

The image features a large, light gray watermark of the IGNOU logo and text. The logo on the left consists of a stylized 'U' with a circular emblem inside. To its right, the text 'ignou' is written in a lowercase, sans-serif font, followed by 'THE PEOPLE'S UNIVERSITY' in all caps, also in a sans-serif font. A vertical line separates the logo from the text.

BLOCK 3

DEVELOPMENT OF RURAL CHILDREN

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The previous Block shed light on importance of rural women's development for the nation as well as for the children who are its future. Children in India constitute the age-group of 0-14 years, a big segment of the population. Moreover, a huge portion of the child-population living in rural areas poses distinct challenges for social development in terms of health and nutrition, sanitation, education, rehabilitation of the differently-able, etc. Many children, especially those from disadvantaged groups, are lacking in all major indicators of social development- health, nutrition and education. However, since Independence, the situation has significantly improved in all indicators. A dramatic decline in IMR and MMR owes to improved health services, health- and nutrition-education and universal vaccination and a notable enhancement of primary education is attributed to efforts like making education a fundamental right and expanding it in disadvantaged sections. The programmes like ICDS, Mid-day Meal and various schemes launched specially for promoting education among disadvantaged sections have really changed the children's scenario. But much is still awaited in health and nutrition as well as education. Until all children are in school, poverty in disadvantaged sections will continue to breed child labour, even bonded child labour, and ruin the child-situation in the country. So this Block will discuss development of rural children.

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UNIT 9 STATUS OF RURAL CHILDREN

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9.1 OBJECTIVES

After reading this unit, you will be able to:

- understand demographic characteristics of children in India;
- identify commonly used indicators of children's health, nutrition and educational status;
- discuss status of girl-child in rural India;
- discuss initiatives taken for development of children; and
- describe the situation of children at work.

9.1 INTRODUCTION

In the preceding Block you were introduced the development of women. Like women, children also need attention for development as they constitute the foundation of any nation. Census of India 2011 reported the total population of India being 121.02 crore. Of this, the rural population constituted 68.727% and the urban population constituted 31.28%. Of India's population, children constitute a large segment. As their number keeps on increasing, more and more resources are needed to ensure that children do not stay hungry, remain poor, suffer from preventable diseases, lack education and training facilities and suffer from any kind of exploitation. The larger portion of this child population lives in rural areas, posing distinct challenges for development. This unit will give an overview of the situation of rural children with the help

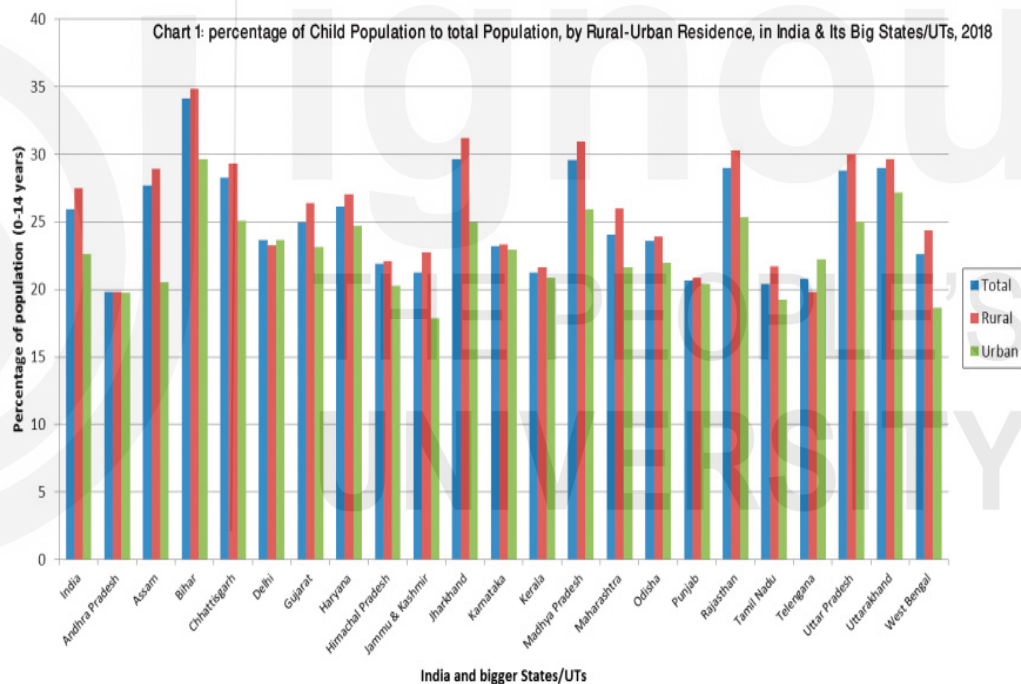
of some selected indicators which will enable you to see their relative position and measure changes in their situation. We shall also discuss the situation of those children who are at work. To start, let us see demographic characteristics of children in India.

9.2 DEMOGRAPHIC CHARACTERISTICS

To analyse situation of rural children we need to consider magnitude of the child population and its age-structure in rural India. Let us look into these features.

9.2.1 Magnitude of Child Population

According to the Census 2011, India's child population was 15,87,89,287 that constituted 13.12% of its total population. The rural child population was 11,75,85,514 that constituted 74.05% of the total child population. Let me show you in the following chart the percentage of child population (0-14 years) by rural-urban residence in the total population of India and its big States/UTs, as per the SRS Report 2018-19:



Source: Census of India 2018.

https://censusindia.gov.in/vital_statistics/SRS_Report_2018/9

9.2.2 Age-Structure

Demographers use age-structure of a population in a variety of ways. The percentage of children, aged 0-14 years, in the total population is computed by using the following formula:

$$\frac{\text{No. of Children (0 - 14) years}}{\text{Total Population}} \times 100$$

As noticed the population of India is young which reflects a high birth rate. India has, thus, to invest heavily in child survival and child development.

It is observed that for most of the age-groups, male-female differences in the distribution are negligible, except in the combined age-group of 0-14, 15-59, 60+, 15-64 and 65+. In the age-group 0-14, male population is more than female population, by about one per cent, whereas in the older age-groups 15-59, 60+, 15-64 and 65+, percentage of females is greater, by 0.6, 0.6, 0.6 and 0.5 percentage points respectively, than that of males (SRS Report 2018-19).

The age-group 0-14 is further divided into three sub-groups: 0-4, 5-9 and 10-14. The proportion of young children in the age-group 0-4 and also the proportion of population in the age-group 0-14 are higher in rural areas than in urban areas both for males and females. Where female literacy is high the proportion of children in the population is low, as educated mothers tend to have fewer children (SRS Report 2018-19).

Demographers also refer to child dependency ratio which is a measure of the child population (0-14 years) relative to the size of the population in the working age-group, i.e., 15-60 years. The child dependency ratio is computed by using the following formula:

$$\frac{\text{No. of Children (0 - 14) years}}{\text{Population (15 - 60 years)}} \times 100$$

Conventionally, demographers divide a population into age-groups with a class-interval of five years. Let us distribute the population into age-groups such as less than 1 year, 1-2 years, 3-5 years, 6-10 years, 11-13 years and 14-15 years. These groups are more relevant for planning purpose. Of these, the early childhood years (below 1 year and 1-2 years) are important for child survival; the period of 3-5 years is important for early childhood stimulation programmes at home and in pre-school, and the period of 6-11 years is relevant for primary schooling.

9.2.3 Sex Ratio

The population of India comprises of 62,37,24,248 males (51.54%) and 58,64,69,174 females (48.46%)_with the sex ratio of 940 females per '000 males. The top five States/Union territories having the highest sex-ratio are Kerala (1,084), followed by Puducherry (1,038), Tamil Nadu (995), Andhra Pradesh (992) and Chhattisgarh (991) the five States/UTs from the bottom having the lowest sex-ratio are Daman & Diu (618), Dadra & Nagar Haveli (775), Chandigarh (818), NCT of Delhi (866) and Andaman & Nicobar Islands (878) (Census India 2011). However, recently the fifth National Family and Health Survey (NFHS-5) held in 2019-20 reports that the number of women has surpassed men for the first time in India with the sex-ratio being 1,020 females per '000 males. NFHS-4 held in 2015-16 recorded 991 females per '000 males.

Low status accorded to women and girls and the prevailing custom of dowry are some of the factors that influence parents to prefer son and abort the female foetus, or neglect the girl child, leading to higher mortality among girls. To raise their status, girls need education and training for becoming financially independent. Other support measures, such as shelter, should also be provided to girls and women to empower them.

Gender discrimination in access to food, health-care, literacy, livelihood and wages is of great concern. Women and girl-children often suffer greater nutritional deprivation and they are victim of all forms of violence in the public and private spheres, including trafficking and sexual and other types of exploitation (Health and Family Welfare Statistics in India (2019-20)). These trends, contrary to global developments, point to the need for designing special programmes and strategies based on individuals, and not based on households.

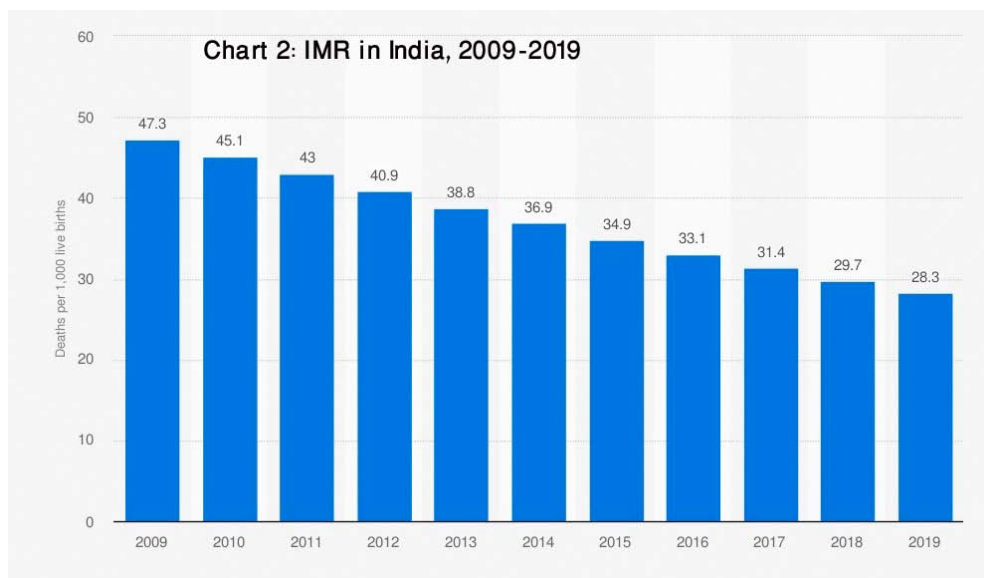
According to Health and Family Welfare Statistics in India (2019-20), India has the largest child population in the world, comprising 190,075,427 (52.38%) male children and 172,799,553 (47.62%) female children in the age of 0-14 years, constituting nearly 28.6 per cent of the population. Rural areas in India have a number of infrastructural problems such as lack of roads, schools, health centres, environmental sanitation facilities, employment opportunities, rehabilitation facilities for disabled, etc. Also, rural areas vary widely in their topography such as stark mountainous regions of Ladakh and Arunachal Pradesh, etc., coniferous forested areas of Himachal Pradesh, Uttarakhand, etc, rolling hilly areas of the North-Eastern States, the dry desert areas of Rajasthan, the arid regions of Gujarat, the fertile plains of Uttar Pradesh, Bihar, Madhya Pradesh, Maharashtra, etc. and the coastal areas of Kerala, Andhra Pradesh, Tamil Nadu, Karnataka, Odisha and West Bengal. These terrains present different problems to widely scattered beneficiaries in their access to various programmes and services, though, since Independence, significant improvement has been seen in several indicators of social development.

Let the situation of rural children be discussed, based on major social indicators used in determining health, nutritional, educational and work status. Before we proceed, let me check your progress.

9.3 HEALTH STATUS

Health status of children in India has improved tremendously. Infant mortality rate (IMR) is an indicator to measure health. It is defined as the number of infant deaths per thousand live births in less than one year. In India, IMR was 146 per '000 live births in 1951, which has fallen to 28.3 per '000 live births in 2019. The following chart shows the decline in infant mortality rate (IMR) in India from 2009 to 2019:

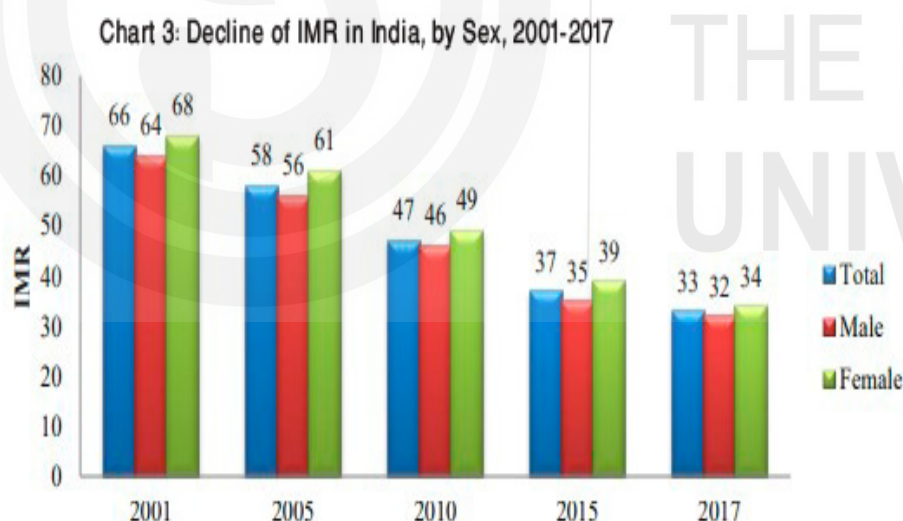
This decline owes to expansion of health services, organising immunisation camps, spread of health and nutrition education and awareness through Anganwadi Centers under ICDS, Primary Health Centres (PHCs) and Food and Nutrition Board's nutrition-related activities and other initiatives taken by the Government, NGOs and international organisations. A sharp drop in the incidence of vaccine-preventable diseases is seen and polio has been almost eliminated.



Source: World Bank © Statista 2021

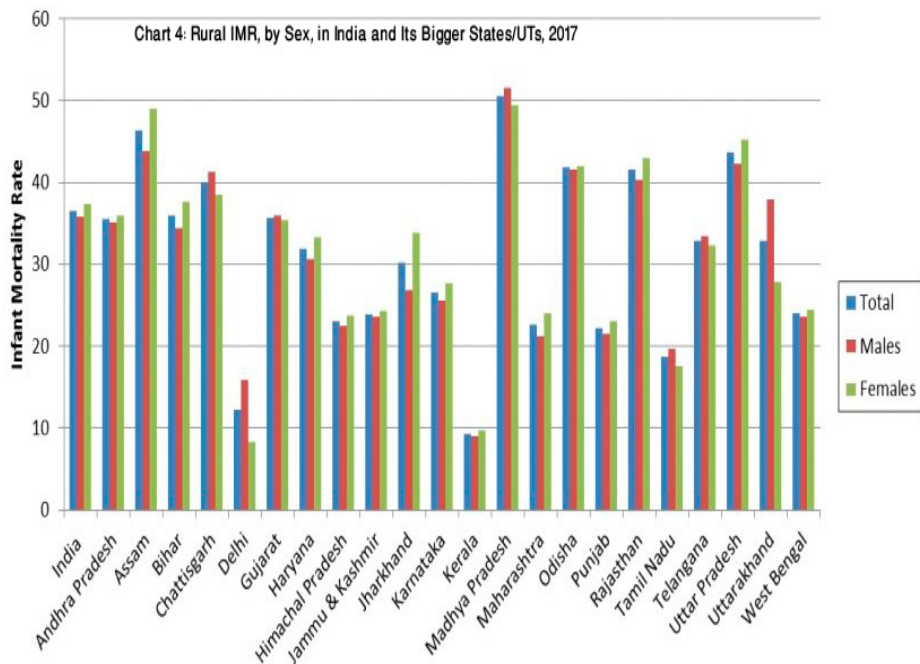
Infant Mortality Rate (IMR) has registered a decline, of 4 points, to 33 in 2017 from 37 in 2015 at the national level. The highest IMR (47) has been observed in Madhya Pradesh and the lowest in Kerala (10).

Female IMR is higher than male IMR in all but the States of Chhattisgarh, Delhi, Madhya Pradesh, Tamil Nadu and Uttarakhand. The following chart shows the trend of decline in IMR of males and females in India for the period from 2001 to 2017:



Source: Ministry of Health and Family Welfare, Government of India, 2019.

IMR is reported to be 33 in 2017, comprising 37 in rural areas to 23 in urban areas. It is higher in rural areas than in urban areas because health facilities in rural areas are inadequate and timely medical attention is not available when required. The following chart shows the rural IMR in India and its big States/UTs, by sex, in 2017:



Source: Census of India, SRS_Report_2017.

Immunisation programme has been one of the major factors in reducing infant mortality. A child is fully immunized when received all the required doses of vaccine for diseases like polio, whooping cough, TB, measles, diphtheria, tetanus, etc. Low immunisation is prevalent in areas where literacy is low, especially female literacy, and in remote hilly areas of the North–Eastern States where the population is scattered, terrain is difficult and health infrastructure is inadequate. The health facilities available in rural areas in these States and some other States are not adequate. Although the health infrastructure is in place, it is inadequate in certain areas and often plagued by lack of personnel, equipment, medicines, etc. The quality of health services in rural areas has much scope for improvement.

Rural health infrastructure plays an important role in reducing infant and child mortality rates and improving life expectancies and nutrition status, even if the access is not so good and calorie-consumption is low. The Government programmes, such as Mid-day Meal, Integrated Child Development Services (ICDS), universal immunisation etc, have provided better health and nutrition to the population. Those who seem food-secure and consume sufficient calories have low infant mortality rate, low maternal mortality rate (MMR) and high life-expectancies. Female literacy and rural health infrastructure have also a bearing on the mortality and life-expectancy. A life-cycle approach needs to be followed in the case of nutrition, ranging from *in utero* to old age.

9.4 NUTRITIONAL STATUS

“The world, both, animate and inanimate, is sustained by food... The giver of food is the giver of life and indeed of everything else. Therefore, one who is desirous of well-being in this world and beyond should make special endeavour to give food...” (Bhagwad Gita).

For a healthy working population, it is essential that children receive adequate nutrition during childhood and adolescence to ensure proper physical and mental growth. Erratic or insufficient availability of food leads to its uneven distribution. Inevitably, those who need food-security most are also the most food-deprived. They are rural children, especially female children, adolescent girls, women, those belonging to SCs, STs, OBCs, landless and agricultural labourers, marginal and small farmers, workers employed in unorganised sectors, the illiterate, the poor and those whose coping mechanisms have been brutally damaged or undermined by recurring or one-time disaster and form the invisible hungry in India.

ICDS started in 1975 provides a package of services to pre-school children and expectant and nursing mothers, consisting of health check-up, nutrition, immunisation, nutrition and health education, referral services and pre-school education. Malnutrition among under-five children is an important concern for the health authorities. Various risk factors and their influence on nutrition-status of children in a given set-up should be analyzed for planning the control measures. Strengthening public health interventions for mild malnutrition cases and vulnerable groups, effective implementation and evaluation of the strategies at regional level, research on overweight, obesity and its etiological factors and steps for improving socio-economic development are the pre-requisites for tackling malnutrition among under-five children in India (Sahu 2015, 18). The four segments critical to food security are nutrition, poverty alleviation, agricultural production and disaster mitigation. These can be addressed by the following four-pronged programme:

- 1) Food for Work,
- 2) Food for Education,
- 3) Vulnerable group feeding and
- 4) Disaster Response.

A multi-pronged strategy can be introduced in every village, consisting of direct interventions like fortification of food, administration of oral doses of Vitamin-A, iron and iodine fortified salt and promotion of cultivation of vegetables and trees like *amla* in small areas surrounding huts/homes. The 'India-mix', fortified with essential vitamins and distributed through ICDS centres in selected States, needs to be extended to all the States and Union Territories. The highest priority is to be given to eliminate hidden hunger in the shortest period. The programmes can be designed in a campaign mode as done in the case of vaccination against major diseases.

Existing projects like Targeted Public Distribution System (TPDS) and nutrition programmes (e.g., ICDS, Mid-Day Meals, and Antyodaya Anna Yojana) should be mobilised to ensure their reach to those who have thus far been by-passed. TPDS should include distribution of nutritious cereals like *jowar*, *bajra*, *ragi* and millets because they have low cost, high calorie/protein/micronutrient advantages. Knowledge of childcare, healthcare practices and support services should be targeted to pregnant and nursing mothers to ensure effective protein-calorie nutrition for young children.

ICDS should encourage increased involvement of women in managing feeding programmes. Greater attention to appropriate supplementary nutrition is needed for children in the age of 0-2. This age is the most critical period for the growth of brain and body. Moreover, this age-group is the most neglected in ICDS, yet, having the highest level of malnutrition. These measures can ensure better health and nutrition of both infants and mothers.

9.5 EDUCATIONAL STATUS

A study conducted by National Statistical Office on *Household Social Consumption: Education in India* as part of NSSO's 75th survey-round, held from July 2017 to June 2018, provides a comprehensive analysis of female literacy rates for all the States of India, considering persons aged seven years and above. It estimates India's average literacy rate at 77.7%; the female literacy rate at 70.3% and the male literacy rate at 84.7%. Kerala tops among the States with the highest female literacy rate of 95.2% while Rajasthan performs the worst with the female literacy rate of 57.6%. However, special innovative projects are being carried out to raise female literacy and increase girl enrolment and retention and the Government is fully committed to the goal of Universalisation of Elementary Education (UEE). Today, children need a quality education that must:

- encourage a more integrated view of how the world operates and how development does or does not occur,
- make students more critically aware of how their actions, individually and collectively, will hinder or help the world in meeting challenges in future and
- help mobilise and empower people with knowledge and skills to participate more actively, democratically and collectively in the development process. Let's look into the States' initiatives towards this end.

9.5.1 Initiatives Taken by the States for Community Participation

Though most of the States in India have elected local bodies/panchayats in rural areas, their involvement in the functioning of schools is limited. Mostly, panchayats have been responsible for constructing, repairing and maintaining school-building only. The lowest tier of the panchayats at village level has hardly any say in children's education and local school's functioning. However, some States have taken important initiatives to involve local community in children's education.

Andhra Pradesh involves community members on a large scale through programmes such as *Chaduvula Panduga*- the festival of education. Assam's *Alokar Jatra*, a programme, involves local communities to conduct a household survey, resulting in a local-level database on the educational status of children with positive impact on access and enrolment.

In Rajasthan, Shiksha Karmi and Lok Jumbish have been two externally

aided projects for universalisation of basic education of a quality in the remote and socially backward villages, with a special emphasis on community-participation. In the Shiksha Karmi Project initiated in 1987, the village communities (VECs) have a great contribution to improvement of the school environment, infrastructure and facilities, enrolment of children through school mapping and micro-planning in the Shiksha Karmi School. The project covers 2,708 villages in 147 blocks spread over 31 districts.

Lok Jumbish project, launched in 1992 by Government of India and Government of Rajasthan with the support of Swedish International Development Agency (SIDA), has been set up for innovative management structures on the principle of decentralisation. It aims to build a partnership with local communities and the voluntary sector to improve quality education. It positively contributed to improve text-books for Classes I to IV, based on minimum level of learning (MLL). It has conducted school mapping in 8,921 villages, opened 2,560 Sahaj Shiksha Centres covering 47,000 children and started 529 new primary schools and 268 upper primary schools, 239 pre-school centres of Anganwadis and formed over 7,600 Mahila Groups (the 10th Planning Commission Report).

Under the Kerala Panchayat (Amendment) Act, 1999, the panchayat Ward Members are members of Panchayat Education Committee (PEC) which develops school-plan. The funds are routed through the Panchayat and some of the Panchayats use their own resources for the school. Parent-Teacher Association (PTA) and teachers make special efforts to enrol all children, including migrant children, with special focus on gender-equity and promotion of girl-child's education. All Head Masters under the Panchayat present report in PEC's monthly or bi-monthly meeting, chaired by the Sarpanch.

Bihar Vidyalaya Shiksha Act, 2000, provides Vidyalaya Shiksha Samiti (VSS to supervise civil works, oversee financial transaction, organise campaigns to enrol out-of-school children and ensure their retention. However, VSS does not involve in academic matters inside the classroom.

In Karnataka, a special Government order of 2001 provides for Village Education Committees (VEC), chaired by a member from the elected Panchayat. In 2007 the Government introduced *Namma Shale-My School* (a school-community connect programme) which runs in four clusters of four districts. It has seven important stakeholders: teachers, parents, children, School Development and Monitoring Committee members, CBO members, Gram Panchayat and the government's education department. They are involved in all the issues of school's development ranging from monitoring to capacity-building.

Under the Nagaland Education Institutions and Services Rule 2002 which provides for communitisation of elementary education the Village Education Committee (VEC) has got administrative, academic and financial powers and functions to manage elementary education in the village. It disburses salaries and grants casual leave to school-teachers and staff, procures furniture, stationery, etc. and selects/recommends appointment of substitute teachers

against long term vacancy. Also, it ensures universal enrolment and retention of all children aged 6-14 years, implements annual plans and programmes of the Government and ensures that free text-books reach to the children and the mid-day meal is managed well.

In Madhya Pradesh, *Jana Shikshan Adhiniyam* promotes decentralisation of school education and provides for PTA and Teachers Association to ensure enrolment of all children, monitor regular attendance of teachers, mobilise local resource persons for teaching, monitor on-going learning of children, organise remedial education and mobilise resources for small requirements of the school. Inclusiveness is promoted through community-members.

In Gujarat, an Act enacted in 2003 created VEC and Ward Education Committee under the decentralised structure of district, taluka, and village levels. District Panchayat recruits primary school teachers through a staff selection committee. The funds for Meena Manch and Residential Alternative Schools, payment of Bal Mitras' salaries, civil works, disbursement of teachers' salaries and school-grant and Inclusive Education for Differently-abled (IED) grant for children with special needs (CWSN) have been transferred to the village or the school.

Though education in India is improving, all children are yet to be in school. Rural schools have peculiar problems. Curricula and teaching methods are irrelevant to rural life. Written words have not much place in rural life. So, many students lapse into illiteracy after leaving school. Students memorize many subjects only to regurgitate in examinations. Teachers generally teach by reading from a text book. School-buildings are in poor condition, without furniture and amenities. Schools do not open for the stipulated number of days, supervisory visits are few and there is very little community-participation. This all leads to disenchantment with the education system. To bring about a change, teachers' training in development skills is necessary to have an immediate impact on rural development. Some serious problems in rural areas require only awareness that the problem exists as rural people have the knowledge and expertise to solve it.

9.5.2 Government Schemes for Improvement in Girls' Education

Expansion of girls'/women's education has been an integral part of the Government's educational policies and programmes. The Ministry of Human Resource Development has taken several initiatives for expansion of girls' education. Let us see what they are.

- ***Kasturba Gandhi Balika Vidyalaya*** scheme, launched in 2004 to provide primary education to girls, is primarily for underprivileged people and rural areas where girls' literacy rate is very low. The schools opened under the scheme have 100% reservation: 75% for backward class girls and 25% for BPL girls.
- ***Beti Bachao, Beti Padhao*** is the scheme launched in 2015 to generate awareness to save girl child and enhance girls' education in India by ensuring efficient delivery of welfare services meant for girls.

- **UDAAN - Giving Wings to Girl Students** is a scheme to enhance enrolment of girl-students in prestigious institutions of technical education through incentives & academic support and bridge the gap between school education and engineering entrance examinations for girls.
- **Mahila Samakhya** is an on-going scheme, initiated in 1989, to translate the goals of National Policy on Education into a concrete programme for education and empowerment of women in rural areas, particularly those from socially and economically marginalised groups.
- **Saakshar Bharat**, a new variant of the National Literacy Mission, launched in 2009, targeted female literacy as a critical instrument for women's empowerment. It aims to accelerate adult education, especially for women, in the age of 15 years and above, who have no access to formal education.
- **Mid-Day Meal Scheme:** The gender-gap in school-participation tends to narrow, as the Mid-Day Meal Scheme helps remove the barriers that prevent girls from attending school.
- **Mid-Day Meal Scheme** is an effective means to increase school enrolment and retention of children from food-insecure families and ensuring that short-term hunger does not inhibit their capacity to learn. It helps avert child labour and facilitates girls' entry into schools.

In spite of these initiatives, many children are found at work whereas they should have been studying in school. Such a situation further lowers children's status. Let us see children at work.

9.6 CHILDREN AT WORK

Poverty compels families to utilise all their resources to merely survive. So, to supplement their income poor families often send their young children to work. Niti Aayog's first *Multidimensional Poverty Index (MPI) Report* released in November 2021 informs that Kerala has the lowest poverty rate in India whereas Bihar, Jharkhand and Uttar Pradesh registered the highest poverty rate across India, emerging as the 'poorest States'. Bihar's 51.91% people are poor, followed by Jharkhand (42.16%) and Uttar Pradesh (37.79%). The age-group 0-19 years is the most affected by extreme poverty. This can lead the youngsters to malnutrition and illiteracy.

The Census 2011 enumerates 10.1 million child workers, a decline of about 1 per cent from the Census 2001 which estimated 12.7 million child workers. Reduction in child workers' number is more pronounced in rural areas than in urban areas. In India, child labour is inextricably linked to the issue of social inclusion as children belonging to poor and marginal farmers as well as landless households who form part of the excluded social groups are mainly exploited as child labour (George and Panda 2015: 17).

International Labour Organisation's *World Report on Child Labour 2015* reveals that India has around 168 million children trapped in child labour, 75 million young persons- aged 15-24- unemployed and many more in jobs that

fail to offer fair income, security in workplace, social protection and other basic/decent work conditions. The magnitude and incidence of child labour varies across the States, with some States reporting its higher incidence while in others it is comparatively lower (UNICEF, 2016). Girls form a sizable proportion of the working children yet their work in households is hardly recognized as work.

India has made significant progress in reducing child labour in the last decade. Data from the Census 2011 show the largest decline of child work in the age group 10-14 years in rural areas. Child labour elimination is one of the targets of the Sustainable Development Goals and to achieve this India is taking required measures.

Social, economic and educational factors cause child labour. Illiterate parents do not attach much importance to schooling, especially of girls. Early drop-out from school facilitates their entry into a work-place. Many parents see nothing wrong in their child being engaged in work; rather, they consider it a useful way to engage the child who does not attend school, never realizing that the child gets inducted in the inter-generational cycle of low wages, ill-health, under-nutrition and poverty.

Child Labour (Prohibition and Regulation) Act, 1986, aims to prohibit children's entry into hazardous occupations and to regulate their services in non-hazardous occupations. Juvenile Justice (Care and Protection) of Children Act (JJ Act), 2000, amended in 2006, states, "any working child below the age of 18 years is a child in need of care and protection". It accords authority to its notified officers to take action, with the help of the Child Welfare Committee (CWC), against employers for employing children in prohibited employment.

Government of India has taken proactive steps towards eliminating child labour, preventing it and rehabilitating children previously engaged in workforce. By the 86th amendment in the Constitution made in 2009, education has become a fundamental right for all children in the age group of 6–14 years. Besides, the Government has introduced various schemes for rehabilitation of the children withdrawn from work. National Child Labour Project (NCLP), launched by the Government in 1988 as part of a larger Plan of Action arising out of the National Child Labour Policy, has been supported by several major initiatives at national, State and district levels to eliminate child labour. It includes establishment of Special Training Centres, as specified in RTE Act, 2009, to provide children with education and vocational skills and prepare them to be mainstreamed into the formal education system. India has signed a Memorandum of Understanding (MoU) with ILO for the International Programme on Elimination of Child Labour (IPEC) in 1992, which concluded in 2013. India has also signed the United Nations Convention on the Right of Child (UNCRC) in 1992. India is actively striving to ratify ILO Convention No. 138 on Minimum Age and No. 182 on the Worst Forms of Child Labour to eliminate child labour from India.

India's judiciary has demonstrated profoundly empathetic response to the practice of child labour. Various labour commissions and committees

constituted in India from time to time have focused on the issue of child labour and have made extensive recommendations. UN and ILO Conventions, Indian Constitution's provisions relating to child labour and other Central and State laws provide the most comprehensive protection to child labour and grounds for elimination of all of its forms. Policies, legislation and schemes/programmes addressing child labour are expected to change those aspects of the socio-economic structure that allow child labour to persist.

9.7 BONDED CHILD LABOUR

Bonded child labour refers to the children working in conditions of servitude to pay off a debt that, binding them to their employer, is incurred not by the children themselves but usually by their parents or in some cases by relatives or guardians. In India, millions of children are forced into child labour due to poverty, illiteracy, unemployment, overpopulation, etc. Child debt servitude has existed as an illegal practice since 1933 when Children (Pledging of Labour) Act was enacted in the British rule. Since Independence, there have additionally come up several protective legal measures to govern the conditions of child labour in distinct sectors such as factories, commercial establishments, plantations, apprenticeships and migrant labour and contract labour. However, data on children working as bonded labour are not available, though many children are working for long hours as full-time workers in the conditions of exploitation. Often, their parents have taken loans, pledging, in return, the labour of their children who, severely exploited, work for paltry wages for years, continuing even beyond what would have redeemed their debt because there is no one to intercede for them.

In India child labour continues due to the following reasons:

- i) prevalence of myths justifying child servitude/labour,
- ii) lack of social awareness and sensitisation,
- iii) lack of political will,
- iv) ineffective legal instruments,
- v) ignorance of children in servitude and their parents, and
- vi) anti-childhood development policies and programmes.

Child labour is rampant where parents get employment for not more than 100 days in a year on wages far less than the statutory minimum wages. So, its elimination benefits both parents and adults in families as the employers' account books show payments to adults whereas, in reality, it is a pittance paid for child labour, thus, saving billions of rupees as a black money for big industries in the sectors such as carpet making, diamond cutting and polishing, matches and fireworks, handlooms, etc.

Population control programmes will not be successful unless all employment avenues for child labour are closed, thereby, making children a liability to their parents. Besides, for these children, a conscious educational approach needs to be adopted. Though, for a pretty long time, there have existed two

laws; namely, Bonded Labour Abolition Act 1976 and Child Labour (Prohibition and Regulation) Act 1986 to mainly deal with child labour, they are seldom enforced and punishment for their violation being too nominal to have any deterrent effect. So, a strong political will is needed to ensure that children are not made to work. The media can be a powerful source of information and awareness generation on such issues of human importance. Lopsided development projects uproot thousands, forcing the poor to migrate to cities where they eke out a living, and their children engage in rag picking, another hazardous job, merely to survive. Only social policies based on humanitarian values can guarantee a child his/her childhood, and not the free market oriented to maximise profit with minimum input.

Voluntary Organisations have a major contribution in identifying and securing release of bonded labour with the help of the Supreme Court of India. South Asian Coalition Against Child Servitude (SAACS) founded in 1980, Bandhua Mukti Morcha (Release of Bonded Labour), *Bachpan Bachao Andolan* (Save Childhood Movement), Campaign Against Child Labour (CACL) and several other organisations have taken the lead in this matter. This coalition of organisations tried to educate buyers not to buy products made by child labour. They devised a mechanism to put a trade mark, RUGMARK, to carpets produced without child labour, to be bought by foreign buyers. These organisations involve religious leaders, trade unions, socially conscious individuals and all those who are concerned to put an end to child labour.

A rise in the minimum wages in the States/UTs where the wage rates are low will help in arresting the processes of distress migration and debt bondage to some extent, preventing child labour and enabling children to continue with schooling in their native homes. If these children do not work along with their parents, they stay at the temporary settlements to look after their siblings. They, thus, get completely excluded from the education system and fall prey to illiteracy. These children who are unable to access the formal schooling system need to be provided education through means of mobile schools. Works of girl children also need to be accounted in official statistics to capture the magnitude of domestic child labour and plan policy interventions for their education. Thus, the most important intervention in child labour is to provide compulsory primary education of a good quality.

9.8 LET US SUM UP

Children in India, the age-group of 0-14 years, constitute a large segment of the population. India has to invest heavily in child survival and child development. Moreover, a huge portion of the child population lives in rural areas, posing distinct challenges for development. Rural areas in India have a number of infrastructural problems such as lack of roads, schools, health centres, sanitation facilities, employment opportunities, rehabilitation facilities for disabled, etc. Wide topographical variations, scattered people and lack of resources in rural areas further complicate the problem of children's development. Hence, rural children, especially those belonging to various disadvantaged groups have suffered in major indicators of social development such as health, nutrition and education.

indicators. A huge decline in IMR and MMR can be seen, owing to improved health services, health and nutrition education and access to primary education. In spite of education being a fundamental right and its expansion in disadvantaged sections, all children are still not in school. Besides, rural schools have peculiar problems. Poor families, compelled to utilise all their resources to survive, often send their young children to work so as to supplement their income. This situation sustains child labour, even bonded child labour, still ruining childhood of a good number of children.

9.9 KEY WORDS

Children: The persons aged 0-14 years are children in India.

Child Sex Ratio: The number of females per thousand males in the age group 0–6 years in the specified population.

Child labour: Children engaged in work instead of being in schools, owing to poverty and ignorance by parents.

Bonded Child Labour: Children working in conditions of servitude to pay off a debt, that binds them to their employer, is incurred not by them but usually by their parents or in some cases by relatives or guardians.

9.10 SUGGESTED READINGS

Mazumdar, Indrani and Neetha N. (2011). 'Gender Dimensions: Employment Trends in India: 1993-94 to 2009-10'. Occasional Paper No. 56. New Delhi: Centre for Women's Development Studies.

Mehrotra, Santosh and Biggeri Mario (eds). (2007). *Asian Informal Workers: Global Risks, Local Protection*. London and New York: Routledge:.

MHRD. (2011). *Working Group Report on Elementary Education and Literacy: 12th Five-Year Plan 2012-2017*. New Delhi: Department of School Education and Literacy, Government of India.

Mishra, Lakshmidhar. (2000). 'Child Labour in India'. In *Carpet Weaving Industry in Jammu & Kashmir and UP*. New Delhi: Oxford Press. Pp. 95-101.

Mukherjee, Dipa. (2011). *Reducing Out-of-School Children in India: Lessons from a Micro Study*. New Delhi: NUEPA.

Murphy, Damien. (2005). *Eliminating Child Labour through Education: The Potential for Replicating the Work of the MV Foundation in India*. University College, Dublin: Centre for Development Studies.

Sahu, Swaroop Kumar *et al.* (2015). 'Malnutrition among Under-five Children in India and Strategies for Control'. *Journal of Natural Science, Biology and Medicine*, 6(1): 18–23.

Sanghi, Sunita *et al.* (2015). 'Decline in Rural Female Labour Force Participation in India: A Relook into the Causes'. *Vikalpa*, 40(3): 255-268. Sage Publications.

UNICEF. (2016). *State of Child Workers in India: Mapping Trends*. India: VV Giri National Labour Institute.

UNIT 10 RURAL CHILDREN: HEALTH AND NUTRITION

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- 10.0 Objectives
- 10.1 Introduction
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10.0 OBJECTIVES

After reading this unit, you will be able to:

- understand rural children's health with the help of infant and child mortality rates;
- highlight health problems commonly found among children;
- identify nutritional needs of children;
- analyze nutritional status of children;
- know about common nutritional deficiencies in children; and
- acquaint yourself with policies and programmes implemented for raising children's health and nutritional status.

10.1 INTRODUCTION

Health and nutrition are interrelated phenomena. A good level of nutrition and health opens the gateway to qualitative life of a people, among whom healthy children constitute a potential resource of the nation. For utilizing this resource potential, it is imperative to ensure adequate health and nutritional status of children, especially rural children who live in a setting of relative disadvantages. The social cost of malnutrition and unhealthy children is really high, which is quite evident from high death rates and unproductiveness of people in many nations. Childhood nutritional deficiencies lead to a vicious circle of infections, reduce resistance to diseases and, sometimes, result in high mortality rate, too. In rural India, malnutrition and infections prevailing in the millions of deprived children

have been major causes of chronic physical and mental growth deficiency. Unfortunately, there exists poor nutritional status among Indian children even when high economic growth rate is being witnessed. In this unit we will discuss health and nutritional status of rural children. Let us start with infant and child mortality.

10.2 INFANT AND CHILD MORTALITIES

Mortality rate, also, referred as death rate, is a measurement that tells us about the number of deaths in a given population. The early years of children's life are significant in terms of growth, development and survival. In India, due to poor nutritional status and nutritional deficiencies the mortality rate is unacceptably high among infants and children. It is measured by infant mortality rate (IMR) and child mortality rate (CMR) among infants and children respectively. Let us know about them.

10.2.1 Infant Mortality Rate

Infant is a newborn baby in the age ranging from 0 to 12 months. IMR is calculated as the number of deaths per '000 live births of children aged under-one year, i.e., 0- 12 months. In India there has been a constant decline in IMR over the last decade but the decline in IMR is not uniformly distributed across the States as well as rural and urban areas.

According to the Sample Registration System (SRS) based data of the Registrar General and Census Commissioner of India, in 2018 the national IMR stood at 32; it is 36 for urban areas and 23 for rural areas and 22 for males and 23 for females.

Among the States/UTs, Kerala has the lowest IMR, i.e., 7 deaths and Madhya Pradesh has the highest IMR, i.e., 48 deaths per thousand live births in 2018. Kerala could lower IMR because it mainly focused on human resource development and made adequate provisions of health and educational facilities. India's IMR in 2021 is **28.771** deaths per '000 live births that shows a **3.61% decline** from 2020. Like IMR another important measurement is CMR that is used to know the status of early childhood.

10.2.2 Child Mortality Rate

The child mortality rate, also, under-five mortality rate, refers to the number of deaths per '000 live births of children between the birth and not exactly five years of age. It encompasses neonatal mortality, post-neonatal mortality and infant mortality. Neonatal mortality denotes the number of deaths per '000 live births of children aged under-28 days. Post-neonatal mortality is defined as the number of deaths per '000 live births of children aged between 28 days and one year. The trend of child mortality rate in India has shown a decline over the past few decades.

As per the NFHS-4 (2015-16) the child mortality rate has declined to 50 deaths per '000 live births of children aged under-five years in 2015-16 whereas infant and neonatal mortality rates are 41 and 30 respectively. Male child mortality rate (MCMR) is 52 and female child mortality rate (FCMR) is

48. Uttar Pradesh has the highest CMR, i.e., 78 deaths and Kerala recorded the lowest, i.e., 7.1 deaths per thousand live births of children under-five years.

The following table shows the early childhood mortality rates in rural India:

Table 2.1: Early Childhood Mortality Rates

(Neonatal, Post-neonatal, Infant, Child and under-Five Mortality Rates for Five-year Periods Preceding the National Family & Health Survey, 2015-16)

Years Preceding the Survey	Neonatal Mortality	Post-neonatal Mortality	Infant Mortality	Child Mortality	under-five Mortality
Years	(NN)	(PNN)	(1q0)	(4q1)	(5q0)
0-4	33.1	12.4	45.5	10.7	55.8
5-9	35.5	13.4	48.8	13.1	61.3
10-14	36.5	14.9	51.4	15.4	66

Source: NFHS-4 (2015-16).

There are several factors that cause infant and child mortalities in India. Major factors are given below.

- 1) **Lack of Availability of Doctors:** There is one government doctor for every 10,189 people whereas WHO recommends a ratio of 1:1000.
- 2) **Huge illiteracy:** According to UNICEF, children born to the mothers with at least 8 years of schooling have 32% less chances of dying in the neonatal period as compared to illiterate mothers. India has a huge number of illiterate women/mothers.
- 3) **Poverty:** The higher IMR and CMR are seen in the poorer States of the north, central and eastern regions of India. It signifies a connection between poverty of families and mortality of children.
- 4) **Neonatal Infections:** As per the NFHS-4, 2015-16, 21% infants who are born outside medical facilities have higher chances of infections.
- 5) **Non-acceptance of Girl Child:** Patriarchal societies like India do not accept girl child easily.
- 6) **Poor Vaccine Compliance:** 33 lakh children continue to miss out some or all vaccinations every year, making a probability for children's morbidity and mortality.
- 7) **Malnutrition of Mothers:** 58% of breastfeeding mothers and 50% pregnant women are anemic, contributing to poor health and nutrition of children.
- 8) **Poor Health Expenditure:** From 2009-10 to 2018-19, India's public health spending has increased only by 0.16 percent points, which is quite

low in size. For providing better health services expenditure on health has to be increased substantially.

- 9) **Underage Mothers:** IMR and CMR are found higher among the mothers aged under-20 years, which adversely affects health of their children.
- 10) **Policy-related Intervention Failures:** Many-a-times, set targets are not achieved as seen in the case of National Rural Health Mission, launched in 2005, where the target was to bring down IMR to 30 deaths per '000 live births by 2012, but it could be achieved in 2019 only, after a delay of 7 years.
- 11) **Nutritional Deficiencies:** Nutritional deficiencies make child weak and reduce his/her years of survival.
- 12) **Proneness to Communicable Diseases:** Due to less immunity, children are more prone to communicable diseases.
- 13) **Lack of Health Awareness:** People are not aware about health and its related complications. So they do not take proper health measures for children.
- 14) **Poor Sanitation:** Consumption of contaminated foods and drinking water and less hygienic living conditions are a common and major cause of high IMR and CMR.
- 15) **Premature Birth and Low Birth Weight:** Infants born premature and with low birth weight have less chances of survival and such births significantly take place, due to lack of parents' awareness about child's health.
- 16) **Birth Asphyxia:** It is one of the causes of mortality among children.

In spite of these factors being present, IMR and CMR in India have, though at a slow pace, shown a continuous decline from 1990s onwards for several reasons. Major ones of them are given below:

- 1) **Countrywide quality health service coverage** has been carried out over different intervals of time.
- 2) **Assistance in cash** is being given to the Below Poverty Line (BPL) people and tribal women.
- 3) **Improved awareness level** has emerged among parents in rural areas, as well.
- 4) **Improved health services** have been made available to pregnant women.
- 5) People have got **access to more health centers** in the rural and nearby areas.
- 6) **Improved road infrastructure and technological assistance** have contributed specially to rural people's access to health services.
- 7) **Service of free ambulance** has been a boon to rural and far-flung areas to avail emergency medical services.

- 8) **Toll-free telephone number** has also facilitated rural and poor people to avail required health services.
- 9) **Availability of medical facilities for 24x7** has contributed to ease of availing health services.

Leading a wrong and unhealthy lifestyle costs health. It invites several health problems, as well. Many children also suffer from various diseases, due to multiple reasons. Let us discuss them.

10.3 HEALTH PROBLEMS AMONG CHILDREN

Major health issues among children in India are discussed below:

- **Gastroenteritis-** It is an infection of digestive system. The symptoms of this commonly found childhood illness are diarrhea, nausea, vomiting, tummy cramps and fever. It can cause dehydration, too. Proper medical attention is necessary if a child is suffering from this health problem.
- **Conjunctivitis-** It is caused due to inflammation of the conjunctiva which is the outermost layer of an eye and the inner surface of the eyelids. Its symptoms include redness, irritation and watering in eyes. It usually starts with one eye and gets spread to another one. Medical attention is necessary to cure the problem of conjunctivitis.
- **Scabies-** It is a skin infection caused by tiny insects called mites which burrow into skin, lay eggs and become adult, soon. Its symptoms include superficial burrows, rash and severe itching, blisters on palms and feet soles. It is highly contagious disease for children. Proper medicine is needed for children suffering from scabies.
- **Upper Respiratory Tract Infection (URTI) -** It is caused due to air pollution and vehicular emission. Its symptoms include common cold, influenza and sore throat. Tonsillitis is one of upper respiratory tract infection. So, children suffering from URTI need to avoid going into polluted air.
- **Tuberculosis-** Children aged under-two years are more prone to it. The early signs of tuberculosis are fever, chill and loss of appetite. Proper medical advice is needed for a complete cure of tuberculosis.
- **Typhoid-** It occurs due to poor sanitation. In rural India it is commonly found in children. Its symptoms include poor appetite, body-ache, problems in abdomen, lethargic body, weakness, fever, diarrhea, headache, chest congestion and spots on abdomen. Its best prevention is proper vaccination of children at the right time.
- **Asthma-** In children, asthma usually occurs due to poor lifestyle. It can start at any age, even in an infant. The air pollution is also responsible for increasing cases of asthmatic children in India. Its symptoms include difficulty in breathing, especially in air pollution and presence of dust particles. Such children need inhaler to regulate their breath.
- **Eczema-** It is a skin problem which occurs due to poor lifestyle. Rashes

can be seen on the skin of the children suffering from eczema. Help of dermatologist is required to be taken in this illness.

- **Anxiety-** Modern lifestyle has made children more anxious. Among many psychological disorders they usually suffer from, anxiety is the most common.

The children suffering from anxiety are not able to control their psychological balance. It can also create eating disorders and mood disorders in the children. Parents' proper attention is necessary to stop anxiety in their children.

- **Cancer-** It is one of the widely found modern-day health problem in children. It is deadly disease which can take child's life, too. There are many types of cancer such as lung, skin, blood, etc. Proper medical treatment is necessary to cure cancer.
- **High Blood Pressure-** The poor lifestyle choices have made children to suffer from high blood pressure. Earlier, it used to be only adulthood health problem. Parents need to adopt healthy lifestyle for their children to keep them away from this menace.
- **Diarrhea-** It occurs due to lack of safe drinking water supply and dehydration in children. Its symptoms include fever, vomiting, loose motions, etc. Oral rehydration solution (ORS) or simply sugar-salt solution is quite effective in dealing with this health problem.

10.4 NUTRITIONAL NEEDS OF CHILDREN

An adequate, well-balanced and nutritious diet is crucial for healthy child, his/her better survival, proper growth and development. Usually, healthy children are more likely to be productive and ready to learn. To keep a child healthy, food in proper amount and with adequate nutritional value is necessary. Generally what we eat and drink can be referred as food. Healthy food is prominent at all stages of growth and development of a person but it is the utmost nutritional need of every child.

The following foods fulfill common nutritional needs of children:

1) **Body-building Foods- Proteins**

In nutritional terms, protein is one of the macronutrients that our body consumes in significant amount. It is basically used as fuel. Proteins are the nutrients that promote growth and repair tissues in addition to other functions in the body. A growing child needs more proteins during his/her physical and mental growth. Soya beans, groundnuts, grams, lentils, beans and peas constitute a good source of proteins and are less expensive whereas milk, meat, fish and eggs, also, though a good source of proteins, are comparatively expensive.

2) **Energy-giving Foods- Carbohydrates**

Like proteins, carbohydrates are one of the macronutrients. They are mainly

known as energy-giving foods that provide us strength to work hard. Children need more energy-giving foods, due to their growing body. Foods such as wheat, rice, *bajra*, *jowar*, *ragi*, potato, banana, etc. are a good source of carbohydrates.

3) Extra Energy-giving Foods- Fats

Fats are also one of the macronutrients. Foods containing fats give extra energy to body, especially children's growing body. Foods like jaggery, oil, *ghee*, dark chocolate, nuts, etc. are a good source of fats.

The following table informs us about the Acceptable Macronutrients Distribution Range (AMDR):

Table 2.2: Acceptable Macronutrients Distribution Range (AMDR) by Age of Physiological Group and Percent of Energy (%E)

Nutrient	Age Group	
	1-2 years	3-18 years
Protein (PE ratio)	5-15	5-15
Total Fat	30-40	25-35
Carbohydrate	40-60	45-65

Source: ICMR-National Institute of Nutrition (NIN) Expert Group on Nutritional Requirements for Indians, Recommended Dietary Allowance (RDA) and Estimated Average Requirements (EAR), 2020 Report.

4) Protective Foods- Vitamins & Minerals

Vitamins and minerals are the micronutrients, referred as protective foods. Their major function is to protect our body and fight against diseases. Children need proper protective foods; otherwise, their mental and physical growth is hampered. Foods like fish, dark leafy greens, seeds, broccoli, pork, beef, lamb, mushrooms, nuts, eggs, sweet bell peppers, avocados, peas, winter squash and fruits are a good source of various vitamins.

On the other hand, foods like nuts, shellfish, cruciferous vegetables, organs, meats, eggs, beans, cocoa, berries, yoghurt, cheese, starchy vegetables, tropical fruits, leafy greens, etc. are a good source of minerals. There are other minerals and trace elements, intake of which is required for a healthy body.

The following table gives the recommended intake of other minerals and trace elements:

Table 2.3: Recommended Intakes for Other Minerals and Trace Elements

S. No.	Mineral/Trace Element	Recommended Intake (per day)
1	Phosphorous	1000 mg
2	Sodium	2000 mg

3	Potassium	3500 mg
4	Copper	2 mg
5	Manganese	4 mg
6	Chromium	50 µg
7	Selenium	40 µg

Source: ICMR-National Institute of Nutrition Expert Group on Nutritional Requirements for Indians, Recommended Dietary Allowance (RDA) and Estimated Average Requirements (EAR), 2020 Report.

5) Water

Water is like a messenger in our body-system. It carries nutrients to cells and takes out waste and toxins. Our body is made up of water up to about 60-70 percent. In fact, 80 percent of brain is made of water and of liver about 7 percent is water. So, it is crucial to drink adequate water, especially for children.

6) Balanced Diet

Balanced diet contains all the nutrients in right amount as per one's age requirement. In childhood, proper/balanced diet is necessary to ensure good growth and development as children are what they eat. Generally, a balanced diet contains all the micro- and macro-nutrients and it is made up by mixing various food stuffs in appropriate proportions to meet the daily needs of body.

For people living in different climatic and ecological regions with different body-built, the dietary requirements also vary. Hence, one needs to take a balanced diet recommended by experts for the place s/he lives in.

In India, the Recommended Dietary Allowances (RDA) is computed by Indian Council of Medical Research (ICMR), which varies according to age, sex and activity of an individual. A report by the ICMR--National Institute of Nutrition (NIN) Expert Group on Nutritional Requirements for Indians containing a Recommended Dietary Allowance (RDA) and Estimated Average Requirements (EAR), 2020, has given a revised RDA for children. It is given in the table below:

Thus, it is really crucial for the growing children to have diets based on the RDA given by ICMR-NIN, 2020. The parents need to value the nutritional needs of their children; otherwise, they will suffer from the menace of nutritional deficiencies. A balanced diet is the best medium to ensure the proper development and adequate nutrition level in children.

Table 2.4: Summary of RDA for Indians, 2020

Type of Body	Age Group	Body Weight	Protein	Dietary Fiber	Calcium	Magnesium	Iron	Zinc	Iodine	Thiamine
		(kg)		(g/d)	(mg/d)	(mg/d)				
		(g/d)		(mg/d)	(mg/d)	(mg/d)				
Infants	0-6 m	5.8	8	-	300	30	-	-	100	0.2
	6-12m	8.5	10.5	-	300	75	3	2.5	130	0.4
Children	1-3y	12.9	12.5	15	500	90	8	3.3	90	0.7
	4-6y	18.3	16	20	550	125	11	4.5	120	0.9
	7-9 y	25.3	23	26	650	175	15	5.9	120	1.1
Boys	10-12y	34.9	32	33	850	240	16	8.5	150	1.5
Girls	10-12y	36.4	33	31	850	250	28	8.5	150	1.4
Boys	13-15y	50.5	45	43	1000	345	22	14.3	150	1.9
Girls	13-15y	49.6	43	36	1000	340	30	12.8	150	1.6
Boys	16-18y	64.4	55	50	1050	440	26	17.6	150	2.2
Girls	16-18y	55.7	46	38	1050	380	32	14.2	150	1.7

Source: ICMR- National Institute of Nutrition (NIN) Expert Group on Nutritional Requirements for Indians, Recommended Dietary Allowance (RDA) and Estimated Average Requirements (EAR) Report, 2020.

10.5 NUTRITIONAL STATUS

Quantitative or qualitative deficiency and, sometimes, inability to absorb the necessary nutrients lead to malnutrition. Rural Indian children's nutritional status is not quite satisfactory. A large number of them suffer from malnutrition that affects their physical and mental development. Inadequate nutritional level causes many nutritional problems in children.

Thomas Edison (1903) states, "The doctor of the future will give no medicine but will interest his patients in the care of the human frame, diet and in the cause and prevention of disease". However, we are still struggling hard to realise the true meaning of this statement, reasons of which in the Indian children's context will be clear to you after mapping their nutritional status hereunder.

1) Wasted, Stunted and Anaemic Children

In fact, India is one of the largest producers of milk, pulses, rice, wheat, sugarcane, groundnut, vegetables and cotton worldwide but almost 38.4 percent of the children aged under-five are stunted. The percentage of stunted children in 2019 dropped to 34.7.

Also, 7.5 percent weight is too low for their height, as per the report on 'The State of Food Security and Nutrition in the World' (2020).

Moreover, 58.6 percent children are anemic.

The following figure shows the percentage of stunted, wasted and anemic

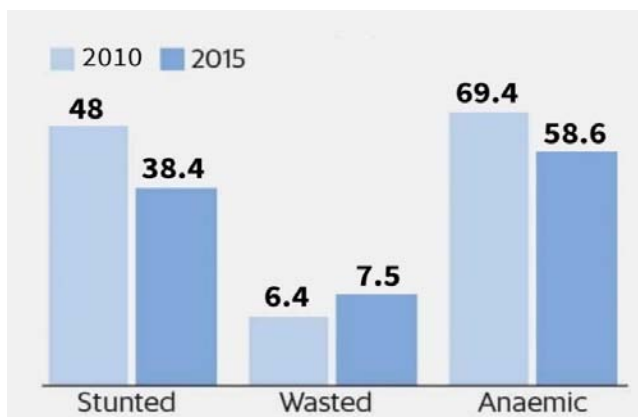


Figure 1: Stunted, Wasted and Anemic Children

Source: National Nutrition Month 2020: An Analysis of India's Nutritional Status.

- Anemia is a serious concern for women as it can be the reason for maternal and infant death or premature delivery and low birth weight.
- In young children, anaemia can impair cognitive development and hamper behavioural, motor & scholastic development.
- It increases the risk of infectious diseases.
- Wasted and stunted children also face many problems related to growth and development.

2) Malnourished Children in Different States

- As per the National Family & Health Survey-4 (2015-2016), 35 percent of malnourished children are below the age of five years.
- Bihar and Uttar Pradesh have the highest number of malnourished children.
- In Madhya Pradesh, 42 percent children under-five years are malnourished.
- Kerala, Goa, Meghalaya, Tamil Nadu and Mizoram have better percentage of children in term of nutritional level.
- The 2020 Global Hunger Index (GHI) Report by IFPRI ranked India 94th out of 107 countries with a serious hunger situation.

3) Undernourished Children

- The joint report prepared of the Food and Agriculture Organisation of the United Nations (FAO), the International Fund for Agricultural Development (IFAD), the United Nations Children's Fund (UNICEF), the UN World Food Programme (WFP) and the World Health Organisation (WHO) informs that the number of undernourished people in India has decreased from 249.4 million in 2004-06 to 189.2 million in 2017-19.

- Further, the numbers of breastfed infants, aged 0-5 months, increased from 11.2 million in 2012 to 13.9 million in 2019. The number is still not very satisfactory.
- Undernutrition is most dangerous among the children aged 12 to 35 months.

4) Nutritional Status during Covid-19 Pandemic

- The Covid-19 pandemic has affected children's nutritional .
- Children could not get their share of mid-day meal from school, due to lock-downs.
- Supplementary nutrition for ICDS projects in rural areas through Anganwadi Centres also got disrupted, to a larger extent, in 2020.
- A study published in the Journal of Global Health Science on July 16, 2020, reveals that over 5 million children were at the risk of coming into the category of the wasted or malnourished.
- It further informs that in 2020, two million children were at the risk of being included in the category of severe wasting.

10.6 COMMON NUTRITIONAL PROBLEMS/DEFICIENCIES

- **Protein-Energy Malnutrition (PEM)**

This malnutrition generally affects the children, aged from 6 months to 5 years. Of many short-term and long-term mental and physical effects it leads to, Marasmus and Kwashiorkor are two major diseases. Marasmus, resulting from prolonged starvation, muscle degeneration, thinness of limbs and abdominal wall, mainly occurs in the babies, aged below one year. Sufficient breastfeeding is the best cure for Marasmus.

On the other hand, Kwashiorkor occurs mainly due to the deficiency of amino-acids. Its common symptoms include diarrhea, mental laziness, decreased pigmentation, hair changes, etc. It usually affects children of 1 to 4 years. As in the case of Marasmus, breastfeeding is quite effective in its treatment, as well.

- **Iron Deficiency/Anaemia**

Iron is present in foods of animal and vegetable origins. Anaemic children have deficiency or low level of iron. To cure this, iron supplements are needed. Anemic children are usually weak and have low stamina. WHO's estimates that in India anaemia prevails in 65-75% of pregnant women.

- **Iodine Deficiency Disorder (IDD)/Goiter**

Lack of iodine which is an important micronutrient causes Iodine deficiency disorders. Children with these disorders have generally retarded psychomotor development, speech & hearing impairments and mental retardation. IDD is

prevented by a regular consumption of iodized salt.

- **Vitamin-A Deficiency**

Deficiency of Vitamin-A causes a preventable blindness in young children and high death rates of infants and young children. The foods like green and yellow vegetables and fruits, carrots, pumpkins, mangoes, papayas and red palm oil are rich in Vitamin-A.

- **Obesity**

Excessive intake of calories makes a child overweight, causing obesity. Interactions between genetic, neuroendocrine, metabolic, psychological, environmental and socio-cultural factors are responsible for childhood obesity. The adverse outcomes of obesity are hypertension, diabetes, menstrual disorders, liver disorders, depression, etc. Dietary management is helpful in reducing obesity.

- **Rickets**

Occurring due to deficiency of Vitamin-D mainly in the children of the first two years this disease has common symptoms like sleeplessness, pale face, diarrhea, skull deformities, bow-legs and deformities in ribs & spine. Proper intake of Vitamin-D can cure it.

- **Scurvy**

Caused by deficiency of Vitamin-C this disease has major symptoms like weakness, sore arms & legs, decreased red blood cells, gum diseases, changes in hairs and bleeding from skin. Supplementary intake of Vitamin-C is crucial to cure it.

10.7 POLICIES AND PROGRAMMES

Improving health and nutritional status of children is prominent for a nation. So India is also trying in every possible way to ensure good health & nutrition of its children through various policies and programmes. Let us discuss some of them.

- **NetSCoFAN-** Launched in 2019 by Central Ministry of Health & Family Welfare, it is a network of research and academic institutions working in the area of food and nutrition.
- **Social Awareness and Action to Neutralise Pneumonia Successfully (SAANS)** - Launched in 2019 by the Ministry of Health and Family Welfare it aims to reduce child mortality caused by pneumonia.
- **Intensified Mission Indradhanush (IMI) 2.0-** Started by the Government of India it aimed at accelerating the coverage of **children and pregnant women in the identified districts and blocks from December 2019 to March 2020.**
- **National Digital Health Blueprint-** Launched in 2019 by the Government of India, it aims to create National Digital Health Eco-

system which lays out the building blocks for implementation of National Health Stack (NHS) to make possible Artificial Intelligence in leveraging health records.

- **Poshan Abhiyaan 2018-22-** Launched by the Prime Minister, Shri Narendra Modi, in Jhunjhunu, Rajasthan, in March 2018, it mainly aims to ensure holistic development and adequate nutrition for pregnant women, mothers and children. It is multi-ministerial convergence mission with a vision to make India free from malnutrition by 2022. The Ministry of Women and Child Development is playing a major role in its implementation.
- **Pradhan Mantri Matru Vandana Yojana (PMMVY):** It is basically a maternity benefit scheme of is a conditional cash transfer for pregnant and lactating women of 19 years & above, implemented by the Ministry of Women and Child Development in 2017. It is basically. It mainly aims to provide conditions for safe delivery and nutrition & feeding practices.
- **National Crèche Scheme-** Initiated by the Ministry of Women and Child Development in 2017, it is an intervention to help working mothers and provide protection to children, aged from 6 months to 6 years.
- **Pradhan Mantri Surakshit Matritva Abhiyan-** Introduced in 2016 by the Ministry of Health and Family Welfare, it is a fixed-day strategy, in which on 9th day of every month every pregnant woman gets at least one checkup in the 2nd/3rd trimester of pregnancy at the Pradhan Mantri Surakshit Matritva clinics. It includes quality maternal health services which are envisaged to be provided as part of antenatal care.
- **National Deworming Day:** It was initiated by the Ministry of Health and Welfare in the year 2015 to combat soil-transmitted infections in children with a dose of Albendazole to children.
- **India Newborn Action Plan (IANP)** was launched in 2014 with the goal of eliminating single digit neonatal mortality rate and single digit still-birth rate by 2030.
- **Mission Indradhanush** started in 2014 by the Government of India to fully immunize more than 89 lakh children who were left out of vaccination.
- **National Health Mission (NHM) -** Started by the Government of India in 2013 it comprises two sub-missions: National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). It is mainly aimed at strengthening the rural and urban health systems for improving reproductive, maternal, neonatal child and adolescent health (RMNCH+A) and also providing equitable affordable and quality health care services. Its targets are to reduce MMR to 1/1000 live births, IMR to 25/1000 live births and TFR to 2.1.
- **Rashtriya Bal Swasthya Karyakram (RBSK)-** Launched in 2013

under the National Health Mission for health screening of children aged 0-18 years this programme mainly aims at detecting birth defects, diseases, deficiencies, development delays and others problems.

- **Iron and Folic Acid (IFA)** supplementation was started in 2012 by the Ministry of Health and Family Welfare to prevent anaemia.
- **Janani Shishu Suraksha Karyakaram (JSSK)** was launched in 2011 by the Government of India to improve infant health.
- **Janani Suraksha Yojna (JSY)** was started in 2005 under the National Rural Health Mission to improve pregnant women's health.
- **Promotion of Infant and Young Child Breastfeeding** practices has been operated by the Ministry of Women and Child Development since 1993.
- **Wheat Based Supplementary Nutrition Programme** is a centrally-sponsored scheme, started in 1986, to provide supplementary nutrition to children and popularize wheat intakes.
- **Pulse Polio-** It is an immunisation campaign operated by the Government of India, since 1985, to completely eradicate polio in India by vaccinating all children aged under-five years .
- **Universal Immunisation Programme (UIP)** was started by the Government of India in 1985 to provide vaccination to each child against various diseases.
- **ICDS-** Launched in 1975 by the Government of India this programme consists of supplementary nutrition, immunisation, health checkups, referral and education services for the children.

Special Nutrition Programme (SNP)- It was started in 1970-71 for children under-6 years and expectant & nursing mothers by the Central Ministry of Social Welfare.

10.8 LET US SUM UP

Children are the future of a nation. When it is the matter of rural children's health and nutrition, infant and child mortality rates become a more serious concern . Rural children face various health problems for multiple reasons. Their various nutritional needs remain unfulfilled, causing a low nutritional status. Also, they suffer from common nutritional deficiencies. Various policies and programmes implemented for improving children's health and nutritional status have made much impact on their situation; yet, India still has to tread a long way ahead to make its children safe.

10.9 KEY WORDS

IMR: The number of deaths per '000 live births of children under-one year of age.

CMR: Also, under-five mortality rate, refers to the number of deaths per '000 live births of children aged between birth and under-five years. It

encompasses neonatal mortality, post-neonatal mortality and infant mortality.

Neonatal Mortality Rate: The number of deaths per '000 live births of children aged under-28 days.

Post-neonatal Mortality Rate: The number of deaths per '000 live births of children in the age between 28 days and one year.

10.10 SUGGESTED READINGS

ICMR--National Institute of Nutrition (NIN). (2020). Expert Group on Nutritional Requirements for Indians, *Recommended Dietary Allowance (RDA) and Estimated Average Requirements (EAR), 2020 Report*.

National Family Health Survey (NFHS)-4 (2015-16).

Pande, R. P. (2003). 'Selective Gender Differences in Childhood Nutrition and Immunisation in Rural India: the Role of Siblings'. In *Demography*, 40(3): 395-418.

Sample Registration System Bulletins, Government of India.



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UNIT 11 EDUCATION OF RURAL CHILDREN

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11.0 AIM AND OBJECTIVES

This unit aims at familiarizing you with the educational status of children in rural India. After going through this unit, you will be able to

- describe current educational situation of rural children
- enumerate key provisions under various programmes of education for rural children
- understand importance of early childhood care and education and the present provisions for it
- discuss some major concerns for education of rural children

11.1 INTRODUCTION

Learning gives creativity, creativity leads to thinking, thinking provides knowledge and knowledge makes you great- Dr. A.P.J Abdul Kalam

Education is the foundation of every human life. It begins one's journey towards enlightenment. In the Constitution of India the Directive Principles of State Policy provide for universalisation of elementary education (UEE) and proclaim, "The State shall endeavour to provide, within a period of ten years from the commencement of this Constitution, for free and compulsory education for all children until they complete the age of fourteen years" (Article 45). Right of Children to Free and Compulsory Education Act 2009, also, popularly known as the Right to Education (RTE) Act 2009, enacted by the Parliament of India on 4th August 2009, outlines importance of free and

compulsory education for children aged 6-14 years under the Article 21 (A) given in the Constitution's Part III. This Act which came into force on April 1, 2010, set an obligation on the State to provide free and compulsory education to children in the age of 6 - 14 years in a neighbourhood school. Under these provisions, education, particularly early education, got primacy and has become an important item on the national agendas for the successive Central and State governments. After Independence, India has implemented various programmes for education of children, including rural children; however, they have not been successful to bring a large proportion of rural children into the fold of formal schooling. This unit deals with these efforts for and issues in education of children, especially rural children. Let us take account of initial attempts for universalisation of education in India.

11.2 INITIAL EFFORTS FOR UNIVERSALIZATION OF EDUCATION

Attempts for universalisation of education through legislation, programmes and policies were initiated in the decades soon after Independence. Universalisation of elementary education and its target was set up in 1966 by the Kothari Commission which proposed to achieve this goal by 1986. This target remained pending and in 1986 the National Policy on Education articulated the goal to ensure that by 1990 all children aged 11 years would have completed five years of formal or non-formal education (Mehta 1994). Much of these targets remained yet to be achieved, particularly in parts of rural India.

National Policy on Education in 1986 set the stage for the Central Government to play an increasingly important role in primary education. It explicitly recognized the need for a concerted effort to expand and improve basic education, ie, formal and non-formal, and primary and adult literacy education. At primary school level, the policy gave priority to reducing disparities in enrolment of girls and students from the scheduled castes and scheduled tribes. To implement the policy, the Department of Education, Government of India, created a set of centrally sponsored grant schemes to assist the States in development of basic education. Let these be discussed here.

- **Operation Blackboard (1986):** The scheme provides grants to the States to construct buildings and provision for additional teachers in single-teacher schools, requiring that half the teachers posted be women.
- **District Institutes of Education and Training (DIET), 1988:** The Department of Education established a scheme to finance creation of institutes of education and training in all rural districts by converting existing teacher training institutes and constructing new ones.
- **Total Literacy Campaign (1988):** After an unsuccessful attempt to provide adult literacy instructions, along with vocational skills' training through formal classes, the Department of Education turned to total literacy campaign to increase adult literacy.

- **Minimum Levels of Learning (1989):** Inappropriately complex and difficult primary curricula and textbooks were recognized as a barrier to learning and a factor in pupil's decision to drop out. To address this problem, the Department of Education initiated a national basic competency in language, mathematics and social and environmental studies to be taught in the primary grades, known as minimum levels of learning.

In 1992 the Central Advisory Board of Education (CABE), revising the National Policy on Education of 1986, called for an integrated approach to primary education's development focused at the district level. Its outcome has been the District Primary Education Programme (DPEP), the most intensive effort by the Central Government to increase enrolment, retention and quality of primary education.

The programme has been strengthening community and school organisations and replacing Operation Blackboard materials approach with grants to these organisations and to teachers for purchase of the materials. It also enhanced the state education support programmes, including textbook development and publication, planning and management, research and evaluation, and teacher training. In 2001, 46 per cent of female population and 24 per cent of male population in India, aged seven and above, were unable to read or write. There were large disparities between regions of the country. While the female literacy rate in rural Kerala was more than 90 per cent, only 44 per cent of persons aged seven and above in rural Bihar and 46 per cent in rural Jharkhand could read and write. In Rajasthan the situation was only slightly better with rural literacy being 56 per cent

In many villages and urban areas, barriers to attend school regularly were even higher for certain groups of children, particularly working and street children, children belonging to ST and SC communities and children with special needs. In Madhya Pradesh, 30,000 habitations, mostly inhabited by deprived communities, were without schooling facility when DPEP decided to pool together human and financial resources to ensure that the gap in access to and enrolment for education is bridged.

Community participation has been the mainstay of DPEP interventions. Under DPEP, there have been opened new child-friendly schools and classrooms and designed specific interventions to reach children of disadvantaged sections with the active support from the community. The role of Parent-Teacher Associations, Village Education Committees and other community groups has been commendable to enrol children and ensure their regular attendance in classes regularly. These community groups have shown great potential to transform themselves into vehicles of overall development for the village as a unit in itself.

After having accounted initial efforts for children's education, let us know about implementation of the Right to Education.

11.3 RIGHT TO EDUCATION (RTE) AND ITS TRAJECTORY

Right of Children to Free and Compulsory Education, 2009, came into force on April 1, 2010. The Act makes an obligation on the State to provide free and compulsory education to children in the age of 6-14 years in a school in their neighbourhood. Sarva Shiksha Abhiyan (SAA) is the flagship programme and primary vehicle, started in 2001, to implement the Act and achieve the goal of universal education. The following are salient features of the Act:

- The Act mandates unaided and non-minority schools to reserve 25% seats for underprivileged children to be admitted through a random selection. The fees of these students would be reimbursed by the Government.
- It mandates that “No child can be held back, expelled and required to pass the board examination till the completion of elementary education”. This ‘no-detention policy’ was implemented to retain the children in schools. However, the policy was reviewed recently and it discarded by enacting the Right to Free and Compulsory Education (Amendment) Act 2019.
- It lays down the norms and standards of Pupil-Teacher Ratio (PTR) of 1:30, buildings and infrastructure, school working days, teachers’ working hours, ramps for students with disabilities, provision of drinking water and availability of playground, etc. The Act also provides for appointment of appropriately trained teachers. It clearly lays down norms and standards of teachers’ qualifications and training.
- The Act specifies duties and responsibilities of appropriate Government and local authority to provide free and compulsory education and to share financial and other responsibilities between the Central and State Governments.

Let us see the role of SSA in implementation of RTE.

11.3.1 Sarva Shiksha Abhiyan (SSA)

The Centrally-sponsored Sarva Shiksha Abhiyan (SSA) has been the vehicle to ensure successful implementation of RTE- 2009 with the aim of universalizing elementary education. The main goals, with which SSA was envisaged, include enrolment of all children in school, bridging of gender and social category gaps in enrolment, retention and learning and ensuring a significant enhancement in the learning achievement levels of children at the primary and upper primary stages.

The SSA has made significant progress in achieving near universal access and equity. National University of Educational Planning and Administration (NUEPA) annually collects information in the form of Unified District Information System for Education (UDISE) on various educational indicators.

As per UDISE 2015-16, enrolment in elementary schools has increased to 19.67 crore children from 18.78 crore children in 2009-10. The number of out-of-school children in the age of 6-14 years has significantly reduced from 134.6 lakh in 2005 to 81 lakh in 2009 and, further, to 61 lakh in 2014.

The annual average dropout rate at primary level has come down from 9.11% in 2009-10 to 4.13% in 2015-16.

The transition rate from primary to upper primary has gone up from 83.53% in 2009-10 to 90.14% in 2015-16.

The Pupil-Teacher Ratio (PTR) has improved from 32 in 2009-10 to 24 in 2015-16.

These figures give an encouraging report of the improved status of early education amongst children and also indicate some levels of formal schooling being accessed by children in the bracket of 6 - 14 years across India's States.

The primary objective of the Act is to ensure equal opportunity for basic education for all children, irrespective of their socio-economic status. This objective is supported through a robust legislative action that has made education for all children a fundamental right and a legal and constitutional obligation upon the Government.

Public policy with legislative support and periodical reviewing performs well and shows good results. Early education has been such an important arena of work in India since Independence. Till date new methods of learning, upgrading pedagogy, training to perform beyond the traditional chalk and talk methods and engaging with tools of digital teaching and learning have made a positive effect on education of children across the States of India.

11.3.2 The Present Educational Scenario

Some surveys conducted by the state and central governments reflect the present situation of education in rural India . The most recent survey, 8th All India School Education Survey (AISES), conducted by the National Council of Educational Research and Training (NCERT) reports a good progress of early schooling facilities in rural areas which can be read from the figures given in the Box No. 1. The 8th AISES was an elaborate exercise conducted at the national level with harmonious coordination between three organisations: Union Ministry of Human Resource Development (MHRD), National Council of Educational Research and Training (NCERT) and National Informatics Centre (NIC). MHRD provided funds and administrative support for its efficient execution. NCERT shared the responsibility of providing all academic inputs, management and coordination of activities right from planning of the survey to dissemination of outcomes/reports. NIC was responsible for all computerisation activities of the survey and their coordination.

Primary Stage Schooling Facility in Rural Areas

The most recent figures of 8th All India School Education Survey (AISES) reveal that of **the total 11,37,833 habitations** in the country, 10,37,833 (91.21%) habitations have primary education facilities within a walking distance of 1 km.; including 7,54,406 (66.30%) habitations which have these facilities within them . Of **the rural population**, 83,68,82,700 (96.19%) people have access to primary stage education facilities within a walking distance of 1 km., including 73,76,75,159 (84.79%) people which have these facilities within the habitation itself. The facilities have been extended now to a larger number of habitations either within them or up to a distance of 1 km.

Habitations predominantly populated by Scheduled Castes (SCs) – habitations having 50% or more Scheduled Caste population- have been termed as ‘predominantly populated by Scheduled Caste (SCs) habitations’. There are 1,81,753 SC habitations in the country, showing their growth of about 4% from 1,74,700 habitations at the time of 7th Survey. Of the total SC habitations, 1,65,884 (91.27%) habitations have primary stage education facilities within a walking distance of 1 km.; including 1,16,144 (63.90%) habitations having these facilities within the habitations itself. Of the **rural SC population**, 12,51,09,500 (96.01%) people have access to primary stage education facilities within a walking distance of 1 km., including 10,75,89,646 (82.57%) people who have these facilities within their habitations.

Habitations Predominantly Populated by Scheduled Tribes (STs)- habitations having 50% or more Scheduled Tribe population have been termed as ‘predominantly populated by Scheduled Tribe (ST) habitations. There are found 1,98,493 ST habitations in the 8th Survey while their number was 2,42,993 at the time of 7th Survey, showing a decrease of 22.4% in the habitations at the time of the 8th survey. 1,77,929 (89.64%) habitations predominantly populated by ST have primary stage education facilities within a walking distance of 1 km., including 1,36,699 (68.87%) habitations having these facilities within them only. Of the **rural ST population**, 7,85,11,204 (95.49%) people have access to primary stage education facilities within a walking distance of 1 km., including 7,00,49,967 (85.20%) people who have these facilities within their habitations.

Box 1- Source: 8th_AISES_Concise_Report.pdf

Notably, the 8th AISES Report signals a positive shift in rural education and its access for children across different states. About 96 % of rural population have access to primary stage education facilities within one kilometre of their habitation or place of living. Enrolment in schools depends not only on access but also on availability of associated/ancillary facilities within school premises like drinking water, toilet facilities, electricity connection and playground.

The report informs that about 87% of the government-run primary schools in rural areas have drinking water facilities in their premises. Several states are

yet to be able to provide urinal and lavatory facilities within school premises and electricity connection in primary schools in rural areas. The availability of toilets with running water is an important factor that directly impacts upon enrolment of girl students in the institutions of early education.

Though several factors still await attention of the states, the overall enrolment in primary schools bringing children into the fold of formal schooling in rural areas has shown a significant progress in the last few years. Before we proceed to know about early childhood care and education, let me check your progress.

11.4 EARLY CHILDHOOD CARE AND EDUCATION

Providing children with optimal opportunities to grow and develop is acknowledged by nations as a strategy of human resource development and an important facet of their national development. It is also well-acknowledged that investment in young children, especially in the first six years, shows immediate results and long-term benefits. Therefore, most countries have taken up policy initiatives, services and concrete programmes to safeguard development of the young child.

We need to know how this vast child population living in different settings and often different circumstances can develop and how to provide inputs to ensure children's optimum development. National Policy on Education (NPE), way back, in 1986, included Early Childhood Care and Education (ECCE) among its priorities. It viewed ECCE as an important 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 of disadvantaged sections in the society. The activities which foster and promote balanced development of a child in the age group of 0 – 6 years in all dimensions – physical, mental, social, emotional and moral--have been collectively described as Early Childhood Care and Education.

While the early years are important, the experiences that a child undergoes in the early years determine outcome of this stage of development. Though biological factors establish a timetable for the process of development the process is not passive; rather it interacts with the environment to provide experiences to the child. It is thus the process that determines what sort of development is to take place.

Children are endowed with a natural curiosity that propels them to explore the environment as well as the ways in which they can act on it. This tendency to explore is sustained by a kind of internal feedback system that provides them with a sense of inner competence and supports children to move on to achieve the next developmental stage. Learning from visual and audible experiences is the predominant mode of learning in the early years when other ways are still being developed. The environment provides opportunities for all-round development of the child and optimises the development gains. This comprehensive understanding of development has remained central to ECCE.

With its holistic approach, ECCE provides for development of all aspects of a child. Its content, in addition to the vital and central inputs of health care and nutrition, is a programme of structured and unstructured play activities and play materials and learning experiences which promote social, emotional, mental, physical and aesthetic development of the child. Existing ECCE Programmes in India include

- Integrated Child Development Services (ICDS).
- *Balwadis*, crèches, day-care centres and early childhood education centres run by voluntary agencies with financial assistance from the Government.
- Pre-primary schools and classes run by municipal and local authorities and State Governments.
- Crèches run by employers (mandatory under existing labour legislation).

NPE emphasised the Integrated Child Development Services (ICDS) programme as the major vehicle for achieving the goals of ECCE. Let us see what the RTE tells about ECCE services.

11.4.1 Right of Children to Free and Compulsory Education Act

The Right of Children to Free and Compulsory Education Act 2009, popularly the Right to Education (RTE) Act, which came into effect from April 1, 2010, was a progressive step in India. However, while implementing it, the policy makers left ECCE out, ie, children of under- 6 years could be benefitted as it covered the children of 6 to 14 years (Chopra 2015). It is well-known that a strong foundation of elementary education and issues of availability and accessibility of meaningful education can be built only on a strong foundation of ECCE in the country. So, ECCE services still have a wide scope for improvement and much can be done in the years to come.

Some indicators that may help in policy making are given below:

- Access to ECCE:** ECCE is meant for very young children and so there are problems of making the service accessible to them. In fact, an ECCE centre should be located in or close to the local primary school because in any case it is mostly older siblings who look after young children. However, there are many places, particularly in difficult terrains, where even a primary school is too far for children to attend every day. It is necessary to think of alternative strategies in such cases.
- Content of ECCE:** Early introduction of formal teaching methods should be discouraged. Instead, emphasis should be on child-centred approach and play-way method. Keeping in view the regional and cultural diversities in India, flexibility in models for ECCE should be encouraged. The basic curriculum of ECCE should be translated into local content for wider access.
- Play Material:** Children learn through observation which should be encouraged. For play materials, adequate budget allocation for recurring

and non-recurring expenditure should be provided. Since most programmes suffer from financial constraints, it is important to develop low cost play materials/toys from waste and locally available material. For this, ECCE workers should be trained in toy making. Mere development of play materials is, however, not sufficient. The more important is the extent, to which it is provided to the children. For this, breakage and loss of equipment and play materials in ECCE centres should be viewed as normal and provision should be made for their periodic replacement. This would encourage the workers to allow the children make use of the materials and not to merely keep them as decoration pieces.

- iv) **Training of ECCE Workers:** Worker is the most crucial factor in determining success of the ECCE programme. In our given circumstances, training of ECCE workers assumes great importance. At present, most training programmes deal with mechanical coverage of a syllabus. The prerequisite for a good programme is first-hand experience in the field, supported by field guides. There should be continuity in training from pre-service to periodic in-service and on-the-job training.

11.5 NON-FORMAL EDUCATION

In India, there are still a large number of children who are unable to complete their education beyond primary schooling or to access to formal schooling, at all. So, some early efforts for non-formal education were initiated by the Central Government in 1978 in collaboration with the State governments and a large number of voluntary agencies. These initiatives were primarily meant for the children aged 9 - 11 years, considering that the fixed hours and rigidity of formal schooling are mainly responsible for the low attendance rates in rural areas.

Many children are engaged in household chores or in assisting their parents in agricultural fields and other income generating activities. So, they find it difficult to attend school regularly. Non-formal education, therefore, has been viewed as a practical and appropriate mode of imparting education to such children, as it allows them to progress at their own pace and study at a time convenient to them.

Let us take some examples of Non-Formal Education (NFE) to understand it better.

- **Alternative Schooling through Moktabs (Assam):** The strategy to use *moktab* schools for girls belonging to minority community, particularly in *Char* (riverine) areas, was initiated during 1995-96. Moktabs are selected based on two criteria: adequate number of out-of-school children, especially girls, in a particular village and academic qualification of the *jonab* (religious teacher in moktabs).

The selected moktabs should have more than 25 out-of-school children, including minimum of 15 girls and a matriculate *jonab*. After identifying *moktabs*, advocacy campaigns are organised involving Village Education Committees (VECs) and local religious leaders. The most difficult aspect

of this campaign is to convince the concerned *jonab* to conduct extra hours of non-formal education without any extra remuneration from DPED. An agreement is signed with the Village Education Committees (VECs) to formalise the process. Before beginning the teaching based on school textbooks, the willing *jonabs* are given an induction training to prepare them for teaching. Supervision of the centres is entrusted to VECs.

The Cluster Resource Centre Co-ordinators (CRCCs) provide regular academic support to the *jonabs*. Besides, Block Level Resource Persons also make periodic visits to the centres. The children are evaluated through an open evaluation system.

- **Nali-Kali– *Recipe for Joyful Learning*:** The Karnataka Government and UNICEF collaborated to create a virtual revolution in education in Mysore district. Nali-Kali has created a veritable revolution in classroom transactions. Nali-Kali or ‘joyful learning’ was started as an experiment in classroom transaction, spearheaded by teachers themselves.

It all began in Heggada Devana Kota Taluk in Mysore district. UNICEF prepared a micro-plan which included a survey of in-school and out-of-school children in the taluk, primarily an SC/ST constituency. In 1995, M N Baig, Education Officer in Mysore district, along with UNICEF and the Commissioner of Public Instructions, decided to revive the micro-plan and look into activity-based learning. They held a meeting with school teachers in the taluk. The local teachers sorted out some problems which they could tackle themselves. These included absenteeism of children who were involved in farm labour, unattractive curricula and teaching methods and lack of support at home.

To give a fillip to the cause of primary education the Government has been taking various initiatives, directed at different categories of stakeholders– the community, teachers and children. Some of the efforts have been successful and others needed more work.

- **Samudayadatta Shale:** This initiative was taken to enhance community participation. Teachers were expected to organise some events in school, which would offer scope for interactions with members of the community. The purpose was to generate discussion on educational issues at village level, leading to suggestions and solutions from the local community for different problems and challenges in relation to education. The effort did not work out the way it was planned. This initiative did not achieve desired results and was also not sustainable for both children’s parents and teachers.

Some lacunae that have been traced in functioning of the non-formal education centre include lack of flexibility and innovation- particularly in relation to teaching materials and methods, inadequate teacher training and weak monitoring and evaluation, irrelevant curricula and insufficient funds. These lacunae have to be dealt with by using some mechanism to reach out to children outside the formal education system.

Oriental Schools as per the 8th AISES

Sanskrit Pathshalas- There exist 715 Sanskrit *Pathshalas* which provide education at the primary stage. Of these, 78.60% are run by government/local body; 14.27% are private aided; 5.45% are private, unaided and recognised while 1.68% are private, unaided and unrecognised. There are 805 Sanskrit Pathshalas which provide education at the upper primary stage. Of these, 76.65% are run by government/local body; 17.02% are private aided; 4.97% are private unaided recognised while 1.37% are private unaided unrecognised. In 25 States/UTs, Sanskrit Pathshala facilities are available; however, 10 States/UTs have no Sanskrit Pathshala.

Maktabs and Madrasas Following the System of General Education- There are 711 Maktabs which provide education at the primary stage. Of these, 49.79% are run by government/local body; 14.63% are private aided; 25.74% are private, unaided & recognised while 9.85% are private, unaided and unrecognised. Out of total Maktabs, 82.96% are in rural area. A total of 87 Maktabs provide education at the upper primary stage. Of these, 57.47% are run by government/local body; 19.53% are private & aided; 16.09% are private, unaided & recognised while 6.90% are private, unaided & unrecognised. Of the total Maktabs, 82.63% are in rural area.

Box No. 2 - Source: 8th_AISES_Concise_Report.pdf

11.5.1 Alternative Schools

Alternative Schools set up in habitations with no schooling facilities within one km under the Education Guarantee Scheme (EGS) component of the EGS and Alternative and Innovative Education (AIE) scheme to provide education to out-of-school children are termed as Alternative Schools.

EGS schools in the States of Madhya Pradesh, Odisha, Uttar Pradesh, Maavadi in Andhra Pradesh, multigrade learning centers in Kerala, Shishu Shiksha Karamsuchi Kendras in West Bengal, contract schools in Maharashtra and Rajiv Gandhi Swarna Jayanti Pathshalas in Rajasthan are some of the examples of Alternative Schools. Alternative and Innovative Education (AIE) Centres are set up for very specific, difficult groups of out-of-school children for mainstreaming and learning.

Some of the examples of AIE Centres are seasonal hostels for migrating children, condensed bridge courses/back to school camps for mainstreaming out-of-school children and to achieve competencies appropriate for their age in a short period, residential camps/drop-in centres for street and slum children.

11.6 THE ROADMAP AHEAD

Universal primary education of good quality is the key to boosting socio-economic growth of the country. Completing a good-quality primary education and acquiring basic skills will be essential in enabling India's poor people to participate in growth and benefit from health and family welfare services. Better primary education for girls will help in development of the family, the community and the nation as a whole.

India has made substantial gains toward achieving education for all, envisaged in the RTE Act in 2009. But it still needs to address four overarching issues in education: access, efficiency, learning achievement and schooling efficacy along with working on review and reform of the on-going policies for education in rural areas. Let us explain these issues.

Access

Access to primary schooling across the States, without any social hierarchy and gender discriminations, is yet to be achieved. Differences among the States in respect of primary education coverage largely reflect differences in population growth trends. Children from the poorest families and rural girls are still struggling for their inclusion in formal schooling.

Efficiency

Rural dropout rates are higher than the national averages. Schools that are unable to provide basic infrastructure within their premises still exist in a large number. Playground and functioning toilets within school premises are factors as important as other education indicators.

Learning Achievement

Children who do reach the final year of lower primary school often have low learning achievement. For example, in a study conducted in 1991 in 23 states, the National Council of Educational Research and Training (NCERT) found that the average achievement on curriculum-based skill tests of arithmetic, reading, comprehension and spelling for a sample of 65,000 urban and rural students in Grade- IV was 46 per cent. The situation has not been very progressive and students, though promoted to upper class through continuous evaluation, still find it difficult to comprehend lower class curriculum when tested in strict exam modules.

The quality of rural schooling is often inadequate, as reflected in low levels of learning achievements and, at times, high dropout rates. Rural schools do not have adequate infrastructure; they lack water supply and sanitary facilities; their electricity connection is poor and they have an average floor space per pupil well below the norms.

Though India faces these challenges, yet it has achieved four major assets. The first one is an expanded primary education system that has put the basic elements of schooling within the reach of many children. Second, policy framework supported with strong legislative framework has exhibited significant commitment from the Central and State Governments. The third one is an innovative and well-structured reform programme aimed at strengthening primary education with the principal focus on improving the quality of schooling. Fourth, there is in place an educational research and development community that is increasingly engaged with the problems of primary education and its review.

11.6 LET US SUM UP

RTE Act has been able to bring improvement in the enrolment rate for the students in primary and upper primary schools. The gap of enrolment rate between boys and girls is consistently reducing but the figures differ significantly from one State to another, questioning the policy of 'education for all children'. In spite of improvement in enrolment rates, the quality of education is dismal. The learning outcome of the students is very poor. The quality of education is a cause of concern. Moreover, learning deficits seen in elementary school in previous years seem to carry forward as young people transit from being adolescents to young adults.

A consistent improvement has been in the basic infrastructure facilities in schools. The facilities of basic sanitation, drinking water and provision of separate toilets for boys and girls have improved since the enactment of the RTE Act. A new direction and way forward can be seen through the most recently adopted National Education Policy (2020) which has turned its focus on elementary education. After decades of concentrated efforts the goal of universal enrolment now seems to be achievable. However, there is need to focus on quality of education in the schools at primary and upper primary levels.

As these children will join the workforce and become part of demographic dividend in the decades ahead, there is need to focus on early childhood care and education (ECCE) within the ambit of RTE Act 2009 as proposed in the National Education Policy, 2020. Under the policy, the current structure of 10+2 is to be replaced by a new, 5+3+3+4. This will bring the hitherto uncovered age group of 3-6 years under the school curriculum, which has been recognized globally as the crucial stage for development of learning faculties of a child. The next decade is of crucial importance as it will set the stage for a major structural overhauling of the school system across the country. Let us hope for the best results for schools that shape young minds in the rural areas.

11.7 KEY WORDS

RTE: Right to Education has set an obligation on the Indian State to provide free and compulsory education to children in the age-group of 6-14 years in a school in their neighbourhood.

Elementary Education: It consists of two stages of formal schooling: Grade I to V and VI to VII.

Non-formal Education: The initiatives primarily meant for the out-of-school children aged 9 - 11 years, considering that the fixed hours and rigidity of formal schooling are mainly responsible for the low attendance rates in rural areas.

Alternative Education: Schools set up in habitations with no schooling facilities within one kilometre and also to provide education to out-of-school children.

11.8 SUGGESTED READINGS

Chopra, N. (2015). 'A Focus on Early Childhood Care and Education to Ensure Fulfilment of Right to Education 2009'. *Innovate Journal of Education*, 3(1), 7-9.

European Union and India. (2002). *No Boundaries for Learning*. New Delhi.

Metha, Arun C. (1994). *Education for All in India: Myths and Realities*. New Delhi: Kanishka Publishers and Book Sellers.

NCERT & UNESCO. (2003). *Different Approaches for Achieving EFA–Indian Experience*. New Delhi.

NCERT. (1998–99). *Sixth All India Educational Surveys (1993-94)*. New Delhi.

World Bank. (1997). *Primary Education in India*. A World Bank publication.

World Bank. (2003). *Snakes and Ladders– Factors That Facilitate or Impede Successful Primary School Completion*. Qualitative study commissioned by the World Bank.



UNIT 12 POLICIES, PROGRAMMES AND LEGISLATION FOR CHILDREN

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12.0 OBJECTIVES

After reading this unit, you will be able to:

- know provisions for children enshrined in the Indian Constitution;
- acquaint yourself with provisions made under the National Policy for Children; and
- highlight major programmes/schemes of children's well-being, specially of rural children.

12.1 INTRODUCTION

Directive Principles of State Policy in the Constitution of India and the National Policy for Children 1974 recognize and emphasise to address needs of young children as they are the foundation of the national human resource development. Integrated Child Development Services (ICDS) programme is a unique initiative of India and the world's widest coverage programme which offers an integrated package of services to mothers and children. The integrated cluster of services comprises mutually reinforcing components of health, nutrition, pre-school education and also an essential component of empowering women by educating adolescent girls and young mothers about

their health and nutrition. This unit aims at in- depth understanding of the ICDS programme and some other measures taken for development of children. Let's begin with Constitutional provisions for children.

12.2 CONSTITUTIONAL PROVISIONS FOR CHILDREN

The Constitution of India makes special provisions for children. After the Constitution (86th Amendment) Act enacted in 2009, the fundamental right to free and compulsory elementary education for all children in the age 6-14 years has been provided under the Article 21-A. The Article 23 under the fundamental rights prohibits employment of children in hazardous occupations like factories etc.

Besides, under the Directive Principles of State Policies the Article 39(e) asks the State to provide individuals with their right to be protected from being abused and forced by economic necessity to enter occupations unsuited to their age or strength. The Article 39(f) directs the State to guarantee protection of childhood and youth against exploitation and against moral and material abandonment. The Article 45 says that the State is to ensure the right to early childhood care and education of all children until they complete the age of six years.

Fundamental Duties in Article 51 A(k) bounds a parent or guardian to provide opportunities for education to his child or, as the case may be, ward between the age of six and fourteen years.

12.3 NATIONAL POLICIES ON CHILDREN

National Policy for Children 1974 acknowledges that economic and social environment in case of majority of children in India impeded their physical, social and mental development and special interventions were required to provide them equality of opportunity. It stressed on continuity of poverty alleviation and community development programmes and focussed on child-centred interventions to address the interrelated needs of children and women from disadvantaged communities.

National Charter for Children, 2003, intended to secure for every child an inherent right to be a child and to enjoy a happy and health childhood, to address root causes negating healthy growth and development of children and to awaken societal conscience to protect children from all forms of abuse.

National Policy for Children, 2013, affirmed the Government's commitment to the right-based approach to address children's all challenges including emerging ones. It set key priorities such as survival, health, nutrition, development, education, protection and participation and recognized them as every child's undeniable rights. This policy provided for formation of a National Co-ordination and Action Group (NCAG) under the Ministry of Women and Child Development to coordinate and implement the plan and monitor the progress with other Ministries concerned as its members.

So, National Plan of Action for Children, 2016, was formulated. It also focused on new and emerging concerns for children such as online child abuse, children affected by natural and man-made disasters, climate change, etc. Its strategies and action points largely drew upon the existing programmes and schemes of various Ministries/Departments.

Finally Draft National Policy for Children 2018 aims at bringing together children's various dimensions that include well-being, rights and obligations, protection, active participation, inclusion, creativity and leisure.

12.4 INTEGRATED CHILD DEVELOPMENT SERVICES (ICDS) PROGRAMME

ICDS is globally one of the largest and most unique community-based outreach systems for promoting early childhood care for survival, growth and development. It has covered many milestones since its inception in 1975. Based on directive principles and objectives of the policy on children 1974, the programme was launched on 2nd October, 1975, in 33 blocks across India. Over the years several schemes have been added to this programme, expanding the ambit of its services. After over four decades of its successful functioning this programme has prominently included the schemes like Anganwadi Services Schemes, Pradhan Mantri Matru Vandana Yojana, Poshan Abhiyaan, Schemes for Adolescent Girls, National Crèche Scheme and Child Protection Scheme and is collectively termed as the Umbrella ICDS.

12.4.1 Objectives, Target Groups and Services

The ICDS programme provides an integrated approach for covering basic services for improved child care, early stimulation and learning, health and nutrition, water and environmental sanitation, targeting young children, adolescent girls, and expectant and nursing mothers. It offers a powerful community-based outreach system that functions as the convergent interface between disadvantaged communities and government programmes, such as primary health care and education. It contributed to the achievement of major nutrition and health goals embodied in the national plan of action for children 1992 and national plan of action on nutrition 1995, continuing its efficient service schemes till date.

Objectives

Major objectives of the programme are as follows:

- Laying proper foundation for psychological, physical and social development of the child
- Improving nutritional and health status of children under the age of six years
- Reducing incidence of mortality, morbidity, malnutrition and school dropouts
- Achieving effective coordination of policy-implementation among various departments to promote child development

- Enhancing mothers' capability to look after the normal health, nutritional and development needs of the child through proper community education

Target Beneficiaries

Its target beneficiaries are women and children. The principal participants are children below six years, expectant and nursing mothers and women in the age group of 15 - 45 years who receive supplementary feeding, growth-monitoring and promotion, immunisation, health check-up, referral services, nutrition and health education, and early childhood care and preschool education. Besides, there covered other important supportive services like safe drinking water, environmental sanitation, women's development and education programme. Different target groups are provided a different package of services. Beneficiaries are selected after a comprehensive survey of all families in the area to ensure that the most deprived are covered under the programme.

Beneficiary Services

Under the scheme beneficiaries avail the following services :

- 1) Supplementary nutrition, immunisation, health check-ups and referral services to children below three years
- 2) Supplementary nutrition, immunisation, health check-ups, referral services and non-formal pre-school education to children between three and six years
- 3) Supplementary nutrition, immunisation, health check-ups and referral services, nutrition and health education to expectant and nursing mothers.
- 4) Nutrition guidance and health education for women in the age between 15 and 45 years.

12.4.2 Cluster of Services

In rural areas the focal point for delivery of these services is the Anganwadi Center. It is run with the help of the Anganwadi Worker, educated up to Standard-X and selected preferably from the same village. Depending on the nature of the project being rural/urban or tribal, an Anganwadi Centre serves a population of 1000 in rural or urban area and 750 in tribal area. Therefore, in a block of one lakh population there would be 100 Anganwadi Centers. For location of rural and tribal projects, priority is given to areas predominantly inhabited by scheduled castes/scheduled tribes, backward areas, drought-prone areas, nutritionally-deficient areas and areas poor in development of social services. In its implementation, the helper assists the Anganwadi worker. A supervisor supervises the activities of the center and reports to the Child Development Project Officer who is the overall in-charge of the programme implementation in a community development block.

The six services are provided in an Anganwadi Centre. These are given hereunder.

1) *Health Check-ups*

This service includes health care of children under the age of six years, antenatal care of expectant mothers and post-natal care of nursing mothers. The various health services, provided for children by Anganwadi workers and PHC staff, include regular health check-ups, recording of weight, immunisation, management of malnutrition, treatment of diarrhoea, de-worming and distribution of simple medicines, etc. At an Anganwadi centre, children, adolescent girls, pregnant women and nursing mothers are examined at regular intervals by a Lady Health Visitor (LHV) and an Auxiliary Nurse Midwife (ANM) who also diagnose minor ailments and distribute simple medicines.

2) *Immunisation*

Immunisation of pregnant women and infants protects children from six vaccine-preventable diseases; namely, poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles. These are major means of preventing child mortality, disability, morbidity and related malnutrition. Immunisation of pregnant women against tetanus also reduces maternal and neonatal mortality. PHC and its subordinate health infrastructure carry out immunisation of infants and expectant mothers as per the national immunisation schedule. Children are given booster doses also. The Anganwadi worker assists health functionaries in coverage of the target population for immunisation. She helps in organisation of immunisation sessions on fixed days which are now called 'Mother-Child Protection Days'. She maintains immunisation records of ICDS beneficiaries and follows up to ensure full coverage.

3) *Referral Services*

During the health check-ups and growth monitoring, sick or malnourished children who are in need of prompt medical attention are provided referral services through ICDS. The Anganwadi worker has also been oriented to detect disabilities in young children. She enlists all such cases in a special register and refers them to the medical officer. The effectiveness of this service depends on timely action, cooperation from health functionaries and willingness of families to avail these services. Health departments in States/UTs identify one hospital at the district level which attends to the referral cases coming from ICDS areas.

4) *Supplementary Feeding*

All families in the community are surveyed to identify low-income families and deprived children under the age of six years, pregnant and nursing mothers and adolescent girls. They avail supplementary feeding support for 300 days in a year. By providing supplementary feeding, the Anganwadi Centre attempts to bridge the calorie gap between the recommended national intake and the average intake of children and women in low income and disadvantaged communities. Food supplements are provided to pregnant women and nursing mothers (up to six months of nursing) to help them meet the increased requirements during this period.

Special care is also taken to reach children under the age of two years and to encourage parents and siblings to either take ration home or to bring them to the Anganwadi centre for supplementary feeding. This provides a contact opportunity for growth monitoring of children under the age of two years and nutrition counselling of mothers for improved childcare and development practices.

National Prophylaxis Programme for prevention of blindness caused by Vitamin-A deficiency and control of nutritional anaemia among mothers and children constitute two direct nutrition-interventions integrated in ICDS. Dietary promotion of food rich in Vitamin-A, iron, folic acid and Vitamin-C is an important part of nutrition and health education. Besides, targeted supplementation is also provided. The use of only iodized salt is promoted, especially in the food supplement provided, to prevent iodine deficiency disorders.

5) *Nutrition and Health Education*

Nutrition, Health and Education (NHED) make a key element of an Anganwadi worker's job. This has the long-term goal of capacity-building of women, especially in the age group of 15-45 years, so that they can look after their own health, nutrition and development needs and, also, of their children and families. All women in this age group are expected to be covered under this component. NHED comprises basic health, nutrition and development information related to child-care and development, infant-feeding practices, utilisation of health services, family planning and environmental sanitation. Community education is imparted through counselling sessions, home visits and demonstration.

6) *Early Childhood Care and Pre-school Education*

Early Childhood Care and Pre-school Education (ECCE) component of ICDS is its backbone, as all of its services essentially converge at the Anganwadi centre. This is also the most joyful play-way daily activity, visibly sustained for three hours a day. It brings and keeps young children at the Anganwadi Centre--an activity that motivates parents and communities. As envisaged in the ICDS, ECCE focuses on total development of children from underprivileged groups in the age up to six years. It includes promotion of early stimulation of the under-three years' children through interventions with mothers/caregivers. Its programme for the three to six years old children in the Anganwadi centre is directed towards providing and ensuring a natural, joyful and stimulating environment, with emphasis on necessary inputs for optimal growth and development.

Child-centred play-way activities are promoted. These activities are built on local cultures and practices, using local support materials developed by Anganwadi workers through their enrichment training. The early childhood pre-school education programme, conducted through the medium of play, aims at providing a learning environment for promotion of social, emotional, cognitive, physical and aesthetic development of the child. The early learning component of ICDS is a significant input for providing a sound foundation for cumulative life-long learning and development. It also contributes to

universalisation of primary education to prepare the children for primary schooling and offering substitute care to younger siblings, thus, freeing the older ones- especially girls- so as to attend school. For this, improved local level coordination between the Anganwadi worker and the primary school teacher is being promoted.

Growth-monitoring and promotion and nutrition-surveillance are two important activities operated at the field level in ICDS. Both are important for assessing impact of health and nutrition- related services and enabling communities to improve these. Children under the age of three years are weighed once a month and those in the age group of 3-6 years are weighed quarterly. Fixed day immunisation sessions or days are opportunities for growth monitoring and promotion of younger children as on these days mothers of children under-two years collect and take home ration,. Weight-for-age growth cards are maintained for all children under-six years. This helps detect growth-faltering and assess nutritional status.

12.4.3 Administrative Structure

ICDS team consists of Anganwadi helpers, Anganwadi workers, Supervisors and Child Development Project Officers (CDPOs). In large-size rural tribal projects, Additional Child Development Project Officers (ACDPOs) are also a part of the team. Medical officers (MOs), lady health visitors (LHVs) and female health workers (FHW) from nearby primary health centres (PHCs) and sub-centres form a team with functionaries of the social welfare/women and child development departments to implement ICDS.

Anganwadi worker is a community-based, frontline voluntary worker of ICDS programme. Being selected from her community itself she assumes a pivotal role due to her close and continuous contact with the people, especially the women she works with. As a crucial link between the village population and the Government administration she becomes a central figure in helping the community identify and meet the needs of their children and women. As a caregiver of children at Anganwadi Centre she plays a crucial role in promoting child's growth and development. Also, as an agent of social change, she mobilises community support for better care of young children, girls and women. Anganwadi worker is expected to monitor and promote the children's growth with the communities'/families' active participation. She enhances their capability for preventive and supportive actions for child's growth and development. She also enables them to prevent diseases/infections.

Anganwadi Worker organises supplementary feeding, helps organise immunisation sessions, distributes Vitamin-A supplement and iron and folic acid tablets, treats minor injuries and ailments and refers cases to medical services. Her role is more visible in making Anganwadi literally a courtyard play centre- nurturing and joyful with play-way activities, attracting and sustaining participation of children and families. She strengthens capacity of caregivers- the mother, family and the community for childcare and development by building upon local knowledge and practices. This creates a nurturing physical and social environment for the child not only at the

Anganwadi Centre but also in the family and the community. Supervisor (*Mukhya Sevika*) is responsible for 17 to 25 Anganwadi Centres, depending upon the nature of the project. She supports and guides the Anganwadi workers and assists them in recording home visits, organising community meetings and visits of health personnel and providing them on-the-job orientation.

CDPO provides a link between ICDS functionaries and the Government administration and is responsible for securing Anganwadi premises, identifying participants and ensuring supply of food to the centres and flow of health services, conduct of play-way activities, monitoring of the programme and reporting to the State Government. Also, CDPO ensures convergence of services by networking with other government departments and voluntary agencies. At the community level, other frontline workers such as Gram Sevika and primary school teachers link with the Anganwadi Worker. Anganwadi Worker is provided support by local women's groups, Mahila Mandals, youth clubs, local organisations, Panchayat Samitis, Bal Vikas Mahila Samiti members like DWCRA/Mahila Samakhya groups and total literacy campaign volunteers, as well.

ICDS team can help create partnership between frontline workers and community/women's groups, facilitating an integrated approach for improved childcare, health, nutritional well-being and women's development. Training is the most crucial element in ICDS because achievement of programme's goals depends upon effective frontline workers in empowering communities for improved childcare practices and effective inter-sectoral service delivery. Recognizing this necessity, from its very inception, the Government has included a comprehensive training strategy. Expenditure on a project is borne by the Central Government, except for the expenditure on supplementary nutrition which is borne by the State Government concerned. ICDS is monitored by the Department of Women and Child Development, Government of India, whereas it is implemented by the State Government.

The Central Ministry of Health facilitates delivery of the health components of the programme. At the State level, responsibility for its implementation and monitoring lies with the nodal department designated by the State Government, like Department of Social Welfare/Department of Women and Child Development/Department of Health. A separate ICDS directorate has also been established in several States. With the programme's expansion to a large number of blocks and districts in the States and Union Territories, provision has been made for establishing ICDS cells in the districts having five or more ICDS projects.

12.5 SCHEMES FOR ADOLESCENT GIRLS

To address concerns for women and the girl child, it necessitated to design interventions for adolescent girls. ICDS Scheme for Adolescent Girls (SAG) seeks to reduce both socio-economic and gender inequities. It aims at breaking the intergenerational life-cycle of nutritional disadvantage and providing a supportive environment for self-development. Using ICDS infrastructure, India devised a special intervention for adolescent girls for the

first time. This focuses on school drop-outs, girls in the age group of 11-18 years, with a view to meet their needs of self-development, nutrition, health, education, literacy, recreation and skill-formation. Special emphasis is also placed on reducing nutritional anaemia in this group. This scheme runs in several blocks, covering all the States and UTs.

Launched as a part of the ICDS programme, Adolescent Girls Scheme makes an additional support area of it, recognizing that:

- Any programme, in terms of its basic needs, does not cover girls in the crucial age group of 11-18 years.
- Adolescent girl is a crucial human resource and a potential bridge between the community and the changes that ICDS intends to bring about in the lives of children and women and, through them, in the entire community.

The objectives of the scheme for adolescent girls include:

- i) To improve nutritional and health status of girls in this age group.
- ii) To provide them required literacy and numerical skills through the non-formal stream of education.
- iii) To stimulate in them a desire for more social exposure and knowledge and help them improve their decision-making capabilities so as to use them to improve and upgrade home-based skills and
- iv) To promote awareness of health, hygiene, nutrition, home-management, child-care and family welfare.

More importantly, the scheme aims at empowering and improving social status of the out-of-school girls in the age 11-14 years through nutrition, life-skills and home-skills. The scheme has nutritional and non-nutritional components that include nutrition, iron and folic acid supplementation, health check-up and referral service, nutrition and health education and mainstreaming of out-of-school girls by providing formal schooling bridge course/skill training, life skill education, home management and counselling/guidance for access to public services.

Girl-to-Girl Approach Scheme

Initiated for the age group of 11 - 15 years, this scheme requires to identify three girls, one each, from three selected Anganwadi Centres. Preference is given to those girls who are from families below the poverty line. Besides the services mentioned earlier, these girls receive (i) a meal of 500 calories and 20g proteins, on all six working days in the week and (ii) an in-service training from the Anganwadi Worker and the Supervisor for a period of over six months.

Balika Mandal Scheme

Objectives of this scheme, initiated for girls in the age group of 15 - 18 years, include involving and motivating of these girls in non-formal education, up-

grading their home-based skills and educating them about personal hygiene, environmental sanitation, first aid, nutrition and child care. Besides, recreation and entertainment facilities are also provided. It is expected that 10 per cent of the Anganwadis in the selected ICDS Blocks will act as the centres for Balika Mandal. National Institute of Public Cooperation and Child Development (NIPCCD), New Delhi, is the apex body to train the ICDS functionaries. The institute is responsible for planning, coordinating and monitoring of the ICDS functionaries' training; revising, standardizing and updating the training syllabi, developing effective training methods, preparing, procuring and developing the training materials and organising the training of trainers. A number of training programmes have been designed for ICDS personnel. While training CDPOs is the direct responsibility of NIPCCD, Supervisors' training is conducted by about 30 training centres, one each, located in the States, depending on the training targets. These centres are known as Middle Level Training Centres (MLTCs).

Anganwadi Workers' training is entrusted to Non-Governmental Organisations and also to Schools of Social Work, Colleges of Home Science and training institutions run by State governments. There are about 300 Anganwadi Training Centres all over the country.

Strengthening women's empowerment (*Swayamsidha*) is an initiative that aims at mobilizing women for promoting their own health, nutritional well-being and self-development as well as that of their children. It makes an underlying principle of ICDS. *Swayamsidha*'s objective is all-round empowerment of women, especially from social and economic disadvantaged groups, by ensuring their direct access to and control over resources through a sustained mobilisation and convergence of all the on-going sectoral programmes. Its immediate objectives include establishment of women's self-help groups (SHGs), creation of confidence and awareness among members of SHGs regarding women's status, health, nutrition, education, sanitation and hygiene, legal rights, economic uplift and other social, economic and political issues.

12.6 OTHER SCHEMES UNDER UMBRELLA ICDS

4.6.1 Pradhan Mantri Matru Vandana Yojana

Pradhan Mantri Matru Vandana Yojana (PMMVY) scheme provides cash incentive in three instalments directly into Bank/Post Office Account of the Pregnant Women and Lactating Mothers (PW&LM) in Direct Benefit Transfer (DBT) Mode during their pregnancy/lactation.

The cash incentive of Rs 5000/- is provided directly in the account of beneficiaries for first living child of the family, subject to their fulfilling specific conditions relating to Maternal and Child Health. The eligible beneficiaries receive the remaining cash incentives as per approved norms towards maternity benefit under Janani Suraksha Yojana (JSY) after institutional delivery so that, on an average, a woman will get Rs 6000/-.

This Centrally sponsored scheme provides grants-in-aid to the State Governments/Union Territory Administrations in a dedicated account for the purpose of direct benefit transfer to the beneficiaries. It functions through the platform of Anganwadi Services Scheme of Umbrella ICDS under the Ministry of Women and Child Development in respect of States/UTs. It is implemented by Women and Child Development Department/Social Welfare Department through Health System of the respective State/UT. Focal points in the implementation are Anganwadi Centre (AWC) and ASHA/ANM workers.

12.6.2 Poshan Abhiyaan

Poshan Abhiyaan (National Nutrition Mission) targets to reduce the level of stunting, under-nutrition, anaemia and low birth weight babies by reducing malnutrition/undernutrition and anaemia among young children and, also, focuses on adolescent girls, pregnant women and lactating mothers.

POSHAN or National Nutrition Mission is Government of India's flagship programme to improve nutritional outcomes for children, pregnant women and lactating mothers. Launched by the Prime Minister on the occasion of the International Women's Day on 8th March 2018 from Jhunjhunu in Rajasthan, POSHAN, ie, Prime Minister's Overarching Scheme for Holistic Nutrition draws the country's attention towards the problem of malnutrition and addresses it in a mission mode.

NITI Aayog has played a critical role in shaping the POSHAN Abhiyaan. National Nutrition Strategy, released by NITI Aayog in September 2017 presented a micro analysis of the problems persisting in this area and chalked out an in-depth strategy for their solution. Most of the recommendations presented in the strategy document have been subsumed in the POSHAN Abhiyaan's design. Now, NITI Aayog has been entrusted with the task of closely monitoring POSHAN Abhiyaan, undertaking its periodic evaluations.

With the overarching aim to build a people's movement around malnutrition, POSHAN Abhiyaan intends to significantly reduce malnutrition in a period of three years from its launch.

For its implementation there is a four-point strategy that includes:

- Inter-sectoral convergence for better service delivery
- Use of technology (ICT) for real time growth-monitoring and tracking of women and children
- Intensified health and nutrition services for the first 1000 days
- *Jan Andolan*/people's movement

12.6.3 National Crèche Scheme

This scheme, managed by the Ministry of Women and Child Development, provides day-care facilities to children of the age from 6 months to 6 years of working women. The facilities are provided for seven and half hours a day for 26 days in a month. Children are provided with supplementary nutrition,

early childcare education and health and sleeping facilities.

Earlier named as Rajiv Gandhi National Crèche Scheme this centrally-sponsored scheme has been implemented through States/UTs from January 1, 2017. Its salient features are as follows:

- i) Day care facilities including sleeping facilities.
- ii) Early stimulation for children under-3 years and pre-school education for children of 3 to 6 years.
- iii) Supplementary nutrition sourced locally
- iv) Growth monitoring
- v) Health check-up and immunisation

Further, the guidelines provide that:

- i) Crèches shall be open for 26 days in a month and for seven and half hours per day.
- ii) Children's number in a crèche should not exceed 25 in a crèche with one Worker and one Helper.
- iii) User-charges, to bring in an element of community ownership, are to be collected in the following manner:
 - a) BPL families: Rs 20/- per child per month
 - b) Families with income (both parents) up to Rs. 12,000/- per month: Rs. 100/- per child per month
 - c) Families with income (both parents) above Rs. 12,000/- per month: Rs. 200/- per child per month.

Till March 2020, there were 6453 crèches, functioning across the country under the scheme. Monitoring of its implementation of the scheme is being undertaken through meetings and video conferencing with the officials of State Governments/UTs. The ministry officials undertake field visits to ascertain its implementation status. NITI Aayog conducts the third party evaluation.

12.6.4 Integrated Child Protection Scheme (ICPS)

Integrated Child Protection Services Scheme aims to improve well-being of children in difficult circumstances and reducing vulnerabilities to the situation and the actions that lead to their abuse, neglect, exploitation, abandonment and separation from parents. It aims at spreading awareness regarding the ways and means to prevent all children from any kind of abuse, including child sexual abuse.

ICPS brings multiple existing child protection schemes of the Ministry under one comprehensive umbrella and integrates with it additional interventions for protecting children and preventing them from harm. ICPS, therefore, institutionalises essential services and strengthens structures, enhances

capacities at all levels, creates database and knowledge base for child protection services, strengthens child protection at family and community level and ensures appropriate inter-sectoral response at all levels.

It aims to set up a child protection data management system to formulate and implement effective intervention strategies and monitor their outcomes. Regular evaluation and course correction of the programmes and structures are to be undertaken.

12.7 A CRITICAL VIEW

Started on an experimental basis in 33 projects, ICDS, from 1975 onward, has a country wide network of services, today. Some State governments have sanctioned ICDS projects from their own resources, so that the services could be extended to cover a larger area. It is visible that ICDS is unique in several respects. It is a programme which encompasses in itself three major components of integrated human resource development; viz., health, nutrition and education. It is a coordinated endeavour of several departments with the health directorates providing the health inputs and services. It is a preventive and developmental programme beamed to the poorest and, among them, the most vulnerable segments; namely, children and women. It is uniquely Indian in the sense that it will be difficult to find another massive national level integrated programme, with as broad an agenda and coverage as that of ICDS.

Moreover, ICDS is a programme which is almost entirely funded from national resources. An important feature of the ICDS programme is that it employs community level female workers at the grassroots level as the Anganwadi workers and helpers. This facilitates acceptance of the worker and the programme. Also, as the programme follows an integrated approach, providing a package of mutually supportive services, it is more cost-effective than individual services delivered separately.

It has been observed that ICDS has brought about reduction in the incidences of protein energy malnutrition. Several research studies have reported that nutritional status of children in ICDS areas is better than in comparable non-ICDS areas. Further, their health and nutritional status has improved in the project area after the programme has been in operation for several years.

There are seen definite improvements in the educational qualifications of women appointed as the Anganwadi workers. Higher percentage of babies had low birth weight in non-ICDS areas as compared to ICDS areas. In tribal areas, the difference was even more marked. The coverage of children for immunisation is reported to be higher in ICDS areas as compared to non-ICDS areas. The utilisation of health services is also better, indicating the effective role played by ICDS in mobilizing the health system and linking the community and health system. The nutritional status of children in ICDS areas is better than that of children in non-ICDS areas. A decline in percentage of severely malnourished children has been successfully achieved under this scheme.

The ICDS programme has resulted in:

- 1) Decline in incidences of nutritional anaemia, ie, Vitamin-A deficiency.
- 2) Improvement in nutritional status of children (0-6 years) and expectant and nursing mothers.
- 3) Increase in birth weight.
- 4) Decrease in infant mortality and morbidity rates
- 5) Significantly more immunisation coverage in ICDS than in non-ICDS areas.

ICDS programme continues to be the world's most unique early childhood development programme, being operated satisfactorily for over four and half decades of its existence. Its rich experience has brought about a welcome transition from welfare orientation to a new challenging perspective of social change. It continues to provide package of services, comprising supplementary nutrition, immunisation, health check-up, referral services to children below six years of age and expectant and nursing mothers. Non-formal pre-school education is imparted to children of the age group 3-6 years and health and nutrition education to women in the age group 15-45 years. High priority is accorded to the needs of the most vulnerable younger children under three years of age in the programme through capacity building of caregivers to provide stimulation and quality of early childhood care.

The scheme has performed considerably well in our socio-cultural system during the last few years to ensure children's right for survival, growth, protection and development and their active participation in environment where they live, grow and develop. It attempted to gear up to the holistic vision of a comprehensive intervention programme with a child-centred approach respecting all cultural patterns and diversity and served as an instrument of change to reduce social inequality in the society.

The concept of providing a package of services is based primarily on the consideration that the overall impact would be much larger if different services are delivered in an integrated manner, as efficiency of a particular service depends upon the support it receives from the related services. The other unique feature of the programme is that it utilises and mobilises all available governmental services at the level of the project. It is multi-sectoral and so its successful implementation depends on inter-sectoral functional linkages. It calls for coordination among concerned departments and ensures optimal use of the existing governmental infrastructure at the project level.

To address the interrelated needs of young children, adolescent girls and women of disadvantaged community groups, ICDS solicits convergence with other services/programmes like Antyodaya, micro-credit schemes and other development programmes of the rural development, education, environmental science and technology and so on.

12.8 LET US SUM UP

comprises an integrated package of services; viz., (i) supplementary nutrition, (ii) immunisation, (iii) health checkup, (iv) referral services, (v) nutrition and health education and (vi) non-formal preschool education. Providing a package of mutually supportive services has been found to be more beneficial and cost-effective than delivering individual services separately.

These services are provided to children of 0-6 years, expectant and nursing mothers and women of 15-45 years from the disadvantaged segments of the society. Focal point for the delivery of its services is the Anganwadi Centre, an Anganwadi worker and a helper, catering to the needs of a population of about 1,000. Initiated on an experimental basis in 33 blocks in 1975, ICDS has emerged as a major national programme for development of the children. It is a unique programme, well-conceived and with a wide coverage strategy to deliver multiple services.

12.9 KEY WORDS

ICDS: The programme offers an integrated package of services to lactating mothers, pregnant women and children, consisting of services related to health, nutrition, pre-school education and also educating adolescent girls and young mothers about their health and nutrition.

Anganwadi Centre: The focal point at village level, staffed by an Anganwadi worker and a helper, for delivery of services to beneficiaries of ICDS.

ICPS: The scheme to create awareness regarding the ways and means to prevent all children from any kind of abuse, including child sexual abuse.

12.10 SUGGESTED READINGS

GOI. (2000). *Integrated Child Development Services– A Compendium of Guidelines 2000*. New Delhi: Ministry of Human Resource Development, Government of India.

GOI. (2017). *Integrated Child Development: Manual for District- Level Functionaries*. New Delhi: Ministry of Women & Child Development, Government of India.

GOI. (2017). *Pradhan Mantri Matru Vandana Yojana (PMMVY) Scheme Implementation Guidelines, 2017*. New Delhi: Ministry of Women & Child Development, Government of India.

GOI. (2018). *Poshan Abhiyaan, 2014-2018*. New Delhi: Ministry of Women & Child Development, Government of India.

NIPCCD. *Integrated Child Development Services (ICDS) Scheme: Guidelines for Monitoring & Supervision of Scheme- Central Monitoring Unit (ICDS)*. New Delhi: National Institute of Public Cooperation & Child Development.



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