working of a department. Some are made for public dealing.

There are administrative orders and judicial orders. Administrative orders are passed by government officers. Officials can only pass those orders for which they have the power to do so. Only orders made by the person who has the power by law to pass such an order is legal, otherwise it has no meaning. Judicial orders are passed by courts.

Circulars: are like orders, made for wider circulation through a printed format.

Notifications: Laws or rules must be notified, i.e, made public officially. Some orders also need to be notified. This is done by putting them in a document called the "Gazette".

Policy: Policy is the intention of the government, which becomes effective by issuing an administrative order. The government can change its policy by amending the prevailing government order. Only a legislature can amend a statute, which is more difficult to do.

ANNEXURE 2: The Maternity Benefit Act, 1961 (Abridged Version)

1. Object

An Act to regulate the employment of women in certain establishments to provide for maternity benefit and certain other benefits.

2. Applicability

It extends to the whole of India and applies to:

(i) every factory, mine or plantation and to every establishment wherein persons are employed for the exhibition of equestrian, acrobatic and other performances.

(ii) to every shop or establishment in which ten or more persons are employed or were employed on any day of the preceding twelve months.

Government of Karnataka extended the applicability of this Act to the following establishments, vide notification No. SWL 151 LBW 83, dt.1.8.89.

1. Private hospitals nursing homes and dispensaries
2. Private schools and other education institutions

3. Employment of or work by women prohibited during certain periods

i. six months immediately following her delivery or miscarriage.

ii. in any work, which may interfere with pregnancy or health of the women, one month immediately, preceding the period of six weeks before the date of her expected delivery.

iii. Any period during the period of six weeks for which the pregnant women does not avail of leave of absence. (Section 4)

4. Payment of maternity benefit

Every women shall be entitled, to and her employer shall be liable for the payment of maternity benefit if the women has actually worked not less than eighty days in the twelve months immediately preceding the date of her expected delivery.

Maternity benefit shall be paid at the rate of the average daily wage for the period of her actual absence and maximum period shall be twelve weeks of which not more than six weeks shall precede the date of her expected delivery (Section 5).

5. Other benefits

(i) Medical bonus: In addition to maternity benefit every women shall entitle to a medical bonus of Rs. 250/- if no prenatal confinement and postnatal care is provided by the employer (Section 8 read with Rule 5).

(ii) Leave for miscarriage: A women shall on production of a certificate signed by a registered medical practitioner or medical officer of the Government in Form B as proof of miscarriage, is entitled to leave with wages at the rate of Maternity benefit for a period of six weeks immediately following the day of her miscarriage (Section 9 read with Rule 4)

(iii) A woman, suffering from illness arising out of pregnancy, delivery, premature birth of child or miscarriage shall on production of a certificate from a government, medical officer/registered medical practitioner as proof, be entitled to leave with wages for a period of one month (Section 10 read with Rule 4).

(iv) Nursing breaks: In addition to the interval for rest, a woman shall be allowed in the course of her daily work two nursing breaks of 15 minutes duration for nursing the child until the child attains the age of fifteen months. A journey time of 5 to 15 minutes is also provided under the Act (Section 11 read with Rule 6).

6. Notice of claim and payment thereof

A women entitled to maternity benefit shall give notice in Form D and employer shall pay the maternity benefit or any other amount to the women concerned or to her nominee in case of her death.

7. Appeal

Any person aggrieved on the decision of the Inspector may, within thirty days, appeal to the authority appointed under Section 17 or section 12 as the case may be. (Section 17)

8. Registers and records to be maintained by the employers.

i. Maintain a muster Roll in Form A
ii. Display of the abstract of the Act in Form J
iii. Submit an annual return on or before 31st January every year to the competent authority in Form K, L and M

9. Penalty

Offences under this Act be punishable as follows:

(I)	Fails to pay maternity benefit or Discharges of dismisses a women During the period of maternity	With imprisonment not less than 3 months but may extend to one year or with fine not less than Rs. 2000/- but may extend to Rs. 5000/-
(II)	Contravenes the provisions of the Act or the Rules	With imprisonment which may extend to one year or with fine which may extend to Rs. 5000/- or both.
(III)	Obstruction to inspector or fails to produce the registers or documents, etc.	With imprisonment which may extend to one year or with fine which may extend to Rs. 5000/- or both.

10. Who can file prosecutions

1. any aggrieved woman
2. an office bearer of a trade union
3. a voluntary organisation registered under the Societies Registration Act, 1860
4. an Inspector

Complaint shall be filed within one year from the date of offence and no court inferior to that of a Metropolitan or a Magistrate of the First Class shall try an offence under this Act.

11. Authorities under the Act

1. Inspectors under the Act 1) Labour Commissioner 2) Addl. Labour Commissioner 3) Joint Labour Commissioners 4) Deputy Labour Commissioners 5) Asst. Labour Commissioners 6) Labour Officers

2. Appellate Authority (under Section 17(3); Assistant Labour Commissioners in relation to plantations

3. Competent authority (Rule 2(b): Asst. Labour Commissioner in relation to plantation, Chief Inspector of Factories in relation to other establishments.

ANNEXURE 3: Circular to implement national maternity assistance scheme

No: MME:132:MMA:98 Office of the Government of Karnataka
MS Building, Bangalore, dated 7.9.1998

Circular
Sub: Simplified directions to implement National Maternity Assistance Scheme

Eligibility: Pregnant women who are 19 yrs and above, income limit as suggested by central government, should be members of the family below the poverty line. Such women should submit a form MB-1 to avail the facilities of this scheme. The annual income of the family of such women should be as recommended in IRDP, Rs.24,000 in urban areas and Rs.11,500 in the rural areas. The women should have lived in the scheduled district for not less than 3 years from the date of application. This facility is given for the first two children only.
Sum: The beneficiaries under this scheme will get Rs. 500/- from 1/8/98 onwards.
Procedure: The applicant should register her name in the nearby anganwadi. Within six months from the date of conception, she should fill up form MB-1 and submit it to the anganwadi worker. After receiving the form, the anganwadi worker should verify the income of the applicant's family, her caste and the number of years of her stay in that district. Such women should be considered as living below the poverty line if she has registered her name in the anganwadi centre. If not it could be verified by looking at the income of her family, ration card and the assets that her family owns. Later the application should be handed over to the respective ANM within a week's time. After receiving the application, the ANM should verify the number of children the women has given birth to and whether the pregnant woman has undergone the primary health check ups and then recommend the application to the CDPO within ten days. The CDPO should record all the applications in MB-2 and should record details of beneficiaries in MB-3.
Sanction and Distribution: CDPO should verify the details provided in the application as per the guidelines of this scheme and if it is found satisfactory should sanction the maternity assistance. The copies of the sanction order should be sent to District Commissioner, Assistant Director- Department of Women and Child Development and Medical Officers of the Taluk. In case the application is rejected, the scheduled application should be returned to the ANM with the reasons for rejection on it.

District Commissioner should send the sanctioned amount by cheque through the CDPO's office. The CDPO's office should disburse the sanctioned amount to the beneficiary through money order, cash, bank account or savings account in the post office. If the money is disbursed as cash, it should be done in public meetings primarily during gram sabhas in rural areas and in mohalla committee meetings in the urban areas.

(Geetha Ramesh),
Assistant Secretary to the government (Pr)
Department of Women and Child Development
Bangalore

ANNEXURE 4 A: Circular regarding supplementary nutrition under ICDS

Government of Karnataka

No: DWC:ICD:PRC:3:03-04:

Office of the Director
Department of Women and Child Development
MS Building, Bangalore –1 Date: 21.5.2003

Circular

Sub: To initiate supplementary nutrition programme under Integrated Child Development Scheme.

Note: 1. Government order no: MME 208 ICD 2001 Bangalore, dated 17-10-01 and amendment dated 30-11-2001

2. Official circular no: MMI:ICD:PRC:34:01-02: dated 10-12-01

3. Office letter no: DWC:ICD:PRC:4:2000-01 dated 13-2-2001 and 3-3-2001

4. Official circular no:DWC:ICD:PRC:34:1999-2000 dated 27-4-2001

Note 2, 3, 4 in the circular sent from this office regarding distribution of supplementary nutrition to all the beneficiaries under Integrated Child Development Scheme in the whole state. The following instructions have been incorporated by changing the previous instruction to be implemented in all the anganwadis in the state regarding the supplementary nutrition programme.

1. Six months to 3 year old children:
Six months to 3 year old children be given A.R.E.F six days in a week. 2 to 3 year old children present in the anganwadi to be given food prepared at the centre. (The incidental expense Rs.1.50)

2. For 3 to 6 year old children:
2 days in a week A.R.E.F
1 day egg / food made of rice
3 days food made of rice

3. Pregnant and lactating mothers:
A.R.E.F 2 days in a week, 4 days rice with green gram, which can be taken home.

4. Anganwadi worker and Anganwadi helper:-
Food prepared in anganwadi centre i.e., A.R.E.F 2 days.
1day boiled egg / food made of rice.
3 days food made of rice.
The food items should not be taken home.

5. 3rd to 4th grade children: 3 to 6 year old children
1. One portion of the food prepared in the anganwadi for all the children
2. One portion of A.R.E.F.

6 months to 3-year-old children:
One portion of A.R.E.F /one egg every day, if there is no egg then another portion of A.R.E.F.

To distribute 50% of A.R.E.F and 50% of green gram if the ration rice is not available (0.75 Paise A.R.E.F and 0.75 paise green gram). Green gram should not be purchased in larger quantity for any reason.

Centres where egg is not available, food made of rice should be given 4 days in a week.

The incidental expense of the food is Rs. 1.50. Upto Rs. 3/- for double food: can be spent.

If the incidental expenses are Rs. 2/- for children between 6 months to 3 years, Rs.1.50 should be spent from the state budget and 0.50 paise from P.M.G.Y. Expenses towards transport and fuel should be spent under contingency. It's been informed not to exceed incidental expenses for any reason.

Approved by Director

for the Director
Department of Women and Child Devpt

Copy of this has been sent to the following for their information and implementation:

1. To the Sub-Assistant Directors, Dept of Women and Child Development of all the districts
2. To all the Program Officers, ICDS program
3. To all the CDPOs
4. The Principal Secretary of all the Zilla Panchayats
5. To all the Nodal Officers, Central Office, Bangalore

ANNEXURE 4 B: Physical target for supplementary nutrition for pregnant women and mothers, ICDS

Sl No	District	March 2002						March 2003					
		PW (Target)	PW (Achievement)	%	NM (Target)	NM (Achievement)	%	PW (Target)	PW (Achievement)	%	NM (Target)	NM (Achievement)	%
1	Bagalkot	7458	6979	93.57	7496	7368	98.29	10339	8991	86.92	11568	9782	84.56
2	Bangalore (R)	8189	7681	93.79	9513	8918	93.74	8428	9455	112.2	9539	10722	112.40
3	Bangalore (U)	5368	5274	98.24	5944	5785	97.32	6026	6010	99.73	6317	6424	101.69
4	Belgaum	19129	16897	88.33	19028	16677	87.64	21322	19561	91.74	21659	19483	89.95
5	Bellary	6802	6710	98.64	6712	6666	99.31	9374	9765	104.2	9139	9330	102.08
6	Bidar	8705	6981	80.19	8732	7311	83.72	11757	9080	77.23	11585	9215	79.54
7	Bijapur	6476	5930	91.56	6623	6178	93.28	6797	6579	96.79	6895	6664	96.64
8	Chamrajnagar	6605	6419	97.18	6958	6526	93.79	6458	6354	98.38	6935	6178	89.08
9	Chickmagalur	4589	4630	100.8	4760	4805	100.94	5159	5085	98.56	4949	5370	108.50
10	Chitradurga	8265	8106	98.07	9153	8607	94.03	9416	8588	91.20	10239	9040	88.28
11	Dakshina Kannada	6806	7878	115.7	8301	8799	105.99	8634	8803	101.9	9544	9108	95.43
12	Davanagere	6647	6161	92.68	6701	6324	94.37	7240	6496	89.72	7009	6341	90.46
13	Dharwad	5606	5177	92.34	5454	5148	94.38	7159	6740	94.14	7188	6429	89.44
14	Gadag	6600	5694	86.27	6668	5827	87.38	6727	6514	96.83	6792	6498	95.67
15	Gulbarga	14386	12666	88.04	14282	12865	90.07	18431	15170	82.30	18484	15372	83.16
16	Hassan	8219	7829	95.25	8365	7829	93.59	8223	8039	97.76	8020	7794	97.18
17	Haveri	6913	6426	92.95	6552	6264	95.60	9685	8861	91.49	9744	8254	84.47
18	Kodagu	3373	3089	91.58	3587	3409	95.03	3533	3104	87.85	3477	3167	91.08
19	Kolar	13762	12849	93.36	14792	13608	91.99	13499	13872	102.9	14522	14733	101.45
20	Koppal	4651	4304	92.53	4676	4368	93.41	5966	5458	91.48	6138	5535	90.17
21	Mandya	9645	8819	91.43	9235	8484	91.86	9594	9154	95.41	9259	8935	96.50
22	Mysore	10833	9683	89.38	10631	9331	87.77	11058	9680	87.53	10762	9466	87.95
23	Raichur	6535	5994	91.72	6750	6016	89.12	7151	6856	95.87	7165	6987	97.51
24	Shimoga	5887	5083	86.34	5360	4374	81.60	7917	6804	85.94	6908	5513	79.80
25	Tumkur	11881	11299	95.10	13678	12873	94.11	11944	12697	106.3	13719	13298	96.93
26	Udupi	3860	4686	121.4	4710	5743	121.93	5144	5115	99.43	5836	5798	99.43
27	Uttar Kannada	5270	4928	93.51	5288	4914	92.92	5663	4980	87.93	5703	4670	81.88
28	Total	212460	198172	93.27	219949	205017	93.21	242644	227811	93.88	249095	230106	92.37

Source: Dept. of Women and Child Development PW: Pregnant Women NM: Nursing Mothers



Crèches and day care centres

Archana Mehendale

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1. Introduction

Traditionally, child bearing and child rearing have been considered to be primary responsibilities of the woman. In most patriarchal societies, there is a strong gender demarcation in roles performed and work assigned within the household. In the event that the mother is unable to look after her children, the responsibility is taken up by female members of the immediate family.

Women, all over the world, perform multiple roles in addition to their roles as mothers. With an increasing number of women seeking paid employment and leaving their homes for most part of the day, there is a growing need for child care services. In most Indian families, women struggle to balance their work and child care roles. This applies to women from all socio-economic strata, and barring a few who can hire personal child care services, most women have to face the nagging question of substitute child care while they are away at work.

As some research points out, exclusive maternal care became an option for a small privileged segment of society; but it gradually came to be labelled as a traditional and natural form of human child care, and all deviations from this were portrayed as unnatural and potentially dangerous (Lamb and Sternberg, 1992). In the Indian context too, the general reaction towards women who seek substitute child care is that of prejudice, leaving a sense of guilt amongst most working women who leave their children under someone else's care. Many a times, there is a tendency to romanticise the joint family system and view extra-domestic child care services as a western concept. This clearly shows a strong class bias and a lack of understanding of how poor families in rural and urban areas handle these issues (Swaminathan, 1998:27).

In India, the issue of providing universal child care services has not been addressed comprehensively. Questions about whose responsibility it is to care for the young child, what is the responsibility of society and what is the responsibility of the State are left unanswered. At present, women's needs in relation to child care are hardly attended to, except by the crèche programmes and the Integrated Child Development Scheme which between them cover an estimated 14% (Muralidharan and Kaul, 1993) to 19% (Kaul, 2002) of the pre-school child population in the country. This dismal coverage reflects that child care services have not received the attention from policy makers that they deserve.

Groups like FORCES, which is a network for crèches and child care services, have been advocating and lobbying for enhanced child care services at the national level. FORCES believes that a child deprived of critical inputs in the first few years of life weakens the foundation for the child's future growth and development. It also adversely affects the family and the community in the long run. Malnutrition that sets in between the ages of six months to two and a half years is most often caused not by lack of calories but by the lack of a caregiver with time to feed the child appropriately.

The chances of child survival increase with child care support services, and there is evidence that higher child survival leads to a lowered birth rate, increased productivity of women, improvement in economic status, better educational access and school achievement for girls. The network points out that **children below three years of age are relatively neglected in the early childhood programmes of the State**. Good child care is also endangered where families are stressed by work and economic pressures. It is therefore important to lobby for improved child care services for children in the country.

This thematic study looks at the provision of crèches and day care centres in Karnataka. It attempts to document the status of child care services in the state and is expected to serve as a reference tool for those interested in advocating and lobbying in this area. The first section highlights the importance of child care facilities such as crèches. The national and international policy proclamations related to crèches are presented in the second section. The third section elaborates on the different types of crèches, namely:

1. crèches set up using the grants-in-aid schemes of the central and state government
2. statutory crèches
3. crèches set up by voluntary organisations
4. crèches run on a commercial basis

The key issues and problems related to child care in general and the provisions of crèches in particular are discussed in the next section. The last section offers concluding remarks that could stimulate further research and action in this area.

2. The importance of crèches

Industrialisation accompanied by migration and urbanisation, has significantly changed the family structure and composition of Indian society. Extended families are on the decline. Nuclear and single parent families are becoming more and more common. While child care was not always a pressing issue in traditional joint families, it has always been an issue for most working couples from lower socio-economic strata of society.

To some extent, child care was a concurrent task with all the other daily chores related to home (Sriram, 1998). But with an increasing participation of women in the paid labour force, new demands for programmes of early childhood care have been created within all sections of Indian society. Changes in the nature of women's employment have had certain implications on child care as well. It is seen that industrial employment makes it more difficult to combine work and parenting roles than agrarian work. Even in the agricultural sector, with an increasing number of women working as wage labourers, carrying along young children to work is becoming more and more difficult. **The overall separation of work and home has adversely impacted child care within the household.**

For many women, giving up work in order to look after children is not an option and children have to be left behind, irrespective of the availability of child care services. Working is the only way to ensure the survival of the family.

Studies on poor rural women show that only a small percentage of women do not take up work due to conflict between economic activities and child care. **Data shows that the number of women in the unorganised sector is increasing, and one-third of all households in the country are headed by women. For these women, child care services are not easily available or often unaffordable.** The responsibility of child care then falls on the shoulders of the elder sibling, very often the older girl child. Research shows that children in the age group of 6-14 years, especially girls, are deprived of schooling because of caring for younger children (Arulraj and Samuel, 1995).

Crèches and childcare services are thus an essential facility for the children of working mothers, both as a support service for working women and as a strategy for the protection, care, and healthy, all-round development of young children. With the human rights discourse gaining ground, child care services are viewed as an intersection of women's rights and children's rights. **Crèches and day care centres are seen as strategies which will ensure the right of the woman to work and the right to survival, growth and development of the child.** The care of the young child is no longer a private, family matter of adjustments but a crucial social need.

With the onset of globalisation and the State withdrawing itself from performing its basic welfare functions, the magnitude of the need has not fully registered. Moreover, since it challenges the conventional norms about child care and the role of the woman, the need for child care services is met with apathy or indifference.

Providing substitute care of children is intrinsically linked to women's development and empowerment processes. Yet available data shows that no institutional care exists for nearly 235 lakh pre-school children of working mothers (NIPCCD, 1978). Between 1996-97, there were only 14,313 centres in India providing crèche and day care services for children below five years. Earlier studies have shown that in the absence of child care support, children are left to look after themselves. About 42.4% of families leave their children unattended and around 28.8% carry them to work (NIPCCD, 1978). Among migrant women in Delhi, it was reported that as many as 78% had no other help for their children and 40% had to leave their child unattended (D'Souza, 1979). However, the government estimates on the number of children left unattended are much lower. Official data collected from lower class working women indicates that while the major caretakers are mostly mothers, their grandparents, and other relatives; the incidence of children left unattended in urban areas varies from 1.9% male and 2.16% females under one year to 11.4% males and 11.5% females at six years, with a similar trend in rural areas (Government of India, 1985). This data must be read with caution since it departs significantly from the trends observed in other studies. Forty percent of women stated that lack of child care was a constraint to employment (Sriram, 1994).

Child care outside the home, by people other than parents, has proliferated because of the need to release parents for economic roles. Support for child care is a must in helping women forward their own interests as well as that of their children; and allowing them to be released from the vicious cycle of poverty. The following sections present the government policies with respect to child care services in India.

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Box 1: Crèches in India: A timeline of progress

Period 1965-75

- Schemes launched for the provision of day care centres and statutory obligation to provide crèches extended to women in the unorganised sector. The difficulties faced by working women in the absence of day care centres was first noted.
- Beedi and Cigar Workers Act, 1966, Contract Labour Act 1970, Hostels for Working Women with Day Care centres in 1973. Central Social Welfare Board's scheme for crèches in 1974-75

Period 1975-84

- Setting up of child care centres as a part of the Minimum Needs Programme was recommended. Planning Commission Report of Working Group on Employment of Women.
- The Committee for the Status of Women in India (1974) recognised that day care services as a pre-requisite for women's development was inadequately perceived.

Period 1985-1994

- The National Crèche Fund to support the voluntary sector was started in 1994 even though a Working Group of the Planning Commission had already provided guidelines for crèche operations as far back as 1972.

Source: Swaminathan, M. (1998)

3. Important policy declarations related to Crèches

Policy directives on the provision of child care services present a mixed picture. The lines between early childhood care and pre-school education are blurred. Early Childhood Care and Early Childhood Education are sometimes viewed synonymously, and at other times, complementary to one another. The two are rarely viewed by themselves. However, the importance of child care and the role of the State in providing child care support and services has been recognised in several legal documents.

3.1. Article 45, directive principles of state policy, constitution of India

The Constitution of India, subsequent to the 86th amendment, does not recognise the fundamental right to education as applicable to children below six years of age. However, Article 45 says that the State shall endeavour to provide early childhood care and education to all children until they complete the age of six years. This provision which appears in the Directive Principles of State Policy is expected to guide the formulation of policies and programmes. There is a significant departure here from the pre-amendment provision. Prior to the amendment, early childhood care was not recognised within Article 45 and the reference was merely made to education of children below six years. While re-wording the provision for the amendment, the idea of the State endeavouring to provide early childhood care (along with early childhood education) has secured a place in the Constitution.

3.2. The United Nations Convention on the Rights of the Child, 1989

The United Nations Convention on the Rights of the Child, which is an international law ratified by India, also emphasises the role of the State in supporting child care functions of the family. Article 18 recognises the principle that both parents have a common responsibility for the upbringing and development of the child. Furthermore, ensuring the best interests of the child should be their basic concern. For the purposes of guaranteeing and promoting child rights and interests, the Article states that 'States Parties shall render appropriate assistance to parents and legal guardians in the performing of their child rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of the children'. It continues by referring to the State's obligations towards children of working parents; 'States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child care services and facilities for which they are eligible'. It is important to note that firstly, this entitlement is broadly worded with phrases such as 'appropriate assistance' and 'child rearing responsibilities'. Secondly, it refers to the State's obligation towards the working parents and not working mothers. This gender neutral criteria is not reflected in the case of Indian statutes (see section on statutory crèches in this paper). Thirdly, it leaves the clause of eligibility loose-ended and does not restrict the right to parents belonging to a particular socio-economic stratum.

Box 2: Incentives for crèches

As a fiscal incentive for women and child welfare, full deduction from income tax has been granted by the central government on payments to projects engaged in establishing and running educational institutions and hospitals in rural areas for women and children, and for crèches and schools for children of workers employed in factories or at project sites.

Source: http://www.bharatguru.co./Newbuzz/watch/achievements.htm accessed on 12 Feb 2004.

3.3. The National Policy for Children, 1974

The first official reference to crèche and day care facilities was made in the National Policy for Children in 1974 where it resolved that '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. Although the specific policy measures did not mention provision of child care services, the **'priorities in programme formulation'** pronounced within the policy stated that **while formulating programmes in different sectors, priority shall be given to programmes related to crèches and other facilities for the care of children of working or ailing mothers.** As a direct consequence, grant-in-aid schemes for crèches and day care were launched by the central government (discussed in the following section on Crèches under Grants-in-Aid).

3.4. The National Policy on Education, 1986

The linkages between early childhood care and early childhood education were first recognised in the National Policy on Education in 1986 and reiterated in the Plan of Action, 1992. It stated, 'day care will be provided as a support service for the universalisation of primary education to enable girls engaged in taking care of siblings to attend school and as a support service to working women belonging to poorer sections. Full integration of child care and pre-primary education will be brought about, both as a feeder and a strengthening factor for primary education and for human resource development in general'. This reference continues to be the only one which so cogently emphasises the importance of child care facilities from the perspective of early childhood development, girls' education as well as a support for working women.

These linkages between the components of care and education have got reinforced even subsequently under various international commitments. The Framework of Action adopted in the Dakar Conference of the World Education Forum, 2000, to which India was a party, identifies six goals, one of them being 'expanding and improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children'. Subsequently, India charted out national goals corresponding to the six Dakar goals. The universalisation of the Integrated Child Development Scheme (ICDS) with an early childhood care and education component is one of the goals adopted. Even the Ninth Five Year Plan had stated that there is an urgent need for crèches and day care services as a support to women and young children.

Like most welfare goals, there is a wide gap between intent and actual operationalisation of the intent. While the goals and commitments towards early childhood care appear to be in place, they have not been supported with adequate programmes in terms of both the quality and quantity of schemes for providing child care facilities. Although the Convention on the Rights of the Child purports a 'first call to children' while allocating resources, the ground realities show that children in general and child care in particular is hardly a priority. This gap at the level of programme definition and resource allocation is further broadened at the level of programme implementation. The following section presents the available range of child care services and brings out the inadequacies in their design and coverage.

4. Crèches in India

Pre-school centres and balwadis are also referred to as crèches in government parlance. This distorts estimates on the number of crèches that serve as child care support to children below six years of age. According to Government of India (Programme of Action, National Policy on Education, 1992, the Ministry of Human Resources Development) there were 12,470 crèches in 1991-92 serving about 3 lakh children in India.

These figures, which include both statutory and voluntary crèches, neither specify the number of children in each group nor do they give the number of working mothers who have benefited from them. Another national estimate (Swaminathan, 1991) indicates that about 2.5 lakh children are found in 10,000 crèches in the voluntary sector and only about 50,000 children are in crèches in the statutory sector. The table below shows that the actual coverage of these schemes is very little.

Table 1: Status of child care facilities in India in 1996-97

Provision	Number of centres	Number of beneficiaries (in millions)
Crèches and day care centres (0-5 years)	14,313	0.342
Statutory crèches (0-6 years)	5000 (approx.)	0.050 (approx.)

Source: Kaul, 1998

Although these figures may not be highly accurate due to reasons such as poor record keeping, and ambiguity in defining crèches as distinct from pre-schools, they indicate that efforts to provide child care services are far short of the existing need.

Another important aspect to be noted is that day care was not originally a component of the Integrated Child Development Scheme. The National Policy on Education and the Plan of Action stated that a fixed number of Anganwadis (25%) would be turned into Anganwadi-cum- crèches by year 2000. Till the end of 1996, only 659 Anganwadi-cum-crèches had been approved for the entire country, although 25% would imply 100,000 centres.

5. Crèches in Karnataka

There are several types of crèches in Karnataka: those set up by organisations with grants received from the central and state government; crèches set up under various labour legislation for the benefit of women employees; there are some set up by voluntary organisations with funding received from private donor agencies; and there are crèches set up on commercial lines. These categories may appear broad and reaching out to a large segment of the deserving population. This section discusses in detail the following types of crèches.

1) Grant-in-aid crèches: This category covers crèches set up under:

- **Central Scheme for Assistance for Working and Ailing Mothers:** implemented by two agencies in Karnataka, the Karnataka State Social Welfare Advisory Board and the Karnataka State Council for Child Welfare (407 and 50 crèches respectively)
- **National Crèche Fund**: a central government scheme implemented by various voluntary organisations in Karnataka (93 crèches are run under this category).
- **Karnataka Government Scheme of Assistance to voluntary organisations for crèches for working women's children** (193 crèches are run under this scheme).

2) Statutory Crèches set up under various labour legislations eg. plantations, mines, factories (550 creches have been set up in factories)
3) Crèches run by voluntary organisations
4) Commercially run crèches

The section looks at the coverage, allocations and implementation of these services.

5.1. Grant-in-aid crèches

Grant-in-aid crèches are those set up by organisations with grants from the central and state government. As noted above, the national coverage is much lower than the need and there are only 13,700 crèches (12,500 under the Scheme for Assistance to working and ailing mothers and 1200 under the National Crèche Fund) catering to about 3,50,000 children throughout the country. In Karnataka there are approximately 742 grant-in-aid crèches reaching out to 18,550 children below six years of age. Let us look at the provisions of these schemes and their implementation in Karnataka.

5.1.1. Central Scheme for Assistance for Working and Ailing Mothers

The Scheme for Assistance for Working and Ailing Mothers is a central government scheme formulated in 1975 after crèches got identified as a priority area of action under the National Policy for Children, 1974. It is also referred to as the Scheme of running Crèches/Day Care Centres.

5.1.1.1. Description of the scheme

The scheme aims to provide day care services for the children (0-5 years) of mainly casual, migrant, agricultural and construction labourers. The children of those women who are sick or incapacitated due to sickness or suffering from communicable diseases are also covered under the scheme. One crèche centre is expected to run for 25 children of working and ailing mothers. Most crèches operate from 9 a.m. to about 4.30 p.m. The scheme lays down that the crèche must function for at least five hours. The children take rest, and are provided basic recreational and educational material. Cradles and mats are provided for the care of young infants.

Allocations

A small amount of Rs. 1.05 per child per day is provided under this scheme. Each centre is given Rs. 18,480 per year as a recurring expenditure for providing sleeping facilities, health care, supplementary nutrition and immunisation. An amount of Rs. 4000 is provided for non-recurring expenses. After every five years, Rs. 2000 is given as a replenishment grant for each crèche. The budgetary break-up is as follows:

Procedures followed by KSSWAB

Any organisation which has a minimum work experience of three years in child welfare can apply for grants with its annual reports and an audited statement of accounts. The District member/representative of the Board forwards the proposal. The field officers of the Board make a visit and file an appraisal report which is then taken up for discussion at the State Board meeting. If the proposal is approved by the State Board, it is then sent to the Central Social Welfare Advisory Board for its final acceptance. **For the last ten years, no additional crèches have been sanctioned.**

The amount is disbursed to the organisations in three instalments. The first instalment is given after the proposal is sanctioned by the Board, the second instalment is given after the field officer files his appraisal report, and the third instalment is extended after the organisation sends its audited statement of accounts. One organisation may apply for running more than two crèches. In such cases, the proposal has to be presented to and sanctioned by the Central Social Welfare Board.

Monitoring by KSSWAB

The implementation of this scheme is monitored by field officers of the Board. There are eight field officers who are responsible for 4-5 districts each. They are expected to make at least one annual visit to the crèches covered in their respective districts and file a report with the Board. Inspections carried out give the following details: location of the crèche, number of children enrolled according to sex and social group, number of children present on the day of the visit and on an average during the last three months, age of the children, staff employed, their qualifications, training, honorarium paid, presence of crèche workers, working hours of the centre, whether supplementary nutrition is provided, accommodation, equipment for kitchen, sleeping, recreation, education, grants received, health check ups by the Primary Health Centre doctor, medical register, records maintained, opinion about the performance of the crèche by the local panchayat, school head master or community leader. General remarks, suggestions. Copies of these reports are sent to the CSWB and the State Social Welfare Advisory Board.

Problems and complaints

According to one of the field officers, the most common complaints **relate to the poor quality and inadequacy of food since the budget provides a very small amount of funds.** Sometimes, there is a considerable gap between children registered with the crèche and those who actually attend the crèche. This may happen because the scheme does not allow the centres to function for less than 25 children. Thus, there is a tendency to over-register in order to ensure that the crèche survives.

The crèche workers are also expected to be given training once in two years by the Board. These training programmes have not been conducted for several years due to lack of funds. The budget provides Rs. 1000 per trainee for a training of forty days. This includes the training costs as well as their lodging, boarding and other incidental expenses. While this amount is not sufficient for organising a 40 day training programme, the Board has not even attempted to organise training for a shorter duration.

5.1.1.3.2. Implementation by the Karnataka State Council for Child Welfare (KSSCW)

Since the last 22 years, the Karnataka State Council for Child Welfare has been running crèches throughout the state. Each crèche caters to 25 to 30 children between two and a half and five years. Each crèche has a teacher and an assistant to run the pre-school education programme and to provide mid-day meals. Parents' meetings and health check-ups are conducted regularly. The crèche teachers are also given in-service training. The crèches are open between 9-9.30 a.m. to 4-4.30 p.m. so that they coincide with the working hours of the mothers.

Coverage of the scheme

At present, the KSSCW runs 50 crèches in Karnataka with the grants-in-aid routed through the Indian Council for Child Welfare. The geographical spread of these crèches is as follows.

Table 4: Crèches run by KSCCW in Karnataka

District	Number of centres
Bangalore	21
Dharwad	10
Chikmagalur	2
Davangere	5
Bagalkot	3
Tumkur	6
Kolar	2
Kudligi	1
Total	**50**

As the table above indicates, more than half of the total crèches are located in Bangalore and Dharwad districts of the state.

Problems and complaints

The main problem faced by the Council is lack of funds for buying toys and other equipment. Teachers are unwilling to work for low salaries and often join NGOs where they receive higher salaries. The salaries paid to the teachers and assistants are very low. As per the programme, the teacher is to be paid Rs. 500 per month and the assistant is to be paid Rs. 300 per month. The Council has raised additional resources on its own to enhance the honorarium given to the staff. The scheme does not provide funds for travel, rent or other programmes. In rural areas, the crèches are mostly run in community owned spaces; but in urban areas, it becomes difficult to find space and pay a high rent for running the crèches.

5.1.1.4. Critique of the scheme

This central scheme was the first direct step undertaken by the Government after adopting the National Policy for Children that identified crèches as one of the strong needs. But since its inception, nothing has changed in the overall framework of the scheme as well as its implementation.

The Parliamentary Committee on Human Resources Development, 2001, had noted that **during 1999-2000, the budgetary provision of Rs. 20.50 crore was reduced to Rs. 17.00 crore at the revised estimates stage keeping in view the unspent balances available with the implementing agencies** as on 1.4.99 out of the earlier releases. Expenditure incurred up to 31.1.2000 by the agencies was only Rs. 5.58 crore. The Committee also stated, 'the very fact that unspent balances are lying with the implementing agencies indicates that this scheme is not being implemented properly... the maximum number of crèches are being run by the two national level voluntary organisations and maximum grants are also being released to them. Both these voluntary organisations are Delhi based. The Committee fails to understand the inability of the Department to prevail upon these two voluntary organisations and other smaller ones too to utilise the funds allocated to them within the prescribed time limit and thus successfully implement the scheme. What is more worrying is that there has been no increase in the number of crèches, i.e.12,470 continues since the 8th Plan. The Committee, therefore, is of the strong view that there is need for review and revamping of this scheme. The Department should initiate corrective measures, without any delay'.

The issue of under-utilisation of allocated funds is a complex matter and the reasons for this need to be studied. The amount sanctioned by the scheme is extremely meagre for running crèches of a decent quality. Voluntary organisations are required to meet the additional expenses, which the scheme lays down to be 10 per cent. The question one needs to ask is whether voluntary organisations can run crèches with such a meagre grant. It is very likely that organisations who are not able to raise the remaining amount (which in practice is more than 10%) do not avail of these grants. The funds lying under-utilised are officially seen to reflect either a lack of need for crèches or a lack of capacity among organisations to utilise the grants. This results in a lowered budgetary allocation such as that recommended by the Parliamentary Committee, and pushes the allocations for such services on a downward spiral.

5.1.2. National Crèche Fund

In the early '90s, FORCES and some other social groups lobbied at the national level and got the government to form a separate fund to support the crèche programmes throughout the country. The National Crèche Fund (NCF) was thus set up in 1994 with a grant of Rs. 19.9 crore given to the NCF corpus. The scheme for administration of the National Crèche Fund is called the National Crèche Funds Scheme, 1994.

Objectives of the scheme

The Fund was set up under section 4 and 5 of the Charitable Endowments Act, 1890, for achieving the following objectives:

1. to administer grant-in-aid programmes for voluntary organisations, mahila mandals and State Governments to implement the crèche programmes especially in rural areas and slums for the welfare and development of children below the age of five years whose parents' income does not exceed Rs. 1800 per month; children of agricultural labourers, Scheduled Castes and Scheduled Tribes, and of women employed in employment generating schemes, and persons who were victims of communal violence
2. to convert some of the Anganwadis into Anganwadi-cum-crèches
3. to organise programmes for training/refresher courses for crèche workers through specialised training institutions
4. to take up activities which promote the above objectives

Eligibility

Voluntary organisations and mahila mandals registered as a society or trust for at least two years and with a known record of child welfare services are eligible for applying. Programmes that are eligible for assistance under various labour laws cannot qualify for financial assistance under the National Crèche Fund scheme.

Allocations

Grants are given to two types of crèches – the general crèches and anganwadi-cum-crèche centres. Financial assistance of Rs. 18,480 per crèche per annum for voluntary organisations and mahila mandals for general crèche centre; and Rs. 8,100 per centre per annum for an anganwadi-cum-crèche is provided. The initial cost of establishing a crèche is provided as a one time non-recurring grant of Rs. 4000.

For the **General Category Crèches,** the recurring grant includes the following: Honorarium for two crèche workers is Rs. 800 per month, provided entirely through grants. The ceiling for supplementary nutrition is Rs. 687 per month; of which 90% i.e. Rs. 615 is given as grants. This is Rs. 1.05 per child for 25 children for 26 days.
The ceiling of expenditure for contingencies and emergency medicines is Rs. 139 per month of which 90% i.e. Rs. 125 is given as grants.

The government assistance for crèches opened under the general category is limited to 90% of the schematic pattern (except honorarium of crèche worker) or the actual expenditure, whichever is less, and the remaining expenditure has to be borne by the organisation/mahila mandal concerned. A non-recurring grant of Rs. 4,000 is given to meet the initial cost of establishing the crèche. Crèches opened under the general category are required to provide day care facilities, nutrition, pre-school education, entertainment and medical facilities, and they are expected to work for eight hours per day.

The **anganwadi-cum-crèche** is managed by agencies that operate the ICDS, i.e. the Department of Women and Child Development. Assistance for an anganwadi-cum-crèche includes an honorarium of Rs. 600 per crèche for one crèche worker. An amount of Rs. 75 per month is allocated for contingencies and emergency medicines. An initial cost of establishing the crèche is to be met with Rs. 4000 which is given as a non-recurring grant.

In the case of the anganwadi-cum-crèche centre, 100% financial assistance is provided to the concerned agency. The existing anganwadi-cum-crèche centres presently working for four hours are expected to work for eight hours. Additional workers are expected to be provided for running the anganwadi centre for the remaining four hours. In Karnataka, **no anganwadi has been converted into a crèche even when the State Scheme provides grants for the same. It may be noted that anganwadis in Tamil Nadu and Kerala function for six to eight hours, thus providing child care services to the immediate community.**

Training of crèche workers is also provided under the NCF. For 40 crèche workers, an amount of Rs. 25,200 is provided. However, **no data is available with the State Government on the kind of training programmes held under this scheme so far.**

Management of the scheme

The NCF scheme extends to the entire country except the state of Jammu and Kashmir. The Board of Management of the NCF is constituted by: Chairman who is the Minister of State for Women and Child Development; a Working Chairman who is the Secretary, Department of Women and Child Development; and other member who are the Joint Secretary in charge of Nutrition and Child Development; Joint Secretary, Department of Expenditure, Ministry of Finance; Director, National Institute for Public Co-operation and Child Development; Executive Director, Central Social Welfare Board. The Deputy Secretary/Director of the Department of Women and Child Development, in charge of the Crèche Scheme, is the Member-Secretary of the Board. There is no parallel administrative structure at the State level and it is the Central Board that has all the grant-making powers.

Applications are sent by voluntary organisations/mahila mandals to the Department of Women and Child Development (DWCD), Karnataka State Government. This department forwards them to the NCF Board that finally approves the applications. The DWCD at the State level is not involved in monitoring the scheme. The State DWCD official says that the Department is not always informed about the sanctioned crèches in the State.

Communication between the NCF and the State DWCD is sporadic and not formally established. The NCF Board also has the powers to withhold, reduce or stop the grants being made.

Coverage

The grants are provided largely out of the interest accrued on the corpus of the Fund and partially out of a small portion of the corpus fund. In 1995-96, the Fund had assisted 1856 general crèches and 599 anganwadi-cum-crèche centres in the country. During 1999-2000, the number of crèches supported and the quantum of assistance remained the same. In 2002, 3114 crèches received grants under the NCF throughout India.

In Karnataka, the Fund presently supports 93 crèches. The voluntary organisations receiving these grants come from the following districts (figures in brackets indicate number of crèches); Mandya (16), Davangere (20), Belgaum (33), Kolar (5), Bagalkot (3), Dharwad (3), Bijapur (7), Koppal (2), Chikmagalur (2), Bangalore (2). These organisations receive grants directly from the NCF and hence no information is available with the state government about these organisations and their beneficiaries.

Critique of the scheme

Since its inception, the number of crèches supported has grown marginally but the amount sanctioned has remained the same. **There have been several proposals, both from the government and groups such as FORCES, to increase the corpus amount.** One suggestion is that the contributions from the government to the Fund should be one per cent of the Gross National Product. But this has not been taken seriously. The Parliamentary Committee under the Department of Human Resources Development wrote in its 2001 report, 'this Committee is perturbed to note that a proposal to increase the corpus amount has not yet been approved and only token provisions are being made during the last several years. The Department informed that an amount of Rs. 20.00 crore for National Crèche Fund was proposed for the year 2000-2001. However, due to paucity of funds only a token provision of Rs. 1.00 lakh has been provided and efforts would be made to consider enhancement at a later stage. The Committee emphasises that concerted efforts should be made to finalise the proposal regarding enhancement of corpus amount under the National Crèche Fund'. These observations reflect the fact that the government accords a low priority to the provision of crèches, despite an increasing need felt by a cross section of the Indian population.

5.1.3. Karnataka Government Scheme of Assistance to Voluntary Organisations for Crèches for Working Women's Children.

This scheme was initiated with a view to cater to the needs of children below three years of age since children between 3-6 years are taken care of in balwadis or anganwadis. The scheme is meant to address the various issues pertaining to the welfare of the very young child, siblings, as well as the working mother.

It outlines its purpose as follows: to provide for a better and safe environment for young children, to ensure their healthy growth and thereby a lower mortality rate, to free the older siblings from their child care responsibilities so that they can attend school, and to allow the mothers to work without having to take their children to the work spot. Given the fact that child care services for children under three are extremely sparse, this scheme holds great potential of filling in the void.

Eligibility

Any voluntary organisation which is registered under the Societies Registration Act, 1980, and which has a properly constituted managing body with their powers, duties and responsibilities clearly defined in a written constitution can apply. It should have facilities, resources, experience and personnel to initiate and execute the scheme. They should provide a building with a big hall, kitchen, bathroom and toilet and enough space outside for children to play. It should not run for profit to any individual or a body of individuals.

Nature of assistance

Two types of assistance are provided under the scheme:

Class 1- Is for women who have no assistance at home and who belong to the lower working status with monthly income of the family not exceeding Rs. 300 per month in cities and Rs. 250 per month in rural areas.

Class 2- Is for children between 3-5 years, of working women who have no assistance at home, who belong to middle income groups with a monthly family income not exceeding Rs. 750 in cities and Rs. 300 in rural areas. The inclusion of this category of children (between 3-5 years) does not fit into the very young child-focus expressed in the purpose of the scheme.

Extent of assistance

Government assistance is limited and is expected to help the voluntary organisations to initiate the programme. Subsequently, voluntary contributions are expected to increase and form a substantial portion of the budgetary requirements of the organisations. In the case of Class 1 crèches, government assistance is limited to 90% of the expenditure of the schematic pattern and the remaining 10% is to be borne by the organisation concerned. In the case of Class 2 crèches, government assistance covers only the non-recurring equipment cost and recurring cost of remuneration of helpers and supervisors. The voluntary organisation is entitled to collect maintenance charges of Rs. 20 per child in rural areas and Rs. 30 per child in cities.

The grant is paid in two instalments. After submitting the accounts of the first instalment and an inspection from the department, the second instalment is released.

These organisations are supposed to be open for inspection by any officer of the Department of Women and Child Development. The equipment is to be used for the specified purposes only. If not, the payment of grant can be stopped and earlier grants can be recovered by the Department.

If any equipment/asset is to be disposed off, prior sanction of the department is mandatory. The scheme states that the organisation must exercise reasonable economy in the working of the approved crèches.

Schematic pattern

The scheme lays down certain basic conditions that must be provided in these centres and calls it the 'schematic pattern'. The crèches for babies (0-3) years should provide nursery (play), sleeping facilities, health care, supplementary nutrition, immunisation for 25 babies from 8 a.m. to 5 p.m. or 9 a.m. to 6 p.m. The crèche should provide cradles, and beds for sleeping. It should provide facilities for health care, sanitation and nutrition. The children have to be bathed and dressed. The nursery should have good play materials. The supervisor should encourage children to play, teach good habits. A first aid kit should be available at the crèche. The crèche should arrange and insist on weekly visits by the doctors from the Primary Health Centre. Children from all castes should be allowed to mix well. Daily visits must be made by the Health Visitor or the Auxiliary Nurse-cum-Midwife. Growth charts and health records must be maintained for all children.

Recurring expenditure

The scheme gives the following break-up for the recurring expenditure. One Supervisor on a consolidated salary of Rs. 200 per month; two helpers on a consolidated salary of Rs. 90 per month each; contingencies such as soaps, oil, brooms, fuels etc. are Rs 25 per month; and medicines are Rs 25 per month. Supplementary nutrition is provided at the rate of Rs. 1.25 per child per day for 300 days for 25 children. Non-recurring expenses such as cradles, cupboards, glasses and plates, stove, containers, buckets, mats, toys, first aid box, etc. are Rs. 2,930. The amount sanctioned per year is Rs. 14,535; and Rs. 2,930 for non-recurring expenses.

The scheme also suggests the diet schedule of children. For children below five months, milk is to be provided at three hours intervals. There is no mention of breast-feeding.
For children between 5 to 10 months; mixed cereal porridge, vegetable juice, and milk are to be given. For children between 10 to 18 months; milk, *khichdi* with green leafy vegetables, and porridge are given; and for children between 18 to 30 months; milk, rice, *dal*, vegetables, porridge, sprouts, and seasonal fruits are to be provided.

Coverage

The coverage of this scheme is presented in Table 5.

Table 5: Number of crèches under the state scheme for assistance to working and ailing mothers in Karnataka

	District	**2001-2002**	**2002-2003**
1.	Bangalore	7	11
2.	Bangalore Rural	6	7
3.	Bijapur	10	-
4.	Bellary	5	3
5.	Belgaum	17	10
6.	Bidar	30	-
7.	Bagalkot	4	4
8.	Chamrajnagar	2	2
9.	Chitradurga	7	10
10.	Davangere	14	29
11.	Dharwad	2	2
12.	Gadag	4	13
13.	Hassan	3	3
14.	Haveri	4	17
15.	Kolar	16	-
16.	Karwar	7	-
17.	Koppal	18	28
18.	Mysore	3	3
19.	Mandya	9	-
20.	Raichur	36	36
21.	Shimoga	4	-
22.	Tumkur	8	11
23.	Gulbarga	13	-
24.	Chikmagalur	8	-
25.	Udupi	NA	3
26.	Dakshina Kannada	NA	-
27.	Kodagu	NA	-
	State	**237**	**192**

Source: File records at the Department of Women and Child Development, Govt. of Karnataka. Data for all the districts is not available. NA indicates that data is not available. - indicates that no crèche facilities exist under the State Scheme.

The table indicates that **the number of crèches supported under this state scheme has dropped from 237 in 2001-2002 to 192 in 2002-2003**. Districts such as Bijapur, Bidar, Kolar, Karwar, Mandya, Shimoga, Gulbarga and Chikmagalur were the worst affected. While 97 crèches were supported in these districts during 2001-2002, no crèches were supported the following year i.e. in 2002-2003 in these districts. In Belgaum and Bellary, the number of crèches receiving grants has also reduced.

No information is available regarding the reasons for stopping aid and its impact on the former beneficiaries. Districts such as Bangalore, Bangalore Rural, Chitradurga, Davangere, Gadag, Haveri, Koppal, Tumkur and Udupi had more crèches supported during 2002-2003 than the previous year. **These fluctuations are serious, particularly as the total number of crèches supported under this scheme is extremely low.**

Table 6: State scheme on crèches, 2002-03

	District	Total crèches	Total Children	Children belonging to			
				SC	ST	Minorities	Others
1.	Bangalore	11	275	123	22	93	37
2.	Bangalore Rural	7	175				
3.	Bellary	3	75	7	27	27	15
4.	Belgaum	10	250	53	36	49	112
5.	Bijapur	-	-	-	-	-	-
6.	Bidar	-	-	-	-	-	-
7.	Bagalkot	4	200				
8.	Chitradurga	10	251	41	36	105	69
9.	Chikmagalur	-	-	-	-	-	-
10.	Chamarajanagar	2	50	10	2	-	38
11.	Dharwad	2	50	5	2	11	32
12.	Davangere	29	725	140	68	74	443
13.	Gulbarga	-	-	-	-	-	-
14.	Gadag	13	326	97	9	63	117
15.	Hassan	3	75	2	2	49	22
16.	Haveri	17	425	150	115	65	95
17.	Karwar	-	-	-	-	-	-
18.	Kolar	-	-	-	-	-	-
19.	Kodagu	-	-	-	-	-	-
20.	Koppal	28	700	95	79	63	463
21.	Mandya	-	-	-	-	-	-
22.	Mysore	3	75	18	12	5	40
23.	Dakshina Kannada	-	-	-	-	-	-
24.	Raichur	36	805	224	140	175	230
25.	Shimoga	-	-	-	-	-	-
26.	Tumkur	11	278	45	45	94	94
27.	Udupi	3	67	28	-	-	39
	State	192	4,802	1038*	595*	873*	1846*

* does not include children from Bangalore Rural and Bagalkot where the community-wise break-up is not available. – indicates that no crèche facility exists under this scheme.
Source: Computed from the file records of the Department of Women and Child Development.

Details about the beneficiaries are shown in the above table. The 192 state government supported crèches reached out to a total of 4,802 children in Karnataka in 2002-2003. The highest number of child beneficiaries are in Raichur, Davangere and Koppal which also have the highest number of grant-in-aid crèches. **There are 10 districts where no crèche facilities exist under this scheme at all.** Children from 'other' communities were the largest constituency of beneficiaries (1846 children) followed by children from Scheduled Castes (1038 children). Children from Scheduled Tribes (595) and Minorities (893) are relatively smaller sub-groups. **This raises questions about whether the scheme is actually reaching out to those who are most deserving.** The distribution among social groups is most skewed among crèches run in Davangere and Koppal.

Table 7: State scheme for crèches: expenditure in 2002-03

District	Amount released (in lakhs)	Expenditure (in lakhs)
Bangalore	3.77	3.77
Bangalore Rural	1.46	1.46
Bellary	1.23	1.07
Belgaum	1.72	1.72
Bijapur	-	-
Bidar	-	-
Bagalkot	0.81	0.55
Chitradurga	1.64	1.64
Chikmagalur	-	-
Chamarajanagar	0.46	0.46
Dharwad	0.94	0.94
Davangere	2.86	2.34
Gulbarga	-	-
Gadag	4.83	4.83
Hassan	0.12	0.11
Haveri	0.95	0.95
Karwar	-	-
Kolar	-	-
Kodagu	0.14	-
Koppal	11.77	10.63
Mandya	-	-
Mysore	0.24	0.24
Dakshina Kannada	-	-
Raichur	12.83	12.83
Shimoga	-	-
Tumkur	13.32	13.32
Udupi	0.44	0.11
State	**59.53**	**56.97**

The table indicates the amount of money released and its utilisation by various districts during 2002-2003. Of the Rs. 59.53 lakhs released for the entire state, Rs. 56.97 was actually utilised and Rs. 2.56 lakhs was left unspent. The amount sanctioned to the crèches is extremely inadequate if the crèches were to implement the entire schematic pattern prescribed. But it is ironical that some crèches have not been able to utilise even this paltry amount. In a way, this reflects the poor quality of crèche services offered to young children, especially from poor families who do not have much choice. Districts such as Bellary, Koppal, Bagalkot, Davangere and Udupi have been unable to spend a part of the grant released while Kodagu has not spent any part of the grant received.

Implementation of the scheme

This scheme is implemented through the Zilla Panchayat (ZP). Proposals to set up crèches under this scheme are sent to the Taluka Panchayats who in turn forward them to the ZP. The Child Development Project Officer (CDPO) conducts an inspection and scrutinises the agency making the proposal. S/he then files an inspection report with the ZP who finally decides who should receive the grants. This is a decentralised scheme and the sanctioned amount is released directly by the State to the ZP. The State officials claim that they know very little about the scheme and its day-to-day functioning since it is completely handled by the ZP. Even when the CDPOs carry out routine monitoring of crèches, the reports are filed with the Deputy Directors of the Department of Women and Child Development at the District level. The CDPOs normally check the attendance register maintained at the crèche. Whenever there are less than 25 children enrolled, there is a pro-rata deduction in the grant released. At least two detailed inspections per year are mandatory by CDPOs, following which grants are released in two instalments.

5.2. Statutory crèches

Statutory crèches are the oldest type of crèches in existence. They refer to crèches that are set up under various statutes by employers of working women. Before looking into the various statutes and their provisions with respect to crèches with particular reference to Karnataka, it is important to note some of the key aspects related to these kind of crèches.

- Firstly, crèches of these kind are set up by the employers primarily to fulfil their statutory mandate. Not respecting this mandate can invite legal action from the state.
- Secondly, these crèches are based on the premise that the working woman can ensure her productivity if her young children are close to her and are being looked after. This is in contrast with the grant-in-aid crèches where the state supports the establishment of crèches primarily for the welfare of the child. Employers set up crèches for their own women employees and not for the community in general. Such crèches are essentially a labour welfare measure.
- Thirdly, statutory crèches are not gender neutral. Providing crèches for young children is perceived as a *woman* employee's need, and not an employee's need. Hence, the provision of these crèches is often determined by the number of women employees rather than the number of employees (men or women) with very young children who may need such assistance. **Only in mines does an employer have to provide a crèche even for a single woman employee.**

- Fourthly, the statutory provisions with respect to crèches do not apply to the large pool of unorganised labour. According to the Shramshakti report (1988), there are 100 million working women of which 90% are in the unorganised sector, most of whom do not have access to these crèches. Furthermore, women workers often work as supplementary workers and face difficulties establishing their status as a worker. The absence of identity cards or their names on the employee muster roll are common problems. Groups working on this issue have for long advocated that the onus should be on the employer to prove that the person is not a worker if any of the labour welfare measures are being denied.

Statutory provisions for crèches

Crèches are statutorily provided to women working in mines, factories and plantations (under the Mines Act, the Factories Act, and the Plantations Act) and also to contract labour and inter-state migrant labour (under the Contract Labour Act and the Inter-State Migrant Workers Act). The statutory obligation applies to establishments where more than a specified minimum number of women (see annexure) are employed (except in the case of mines). Provision of crèches at the workplace is also stipulated under the Builders and Construction Workers Act, 1996. Many a times, employers try to avoid these provisions by hiring a lower number of women than that prescribed for starting a crèche. A number of builders evade the law by providing labour camps off-site and hiring male workers from distant parts of the country. There is no statutory provision for women in the services and professions, who hence have to depend on crèches in the voluntary and private sectors.

Coverage of statutory creches

Research on statutory crèches in different parts of the country reveal that crèche facilities are available to only 3-5% of women workers in the organised sector (Khullar, 1991). It is estimated that about three lakh women (with six and a half lakh young children) are covered by the existing laws related to crèches at the workplace. Many factories avoid implementation or do so in a haphazard manner, with poor facilities and untrained workers (Bhatia, 1975). Moreover, the **differential needs of children below three and children from three to six** is not recognised even in the statutory crèches. The best record as far as the provision for infants close to the mother's place of work is concerned, is in the **plantation sector** in South India (Swaminathan, 1985), that also encourages the mother to breast feed her young infant.

Box 3: Some recent legal amendments in Karnataka

Rule 104B Karnataka Factory Rules: The Government of Karnataka has issued the following notification on July 6, 2002 under the Factories Act, 1948.
Exemption from the provision of crèche in certain cases- In factories where it is reasonably not practicable to provide and maintain a crèche in accordance with law, the Chief Inspector of Factories may exempt such factories from the provision of crèche if he is satisfied that alternate arrangements are ensured by the factory. The occupier of the factory should take the consent of the employee, furnish details of the places, owners or persons or NGOs who are providing such a crèche and the infrastructure facilities therein, bear the cost incurred by the parent on the child and furnish the information of the child as and when s/he is admitted and withdrawn. These alternate arrangements shall include a crèche provided and maintained by private agencies or persons or an individual or NGO. If the Chief Inspector finds that the occupier of the factory has committed a breach of this rule, this exemption may be withdrawn.

Exemption under Section 25 of Karnataka Shops and Commercial Establishment Rules, 1963.
The exemption permits establishments of Information Technology and Information Technology enabled services to engage women employees during night shifts; one of the conditions is that the establishment should bear the cost of crèche facility obtained by the women employees from voluntary and other organisations. If there is a breach of this condition, the permission to engage women during night shifts may be withdrawn by the Labour Commissioner.

5.2.1. The situation in Karnataka

This section presents data with respect to crèches under the Factories Act. The data for crèches under the Plantations Act and the Mines Act is not available.

Data for March 2003 showed that there were 9,478 factories registered in Karnataka. These factories employed a total of over 90,000 workers. The sex-wise number of workers in Karnataka is given below.

Table 8: Number of workers in Karnataka

	2000	2001	2002	2003
Total Workers	9,01,448	8,06,216	9,11,221	9,04,904
Women Workers	1,47,235	1,37,216	2,23,799	2,33,462

The number of women workers employed in factories in Karnataka has gone up over the last three years. The increase has been particularly steep from 2001 to 2002. **Women workers account for one-fourth of the total workforce employed in factories in Karnataka.**

In 2001, there were 598 factories where crèches should have been provided but only 525 factories were providing them. In the year 2002, there were 952 factories where crèches should have been provided, but only 550 factories were providing them. **This data shows that the number of factories which are evading the legal mandate on providing crèches is increasing.**

Table 9: Status of crèches in factories, 2001

Division	Number of factories with more than 30 women workers	Number of factories where crèches are provided
Bangalore Div. 1	13	9
Bangalore Div. 3	85	84
Bangalore Div. 5	70	69
Bangalore Div. 6	37	23
Bangalore Div. 7	19	19
Bangalore Div. 9	47	35
Bangalore Div. 10	42	40
Bangalore Div. 11	43	38
Bangalore Rural -Anekal	11	11
Bangalore Rural - Doddaballapur	2	2
Belgaum	2	1
Belgaum-2	1	1
Mangalore	36	32
SIF Mysore	11	9
Mysore	11	9
Mandya	N.A.	9
Tumkur	4	4
Gadag	5	6
Bijapur	N.A.	N.A.
Shimoga	20	20
Raichur	4	4
Bellary	-	-
Davangere	4	4
Total	**467**	**429**

Source: File records at the Department of Factories, Govt. of Karnataka
N.A= Not available
Note: Data for all divisions was not available and hence the total number of crèches does not add up to 525.

A look at the district-wise break-up of defaulters indicates that factories flouting these provisions are located mainly in Bangalore, Mysore and Mangalore divisions. It must be noted that this data pertains to only those factories that are registered under the Factories Act.

The enforcement authority under the Act, i.e. the Factories Inspector under the Factories Act or the Labour Inspector under the various labour statutes, visit the place of work and check if the legally prescribed norms are met by the employer. If the employer is found defaulting on any of the provisions, the Inspector gives an oral warning. If these warnings are not heeded to, a show cause notice is given to the errant employer. **So far, no case has been registered against any factory owner for not providing crèches in Karnataka.**

5.3. Crèches run by voluntary organisations

Many voluntary organisations have set up crèches in their areas of work in order to ensure children's well-being and also to free up women from domestic responsibilities so that they can take up economic activities. Most of these crèches are those running with private donations and not with grants-in-aid schemes of the central or the state government. Some of the characteristics of crèches in the voluntary sector are:

- Firstly, they may not operate for the whole day and their timings may not coincide with the working hours of mothers.
- Secondly, they usually do not cater to children below two years of age.
- Thirdly, they may not be located in close proximity to mother's work places. (Swaminathan, 1985).

Mahila Samakhya has been running crèches in Karnataka since 1992. These cater to the needs of women daily wage workers and are run by mahila sanghas. However, every year some crèches are being closed down since anganwadis have started in these areas and the crèche beneficiaries now go to the anganwadis. Mahila Samakhya presently runs three crèches in Gulbarga and five in Bijapur.

Ashraya has run crèches at construction sites since 1983. At present they run crèches at four construction sites, which provide education and care to children from infancy to 12 years. Since its inception, Ashraya has run crèches at over 30 large construction sites in the city of Bangalore. Since the past 4-5 years, there have been a lot of changes with respect to labour hired in the construction sector. There are fewer female labourers and the contractors bring in only male labourers from distant areas. Even in the case of labourers with families, the contractors normally house them in off-site labour camps.

Ashraya runs crèches in partnership with builders and contractors in the city of Bangalore. The builders are asked to pay Rs. 5000 per month as a donation towards the crèche functioning on their site. Three staff members including a teacher, a worker and a helper look after the children. Children are fed breakfast and lunch at each centre. Doctors visit crèches regularly for health check-ups and immunisations.

Parents are asked to contribute Rs. 5 per child per month. Children of construction workers are also sent to Ashraya's residential school near Kolar. In all, the organisation reaches out to 150 children.

Some other voluntary organisations also have crèches in Karnataka. Outreach has 17 day care centres reaching out to 1200 children in Bangalore. Sumangali Sevashram ran 15 crèches financed by the Swiss-based organisation, Shiftung Kindergarten Programme (SKIP) between 1990-96. Under the India Population Project-VIII it ran 19 crèches in and around Bangalore till 2003. These crèches have now been closed down and most of these children have been sent to the anganwadis. Presently, Sumangali Sevashram runs a crèche on its own premises for children of vendors and domestic workers. DEEDS, another voluntary organisation, runs 19 day-care centres for 456 children between three to five years, with special emphasis on the girl child. Of these, two are in the urban slums of Bangalore, four are in Hassan and Tumkur districts and the rest are distributed in Tamil Nadu.

There is very little information available on the exact number of crèches run by voluntary organisations. Data is particularly lacking from the districts. **Since all crèches are not required to be registered with the Department of Women and Child Development, there is no reference on the spread and quality of these crèches.**

5.4. Commercially run crèches

Commercial crèches are those crèches that are run by individuals/organisations for profit. These crèches, which are also called day care centres or play homes, cater mainly to the middle class population of working couples. Parents from lower classes are not able to afford such child care services. They are either run as separate centres similar to pre-schools, or are run privately by caretakers out of their homes. The latter are very often informal arrangements between the parents and the caretaker. Often these care arrangements are located near the child's residence and not near the mother's place of work. Caretakers are usually women sharing a similar socio-economic background of the parents. These crèches stay open for the whole day and are often flexible depending on the needs of the parents. Children aged from a few months old to those who go to school are looked after. School going children use crèches mainly as an after-school care arrangement. These crèches charge fees ranging from a few hundred to a few thousand rupees, depending on the type of services provided and the background of the children catered to. Most of these crèches are not even registered since there are no rules, or policies governing the functioning of these crèches. **There is a complete lack of regulation and standard setting with respect to services provided by these crèches. No reliable data on the extent of such child care arrangements in the state is available.**

Of late there is a growing concern among various groups, including activists and parents, about the growth of these private-for-profit centres attending to young children, since they are completely unregulated (Swaminathan,1988: 21). **With more and more establishments preferring to reimburse working women for crèche facilities instead of setting up crèches themselves at the workplace, and with the statutes supporting such arrangements, the role of such commercially run crèches is becoming increasing significant.**

6. Key problems and issues

Swaminathan (1998: 21) points out that there is a confusion of goals and objectives with respect to child care services. Is the purpose of early childhood care and education in order to get children into schools or in order to take care of them while their mothers are at work, or a combination of both these reasons? Perspectives may indeed differ depending on how the government views child care services; i.e. as a measure towards women's empowerment, or a strategy of ensuring universalisation of elementary education, or a child development programme. In turn, these positions may influence the specific programme of action as well as resource allocation. At present, the programme seems to be defined for these three purpose, despite which there is insufficient government action. Another problem is that none of the departments take full charge of planning, designing, executing and evaluating the child care services that are in place. These services are fragmented across the Department of Women and Child Development, Department of Labour, Department of Factories and Department of Education. Inter-departmental co-ordination and planning is completely non-existent and there is a tendency to pass the buck on.

Other issues related to crèches are:

Inadequate coverage

Out of 6,50,000 children eligible in the country, crèches cover only 50,000 children (Sriram, 1998). In quantitative terms, the present laws and policies regarding crèches leave out the majority of working women in the unorganised sector and their children. Another estimate is that there are 90 million women and 24 million are estimated to have children below six years in need of child care support (Swaminathan, 1998:26). A large majority of these women and children are without any child care service.

Timings and duration

Crèches are also found to function mostly like pre-schools. A lot of them work for three to four hours per day. Moreover, the timings are not adapted to those of working women, except in Kerala and Tamil Nadu where all crèches are obliged to function for six hours, usually 9.30 a.m. to 3.30 p.m. or longer. These arrangements are inconvenient for most working mothers and crèches in such instances offer only partial support.

Custodial care or holistic development

Given the fact that child care services focus on the most critical period in the life cycle, it is pertinent to examine whether these services actually utilise this opportunity to provide holistic development activities for children. In reality, inadequate resources make even the simplest toys unaffordable. Lack of sufficient staff, their poor educational background as well as lack of training in child development make it extremely difficult to convert custodial crèches into environments that provide stimulation for sensory, mental and motor development.

Diversity of needs

Do crèches cater to a diversity of needs required by children? Children coming to crèches come from varied backgrounds and belong to families of working mothers or are children of ailing mothers. There are children who are differently-abled and children with various health disorders. Most of these crèches do not have the capacity to offer differentiated care for such children. Thus, important psycho-social and health problems are likely to go unidentified and therefore unattended.

Breast feeding

Breast feeding of very young infants by working mothers is extremely difficult and many women have to resort to bottle feeding children left in crèches. Crèches have to be close to the place of work in order to facilitate breast feeding. Apart from the statutory crèches, many of the crèches are not close to the mother's workplace. Even when women are entitled to nursing breaks, it is often impractical to travel long distances to the crèches for nursing the babies. As a result, most women have to stop nursing as soon as they resume work, and place the child under substitute care. Many a time, working women in the organised and unorganised sectors cannot breast-feed since the environment is not conducive.

ICDS and crèche services

As the biggest early childhood programme in the country, the ICDS has not provided adequately for a crèche component in its scheme, particularly for 0-3 year olds. Day care/crèche facilities are not provided in most anganwadis although a beginning has been made towards integrating the two. The government's contention has been that day care requires responsible skilled human inputs. With the limits on the availability of funds, crèches are not universally implemented. Even the ICDS as a scheme does not respond to the mother's work roles and timings and children under three years are neglected in aspects other than health care.

Documentation and records

Since child care services are not high on the government agenda, there is little effort towards collecting or maintaining records about crèches. This researcher came across several conflicting data from government sources. In Karnataka, no study/evaluation has been done so far on the utilisation of grants-in-aid schemes for crèches.

The government is therefore unclear about the implementation of these schemes and the impact they have had so far in meeting the needs of working mothers and children.

Reliance on NGOs

The entire network of child care services in the country depends on the voluntary sector. In some sense, the existence of crèches or day care facilities is determined by the presence of NGOs and their scope of work. If an NGO is not located within a particular community, the chances of the community getting a crèche are very remote. Moreover, there is very little regulation in terms of standard setting and continuous monitoring of crèches run by these organisations. None of the schemes specify the need for community participation in monitoring the functioning of the crèche. The organisational staff is thus accountable only to the government and not to the beneficiary community. The number of NGOs running crèches is also minuscule compared to the need.

Inadequate funding

Children are clearly not placed first in terms of budgetary resources. There is definitely a need to increase the funding provided under the various grants-in-aid schemes of the government. A meagre corpus of Rs.19 crore towards the National Crèche Fund generates only Rs. 1.5 crore for crèches. The funding pattern of the scheme for crèches makes it very difficult for NGOs to run crèches satisfactorily without additional resources. Even the remuneration offered to the crèche staff is not lucrative enough to attract the best. This low remuneration appears to be accepted by state as well as society and there is very little unrest reported among crèche workers for better wages. The small size of this category of workers and their disparate locations also make their association and lobbying as a group extremely difficult. A full day, high quality care would cost only Rs. 5 per child per day. Even if this was provided to all the six crore children, the expenditure would be less than 1% of the nation's GNP (FORCES). Another issue is that of the utilisation of funds. The relevant sections in the paper above show that the grants are not fully utilised and this has also been noted by the Committee of Ministers. As the grant given is too meagre to provide an adequate service, it results in the sorry state of under-utilisation of grants released.

Care of the very young child

Another striking problem with the existing child care services is the lack of focus on the very young child. Despite being the most vulnerable group within the young child population, child care services for this group are highly inadequate. Most crèches take children between two and six years. Even the system of funding is not tailored for the care of children below three years which requires more adult supervision, special diet, health care, training and equipment. A direct fall-out of this is the withdrawal of elder siblings from education in order to care for the very young child. If universalisation of girl's education is to be attained, providing child care for the very young is a pre-requisite.

Policies and legislation

Child care services in general have received scarce attention in national policies and legislation. Children below three years are further marginalised since their independent needs go unregistered and the mother's need for support in child rearing responsibilities is looked on with suspicion. The fact that child-rearing is seen as a private family affair also contributes to this inaction. The CRC and the National Policy for Education lay down sound goals to be achieved and the role of the State, but this has still not translated into action.

Alternative approaches to centre-based child care

Experts have called for exploring alternate approaches to centre-based child care, but these have not received adequate attention within official circles. Newer models of child care such as crèches attached to schools; family based, home based, community based, women's group based crèches; and anganwadi-cum-crèches have not been fully tried out. In Karnataka, even the anganwadi-cum-crèche model has not been adopted by the government although separate allocations are provided for this. Decentralising the administration of the state government's scheme is not enough. The panchayat's duty towards maternal and child welfare, however discretionary it may be, needs to be formalised and incorporated in the scheme itself.

7. Conclusion

Crèches and child care have to be part of a holistic, integrated strategy for the development of the poor in our country as they permit women to work and improve their economic conditions (Pandit, '95). Given the criticality of the early years of life, child care should be a priority for ensuring children's survival, growth and development. In a way, it not only intersects the needs of women and children, but also those of the family and society. Yet, as this paper shows, child care services in India have largely failed to meet the needs of working women in terms of the extent of coverage, provision of services, and quality of service delivery. Most crèches are reduced to providing only custodial care. These weaknesses are mainly due to the faulty pattern of the schemes themselves; their inadequate pattern of funding, staffing and training; and the failure to spell out the methods, programme content and criteria in line with the stated objectives (Swaminathan, 1993). Even as government funding for crèches remains totally inadequate, the issue of non-utilisation of government grants is also a matter of concern. Furthermore, data about crèches needs to be collected at all levels. This will help in identifying the ground level lacunae and facilitate revamping and upgrading government policy with respect to crèches.

In sum, all child care services should aim at long hours of care that match mothers' work timings; location within half a kilometre from home, or proximity to the workplace to facilitate breast-feeding; meeting the needs of various age groups; and the caregiver being from the same social group. This basic standard of service to families in need would go a long way in strengthening the state's pool of vital human resources.

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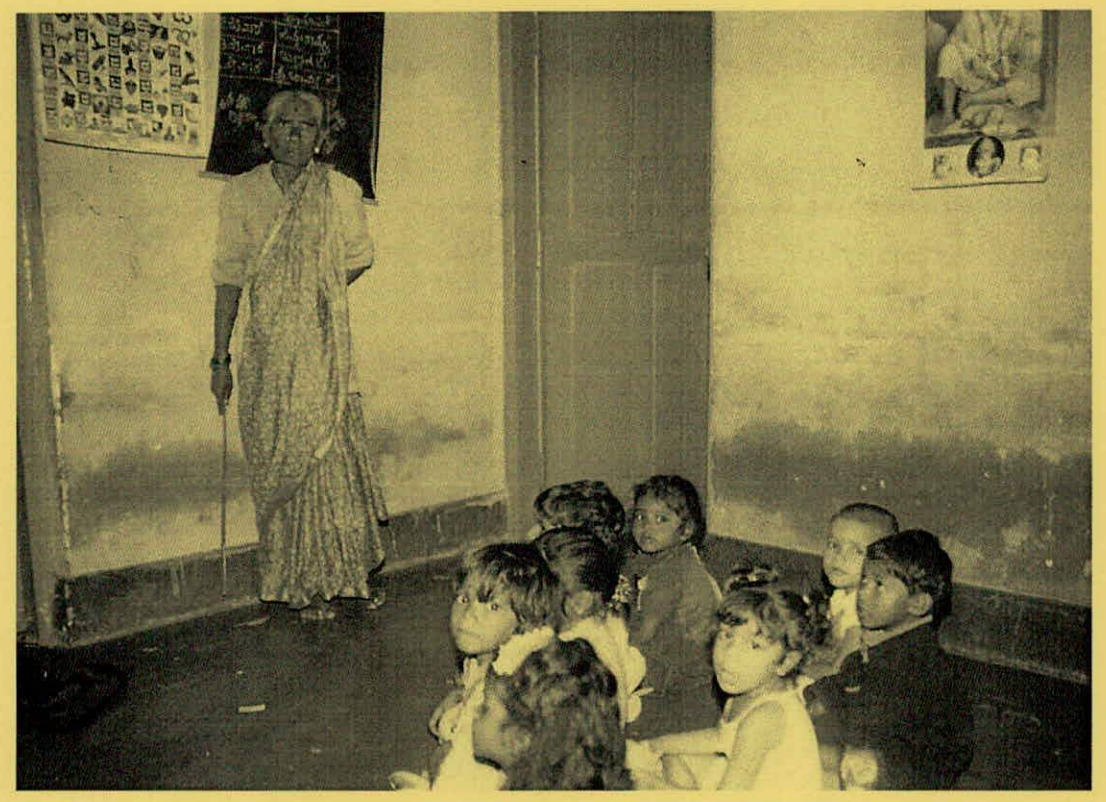
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ANNEXURE : Legislation related to crèches

Name of Act	Min. no. of workers	Min. no. of children	Age of eligible children	Provision	Authority to make rules
Factories Act 1948	30	********	Up to 6 years.	A suitable room or rooms for the use of children with trained women in charge	State Govt. shall make rules regarding location, construction, accommodation, furniture and equipment, amenities and facilities, milk and refreshments, breast feeding by mothers etc.
Plantation Labour Act 1951 (d) & (w)	50	20	Up to 6 years	As above	State government
Mines act 1952 section 58	No min. number specified	****	Up to 6 years	Room or rooms, amenities and supervision	Central government

Name of Act	Min. no. of workers	Min. no. of children	Age of eligible children	Provision	Authority to make rules
Beedi and Cigar Workers (Conditions of Employment) Act 1966	50	****	Up to six years	Room or rooms and trained in-charge	State Govt.
Contract Labour (Regulation & Abolition) Act 1970.	20	****	Up to six years	Two rooms to be provided for children, one play room and one sleeping room	Chief Labour Commissioner Central Govt.
Inter-State Migrant Workers Act 1980	20	****	Up to six years	As above	As above



The Integrated Child Development Services

Kavitha Krishnamoorthy

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1. Introduction

The first few years of life have always been regarded as something special. The new-born through a series of experiences grows to understand the world around her/him, attributing meaning to all that s/he sees, hears, touches, feels. Traditional practices of child rearing have placed a great importance on stimulation of the infant and young child through songs, stories and games; practices that today find support by advances in medical science. In addition to appropriate stimulation, an environment that promotes the health and well-being of the child is of paramount importance.

The first six years represent the window period within which cognitive, language, physical, social and emotional development is at its highest. At each of the sub-stages within this period, the brain is primed for certain developmental tasks. Appropriate stimulation and opportunities will lead to the child developing to her/his true and fullest potential. While it is true that the brain's malleability allows for compensation to take place later (in the event of the developmental prime time being inadequately availed of); it is also true that the best years for inputs are the first six years.

The recognition that the first few years provide the foundation of each individual's life has led to initiatives across the world - by the government, private and voluntary agencies - to meet the needs of the child under six years.

The **Integrated Child Development Services (ICDS),** operational in India since 1975 represents the largest State-driven initiative globally to address the needs of the child under six years. The ICDS is the only government programme for children below 6 years that offers **an integrated package of services, catering to the related needs of health, nutrition and education**. It is also the only programme that addresses itself to **children living in poverty** and holds the potential to compensate for a poor home environment.

Through this paper, an effort is made to assess the situation of the ICDS within Karnataka. The first section looks at the origins, growth and impact of the ICDS nationally. The second section analyses the performance of the ICDS in Karnataka; with a focus on the impact of services. The next section looks at efforts by NGOs to support ICDS functioning. The concluding section throws up issues for further discussion and areas for advocacy.

2. ICDS in India

The developmental needs of the young child first finds mention in national developmental policy somewhere in the 1960s, a period when knowledge about the possible effects of malnutrition on the growth of young children was coming to light. This awareness was manifested programmatically through the introduction of the Supplementary Nutrition Programme, under the Fourth Five Year Plan (1969-74).
Subsequent Plans laid great emphasis on child development with 48% of the Fifth Plan (1974-79) and 59% of the Sixth Plan (1980-85) central sector outlay being spent on child development programmes (Sharma, 1987). At this point in time, the perspective of welfare underlined all interventions in child development.

A shift in emphasis from welfare to development, at least in letter, came with the formulation of the National Policy for Children, 1974. Its primary goal, to 'provide adequate services for children, both before and after birth and throughout the period of growth to ensure their full physical, mental and social development' led to the initiation of the ICDS on October 2nd, 1975. The idea of the ICDS Scheme was first presented at a Conference of the Indian Association of Pre-school Education (IAPE) in October 1972, by the Chief of the Department of Nutrition and Family Welfare, Planning Commission of India. It is worth noting that the Scheme did not initially include any component of pre-school education.

In 1972, the Ministry of Education also set up a study group for pre-school education, which recommended that a comprehensive programme for the development of the pre-school child be undertaken. The study group recommended an integrated approach interweaving health, education and nutrition into the programme. The IAPE also submitted a memorandum to the Planning Commission, exhorting it to include psycho-social development of children into the programme.

Thus, the ICDS, when it was launched, sought to 'promote the holistic development of children under 6 years through the strengthening of the capacity of caregivers and communities and improved access to basic services at the community level' (NCAER, 2000). In addition, the Scheme envisages effective convergence of inter-sectoral services such as health, nutrition and pre-school education.

Launched as an experimental project in 33 blocks, the ICDS today covers 5652 projects spread across 4553 rural, 759 tribal and 360 urban areas (www.indiabudget.nic.in; 2004).

2.1 Objectives of the scheme

As detailed in the official document brought out by the Department of Women and Child Development, Government of India, the main objectives of the ICDS Scheme are as follows:

- To improve the nutritional and health status of children in the age group 0-6 years
- To lay the foundation for proper psychological, physical and social development of the child
- To reduce the incidence of mortality, morbidity, mal-nutrition and school dropout
- To achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and
- To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

The national evaluation of the ICDS carried out by the National Institute for Public Co-operation in Child Development (NIPPCD) in 1992, stresses the fact that the objectives of the ICDS "are not limited to a mere delivery of services but emphasise the initiation of a process aimed at bringing about **social change** in the life of the community". Anecdotal information from organisations working in the field as well as a scan of secondary research reveal that this objective has rarely been in the consciousness of people implementing the project, who continue to look at the ICDS as a package of services to be delivered.

It is also worth noting that the essential **temporary nature** of the ICDS is underlined by the fact that it is a Scheme, which could be withdrawn or pared down if there is no political will to keep it running.

2.2 The range of services

While the focus of the ICDS has been promoting the wellbeing of children, the realisation that the child's health and nutritional status depends on the health of the mother, especially during pregnancy and lactation; led to the inclusion of women in the reproductive age-group within its ambit of services. The ICDS seeks to be a multi-sectoral programme "**aiming at convergence of services at the local community level for the young child, pregnant and lactating mothers, and adolescent girls belonging to marginalised families and living in disadvantaged areas including backward rural areas, tribal areas and urban slums**" (ICDS, GOI, 1995).

The package of the six services provided, as listed in the ICDS document of the Department of Women and Child Development, Government of India, 1995, are as follows:

Health

- Immunisation
- Health check-up
- Referral services

Nutrition

- Supplementary Nutrition
- Nutrition and Health Education for women
- Growth Monitoring and promotion

Education

- Early Childhood Care and pre-school education to children in the ages of 3-6 years.

Convergence

- Of other supportive services such as safe drinking water, environmental sanitation, women's empowerment programmes, non-formal education and adult literacy[1].

These services are distributed across different age-groups as the table that follows shows.

[1] While all these services have an implication on the child's well-being, this paper does not address this area; both due to the paucity of data as well as the fact that the paper's focus is on the services directly concerning the child.

Table 1: ICDS services across age groups

Target group	Children (6-12 months and 1-3 years)	Children (3-6 years)	Women (15-45 years) esp. pregnant and lactating mothers	Adolescent girls (11- 18 years)
Services offered	• Health check-up • Immunisation • Growth promotion • Supplementary feeding • Referral services			
	• Vitamin and iron supplement	• Vitamin A and iron supplement • Early childcare and pre school education	• Registration for ante- and post-natal care • Vitamins, folic acid and iron supplement • Nutrition and health education	• Vit A and iron supplement • Nutrition and health education • Self-development, recreation and skill formation

Source: ICDS, Ministry of HRD, GOI, 1995

While the above range of services are listed on paper, on the ground, the focus of the ICDS is the child under 6 years and pregnant and lactating mothers. NGOs working in areas where ICDS anganwadis operate testify to the fact that programmes with adolescent girls are conspicuous by their absence in the field.

It is pertinent to note that all of the above tasks are to be administered by one anganwadi worker and one helper who are essentially seen as voluntary, part-time workers. The workload and burden of responsibility seem well outside the scope of any two human beings, however committed and well trained *(for more details see page 33).*

2.3 Modalities of operation

The Department of Women and Child Development in the Ministry of Human Resources Development, Government of India, holds the administrative and financial responsibility for the ICDS at the central level. While the cost of the feeding programme as well as additional honoraria to anganwadi workers (if so decided) is met by the State Governments; the Central Government funds the initial non-recurring expenditure as well as salaries and other administrative costs.

The Scheme being an integrated one, calls for coordination between different Ministries and Departments, the chief being the Ministry of Health and Family Welfare. In addition, the Ministry of Food and Civil Supplies, Department of Education, Ministry of Urban Development and Ministry of Agriculture are also involved. Mechanisms for coordination are set up at all levels but their effectiveness remains a question mark.

2.4 Coverage

The jurisdiction for one project is the Block. Within one project, there may be between 125-250 anganwadi centres (AWCs). Universalisation of the ICDS is said to have taken place if each Block has an ICDS Project.

The services are provided through the anganwadi centre. One anganwadi centre covers a population of 1000 in urban and rural areas and 700 in tribal areas. Each AWC is to cater to a maximum of 80 children below six years (40 children below 3 years and 40 between three and six years) and 20 women – pregnant and nursing mothers[2] (16 women for SNP+ 4 referrals) and 2 adolescent girls. The actual number of beneficiaries who are eligible within a population of 1000 in urban and rural areas and 700 in tribal areas is determined by a survey.

The table that follows, drawn from the GOI document on the ICDS gives an idea of the approximate coverage in an ICDS project.

Table 2: Approximate coverage (intended) in an ICDS Project

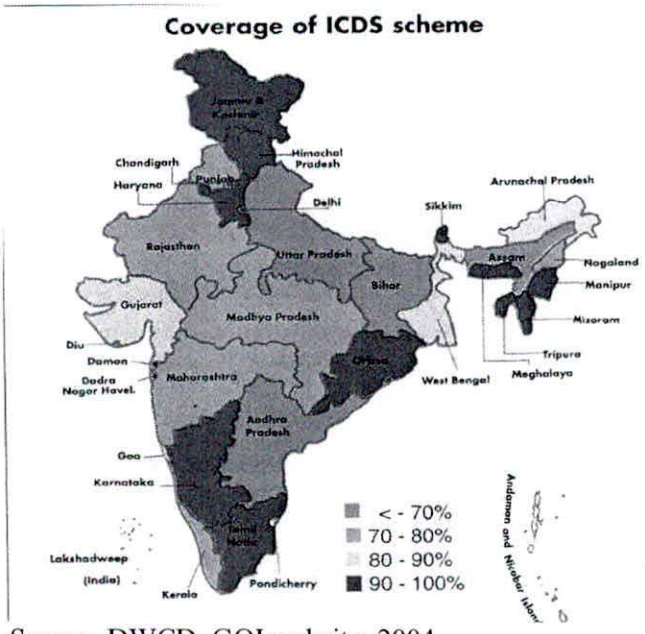
	Beneficiary	Services	Rural/Urban project			Tribal project		
			Total popln	Intended reach	Coverage	Total popln	Intended reach	Coverage
1	Children below 6 years							
	0-6 years	Supplementary nutrition	17,000	6,800	40 %	5,950	4,462	75 %
		Immunisation		17,000	100 %		5,950	100 %
		Health check-up		17,000	100 %		5,950	100 %
	3-6 years	Non-formal, pre-school Ed	8,000	4,000	50 %	2,800	2,100	75 %
2	Expectant and nursing mothers	Supplementary nutrition	4,000	1,600	40 %	1,400	1,050	75 %
		Health Check-up	4,000	4,000	100 %	1,400	1,400	100 %
		Immunisation against TT	2,400	2,400	100 %	910	910	100 %
3	Women (15-45 yrs.)	Health and Nutrition Ed	20,000	20,000	100 %	7,000	5,250	75 %

Source: DWCD, Ministry of HRD, GOI, ICDS, 1982

[2] Earlier the norm was 32 children below 3 years, 36 children in the 3-6 age group and 10 mothers.

These targets reflect the priorities of the ICDS programme – greater for immunisation (100%) as against 40% for nutrition and 50% for pre-school education in rural and urban areas and 75% each for nutrition and pre-school education in tribal areas. It is also pertinent to note here that as per the NHFS II survey (IIPS, 2000), the national coverage for immunisation is only 42% though the ICDS has set for itself an aim of 100% coverage.

Figure 1: Coverage of ICDS scheme – government estimates



Source: DWCD, GOI website, 2004

The map above, drawn from government data, shows full coverage (in that every Block has an ICDS project) in the Southern states of Karnataka and Tamil Nadu; Orissa, a few of the North-Eastern states, Himachal Pradesh, and surprisingly, Jammu and Kashmir. Andhra Pradesh, Bihar, Uttar Pradesh and Assam represent the states with the lowest coverage.

A Report by the Ministry of HRD (2003), entitled *Early Childhood Care and Education – An Overview,* states that the ICDS covers 3.44 crore children in the age group of 0-6 years in the country, with a total coverage for children in the 3-6 age group of 1,87,59,510. With the total 0-6 population in the country being approximately 15.79 crores as per the 2001 Census, **ICDS actually covers only 22 percent of children below six years**. However, we also need to be aware that there may be children who access services such as health and pre-school education through private and voluntary agencies, which is not reported. We would need to see how many children less than six years have no access to services provided by voluntary or private agencies to get an accurate idea of whether ICDS is reaching out to the uncovered groups of children.

BOX 1

Children of the urban poor – unreached by the ICDS

A study by the National Institute of Urban Affairs (1998) shows that only 8% of all ICDS projects are located in urban areas, and that too, not always in the most needy areas. The urban population of India constitutes 26% nationally, with no less than an estimated 20% of the urban population (40% in the case of metropolitan cities) living in slums.

In the seven cities studied, there was an overall shortfall in terms of meeting the needs of the urban slum population. The coverage varied from 25% of the children of the urban poor in Kanpur, Patna and Bangalore to 50% in Ahmedabad and Amritsar to 75% in Trivandrum and Nasik. Though some of these estimates relate only to the age group 3-6 i.e. for preschool education, the low coverage is still a cause for concern.

It was also found that the services were not reaching all the poor within the slum. Most of the children were excluded for a variety of reasons, ranging from concentration of certain ethnic groups to mixed patterns of residence, non-availability of accommodation, unsuitable timings etc. The general impression was that the most needy groups seemed to be the ones left out. At the same time, however, even with limited coverage, there were some instances of duplication of services, indicating the need for spatial mapping before programmes are launched.

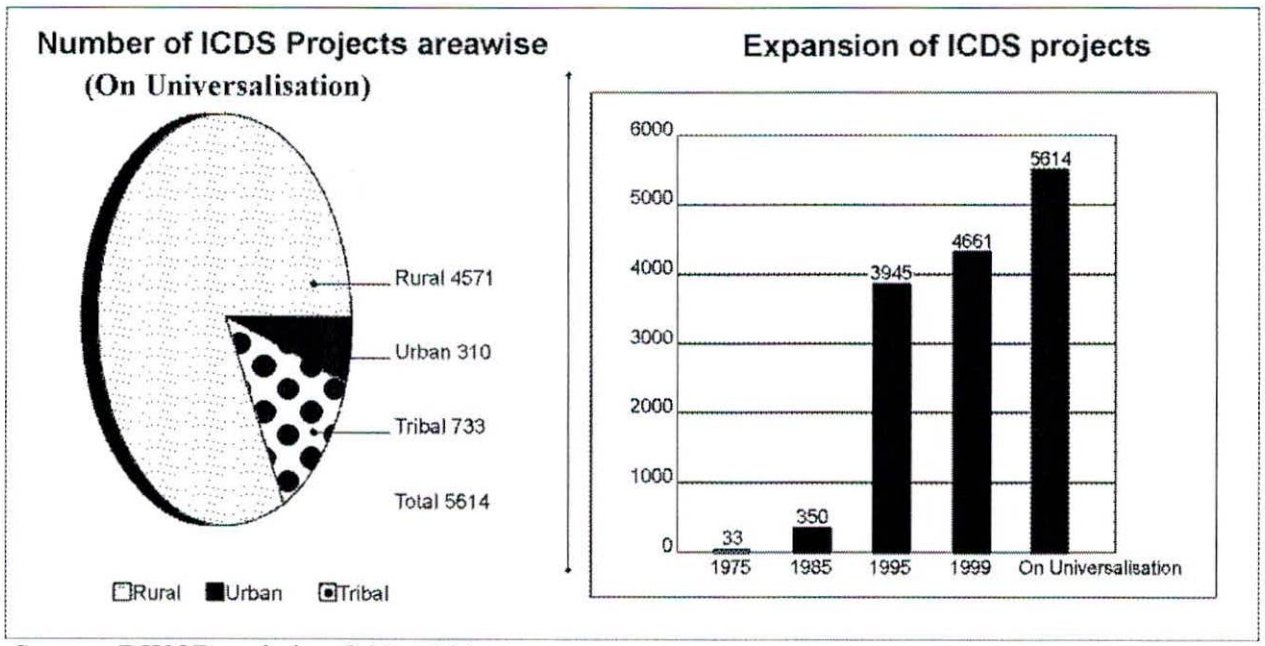
Source: Swaminathan, Mina, *Process and Outcome Documentation of ECD in Urban Disadvantaged Areas,* National Institute of Urban Affairs 1998; Mimeo, quoted in Report of the Committee on Early Childhood Education, Ministry of HRD, 2004.

Universalising ICDS

A move to universalise the programme was made in 1992, under the Eighth Five Year Plan (1992-97), when 1346 more projects were initiated. By the end of 2001-02 it was proposed that the ICDS expands to 5171 blocks implying a coverage of 90% by the end of the Ninth Plan (1997-2002). This has however not been achieved as evident by figures from the Department which state that as of Sept 2002; 4761 projects were operational (www.indiabudget.nic.in). The most recent figures available from the DWCD GOI (2004) website puts the total number of projects at 5652, implying complete universalisation.

These figures have to be read with caution. **Universalisation simply means that every Block has an ICDS project, which does not necessarily mean that all habitations are covered** (*for more details in Karnataka, see page 16)*

Figure 2: ICDS projects



Source: DWCD website, GOI, 2004

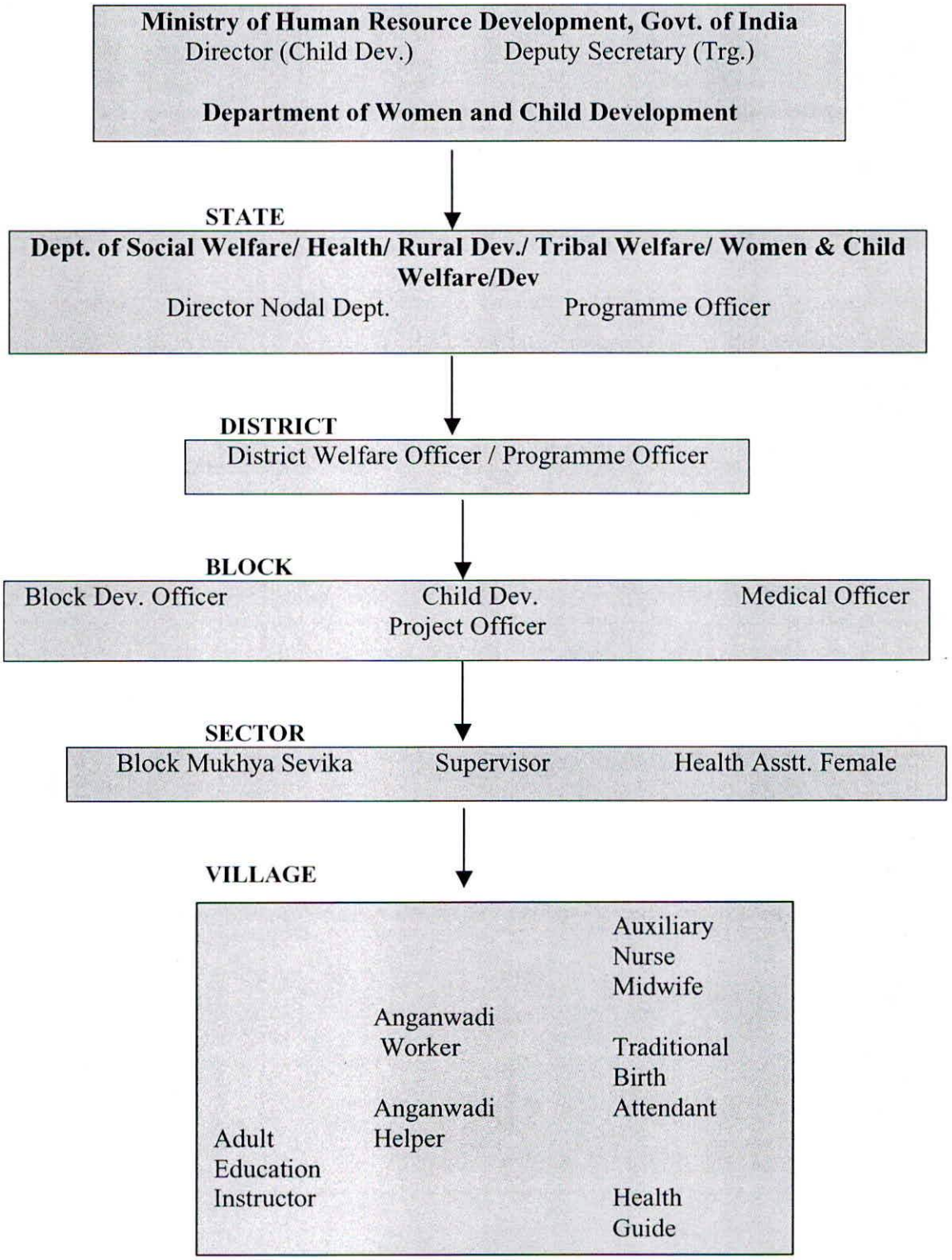
Criteria for setting up an AWC

According to the GOI document on the ICDS, while selecting the location of a project, preference is given to 'those areas which are predominantly inhabited by the vulnerable and weaker sections of society, that is Scheduled Castes and Tribes and low-income families found in economically backward areas, drought-prone areas and areas in the development of social services that requires strengthening' (ICDS, DWCD, GOI, 1995).

The identification of beneficiaries is done through surveying the community and identifying the families living below the poverty line. In order to enhance community participation, efforts are being made to use mapping and other techniques for pre-project activities such as selection of villages, identification of AWWs etc. (ICDS, DWCD, GOI, 1995).

The Committee on ECCE of the Ministry of HRD (2004) has called for a **review of the ICDS norms (laid down in 1974) for opening anganwadis**. It recommends that for a **population of approximately 300 people and 20 (+/- 5) children of the related age group, there should be one ECCE centre within walking distance from the home of the child**. It also recommends the provision of home-based ECCE facilities for smaller communities, scattered populations, and tribal and hilly areas. This is a welcome move and needs to be implemented immediately.

2.5 Figure 3: Organisational set-up of ICDS (National)



(Source: Sharma, 1987)

ICDS is the responsibility of the Ministry of HRD, Government of India. In most states, it is administered by the Department of Women and Child Development. At the district level, a Programme Officer monitors and administers the programme. From the block level and below, ICDS functionaries – the Child Development Project Officers (CDPOs), Supervisors, anganwadi workers (AWW) and helpers – with the co-operation of staff of the health department – Medical Officers, Health assistants, Auxiliary Nurse Midwifes (ANMs), Traditional Birth Attendants (TBA) – and other development staff implement the ICDS.

2.6 Staffing

Table 3: Staff at each block (for one project), as stated in the ICDS, GOI document (1995)

Designation	Number	Rationale	Persons reporting to her/him	**Responsibilities** *(adapted from Sharma, 1987)*
CDPO	1		6 Supervisors	Administrative head at the Block level responsible for implementation and day-to-day functioning
ACDPO				Same as above (for bigger blocks: may or may not have)
Supervisor	6	1 for 17-25 AWWs	17-25 AWWs	Guidance to enable continuous improvement
AWWs	125-150	125-150 AWCs in one project		• non-formal pre-school education • organisation of the supplementary nutrition programme • imparting health and nutrition education to women • educating parents through home visits • eliciting community participation and support • referrals to PHC for children and mothers • liasing with mahila mandals and other community groups and the primary school • maintaining prescribed records and furnishing monthly reports to the CDPO
AW helpers	125-150			• *Not listed anywhere*

While the responsibilities of the AW helper are not listed anywhere, it may be assumed that it is to help the AWW in the fulfilment of her tasks. She may often take on roles such as keeping children quiet, bringing children from and dropping them off at their homes, helping prepare the supplementary nutrition etc.

The Medical Officers (MOs), the lady health visitors (LHVs) and female health workers from nearby primary health centres (PHCs) and sub-centres form a team with Social Welfare/DWCD functionaries to implement the health component of the ICDS programme (Sharma, 1987).

2.7 Financial outlays

Alongside gradual expansion of the Scheme, there has also been a significant increase in the Central Government's spending on implementation of the Scheme. As against the expenditure of Rs. 1190.21 crores during 17 years, i.e. 1975-76 to 1991-92, the expenditure during the five years of the Eighth Plan period (1992-97) was Rs. 2271.28 crores representing 191% increase in just 5 years; which is in tune with the expansion of the project. During the Ninth Plan period (1997-2002), a sum of Rs. 4960 crores was allocated (DWCD, GOI website, 2004), a more than 100% increase in allocation.

The Budget estimate for the year 2002-03 was Rs. 163544.00 Lakhs while for the year 2003-04 it was Rs. 1657597.00 (DWCD, GOI, 2004)

The ICDS has also received external funding from the World Bank (WB) for the Tamil Nadu Integrated Nutrition Project (1980-89); as well as ICDS Projects (922 projects) in Andhra Pradesh, Orissa, Bihar, Madhya Pradesh, Uttar Pradesh, Tamil Nadu, Maharashtra, Rajasthan and Kerala.

Under the Andhra Pradesh Economic Restructuring Project, WB funding to expand the ICDS Scheme in 143 new blocks in Andhra Pradesh and to enrich quality of services in 108 existing ICDS blocks has also been committed. In addition, UNICEF has been providing resources for essential supplies, and the World Food Programme and CARE have been supporting the Supplementary Nutrition Programme (DWCD, GOI website, 2004).

2.8 Training

NIPCCD is the apex organisation for designing training programmes for ICDS functionaries. Training for CDPOs and ACDPOs is imparted to ICDS functionaries by NIPCCD through its three Regional Centres at Lucknow, Guwahati and Bangalore. Supervisors are trained in 18 Middle Level Training Centres and 300 Anganwadi Workers Training Centres. In addition, the Central Technical Committee – Integrated Mother and Child Development also gives training to medical and para-medical staff. NGOs have also been involved in training in the areas of community participation, disability, pre-school education etc.

Udisha – A move to revitalise the training component of the ICDS was undertaken through the initiation of Udisha – a nation-wide World Bank-assisted training programme for ICDS functionaries, launched in 1999. It consists of three major components – job training, other trainings (innovative, area-specific training) and provision of Information, Education and Communication material (IEC). Udisha envisages a spectrum of locally relevant training interventions for achieving women and child development goals. It is being supported nationally by an assistance of Rs. 600 crores by the World Bank for a time period of five years, which ends in September, 2004 (www.indiabudget.nic.in, 2004).

Udisha seeks to redefine training of ICDS functionaries through a decentralised, participatory approach. It aims at improving the communication skills of the functionaries, developing their self-esteem, and introducing them to issues of empowering women. It also seeks to revise the syllabus of training to make it more State-specific (DWCD, GOI, 1995; www.indiabudget.nic.in, 2004).

A series of consultation were held over two years (along with NIPCCD and UNICEF) with training institutes, trainers, community members etc. focusing on emerging programme strategies, training needs assessment and methodologies, syllabus etc. A redefinition of approaches towards training of child care functionaries and caregiver education was arrived at, which stressed a holistic approach "reflected in the new child-centred curriculum that is structured along the life cycle and development continuum of the child, pulling together different sectoral interventions in a rights perspective" (Udisha – National ICDS training, DWCD, GOI, 2000).

Probably for the first time in the history of the ICDS, **Udisha looks at the Anganwadi worker as the key functionary, worthy of the best possible inputs**. It talks of empowering the AWW, building her self-esteem and enabling her aspirations to be realised.

For regular monitoring and evaluation of the training component, State-level Training Task Forces have been set up. The purpose of the Task Force is to integrate and coordinate all aspects of the training and to recommend changes in curriculum, strategies and methodology.

2.9 Monitoring and evaluation

Monitoring is in-built in the ICDS programme with the Ministry of Human Resources Development holding the overall responsibility. Monitoring is done through a central cell established in the Department of Women and Child Development, which collects and analyses the work reports. A national ICDS Management Information Systems (MIS) working group facilitates the process of using the information to refine programme strategies. State governments with more than three projects and Districts with more than five projects also have MIS facilitating cells at the respective levels.

The MIS consists of the Monthly Progress Report which details information such as supplies, staff in position, coverage of beneficiaries, percentage of severely and moderately malnourished children etc.; and the Monthly Monitoring Report which relates to health staff in position, supplies of medical and health items, birth rate, infant mortality rate etc.

The reports are consolidated at the Central Technical Committee for Integrated Mother and Child Development. The Central Technical Committee has also been carrying out research on the health and nutrition components of the Scheme. A national evaluation was conducted in 1992 by NIPCCD to assess the impact of the ICDS, the findings of which are summarised in the box below.

BOX 2

Impact of the ICDS nationally

Immunisation – 49% of children and 46% of mothers immunised in ICDS areas as against 32% and 33% respectively in non-ICDS areas.
Infant Mortality Rate (IMR, 1990) – 71 for ICDS areas as against 80 (SRS estimates for 1989) for non-ICDS areas.
Pre-school education – 88% of children from ICDS areas enrolled into primary school as against 60% from non-ICDS areas.
50% mothers in ICDS areas get their children **medically examined** as against 38% in Non-ICDS areas
A lower percentage of babies had low **birth weight** in ICDS areas compared to non-ICDS areas.

Source: (ICDS, DWCD, GOI, 1995)

The mid-term evaluation of the World Bank supported ICDS projects in Andhra Pradesh also found a positive impact of the ICDS on severe malnutrition and IMR. However, the gains were not found to be entirely commensurate with investment due to problems of effective targeting, implementation and coverage. The report drew attention to the fact that ICDS, even after twenty years, covered less than half the target population and with far from satisfactory services (World Bank, 1998-99 in Venita Kaul, in India Education Report, 2002).

3. ICDS in Karnataka

Prior to the ICDS being initiated, a Scheme called the Shishu Vihara was operational in some parts of the State. This functioned under the aegis of the Block Development Officer and aimed at providing nutrition and pre-school education to children.

ICDS was initiated in Karnataka in 1975 with a pilot project at T. Narsipur in Mysore district, with 100 anganwadis. In 1993-93, ICDS was universalised in Karnataka, with each of the 185 blocks in 27 districts having an ICDS project. Of the 185 projects, 166 are in rural areas, 10 in urban areas and 9 in tribal areas.

3.1 The profile of projects and anganwadis in Karnataka

Table 4

	Rural	Urban	Tribal	Total
ICDS Projects				
Sanctioned	166	10	9	185
Operational	166	10	9	185
Anganwadi Centres				
Sanctioned	35,898	1,151	3,252	40,301
Functioning as on Feb. 2003	35,898	1,151	3,225	40,274

Source: Dept of Women and Child Development, GOK website

While, at the macro level there seems to be universalisation of the ICDS, in that every Block has an ICDS project functioning; **at the ground level, there are many communities not served by an AWC** (Anita Kaul, 2000 in Lakshmi Krishnamurthy et al, 2000). In all probability, these are areas in remote rural and tribal areas which do not fulfil the population criterion needed for initiating an AWC. Urban poor communities may also be left out since they are considered 'unauthorised' settlements; not deserving of government services; the provision of which, the government fears will give them some level of security. This implies that children of socially and economically marginalised communities have little or no access to health, nutrition and educational services. That it is the tribal areas in which AWCs fall short of the target is borne by the fact that as against 3252 sanctioned projects, 3225 are functioning as opposed to 100% functioning against sanctioned in both rural and urban areas (*refer Table above*).

Of the 40,274 AWCs operational in Karnataka; 310 are run by an NGO Sumangali Seva Ashram (*see page 45);* while the rest are run by the DWCD.

3.2 Expansion of the ICDS projects in Karnataka

Table 5

Sl. No.	Year	State Sector	Central Sector	Total
1	1975-76	-	1	1
2	1976-77	2	-	2
3	1977-78	7	-	7
4	1978-79	5	4	9
5	1979-80	1	3	4
6	1980-81	-	3	3
7	1981-82	15	19	34
8	1982-83	-	18	18
9	1983-84	-	-	-
10	1984-85	-	8	8
11	1985-86	-	-	-
12	1986-87	-	8	8
13	1987-88	-	-	-
14	1988-89	-	14	14
15	1989-90	-	28	28
16	1990-91	-	6	6
17	1991-92	-	6	6
18	1992-93	-	18	18
19	1993-94	-	19	19
Total		**30**	**155**	**185**

The first project initiated in 1975-76 was supported entirely by the Centre. From 76-77 to 81-82 projects received support both from the State and the Centre. From 1982-83 onwards, all projects have come under the Central sector. Growth in ICDS projects is determined by the allocations made at the Central level, which may be a function of the resources made available both through the Planning process as well as through external funding.

3.3 Table 6: District-wise profile of coverage

Sr. No	District	No. of AWC	Total population within project		AWCs giving SNP for 21 days	No. of SNP beneficiaries		No. of PSE beneficiaries	
			< 6 yrs	Women		< 6 yrs	Women	Boys	Girls
1	Bagalkot	1,363	1,79,877	32,735	1,355	91,878 (51%)	21,138 (64.5%)	22,926	23,667
2	Bangalore (Urban)	1,192	1,49,298	19,603	1,192	68,573 (45.9%)	14,028 (71.5%)	16,343	16,881
3	Bangalore (Rural)	1,890	1,20,809	22,390	1,890	92,811 (76.8%)	20,325 (90.7%)	22,778	22,919
4	Belgaum	3,773	4,67,791	80,252	3,773	1,67,588 (35.8%)	50,369 (62.7%)	73,924	69,124
5	Bellary	1,371	2,16,282	34,510	1,371	96,504 (44.6%)	19,619 (56.8%)	26,624	26,745
6	Bidar	1,151	1,83,518	34,969	1,151	91,493 (49.8%)	18,060 (51.6%)	25,717	25,218
7	Bijapur	1,300	2,03,157	37,559	1,292	91,612 (45%)	17,145 (45.6%)	24,973	24,551
8	Chmrjngr	1,085	86,600	15,720	1,085	61,869 (71.4%)	10,240 (65.1%)	13,453	13,401
9	Chikmglr	1,226	72,355	11,951	1,226	51,458 (71.1%)	9,872 (82.6%)	14,519	14,448
10	Chitrdurg	1,335	1,38,342	26,196	1,336	95,390 (68%)	19,805 (75.6%)	23,502	23,729
11	Dakshin Kannada	1,775	1,35,311	20,723	1,775	87,802 (64.8%)	17,735 (85.5%)	20,778	20,554
12	Davngere	1,262	1,63,828	26,356	1,238	92,065 (56.1%)	14,265 (54.1%)	23,812	24,271
13	Dharwad	806	1,06,711	19,871	806	62,970 (59%)	13,243 (66.6%)	16,956	16,542
14	Gadag	835	1,05,243	19,915	836	69,350 (65.8%)	11,863 (59.5%)	15,716	15,683
15	Gulbarga	2,350	4,02,893	64,014	2,350	1,87,545 (46.5%)	33,086 (51.6%)	50,685	50,083
16	Hassan	1,602	1,16,216	19,308	1,602	70,911 (61%)	16,772 (86.8%)	18,006	17,846
17	Haveri	1,167	1,63,519	30,601	1,167	95,354 (58.3%)	21,819 (71.3%)	25,980	25,970
18	Kodagu	692	44,796	8,037	692	30,610 (68.3%)	7,273 (90.4%)	6,017	6,252
19	Kolar	2,360	1,76,173	34,603	2,360	1,37,165 (77.8%)	31,840 (92 %)	33,245	33,482
20	Koppal	893	1,56,619	25,220	893	68,563 (43.7%)	16,199 (64.2%)	17,608	17,432
21	Mandya	1,655	1,54,603	24,987	1,656	86,996 (56.2%)	18,553 (74.2%)	20,106	20,342
22	Mysore	1,886	1,83,411	34,033	1,886	1,06,838 (58.2%)	22,256 (65.3%)	26,656	27,260
23	Raichur	1,306	1,84,336	36,795	1,306	99,307 (53.8%)	21,428 (58.2%)	24,940	24,217
24	Shimoga	1,323	1,09,434	19,210	1,323	65,868 (60.1%)	12,811 (66.6%)	17,490	17,118
25	Tumkur	2,337	1,79,592	32,464	2,337	1,28,875 (71.7%)	28,012 (86.2%)	32,595	32,248
26	Udupi	1,027	73,952	12,487	1,027	50,394 (68.1%)	11,028 (88.3%)	11,667	11,738
27	Uttar Kannada	1,201	82,189	13,448	1,201	57,994 (70.5%)	9,441 (70.2%)	15,460	14,940
	Total	40292	43,56955	7,57960	40124	25,08793 (57.5%)	5,08734 (67.1%)	6,42476	6,36761

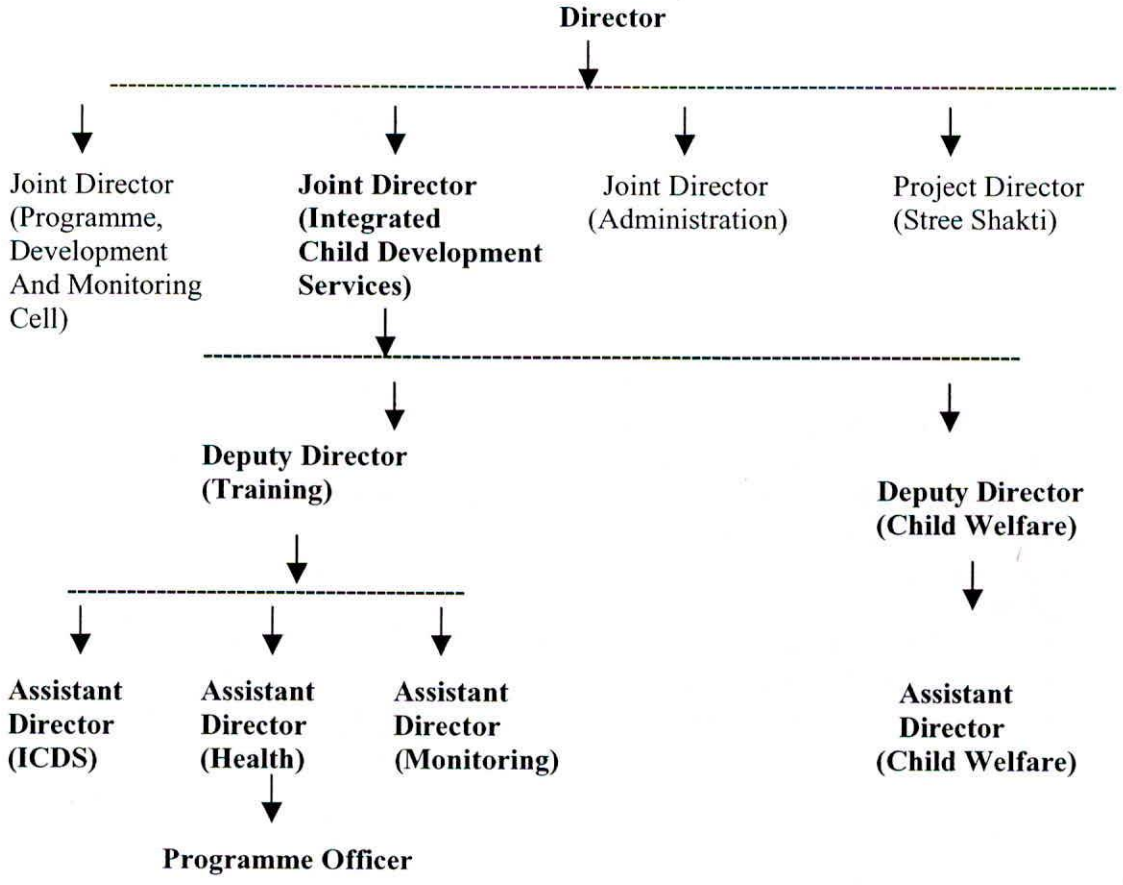
The above table has been taken from the Reporting format II for the month of December 2003 used by the DWCD for monitoring the ICDS. This is taken as **indicative of broad trends** and lends itself to the following analyses:

1. The State coverage for the Supplementary Nutrition Programme (SNP) for children in the 0-6 years age group is 57.5% and for pregnant and lactating mothers is 67.1%. Considering that as much as Rs. 10566.02 lakhs is spent on the programme every year, the coverage seems abysmal. However, it falls within the national norm of expected coverage of 40% for the SNP. When seen District-wise, districts in North Karnataka fair worse than those in coastal and South Karnataka as seen in the case of Belgaum (35.8%), Bellary (44.6%), Bijapur (45%), Gulbarga (46.5%), Bidar (49.8%), Koppal (43.7%). Bangalore Urban (49.5%) also shows less than 50% coverage which seems surprising but may be explained by the fact that given the option of other private pre-school centres, the numbers of children attending ICDS centres may be less.
2. Overall, the SNP for pregnant and lactating mothers seems to fare better than that for children. Some districts show more than 90% coverage (Bangalore Rural. Kodagu, Kolar). In general, Northern districts fare worse.
3. It is astonishing to note that as many as **168** AWCs do not supply supplementary nutrition for 21 days. While it may be true only of this particular month and while any AWC that falls short of even one day is included; it still raises cause for concern.
4. Data presented by the Department is in a form that often defies analysis. One wonders whether this is just a lack of application or whether it is by design. While the figures of children attending the pre-school education programme is given; the total population under six years is not differentiated into 0-3 and 3-6 years, making any analysis of coverage impossible.

3.4 Staffing

The ICDS functionaries come under the administrative control of the Department of Women and Child Welfare. The Department is responsible for the recruitment, training and supervision of all the functionaries.

Figure 4: Organisational structure of the Department at state level



Organisational structure at the district level



Table 7: Staff position as on March 31st, 2003

Sr. No.	Designation	Posts sanctioned	Actual number in place	Posts vacant
1	CDPO	185	171	14
2	ACDPO	219	184	35
3	Supervisors	1875	1592	283
4	Anganwadi workers	40301	39785	516
5	Anganwadi helpers	40301	40265	36

Source: DWCD, GOK, 2004

It was in the category of Supervisors that a lag had existed which has been minimised with a recent recruitment drive. 40% of supervisor posts have been reserved for AWWs which is a welcome step. This will not only ensure career growth for AWWs, but their knowledge of field realities will also help them perform this role better. The shortfall in AWWs may be explained by the fact that some of them have been promoted as Supervisors.

3.5 Financial outlays

The following table summarises the financial outlays and expenditure for 2000-03.

Table 8: Allocation from the GOI

Rs. in Lakhs

Sr. No.	Scheme	Year	Total GIA	Expenditure	Balance
1	ICDS	2000-01	7466.18	6655.20	810.98
		2001-02	7660.67	7329.77	330.90
		2002-03	10541.29	9860.08	681.21
2	Udisha	2000-01	433.72	213.43	220.29
		2001-02	270.29	189.07	81.22
		2002-03	239.22	196.64	42.58
3	Pradhan Mantri Gramodaya Yojana (PMGY)	2000-01	3000.00	-	3000.00
		2001-02	4573.00	2567.54	2005.95
		2002-03	3778.95	2892.44	886.51

Source: DWCD, GOK, May 2004

The Central assistance for the ICDS went up in the year 02-03. This was due to an increase in the honorarium of AWWs by Rs. 500 per month and that of helpers by Rs. 240 per month. In addition, it was expected that the vacant posts of Supervisors would be filled (Supervisor recruitment drive took place in 2003-04). The funds allocated under the PMGY are used for the Supplementary Nutrition Programme.

Under Udisha, the year 2000-01 saw a higher allocation, probably to take care of start-up costs. However, the entire allocated outlay was not utilised. This is because grants are received on the basis of the expenditure of the previous year. Department officials however say this is a vicious cycle. Grants cannot be spent unless received and receipts are not possible unless expenditure is shown!

Table 9: State government outlays

Rs. in Lakhs

Year	SNP	Additional honorarium for AWWs	Total
2000-01	10908.60	1721.09	12629.69
2001-02	11350.95	1778.48	13129.43
2002-03	8455.15	1430.82	9885.97
2003-2004	10566.02	1461.23	12027.25

Source: DWCD, GOK, 2004

The State Government funds the Supplementary Nutrition Programme (SNP) at the anganwadi centres as well as an additional honorarium of about Rs. 450 for AWWs. The Year 2002-03 saw a decrease in allocations for both SNP as well as additional honorarium for AWWs. This is also the year in which the Central allocations were greater, due to the increase in honorarium of AWWs; which also explains the decrease in State government allocations for additional honorarium.

Though the ICDS programme sees a convergence of services of different departments, the funding for the programme comes only from the DWCD. Other Ministries such as Health contribute through health supplies, vaccines etc.

3.6 Components of the ICDS programme

The ICDS aims at the integrated delivery of health, nutrition and education for the wellbeing of the child under 6 years. The AWC is the site for the delivery of services, and serves as the converging point at the local level for services delivered by different departments; most notably, Department of Women and Child Development and Health and Family Welfare.

3.6.1 Health

Health implies not just an absence of disease but a positive state of well-being. The ICDS aims at enhancing the well-being of the child under six years and pregnant and lactating mothers through a range of services. The intervention on health aims at:

- immunisation of children under six against the six killer childhood diseases, and of pregnant women against tetanus
- reducing anaemia in both children and mothers through iron and folic acid supplements
- reducing night blindness through Vitamin A supplements
- deworming to enhance the nutritional status of the child and
- referrals to Primary Health Centres.

The above services are carried out by the AWW with the support of the functionaries of the Department of Health and Family Welfare.

Immunisation

The intent

Immunisation for children under six years is undertaken against the 6 vaccine preventable diseases - diphtheria, whooping cough, tetanus, poliomyelitis, tuberculosis and measles. In addition, pregnant women are given Tetanus Toxoid (T.T).

Table 10: Service delivery and impact

For Karnataka, the progress achieved under this programme for 2002-03 is as follows:

Target *(in actual numbers)*	**Achievement *(in actual numbers)***			
For BCG, DPT, Polio and Measles	BCG	DPT	Polio	Measles
1026350	994940	982838	782821	928517
	(96.94%)	(95.76%)	(76.27%)	(90.47%)

Target For T.T	**Achievement**
10,99,345	10,29,521 (93.65%)

Source: Dept of Women and Child Development, GOK website, 2004

The above are percentages of the total child population below six years in the ICDS project area and seem to indicate an impressive coverage.

For all immunisations, Karnataka is above the national average. Infant Mortality Rate in ICDS areas has come down from 120/1000 in 1975 to 58/1000 in 2000 (Dept of Women and Child Development, GOK website, 2004).

Comment

From a sample survey, the NCAER study (2000), reports that 70% of the children in Karnataka are immunised against the six killer diseases. More recent reports however report some disturbing trends. For instance, after being polio-free for the last few years, 35 cases of polio were reported in Karnataka in 2004. The NFHS II study (2000), puts the immunisation coverage as 60% of all children below six years. According to UNICEF between 1997 and 2000, the routine immunisation coverage fell for India fell from 60 to 40%.
(www.unicef.org/infoby country/india.html) .

Regional variations within Karnataka also need to be noted. Large-scale migration in North Karnataka, for example, often means that children neither get immunised in Karnataka nor in the neighbouring states to which they migrate.

The high levels of coverage in immunisation against polio may be attributed to the Pulse Polio campaign, which has secured high commitment from the political and administrative machinery. Vaccines for the immunisation programme need to be kept under refrigeration. Whether this is being followed strictly needs to be monitored. Activists have found cold-chain vaccines being kept without being refrigerated in District Offices.

Health check-up and referrals

The Intent

The Health check-up services aim at treatment of common childhood illnesses such as diarrhoea, provision of iron and folic acid and Vitamin A supplements and deworming.

Health check-ups are to be held by Medical officers from nearby Primary Health Centres once a quarter to monitor the ante-natal and post-natal care of mothers and the care of severely mal-nourished children under six years of age and 'at risk' children such as those born with congenital defects. Medicine kits are also provided to Anganwadi centres to render primary health care.

In addition, severely malnourished children identified under Grade III and IV, pregnant women and nursing mothers suffering from serious ailments are referred to nearby Government Hospitals for specialised treatment. As of December, 2003, 8869 children belonging to III Gr. and IV Grade were availing referral services (Dept of Women and Child Development, GOK, 2004).

Service delivery and impact

The NCAER study (2000) reports that the coverage for antenatal services has been poor with only 34% in urban and 48 % in rural areas being registered in the AWC. In a micro study conducted by Karnataka FORCES (an advocacy network on behalf of the young, underprivileged child) of 37 AWCs, it was found that iron and folic acid supplies have not been replenished in some centres in Bangalore (Rural) (FORCES, 2003).

While many of the AWWs covered by the FORCES study said that they organised monthly or quarterly health check-ups; most were vague about the details. In one AWC in Bangalore (Rural), the doctor had not visited for three years!

Referral services translate, on the ground, to a slip of paper given by the AWW referring the mother and child to a nearby PHC. While Department officials claim that AWWs follow-up with the mothers; anecdotal testimony from the field reveal that no follow-up is maintained. There is no record of follow up of whether mothers actually go the PHC and the nature of treatment meted out.

Supplies of medicines and vaccines are not replenished adequately and when needed. This has implications for the impact of the service.

Disability

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995) clearly calls for:

- education of the public through the pre-schools, primary health centres, village level workers and **anganwadi workers**
- screening all the children at least once in a year for the purpose of identifying 'at-risk' cases and
- taking measures for pre-natal, perinatal and post-natal care of mother and child.

The AWC and the PHC seem to be the ideal locations for the spirit in the above Act to be translated on the ground.

Comment

While programmes of the ICDS such as timely immunisation are disability prevention strategies; the potential for identifying and addressing early childhood disabilities, through the ICDS and the public health care infrastructure does not seem to feature very strongly in the ICDS programme.

In only 3 of the 37 AWCs covered in the FORCES study were children with disability seen, suggesting that measures for inclusion need to be enhanced. The staff of only one centre had received the Portage training (a tool for facilitating early diagnosis and intervention for children with disabilities).

There have been some new initiatives such as the training of AWWs in selected districts in early intervention for children with disabilities (undertaken by Seva in Action, based in Bangalore) as well as the DWCD initiated Community-based Rehabilitation Network's Portage training (under Udisha) that aims at early identification and early stimulation of children with disabilities in 16 districts. These need to be strengthened. In addition, disability prevention as well as appropriate remedial measures need to be seen as one of the goals of the ICDS programme.

3.6.2 Nutrition, growth monitoring and health education

There is enough evidence to show that malnutrition has tremendous long-term impact on the child's growth, limiting severely her capacities for learning. Nutritional supplements and monitoring the growth of children through weight-for-age growth charts represent the efforts of the ICDS programme to stem malnutrition amongst children below six years.

The intent

Growth is to be monitored by weighing children below three years once a month and those above three years, once a quarter. Weight-for-age growth charts are to be maintained and a community chart reflecting the nutritional status of all children registered in the AWC displayed.

This data seeks to help mothers and AWC staff to take corrective action, in terms of additional nutrition, in case the child falls below the standard norms; thus preventing malnutrition (ICDS, DWCD, GOI, 1995).
Nutritional supplements are provided to both children and pregnant and lactating mothers with a view of filling the caloric gap between required nutritional intake and what is available through regular intake of food.

The programme reaches out to around 30 lakh beneficiaries. Children in the age group of six months to six years, pregnant women and nursing mothers and adolescent girls in the age group of 11-18 years (in some districts) are provided supplementary nutrition each month. Special attention is paid to children who are severely malnourished, who are given special therapeutic (Amylase Rich Food) supplementary food, or double the ration.

According to the Department of Women and Child Development, GOK, (2004), differential nutritional supplements are given through the programme, varying according to the age of child and location of centre.

- children in the **6 months to 3 years** age group – Amylase Rich Food (ARF) is given 5 days in a week (100 gms. of which provide 13.5 gms. of protein and 380 calories of energy) and egg on one day.

- children in the **3-6 years** age group - Energy food is given for 2 days, egg on one day and rice-based local food for 3 days. Energy food is a mixture of wheat, bengalgram dal, groundnut cake, soya, jaggery, vitamin premix, calcium with iron fortification. This has to be mixed with lukewarm water and made into laddus.

- **pregnant women and nursing mothers** - 1.5 kg. rice and 2.75 gms. of green gram are given as take home food every week.

- Milk bread is given to the beneficiaries of the two **urban ICDS projects of Bangalore** city only. 2 slices of bread weighing 60 grams is provided to each beneficiary per day for 300 days in a year.

Food supplies come from different sources. Rice is sourced from the Ministry of Food and Civil Supplies and oil from the Karnataka Oil Federation. 50% of the ARF is sourced from Karnataka Agrocorn Products and 50% from private suppliers, through tenders. The remaining items are sourced from private suppliers through tenders.

Service delivery and impact

In popular perception, the ICDS is identified as a feeding programme, which is seen as the most visible and tangible service. In fact, in many urban slums in Bangalore, the AWC is called a 'paal-roti' (milk and bread) schools (MAYA, 2002). It is at feeding time that most children turn up at the centre. At one AWC, though 22 children in the age group of 3-6 years were enrolled, 44 children turned up at mealtime (FORCES, 2003).

Comment

According to the NCAER (2000) study, in Karnataka, food is delivered to the centres 288 out of the 300 prescribed days. In terms of coverage, supplementary nutrition was accessed by an average of 62 children and 10 women per AWC, slightly lower than the national average of 74 and 15 respectively. However, a report submitted to the Supreme Court by Commissioners reviewing the performance of welfare schemes for the poor (in response to a Public Interest Litigation filed by the People's Union for Civil Liberties) puts the **national coverage at a mere 16% of undernourished children** *(See Annexure on Page 48).*

At the national level, there is some evidence of the positive impact of the nutrition programme, with a significant reduction being brought about in malnutrition (NIPCCD, 1992). However other studies (Tara Gopaldas and Sunder Gujral quoted in Lakshmi Krishnamurthy et al, 2001) show no significant difference in ICDS and non-ICDS areas except in Tamil Nadu, where results could be attributed to the Tamil Nadu Nutrition Programme which functioned with a concentrated focus on nutrition, in conjunction with an efficient public health system (Lakshmi Krishnamurthy et al, 2001).

Growth monitoring

Maintenance of growth cards was reported by 75% of the AWCs in only 4 districts (NCAER, 2000). The authenticity of this data needs to be seen against the fact that the growth charts are very complex making it difficult for AWWs with limited training to fill them. Though AWWs are aware of the necessity of maintaining various records, the growth chart neither figures as being amongst one of the more important from the point of view of monitoring the growth of the child, nor is its link with nutrition recognised.

While only 13 of the 37 AWCs observed by the FORCES micro-level study had weighing machines, 33 of them said they weighed children regularly. This is one more instance of the AWW probably simply filling up the registers for fear of being pulled up by her superiors for not doing her job. Often AWWs say that superstitious beliefs of parents do not allow the child to be weighed for fear that the child may become thin. In addition, though the growth charts showed most children as being normal in weight; the observation of children in the Centre was to the contrary (FORCES, 2003).

Malnutrition

Across Karnataka, about 64% of children were reported to be moderately malnourished. In 71% of the ICDS Blocks, between 50-75% of children were severely malnourished (NCAER, 2000). Gulbarga and Bellary have the most number of children in the severely malnourished category followed by Belgaum, Koppal and Raichur.

As per data from the DWCD, as of Dec, 2003; 32% of the children in the 0-6 years age group are under grade I and II (moderate) malnutrition and 0.24% are severely malnourished.

Comment

If in spite of such an impressive (on paper) web of services, periodic reports of child deaths due to malnutrition still come in; the question arises whether these initiatives have an **impact on the overall nutritional status** of the child.
It is important to note that the chances of mortality are highest in the severely malnourished category. The low figures for severely malnourished children need not indicate a low occurrence of severe malnutrition given that many infants who are severely malnourished die, and that many infant deaths go unrecorded. Unless this data is seen with data on infant deaths (which may also be underreported), it is difficult to assume that there are very few children who are severely malnourished.

It is also noteworthy that AWWs are inadequately trained and have very little clarity on the different levels of malnutrition. According to an activist, in a training programme, AWWs (who had earlier received training from NIPCCD) reportedly mentioned Grade I and II (moderate malnutrition) as children doing reasonably well and needing no intervention. Children in Grade III and IV (severe malnutrition) were seen as faring badly. That the moderately malnourished children require immediate attention, given that they run the risk of moving into the severely malnourished category even with a small infection; was something that the AWWs had missed.

Malnutrition is monitored by weighing and weight-for-age charts, which as we have seen earlier are not being maintained rigorously. The authenticity of data recorded under such circumstances then becomes suspect.

The ICDS solution of doubling the ration or giving special nutritional supplements to malnourished children does not always work in an environment where food may be scarce. The AWW cannot turn away children, nor can she give extra food to those who may need it more. In addition, food and especially rations may be taken home to be shared with other siblings and sometimes adults.

The poor quality of food is the most oft-repeated complaint from the recipients, with reports of worms found in the food ((FORCES, 2003). The NCAER study states that the poor quality of nutrition impacts the functioning of AWCs adversely in 40% of rural AWCs especially in Bidar, Kolar, Mandya and Mysore districts.

Inadequate supplies, siphoning off of the supplies, transport problems in delivery are also pressing issues in the implementation of the Supplementary Nutrition Programme.

Nutrition and health education

The intent

With the aim of creating awareness about good health and nutrition to women in the age group of 15-44 years with a focus on expectant and nursing mothers; trained Supervisors, Anganwadi Workers, ANMs and LHVs jointly conduct nutrition and health education sessions. Home visits are also undertaken. The content of the sessions include child care, care of pregnant women and nursing mothers, diet needs, immunisation, supplementary nutrition for children, sanitation, hygiene, cleanliness etc. (Dept of Women and Child Development, website, GOK, 2004).

Service delivery and impact

The NCAER study (2000), states that 70% of mothers have been advised with regards to their and their children's diets, a majority of mothers seem to be aware of the basic aspects of child feeding; 70% of mothers breastfed their babies on the day the child was born; breastfeeding was normally carried out for 15 months and was on demand.

Comment

These findings however need to be viewed with caution. Various traditional harmful practices still continue. For e.g. in most parts of Karnataka, colostrum is rejected and not given to the infant. Practices for introduction of semi-solids also vary. In some cases, largely in lower-income groups, supplementary foods are introduced too early. Due to compulsions of the mother going to work, the infant may be given supplementary foods as early as three to four months. Often, this may be just biscuits and tea, inappropriate nutritionally for such a young infant. Though ragi kanji is a common weaning food, it may be prepared under unhygienic conditions putting the infant at risk. Infants also need to be fed frequently, something which a working mother may not have time for and which an older sibling may not be able to do effectively.

There is also evidence that supplementary foods may be introduced too late. Introduction of semi-solids before 8 months is culturally unacceptable in many parts of Karnataka (Lakshmi Krishnamurthy et al, 2001).

The NCAER study also acknowledges that the effectiveness of the NHE sessions is not clear. Response to campaigns through the audio-visual programmes and attendance at mothers' meetings has been poor. This is substantiated by field observations which record that this is one of the weakest components of the ICDS programme (Lakshmi Krishnamurthy et al, 2001). The fact that the AWW is not adequately trained and has little knowledge about the very issues on which she is expected to educate, compounds the matter. In addition, unless the NHE messages are contextualised within the realities of the mothers and made relevant, it is unlikely that these sessions will have any impact.

The **location** of the AWC makes a difference to the frequency of the AWW-community interaction. In cases where the AWC is in the centre of the community, more interaction is possible. The dynamics of **caste and community** underline home visits with access or the lack of, being determined by the AWW's caste; thus notable reducing coverage and impact.

Recommendations

- Deworming every 6 months and giving Vitamin A and iron in tablet or liquid form everyday in the AWC may be tried.
- Early identification and appropriate treatment of childhood disability, through community-based programmes, is crucial.
- Training on why growth monitoring is important and its impact on the nutritional status of the child need to be strengthened.
- Weighing the child and growth monitoring is crucial. Parents need to be educated on their importance and their co-operation sought.
- The AWC must be open throughout the day and a hot cooked meal, along the lines of the primary school meal programme be designed. In addition, the supplementary nutrition component can look at snacks that are packed with nutrition but not very time-consuming to prepare, thus freeing the AWW for other tasks with the children. For example, seasonal fruits, groundnut and other kinds of *chikki*, sprouts *bhel*, as well as energy foods may be given.
- Regular replenishment of medical supplies and the medical kit is essential.
- The NHE sessions can be more effective if they are linked to the local context and possibilities of practice are clearly shown; rather than the focus on ideal messages, which may be difficult to practice.
- The AWC should be located in a central place so that all members of the community have access.

3.6.4 Early childhood care and pre-school education

Advances in neuro-science demonstrate the critical importance of appropriate stimulation to the child under 6 years, the period of rapid brain growth. Though corrective actions may be possible at later stages; the brain is at its most malleable at this age. Studies across the world also show that pre-school education has a remarkably positive impact on school enrolment, retention and learning achievement.

The intent

The ICDS programme is meant to offer pre-school education for three hours to children in the age group of 3-6 years in the anganwadi centres through an integrated approach. The pre-school education component also seeks to provide a better linkage between primary schools and the anganwadi centres. The programme seeks to promote child-centred play-way activities, built on local culture and practices that promote the child's social, emotional, cognitive, physical and aesthetic development (ICDS, DWCD, GOI, 1995).

Service delivery and impact

There seems to be an across-the board acknowledgement that AWCs do help break children and families into the culture of schooling, making it easier for the child to adjust to school. Children are used to the routine of going to school, engaging in structured activities and interacting with other children (FORCES, 2003).

Acknowledging the significance of pre-school education for universalising elementary education, efforts have been made by the District Primary Education Programme (DPEP) to strengthen the pre-school component in the ICDS. Supplementary training and appropriate material have been provided with an aim of impacting the quality of pre school education within the ICDS. In addition, new centres were set up, adjacent to primary schools, in areas where ICDS was not operational. Efforts were also made to improving the ICDS-primary school linkage by encouraging AWCs to extend their timings to synchronise with the primary school, enabling older siblings especially girls to attend school (Venita Kaul in India Education Report, 2002).

Coverage

About 90 children[3] in the coverage area of each AWC (population of 1000 people) would be children in the age group of 3-6 years, making them eligible for pre-school education. Of children eligible for PSE, more than 60% (about 54 children) have been enrolled in rural AWCs, with a marginally less number in urban AWCs (NCAER, 2000).

However, field observations state that there are usually only about 20 children in the AWC, including 1-3 year olds who may have come with their older siblings (Lakshmi Krishnamurthy et al, 2001). Numbers of children may increase around the meal-time, reinforcing the perception that the AWC is largely seen as a feeding centre.

Field experiences of MAYA, an NGO, working on ECCE issues and educational reform, supports the observation that coverage of pre-school education is limited. In some of the low-income areas in Bangalore where MAYA works, there are 22 AWCs to meet the educational needs of 5000 pre-schoolers, an alarming 200 children per AWC. The coverage for PSE through the ICDS centre is thus quite limited.

Content

The DWCD along with UNICEF and other groups has developed an 'activity bank', comprising a collection of 100 stories, songs, creative activities and games for the overall development of the child. An integrated approach of 42 themes has been developed with one theme being taught each week. The Department of State Education, Research and Training (DSERT) has developed an activity-based, thematic approach to PSE called 'Chilli Pilli' and trained 2100 AWWs in 10 Janshala Blocks (educationally backward blocks identified by the Department of Education) in using it. The manual seems developmentally appropriate and very colourful; but its use has not expanded to the whole State.

[3] About 9% of a population of 1000 (the coverage area of an AWC) would be children in the 3-6 age group.

Field observations however suggest that the PSE component is not being fully put to practice. In 22 of the 37 centres visited in the course of the FORCES (2003) study of 37 AWCs, field workers observed no educational activity going on. Often, AWWs were involved in completing records while children just sat around.

In terms of the content of PSE, parental pressure and the AWW's own comfort levels ensure that where there is any educational activity going on, it is largely group activities such as songs and stories and the teaching of the 3 Rs. While AWWs have been trained in activity-oriented teaching and have educational material at their disposal; these are rarely used. For one, they may be worried about being hauled up for material being 'spoilt'; there being no funds for much required replacement due to usage. Very often, the AWW spends her own money on making teaching aids.

The FORCES study reports that toys available at the Centres were far from adequate. Materials are supplied on a one-time basis and not used everyday, or used under strict supervision. Charts are hung much above the eye-level of children. While there seem to be monthly and yearly plans, AWWs question their usefulness to their context.

Achievement

According to the NCAER study (2000), only 40% of children are able to describe the activities of the PSE; with it being an abysmally low 15% in the rural areas of Bijapur and Hassan.

Comment

PSE is not being given its rightful due within the ICDS. While there have been pockets where with highly motivated AWWs and good support from supervisors and CDPOs, there has been some impact (eg. Mandya, Dharwad); in general the picture is dismal.

The AWW is overburdened with many tasks and the requirements of the feeding programme often take up a lot of her time. In addition, parental expectation that children be taught reading and writing and not just songs and games makes it difficult for directions at the macro level (of joyful, activity-based learning) being implemented at the micro level.

The experience of the DPEP- supported AWCs (with extended timings) is a mixed one. In areas such as Mandya, where training and other inputs were also received from CRY, UNICEF etc. the impact has been very encouraging, with higher levels of enrolment, retention and achievement. This however has not taken place across all DPEP districts. Also, there seems to be very little ownership of this component in the ICDS, leading to questions of its sustainability (Venita Kaul in India Education Report, 2002). The issue of poor quality in the PSE component have also been raised by national-level studies (Upadhaya et al, 1998, Kaul et al, 1998 in Venita Kaul in India Education Report, 2002).

In spite of its lacklustre performance, it has been acknowledged by policy-makers, ICDS functionaries, researchers as well as field practitioners in Early Childhood Education that the ICDS does enable higher 'school readiness', creating a culture of schooling in the community and instilling a habit of going to school in children. Evaluations have indicated that the DPEP model for ECCE (adjacent to primary school), was more effective than the AWC in providing a stimulating environment to children and a feeling of bonding with the school (Venita Kaul in India Education Report, 2002).

The ICDS has the potential to play an extremely critical role in the national quest for universalising elementary education, by enabling a strong foundation for later academic achievement. Higher political and administrative commitment is required to enable the realisation of this potential.

Recommendations

- The timings of the ICDS need to be extended and wherever possible, AWCs converted into full-day Anganwadi-cum-crèches. An additional PSE teacher may be appointed whose tasks will be solely that of PSE. Additional resources may be secured from the Department of Education funds, especially the Sarva Shiksha Abhiyan programme; given that there is ample evidence to prove that pre-school education ensures better enrolment, retention and academic achievement. In addition, if younger children are kept in a full-day Centre, older siblings especially girls are freed from sibling care and can attend school themselves.
- The importance of pre-school education in the child's overall development should be made more explicit to ICDS functionaries down the line as well as to parents and the larger community. This will enable the PSE component secure its rightful place in the programme.
- Wherever possible, the AWC should be located in or close to the Lower Primary School.
- Educational materials need to be replenished regularly. Their use rather than their being maintained in their pristine form, should be the indicator for assessing the performance of the AWW.

3.7 Infrastructure of the anganwadi centre

In comparison with the rest of the country, the overall picture of the infrastructure of the ICDS programme in Karnataka looks good, though there is a need for improvement in many areas.

Anganwadis were located within one kilometre in 92% of the villages in Karnataka. Such access was of a lower order in Chikmagalur (64%) and surprisingly 100% in Bijapur, Bellary and Mandya (Public Affairs Centre, 2002).

60% of the urban and 50% of the rural AWCs are centrally located. 2 in 3 AWCs have enough space with rural AWCs being better off; the space constraints in an urban slum being a barrier to having the required space for activities (NCAER, 2000).

Ownership of physical space

Of the 40,274 AWCs functioning in the state, only 22,304 centres (55%) have their own buildings (DWCD, GOK website, 2004). In other cases, they may function from temples, Panchayat buildings, buildings of charitable institutions etc.

This may have implications on access – children of religious minorities or from Dalit communities would not be able to avail of ICDS services, if it functions from a temple. In one AWC in Bangalore that is run in a temple, the local community does not allow the AWW to enter the temple when she has her periods, resulting in the AWC being shut four-five days in a month. Similarly, functioning from institutions owned by other people might mean irregularity in functioning, dependence on the institution's policies, an unsafe and undesirable environment for children etc.
For instance, field observations report that in 24 out of 37 AWCs visited in Bangalore city, cigarette butts were seen lying around. Investigators were also told that the place was used for drinking by men (FORCES, 2003).

Some AWCs function from homes with activities like cooking being simultaneously carried out and the risk of accidents looms large. Storage space for materials may also be limited (FORCES, 2003). In some cases, 2-3 AWCs functions from the same place (Sriramapuram AWC quoted in FORCES, 2003 and Bhangi Colony, Mysore Road quoted in MAYA, 2003). In such scenarios, AWWs may work out shift systems and absent themselves more frequently.

The Department is aiming at constructing buildings for all the AWCs running in makeshift places. **A budget provision of Rs. 11 crores for construction of 835 Anganwadi buildings during 2002-03 has been made by the Government of Karnataka.** In addition, other developmental schemes such as the Employment Assurance Scheme, schemes of the Malnad Area Development Board, Hyderabad Karnataka Development Board as well as loans from NABARD are being used. This needs to be given priority.

Water, toilet and play facilities

Water facilities are available in more than 70% of urban AWCs while only 50% of rural AWCs have piped water, with a few having access to handpumps and tubewells. In more than 75% of the AWCs, awareness on safe measures of water storage is prevalent.

Toilet facilities are abysmal. 90% of AWCs do not have a toilet (NCAER, 2000). The FORCES study (2003) corroborates this by reporting that in 25 of the 37 AWCs, there were no toilets with four of the rest being non-functional.

AWCs in urban areas are marked by the lack of open play spaces for children, located as they may be alongside roads, in small rooms leading out to narrow, often unhygienic lanes etc. (FORCES, 2003).

Comment

While the macro picture may not look as grave as in other parts of the country; the micro picture does reduce the quality of service offered. The lack of infrastructure like water and toilets is but a reflection of the larger failure of development in a region (most urban slums and areas in rural North Karnataka would not have access to water and toilet facilities); yet, provision of quality Anganwadi services require that serious attention be paid to ensure these basic services.

Recommendations

- The efforts of the Department to ensure that the AWC functions from its own premises need to be strengthened. Support from the private sector as well as local charitable institutions may be taken for ensuring that all AWCs have their own buildings as well as supply of water and toilets. This becomes more crucial if the timings of the AWC are to be extended.
- The AWC should be located in the centre of the community and as far as possible in or close to the Lower Primary School.
- Norms for the maintenance and upkeep of the AWC should be laid down and stringently monitored. Leaking roofs, pitted floors etc. need to be immediately repaired. Local resources in the form of labour can be accessed, voluntarily, for these minor jobs.
- Cooking space should be in a separate room with adequate ventilation.

3.8 A profile of the anganwadi worker and helper

The ICDS by design requires the AWW to be a member of the local community so that she is better accepted and will have more effective ways of communicating with the beneficiaries. Her involvement is seen as voluntary by the government, which probably provides the justification for the fact that she is paid less than the legal minimum wage (Lakshmi Krishnamurthy et al, 2001). As of June, 2004, an AWW is paid Rs. 1450 per month, of which Rs. 1000 comes from the central Budget and Rs. 450 is the contribution of the Government of Karnataka. Helpers are paid Rs. 700 per month.

Most AWWs in Karnataka are within the age group of 30-40 years, with the urban AWWs being slightly older and married. Helpers would be slightly older and 20% of them are single women (Lakshmi Krishnamurthy et al, 2001).

That a lot of communities where AWCs are located would be educationally backward communities may have a bearing on the fact that **less than 50% have secured education upto matriculation and above;** though the minimum qualification is matriculation. In 7 districts less than 25% of the AWWs were educated till matriculation. While it is true that motivation and an aptitude for the job may be more important than the formal educational qualifications, there also seems to be a co-relation between better performing ICDS districts and educational qualification of AWWs (NCAER, 2001). **Helpers are most often illiterate,** and yet, in many cases may be running the centre when the AWW has other tasks.

The AW helper escorts children to and from the AWC, collects fuel, minds the children and looks after the children and the centre when the AWW is away (Lakshmi Krishnamurthy et al, 2001). Whether she is equipped to do this, in terms of training support to her, is unclear.

40% of AWWs and 60% of helpers live within the community with the rest usually being within walking distance ((Lakshmi Krishnamurthy et al, 2001). In the FORCES study of Bangalore Urban and Rural, a majority of the AWWs observed stay outside the village or urban community; increasing the likelihood of their absenteeism and irregularity. **In 16 of the 37 centres visited for the FORCES study, the AWCs were managed by helpers who tend to be from the same village or urban community.** This is a shocking reality, given that helpers are not trained to manage the centre at all and may often have their own chores to attend to.

AWWs and helpers have been unionised and belong to different unions. One of the unions – the Karnataka State Anganwadis Workers and Assistants Federation is pressing for a hike in the salaries of the AWWs to Rs. 2450 per month and that of the helper to Rs. 1200 per month (Deccan Herald, June 8, 2004).

Comment

More than 90% of the AWWs have received pre-service training but in-service training seems to have received less attention. Many AWWs have not received any training for as many as twenty years; with some not having received even the pre-service training (observations by MYRADA and Samuha 2004). The complete lack of new ideas and a spirit of freshness as well as opportunities for growth for AWWs, in such a situation, can well be imagined. Refresher trainings are required on a more regular basis to keep the AWW motivated and provide a sense of professional growth.

In addition, the training, while equipping the AWWs with certain knowledge and skills, has not adequately addressed the important area of how to deal with the socio-economic and political realities of the community; of which she herself is a part. Field observations also underline the fact that the AWW requires training that will enhance her self-esteem, social and communication skills and her analytical ability (Lakshmi Krishnamurthy et al, 2001).

Caste represents an important factor in selection and posting of AWWs and has implications on who cooks the food (if the AWW is of a lower caste, either upper caste children will not eat there or the community will ensure an upper caste woman cooks the food) as well as her access to households. While the AWW is seen as a voluntary worker by the government, most AWWs will state that they are in the job because they need the money; it is seen as a job ((Lakshmi Krishnamurthy et al, 2001).

The AWW represents the welfare face of the State to the local community, often, in many rural and tribal areas, the only face of the State. This leads her to be burdened with many tasks that do not fall into her job profile at all. These include being drawn upon for census duties, election duties, etc. In some urban low-income areas in Bangalore city, they have even been asked to sort out problems with electricity meters!

She is also now required to form Stree Shakti groups, help them maintain individual and bank records, accompany them to the bank etc. Her work load includes filling in various records, the most recent additions being birth and death registers; in addition to about 22 registers associated with the ICDS programme. She also has to get signatures of a local eminent person who is supposed to vouch for the fact that she has conducted Nutrition and Health education classes. Often, running after people to get their signatures, takes up her time. It is also another instance of the total distrust placed in the AWW.

In addition, in many areas, the children speak different languages, with the AWW and helper not necessarily being fluent in all. The use of any one single language handicaps those who speak different languages (FORCES, 2003).

Subcontracting of work has also been observed as stated in the FORCES study. In one AWC, the helper works as a house maid and has asked a woman who is a TB patient to take on her role. She often spits on the floor, a potentially contagious activity. In another AWC, the AWW pays Rs. 25 to a blind man to teach the children. In yet another AWC, helpers take care of the children; both are illiterate and one is a deaf-mute (FORCES, 2003).

Recommendations

- It is important to list all the tasks that are essential to the functioning of the AWC and ensure that the AWW is held accountable for only these tasks. It would help to realistically see what a person considered a 'voluntary' worker can do in four hours time and ensure that the quantum of work is commensurate with it.
- Changing the mindset of supervisors to not just criticise or boss over but positively support the AWW would be important.
- To break the isolation of the AWW, fora such as the Cluster Resource Centres can be used where the AWW meets colleagues and is exposed to new ideas, methods etc.
- While record-keeping is an important function, it may be worthwhile to look at less time-consuming ways of ensuring that it is undertaken efficiently.
- The remuneration of the AWW has to be commensurate with the job she performs. The plea that she is but a voluntary worker, can no longer hold good.
- The AWW and helper could be from different castes and language groups, to ensure that all children are attended to.
- More attention needs to be paid to the training of helpers which has been almost completely neglected.

3.9 Training

Training is seen as a key component of the ICDS programme. NIPCCD is the apex body for the training of ICDS functionaries and is concerned with the planning, coordination, monitoring, training of ICDS functionaries, formulation of training strategies, development and updating of training methodologies, aids, curriculum and materials and training of State and district level officials, CDPOs and trainers (ICDS, DWCD,GOI, 1995).

Training of CDPOs/ ACDPOs

The Southern regional centre of NIPCCD, located in Bangalore, offers a two-month job training that seeks to familiarise CDPOs, on joining, with various aspects of the ICDS with a focus on the administrative and organisational structures. Developing skills in project management, monitoring and supervision of staff and service delivery is a key thrust. Refresher courses of a week's duration are held after CDPOs finish two years of service. NIPCCD also trains staff of AWTCs and MLTCs.

Training of supervisors

The Middle-level Training Centre located in Ujire, is responsible for the training of supervisors. Three more MLTCs in Mangalore, Ankola and Dharwad have been sanctioned and will soon become operational. The training of 65 days covers the different components of the Scheme and aims at developing the requisite supervision and programme management skills as well as skills of enabling continuous education of AWWs and facilitating community participation. Refresher courses are held for Supervisors after they finish one and a half years of service.

The recent recruitment of Supervisors has led to a back log of training. NGOs like the Karnataka State Council for Child Welfare (KSCCW), an NGO have been requested to run 6-day induction programmes, as an initial orientation.

Training of anganwadi workers

24 Anganwadi Training Centres (AWTCs) spread all over the State impart training to AWWs and helpers. 10 are run by the Karnataka State Council for Child Welfare, which also oversees AWTCs run by other NGOs.

KSCCW runs AWTCs in Tumkur, Mysore, Davangere, Madikeri, Gulbarga, Bangalore, Shimoga, Anekal, Kanakapura and Kadur. The KSCCW holds the responsibility for administrative and content supervision. It conducts a quarterly 45-day residential Job Training Course (JTC) for 35 new anganwadi workers, and a 15-day refresher course every two years for 50 working anganwadi workers. It also conducts an orientation course for anganwadi helpers. Each centre has seven staff, three of whom are full-time teaching instructors.

The pattern of training and the curriculum being followed is decided by the Department of Women and Child Development. KSCCW influences the curriculum through its role as part of the State Level Task Force on Training. It has autonomy in the choice of resource persons as well as methodology of training. The DWCD draws up a training calendar and deputes trainees.

While initially the job training was a three month course; in 1995, in all the new ICDS projects a sandwich-training approach was implemented. This consisted of an initial phase of 2 months classroom-training, followed by 4 months in the field, concluding with a one-month training at the AWTC. This was thought to be better than the all-at-one-time 3-month course. However, the high incidence of absenteeism and the turnover of trainees for each phase, has led to this pattern of training being withdrawn.

Currently, what is operational in Karnataka for AWWs is a 52-day training. 25% of the syllabus is developed at the State level to incorporate State-level realities.

In order to clear the backlog of training for AWWs, Karnataka had evolved a system of district-level refresher training. A core team of trainers was formed at the district level, initially in 4 districts – Bellary, Gulbarga, Dakshin Kannada and Shimoga. This was later expanded to the whole state and was operational for two years.

In addition, training of health department functionaries through medical colleges also takes place. Along with the Department of Health and Family Welfare Services, the DWCD conducted a two-day training course for anganwadi workers and lady junior health assistants.

Under Udisha, new initiatives such as the Community-based Rehabilitation Portage (seeking to identify and offer remedial support to children with disabilities) training, training of mothers of malnourished children have been held. The backlog of training of Supervisors is also being undertaken under Udisha.

Comment

Training seems to be highly content-driven with not enough attention being given to the processes of training (Lakshmi Krishnamurthy et al, 2001). Separate training programmes are offered to AWWs, Supervisors and CDPOs. While the focus of the training will have to be different for the different functionaries, this compartmentalisation ensures that each never really understands the others. In discussing what had made the training in the Tamil Nadu ICDS programme more effective, a NIPCCD official pointed out that all functionaries from the CDPO downwards had to 'sing and dance' – in other words, what was expected of the AWW, was also taught to higher officials. This integration of certain parts of the curriculum would go a long way in improving the effectiveness of training; as well as fostering a spirit of partnership and team spirit amongst the different functionaries.

The training also needs to reflect the field realities that the AWW would have to face. Managing community dynamics should be integral to the training.

The KSCCW feels that the current 52-day (in effect 45 working days) and the reduction of Block placement days from 15 to 5 days (under the Udisha Scheme), is inadequate. Also, the block placement module is placed right at the end of the training programme, with trainees returning just a day before the course ends. This leaves very little time for debriefing and discussing problems encountered in the field. In addition, the time allotted for Community Participation is limited to 5 days as opposed to the earlier 15 days.

The faculty at the AWTC does not have a good feel of the situation on the ground though they do spend a few days in the field. Feedback from the field is thus completely lacking. This component needs strengthening so that the training programmes can be made more relevant (Lakshmi Krishnamurthy et al, 2001).

There is very little attention paid to the training of helpers, all of whom interact closely with the children and many of whom become de facto AWWs in the absence of AWWs. While the latter is not to be encouraged, the fact that they work so closely with the children as well as have community interactions, warrants their being trained well.

According to the KSCCW, grants are not released in time leading to a lot of difficulties, especially since trainees continue to be deputed for training programmes. In addition, since the funds are now being released directly to the AWTC (as per the Udisha norms), KSCCW has very little fiscal control though they are expected to provide administrative supervision. The withdrawal of a Field Office (as per a GOI notification) has also meant difficulties in discharging the role of supervision of the AWTC by KSSCW.

Recommendations

- The process and methodology of training needs to be given as much attention as its content.
- Evaluation of the effectiveness of training programmes should be regularly held and corrective actions taken to make it more effective.
- Training must look at developing communication skills as well as building the self-esteem and confidence of the functionaries.
- Training of AW helpers needs to be regularised.
- Joint training programmes of AWWs, helpers, CDPOs and supervisors could be held so that there is interaction amongst them and they understand each other's perspectives.
- Training should be an ongoing process. Very often, other than the initial job training given when a functionary joins service, there is very little opportunity for additional inputs. The monthly meeting, though visualised as a space for providing ongoing inputs, is used, in reality only for administrative purposes.
- Faculty of AWTCs should visit the field more often to understand the contextual realities within which the AWC functions as well as to get feedback from AWWs on the training and its effectiveness.

3.10 Monitoring and Evaluation

Monitoring is largely done through records maintained in about 22 registers and the Monthly Progress Report and the Monthly Monitoring Report. For the AWW, maintenance of registers assumes gargantuan proportions, often bogging her down. Every service delivered as well as stocks have to be accounted for. There are registers for each aspect of the programme – attendance, food distribution, immunisation etc. In addition, birth and death registers as also those pertaining to the Stree Shakti programme have been introduced.
The paramount importance given to the registers results in not only overburdening the AWW but, since it is the only means of verification, leads to falsifications that need not always reflect the realities in the AWC. It also reflects the complete lack of trust in the AWW and as a monitoring system is self-defeating ((FORCES, 2003).

Comment

The paradigm within which supervision operates seems to be one of inspection and fault-finding. Positive reinforcement of what AWWs do well is rarely given. AWWs view supervisors as 'bosses' whose 'inspections' have to be feared. Supervision is geared to finding fault and is neither supportive nor facilitative. The very sharp hierarchy followed mitigates genuine team work and collaboration.

Monitoring also seems to follow a 'flavour-of-the-month' policy. Whatever has caught the imagination of the administrative and political leadership may be monitored more closely such as, currently, polio eradication and Stree Shakti.
There is no rigorous internal evaluation system nor is there any space for functionaries to sit across hierarchies and discuss concerns. There have been many external evaluations, with most offering similar recommendations. Yet, very few of the recommendations actually get implemented, suggesting a resistance to change within the system.

As far back as 1987, a NIPCCD report authored by Adarsh Sharma *'Monitoring the Social Components of the ICDS- A pilot project'* called for community monitoring, stating that "the present system of monitoring addresses itself to the operation and process of delivery of services and does not report on quality. The beneficiaries who could be the best judge of the programme are not included in the monitoring system". The potential of a Community-based Monitoring system in ensuring more effective and efficient services is demonstrated through a Pilot Project operational in four Blocks in North Karnataka (*see box below*).

BOX 3

Community Monitoring

An innovative project to enable and empower communities, especially women, to monitor government services in health, education and nutrition, has been initiated by the Department of Women and Child Development in collaboration with UNICEF and Samuha, an NGO.

The project is operational in two Blocks each of Raichur and Gulbarga districts. These areas were chosen on the basis of their low performance on development indices such as literacy, infrastructure, community awareness; high infant and maternal mortality, malnutrition etc.

Groups of women are formed, street- or cluster-wise in each village; each group having about 20 members. Members are trained in understanding government services and schemes available. They are also helped to understand issues in health, education and nutrition and areas of concern are identified as 'red alert' areas. They are then trained in filling up a standard questionnaire that seeks to identify the nutritional, health and educational status of people in their cluster.

Two representatives of each group are selected and form the Village Development and Monitoring Committee (VDMC). The VDMC meets every 15 days and reviews the status within their village. This information is consolidated at the Gram Panchayat level and shared at a monthly meeting alongwith the Medical Officer and Primary Health Centre staff (health care), ICDS Supervisors (health, nutrition and education), and Cluster Resource Persons (education). Issues are raised and accountability sought from the concerned officials.

This process of community monitoring has had visible impact. The Anganwadi workers are more regular; and people ask them questions if the AWCs are closed. Malnutrition is being monitored more closely. Enrolment and retention in schools have improved.

The biggest impact has been in the change in the attitude of the communities from that of the government doing them a favour by running a school or a PHC to that of one of demanding accountability for efficient and effective services.

Recommendations

- The paradigm of monitoring has to shift from one of 'inspection from above' to that of support and facilitation to help the AW functionaries do a better job.
- Stronger mechanisms of community monitoring need to be implemented. The Bal Vikas Samitis[4], community-level bodies that seek to enhance community participation in the AWCs, need to be given more teeth and powers. In addition, they also need to be trained in what the role expects of them.

[4] The nomenclature applied to these community-level bodies by GOI is Bal Vikas Mahila Samiti. However, in Karnataka they are called Bal Vikas Samitis, to enable men also to be part of the body.

3.11 The role of the community

The limited view of the role communities can play is seen by the statements of the ICDS. The ICDS talks of encouraging 'community participation in its processes of implementation, by utilising local resources' and 'improving the capabilities of parents to take care of the child and thus to involve the community'.

Given this restricted understanding, it is not surprising that, in practice, community members are involved in aspects such as contributing fuel, provisions, in some cases space, donating money for buying toys, uniforms, utensils and furniture etc. for use in
Anganwadi centres (ICDS, GOK website, 2004).

Bal Vikas Samitis (BVS) with representation from women Panchayat members, NGOs and ICDS functionaries have been formed. This is being seen as a body that would ensure community monitoring of the programme. While there is no documented evidence of the impact of this body; conversations with NGOs working in the field point to the role that the BVS plays as mere token.

People from the local community may also be nominated/ elected/ selected/ co-opted as members of the Bal Vikas Samitis without having a clue as to their role, and having little or no power to change things. The boundaries for 'participation' have already been drawn by the programme; nowhere is there space for communities articulating their vision for the programme nor for monitoring that the programme delivers. For the community, the ICDS is a government programme whose implementation is the sole responsibility of the AWW.

Against the backdrop of the efforts at decentralisation underway across the country; comes the suggestion that managing and monitoring the functioning of the ICDS be devolved to Panchayati Raj Institutions (PRIs), which are seen as representing the interests of the communities. This is already operational in Kerala.

In Karnataka, the S M Krishna government had passed a Government Order (GO) in May, 2004, to bring the AWCs under the purview of the Gram Panchayat. The GO required the AWWs to obtain permission from the Gram Panchayat for taking leave. It also required the Gram Panchayat to certify their attendance. As may be expected, this move has been resisted by the unions who are egging the new government to withdraw this Order.
While the GO is a positive move to enhance the accountability of AWWs, there is also data (from West Bengal, for example), that Panchayats use this mechanism to harass AWWs.

It is true that devolution to local bodies will bring the administration of the programme closer to the community. Yet, it is also to be borne in mind that PRIs are not homogenous bodies that protect the common interest but are ridden with caste, class and gender divides. Unless the PRIs are empowered to bring about fundamental changes, this move will only mean an administrative token of convenience and political exigency.

It may be more useful to develop community-owned local institutions, which have parents as members and which are primarily constituted for monitoring the ICDS and its functionaries.

Recommendations

- Greater community ownership needs to be built into the system. Looking at the community as mere figureheads, who 'participate' in ways the State thinks fit, is not very effective in the long run. The community needs to feel that it is *their* anganwadi where *their* children go to get a good start in life. Once this feeling is achieved, the community themselves will contribute to ensure that the AWC functions effectively. For this to happen, the ICDS functionaries will have to change their perception of the community as members who will pool in resources to that of members who will arrive at how they want the AWC to operate, and take responsibility to ensure its effectiveness. A stronger training input on this aspect needs to be first ensured.
- Stronger and more autonomous Bal Vikas Samitis need to be built, who along with the Gram Panchayat can take responsibility for ensuring the effective functioning of the AWC.

3.12 Role of NGOs in ICDS in Karnataka

Over the last decade and a half, one sees the shift in emphasis amongst NGOs from running alternate pre-school and non-formal education programmes at the micro level to more macro-level interventions that seek to bring about systemic changes in the educational system. The latter may include efforts to enhance the involvement of the community in educational matters to interventions that aim at supporting State-level structures. Vis-à-vis the ICDS programme, the efforts of NGOs such as Samuha, MYRADA, Seva in Action and Association for People with Disabilities represent some of the initiatives that aim at enhancing the effectiveness of the ICDS programme.

Another discernible trend, to be seen against the backdrop of a gradual withdrawal of services by the State; comes the attempt to involve NGOs in the implementation of the ICDS, in order to demonstrate innovations and possibilities. In Karnataka, Sumangali Seva Ashram, based in Bangalore, has been running ICDS projects for the last seven years.

3.12.1 ICDS projects run by an NGO

Sumangali Seva Ashram runs 130 AWCs in the slums of North East Bangalore; covering 10000 beneficiaries from the slums of Koramangala, Bansaswadi, Ulsoor, D.J.Halli and HAL.

The format of the programme is exactly that of the government-run ICDS. Supplementary nutrition, health check-ups, immunisation and health education and pre-school education are the key activities. Almost 100% of children from the AWC join regular school – whether government or private.

The children are given supplementary nutrition of 300 calories per day. Malnourished children are given twice the amount. Nutritional supplies given by the Department are often delayed, forcing Sumangali Seva Ashram to invest in making their own supplements. Awareness on low-cost community nutrition is regularly held.

Health checkups are conducted every three months and the growth chart of the child is drawn with records of the immunisation given. SSA also refers the child to other hospitals in case it is required. Pregnant women and lactating mothers are also given the required medicines and grains for six days of the week.

Staff are trained through the Department training programmes for ICDS functionaries and also receive inputs from Sumangali Seva Ashram. While the supervisors and project officers are trained by NIPCCD, SSA sends newly appointed anganwadi workers and helpers for training at the Anganwadi Training Centre. In 2002, SSA ran a two-day refresher course for 130 pre-school teachers of the anganwadis; which was funded by the ICDS.

By its own admission and as per the observation of other NGOs working in the field, the programme implemented by the Sumangali Seva Ashram functions much like its government counterpart. Sumangali Seva Ashram bemoans the lack of autonomy to take any decisions regarding the functioning of the ICDS. Every decision has to be mandated by the department officials. In this light, it seems more like the project being sub- contracted to an NGO rather than an experiment in innovation; with ultimate control still in the hands of the government.

Delays in disbursement of salaries as well as other grants (deficit of Rs. 61 lakhs, March 2004) is a key problem that Sumangali Seva Ashram experiences. The AWWs complain about the lack of job security and other benefits for AWWs, Supervisors and CDPOs.

3.12.2 NGO Support to ICDS

Training support

Samuha

Samuha is an NGO that works in four districts in Karnataka – Bangalore Urban, Uttara Kannada, Koppal and Raichur. They ran balwadis for pre-school education for five years. The issue of long-term sustainability of an NGO intervention resulted in Samuha closing the balwadis and strengthening the government-run ICDS Scheme.

Samuha has trained ICDS functionaries of 62 AWCs in Raichur and Koppal. The training programmes, held every two months, aim at changing the attitudes of AWWs, helping them understand the critical role of pre-school education in children's development. Training programmes are held for both AWWs as well as helpers; the latter whom Samuha believes have no real training at all and yet, interact so much with children. AWWs from half of the centres and AW helpers from the other half attend the training programme on any given day, so that the AWC is not closed. The next training programme sees the trainees being reversed.

The content of the training programme ranges from curriculum and methodology of teaching, the manner in which children have to be handled, the importance of involving the community etc. Particular importance is laid on changing the attitude of the AWW and helper towards the children. In addition, efforts are also made to educate parents on the importance of ECCE and the AWC as a space for ensuring appropriate inputs to the pre-school child.

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Samuha has also been involved in upgrading the physical infrastructure of the AWCs through wall painting, construction of extra space for play and other activities, making the interiors more child-friendly etc. Samuha sees its long-term role as that of supporting the existing structure and based on their experience, lobbying for appropriate changes in the programme.

Community Based Rehabilitation Network (CBR Network)

The Community Based Rehabilitation Network (CBR Network) facilitates the networking of NGOs in the field of CBR and the education of persons with disabilities.

Alongwith the Department of Women and Child Development, CBR Network has embarked on two projects: Udisha-Portage project on early identification of disability; and joyful inclusion. The former involves the early identification, intervention and stimulation of children with disabilities in the ICDS programme. CBR Network has trained 28 facilitators, 345 supervisors and 6878 anganwadi workers in 16 districts.

The joyful inclusion project involves the creation of an inclusive classroom. Using individualised teaching methods, adapted curricula and tailor-made teaching aids and materials, children with special needs are enabled to study along with other children in a school nearest to them. Teachers are oriented to child-focused learning from pre-school to primary level. CBR Network has trained 30 schoolteachers of three gram panchayats in Chamrajnagar district as village resource persons and block resource persons.

Association for People with Disabilities (APD)

The Association for People with Disabilities works at the early detection, treatment and rehabilitation of people with disabilities, in both the Bangalore urban area as well as rural areas adjoining Bangalore. APD has been involved with the training of AWWs to enable them to identify children with special needs and either support them through their own intervention or refer them to specialised agencies. Training is not seen as a one-off programme but more as an ongoing support process.

Seva in Action (SIA)

Seva in Action is an NGO working on disability issues, focusing on detection, treatment and rehabilitation as well as training and advocacy.

SIA has been consistently involved with training AWWs in the early detection, assessment and appropriate intervention for children with disabilities. The initial training programme was carried out in Manvi Block in Raichur district in 1997. Out of a total of 250 AWWs, 223 were trained. The training focussed on making the AWWs aware of the issues facing the child with disabilities, the signs to watch out for, how to assess the child and the appropriate intervention. The Portage checklist model was translated into Kannada and used as an assessment and intervention guide. The last day they did a door-to-door survey in which 100 children with disabilities were identified and appropriate referrals made.

This training programme has since been carried out regularly. Between 1999 and 2003 – 503 AWWs have been trained in early intervention through an intensive programme of seven weeks. The training is held over 3 phases with a mix of classroom and field study.

Training is also held for PHC staff. Under the Integrated Education for Disabled Children programme of the Government of India; resource teachers specialised in education for children with special needs have been trained and appointed in AWCs and Government schools.

Adopting and strengthening existing AWCs

AVAS

AVAS is a Bangalore-based NGO working on issues of urban poverty, slum development and housing. The need for a comprehensive holistic approach to community development resulted in the organisation initiating work on ECCD.

AVAS works at strengthening the existing ICDS centres and has adopted 13 ICDS centres and 2 run by the KSCCW in the areas of Koramangala, Jayamahal, Bharatinagar, Basavangudi, Malleswaram, Varthur and the Hosakerehalli slum of Bangalore; covering between 750-1000 children in the 2-6 years age group.

AVAS's role has been in ensuring that the ICDS centres provide quality care. It provides the AWWs with supplementary income and has mobilised funds for building of community centres (which are also used for meetings by the community). The centres have been decorated to reflect a suitable child-friendly environment. Pre-school education through creative activities and appropriate nutrition form the focus of the programme. AWWs have also been trained by the Promise Foundation to help build their creativity.

AWWs also participate in the community meeting once a month and discuss issues of women's empowerment, health, environment etc.

MYRADA

MYRADA works with 200 AWCs in Mysore district. A Community Health Worker works at the village level on health issues and supports the local AWW in health-related aspects of the ICDS such as weighing children, growth monitoring etc.

In addition, MYRADA has contributed in upgrading the infrastructure of the AWCs by mobilising resources from the Panchayats as well as the community. Resources for the upgradation are shared between MYRADA (35%), the Taluk/ Zilla Panchayat (60%) and the community (5%). Each AWC consists of a large open hall which functions as the teaching-learning space, a separate kitchen and a store room. MYRADA has helped enliven the space to make it more exciting for children through wall painting, provision of play equipment etc.

While the involvement of NGOs is heartening and needs to be encouraged, caution has to be taken to ensure that the State does not get into sub-contracting what is legitimately its responsibility to NGOs, under the garb of efficiency and effectiveness.

4. Key areas for advocacy

The provision of ECCE cannot be viewed as homogeneous across the country. A variety of approaches and strategies – including but not limited to home-based as well as centre-based – are required which take into account the needs of children in different cultural and socio-political contexts. There also needs to be a greater emphasis on meeting the needs of the **child under three years**. It is a little distressing to note that the Terms of Reference of Committee on ECCE of the Ministry of HRD, do not address the child under three years; stating as its does "To look at the coverage of ECE facilities and to recommend the requirement, including financial requirement for additional facilities so as to provide Early Childhood Care and Education to all children in the ***age group of 3-6 years***" (MHRD, 2004).

This being said, more specific recommendations include the following:

- **Enhancing coverage to ensure true universalisation** – Ensuring that each and every child under six years has access to quality health, educational and nutritional services necessitates a range of approaches. The norm of one ECCE centre within walking distance from the home of the child, for a population of approximately 300 people and 20 (+/- 5) children of the related age group recommended by the Committee on ECCE of the Ministry of HRD (2004), should be accepted and implemented immediately. In addition, relocation of poorly-attended ICDS Centres to where there is a real need will also help enhance coverage.

- **Extension of timings** – Drawing from the precedent set in Kerala and Tamil Nadu; the timings of the AWC need to be extended from being a four-hour programme to being an eight-hour one. This will allow for more time for pre-school activities. Rest for children can be woven into the programme so that it does not become burdensome. It helps relieve older siblings especially girls from sibling care, thus enabling their participation in school. It will also ensure that children of working mothers are not left unattended for large parts of the day.

- **Initiation of Anganwadi-cum-crèches**– The National Policy on Education (NPE, 1986) and the Plan of Action for the NPE (1992) stipulate that 25% of anganwadis need to be turned into Anganwadi-cum- crèches. This policy directive needs to be enforced with more commitment to enable children below 3 years to avail of the services. This will also be an essential supportive service for working women.

- **Location of AWC** – Wherever possible, the AWC needs to be physically located in the primary school. Where this is not possible, functionally there must be links between the two. This will enable a co-ordination between the pre-school and primary school education programmes ensuring continuity in the educational experience of children. This will ensure that the AWW also gets support in her role as a pre-school teacher. There can also be a convergence of the nutrition programmes.

- **Physical upgradation** – Ensuring that the AWC has its own premises needs to be given priority. The AWC must have its own physical space with space for children's activity, play and rest. The interiors must be colourful and attractive for children in the 0-6 year age group. Water and toilet facilities must be assured.

- **Additional worker for pre-school education** – An additional worker who takes care of pre-school education may be appointed. Funds may be sourced from the Sarva Shiksha Abhiyan, schemes for Girl Child etc. There is enough evidence that pre-school education enhances the enrolment, retention and academic achievement of children. Thus investing in pre-school education would help in ensuring elementary education for all children; a responsibility the State has committed itself to.

- **Community ownership** – Efforts must be made to create structures at the local level that will enable the community to have a greater sense of ownership over the AWC. The Bal Vikas Samitis need to be given more power (akin to that of the School Development and Monitoring Committee for primary school). Members of the Bal Vikas Samitis must be selected from parents whose children come to the AWC. They also need to be trained on their roles and responsibilities.

- **Quality** – There is overwhelming evidence that the quality of ECCE services determines the outcome. It is imperative that measures to improve the quality of the ICDS be undertaken, such that *all* the services produce the desired results. Quality does not imply a one-time input of training or materials or infrastructure upgradation. It needs to be seen as a process of continuous improvement capable of making required changes as the external contexts change.

- **Support system for children with disabilities** – We need support systems, which AWWs can access for dealing with children with disabilities. Ninety percent of the identification and supportive stimulation for children with disabilities can be managed by a well-trained AWW. The Udisha-Portage training programme needs to be implemented on a larger scale. An environment in the AWC and attitudinal shifts and increased commitment in AWWs, which supports the implementation of this training need to be given more attention. For children with more severe disabilities, it may be good to set up a Resource Room within the Cluster Resource Centre, with the necessary specialised equipment. Senior and committed AWWs could be trained as specialised resource teachers at the cluster level, and they could support AWWs in handling children with disabilities at the AWW level as well as work with children with more severe disabilities.

Given that the best prognosis for children with disabilities lie in early detection and appropriate intervention in the first 6 years of life, the period of the most rapid brain growth; it is imperative that attention be paid to this area.

- **Regional differences** – Variations in the performance of the ICDS programme across districts has been observed with districts in North Karnataka performing worse than those from South Karnataka. There is a need to document and analyse these differences. The ICDS will have to allow for regional variations in the programme to suit local needs. Budgetary allocations and other investment such as training will have to be geared towards helping districts performing badly to improve.

5. Conclusion and summary

Karnataka has achieved "universalisation" of the ICDS programme. With performance in areas such as service delivery, infrastructure and training being average, a lot still needs to be done. Priority must be given to strengthening the pre-school education programme, extending timings, infrastructure upgradation and enhancing the role of the community. The potential for early detection and intervention for childhood disabilities needs to be tapped more vigorously. Training needs to be seen as an ongoing process and supervision as more nurturing and supportive than currently exists.

As of May 2004, the government has reiterated its commitment to the ICDS and its universalisation. While this is to be welcomed, it is also true that 'universalisation', as the State defines it does not mean that every vulnerable child is reached. Stronger efforts will have to be made to ensure that children below six years in tribal pockets, urban slums, hilly areas etc. have access to health, education and nutritional services. It is only with greater and more sustained political and administrative will and commitment that this can be achieved.

The road to ensuring that every child in Karnataka has access to health, education, play and leisure, is a long one, requiring contribution from all sections of society – the community, the government, the private sector as well as the voluntary sector. We hope that this report will play its role in tabling the current issues in achieving this challenge and serve as a document on which to base future actions.

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ANNEXURE I - The Intervention of the Supreme Court on ICDS

The Supreme Court has been taking extremely proactive and progressive stands on the tardy implementation of the ICDS. In response to a Public Interest Litigation (PIL) filed by the People's Union for Civil Liberties (Writ Petition (Civil) no.196 of 2001), the Court has appointed Commissioners whose brief includes monitoring the implementation of the Court in matters related to the performance of welfare schemes including the ICDS.

The following figures of coverage, performance and impact of the ICDS which are based on official figures supplied by the government are alarming to say the least:

- The ICDS has catered to only 16% of undernourished children all over India
- Only 3.4 crore children are receiving the benefits of supplementary nutrition under the ICDS. This is nowhere close to the number of children in this age-group (15 crore), the number of malnourished (8.5 crore) or even those from families below the poverty line (6 crore).
- The percentage of adolescent girls being covered under the scheme is even less, as the scheme has not even been made operational in existing anganwadis. The coverage of settlements is not complete.
- In around 14 lakh habitations, only 6.05 lakh have anganwadi centres. Also, states have placed greater emphasis on the number of anganwadis rather than on the quality of services they offer.

The performance in Kerala and Tamil Nadu seems slightly better with the Scheme reaching 50 per cent of the children, whereas in the rest of the country, the average seems to be below 25 per cent.

Reports of the Commissioners to the Court

The Commissioners submit periodic reports to the Supreme Court. The Third Commissioners' Report stresses that "the provision of Integrated Child Development Scheme (ICDS) in every habitation, as directed by the Court, **is not being properly observed and taken seriously.** The Government of India has been more interested in expanding the ICDS programme than in ensuring that it achieves results. Furthermore, **ICDS should aim to give particular attention to children in the poorest families and to reach children aged under three**".

The Fourth Report of the Commissioners points to the lack of attention given by most States to the plight of children from 6-months to 2 years "with no satisfactory arrangement in feeding this extremely vulnerable group. In this context, States should be directed to comply with the directions calling for an Anganwadi to be available in each habitation, and for the coverage of adolescent girls, pregnant and lactating women under this programme. Moreover, there is a need to direct states **to ensure that all slums are within convenient reach of an Anganwadi and urban homeless children are also covered**".

The Court passed an order on November 28, 2003, stating that "every settlement should have a disbursement centre (anganwadi), and that every child up to the age of six, adolescent girl, pregnant woman, nursing mother and malnourished child should be covered by the scheme".

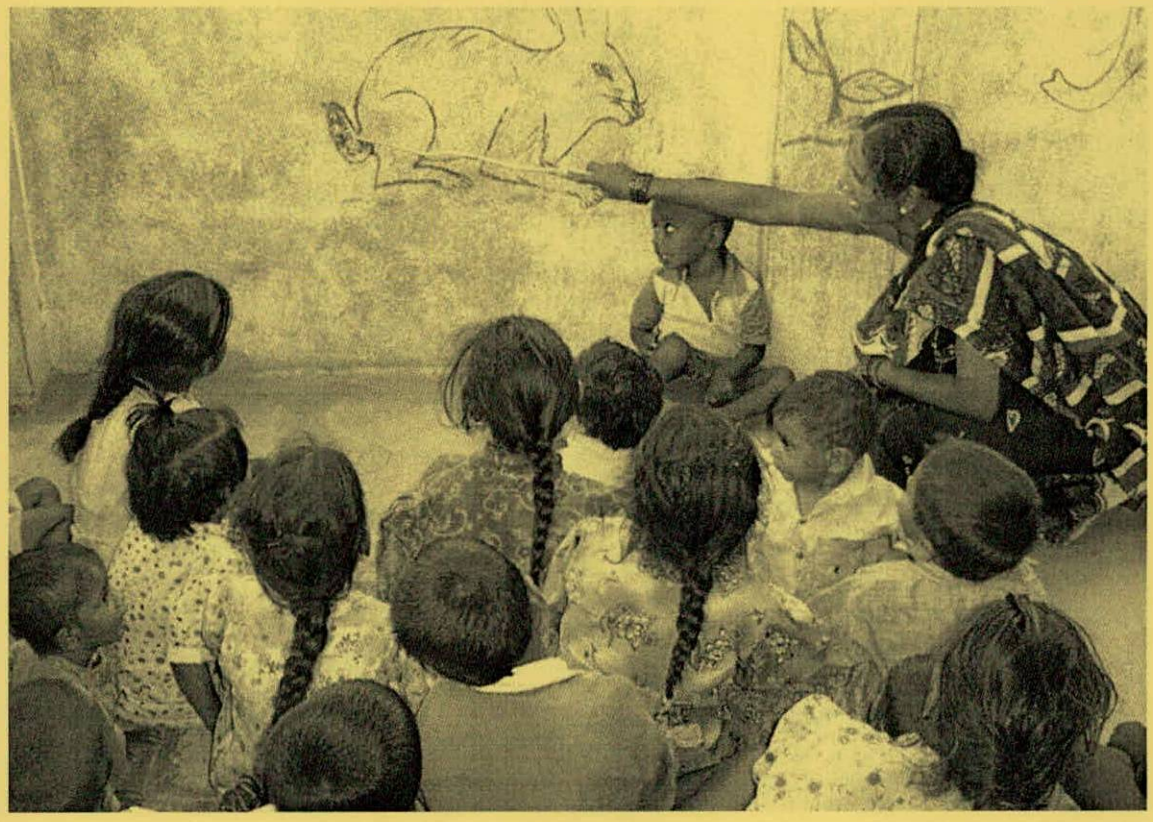
The DWCD response

In a meeting with the Commissioners, held in November 2003, the Department for Women and Child development (DWCD) argued that it had "neither the resources nor the mandate" to universalise the ICDS as directed by the Supreme Court. The programme does not reach every settlement even within the sanctioned project area and is only targeted at disadvantaged families. Given the constraints, the Department is interpreting the Court's orders "within the existing guidelines".

Taking serious note of this argument, the Commissioners have recommended that the Court issue a clarification that the term "settlement", as used in the November 2003 order, pertains to a cluster of households within a village. The order must not be interpreted by the DWCD as only including present centres.

The PIL, the Commissioners' Reports and the Supreme Court orders represent major victories in the struggle for ensuring food security and combating malnutrition among children. They are also potent weapons that can be used to ensure compliance at the local level and need to be more wisely disseminated and applied.

Sources: Indian Express, April 26, 2004
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Early Childhood Education

Kavitha Krishnamoorthy

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1. Introduction

The importance of the first few years of life to future well-being has been acknowledged the world over. The care and nurturance needed by the new-born and the infant have led to a host of traditions that continue to be followed to this day. Most of these traditions have their roots in an understanding of the criticality of this phase to an individual's optimal growth and development.

Education plays a critical role in helping a new-born slowly adapt to the world, and grow to be a healthy member of society. Education is used here not in the narrow sense of formal, institutionalised education, but to denote a process of learning that begins at birth and continues throughout life. The new-born, learns – through every interaction, every smile, and every touch. As s/he grows, s/he requires more and more stimulation that enables her/ him to make sense of the world. While there is an intuitive understanding of such processes ingrained within communities; the struggle for survival amongst people living in poverty often does not allow them to be practiced.

At a macro level, formal education is seen as contributing to the human capital of the nation; at a micro level, it holds the potential to transform individual lives. While a lot of attention has been paid to evolving strategies for ensuring elementary education; very little attention has been given to developing well-thought out programmes – including home-based ones – for the education of children below six years.

This paper seeks to highlight the critical significance of Early Childhood Education (ECE)[1] or Pre-school Education (PSE) in the development of the child. It then looks at the trends of ECE, since Independence, in India. A focus on the key milestones in the development of ECE in Karnataka with a special focus on the governmental and voluntary sector follows. The paper ends with identifying the current issues as well as future directions in ECE.

2. What is early childhood education?

At its broadest and most general, early childhood education may be termed as all those processes and activities that ensure that a child in the under 6 years age group receives developmentally appropriate stimulation and nurturance, that fosters and enhances her/his complete physical, cognitive, language, emotional, spiritual and social development. This may range from stimulation provided at the home, as a natural part of child rearing to that provided in more structured or institutional forms such as crèches, pre-schools or nurseries.

[1] The terms Early Childhood Education (ECE) and Early Childhood Care and Education (ECCE) are used synonymously in this paper.

ECE is seen as a component of Early Childhood Development; which refers to "a comprehensive approach to policies and programmes for children from birth to eight years of age, their parents and caregivers". Its purpose is to promote the child's total development (UNICEF, 2001).

Early Childhood Education has been defined by M S Swaminathan Research Foundation as "a term that describes a programme aimed at providing opportunities for the all-round development of children between the ages of 2 and 6 years" (M S Swaminathan Research Foundation, 2000).

The Committee on Early Childhood Education[2], Ministry of HRD, Government of India, looks at ECE as 'preparatory education prior to formal education, including experiential, incidental and informal education, imparting primarily life skills'.

Making the child below three years visible

Often, ECE is seen as a programme or a set of activities that apply to all children below six or eight years, when in fact, the needs of the child vary greatly within this broad band. In addition, most programmes have actually concentrated on the child in the 3-6 years age group; probably because it is a more manageable group as compared to those below three years. It is distressing to see that even the Committee on ECE set up by the Ministry of HRD, GOI; in its Terms of Reference looks at children in the 3-6 years age group and does not make too much reference to infant stimulation.

For children below three years, ECE would refer to processes and activities that comprise **infant stimulation;** including development in the areas of cognition and language, social interaction, fine and gross motor coordination and emotional growth. This would need to be addressed primarily by parents and other caregivers in a 'way-of-life' approach; which is informal and part of normal child-rearing. The movement to enhance parenting skills represents a step in the direction of ensuring that infants secure developmentally appropriate and adequate stimulation. This approach needs to be integrated into care-giver practices within crèches and other institutions for the child below three years.

For children from 3-6 years, ECE would be more structured. While following an informal approach and without burdening the child; it would look at enhancing the child's mental, physical, social and emotional capacities through developmentally appropriate activities. It would also aim at enhancing the child's readiness for formal school.

[2] This Committee was constituted by the Ministry of Human Resources Development to look at the coverage of ECE facilities and to recommend the requirement, for additional facilities for Early Childhood Care and Education to all children in the age group of 3-6 years. It submitted its report in January 2004.

3. The imperative of early childhood education

Possibly the strongest argument for investing in ECE comes from the perspective of the rights of the child. Every child has a basic, fundamental right to survival and development; to the opportunities that will help her/him realise her/his potential to the fullest. This means, amongst others, an adequate and safe standard of living, health care and adequate nutrition, education, play and recreation.

In addition, evidence from the disciplines of child development, child psychology neurosciences as well as studies on the impact of ECE clearly demonstrate the fact that ECE is not a luxury but an absolute imperative, necessary to the cause of full human development.

The importance of early stimulation

Recent advances in neuroscience establish that the first few years represent a rapid phase of brain growth, unparalleled in the rest of a human being's life. Appropriate stimulation in this period is the key to later success – both academic and otherwise – in life. The rich heritage of songs, stories, and games in traditional societies are but a means of providing a rich and varied stimulating environment for the child to blossom in.

Research tells us that the effects of what happens – or does not happen – during the pre-natal period and the early years of life, last a lifetime (Shore, 1997 in UNICEF, 2001). **The timing of appropriate stimulation is critical**. There are periods when the brain is particularly open to new experiences. If these sensitive periods pass by without the brain receiving the kind of stimulation for which it is primed, opportunities for various kinds of learning are substantially reduced.

When children do not get the care they need during 'developmental prime times', or if they experience starvation, neglect and abuse, brain development may be compromised. While there continues to be a debate on what constitutes the critical period, (since the brain is capable of malleability and reorganisation throughout life); there is a general consensus that the best period for intervention is the first five years of life (Gunston et al., 1992 in UNICEF, 2001).

In addition, the key ingredients of emotional intelligence – confidence, curiosity, intentionality, self-control, relatedness, capacity to communicate and cooperativeness – that determine how a child learns and relates in school and in life in general, depend on the kind of early care s/he receives from parents, caregivers and pre-school teachers (Daniel Goleman, 1995 in UNICEF, 2001).

Impact of Pre-school education (PSE)

As evidence from the neurosciences show, the most critical period for brain development is over by the time the child reaches school-going age i.e. 6 years. This has implications on the child's performance in school.

Micro-level observations (by NGOs engaged in ECE) as well as studies at both micro and macro levels have proven beyond doubt that **children who have had access to ECE are more likely to enroll in school, show better retention and academic success**. This assumes importance given the large wastage from primary school.

Seventy per cent of children who had received ECE later enrolled in primary school, and were better adjusted than those children who had not received ECE (Sunder Lal, 1981 in M S Swaminathan Research Foundation, 2000).

The longitudinal study of the NCERT on the impact of ECE on Retention in Primary Grades[3] establishes the positive role of ECE in promoting cognitive and social skills and improved participation and learning achievement in primary school. The impact is evident not only in the initial years but right through primary school. It was also found that only 31.8% of children with ECE dropped out of school in Grade IV, as opposed to 48.27% without ECE (Kaul et al, 1993).

The national evaluation of the Integrated Child Development Services (ICDS), India's largest early childhood intervention programme, found significant differences in children who went to ICDS centres and those who did not, in terms of higher enrolment and retention (NIPCCD, 1992). This is supported by micro-level research which establishes that children who have attended an ICDS centre perform better than those who do not, in the development of motor and language skills and psycho-social behaviour (Anandalakshmy et al, 1986; Devadas, 1986; Mistry et al, 1988; Sood, 1987; Tarapore et al, 1986; Bilquees, 1986 in M S Swaminathan Research Foundation, 2000). They also performed better in tasks involving "listening comprehension, object vocabulary, sequential thinking and time perception" (Khosla, 1985; Sahni, 1984 in M S Swaminathan Research Foundation, 2000).

ECE brings about an improvement in various inter-related dimensions of child development such as social, cognitive and emotional development (Adish, 1983; Chaturvedi, 1985; Paranjpe et al, 1985; in M S Swaminathan Research Foundation, 2000).

[3] The study covered 31,843 children in eights states of India – Maharashtra, Karnataka, Rajasthan, Tamil Nadu, Bihar, MP, UP and Goa

While there are no studies to show long-term gains of ECE in India; the High/Scope study in the US – a carefully controlled study of the ECE Perry pre-school project – showed that children who had accessed the ECE programme, were at 27 years better socially adjusted, showed more participation in community matters, and showed fewer instances of involvement in crime (Larry et al, 1988; in M S Swaminathan Research Foundation, 2000). While it is true that these outcomes may be a result of many factors; one may assume that ECE played a vital role.

The importance of quality in ECE

There is also evidence to suggest that it is not the mere provision of ECE that is important but that it is its **quality** that determines outcomes. A significant relationship between the quality of ECE and the level of learning competencies was established by a study conducted by the M S Swaminathan Research Foundation on 'Understanding the relationship between quality of ECE and learning competencies of children'.

Quality was measured using indicators such as:

- Availability of infrastructure facilities for ECE – including toilet, water, classroom space, storage space, cleanliness of surroundings etc.
- Personal care given to children during routine activities; including grooming, hand washing etc.
- Availability of teaching and learning material, their display and accessibility to children
- Schedule of activities – language and reasoning experiences, fine and gross perceptual-motor activities, creative and social development activities
- Process involved in conducting the activities and opportunity given to children to participate

The study also established that active learning involving perceptual and motor skills was the main reason for children's enhanced learning competency.

This is supported by another study carried out by NIPCCD that reasons that unless an input is of good quality, children may not develop and demonstrate the competencies intended to be promoted through ECE (NIPCCD, 1997).

Social and economic reasons

Good quality ECE could also lead to other spin-offs. Universalising ECE holds the potential to reduce social disparities – of caste, class and gender. If younger siblings are taken care of, older girls will be released to attend school, ensuring their own advancement. ECE can enable a level playing field, making it possible for children from disadvantaged and marginalised communities to fare better in elementary schooling. It holds the potential to compensate for a poor home environment that provides limited stimulation, which puts children from such homes at a disadvantage.

The economic spin-offs would include better productivity as adults; cost savings in terms of remedial education, health and rehabilitation services; and higher earnings for parents and other caregivers who have more time to engage in economic activities.

ECE and Basic Education

ECE is the building block of basic education and needs to be seen as the cornerstone of efforts to ensure Education for All. Recent world conferences testify to a growing appreciation of the crucial importance of the child's earliest years, and the need to support families and communities in their role as the child's most influential educator.

Given that the learning capacity and value orientations of children are largely determined by the time the child reaches the age of formal schooling, efforts to ensure education for all necessitate programmes that help enhance the child's cognitive and psycho-social development as well as help raise the life-skills of families and communities (www.unescobkk.org).

There is enough documented evidence to show that well-conceived quality early childhood programmes help meet the diverse needs of young children during the crucial early years of life, enhance their readiness for schooling, have a positive and permanent influence on later schooling achievement. In addition, countries that succeed in mobilising local government, municipalities, communities and voluntary organisations in the care and education of young children have been able to decentralise and innovate in their educational systems (www.unescobkk.org).

4. ECE in India – a historical perspective

1953-1966: Onus on voluntary agencies

The setting up of the Central Social Welfare Board in 1953 represents the first step of Independent India in addressing the concerns of the under six year old child. In 1960, the CSWB set up a Committee to study problems related to children below six years of age. The Committee recommended that the government encourage voluntary agencies to run pre-school centres, with government support. It also emphasised the importance of training and recommended that a cadre of adequately trained child welfare workers be prepared.

Accordingly, the CSWB started a grants-in-aid programme for voluntary agencies that would run centres for pre-school education. In both the First (1951-56) and Second (1956-60) Five Year Plans, education for children upto six years was an important part of programmes for the welfare of women and children. The Third Plan (1961-65) period saw the growth in the CSWB supported pre-schools to 6000, but concern over their quality was emerging and the care of the young child was still seen within the child welfare paradigm. The Education Commission (1964-66), while recognising the importance of pre-school education, continued to reiterate that it be left to voluntary agencies.

1968 onwards: The government recognises pre-school education

In 1968, the Committee for the Preparation of Programmes for children (Ganga Sharan Sinha Committee) **recommended, for the first time, that the government invest in preschool education**. The action taken on this was however limited (Kaul, in India Education Report, 2000).

The Fourth Plan (1969-74) saw the introduction of the Scheme for Family and Child Welfare, whose objective was to foster the all-round development of the pre-school child, through comprehensive welfare services, and by strengthening the family to play its role in the child's development.

The Fifth Plan (1974-79) represents a breakthrough, at least in letter, from looking at children's issues through a perspective of welfare to a more development oriented one. This is seen in the formulation of the National Policy for Children in 1974, and its programmatic manifestation in what was to become one of the largest early childhood development programme – the Integrated Child Development Services (ICDS).

The idea of the ICDS Scheme was first presented at a Conference of the Indian Association of Pre-school Education (IAPE) in October 1972, by the Chief of the Department of Nutrition and Family Welfare, Planning Commission of India. It is worth noting that **the ICDS did not initially include any component of pre-school education**.

In 1972, the Ministry of Education set up **a study group for pre-school education**, which recommended that a comprehensive programme for the development of the preschool child be undertaken. The study group recommended an integrated approach interweaving health, education and nutrition into the programme. The IAPE also submitted a memorandum to the Planning Commission, exhorting it to include psycho-social development of children into the programme. Non-formal pre-school education was thus introduced as a major component of the ICDS programme along with nutrition and health.

An expert group on Early Childhood Education was constituted in 1980, which looked into the problems of pre-school education, especially its quality. The Expert Group suggested viable models for both the training of personnel as well as for providing pre-school education to marginalised children in tribal, rural and urban areas. While action taken on the recommendations was limited, a grants-in-aid Scheme for voluntary agencies working in educationally backward states was initiated (Kaul, in India Education Report, 2000).

1986 saw the formulation of India's first-ever **National Policy on Education**, which explicitly recognised the importance of early childhood care and education. ECCE was viewed as a crucial input in the strategy of human resource development and took into account the holistic nature of ECCE (see below).

Constitutional and policy directives pertaining to ECE

The Constitution of India

Article 45 (Directive Principles of State Policy) of the Indian Constitution directed the State to provide free and compulsory education to all children up to the age of fourteen. The framers of the Constitution wisely understood the imperative of providing what we now call ECE for the holistic development of the young child.

This has however been diluted with the passage of the Ninety-third Amendment to the Constitution that guarantees, as a fundamental right, the education for children from six to fourteen years, through the introduction of Article 21A that reads "The State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine." As far as ECE goes, Article 45 (Directive Principles of State Policy) now reads "The State shall ***endeavour*** to provide early childhood care and education for all children until they complete the age of six years." **There is no binding, therefore, on the State to ensure that the child under six years is provided with ECE.**

National Policy on Education (NPE)

The National Policy on Education (NPE) adopted in 1986 views Early Childhood Care and Education (ECCE) as a crucial input in the strategy of human resource development, as a feeder and support programme for primary education, and as a support service for working women. ECCE Policy Directions include the following:

5.1 The National Policy on Children specially emphasises **investment in the development of the young child**, particularly children from sections of the population in which first generation learners predominate.
5.2 Recognising the holistic nature of child development, viz., nutrition, health and social, mental, physical, moral and emotional development, **Early Childhood Care and Education (ECCE) will receive high priority** and be suitably integrated with the Integrated Child Development Services programme, wherever possible. Day care centres will be provided as a support service for universalisation of primary education, to enable girls engaged in taking care of siblings to attend school, and as a support service for working women belonging to poorer sections.
5.3 Programmes of ECCE will be **child-oriented**, focusing around play and the individuality of the child. Formal methods and introduction of the 3 R's will be discouraged at this stage. The local community will be fully involved in these programmes.
5.4 A full **integration of childcare and pre-primary education** will be brought about, both as a feeder and a strengthening factor for primary education and for human resource development in general. In continuation of this stage, the School Health Programme will be strengthened.

Source: NPE, 1986, The Report of the Committee on ECCE, Ministry of HRD, GOI, 2004

Almost twenty years down the line, the above well-intentioned statements remain just rhetoric. We still do not see any form of integration between ECE programmes and primary school, except, in some cases, in the DPEP areas. ECE programmes, for the large part, continue to represent a downward extension of primary education, with the teaching of the 3 Rs assuming more importance than more developmentally appropriate curriculum. The pre-school component of the Integrated Child Development Services is one of the weakest in the overall programme (See Section 5.1)

The NPE envisaged the establishment of 2,50,000 centres by 1990 to cover all tribal development blocks, urban slums and areas having a substantial SC population, and the **coverage of 70% children in the pre-school age by 2000**. The Acharya Ramamurti Committee set up in 1990, however, noted that only 15% of children in the age group of 3-6 years had received any pre-school education, and only 10% of children in the under 6 years age group any child care service (Kaul in India Education Report, 2000).

The Tenth Five Year Plan (2002-2007)

The Tenth Five Year Plan also talks of the State's commitment to ECE, and seeks:

- To reaffirm the commitment of the 'Development of Children' with a special focus on **early childhood development**, not only as the most desirable societal investment for the country's future, but as the right of every child to achieve his/her full development potential.
- To adopt a **rights-based approach** to the development of children, as being advocated by the draft National Policy and Charter for Children (2002).

While the approach paper is meant to only draw up a broad framework; the above statements again seem like just so much rhetoric, in which politically correct pronouncements are being made. It remains to be seen how much of this is actually translated in the ground and in what manner.

Table 1: Coverage of ECE Services in India (2002)

Total Population	102,70,15,247
Total child population (under 6 years)	15,78,63,145
Estimated population in 2001 (3-6 years)	7,18,91,067
Number of ICDS centres	4,27,862
ICDS beneficiaries (under 6 years)	3,15,03,764
Preschool education beneficiaries (3-6 years)	1,66,55,533

Source: The Indian Child: A Profile, Ministry of HRD, GOI, 2002

According to this table; in 2002, ICDS serves approximately 19% of children under 6 years. **Preschool education is offered to 23% of the 3-6 years population in 2002; as against the target of 70% coverage aimed for by year 2000.** The contribution of private preschools is minuscule and unrecorded.

The coverage is extremely low, compared to the targets set out by the Programme of Action, 1992 (POA to the National Policy on Education, 1986). The POA targeted at setting up 10 lakh ECCE centres in 1995, and another **20 lakh by 2000**. But the actual **coverage in 2001 was only about 4.28 lakh centres**. The NPE targets laid out by the Department of Education were to be implemented by the Department of Women and Child Development; and lack of convergence between them could be one reason for the limited achievement (Ramamurti, 1990).

The Committee on ECCE, Ministry of HRD, GOI, recommends that 'For a population of approximately 300 people and 20 (+/- 5) children of the related age group', there be 'one ECCE centre within walking distance from the home of the child. The provision of home-based ECCE facilities should be encouraged and experimented with for smaller communities, scattered populations, and tribal and hilly areas' (Ministry of HRD, GOI, 2004).

Trends in ECE

Three trends are visible from the 1970s. The first is that of a **rapid growth of programmes** for children and an expansion in terms of coverage in the ICDS Scheme. Swaminathan remarks that while the schemes, in design, did attempt to address educational development of the child under six years; in practice, **they often degenerated into feeding programmes or custodial centres with little regard for psycho-social development** (Swaminathan, 1999).

The mushrooming of pre-school centres – variously called nurseries, kindergartens, play schools, play homes – represents the second trend. These are **privately-run, for-profit** enterprises; more often than not developmentally inappropriate, academically-oriented programmes, representing a downward extension of the primary curriculum. There is no regulatory mechanism for such centres, which flourish in both middle and lower-income communities in urban and rural areas. They have become the role models for the programme content in the government sector and typify the aspiration of many a parent (Swaminathan, 1999; Kaul, in India Education Report, 2000). The lack of regulation has meant that while there has been a lot of innovation and flexibility in some centres in the private sector, the majority are of very low quality.

The third trend is the growth of the 'third sector'– **the voluntary development organisations,** whose focus lies in the empowerment of groups living in poverty and their organisation to advocate their own cause. Their perspective and approach make these organisations – also called non-government organisations (NGOs) – different from those supported earlier by the CSWB. A variety of innovative approaches, albeit at small scale, have been initiated in differing contexts, and hold the potential for replication.
These trends are visible in Karnataka too and the analysis of the approach, coverage and efficacy of the governmental and voluntary sector in Karnataka is detailed in the following section.

5. The status of early childhood education in Karnataka

ECE in Karnataka is carried out by the government – through the Department of Women and Child Development's ICDS programme as well as by local city corporations; by voluntary agencies and the private sector. The private sector has not been considered here, except in terms of broad observed trends, since there is very little documented information.

5.1 Early Childhood Education undertaken by the government

Integrated Child Development Services (ICDS)

The ICDS programme offers pre-school education (PSE) for three hours to children in the age group of 3-6 years in the anganwadi centres (AWC) through an integrated approach. The pre-school education component seeks to provide a better linkage between primary schools and the Anganwadi centers. The programme aims at promoting child-centred play-way activities, built on local culture and practices that promote the child's social, emotional, cognitive, physical and aesthetic development (ICDS, GOI, 1995)

In popular perception as well as observations of organisations working in the field, the AWC is largely seen as a feeding centre, indicating a lack of rigour and focus on the educational component.

Targets and coverage

The provision of preschool education through the ICDS anganwadis is limited. In 1982, ICDS set targets to provide preschool education to only 50% of 3-6 year olds in rural and urban areas; and 75% of 3-6 year olds in tribal areas. (DWCD). The National Policy on Education, 1986, aimed to provide pre-school education to 70% of 3-6 year olds by 2000.

Table 2: Coverage through ICDS in Karnataka (2002)

Number of AWCs providing services	39,878
Total child population (under 6 years)	68,26,168
Supplementary Nutrition beneficiaries (under 6 years)	24,76,278
Estimated child population, (3-6 years), (7% of total population, 2001)	36,91,377
Preschool beneficiaries through ICDS	12,85,812

Source: The Indian Child: A Profile, Ministry of HRD, GOI, 2002

Despite ICDS being "universalised" in Karnataka; we can estimate that only about 36 % of 0-6 year olds are receiving services at anganwadis. About 34 % of 3-6 year olds are receiving preschool education through ICDS. As we know, the number of marginalised children requiring services is much more; and 34% falls far short of the targets set by the NPE.

The number of children enrolled and the number attending an AWC and availing of preschool education may also vary. Field observations state that there are sometimes only 20 children in the AWC, including 1-3 year olds who may have come with their older siblings (Lakshmi Krishnamurthy et al, 2001). Numbers of children may increase around meal-time, reinforcing the perception that the AWC is largely seen as a feeding centre.

Field experiences of MAYA, an NGO working on ECCE issues and educational reform, supports the observation that coverage of pre-school education is limited. In one of the low-income areas in Bangalore where MAYA works, there are 22 AWCs to meet the educational needs of 5000 pre-schoolers, which would work out to 200 children attending one AWC (MAYA, 2003). This is supported by the observations of the Paraspara Trust that in Akkiappa Garden, a low-income colony in Bangalore North, a community of 445 families has no AWC.

Pedagogy, methodology and materials

The DWCD along with UNICEF and other groups has developed **an 'activity bank'**, comprising a collection of 100 stories, songs, creative activities and games for the overall development of the child. **An integrated approach of 42 themes has been developed** with one theme being taught each week.

The Department of State Education, Research and Training (DSERT) has developed an activity-based, thematic approach to ECE called 'Chilli Pilli' and trained 2100 AWWs in 10 Janshala Blocks (educationally backward blocks identified by the Department of Education) in using it. The manual seems developmentally appropriate and very colourful; but its use has not expanded to the whole State. An annual allocation of Rs. 500 is made for replenishing teaching-learning material.

The reality on the ground, however suggests, that the intent within the ICDS is not being effectively translated into practice. In 22 of the 37 centres visited in the course of a micro study by FORCES, an advocacy network on behalf of the young, underprivileged child; field workers observed no educational activity going on. Often, AWWs were involved in completing records while children just sat around.

In spite of being trained in developmentally appropriate play-way methods of learning, the AWW, either because of her own comfort levels or because of parental expectations, prefers the teaching of the 3 Rs and group activities such as songs and stories. While AWWs have educational material at their disposal; these are rarely used. For one, they may be worried about being hauled up for material being 'spoilt'; there being no funds for much required replacement. In addition, the numbers of children may sometimes be large and it is much easier to organise a group activity that does not require distributing and collecting play materials.

Achievement

In terms of achievement, a study by the NCAER in 2000 found that only 40% of children are able to describe the activities of the PSE; with it being an abysmally low 15% in the rural areas of Bijapur and Hassan. While there have been pockets where with highly motivated AWWs and good support from supervisors and CDPOs, there has been some impact (eg. Mandya, Dharwad); in general the picture is dismal.

Comment

This being said, different studies have found that coming to an AWC before joining school has helped introduce the culture of schooling to the child and its family. Children get used to the structure of a school and its routine and learn to engage in structured activities and interact with other children (FORCES, 2003). This has led to greater enrolment; and since the child is used to the habit of school; it has led to greater retention. In addition, care of younger siblings through the AWC has released older siblings from the burden of child care, thus freeing them to attend school.

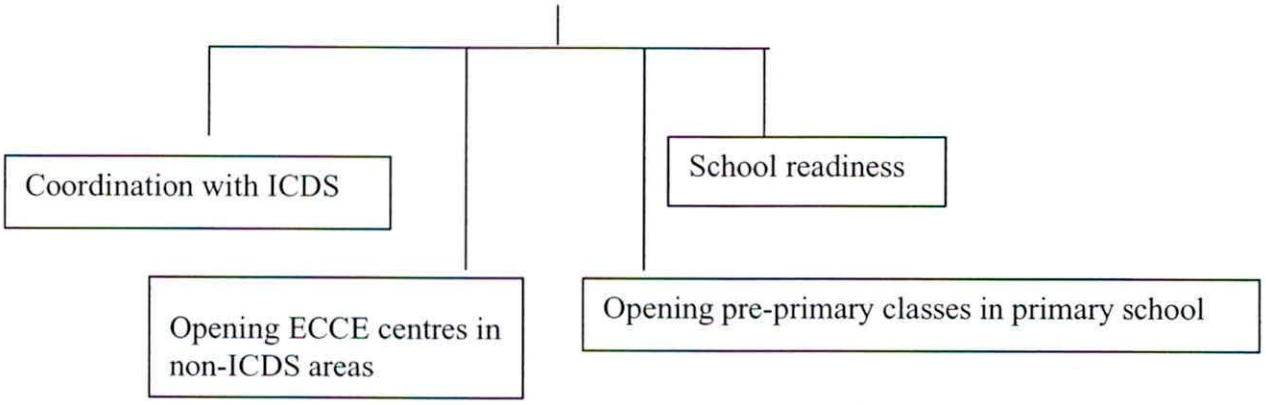
It has been acknowledged by policy makers, academics as well as field practitioners that PSE has a very important role to play in enrolment, retention and later academic achievement. The import of this however has not steeped into field practice, resulting in poor quality PSE being delivered through the ICDS programme. Two recent studies continue to raise **concerns of quality in the ECE component of the ICDS** (Upadhayay et al, 1998; Kaul et al, 1998) and have recommended a review of the existing arrangements and provisions from a holistic ECCE perspective.

Given that the ICDS as a programme has reasonably large outreach, and is the only programme at this scale; it is indeed unfortunate that its performance in pre-school education is so lacklustre.

District Primary Education Programme (DPEP), 1993

The District Primary Education Programme (DPEP) initiated in 1993, and supported by the World Bank and other bi- and multi-lateral agencies, aims at improving educational performance at the primary and pre-primary stage, through a decentralised planning and implementation approach.

Fig.1: ECCE Strategy under DPEP



Recognising the significance of pre-school education for universalising elementary education, efforts have been made by the DPEP to strengthen the pre-school component within the ICDS programme. Supplementary training and appropriate material have been provided with an aim of impacting the quality of pre-school education within the ICDS. DPEP also supported the opening of ECCE centres in non-ICDS areas.

A DPEP innovation was the **setting up of new pre-school education centres, adjacent to primary schools, in areas where ICDS was not operational.** Evaluations have indicated that this DPEP model for ECE (adjacent to primary school), was more effective than the AWC in providing a stimulating environment to children and a feeling of bonding with the school (Venita Kaul in India Education Report, 2000).
Efforts were also made to improve the ICDS-primary school linkage **by encouraging AWCs to extend their timings** to synchronise with the primary school, enabling older siblings, especially girls, to attend school.

An effort to build programmatic linkages between the ICDS and the school was also made through continuing the play-way method of learning in the lower primary school. A component of school readiness was introduced in the lower grades of formal school since almost 81% of children being enrolled had no prior school experience. (Venita Kaul in India Education Report, 2000).

Comment

The experience of the DPEP-supported AWCs (with extended timings) is a mixed one. In areas such as Mandya, where training and other inputs were also received from CRY, UNICEF etc. the impact has been very encouraging, with higher levels of enrolment, retention and achievement. This however has not taken place across all DPEP districts.

Also, there seems to be very little ownership of this component in the ICDS, leading to questions of its sustainability (Venita Kaul in India Education Report, 2000).

Sarva Shiksha Abhiyan, 2000

The gains of the DPEP are sought to be consolidated through a vertical expansion through the national programme for Universal Elementary Education (UEE) –the Sarva Shiksha Abhiyan. The Sarva Shiksha Abhiyan recognises the importance of pre-school learning and early childhood care and its role in improving participation of children in schools. **It seeks to work through the Integrated Child Development Services for the provision of ECCE.**

A provision of up to **Rs 15 lakhs per year** in a district for any innovative intervention **including for Early Childhood Care and Education** has been made under the SSA. Provision of honoraria for pre-school teacher, training of Anganwadi Sevikas for Pre-school learning, activity materials, organising training programmes for community leaders, and promoting convergence between the school system and the ECCE arrangement are some of the activities that could be supported under the SSA. (Department of Education, GOI website, 2004).

Further, under the National Programme for the Education of Girls at the Elementary Level (NPEGEL), which forms a part of the SSA framework, provision has been made for **setting up of community-based child care centres in areas where such services are not provided under ICDS** (Ministry of HRD, 2004).

In Karnataka, as in other States, the SSA is supporting the initiation of AWCs, with extended timings, in areas where there are none. The infrastructure developed under the DPEP has now been transferred to the SSA. While funding support is provided by the SSA, the administration and monitoring is left to the Department of Women and Child Development, the agency that oversees the ICDS programme. The risk of mediocre pre-school education under the ICDS is of concern in this modality.

Though the national policy seems to indicate a commitment to ECCE; in Karnataka, **45 pre-school centres that were being run under the DPEP have been closed down** following a government order. This may have been done in keeping with the policy directive of government engagement primarily for education of children above six years, as evident through the 93rd Constitutional Amendment for free, quality education for all children in the 6-14 years age group.

Given that the SSA is the major initiative of the Central Government in the area of elementary education; its scope needs to be enlarged to include the coordination, supervision of quality, and monitoring of all efforts for ECE. This could be incorporated into and achieved through the District SSA Plans.

Bangalore Mahanagar Palike

The Bangalore Mahanagar Palike (BMP) runs 78 nursery schools, located mostly in low-income areas of Bangalore, reaching about 2500 children. While the BMP also runs 11 primary schools, it is in only 3 schools that the pre-primary centres and the primary school are linked.

The syllabus followed is similar to that of the ICDS programme, and focuses on joyful learning. The BMP claims almost 98% retention rate of children in the pre-school centres. Mid-day meals are provided with partial support from ISKCON.

Teachers are appointed by the BMP, and the minimum qualification is that of X/XII pass with a Nursery Teachers Training Certificate. Private institutions such as Hymanshu Montessori teachers' training centre and as well as the District Institute of Education and Training (DIETs) have been involved in the in-service training of the teachers.

While in other cities like Mumbai, the Municipal Corporation alone runs primary schools; in Bangalore, the BMP plays a very limited role with the State Government taking the responsibility for running almost all primary schools. Whether provision of primary education is the job of the Municipal Corporation in big cities is debatable.

What is a source of concern is that **the BMP seems very ill-equipped to handle the task of running even 78 nursery schools** and 11 primary schools. The links with the State Government's Department of Education seem nebulous and the priority for this task non-existent. In the absence of a clear policy for ECCE, the attention given to the educational needs of children in the under 6 years age group is markedly low.

Karnataka State Social Welfare Advisory Board

The KSSWAB runs crèches as well as a Demonstration project for pre-school education. The **Demonstration project was initiated in 1964** and is fully funded by the Government of India with the KSSWAB channelling funds and monitoring the centres. **18 balwadis** were set up to provide recreation, basic education and nutrition to children below six years. However, following the expansion of the ICDS, the demonstration projects are not considered useful. The effort is on to shut these centres. *This is possible only when the appointed teachers reach superannuation or in the case of death!* Thus, today 11 centres are being run in Anekal taluk with about 25 children in each balwadi.

The PSE curriculum consists of teaching children songs, stories, concepts such as colours, shapes etc. Though nutrition forms the major attraction for children to come to the balwadi, the allotted sum of Rs. 1.05 p per child per day is inadequate. Children are given ragi porridge, upma, fruit etc.

The balwadis operate in panchayat premises or the local government school. Teachers need to have completed the Balsevika training prior to joining. Field officers monitor the programme through monthly inspections to monitor cleanliness, quality of teaching etc.

The emergence of the ICDS and its outreach means that there is duplication within the same communities. **While there seems to be a marked lack of dynamism and interest within the programme, the programme continues because it cannot be shut down.**

A comment on state responsibility for ECE

The importance of ECE finds mention in both the National Policy on Education and its programmatic expression – the Sarva Shiksha Abhiyan. The strategy of the SSA to work through the ICDS has its benefits and limitations. While it can capitalise on an already existing network of anganwadis; it is also true that, as we have seen earlier in the paper, the PSE component of the ICDS continues to be its weakest. Unless strong links are built with the ICDS functionaries, this strategy will only end up in SSA providing resource-intensive inputs and becoming funders of additional anganwadis, which continue to operate in the old way.

In addition, it is primarily the duty or responsibility of the government to ensure that all children, including children below six years, have access to appropriate and quality education. It is only the government which has the resources and the reach that cannot be matched by any other agency; which makes it all the more imperative that the government enters the pre-school education field in a more planned and conscious manner; giving pre-school education the priority it deserves. **The quest for universalising elementary education needs to begin with ensuring quality, universal pre-school education.**

5.2. Pre-school Education undertaken by the voluntary sector

The last couple of decades have seen a growth in the number of voluntary development organisations, also called non-government organisations (NGOs). NGOs have been playing a critical role in working directly at the field level to address issues of marginalised communities, and using this knowledge to lobby for and advocate desired policy changes.

In the field of ECE, NGOs have been involved in running pre-school centres for children in the 3-6 age group, and sometimes crèches for children below six years. These programmes have largely been small-scale, limited to the areas of operation of the NGO – often a few slums in urban areas, and a few villages in rural and tribal areas.
NGO programmes are generally more flexible and allow for more innovation than other large-scale programmes permit. In this section, we will review the work of NGOs involved in ECE in the city of Bangalore.

Some NGOs such as Akshara and MAYA run or help communities run ECE centres. There are others such as Akshayam, The Promise Foundation and Sutradhar that provide early learning materials or training to anganwadis and balwadis. There are also NGOs that have a different approach; such as teaching parenting skills.

Akshara Foundation

The Akshara Foundation is an NGO founded in 2000, and believes in private-public partnership to attain its goal of Universal Primary Education for every child below eleven years of age in Bangalore. This partnership involves the Government, the local community, the corporate sector and individual partners. Akshara enjoys a good strategic relationship with the government and has key functionaries of the Department of Education on its Board.

The pre-school programme

Recognising the lack of government facilities for pre-school education and realising its importance in the campaign for universalisation of primary education; Akshara Foundation started a Balwadi or pre-school programme. The programme is directed towards children in the age-group of 3-5 years and focuses on preparing children for primary school. It also seeks to make education a priority for parents.

Akshara begins by identifying an Educational Block and delimits a School Zone within it. The School Zone refers to an area of 1 kilometer around the school or 500 children around the school. A survey of all children in the 3-5 age group is done in the School Zone. A local community person is identified as a volunteer to teach children. More than 90% of volunteers are women.

Following a screening process, the volunteers, who are at least high school graduates, are selected and trained for 4-5 days in child development, the pedagogy of teaching very young children, community participation, and modalities of conducting classes.

Most of the centres are run in the volunteers' home for 2 hrs a day. Each class has around 20 children who are taught using the play-way methodology. Once the child crosses the age of five years, the volunteer assists the parents to enroll the child in formal school. According to Akshara, 90% of the children enrolled in primary school have been retained. In addition, observation indicates that children from the Akshara balwadis perform better in school compared to children with no earlier school experience or even children who attend the ICDS Anganawadi.

An honorarium of Rs.300 per month is paid to the teacher. In addition, she is also allowed to charge fees from the children. In June 2003, a one-week comprehensive training was provided to 46 balwadi volunteers who have been termed as '**edupreneurs**'. These edupreneurs have been given an ECCE kit, and supported to set up balwadis in their own communities. As on Sept, 2003; Akshara ran 321 pre-school centres for 4,968 children. 42,869 children have accessed pre-school education over the last three years.

Comment

Concerns of quality and sustainability loom large with the Akshara approach. By their own admission, conditions are not often ideal – the volunteer may be cooking while simultaneously 'teaching' children; the rooms may be dingy and lack ventilation. In addition, whether a one-week training programme is sufficient to train teachers is questionable.

In terms of sustainability, the Akshara approach seeks to identify all 3-5 year old children in a community and with inputs of pre-school education, enroll them into primary school once they are five years of age. In any particular area (School Zone, of one kilometer radius), it is assumed that this task will take about 2-3 years. Beyond this Akshara believes that the community will have to take responsibility. While ultimately the most sustainable model would be that of community ownership, this can happen only if there are clear and conscious steps to build the institutional capacities within communities. The Akshara team has yet to think through strategies for this.

MAYA

MAYA (Movement for Alternatives and Youth Awareness) is a development organisation working on issues of child labour and elementary education reform, through the building of community-based institutions.

MAYA's foray into ECCE began as a strategy for the elimination of child labour. Pre-school centres were initiated in response to the observation that older children stay at home to look after younger siblings; or younger children accompany their parents and older siblings to work, rather than going to school. MAYA analysed that exposure to pre-school had a positive impact on the schooling opportunities of children; in inculcating a habit of learning and a culture of schooling.

Initially, in 96-97, MAYA ran the pre-schools. However, it soon became apparent that unless the community took on more responsibility, the programme ran the risk of being external to the community. This had implications not only on its sustainability, but also went against MAYA's core belief in building the community's capacities to respond to their issues. Mahila sanghas (women's groups) were therefore facilitated to run the pre-school centres. Discussions are held to establish the need for a preschool, to find space and teachers, to communicate with parents, and supervise the preschool.

The monthly fee of Rs. 25/- forms the honorarium of the teacher. Parents and teachers are supported to create learning aids through locally available materials. Community groups raise additional resources by approaching elected representatives and individuals in their locality.

Training of teachers is on-going, including weekly theme-based planning sessions, monthly meetings and refresher trainings. The approach is eclectic and informal, drawing on Piaget, Gardner and Montessori, with mixed and ability grouping of children.

MAYA sees its role as building the institutional capacity of the co-operatives to run the pre-schools, on the one hand; and of building the capacities of the teachers, on the other. At the end of 2003, MAYA has facilitated 90 centres reaching out to 2200 children. In MAYA's working areas, around 70% of the children in the 2-6 years age group now have access to an ECCE facility. Since initiation, about 430 children have been enrolled into formal school.

Comment

The strength of the MAYA approach lies in its focus of building community-level institutions for addressing ECCE. While this model seems to have achieved success at the local level, it remains to be seen whether it can be replicated at scale.

MAYA is trying to find ways of ensuring that structures of community ownership become part of the mainstream political structure. This will ensure that not only are children's rights in the local area addressed, but also that, community institutions become an important voice to articulate policy agendas.

Paraspara Trust

Paraspara Trust has been engaged with ECE in an attempt to prepare children to join primary school and to prevent children from slipping into child labour. Paraspara is currently running 14 balwadis with about 400 children in the 3-6 years age group accessing the services. An attempt is being made to have communities run the balwadis.

The programme focuses on pre-school education. The curriculum consists of songs, play activities, stories and pre-writing and reading skills. Paraspara trains teachers. Classes are conducted in the teachers' homes or in community halls or other spaces located by the community. Each centre has about 30 children.

Paraspara has also worked with ICDS anganwadis in two areas –Vivekananda Block and Subedraplaya, in extending the timings and enhancing pre-school education. However this intervention has been withdrawn due to lack of funds.

Sutradhar

Sutradhar is an educational resource center involved with the design and dissemination of early learning resources. One of their innovations is an "Early Learning Kit" developed to promote the all-round development of children from 3-6 years. It includes three-dimensional, sturdy, and pedagogically rich materials for young children to use, complementing locally available material. In 2000, a thousand of these kits were tested in government-run anganwadis across Karnataka, with the support of CRY. Anganwadi workers and CDPOs were oriented on how to use the play materials. The project included follow-up visits to understand the effectiveness of the material.

Network for Information on Parenting/ Community Health Cell

The Community Health Cell is engaged in action and research in community and public health issues, in the low income areas of Bangalore.

In early 2002, CHC initiated a parent skill programme for the Balamandir Research Foundation in Chennai, involving 13 local organisations, including MAYA and APSA. The development of training and tools included a learning-to-play calendar, with follow-up programmes in the field.

As a result of this programme, the Network for Information on Parenting was formed in March 2003, to understand nutritional requirements, care and bonding, gender issues, disability, pre- and ante-natal care, and female foeticide, among other issues. This information, disseminated over several months, is now available in Kannada, Tamil and English.

This effort represents a larger global movement of building and enhancing parenting skills. Special attention is played to developing skills of parents and other caregivers so that they are better able to respond appropriately and adequately to the child's need for stimulation, laying the foundation for the child's all-round development. This is seen as an intervention in enhancing the environment in which the child grows, helping her/ him thrive and develop to her/ his full potential.

The Promise Foundation (TPF)

The Promise Foundation set up in 1987 provides services in the area of mental health, education and potential realisation. Recognising the need for early childhood intervention for cognitive development, TPF has a two-level Stimulation Intervention Programme (SIP) for children in the 3 to 6 years age group.

Promise Shishukendra is a preschool and demonstration centre catering to the needs of 30 children in a slum in Koramangala. The pre-school demonstrates TPF's methods for early childhood care and stimulation. With the aim of laying strong foundations for later formal learning, the preschool lays emphasis on literacy acquisition skills, balancing all round stimulation with individualised school-readiness stimulation.

TPF conducts training programmes primarily for anganwadi workers, ECCE workers in NGOs, and community-based organisations. The programmes range from monthly sessions to modular inputs spanning 3 to 12 months. TPF specialises in training people who work in the rural sector and urban slums. An early stimulation kit has been developed that is given to every trainee.

Akshayam - Cognitively Oriented Programmes for Pre-School Children

Based on the Play House Nursery School experience (since 1966), and several experiences from children in rural areas as well as children with special needs; Indira Swaminathan of Akshayam evolved the Cognitively Oriented Programme for Pre-School Children (COPPC). This has also been used with anganwadis run under the ICDS. Initiated in 1985, COPPC training was given to 140 child workers, including nursery teachers, Balasevikas, and anganwadi workers and trainers. The ripple effect of this training has since extended to 60,000 anganwadi and balwadi workers, and over a lakh of pre-school children.

Comment on voluntary sector involvement

The voluntary sector has shown innovative experiments in ECE. The initiatives have focused on building the preschool-primary school linkages, on supporting government programmes for universalisation, and on strengthening community capacities to own and run ECE programmes. While some organisations support the efforts of the government, others work towards making the State institutions more accountable; still others focus on building community institutional capacities.

The role of these initiatives in the larger canvas of ECE has been that of highlighting issues that need to be addressed in the government sector. While these initiatives have not been at scale, they do hold important lessons that can be assimilated in mainstream initiatives.

5.3. ECE in the private sector

The last two decades has seen a mushrooming of privately-run ECE centers; variously called play schools, play homes, nurseries, pre-nurseries etc. While they began as centres catering to children of the upper income groups; today they exist in urban poor communities and in rural areas as well. They are said to have contributed to decreasing enrolment in government-run facilities, discredited as the latter are in popular perception. The focus on English education and preparation for an English-medium primary school seem to be the reason for their appeal.

One of the reasons it is difficult to make any analysis on this sector is that there is so little data. We have no idea about their magnitude, as they are not registered. There is also no uniform curriculum save for the fact that they represent a downward extension of the syllabus of the first few years of primary school. Often, **developmentally inappropriate activities such as writing are introduced at ages as young as two and a half**.

These initiatives are often staffed by untrained persons, leading to a fall in the quality of the programme.

6. Training in ECE

ECE training takes place under the auspices of the government, voluntary as well as private sectors.

Training by the government

A large part of the training undertaken by the government is geared towards preparing functionaries for the different government schemes – primarily for the ICDS. A 52-day training programme for Anganwadi workers, a 65-day training programme for Supervisors and a 60-day training is held as soon as the functionaries are recruited. Periodic refresher training programmes are also held.

In addition, pre-service training is offered by the Department of Education that runs 6 Nursery teacher training institutes. The DSERT (the state body of the NCERT) prepares the syllabus and curriculum for the course.

The District Institutes of Education and Training (DIETs) as well as the Block Resource Centres (BRCs) established under the DPEP programme also have an ECE component in their elementary education programme, which may be seen as an attempt to strengthen the linkages between pre-school and primary school, at least in training.

According to the National Council for Teacher Education (NCTE); there are 68 recognised courses at the pre-primary level out of the total 2871 courses recognised for all other levels. **12 of the pre-primary courses are in Karnataka**.

The pre-primary courses nationally are **approved for an intake of 3021 students only**, which is **insignificant** in relation not only to existing requirements, but also with reference to future demand. In addition, there are courses run by the Rehabilitation Council of India and by many NGO and other private systems that prepare human resources for their own requirements, but these do not significantly add to the overall pool of ECE workers (Ministry of HRD, GOI, 2004).

Training by NGOs

The Karnataka State Council for Child Welfare (KSCCW) runs an eleven-month course (Bal Sevika Training) on preparing young girls – who have passed their matriculation— as child care workers. 40 batches of child care workers have been trained by KSCCW. Trainees study child development, pre-school education services, health, hygiene and nutrition.

In addition, NGOs are also involved in providing specific inputs to government programmes. For e.g. Seva in Action and Association for People with Disabilities (APD) have been training Anganwadi workers on identification and rehabilitation of children with disabilities. Pedagogic training on a small-scale has also been undertaken by NGOs like Samuha and Paraspara.

7. Issues in ECE

- **The invisible child below three** – the child below three years exists in almost all policy documents and programme design. Interventions with this group have however, largely focused on health and nutrition, two critical components of growth. There is evidence that the child in this age group too requires educational – cognitive and language – stimulation; which is not often addressed. The recent efforts at developing parenting skills seem to be a movement in ensuring appropriate stimulation for the child under three years, and needs to be encouraged. Interventions focused on this age group need to look at alternative strategies such as family-based care, in addition to centre-based care.

- **Limited reach of services** – Given that there is so much evidence of the critical need for early stimulation for realising every child's potential; it becomes imperative that priority be given to ensuring universalisation of quality ECE services. Currently only about 19% of children in the under 6 age group seem to be accessing any kind of ECE (Venita Kaul, India Education Report, 2000).

- **Neglect of ECE by Department of Education** – The ICDS as a programme focuses, at least in design, on convergence of different departments. However, in practice its primary focus is on health and nutrition. The role of the Department of Education is minimal, if at all. A recognition of the crucial role of ECE in enrolment, retention and later academic achievement necessitates that ECE be taken more seriously in our quest for universal elementary education.
  This assumes importance since the Department of Education's strategy for ECE is to work within the framework of the ICDS. Unless stronger links are built between the two departments, the danger lies in the pre-school component of the ICDS running in much the same mediocre manner.

- **Quality Concerns** - There is evidence to state that not only is ECE important but that it has to be of a certain quality to have an impact. Given this, more efforts are needed to regulate and ensure certain minimum levels of quality especially in the unregulated private ECE services, much of which have degenerated into 'teaching shops'. In the governmental sector, what is needed is more optimum utilisation of resources to ensure quality services. Monitoring and supervision, including that by the community, need to be strengthened.

- **Training** – Much of ECE training is happening within the government sector and is geared towards staffing government programmes. Though there are fairly strict prescribed norms for in-service and refresher trainings; often, the reality is that many functionaries have not undergone any training.

  Teachers in the unregulated, privately-run ECE centres **are not mandatorily required to have any formal qualification, and this dilutes quality**. There is a great need for ensuring that training of a certain quality is provided.

  There also seems to be a gap between the 'ideal' in terms of what is taught in training schools and the 'reality' of what is practiced in ECCE centres. A classic example is the stress on learning the 3 Rs in an anganwadi, while what is supposed to be followed is an informal methodology. Bridging this gap and making the programme more sensitive to field realities will enhance the quality of the programme.

- **Community alienation** – Within communities exist a rich treasure of songs, stories and games that fulfill the developmental needs of the very young child. These need to be built upon. Imposition of a centrally formulated curriculum and patterns of learning alienate the child and her/his family from what is culturally acceptable. ECE then begins to be seen as a service external to that of the community, making it impossible for the community to take any ownership.

- **Absence of linkages** – ECE needs to be integrated with what follows in the child's life educationally viz. primary school. A shared understanding between teachers in ECE centres and primary school needs to be developed. A document that summarises where the child is developmentally may be introduced; one that the ECE teacher gives a child prior to her/ his admission in primary school. The two stages – ECE and primary – are also seen as distinct, especially in the government-run programmes where they are administered by different departments. This barrier may be broken through the upward extension of the ECE curriculum by 'focusing on themes/concepts, skills and competencies to be developed in primary classes rather than lessons/syllabus to be completed' (Ministry of HRD, GoI, 2004).

  The Committee on ECE of the Ministry of HRD, GOI, also recommends locating the ECCE centres near the primary school and synchronising the timing with the primary school. Proper linkages between ECCE and primary education may also be established through school readiness programmes and joint in-service training of ECCE workers and teachers of early primary grades (Ministry of HRD, GOI, 2004).

8. Directions for future advocacy

- **Age-appropriate intervention** – Given that the developmental needs of children vary according to their age, it may be useful to disaggregate ECE services on the basis of age. Thus a programme for **children below three years** will need to look at a primarily home/family-based intervention and institutional options such as crèches that emphasise health and nutrition along with appropriate stimulation. This could be handled as a convergent programme meeting health, nutrition and early stimulation needs by a programme such as the anganwadi-cum-crèche run by the Department of Women and Child Development.

  Enhancing parenting skills as well as skills of other caregivers (in institutional settings such as orphanages, for instance) through parenting programmes that are contextualised within the experience of parents and care-givers is critical. Such programmes could address the fundamental question of how parents can meet the developmental needs of the child appropriately.

For the **3-6 year old child**, it may be best to locate services within the primary school. The DPEP experience shows that this is a far better model to meet the educational needs – both present and future – of the child. This allows the child to get into the habit of schooling at an appropriate stage. The presence of an older sibling in the vicinity is reassuring both for the younger child as well as the older sibling.

The programme for the 3-6 years old child can be further broken into two sub-stages – 3-4 and 4-6 to allow for differences in their capacities (Venita Kaul in India Education Report, 2000).

The Sarva Shiksha Abhiyan – the GOI's universalising elementary education programme – would seem to be the appropriate vehicle for this. It is also important that not only is the pre-school centre located within or very close to the primary school but that there is also an interlinkage between the curriculum and teaching methodology. Rather than a downward extension of primary school curriculum into the pre-school curriculum, it would be more effective to ensure a bottom-up, process of integrating developmentally appropriate syllabus at the lower primary classes.

In addition, given that a large majority of children coming into Std I have no prior school experience, it may be worthwhile to introduce a school readiness component in Std I. This may be integrated into the functioning of the Department of Education.

- **Supportive interventions** - Interventions such as nutrition and health form an important component of any effective ECE programme. Research indicates that short-term memory, alertness and capacity to process information, among other processes, are adversely affected by nutritional and health deficits (Levinger, 1994 in Venita Kaul, India Education Report, 2000). A supplementary nutrition programme can be organised along with the primary school meal programme. While ICDS offers this support, privately-run pre-schools as well as those run by voluntary agencies and other governmental agencies such as the DPEP and SSA also need to incorporate health and nutritional support into their programmes.

- **Addressing quality concerns** – Quality concerns abound both in the governmental as well as the private and voluntary sector. Quality would imply setting up mechanisms that allow for a continuous improvement based on feedback from the end user. Within the government sector, this may involve ensuring a better and more optimal utilisation of resources, better supervision and monitoring, as well as substantive upgradation of the programme. Within the private sector, there is an urgent need for registration so that accurate data about such centres is made available. This can then form the basis for ensuring that all ECE centres in the State follow certain standards.

- **Preschool materials** – While the government has allocations for preschool materials, this money is often given to the Zilla Parishad to spend; and at that level, the materials available may only be KG cardboard and thermocole. Efforts need to be made to scrutinise the process of purchasing materials; which is based on inviting tenders, sometimes at the cost of quality; and promoting corruption. Resources need to be available annually; so that play materials become a recurrent rather than a one-time expenditure. This would be a true gesture of the state's commitment to improving the quality of preschool education.

- **Regulation of the private sector** – As we have seen, the private sector caters to a large number of children. Quality issues loom large in such centres, managed as they are by largely untrained people. In the absence of some basic criteria, including amongst others, space, training of teachers, appropriate teaching-learning material and methodology; what goes in the name of pre-school education is potentially harmful. In Maharashtra, FORCES has taken up the task of setting up a regulatory body to monitor the quality of pre-schools and offer accreditation. As a first step, **registration of all ECE centres** within Karnataka may be undertaken. However, care should also be taken to ensure that regulation does not imply greater bureaucratisation; such that genuine innovation and flexibility is thwarted.

- **Community ownership** – The root of a lot of dissatisfaction and lack of impact of developmental interventions may well lie in the fact that the communities for whom they are meant are completely alienated from the design and delivery of the intervention. A sense of ownership of communities can only emerge if ECE interventions build on their own capacities. It is important that communities articulate what they would like from an ECE service. While there can be a broad framework which may be uniform, these community articulations would need to determine the content and process of ECE, contextualising it within their own traditions, while at the same time bringing in aspects from current thinking. This will lead to a greater accountability of both the service providers as well as the community in ensuring that quality ECE services are delivered.

- **Curriculum for ECCE** – Developmentally appropriate curriculum needs to be developed for ECE programmes. The idea is not to burden the child but introduce pre-school concepts in a way that catches the imagination of the child and builds on her/ his innate curiosity and desire to learn. The curriculum should allow for activities that help in the overall development of the child including physical-motor development, language development, socio-emotional development, cognitive development and development of aesthetic and creative expression. The programme must be joyous and built on the child's interest.

BOX 1

The **Committee on ECCE** set up by the Ministry of HRD, GOI, in its Report (2004) has come up with following recommendations, which are extremely comprehensive:

- Learning at this stage should be characterised by group activities, play-way techniques, language games, number games and activities directed to promote socialisation and environmental awareness among children.
- Children should be provided with ample opportunities for developing the essential skills of identification, comparison, matching, naming, seriating, drawing and counting without subjecting them to formal ways of learning numbers etc.
- The methods of ECCE have to emphasise the activities arising out of the child's interest and not due to teacher initiatives. There has to be more focus on free play activities rather than guided and controlled activities. The basic approach to early childhood education has to be "learning by doing" and "learning through exploration". The play component is the central theme for promoting quality early childhood education. Pretend play, dolls' play, puppet play, playing with blocks, puzzles and variety of local specific games are important ingredients of quality.
- Child-to-child interaction and child-nature interaction should also be promoted apart from organising activities helpful in developing positive attitudes and habits for healthy social participation. Children should also be encouraged to play with pets, recognise common birds, animals, plants and means of transport and some celestial bodies such as the sun, moon and stars.
- The curriculum should lay emphasis on activities like stories, rhymes, music, clay work, drawing and painting and other forms of play. Local plays, games, cultural contents should be appropriately integrated into the programme.
- All ECCE programmes should identify and appropriately integrate children with special needs.
- Formal teaching of subjects, reading and writing must be clearly prohibited.

9. Summary and conclusions

The recognition that the first few years of a child's life are most critical to her/ his optimal development has led to a dramatic rise in the magnitude, nature and scope of ECE programmes over the last two decades. ECE programmes are today being run by government, private as well as voluntary agencies. While the trend of ensuring ECE to the child below six years is to be welcomed; we also observe a great variation in the quality of the programmes. The lack of regulation of the private and voluntary sector and inadequate supervision and monitoring in government programmes has led to diluting the potential of early childhood education.

It is imperative that age-appropriate programmes are developed to cater to the changing developmental needs of young children. Particular attention needs to be paid to the child under three years, for whom home-based and community-based programmes may be most relevant. Programmes for children in the age group of 3-6 years need to be integrated within the primary school system to allow for a smoother transition. There has to be greater integration between ECE programmes and primary school in the areas of curriculum, teaching methodologies and monitoring the development of the child.

The constitution of a **Committee on ECCE** by the Ministry of HRD, GOI speaks of the commitment of the State to address ECE matters. The report of the Committee, submitted in January 2004, represents a comprehensive study of existing facilities as well as makes some far-reaching recommendations. These recommendations need to be implemented in both letter and spirit.

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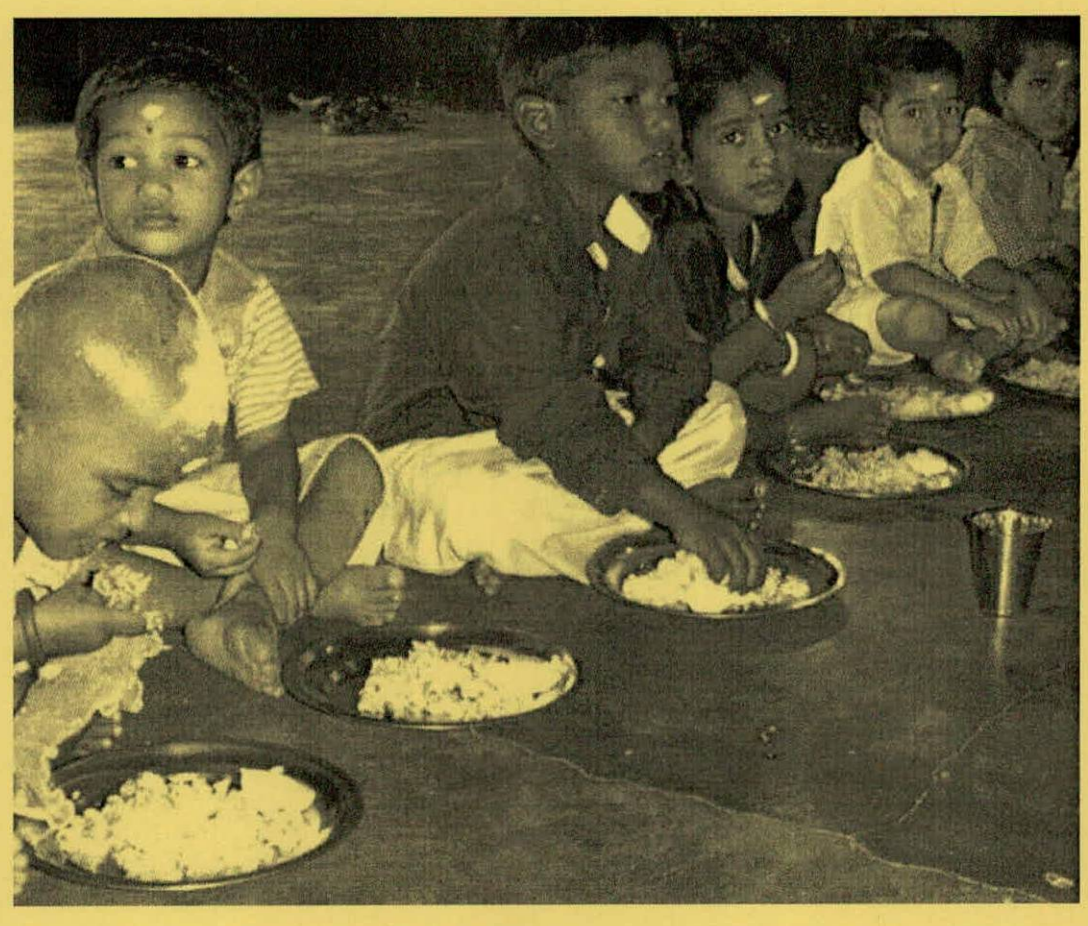
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Health and nutritional status of the young child

Dr. Maya Mascarenhas

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1. Introduction

Every child has basic rights to health and health care. While India has made huge technological advances and improved its health systems, too many infants and children are still dying and many more do not develop to their full potential due to illness. What is worse is that most of the known causes of death are preventable. Even though we have the technical expertise to tackle these problems; most of our policies and programmes, although appropriate, are not effectively implemented.

The average Indian child has a poor start to life. There are nearly 160 million children under six years of age in India: making up a significant 12% of the total population. Poor health at this age has an impact right through adulthood. In fact, almost two million children die each year before reaching their first birthday. Childhood malnutrition has long term effects on cognition and physical development. Preventable and treatable illnesses such as diarrhoea cause many young children to die.

Various factors determine the status of child health in India. Amongst them, the key factors are related to poverty, living conditions, and the mother's health status during pregnancy and childbirth. Children who are more frequently ill, often from preventable infectious disease; and those who are malnourished, and more likely to die of their illness; are from the very young and underprivileged populations within developing countries.

Did you know??

- 1 in 11 children in India die before their 5th birthday.
- 8 lakh children die due to diarrhoea each year
- One in two children is malnourished.
- Every 3rd child is born with low birth weight
- Two thirds of children are anaemic
- Only 42% are fully immunised
- Only 20% get enough Vitamin A to prevent blindness
- 60 million children live below the poverty line

Inequities are seen in both access and quality of care. Each day, millions of parents seek health care for their sick children; taking them either to hospitals or primary health centres, pharmacists, doctors, or traditional healers. Poor quality of treatment and advice, lack of basic diagnostic facilities, equipment and drugs are what they get in return.

India has made an attempt to improve the health and nutritional status of its children through its vast public health system and programmes such as the Integrated Child Development Scheme (ICDS) and the Reproductive and Child Health Programme (RCH). Karnataka's performance in health is mediocre at best, and lower than its neighbours Tamil Nadu and Kerala in child health and nutrition. Important intra-state variations exist: health indicators in some of the northern districts are extremely low even compared to national figures, due to widespread poverty.

This paper attempts to understand the various factors that impact child health in general, and the status of child health in Karnataka, in particular. This paper focuses on the young child under six years of age. It looks at the health system, health programmes and government policies, and indicators of child health.

The aim of this paper is to identify issues related to child health that need immediate attention, as well as put forward suggestions and strategies that may facilitate better health prospects for the young child in Karnataka.

2. The child and the health care system

India has a population well over the one billion mark, and 12% of this population is below the age of six years. It also has one of the largest public health system infrastructures in the world. It is important to understand the components of this system and their potential for improving the health of the young child. There are three service providers:

- **government health services**: publicly financed and managed curative and preventive health services, in general free of cost to the consumer. This accounts for about 18% of the overall health spending and 0.9% of the GDP.
- **private health services**: owned and managed by the private sector, their services tend to be more expensive. This sector accounts for about 82% of the overall health spending and 4.2% of the GDP.
- **health services offered by the voluntary or non-profit sector**: these do not factor significantly in terms of overall health spending or GDP, but offer quality care to the underprivileged.

2.1 The public health sector in India

Health care in rural areas is provided through the public health system and the ICDS. The public health system has three levels of functioning:

Primary level of health care

The **primary health centre (PHC)** is considered the basic health unit. Though this concept was mooted in 1946, it came into being after the Alma Ata declaration of 1978, when India launched its "Health for All by 2000 AD" programme. The PHC was initiated to provide integrated curative and preventive health care to rural India, with a focus on prevention. The key principles of primary health care are equitable **access** to all irrespective of their ability to pay; **community participation** through the Panchayati Raj system; and **inter-sectoral coordination** between departments such as the ICDS, rural development schemes, women and child development schemes, and the panchayats.

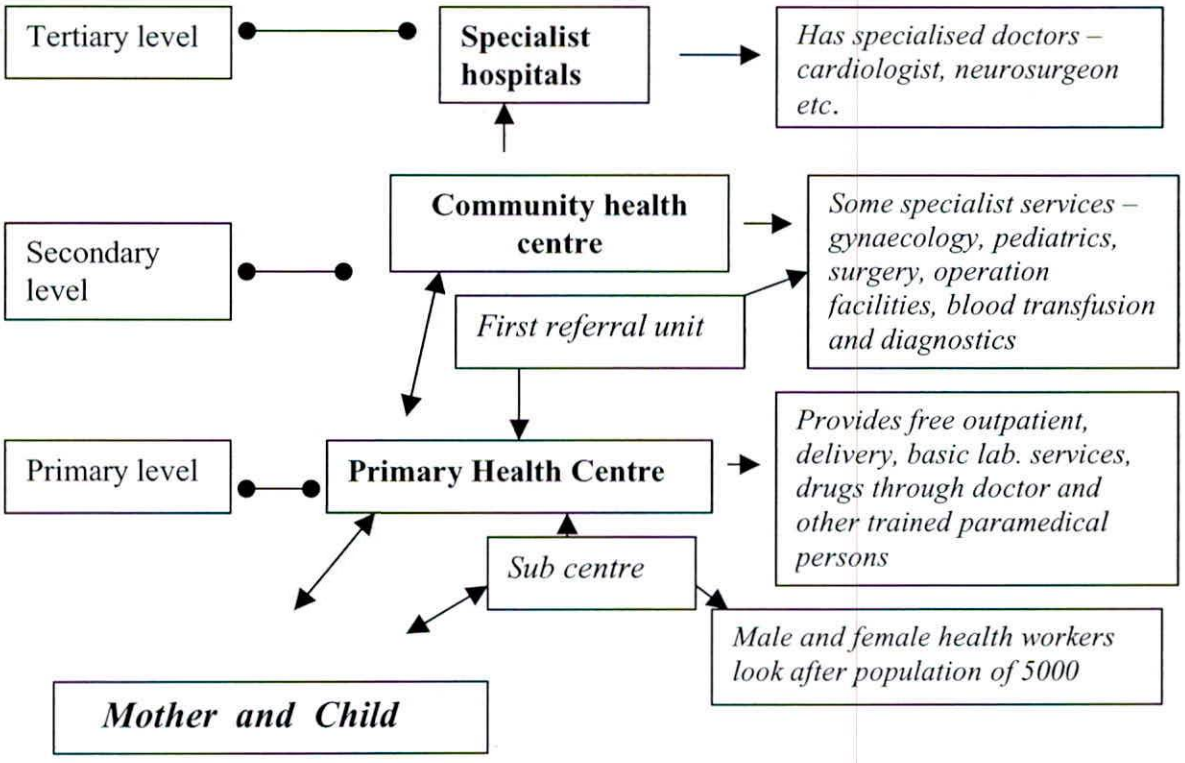


Figure 1: The public health system

The PHC is to cater to a population of around 30,000. A medical doctor aided by about 45 centre and field staff implement programmes. The centre is supposed to offer out patient services, normal delivery care, basic laboratory services, and supply of essential drugs. It also monitors and implements national programmes, including the RCH and ICDS.

The **sub centre** is a smaller unit that provides outreach. It is manned by two field workers - the Health worker (female) or the Auxiliary Nurse Midwife (ANM), and the Health worker (male). They cater to the primary health needs of a population of 5000. The ANM is primarily in charge of maternal and child health, while the male health worker monitors chronic diseases and environmental sanitation and hygiene.

In India there are almost 23,000 PHCs with around 26,000 doctors in place. In Karnataka state, there are 1676 PHCs with 1944 doctors managing these centres (tenth five year plan). There are 8,367 ANMs in Karnataka. According to the tenth five year plan, there is an estimated surplus of doctors at PHCs in India and a surplus of PHCs in Karnataka.

Services provided by the PHC for the mother and child

Besides the out-patient primary care provided at the PHC, several specific interventions are provided for the mother and child. Some of the major ones are:

1. Through the RCH program:
   a. Essential antenatal care and postnatal care
   b. Early diagnosis of high risk pregnancies and referral
   c. Family Planning services
   d. Normal delivery care
   e. Care of the newborn
   f. Immunisation services
   g. Treatment and prevention of diarrhoea and pneumonia.
   h. Micronutrient supplementation of iron and folic acid, and Vitamin A.
2. Through the ICDS scheme (in collaboration with the primary health centre)
   a. Immunisation
   b. Health check-ups
   c. Referral services
3. Treatment of communicable diseases

Secondary and tertiary levels of care

At the secondary level, the **community health centres** are supposed to have facilities for detailed investigations, conducting operations with specialist doctors on board, and providing blood transfusions. One centre caters to a population of around 1,00,000. In the rural areas, most of these hospitals exist at taluka headquarters. For the RCH program, there is a special unit at the secondary level called the **First Referral Unit.** All referrals related to problems of the pregnant mother and the newborn are made to this unit. This unit is equipped to conduct operations, Caesarean deliveries, blood transfusions, emergency newborn resuscitation etc.

The third level provides tertiary care through **hospitals** in district headquarters in urban areas. At this level, major surgeries and super specialist care in areas such as cardiology, urology, neurology etc. are supposed to be available. The fees collected are on the basis of a sliding scale; and BPL card holders get virtually free services.

Problems with existing services

Even though there are many primary health centres, albeit unevenly spread, in reality only 36% of these centres have a doctor coming on a regular basis. Public expenditure on health accounts for only 18% of overall health spending, compared to 82 % in the private sector. People perceive the public sector as inefficient and of poor quality. Besides, with more than 45% of doctors being absent from the PHC at any given time, the rural public would rather go to a private physician who is accessible, available and approachable in their eyes.

The ANM is called upon to deliver community based health care from a sub centre that does not meet basic facility and drug availability requirements in most places.
She has to travel long distances without appropriate transport facilities, and is given targets to work with despite India adopting the "target free approach".

A recent evaluation study conducted in three districts of Karnataka to understand how rural people utilise the primary health centre and its sub centre services found that:

- *All sub centers were under-utilised*
- *No monitoring for utilisation of various health care services*
- *There was no dialogue with the community*
- *Health worker was not trained to use or call for community involvement*
- *Free services were seen as poor services*
- *Location of centre was not suitable to the community*
- *Health worker did not stay at the institution due to security reasons*
- *Institutions were in poor condition; no electricity, water and resources for maintenance and drugs.*

(Source: Evaluation of the PFI-MYRADA RCH training of trainers programme: Internal document)

The task force on health instituted by the Government of Karnataka, under the chairmanship of Dr.H. Sudarshan, conducted an in-depth study of the health system in Karnataka. They found the situation appalling. **Only about one-third of PHCs had critical staff and supplies, or offered delivery services.** There was widespread corruption ? one of the doctors appointed as the PHC officer was getting a salary even though he had moved to another country over six years ago!

Though Karnataka has made several modifications based on the recommendations of the task force by appointing doctors on contract, and introducing monitoring systems, there is a long way to go in making an impact on health indicators. There is some coordination between field level workers such as the ANM and anganwadi worker at the village level, but this is not reflected at the PHC level or higher.

In addition, the Panchayati Raj institutions of gram, taluk and zilla panchayats have specific responsibilities to monitor and support programmes including RCH (73rd and 74th Amendment, the latter known as the Nagarpalika Act for local governance in urban areas). A recent meeting with the elected women representatives of the gram panchayat members in Chitradurga district revealed that over 80% of these women were not aware of their responsibilities in monitoring the RCH programme, or even of the budget allocated towards implementing RCH programmes through the gram panchayat (Mascarenhas et al, 2004).

2.2 The private health sector in India

There are many types of private health providers? from individuals in clinics to nursing homes, to large tertiary level "hi-tech" hospitals. In rural areas, more than 50% of the people go to private doctors and more than 80% are willing to pay for services (Source: World Bank). People perceive private doctors to be available when they need them and willing to lend an ear. However, the quality of care provided by private doctors is often suspect as is their medical qualifications. Some studies have pointed to higher user-fees, and prescription of unnecessary medicines and procedures in private health services.

Paradoxically, especially in Karnataka, multi-specialised, corporate hospitals are increasing which claim to offer quality health care in cities, although at expensive rates. With support from the government, they even cater to persons living in other countries, and encourage a new industry of medical tourism. Often, these hospitals do not honour their commitments to reserve a proportion of their service use for the poor. Some tertiary care hospitals have also been started by charities. Services are free, affordable, or have a sliding scale based on income. Perceptions of these services tend to be better than government services.

In this scenario, is it surprising that the state of our people's health is so dismal? People run form pillar to post trying to seek help, which is either too expensive or of very poor quality, or too late. The poor and uneducated have no recourse but to go to unqualified private doctors who are ready to give them "something for their problem", regardless of the appropriateness of the treatment or the ethics of health care.

3. Programmes and policies for the child in India: a historical overview

Box 1: Key Indian policies on children

- The Indian Constitution – directive and principles
- National Policy for Children 1974
- Integrated Child Development Scheme 1975
- National Health Policy, 1983/ revised 2002
- National Policy on Education 1986/ revised 1992
- National Child Labour Policy 1987
- National Plan of Action for Children 1992
- India's Ratification of UN Convention on the Rights of the Child 1992
- India's Ratification of CEDAW (Convention on elimination of discrimination against women)- 1993
- Infant Milk Substitutes, Feeding Bottles and Infant Foods Regulation and Production and Distribution Act, 1992
- National Policy on Education, Program of Action 1992
- National Nutrition Policy 1993
- 73rd and 74th Constitutional Amendments for Local Self Governance 1994
- National Reproductive and Child Health Programme 1997
- National Population Policy 2000

Post-Independence, no specific programme or policy was spelt out with regard to the health of the child. Constitutional principles determined health plans. The emphasis was on reducing the population through family planning services, and the health of the mother and child was largely neglected. The National Policy for Children in 1974 recognised the child's needs for the first time. The current programmes for child health are the Integrated Child Development Scheme (ICDS) initiated in 1975, with a focus on nutrition; and the Reproductive and Child Health Programme (RCH) of 1997. The RCH builds on earlier maternal and child health programmes. A few important policies are described below (more details are enclosed in the annexure).

1. National Policy for Children, 1974

The National Policy for Children reaffirmed the Constitutional provisions and declared that "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". This would be done in a phased manner so that, within a reasonable time, all children in the country enjoy optimum conditions for their balanced growth.

2. The Integrated Child Development Services (ICDS) Scheme, 1975

Still regarded the most important scheme for children due to the extent of the population it is meant to cover, the Integrated Child Development Services (ICDS) Scheme was conceived as a delivery package of services for early childhood development. It aims to improve the nutritional and health status of vulnerable groups that include pre-school children under six years, and pregnant women and nursing mothers, through services that include supplementary nutrition, pre-school education, health services and health education. These are provided through the "anganwadi centre". The main persons involved in service delivery are the anganwadi worker and the helper. Some of the health services, such as immunisation, are coordinated with the ANM.

3. National Plan of Action for Children, 1992

The National Plan of Action reiterated the promises made by the global fraternity at the World Summit for Children, and set out a time frame for India's Charter of Action for women and children. Some of the specific plans put in place to ensure improved child health included a reduction in the number of infant deaths and the prevalence of malnutrition by the year 2000 AD.

4. India's Ratification of the UN Convention on the Rights of the Child, 1992

The Indian child is entitled to several rights as part of India's ratification to the UN Convention on Child Rights. Some of these are the **right to survival**, with a specific emphasis on the female child right from female foeticide to the survival of the girl child, the **right to health** to prevent childhood physical and mental illnesses, and the **right to nutrition** through adequate supplementary nutrition and environmental hygiene to prevent the contamination of food; for all families below the poverty line.

5. National Reproductive and Child Health Programme, 1997

The Reproductive and Child Health Programme (RCH) in India, which aims to address the reproductive needs of men, women and children through their entire life cycle, evolved from other separate vertical national programmes into the current integrated approach.

India was the first country in the world to pioneer a national program in family planning, with the objective of decreasing the growth rate by controlling family size. This was revised when the government realised that there was little acceptance as families were not assured of the survival of their children, and thus had more children in the hope that some would survive beyond childhood. Later the focus shifted to improving the health of the mother and child. This resulted in the Maternal and Child health Programme and the Safe Motherhood and Child Survival Programme.

Currently, these interventions have been subsumed in the Reproductive and Child Health Programme (RCH).

Family Planning Programme	→ Maternal and Child Health Programme	→ Safe Motherhood and Child Survival Programme	→ Reproductive and Child Health

The RCH programme serves five different groups: mothers, children, eligible couples, women with gynaecological related problems, and adolescents. There is a strong focus on the quality of health and survival of the mother and young child. In contrast to other programmes, the approach is democratic and based on community needs – at least on paper.

The RCH programme is in its 7th year of operation. From the National Family Health Survey
(NFHS – 1 and 2) data we can assess the health status of women and children, and the impact of the RCH at ground level.

6. National Population Policy, 2000

The Population Policy prescribes strategies towards achieving a stable fertility rate and net reproduction rate. One section is devoted to the child. Acknowledging that infant mortality is the most sensitive indicator of health, attention was devoted to various measures that would ensure survival of the infant. These included focussing on the neonate (less than 1 month old) with specialised care through super specialists. Another area emphasised through this policy is immunisation for children.

7. National Health Policy, 2002

Reframed after almost 20 years, this policy has made very strong recommendations to improving health for all in the country. **Surprisingly there is no specific reference to any child health indicators or programmes in this document**. An oblique contribution to reduced infant mortality is through the women's health strategies portrayed in this document, where special emphasis is laid on ensuring essential care to all pregnant women.

Comments on policy and programme

ICDS

Growth monitoring and nutrition supplementation is the main activity of the anganwadi staff. The high levels of malnutrition in children under six years are a sorry reminder that these interventions are not carried out effectively.

While the ICDS scheme has a holistic approach at the field level, and involves the family and community to a large extent, there are several drawbacks. The poorly paid, overburdened anganwadi worker and helper cannot possibly fulfil their job requirement. They also depend on the PHC to provide healthcare, checkups and immunisation, and the PHC system itself is dysfunctional.

In Karnataka, even with "universalisation" of ICDS in all 27 districts, the same problems surface. The anganwadi teachers do not have regular supplies of food or medicines to fulfill the health and feeding programme objectives.

The National Population Policy

This spells out details for specialised care to reduce the high incidence of newborn deaths. Most of these suggestions seem impractical in the rural context, when access to basic primary health care itself is inadequate. How then will it be possible to expect neonatologists and other specialised doctors to be available to the rural poor?

The Reproductive and Child Health Programme (RCH)

The RCH is the most comprehensive program for women and children. If implemented correctly, one can guarantee the reduction of maternal and infant deaths. The often quoted National Family Health Survey conducted in 1992-93 (NFHS-1) and again in 1998-99 (NFHS-2) made a detailed study of the impact of the RCH program.

Its results have clearly established a lack of seriousness on the part of the State to deliver primary health care to the most vulnerable groups – women and children. (NFHS-2 India Report)

4. Factors that influence child health

a) Poverty

Simply put, there is a significant and direct correlation between poverty and ill health all over the world, including India. Current health service delivery strategies do not reach children most in need, especially the poor; because their families lack the knowledge or financial resources to provide good nutrition; or because families do not have access to the solutions that can save lives. Governments and communities have not made a sufficient and sustained commitment to the rights, health and survival of children. Malnutrition is a fundamental problem among children in the developing world. In 2000, **malnutrition** was associated with 60% of all childhood deaths, mainly among the poor. (see pg 14)

A child from a poor family is almost four times more likely to die in childhood than a child in a better off group.

b) Safe and supportive environment

A safe and supportive environment depends on both access to resources as well as good behavioural practices. Access to safe drinking water and sanitation facilities are crucial. Overcrowding and poor ventilation encourage respiratory infections. Good hygiene and sanitation practices protect children from diarrhoea and other communicable diseases. Good practices include hand-washing, proper water storage, defecation in designated sites, burial of faeces, clearing faeces out of homes and compounds.

c) Availability of health care services

It is of little use creating awareness and raising the expectations of people if health care is not accessible. For the poor, accessibility is limited by distance and time, availability of doctors and drugs, and poor quality of care. Any programme to improve childhood mortality and illness needs to address these issues.

d) Women's health and nutritional status

Women in India are disadvantaged throughout their lives. A low birth weight female baby may experience biological and social vulnerability. She is more susceptible to illness and malnutrition. Due to a widespread culture of son preference, girls receive less health care and education, and this makes them more vulnerable. Poor health in young adulthood is further compounded by physiological demands of pregnancy. Poor women have to resume work soon after delivery and are less likely to eat and rest adequately.

More than one third of Indian women have a Body Mass Index[1] of less than 18.5. Anaemia is common throughout a woman's life and poses a heightened risk during childhood and again during childbearing.

The international standard for the minimum weight of a woman prior to pregnancy has been lowered, and this is of concern. It has been lowered from 45 kgs to 38 kgs for no apparent reason (UNICEF, 2003).

e) Maternal practices related to childbirth

These include antenatal care for screening, management and referral of potentially complicated pregnancies, adequate nutrition for women before and during pregnancy and lactation, the presence of a trained attendant at birth, and family planning. These measures will result in healthier newborns; and concurrent family planning can improve the mother's health by increasing birth spacing and prevention of unwanted pregnancy. The challenge is how to provide these to women who need them, especially poor women.

f) Exclusive breastfeeding

Breastfeeding to the exclusion of anything else for the first six months of life helps mothers (because it temporary stops ovulation) as well as babies (reduces infant mortality due to infectious disease and lowers risk of malnutrition caused by premature complementary feeding).

Exclusive breastfeeding includes feeding colostrum ("milk" expressed in the first three days after delivery), no pre-lacteal feeds, and no other liquids or foods in between. In India, it is considered good to breastfeed; but only 37% of children under four months are exclusively breastfed due to various factors. (NHFS-2).

g) Timely introduction of appropriate complementary foods

Appropriate complementary feeding is linked to child survival, especially between the ages of six and 11 months. Many poor children are not introduced to semi solids and solids at the correct age and with adequate frequency and dietary diversity. This is started too late resulting in malnutrition.

Timely introduction requires feeding children nutritious foods of appropriate consistency, and in sufficient quantity, beginning at the age of six months, the age at which breast milk alone does not provide all the needed energy and nutrients.
Caregivers need to feed the child frequently (around three times a day for children who are also breastfeeding, and five times a day for children who are not being breastfed), encourage the child to eat, be responsive to the child's needs during feeding, and give separate servings to each child. The cost of fuel and lack of food and time make this difficult for poor, working families.

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[1] Body Mass Index (BMI) is defined as weight (kg)/height^2 (m) Normal: 18.5-25 (NFHS-2)

h) Correct home management of childhood illness

The mother or caregiver must be able to recognise an illness and respond either with correct home treatment as in early diarrhoea; or by seeking care from a trained health provider. Complete information about where to go, when to go and who to go to should be made available to responsible persons in the community and all family members who have small children in their homes. Women also need to be more empowered in decision making to be able to respond appropriately.

An integrated and holistic approach to child health is important in the treatment of sick children to prevent deaths. This implies considering the many factors that put children at serious risk of disease as well as ensuring a combined treatment of major childhood illnesses. Timely referral, involving parents in effective home based care, emphasising the prevention of disease through immunisation, improved nutrition, and exclusive breastfeeding are crucial to improving the health of our children.

i) Completion of a full course of immunisations

Increased immunisation coverage is linked to better child health. There is general agreement in the public health community that increased coverage in recent decades has led to substantial reductions in child death, to the near eradication of polio, and to major reductions in the case of measles, diphtheria, and pertussis through the world. Better immunisation coverage requires strengthening health care facilities and outreach services with an emphasis on primary care. Ironically, programmes that target only one specific disease often reduce the usage of other services. There is evidence to show that the Pulse Polio programme has actually reduced immunisation coverage of other diseases. (Bhatia et al, 2004).

j) Family and community practices and beliefs

Cultural beliefs and norms vary across communities and impact child survival, health and development: these include practices of hygiene, childbirth and childrearing, feeding, the distribution of food in the home, and the care of sick children.

In India, there are several beliefs related to the pregnant woman and small child. They range from good to benign to harmful. Some of the harmful ones that should be actively banned include feeding of castor oil to the newborn baby (which causes aspiration leading to pneumonia); branding the child with a hot iron, and female infanticide. Pregnant women have restricted quantities of food to avoid having a big baby; and lactating women discard colostrum as it does not look like milk.

Harmful practices are widely prevalent in the south, including Karnataka. Several practices adversely impact the girl child and need to be eliminated through awareness, publicity, and legal threat.

5. Nutrition and child health

Nutrition is the basis for health and well being. Nutritional disorders include protein energy malnutrition and micronutrient deficiency, and result in:

- Increase in mortality and a shortened life span
- Illness
- Poor physical growth, delayed motor development, and later problems in reproductive health
- Impaired cognition, poor school performance, diminished productivity
- Disability

"...Nutrition is a cornerstone that affects and defines the health of all people, rich or poor...Poverty, hunger and malnutrition stalk one another in a vicious circle, compromising health and wreaking havoc on the socioeconomic development of whole countries, entire continents...This is a travesty of justice, an abrogation of the most basic human rights." (Director-General, WHO)

About 50 % of children under 5 years of age are malnourished in our country. They have sub-optimal vigour and stamina, poor neuromotor co-ordination, learning skills and mental capabilities, and end up being adults with a reduced capacity to work and be productive.

Protein Energy Malnutrition

Protein energy malnutrition[2] is classified as mild, moderate and severe, depending on the degree of under nutrition measured as weight for age. Even though there has been a steady decline in the prevalence of severe malnutrition, the prevalence of mild and moderate malnutrition is almost 50% in India. **Various studies show that only 5% of pre school children have normal body weights for age.** Mild and moderate malnutrition are likely to be associated with chronic illnesses, and even a simple bout of viral illness can make a child slip from mild to moderate or even severe malnutrition.

In 2000, malnutrition was associated with 60% of all childhood deaths in India; and in 1998, more than one-third of young children were stunted. Children in poor families and communities are worse nourished, and more likely to be stunted, than children in better-off settings. Furthermore, in most urban and rural locations the proportion of malnourished children among scheduled castes and tribes is consistently higher than in other groups.

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[2] A condition resulting from long-term inadequate intake of protein and energy that leads to wasting of body tissues and increased susceptibility to infection.

BOX 2

LOW BIRTH WEIGHT (LBW): defined as birth weight less than 2500 grams (WHO)

Low birth weight is due to a baby being born preterm or a full-term baby that is small for its gestational age (SGA – Small for Gestational Age). SGA in term can be due to the poor nutritional status of the mother, or because of a congential problem.

LBW is a risk factor for future health problems, such as malnutrition, recurrent infections and impaired physical and mental development. Nearly 50% of neonatal deaths occur among LBW babies. (NFHS-2)

In developed countries, new-borns with LBW are fewer, and approximately two-thirds of LBW babies are pre-term. Out of an estimated 22 million low birth weight babies born worldwide annually, India accounts for about 7-10 million. **A third of all live births in India are LBW**. More than half of these are **full term** babies. Mothers under 20 years, first time mothers, mothers shorter than 150 cm, and mothers weighing less than 45 kilograms deliver more LBW babies.

Micronutrient Deficiencies

The major micronutrient deficiencies are of iron, vitamin A and iodine. **Nearly half of the world's micronutrient deficient people are found in India.**

For example, of the 20-40 million children world-wide who are estimated to have at least mild **vitamin A deficiency (VAD)**, half reside in India. VAD causes an estimated 60,000 children in India to go blind each year. However, only around 20 % of children receive at least one of the compulsory five doses of Vitamin A supposed to be given to children between the ages of 6-36 months.

Iron deficiency anaemia (IDA) is the most pervasive of all nutritional deficiencies in India, particularly affecting women, especially pregnant women, as well as infants, young children, and adolescent girls. Children of 12 to 23 months have a high prevalence of anaemia (78 percent, NFHS-2), perhaps due to the late initiation of weaning at this age, coupled with poor nutritional supplementation. Rural children are more likely than urban children to be anaemic. The poor nutritional status of mothers reflects on their children, and suggests a poor family diet.

The prevalence of anaemia in pre-school and school children is alarmingly high; at around 75% in the rural areas (NFHS-2). This is a critical issue, as iron deficiency anaemia not only leads to illnesses; it also directly correlates with reduced cognitive development.

Hookworm infestation is a major cause of iron deficiency anaemia; second to an inadequate intake of iron rich foods. This can be addressed by regular deworming and footwear outside the home.

The RCH programme and the ICDS are to provide iron supplementation for children and pregnant women. However, **the percentage of children receiving iron and folic acid supplementation is less than 8 %. under six years, actually.**

The burden of **iodine deficiency disorders (IDD)** in India is of major proportions: estimates attribute 90,000 stillbirths and neonatal deaths each year to iodine deficiency.

The three nutrition programs to combat micronutrient deficiencies (Vitamin A, iron and iodine) have been in operation for over two decades through various national programmes, and are currently integrated in the RCH programme. But these have had a negligible impact due to systemic problems such as lack of co-ordination, shortage of resources, inadequate and irregular supplies, lack of proper orientation and training of functionaries, poor monitoring and supervision, poor community motivation and education, and the continuing poverty of those most at risk.

ICDS and nutrition

The ICDS is meant to play an important role in combating early childhood malnutrition in our country. But for the past 30 years, ICDS has been able to cater to only 16 per cent of undernourished children. These alarming statistics tell us the real story: **only 3.4 crore children are getting the benefits of supplementary nutrition under ICDS.** This is nowhere close to the number of children in the age group (15 crores), the number of malnourished children (8.5 crores) or even the numbers from families below the poverty line (6 crores). (New India Press, April 26, 2004)

Causes of malnutrition

India is not deficient in food grains, and yet there is a problem of malnutrition beyond mere nutrient deficiency. The dynamics of food production, distribution and purchasing power; and health factors related to food utilisation are the underlying causes.

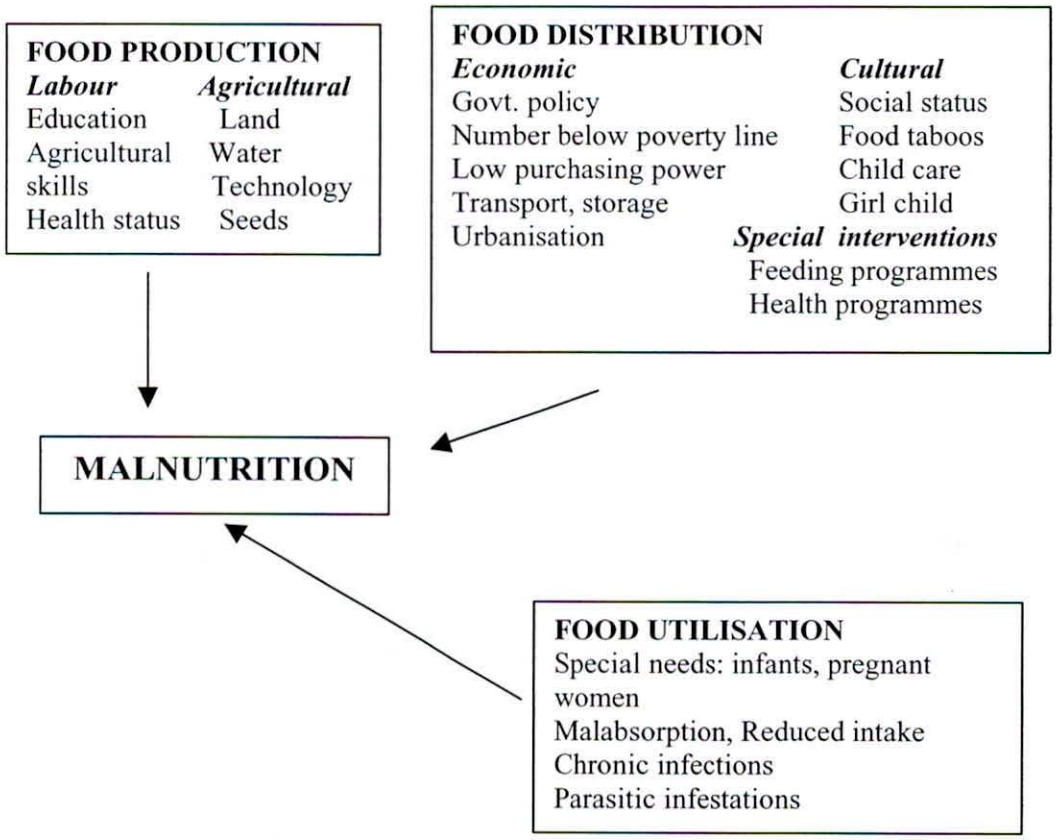


Figure 2: Multiple factors related to malnutrition in India

6. The status of child health in India

Improvements in child health include reduced infant mortality rate, access to drinking water, and a significant increase in polio immunisation. However, the key problems of child health are linked to poverty eg low birth weight babies. The major causes of infant deaths such as diarrhoea, pneumonia, neonatal tetanus, and measles are aggravated by malnutrition. Lack of drinking water, sanitation and poor personal hygiene increase infections.

The health of a child is measured using several indices. Of these, the most sensitive indicator is the infant mortality rate. Mortality estimates are actually underestimates; as many infant deaths are not recorded and occur at home.

BOX 3: Common health indicators

Perinatal mortality rate (PMR)	number of deaths between 28 weeks of gestation to 7 days after birth per 1000 live births
Neonatal mortality rate (NMR)	number of deaths below the age of 1 month per 1000 live births
Infant mortality rate(IMR)	number of deaths below 1 year of age per 1000 live births
Under 5 mortality rate(U5MR)	number of deaths below 5 years of age per 1000 live births

In contrast to other nations, India has a poor health record. The table shows where India stands in comparison to populous countries such as China, or neighbors such as Sri Lanka.

Table 1: Key health indicators of developed and developing countries

	India	**USA**	**China**	**Sri Lanka**
Total population (thousands)	10,25,096	2,91,038	12,94,867	18,910
Births per annum (thousands)	25,112	4228	1,88,857	312
Under-5 mortality rate	93	8	39	19
Infant mortality rate	67	7	31	17
Life expectancy at birth (years)	64	77	71	73
GNI per capita (US$)	460	35,060	940	840

Child mortality

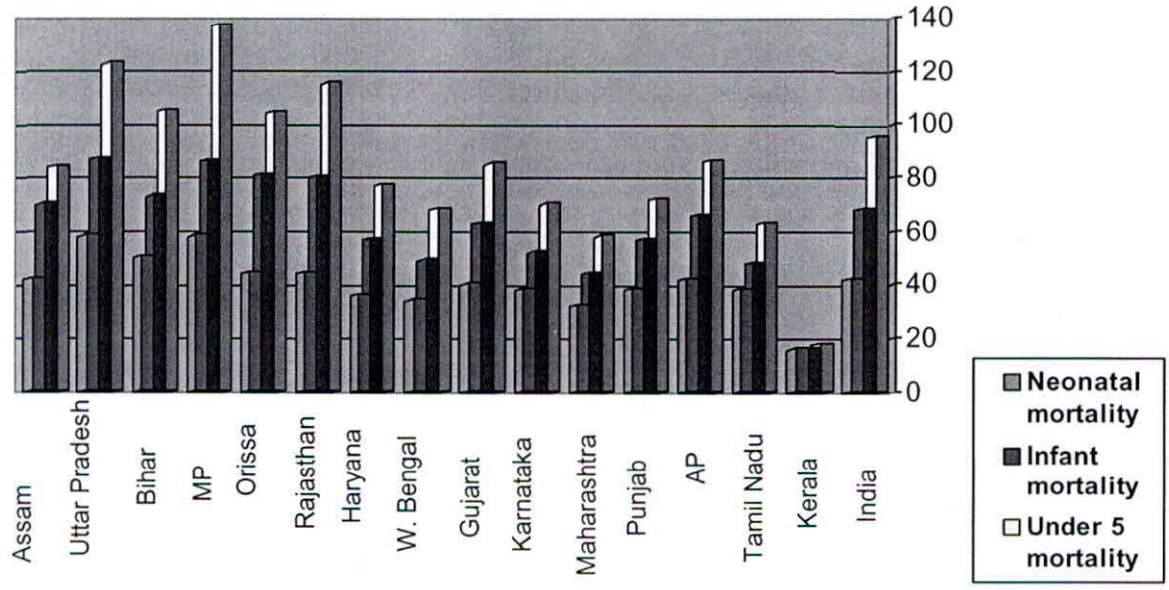
The most widely used indicators are infant and under five mortality rates. In India, neonatal deaths contribute to a large number of infant deaths, and are a significant indicator. Since we do not have an established system to collect and analyse morbidity (illness) data in India, we rely on **mortality data** to help draw up plans and programmes for the child.

BOX 4: Major causes of childhood mortality – medical and social

Period	Medical causes	Social causes
Neonatal mortality	Still birth Prematurity Congenital defects Asphyxia, birth injuries etc Jaundice and septicemia	Poverty Age of mother: too young/old Birth order more than 3 Spacing between children < 2 years Delivery conducted by untrained person
IMR	All of the above Diarrhoea Respiratory infections Malnutrition Anaemia Other infections, accidents	All of the above Poor weaning practices Poor personal hygiene Unsafe drinking water Over crowding
U5MR	Diarrhoea Respiratory infections Other infections Malnutrition and anaemia	All of the above

One could infer that mortality rates could be reduced without waiting for economic improvement; through increased access and utilisation of essential services. These include reproductive health services, prenatal care, breast feeding, immunisation, home-based treatment of diarrhoea, and timely introduction of supplementary foods.

Figure 3: Interstate variations in childhood mortality (NFHS-2)



There are variations across the states, with Kerala doing well, and states like Uttar Pradesh and Madhya Pradesh skewed in the opposite direction. Overall, the neonatal mortality rate for India is around 40, while the infant and under 5 mortality rate stand at 68 and 95 respectively.

In 1998, about 2.5 million under-5-year-olds died in India, the highest total of any country. In the mid 80s and early 90s, there was a rapid decrease in infant and childhood mortality in accordance with the goals for 2000 AD. However, recent data indicate that **the decline in child mortality rates has slowed down since; even showing increasing trends in some states, including Karnataka. (UNICEF report).**

The most recent figures show that the infant mortality rate was 68 per 1000 live births according to the Sample Registration System, Office of the Registrar General, India (2000). This is the good news. The bad news is that we are talking about infant deaths that could be largely avoided, and given India's population, the number of infants that die each year is enormous. Active intervention is required to ensure a reduction in infant mortality. It is not that India does not have the health care or the nutritional knowledge to address the problem. The problem is lack of awareness and accessibility, especially for the rural population.

More money has to be put into health and education, and health services have to improve at all levels and dimensions – infrastructure, training of personnel, availability of medicines, availability of staff for longer hours in the day, better roads and transport for remote areas, essential emergency services and referral mechanisms to those services. We already have the infrastructure in place, but need to work at quality, efficiency and accountability.

Childhood morbidity

Morbidity is a measure of the burden of illness.

Acute Respiratory Infections are a major hazard for the young child, particularly children between 6 months to 3 years. The government has provided the antibiotic cotrimaxazole to trained field nurses for ARI. Unfortunately, families may not refer the child who has fever, cough and rapid breathing to a medical facility in time. It was found that less than 15 % of families with children who had ARI received antibiotic treatment (NFHS-2).

Diarrhoea is a major hazard for children under five years, particularly between 6 to11 months (NFHS-2). To control diarrhoea and for child survival, a decade ago the government launched an Oral Rehydration Therapy (ORT) programme. The community was educated about dehydration and ORT. Unfortunately, only 9 districts (out of more than 600) in the whole country reported over 50 % use of ORT for diarrhoea of children below 5 years.

Pediatric AIDS is emerging as a serious public health concern in India. Out of the 55,764 identified AIDS cases in India in 2003; 2,112 are children. Children get AIDS through contaminated blood and transmission from an infected pregnant woman to her baby. In India, National AIDS Control Organisation (NACO) is a key player in AIDS control. Blood is tested at blood banks, and pregnant mothers who are HIV positive can receive anti-retroviral treatment. In Karnataka, there are 40 PPCTCs (Prevention of Parent to Child Transmission Centres) in 27 districts that offer treatment free of charge. This treatment reduces the transmission of the HIV virus to the baby by more than half.

Vaccine preventable diseases and immunisation coverage services

All children of one year should receive 1 dose of BCG, 3 doses each of oral polio and DPT and 1 dose of measles. This is defined as complete primary immunisation. Analysis of the vaccine-specific data shows that **complete immunisation coverage of children in India is 42%.** NFHS-2 data puts vaccine coverage at 85 percent for BCG, 75 percent for three doses of the DPT vaccine, 78 percent for three doses of the polio vaccine and 67 percent for measles. These figures are believed to be higher than the field reality.

Recently, there have been spates of polio outbreaks in the north-western part of Karnataka. After being polio-free for two years, the outbreak was particularly worrisome for the global eradication effort. Despite the adequate supply of quality vaccines, immunisation was not reaching enough children, especially in rural areas. This was largely due to a lack of mobilisation, poor supervision, insufficient community involvement, and a lack of consistent vaccination delivered by teams going door-to-door. It is events like these that require us to review our programmes and policies and concentrate on the issues that require attention such as community involvement and monitoring of programmes.

7. Status of child health in Karnataka

Karnataka indicators are listed below. While they are better than the national average, most of the indicators are far below neighbouring states of Kerala and Tamil Nadu.

Kerala has outstanding performance indicators in comparison to its neighbours. In fact, Kerala is considered to be on par with most developed countries in its health indicators. Tamil Nadu is a close second, thanks to their strong drive towards implementing primary health care. They have succeeded particularly in the area of deliveries being conducted by trained persons and immunisation coverage. In contrast, both Karnataka and Andhra Pradesh are far behind.

Table 2: Health Indicators of Karnataka and the southern states in relation to India

Parameter	Karnataka	Tamil Nadu	Andhra Pr	Kerala	India
IMR	51	48.2	65.8	16.3	67.6
U5MR	70	63.3	85.5	18.8	94.9
Age at marriage < 18 yrs.	46.3%	25%	64.3%	17%	50%
Institutional deliveries	51%	79.3%	49.8 %	93%	33.6%
Trained delivery attendant	59%	83.8%	65.2%	94%	42.3%
Immunisation coverage	60%	88.8%	58.7%	79.7%	42%
Prevalence of anemia in age 6-35 months	70.6%	69%	72.3%	43.9%	74.3%
Underweight	33.6%	36.7%	37.7%	26.9%	47%
Stunted[3]	44%	29.4%	38.6%	21.9%	45.5%
Wasted[4]	20%	19.9%	9%	11.1%	15.5%

Source: NFHS-2 Survey

There is a significantly high prevalence of malnutrition. Of particular concern is **the incidence of stunting, which is reflective of a chronic malnutrition process**. This is in spite of the fact that a food supplementation program of ICDS covers all these states.

A district wise break up of the important indicators shows a wide disparity with districts like Bangalore Urban and Dakshin Kannada being better off than districts like Bidar, Bellary and Bijapur. These results are also reflected in specific antenatal care services.

[3] Low height for age
[4] Low weight for height

Table 3: District wise break up of key child health indicators

District	Population (lakhs)	Age at marriage <18yrs	Infant mortality rate	Under 5 MR	% of Institution Deliveries
Bangalore	4839.2	37.5	50	67	89.3
Bangalore Rural	1673.2	57.1	50	67	48.9
Belgaum	3583.6	76.3	50	69	40.8
Bellary	1890.1	76.1	79	119	27.5
Bidar	1255.8	90.8	66	85	11.4
Bijapur	2928	87.1	75	88	22.2
Chikmagalur	1017.3	35.8	55	75	53.7
Chitradurga	2180.4	66.5	51	104	37.5
D. Kannada	2694.3	26.9	29	46	77.0
Dharwad	3503.2	67.6	74	95	39.8
Gulbarga	2582.2	82.4	59	86	12.7
Hassan	1569.7	52	61	78	45.6
Kodagu	488.5	28.8	41	66	76.0
Kolar	2216.9	74.3	56	100	36.1
Mandya	1644.4	76.7	67	84	48.8
Mysore	3165	65.1	57	89	51.4
Raichur	2309.9	82.8	59	80	11.9
Shimoga	1909.7	44	69	88	45.0
Tumkur	2305.8	68.2	64	102	41.1
U. Kannada	1220.3	31.8	49	69	72.2
KARNATAKA	**44977.2**	**62.9**	**53**	**90**	**41.8**

(Source: RCH-RHS Survey – 98-99)

Infant mortality is very high in the districts of Bellary, Bijapur and Dharwad, while under five mortality is highest in Bellary, followed by Chitradurga, Tumkur and Kolar. **More than 80% of the women are married below 18 years in the northern districts of Bidar, Gulbarga and Raichur**; and these same districts show a very low (<13%) prevalence of institutional deliveries.

Morbidity status in Karnataka

In Karnataka, the prevalence of diarrhoea in children below 5 years was around 18.9 %, varying from 31.5 % in Kolar to 6.5% in Dakshina Kannada. However, only 6.7 % of the children in Kolar who had diarrhoea received ORS compared to 11 % of the children in Dakshin Kannada. The prevalence of ARI was around 17.7 % overall in the state with variations as large as 60% in Kodagu to 4.1 % in Gulbarga. Approximately 10,000 preschool children go blind every year due to severe vitamin A deficiency (NFHS-2).

Malnutrition and micronutritent deficiencies

44% children below three have some form of malnutrition. The Vitamin A prophylaxis programme is to supplement all children between the age of 9 months and 3 years with 5 doses of Vitamin A at 6 monthly intervals. In Karnataka, **around 52 % of children did not receive even one dose of Vitamin A.**

The number of children who received iron supplementation is equally low. With anaemia prevalence at around 75 % in the pre school age group, this programme deserves serious attention. **Only 5.6 % of children received any form of iron. Even the urban district of Bangalore showed coverage of 4.5 %.**

The Government of Karnataka is in the process of formulating a **State Nutrition Policy** to emphasise the need for reduction of malnutrition of all types; including micronutrient malnutrition among children, adolescent girls and women of child bearing age. The main aim is to reinforce an intersectoral approach to reduce severe and moderate malnutrition among children under five years, micronutrient deficiencies, and low birth weight babies. It addresses chronic energy deficiency among children, nutrition in tribal groups, and the participation of NGOs in nutrition programmes.

A **State Plan of Action for children** (2003-2010) has been formulated for child health, maternal health and other health care services. The plan addresses protein energy malnutrition, micronutrient malnutrition, maternal and fetal malnutrition, diet etc. A coordination committee is in place to review the state plan of action, and it will also coordinate and monitor the implementation of the state nutrition policy.

Vaccine preventable diseases and immunisation coverage

One of the major goals for 2000 AD was universal immunisation for all children below 1 year of age. From the results of the RCH- RHS survey, we see that about 72 % of infants received the complete primary schedule of vaccines (BCG, 3 doses of DPT, 3 doses of oral polio and measles. Around 6 % of infants did not receive any vaccine at all.

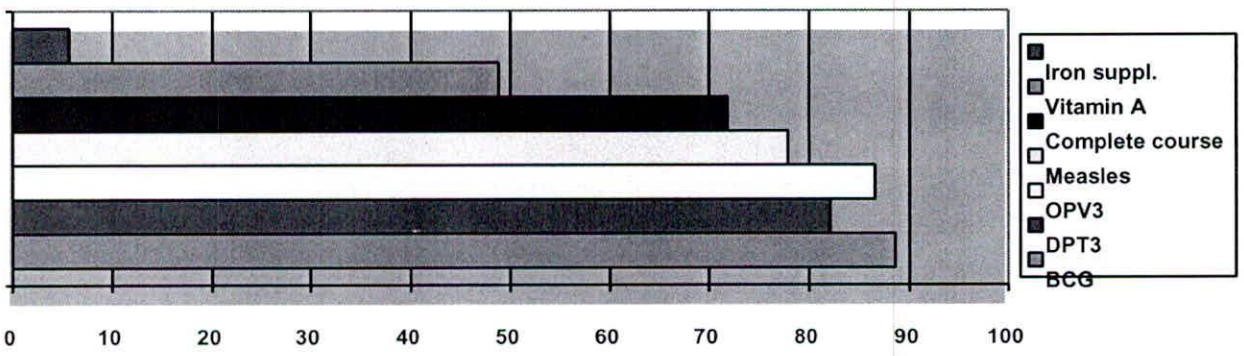


Fig. 4: Coverage of major immunisations and supplementations to children below 5 years in Karnataka

8. Moving forward

There is no doubt that the situation of child health in India, and Karnataka in particular, is depressing. Some of the challenges we face are:

1. A slow rate of decrease in infant mortality and under five mortality in the last few years.
2. Falling immunisation coverage in the recent past, despite intense efforts.
3. Poor maternal health: India's maternal mortality ratio (number of women dying due to pregnancy related causes) at around 540 deaths per 100,000 live births, is one of the highest in the world. This has a direct bearing on the health of the infant and child. In fact, there is not even a direct measure for maternal mortality, these are extrapolated figures.
4. Continued discrimination towards girls; with the child sex ratio falling sharply from 945 females per 1,000 males to 927 per 1,000.
5. More than fifty per cent of children under six years of age are malnourished, the proportion of low birth weight babies remains high, and about 75 per cent of children are anaemic.

Karnataka has made efforts to understand and improve the health status of women and children. Following the recommendations of the Health Task force and the National Health Policy, Karnataka has developed a document highlighting its Vision for the year 2020 (see Annexure) The goals include improving indicators such as infant and child mortality, etc. The government is in the process of developing a planning document for the RCH -2 programme with World Bank assistance to address the vision objectives.

Strategies to move forward

In order to achieve the vision 2020 of Karnataka, it is important that relevant strategies be put in place. One of the main strategies would be to prioritise activities based on performance across the state. Low performing districts will require additional inputs and monitoring in order for them to "catch up".

What the Government should do to address the health needs of poor children.

Make a ***strong political commitment*** to strengthen and expand efforts for the reduction of infant and child mortality, and malnutrition.

Improve health outcomes of poor children by increasing ***availability of resources*** to health centres on a regular basis.

Strive for ***high quality of services*** with interventions that are effective and sustainable.

Review and support efforts and factors that determine the health of the ***poor child***.

A. Enhancing service coverage, making health care more accessible and affordable

This is the key to improving child health. It is the State's responsibility to strengthen existing health systems (e.g. by improving the availability of drugs, monitoring and surveillance). The World Bank has a special financial envelope to provide additional assistance to seven backward districts in Northern Karnataka (RCH Consultant, GOK)

The essential elements of child health and nutrition services (e.g. immunisation programmes and micronutrient supplementation) need to be promoted. We also need to integrate approaches to clinical management of acute respiratory infections, malnutrition, diarrhoea and other major causes of childhood illness with schemes such as the RCH program and the ICDS.

B. Improving health care delivery in terms of quality of health care

- Improving referral services (including obstetric emergencies)
- Reducing neonatal and infant mortality by implementing essential care of the newborn, early detection of illnesses and combating malnutrition.
- All components of the RCH and ICDS package should be implemented, without compromising on any elements.

C. Tackling malnutrition from the level of food production to treatment for the stunted and wasted child

Malnutrition has been identified as the most significant factor that impacts childhood deaths and illnesses. It is critical that policy makers review the existing nutrition supplementation through the ICDS; and the micronutrient supplementation through the RCH program to reverse the appalling situation of malnutrition and anaemia in children.

D. Convergence between ICDS and RCH Programme

There is a large amount of overlap in the child health components of the RCH programme and the ICDS scheme. Better coordination at the field level would improve both access and utilisation of services by the community and the child. This would reduce the burden on both the field workers, who spend much of their time collecting and reporting similar data.

E. Promote community participation in prevention and treatment of illnesses

On one hand, the State is responsible for the "supply" of health services. It is also important to focus on creating a "demand" for these services; this can only be done by the involvement of the community. One of the primary reasons for the failure of several of the programmes listed is due to poor monitoring and a lack of accountability.

This can be remedied to some extent by people assuming a greater voice and responsibility in order to access health services for themselves and their children. The **gram panchayat** has been empowered to monitor and govern several of the services provided to the pregnant mother and child, including essential antenatal care, universal immunisation etc. There should be widespread publicity and training of the panchayat and community members for them to understand and assume their responsibilities as local monitors of national programmes. When the community is an equal partner in planning, implementation and evaluation, such programmes will eventually lead to behaviour change that is sustainable.

> Several NGOs in Karnataka have self help groups (SHG) that have formed *village health committees* made up of SHG members, anganwadi teacher, gram panchayat member, ANM and others to monitor the essential services for a pregnant woman and child. In Chamrajnagar taluka, MYRADA has promoted this as a "credit plus" activity. Samuha, an NGO in Raichur, has special committees to monitor the health and education of young children.

Local community groups, self help groups and community based organisations can make an impact if they are made more aware of their rights to health, and the rights of their children to health and education.

F. Encouraging public private partnerships for improved quality of healthcare services

The private sector, which accounts for more than half the total spending on health, can be recognised and trained to provide and support child health interventions. Privatisation alone cannot be a strategy. The potential of making profit from the poor is much less that of the middle and upper classes, and so the private sector lacks the incentive to provide quality services to poorer populations and rural areas. The partnership between the Government of Karnataka and private health care providers in instituting a health insurance scheme for the rural poor is an example of newer forms of private-public partnership.

G. Periodic review and revision of programmes and policies

Some revisions need to be made based on field practicalities. For example, in the ICDS scheme, growth monitoring is conducted by monthly weighing. It has long been proven that there is no need for such frequent weighing. The frequency can be brought down to once a quarter, thus reducing the burden on the anganwadi worker.

In another instance, a recent Supreme Court order in response to a PIL has demanded the implementation of the feeding program through ICDS in India. This was after an assessment that showed states such as Bihar had *not even initiated* the supplementary feeding program.

9. Conclusion

A world fit for children is one in which all children get a good start in life and where minimum standards of health and education are met. It is a world in which all children have the opportunity to develop their individual capacities in a safe and supportive environment. Children are one third of our population and all of our future.

Improving child survival remains a major development task in India. Future child health policies should build on past lessons from child health programmes, sustain the achievements that have already been made, enhance quality and efficiency, and address specific gaps in infant health and nutrition.

Malnutrition during childhood impacts child development and raises the risk of morbidity and mortality in later years of life. There is an urgent need to combat this crisis by addressing all factors associated with poor nutrition, right from food production to equitable distribution to adequate food intake.

It is also important to have a better understanding of the main determinants of the health and nutrition cycle for children, in order to develop more effective strategies for child survival, health and development. The challenges over the years will be to jointly address the most important determinants and gaps in the cycle with affordable, cost-effective and culturally appropriate interventions. Actively addressing and minimising barriers to access through structural changes, with an awareness program alongside, should prove both efficient and effective. Some key suggestions:

BOX 5: Key suggestions

1. Enhancing service coverage, making health care more accessible, available and affordable
2. Improving health care delivery in terms of quality of health care
3. Implementation of all the components of the currently existing programmes such as the ICDS and RCH programme; and emphasising simple preventive measures such as essential antenatal care, routine immunisation, and micronutrient supplementation.
4. Improving sanitation and drinking water services
5. Promoting community participation in prevention and treatment of childhood illnesses
6. Promoting community participation in the planning, implementation and monitoring of all programmes; so as to ensure ownership as well as quality
7. Tackling malnutrition head on, from food production to the stunted and wasted child.
8. A special focus on the child under 3 years, due to the links between nutrition, health and cognition
9. A special focus on the girl child, to ensure her needs of nutrition, health and education

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Annexure

The government of Karnataka has developed a vision for Karnataka based on the recommendations of the Karnataka Health Task Force which conducted a detailed investigation of the health system and services in the state. Some of the recommendations of the task force that have been incorporated into the **Kartnataka Vision document** are:

1. Infant Mortality Rate

The Infant Mortality Rate in 2020 will come down to less than 25 from the present figure of 51 (in 2001). Proactive measures will need to be taken not only to prevent stagnation of the figures, but to remedy the worsening of IMR occurring over the past 5 years in 10 districts. The process will include the availability of the second birth attendant, recommended by the Task Force for Health and Family Welfare. She will look after the newborn, ensuring spontaneous breathing and preventing hypothermia and other problems, thus reducing neonatal deaths, an important component of infant mortality. Improved birth weight as a result of better nutrition of the mother starting from adolescent period and avoiding infection are other factors helping in the reduction of infant mortality. Better quality and complete coverage of antenatal care, access to emerging obstetric care, implementation of the universal immunisation programme, health promotion including nutrition, education of mothers and families and a focus on caring for infants are all part of the intervention required to achieve lower IMRs.

2. Under – Five Mortality Rate

There will be reduction in the under – 5 mortality from 69.4 (1994-98) to 40-45. The child will be healthier if certain measures are taken: commencement of breastfeeding immediately after the birth of the child (benefiting from the goodness of colostrum); exclusive breast feeding for the first 6 months; better universal immunization coverage (with a good cold chain system) including immunization against measles; better nutrition with weaning (supplementary) food from 6 months (food being given free to the poor), child care and psychosocial stimulation. This will be achieved through working collaboration between anganwadis of the ICDS scheme and primary health centres / subcentres.

3. Crude Birth Rate and Crude Death Rate

Both the indices will have fallen. The Crude Birth Rate will come down to 14 in 2020 from 21 in 2001; the Crude Death Rate to 7.0 from 8.0. The Total Fertility Rate will go down to 1.6; the Couple Protection Rate go upto 75%. Population stabilization will be in sight. We need to achieve this with gender equity, guarding against sex selection practices unfavourable to girls.

4. Nutrition

The percentage and absolute numbers of severely and moderately undernourished children will be significantly reduced, as a result of better nutrition awareness and action. Mid-term goals stated in the health policy document will be improved by a further 50% by 2020.

5. Immunisation

There are many goals for 2020. There should be better coverage of children under the Universal Immunisation Programme. Paralytic polio should be eradicated, and the number of vaccine preventable diseases is reduced There is need for dependable refrigeration system. By 2020, this basic preventive health strategy will have universal coverage with good quality.

Vision Document for Karnataka 2020: the goals

Indicators		**2001**	**Source / Year**	**2020**
Infant Mortality Rate		58 / 1000 live births	SRS 1999	25 / 1000 live births
Under –5 Mortality Rate		69 / 1000 live births	NFHS – 2	35 / 1000 live births
Crude Birth Rate		22.3 / 1000 population	SRS 1999	13 / 1000 population
Crude Death Rate		7.7 / 1000 population	SRS 1999	6.5 / 1000 population
Maternal Mortality Rate		195 / 1,00,000 live births	SRS 1998	90 / 1,00,000 live births
Life Expectancy at Birth	Male	61.7 years	1996-2001	70.0 years
	Female	65.4 years	1996-2001	75.0 years
Total Fertility Rate		2.13	NFHS – 2	1.6
Percentage of Institutional Deliveries		51.1	NFHS – 2	75
Percentage of safe deliveries		59.2	NFHS – 2	> 95
Newborns with Low Birth Weight		35 %	1994	10%
Percentage of mothers who received ANC		86.3	2000	100
Percentage of eligible couples protected		59.7	2000	70%
Percentage of children fully immunised		60	NFHS – 2	90
Anaemia among children (6 – 35 months)		70.6%	NFHS – 2	40.0%
Nutritional Status of children	Severe under nutrition	6.2%	Gomez, 1996	2.0%
	Moderate under nutrition	45.4%		25.0%
	Mild under nutrition	39.0%		43.0%
	Normal	9.4%		30%

Sex (Gender) ratio		964F / 1000M	2001 census	975F / 1000M
Sex (Gender) ratio, 0-6 years		949F / 1000M	2001 census	970F / 1000M
Indicators		2001	Source	2020
Infant Mortality Rate		58 / 1000 live births	SRS 1999	25 / 1000 live births
Under –5 Mortality Rate		69 / 1000 live births	NFHS – 2	35 / 1000 live births
Crude Birth Rate		22.3 / 1000 population	SRS 1999	13 / 1000 population
Crude Death Rate		7.7 / 1000 population	SRS 1999	6.5 / 1000 population
Maternal Mortality Rate		195 / 1,00,000 live births	SRS 1998	90 / 1,00,000 live births
Life Expectancy at Birth	Male	61.7 years	1996-2001	70.0 years
	Female	65.4 years	1996-2001	75.0 years
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Disability and the young child

Padma Sastry

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1. Introduction: historical overview

Since time immemorial, the elimination of the disabled has been a common and widely accepted practice in many cultures, from east to west. Plato and Aristotle approved of this practice; in the belief that "nothing imperfect or maimed should be brought up". In the Indian scriptures, the theory of Karma prevailed. In the medieval ages the notion of the goodwill of man and the responsibility of the strong to protect the weak gained currency. St. Jerome urged "*one should be eye to the blind, arms to the weak and feet to the lame*". Hospital fraternities were set up to care for the physically disabled. With the decline of the power of the church, the care of the disabled became the state's responsibility.

Buddhism and Jainism promoted a positive social attitude towards the disabled. In the reign of Chandragupta Maurya, vocational rehabilitation workshops were established for the physically disabled.

Though efforts for the rehabilitation of persons with disabilities have evolved over time; reflecting a progressive response to persons with disability, the medical perspective dominated well into the 70's. The medical model saw disability as a personal issue; and the negative effects of impairment as something to be cured. The focus was to help such persons adapt to the community using aids and appliances, education and training. Institutional care, promoted both by the state and by the NGOs, was the predominant paternalistic approach, promoting an attitude of dependence. Cases of a community approach to rehabilitation were far and few.

Following this period, discourse at different forums resulted in a paradigm shift in viewing disability. A social approach emerged that saw disability as a form of discrimination, and social justice as central to providing the disabled with equal benefits in society.

Over the last decade; there has been a move away from the medical, welfare, and social model to enabling the **rights of disabled persons, providing them with equal opportunities in all spheres, and enhancing the engagement of civil society in the "inclusion" of the disabled**. Several countries including India have enacted Disability Rights Acts. The Persons with Disability Act, 1995, seeks to empower disabled persons so that they can be part of mainstream society. It is now also accepted that the environment and context in which the disabled person lives must also change.

What disables a person most is the attitude of his/her family, friends and society. Parents of disabled children today are encouraged to seek early identification and support without fearing rejection and alienation in society.

The NSSO survey 2000 reveals that 55 percent of the disabled in India are illiterate. If persons with disability are encouraged to develop a positive self-image; it could change the larger attitude towards disability. A key to this process would be **to enable the disabled to see their abilities**.

This paper seeks to explore what it means to encounter "disability" within the context of the young child.

2. Policies and acts for children and disability

Policies and acts related to disabled persons have become significant only over the last decade. They have emerged in response to a better understanding of disability; as well as consistent advocacy efforts.

A brief historical account of the declarations and policies for the disabled is presented below: from the constitution of India that framed the "care of the disabled" in broad terms; to the Persons with Disability Act, 1995, that speaks of the rights of the disabled.

2.1 The Constitution

The Constitution of India states that the "state shall within the limits of its economic capacity and development *make effective provision* for securing the right to work, to education, and public assistance in cases of unemployment, old age, sickness and *disablement* and in other cases of undeserved want."

The Directive Principles of State Policy include the following:

- The rights of children to be protected against exploitation
- To opportunities for healthy development, consonant with freedom and dignity
- To free and compulsory education
- To promote educational and economic interests of weaker sections
- To protect them from social injustice
- The responsibility of the state to raise the level of nutrition and standard of living
- To improve public health

It follows that these benefits should be available to all children; including those with disability.

2.2 International declarations

India is a signatory to several international declarations: United Nations Rights of the Child, United Nations Standard Rules on the Equalisation of Opportunities, the Jomtien Declaration on Education for all, the Salamanca Statement and Framework for Action, and the Biwako Framework for Action Towards a Barrier-free and Rights-based Society for persons with disabilities. It is also a signatory to the World Declaration (September 1990) in the Survival, Protection and Development of Children; and the Plan of Action for implementing it.

Following the World Summit, India began formulating a National Plan of Action to put into practice the promises made to the global community; by setting out national, quantifiable goals to be achieved by the year 2000. In this context, the government brought out the revised National Plan of Action for Children in 1992; and recently drew up the National Charter for Children, 2003.

2.3 The National Plan of Action for Children, 1992

The National Plan of Action for Children, 1992, identifies quantifiable targets in terms of major as well as supporting sectoral goals. Some of its goals are:

- Eradication of poliomyelitis by the year 2000 A.D.
- Achieve and maintain immunisation coverage at a level of 100 per cent of infants.
- To assist children affected by one or more disabilities, with no access to proper rehabilitative services, and especially to lift the status of those most marginalised.

2.4 The National Policy on Education, 1992

Initially formulated in 1986 and revised in 1992, The National Policy on Education recommends the Integrated Education for the Disabled. Although this policy refers to children above 6 years of age, it brought in a new concept that is now being extended to the under 6 years age group. The outcome of this policy was the formation of State Resource Groups for special needs education; and a cadre of trained teachers. Some states have included Integrated Education as a component in the teacher-training curriculum.

2.5 Sarva Shiksha Abhiyan (SSA), 2000

Sarva Shiksha Abhiyan is a programme initiated by the Department of Education to provide universal quality elementary education for children from 6-14 years. Integrated education is seen as one way to meet this objective of "universalisation". SSA emphasises the prevention and early identification of disability; and calls for functional and formal assessment of identified children. Removal of architectural barriers, teacher training and provision of aids and appliances are also to be implemented. Rs.1200 per child, per year, for the integration of disabled children in regular schools can be accessed.

2.6 The National Charter for Children, 2003

The State and community recognise that all children with disabilities must be helped to lead a full life with dignity and respect. All measures will be undertaken to ensure that children with disabilities are integrated into mainstream society and actively participate in all lifestyles.

- The State and community shall provide for their education, training, healthcare, rehabilitation and recreation in a manner that will contribute to their overall growth and development.
- The State and community shall launch preventive programmes against disabilities and early detection of disabilities to ensure that families with disabled children receive adequate support and assistance in bringing up their children.
- The State shall encourage research and development in the field of prevention, treatment, and rehabilitation of various forms of disabilities.

2.7 National Commission for Disabilities, 2003

The National Commission for persons with disabilities was set up in 2003; and one believes that it will ensure the convergence required to meet the needs of persons with disability.

Its purpose is to recommend programmes for the elimination of inequalities in status; and to ensure facilities and opportunities for the disabled by providing appropriate education and vocational training.

2.8 The Disability Acts

- National Trust Act, 1999, aims to take total care by appointing guardians to persons with autism, cerebral palsy, mental retardation and multiple disabilities so that care is provided throughout their life.
- The Mental Health Act, 1987, pertains to provisions for the mentally ill.
- Rehabilitation Council of India Act, 1992, is responsible for standardising and regulating training programmes for various categories of professionals.
- The Persons with Disabilities (Equal Opportunities, Protection of rights and full participation) Act, 1995, places responsibility on the centre and state to provide equal opportunities for citizens to participate in society.

2.8.1 The Persons with Disability Act, 1995

The Persons with Disabilities (Equal Opportunities, Protection of rights and full participation) Act, 1995, has been a major milestone in the history of the disability movement in India. Some of its features that are relevant to children include:

a) Prevention and early detection of disability (Sec. 25)
b) Free education for every child with disability, in an appropriate environment, till the age of eighteen years. (Sec. 26 a)
c) Schemes and programmes for non-formal education (Sec. 27)
d) Reservation of 3 per cent seats for admission to all government educational institutions (Sec. 39)
e) Non-discrimination in transport, on the road, and in the built environment, so that persons with disabilities can go to any place without any hindrance (Sec. 44-46)
f) Special opportunities to overcome any kind of discrimination being faced, e.g. preference in allotment of land to disabled persons for housing, business, special schools, research centres, recreation centres and factories (Sec. 43)
g) Generic and specialised services for rehabilitation (Sec. 66)
h) Appointment of a Commissioner in every State, to look into complaints relating to deprivation of rights of Persons with disability (PWD). (Sec. 62)

3. The all-India scenario: estimates of disability and causes

The estimations of persons with disability vary a great deal. For policy formulation and the provision of services; it is vital that reliable estimates of incidence and prevalence of various disabilities are made, in line with accepted definitions of the different categories of disabilities. However, disability is not a well-defined condition, and there are many conceptual difficulties in articulation. It is also difficult to enumerate the number of disabled children due to the social stigma attached to disability, and parents' feeling of guilt that make them less than forthcoming in sharing information. "It is important to recognise that the available statistics in India are not very reliable; and more "hard data" is required before more accurate conclusions can be drawn." (Director, Mobility India)

Data on disability has been gathered through the census and the National Sample Survey Organisation (NSSO). In the 1981 census, the enumeration of the disabled was taken up for the first time, as 1981 was declared as the "International year of disabled persons" by the United Nations. This was followed by another enumeration of disabled persons along with the population census in 2001.

The NSSO has been periodically collecting information on disability through large-scale socio-economic samples.

3.1 The National Sample Survey Organisation (NSSO) estimates

The NSSO carried out the third survey (NSSO 58th round) on the disabled in 2002, at the request of the Ministry of Social Justice and Empowerment, Government of India, a nodal ministry for the disabled. Along with details of physical and mental disabilities; the socio-economic characteristics of disabled persons such as their age, literacy, vocational training, employment, and cause of disability were collected. This survey estimated the number of disabled as 18.53 million, comprising 1.8 percent of the total population.

The NSSO Survey 1991, however, estimated the percentage at 5% (2% physical and 3% mental), more in keeping with WHO/UNDP international figures. **This conservative estimate would put the total number of disabled at 50 million in India.** International estimates vary from 5-10% as they also include learning disability as a category.

National Centre for Advocacy Studies (NCAS) is a social change resource centre, working for human rights, social justice and accountable governance. NCAS estimates that **1 in every 10 children is either born with or acquires a disability by the first year of life.** (*Ref: "The Disabled Child").* Despite reservation for persons with disability by the government being at 3%; there are still so many unemployed disabled persons; thereby suggesting that the NSSO survey, 2002 estimate of 1.8% is low. (Perscon: Alternate Law Forum)

The details of the NSSO, 2002 survey presented below reflect an estimate of the number of disabled persons in India by type of disability, by age, by gender, and causes (tables 1 to 4e).

Table 1: Number of disabled persons per 1,00,000 by sex and type (all India)

Type of Disability	Rural			Urban			All		
	Male	Female	Average	Male	Female	Average	Male	Female	Average
Mental retardation	113	69	92	118	81	100	115	72	94
Mental illness	128	91	110	105	71	89	122	86	105
Blindness	191	230	210	116	166	140	171	214	192
Low vision	76	95	86	46	62	54	68	87	77
Hearing disability	319	301	310	234	238	236	296	285	291
Speech	242	176	210	221	151	187	237	169	204
Locomotor	1274	804	1046	1058	730	901	1217	785	1008
Any disability	2118	1556	1846	1670	1311	1499	2000	1493	1755

Source: NSSO 58th Round

We see that locomotor disability has the highest incidence followed by hearing, speech and visual disability.

Table 2: Number of disabled persons per 100,000 population; for children up to 4 and 5-9 years, by type of disability

Age group/ disability	Up to 4 years		5-9 years	
	Rural	**Urban**	**Rural**	**Urban**
Mental retardation	59	75	115	153
Mental illness	12	16	32	35
Blindness	32	30	48	73
Hearing	55	55	172	142
Speech	129	132	297	285
Hearing and speech	86	86	209	215
Locomotor	334	291	716	557
More than one disability	523	487	1167	1015

This table reflects the distribution of type of disability in the age group 0-4 and 5-9 years. The age group of children under 6 years is not reported. **Locomotor and speech disability are seen to be the two most prevalent disabilities in the young child.**

Table 3: Disability-specific data, NSSO, 58th round, 2002

This table provides an overview of the percentage distribution of type of disability.

	Loco-motor	Mental retardatn	Mental illness	Blindness	Low vision	Hearing Impaired	Speech	Multiple Disability
Rural	52%	4%	5%	10%	4%	10%	5%	10%
Urban	55%	4%	5%	8%	3%	9%	4%	12%

3.2 Causes of disability as per the NSSO survey, 2002

Several factors predispose Indian children to disability. The key factors include: malnutrition or other nutritional deficiencies, communicable diseases, early childhood infections like encephalitis or meningitis, poor sanitation, consanguinous marriage, lack of immunisation, early motherhood, and of course, head injuries and accidents *(Tuli, "Seen, but not heard", 2002)*

Physical disabilities due to **polio** constitute the largest cause, followed by **communication** and **visual disabilities**. (*M.J. Thomas and Maya Thomas: An overview*).

The findings reported under the NSSO, 58th round, 2002 are summarised in the following tables 4a to 4e. The reporting is per thousand persons with a particular disability.

Table 4a: Causes of visual disability

Causes of Disability	**Rural**	**Urban**
Sore eyes during first month of life	3	1
Sore eyes after one month	6	8
Severe diarrhoea before 6 years of age	7	8
Cataract	212	196
Glaucoma	52	80
Corneal opacity	21	40
Other eye diseases	170	164
Smallpox	47	36
Burns	4	2
Injuries other than burns	38	47
Medical/surgical intervention	22	49
Old age	250	200
Other reasons	70	74
Not known	90	89
Total	**1000**	**1000**

Diarrhoea-related visual disability is found to be **a preventable causal factor** for the under 6 year old child.

Table 4b: Causes of hearing disability

Causes	Rural	Urban
German measles/rubella	6	8
Noise induced hearing loss	17	31
Ear discharge	165	132
Other illnesses	229	221
Burns	2	2
Injury other than burns	47	59
Medical/surgical intervention	14	22
Old age	254	295
Other reasons	77	99
Not known	183	128
Total	**1000**	**1000**

Table 4c: Causes of speech disability

Causes	Rural	Urban
Hearing Impairment	9	1
Voice disorder	90	67
Cleft palate	15	21
Paralysis	239	250
Mental illness/retardation	79	100
Other illness	222	243
Burns	5	5
Injury other than burns	46	62
Medical/surgical intervention	20	44
Old age	14	10
ısons	68	68
Not known	148	102
Total 1000	**1000**	**1000**

For about 31 per cent, the cause is old age. For a large number, the reasons are unknown. **Ear discharge** appears to be an important cause, applicable to young children.

Table 4d: Causes of locomotor disability

Cause	Rural	Urban
Cerebral Palsy	24	23
Polio	295	270
Leprosy cured	8	29
Leprosy not cured	17	8
Stroke	66	82
Arthritis	29	35
Cardio-respiratory diseases	3	3
Cancer	3	2
Tuberculosis	3	3
Other illnesses	120	120
Burns	20	18
Injury other than burns	256	271
Medical/surgical intervention	20	26
Old age	35	31
Other reasons	46	41
Not known	47	31
Total	**1000**	**1000**

Polio is the main and **preventable** disability.

Table 4e: Causes of mental retardation

Causes	Rural	Urban
Pregnancy and birth related	29	30
Serious illness during childhood	393	460
Head injury in childhood	85	128
Heredity	20	33
Other reasons	201	163
Not known	250	184
Total	**1000**	**1000**

Source: NSSO 58th Round

The principle cause of mental retardation was cited as "illness during childhood" (42%) followed by injury in childhood (10%). Cases of mental retardation due to "pregnancy and birth related factors" were 3%. In 25% cases, respondents were not aware of the probable cause of retardation.

There is a direct link between disability, poverty, and poor health care in the community. Poverty implies living in unsanitary surroundings with a lack of waste disposal treatment, and unsafe drinking water: the breeding ground for many infectious diseases. If childhood diseases go undetected and treated due to poor health care services, they can result in disability.

Poverty also implies food deprivation; leading to malnutrition of children and poor nutrition of pregnant and nursing mothers. Poor nutrition, frequent pregnancies, and poor quality of peri-natal care work in tandem and contribute significantly to disability.

There are some inter and intra state variations with regard to the prevalance of disability. The national average of physical disability is 19/1000 as per the NSSO 47th round, 1991. A few states that have a higher prevalence rate than the national average are: Andhra Pradesh (24.98/1000), Himachal Pradesh (28.70/1000), Karnataka (21.31/1000), Madhya Pradesh (27/1000), Orissa (23.06/1000), Punjab (29.36/1000) and Tamil Nadu (23.72/1000). In Kerala and Gujarat; night blindness, and impairments related to visual, auditory, vocal and locomotor are low; whereas in Bihar and West Bengal they are high in children between under 4 years.

The advocacy internet estimates that 1 in every 10 children is either born with or acquires a disability by the first year of life. This suggests that significant measures need to be taken for both identification as well as prevention and rehabilitation of persons with disability. However, the advocacy internet reports that **97 percent of disabled children in developing countries are without any form of rehabilitation; and 98 percent without any education.**

4. Government schemes for prevention and rehabilitation

The Ministry of Welfare, reconstituted as the Ministry of Social Justice and Empowerment, is responsible for the disability sector in India. It looks after the welfare, social justice and empowerment of disadvantaged and marginalised sections of society viz: scheduled castes, minority, backward classes, persons with disabilities, aged persons, street children and victims of drug abuse!

"The basic objective of the policies, programs, laws and institutions of the Indian welfare system is to bring the target groups into the mainstream of development by making them self-reliant" (*http://socialjustice.nic.in/about/welcome.htm*)

The Ministry identifies seven disabilities:

- Orthopaedically Handicapped
- Visually Impaired
- Hearing Impaired
- Mentally Retarded
- Multiple Handicapped
- Leprosy cured handicapped
- Mental Illness

In 1947, India had a total of 32 schools for the blind, 30 for the deaf, and 3 for people with mental retardation. In 2004, there are around 2,500 **special schools**.

In 1970, there were only two **teacher training institutes**, both leading to a diploma in special education. Today there are 37 centres offering such diploma courses; and about 12 universities offering a B.Ed. degree in special education.

The ministry has set up 11 **District Rehabilitation Centres** across the country, one of them being in Mysore; to provide comprehensive rehabilitation to people in the rural areas. The services include prevention, provision of aids and appliances, therapeutic services; job placement and vocational training.

There are four **Regional Rehabilitation Centres** (RRTCs) in Chennai, Lucknow, Mumbai and Cuttack, to provide training and human resources for rehabilitation services.

While these programmes are very well intentioned, most of them, invariably, remain notional in character. **Their outreach and accessibility in remote and rural areas remain negligible**. As a result, while comprehensive rehabilitation services are provided in few urban agglomerates, a large part of the country, especially the rural areas, remain unserviced. *(Disability India, Journal).*

Since a large number of disabilities are preventable, the guidelines of the National Health Policy promote **prevention**. However, these appear to be limited to immunisation and programmes for the prevention of blindness and leprosy.

As part of its **rehabilitation schemes**, the ministry offers the Scheme of assistance to disabled persons for aids/appliances (ADIP scheme). Under this scheme, aids and appliances that cost less than Rs.6000 can be availed of by people whose income is less than Rs.8000 per month. Apart from different societies, charitable trusts, district rural development agencies, and other bodies authorised by the ministry; this scheme can be availed of at the District Rehabilitation centres, viz Mysore for Karnataka.

Apex level institutes located in different parts of the country develop the human resources required to provide services to the disabled. Each of these institutes works in a different field of disability. These institutes run specialised courses to train professionals in the different areas of disability; and are at the forefront of their respective specialties:

The National Institute for the Mentally Handicapped, Secunderabad
The National Institute for the Visually Handicapped, Dehra Dun
The Ali Yavar Jung National Institute for the Hearing Handicapped, Mumbai
The National Institute for the Orthopaedically Handicapped, Kolkata
The National Institute for Rehabilitation Training and Research, Cuttack
Institute for the Physically Handicapped, New Delhi

5. The situation in Karnataka

Karnataka is the eighth largest state in India; both in geographical area and population. According to the 2001 census, Karnataka has a population of 5,27,33,958; of which 68,26,168 are below 6 years. The percentage of children below 6 years is 12.94 per cent. **With regard to disability, Karnataka has been in the forefront of efforts**. It was the second state, after Andhra Pradesh, to set up the Directorate of Welfare of the Disabled as an independent department, in August 1988. The Directorate aims to bring persons with disability into the mainstream of society.

Karnataka is also the **first state to have conducted a survey on disability** in 1991-92. (Source for Tables 5-6: Survey of persons with disability in Karnataka, 1991-92)

Table 5: Disabled persons by gender

	Male	Female	Total
No. of persons with disabilities	2,04,520	1,44,023	3,48,543

Table 6: Children below 6 years with disabilities

District	**Orthopdc Impaired**	**Visual Impaird**	**Hearing Impaird**	**Mental Ret/ Mental illness**	**Leprosy Cured**	**Multi-disabled**
Bangalore	1223	212	355	297	37	103
Bang (U)	1431	188	259	245	21	0
Belgaum	1945	118	263	260	7	13
Bellary	2538	311	351	227	26	1
Bidar	778	85	121	60	10	3
Bijapur	2330	173	325	238	15	39
Chikmaglur	598	99	193	158	10	23
Chitradurga	1286	208	196	155	8	29
Dharwad	4013	427	622	460	92	261
D Kannada	836	78	289	222	4	68
Gulbarga	2863	353	487	355	64	145
Hassan	616	109	145	161	5	79
Kodagu	164	22	51	57	0	0
Kolar	1212	203	294	196	12	61
Mandya	665	90	231	171	3	60
Mysore	1418	344	433	208	6	25
Raichur	3599	323	418	329	29	119
Shimoga	1630	178	285	317	35	88
Tumkur	1600	243	398	319	2	34
U. Kannada	484	41	101	108	2	12
Total	**31229**	**3805**	**5817**	**4543**	**388**	**1183**

The prevalence and type of disability in the state is in keeping with the national trend (see Table 2). It is also worth noting that so-called developed districts such as Dharwad and Bangalore too appear to have a relatively high number of disabled children. Due to the reasons cited earlier; these figures also appear to under-report the actual prevalence of disability (for example, there are many special schools in Bangalore city that work with children with multiple disability, recorded here as nil). It is also hoped that further enumerations will draw a distinction between mental retardation and mental illness.

5.1 State administration

The state government has constituted a **State Co-ordination Committee** and a **Commissioner** for persons with disabilities as per the provisions of the Act. A deputy director, assistant director and a gazetted manager assist the Director of the Directorate of Welfare of the Disabled. The staff of the Directorate including the ministerial staff is mainly on deputation from other departments such as the Department of Women and Child Development. At the district level, the **District Disabled Welfare Officers** are the implementing officers.

5.2 Schemes and services for the disabled

Although the state has several schemes for the disabled, ***there are no special schemes for children below 6 years.***

Monthly financial assistance to disabled persons

The Department of Welfare of the Disabled provides a maintenance allowance of Rs.125 per month to disabled persons below the poverty line. Disabled persons whose family income is less than Rs.6000 per annum and who have more than 40 per cent disability are entitled to get this allowance. Tahsildars of the concerned taluk are the sanctioning authorities. At present the state dispenses this allowance to around 3,00,000 persons with various types of disability.

Until last year, this allowance was open to any person who was eligible, including children. Now, only persons over 16 years are eligible for this allowance.

Aids and Appliances to disabled persons

Under its rehabilitation schemes, the state provides aids and appliances such as tricycles, hearing aids, Braille watches etc to disabled persons whose family income is less than Rs.11,000 per annum in rural areas and Rs.24,000 per annum in urban areas.

The challenges posed in getting a medical certificate or income certificate to access the monthly pension, scholarship, assistive devices and other schemes ***is a deterrent to accessing the service; and results in the poor utilisation*** of these benefits.

One way of ensuring the inclusion of persons with disabilities as one of the service groups and enhancing access to resources at different levels might be ***by involving persons with disability at the Gram Panchyat,*** Taluk and District level.

Identity card for disabled persons

The state issues identity cards to all categories of persons with more than 40 per cent disability; based on the disability certificate issued by government hospitals. Around 2,50,000 cards have been issued so far. This card entitles the disabled person to avail of any benefits offered by the government.

These cards are issued by the Directorate of Welfare of the Disabled in Bangalore; or by Child Development Programme Officers (CDPOs) of the ICDS; District Disabled Welfare Officers at the district; or the State Referral Centres.

Of all the schemes offered, ***the monthly disability pension takes up roughly 80 per cent of the budget; and is clearly not earmarked for children.*** Educational scholarships, assistance for self-employment, grants-in-aid to NGOs and CBR programmes take up a substantial part of the rest of the budget. Other initiatives such as ***prevention, early identification and intervention get only a small allocation.***

To initiate and sustain new programmes towards bringing a qualitative change in the lives of persons with disabilities, especially the poor in rural areas; ***the reach of the disability welfare department at the district and taluk levels must be strengthened***. A convergence and better utilisation of development schemes is called for.

National Programme for Rehabilitation of Persons with Disability (NPRPD)

The NPRPD is a programme of the Ministry of Social Justice and Empowerment. In Karnataka, it is being implemented in all the talukas of three districts of the state – Tumkur, Bellary, and Mysore. The project aims at providing a comprehensive rehabilitation service under one roof; such as aids and appliances, counselling by specialists, and corrective surgery. A State referral Centre has been set up at the Sanjay Gandhi Accident and Research Institute in Bangalore.

The service, follow up and repairs of appliances for persons with disabilities is not available across the state. For example, to undergo an audiometry test and get fitted with a hearing aid, a person in Koppal district of Karnataka has to travel all the way south 500 kms to Mysore.

Schools

The Department runs four residential schools for the visually impaired and four schools for the hearing impaired.

The schools for the hearing impaired are located in Mysore, Belgaum, Bellary and Gulbarga. While the one in Mysore runs from Class 1-10, the remaining three are from **pre-primary** to Class 7.

The schools for the visually impaired are located in Mysore, Hubli, Gulbarga and Davangere; and except for one, all have classes from Std 1-10.

5.3 Integrated Child Development Scheme (ICDS)

While the Department of Welfare of the Disabled concentrates on the rehabilitation and welfare of the disabled, **the onus of prevention, early identification and intervention** is with the Department of Women and Child Development (DWCD) through its ICDS programme.

The Integrated Child Development Scheme (ICDS) has been "universalised" in Karnataka. It is a comprehensive child development program. The ICDS aims to improve the nutritional and health status of children below 6 years, to serve pregnant and lactating mothers; and enhance the mother's capability to look after the nutritional needs of the child through health and nutrition education. It offers a package of six services:

BOX 1: ICDS services

1. **Supplementary Nutrition**: Children less than six years, pregnant and lactating mothers receive this supplement. Severely malnourished children receive double quantities.
2. **Immunisation:** Children receive immunizations to prevent diphtheria, tetanus, whooping cough, tuberculosis, polio and measles. Pregnant women receive tetanus toxoid.
3. **Health Checkup:** Antenatal care of pregnant women; post-natal care of nursing mothers; and care of children less than six years of age.
4. **Referral Services:** Referral services for both mothers and children to PHC, sub-centres, District or Referral Hospitals.
5. **Nutrition and Health Education:** Nutrition and Health Education is provided to women between the ages of 15 and 45.
6. **Preschool Education:** Children of 3-6 years of age are provided with non-formal pre-school education in an anganwadi in each village or locality.

The focal point of the ICDS is the anganwadi center. One anganwadi is set up for a population of every 1000. The centre works from 9.30-1.30 pm when children, 3-6 years, are given non-formal preschool education and supplementary nutrition.

Therefore, the anganwadi centre is the first institution that a potentially disabled or disabled child encounters. This provides an ideal opportunity for early identification and appropriate stimulation and intervention. However, it has been found that the ICDS has "**failed to focus on prevention and early identification of disability, and concomitantly, on interventions that could minimise the impact of impairments. This is a glaring omission, considering that the ICDS targets children in the under 6 years age group**". *(Tuli: "Breaking Barriers: Physically challenged children")*

Though an awareness module on disabilities has been included in the job training course which every anganwadi worker goes through, children with disabilities are not included *by design* (italics added) in the anganwadi centres. *(CBR network, South Asia)*. A study undertaken by Karnataka FORCES in 2002 shows that in the 40 anganwadis observed in Bangalore (urban and rural); children with disabilities were seen in only three centres.

5.4 Prevention, early detection and intervention initiatives in Karnataka

With the aim of early identification and intervention, the state has implemented two programmes: in Manvi taluk of Raichur district and H.D Kote taluk of Mysore district. This programme has been implemented with the help of CBR Network, an NGO; and NIMHANS (National Institute of Mental Health and Neuro Sciences).

CBR Network conducted a pilot programme on the implementation of the **Portage package** in Manvi taluk of Raichur district. With a population of 2,00,000; Manvi was an underdeveloped area with the highest incidence of disabilities. CBR network trained a range of functionaries, from grass-root workers to government functionaries and members of the local self-government. Children with special needs were identified and integrated to pre-schools; and many received medical rehabilitation.

Portage is an internationally accepted American approach to early intervention. It promotes a package of interventions that apply an inclusive approach; are simple to use; demystify concepts of disability; are precise; and any mother with basic literacy skills can learn to use it.

The CBR network adapted Portage to Indian conditions, and field-tested this model in Manvi. After positive feedback, this package was later implemented in all the 27 districts of the state.

In order to make this effective and sustainable, the Department of Women and Child Development undertook training programmes for its anganwadi supervisors and workers. The table illustrates the coverage.

Table 7: Training of anganwadi supervisors and workers

Posts filled as of May 2004		
	Udisha-Portage programme-For early detection of disability	Total number of Anganwadi Supervisors: 1728
	Udisha-Portage programme-For early detection of disability	Total number of Anganwadi Workers: 39690
Training coverage as of March 2004		
1	Udisha-Portage programme-For early detection of disability	16 districts (First phase in Mysore, Chamrajnagar, Raichur, Koppal and Bangalore).
2	Udisha-Portage programme-For early detection of disability	7676 trained anganwadi workers
3	Udisha-Portage programme-For early detection of disability	1093 trained anganwadi supervisors
4	Udisha-Portage programme-For early detection of disability	11districts - training in progress
5	Udisha-Portage programme-For early detection of disability	54 trained facilitators in talukas (Two facilitators in each district are trained).

Source: Department of Women and Child Development, 2004

The training methodology involved an orientation to members of the Zilla or Taluk Panchayats, community leaders, officials of health, education, agriculture and other related departments. Two facilitators from each district were identified; one from an NGO, and the other a government functionary such as a District Disabled officer or an officer from the DWCD. The facilitators then attended a 15-day training programme at Bangalore. By this methodology, **a permanent human resource team was available in each district to carry out new and ongoing training**. The NGO representative would be the person providing continuity; as compared to the government representative who would be subject to transfers.

BOX 2: Objectives of the training programme

The objectives of the training programme were:

- To enable anganwadi workers and mothers to understand the underlying principles of Early Childhood Care and Development
- To enable anganwadi workers to facilitate a stimulating environment to ensure that the child receives appropriate support during the fundamental developmental period
- To enable Anganwadi workers to identify developmental delays and disabilities in the 0-5 years period; and extend support to mothers to train the children using the residual potential to the optimum extent
- To train supervisors as resource persons; and to train anganwadi workers to use the Indian portage guide for planning and intervention
- To reach out to all the disabled children in rural/tribal and urban impoverished areas

(Source: DWCD)

In 2001-2, NIMHANS worked in H.D. Kote taluk of Mysore district. The project aimed at setting up a network of personnel in three sectors – ICDS, Health and Education – in an integrated manner through the training of anganwadi workers, health workers, doctors and teachers. NIMHANS conducted four multiple disability camps and provided medical and psychosocial rehabilitation.

5.5 Training of Primary Health Care functionaries

In keeping with the spirit of the PWD Act, Chapter IV (d), to provide training to the staff of the Primary Health Centers (PHCs), the RCI (Rehabilitation Council of India) launched the National Programme for Orientation of Medical Officers for disability management in 1999. **Karnataka was the first state in India to take up this programme for all doctors of the primary health centers** as well as orthopedic surgeons; towards important aspects of disability prevention, early identification, intervention and management. The Institute of Speech and Hearing in Mysore was entrusted with the task of conducting the programme
(see Table 8)

Table 8: Training of health personnel

Activity	Personnel/coverage	Place
National Orientation Programme on Disability Management	1600 PHC Doctors	Institute of Speech and Hearing, Mysore
National Orientation Programme on Disability Management	97 Orthopaedic Surgeons	Institute of Speech and Hearing, Mysore

Source: The information is based on pers.comm. with the Asst. Commissioner of Disabilities and http://rehabcouncil.nic.in/home.html

5.6 Evolution and role of NGOs

Traditionally, NGOs working in mainstream development activities such as poverty alleviation, education and health have not attended to persons with disabilities. The general perspective was that working with persons with disabilities required special skills and was best left to specialists. At the most, NGOs met the needs of persons with disabilities through the distribution of out-sized wheelchairs, tricycles or hearing aids at public functions.

Some NGOs began to provided institutional care. It was often parents of disabled children who founded these institutions. Persons with disabilities became dependent on the institution, and lost contact with their family. The State on its part could not manage to deliver services and programmes on its own, and once again relied on voluntary organisations to fill the gap.

The NGO sector has played a very important role; not only in providing services to persons with disability, but also in mobilising people to fight for the rights of the disabled. There are more than 3000 voluntary organisations in the country actively involved in ensuring a life of dignity and equality for differently-abled *children (Tuli: Breaking barriers)*. The only disadvantage is that most of the NGOs are located in urban areas catering to the needs there; while a large percentage of the disabled population requires rehabilitation in rural areas.

In 22 districts of Karnataka, through centrally sponsored schemes, **there are 81 aided NGOs that work with the disabled.**

The department offers up to 100 percent grants-in-aid to voluntary organisations to pay for the salaries of teaching staff; 50% for non-teaching staff; and maintenance charges. Of the **34 institutions aided by the government in Karnataka** working for different types of disabilities; 27 of them are schools for children 6 years and above; and the rest are training centres for technical, mobility and vocational skills. There appear to be no separate grants-in-aid schemes for services for children under 6 years.

5.7 Community based rehabilitation (CBR) and its approaches

The community based approach became a reality when institutions were no longer in a position to provide services for all the disabled. Initially this approach focussed on rehabilitation of persons with disabilities within their own community. Again, the emphasis was more on providing medical services to persons with disabilities such as referrals, corrective surgeries, and provision of aids and appliances. However, this approach over the years did not result in any change in the status or quality of life of the disabled persons; despite their having accessed rehabilitation services.

Soon it became evident that not only were the medical and rehabilitative needs of the disabled necessary; but one would also need to address their **social needs**. This could be ensured by including persons with disability in mainstream education, or equipping them with vocations for their livelihood; both measures would ensure social visibility. This became a more holistic form of rehabilitation.

The current **rights based approach** in community-based rehabilitation believes in **facilitating groups of persons with disability to demand their rights**, access schemes of the government, and generate income for themselves as a group.

In a large developing country like ours, there are numerous gaps left by the government both in terms of reach and in terms of access to quality service. Various NGOs working for the disabled have filled in the gaps by providing required services.

An intervention for Dastagir..

Dastagir is a 9 year old child with cerebral palsy who looks like a 3 year-old. He was born at home after a full-term pregnancy. When he did not cry immediately on birth, the doctor told his parents that he would be severely disabled. As he was growing, his limbs were not strong, he could not move around and could not speak. For the next six years, he remained at home with no intervention. When Mobility India began its CBR programme in the area three years ago, he was identified and put on a rehabilitation programme. Today, he is able to stand with support; calls out a few words and can recognise objects that are placed in front of him.

Kartik rediscovered..

Kartik is two and a half years old and cannot hear. When his developmental milestones were delayed, his parents thought that he was slow to catch up. It was only when he did not speak or show signs of communication even after he was a year and a half that they began to be concerned. It was then that an NGO with its CBR programme intervened and advised testing. The tests proved that he was profoundly deaf. He was advised to wear a behind-the-ear hearing aid that the NGO provided. Besides that, they ensured that he enrolled in a special school where he will begin therapy for two hours a day.

5.8 Groups working on issues of disability

Association of Persons with disabilities (APD), Lingarajpuram, Bangalore
APD runs an integrated school, community based rehabilitation services in rural and urban areas, provision of assistive devices.

Mobility India, JP Nagar, Bangalore
A rehabilitation, research and training centre, and community based rehabilitation – to enhance mobility of persons with disabilities and ensuring access to relevant rehabilitation services for persons with disabilities in rural and urban areas.

National Association for the Blind, Jeevan Bhima Nagar, Bangalore
Has an integrated education programme and community based rehabilitation programme for visually impaired children in urban and rural areas. Mobility and vocations skills are offered to persons with visual impairment.

Shree Ramana Maharishi Academy for the Blind
School for visually impaired children, training programme for community workers, and community based rehabilitation in rural areas.

Spastics Society of Karnataka, Indira Nagar Bangalore
Focus on people with cerebral palsy, community-based rehabilitation, school for children with cerebral palsy, development delays, neuro-muscular disorders and slow-learners.

Dr. S. R. Chandrashekar Institute of Speech and Hearing, Hennur Road, Bangalore
Provides assessment and therapy for speech, language, hearing and learning disorders at its center; and in their urban and rural camps.

RV Integrated School for Hearing Impaired, Lalbagh West Gate, Bangalore
Integrated school and services to help children develop speech and language skills through early intervention.

Action of Disability and Development, Banashankari, Bangalore
ADD India work with organisations in rural areas, in organising disabled persons groups to advocate for their rights and inclusion.

Karnataka Parents Association for Mentally Retarded Citizens (KPAMRC), Bangalore
An association of parents of children with disabilities, with members from across the state working as a support group and in conducting training programmes.

Seva-In-Action (SIA), Koramangala, Bangalore
Community Based Rehabilitation programmes; and working in the areas of inclusive education in collaboration with the government.

CBR Network (South Asia), Banashankari, Bangalore
Community Based Rehabilitation, conducting training in inclusive education; and early identification and intervention of disabilities.

Bangalore Children's Hospital, Bangalore
Specialises in caring for children; runs the Jagruthi school for children with special needs; has a child development centre providing early intervention to infants and toddlers with development delays.

National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore
A teaching hospital that offers comprehensive evaluation for children with development, emotional, behavioural, academic and psychotic disorders.

6. Summary of issues: the young child with disability

The fact that the first six years of a child's life are crucial for his/her development is well known universally. Most of the child's development takes place during this period; including group socialisation, learning, and physical development. The following are a few issues that affect the disabled child in particular.

a. Poverty is a central issue that needs a specialised focus; as it is the root cause for disability. **Malnutrition and limited access to health care as a result of poverty** will continue to be a key underlying problem. **Lack of safe water, sanitation, and poor personal hygiene** contribute to ill health; leading in some cases to disability.

b. Immunisation coverage: Of all the disabilities, the orthopaedically handicapped are in significant numbers. The National Policy for Children mentions the eradication of poliomyelitis, but in Karnataka the task force found the coverage of **immunisation** in the range of 60-80 percent. The government Pulse polio programme yielded a two-year polio free period; but the recent detection of nine new cases in north Karnataka has raised alarm bells again.

c. The **ICDS** programme has the widest reach to service this age group. In Karnataka there are more than 40,000 anganwadis; across all 27 districts. **The ICDS does not have any special early identification program** apart from the training given to anganwadi workers. Early intervention and stimulation are necessary to avoid **secondary disabilities.**

d. The **workload** of the **anganwadi workers** makes implementation of the Udisha Portage a less than feasible option. Since the anganwadi worker works at the grassroot level, she is required to participate in several other government programmes; limiting her time for child-related activities.

e. Not all anganwadi centres are **accessible** to the disabled or barrier free; hence, they prevent a disabled child from coming; even though he or she may be willing.

f. Most disabled children are discouraged by parents and siblings to perform life skills on their own, which makes them dependent. A shift in **cultural perception** is required by all caregivers; and society in general; to bring the disabled into the mainstream.

g. Lack of awareness and the **challenges posed** in getting a medical certificate or income certificate to access the monthly pension, scholarship, assistive devices and other schemes is reflected in the poor utilisation of the schemes; and is a deterrent to access the schemes.

h. Since the District Rehabilitation Center and the Primary Health Care (PHC) systems work independently, there is a **lack of coordination**. The PHC functionaries too are not adequately equipped to provide inputs on rehabilitation. Therefore, early identification does not get the required attention.

i. The **allocation of resources** for prevention, identification and early intervention is limited. Much of the budget goes towards paying pensions, scholarships, providing aids and appliances, maintaining institutions for the care of people with disability, and in the running of special schools.

j. The services for persons with disabilities are **unevenly spread** across the state.

k. In places where NGOs implement a **CBR** programme; early intervention and stimulation takes place (see boxes) and disabled children attend anganwadis.

7. Concluding thoughts

It is imperative that reliable estimates of the incidence and prevalence of various disabilities are available in accordance with accepted definitions of various categories of disability.

With the strengthening of preventive measures and coordinated efforts, the rate of disability ought to reduce. Paradoxically; new modes of living, a dramatic increase in accidents at home and outside (on agricultural farms and in industrial units); the misuse and abuse of drugs and other chemicals; failure of health services to significantly reduce the mortality of mothers and new-born children; and a host of other factors are only adding to the prevalence. Poverty too is the root cause for disability, and unless this issue is addressed head on, all health or social interventions will have a cosmetic affect.

The allocation for early detection and prevention is inadequate. The Primary Health Centre does not coordinate with the District Rehabilitation Centres, and is also woefully under-staffed to respond to local needs.

Government schemes are also underutilised, due to a lack of information as well the difficulties experienced in availing of them. The process of early identification and intervention are more effectively done by NGOs due to their presence in the field. Therefore, some resources could be directly routed through them.

The new trend for enabling the rights and dignity of disabled people can be addressed by planning and implementing a range of services aimed at making them independent in all respects. These services could cover all aspects of an individual's life from before birth to death; from health to education; leisure to employment; housing to transport etc.

The future challenge is to focus on a "zero rejection" in the provision of suitable services for children of all age range and severity levels. There is a need to carry out sustained awareness-raising campaigns on all the dimensions of disability.

The convention on the rights of the child upholds the right to life and development. But society neglects its disabled children in every way: from a denial of the right to life, to be born, to survive, to receive equal opportunities.

Looking back, we have made some strides in the field, considering the socio-economic, linguistic, religious and cultural variations in our country. Looking ahead, we realise that a lot more needs to be done if all persons with disabilities are to be given equal opportunities and access.

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ANNEXURE : Early Childhood Care and Education (ECCE)

(Extracted from "Documentation of Good Practices in Special Needs and Inclusive Education In India" prepared by CBR NETWORK (South Asia) for UNICEF

It is now globally recognized that systematic provision of ECCE helps in the development of children in a variety of ways such as group socialization, inculcation of health habits, stimulation of creative learning process and enhanced scope for overall personality development. In the poorer sections of the society, ECCE is essential for countering the physical, intellectual, and emotional deprivation of the child. ECCE is also a support for universalisation of elementary education and it also indirectly influences enrollment and retention of girls in primary schools by providing substitute care facilities for younger siblings.

At present, Integrated Child Development Services (ICDS) is the most widespread ECCE provision. Besides, there are preschools, *balwadis* and so on under the Central Social Welfare Board, in addition to some state government schemes and private efforts. Efforts have to be made to achieve greater convergence of ECCE programs implemented by various government departments as well as voluntary agencies by involving urban local bodies and *gram Panchayat*. Further, ECCE will be promoted as a holistic input for fostering health, psychosocial, nutritional and educational development of the child (MHRD 2002). The role of ICDS in early identification, early stimulation, pre school preparation of children with disabilities etc. is not yet fully explored. Only the Women and Child Development department in Karnataka through the project titled "Udisha Portage" implement one such initiative of large-scale inclusion of children with special needs. [1]

There are a number of projects initiated in India for early identification and intervention. UNICEF in India has supported such initiatives in different States. These projects were implemented both in urban impoverished and rural areas. The major implementing organizations in these programs have been NGOs such as Spastics Societies, CBR Network, Samadhan, etc. The strategy of these projects was to train families, especially mothers, in early childhood care and education using the locally available resources. Within these projects there were efforts to include children with disabilities into ICDS, however, there are not many projects initiated and supported by the State Govts. promoting a horizontal inclusion of children with special needs in the ICDS program. The only state which has taken a major initiative is the (Women and child development Dept.) Karnataka State which is promoting horizontal inclusion by training all its 40,000 Anganwadi workers in 27 districts to use Indian Portage. This certainly is an initiative by the State Govt. which has replicability value. There is a tremendous need to promote an active policy of inclusion in pre-schools managed by private organizations. India has a very large number of such pre-schools and day-care centers run by private organizations and which are not funded by the Govt. Therefore it becomes important to develop mechanisms to ensure these pre-schools also fulfill their social responsibility by opening their schools to all children including children with disabilities. Having said this there is also an urgent need to develop tools for early identification using inclusive principles

[1] Udisha Portage is the largest inclusive education program initiated by the Government of Karnataka in India. This is a World Bank supported program and is implemented with technical support from CBR NETWORK.

rather than looking at disabilities. Early childhood care and education will be possible only when there are strong linkages with the primary healthcare system. At present experiments such as DRC (District Rehabilitation Center), which worked separately from primary health care has not achieved much in ECCE. This is mainly due to lack of knowledge and skills available in the personnel of primary healthcare on ECCE. At present, in the curriculum of the medical, nursing, health workers training program, as well as primary health care personnel training program we do not see a component on early identification and intervention of children with disabilities. Such a component needs to be incorporated into the training program. The curriculum should go beyond mere awareness building and lead to development of practical skills. For eg. By including functional assessment and Indian portage in these training programs as a compulsory component, these personnel will have necessary skills to guide the families.