

## **Young Children's Well-Being – A Public Concern**

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Any society can be said to be truly developed only when it cares for its children, especially the very young. Our society has failed our children, rendered them unprotected and ignored their basic rights as they are in any case voiceless and do not constitute a vote bank to cry hoarse that they too exist. Our newborn children, toddlers and those who can barely talk or express themselves, the 0-36 month olds live lives so precariously and institutional care and governmental systems have not reached them adequately begging the question on status of India's development in this regard.

In our country, the state of children especially of very young children is not something we can all be very proud of. Although there have been improvements in the last fifty years we are way behind compared to developed countries and in relation to our own targets. As many as 63 for every 1000 children who are born die even before they reach their first birthday. According to the NFHS-2, 47% of children aged below three years are undernourished and 58% of children (in the 12-23 months age group) are not fully immunised. In our country, 2.42 million children under the age of five die annually and there are 60 million underweight children under the age-five (Gupta.A and Rohde.J.E, 2004).

In spite of this, the condition of young children is not a source of much debate in the public domain. The fact that as many as 50% of children under-5 are underweight is neither an issue for our political parties nor something that can make governments fall. In fact the public has tolerated such an appalling condition of our children. In spite of so many children dying preventable deaths each year, there is no public shock or outrage expressed.

The only substantial programme that the government has for children in the age group of 0-6 years is the Integrated Child Development Scheme (ICDS). The ICDS has the tasks of ensuring safe motherhood, immunization, nutrition, adolescent health and pre-school education. Although this programme has great potential to address the needs of infants and young children, it has never been taken up in a whole-hearted manner. It is not a universal programme that covers every village and municipality. While there are 14

lakh habitations in the country, the ICDS project area covers only about 6 lakh habitations, reaching out to only about one-third of all children in the relevant age group. The expenditure on the ICDS is only one half of one per cent of total public expenditure.

There is however some hope that there might be a change in this situation. The present government in its common minimum programme plans to universalise the ICDS. There is a wealth of research available in the country on what needs to be done to universalise ICDS with quality.

This paper talks about the experience of M.V.Foundation in the last couple of months of mobilising communities to protect the rights of the very young children and to demand from the state what is due to them. This programme is still very recent and therefore the observations made are not conclusive and are based on how it is unfolding itself in its early stages.

### **Child Health – A Public Concern**

The M.V.Foundation<sup>1</sup>, based on its experience of working with children's right to education, began working on the issue of children's health in eight mandals<sup>2</sup> of Ranga Reddy District. Initially data was collected on every birth that took place in the village each month and what the prevalent practices of delivery and childcare are. It was found that almost 50% of the women delivered at home and also that the infant mortality was very high. When these figures were compared with the PHC statistics it was seen that most of the deaths were not reported by the government. Even more disturbing was the fact that even when eight to nine children died in a month in a mandal, there was total indifference and this did not disturb the society. It did not become an issue of concern for anyone in the village –neither the gram panchayat, the Anganwadi centre nor the community in general discussed this issue. People at most sympathized with the family for their ill luck. However, it was a personal issue and not something that required any social action.

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<sup>1</sup> The M.V.Foundation is a voluntary organisation working on the issue of child labour and children's right to education since the last 14 years. The M.V.F. is currently present in 6000 villages of Andhra Pradesh.

<sup>2</sup> A Mandal is an administrative unit comprising of about 30-40 villages and an average population of about 50,000. At any given point of time there are 300-400 pregnant women in a Mandal.

Meetings were held at the village and mandal level where this data was shared with the entire community and there was a discussion on how each of these deaths could have probably been prevented. This entire exercise was also to create a mood in the village where the entire community felt responsible for the well-being of the children born in the village. It was then decided that every month the gram panchayat should review the condition of all the children in the village along with all the concerned government functionaries such as the Anganwadi worker (AWW), the ANM and the school headmaster. Others also attended these meetings in the village such as members of youth groups, mother's committees etc. Consequently, in about 50 villages, each month the ANM and the AWW now review with the Sarpanch and the ward members the number of children they immunized, whether the supplementary food is reaching the children, details on whether any children have died during this month and so on. They even discuss cases where the families are not co-operating, where they are unwilling to get their children immunized or are not interested in taking the supplementary nutrition provided at the Anganwadi centre. The gram panchayat then along with others makes a visit to these families and motivates them to access these services.

Many changes have already happened because of these meetings. The gram panchayat now feels responsible for the children in the village. The ANM and AWW discuss with the gram panchayat the obstacles they face in delivering services. For instance, in Sheriguda the ANM complained that she was not doing ante-natal check ups because there was not enough space with privacy in the village. In response the gram panchayat decided to convert a godown into a centre for the ANM when she visits the village. The material that was stored in the godown was shifted to one corner of the gram panchayat office. In village Ervaguda, Shankarpally Mandal there were complaints that the AWW was not maintaining the growth charts for all children. In response the AWW discussed with the panchayat members that there were rats in the centre and that they were eating away all her registers because of which she was not able to maintain any records. The gram panchayat then pooled in resources and bought a steel *almirah* for the Anganwadi centre. In many villages, there was a complaint from the villagers that the ANM is never available while the ANM claimed to be making the requisite number of visits. As a result, in the evening prior to the ANM's visit there is a public announcement

(with drum beats – *dappu*) in the village informing everyone about her visit and asking parents to get their children immunised and checked-up. Many other such small issues are now being tackled at the village level with the government departments and the community coming together.

More importantly, through the meetings with the gram panchayats and campaigns in the village the issue of the health of the newborn and young children which until now was a private issue concerning only the family, and even within the family just the mother, is now becoming a concern for the entire village. In village after village ceremonies are being held where the Sarpanch gives out birth certificates to all children below the age two. Once the backlog of giving birth certificates to all children is covered, in an institutionalized manner now all children in the village are given birth certificates as soon as they are named. So much so that for the sake of the certificate, families are even naming their children within the first month itself. Through this exercise of giving birth certificates the panchayat and the community now celebrate the birth of every child into the community. There is a shift in the rhetoric from a position that if a child died it was the mother's *karma*. Now when a child is born the entire village welcomes the newborn with pride.

It is in the context of such an environment that the specific issues of each child were also taken up. The families were informed about the services available to them from the ICDS and the health department for their children and they were motivated to access these services. Through the review meetings the community exercised pressure to ensure that the ANM came regularly and that the Anganwadi centre functioned.

### **Nutrition – Challenges**

While it was seen that it was comparatively easier to get people to access immunization and get births registered, nutrition was a more complicated issue. Children below three years of age were being weighed every month, and their growth monitored. However, it soon became obvious that just ensuring that children below three got the supplementary nutrition from the AWW was not enough. Time was spent with the

families of undernourished children to try and understand what could be done to tackle this problem<sup>3</sup>.

The strategy evolved to address the issue of malnutrition was based on the age of the child – for those in the age group of 0-6 months and those in the age group of 7-24 months.

### **0-6 months – Breastfeeding a non-negotiable**

It is recommended that children be exclusively breastfed during the first six months. It is also often assumed that this is not an issue for the poor because they have so little access to buy anything else and there is little influence of the advertising of commercial foods on this population and so they must be breastfeeding their children for as long as possible. However, in a study conducted by the Breastfeeding Promotion Network of India in 49 districts of India shows only 39.7 % of children in the age-group of 0-6 months are exclusively breastfed. Although the survey did not cover Ranga Reddy District, the situation here is not very different.

The problem is at two levels. One is that the babies are fed pre-lacteals like honey, sugar water etc. and the newborn babies are sometimes not given any milk for almost three days and are literally starved the first few days after they are born. Sometimes after the pre-lacteals they are fed by another woman, and not the mother. In most cases, therefore, the mother herself starts feeding the baby only on the third day.

It was found that women did not feed their babies colostrum because they believed, and everyone around them believed, that this was not milk and that the mother did not have enough milk for the first three days. This is where the child's deprivation began. Because of this belief the child lost out on the mother's colostrum that is supposed to have micronutrients, especially vitamin A and anti-bodies.

The M.V.Foundation held meetings with pregnant women and their mothers-in-law and discussed with them the importance of exclusive breastfeeding. It was explained to them why it is important to start breastfeeding immediately and to exclusively

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<sup>3</sup> A field visit to the CINI (Child in Need Institute) Nutrition Rehabilitation Centre convinced us that many a time malnutrition only required better food practices along with care and affection. The challenge was however to achieve this without the support of having a centre or having doctors on the team.

breastfeed. Even others such as members of women's self-help groups and mothers' committee members were invited for these meetings. Their only worry was that the child would not have enough if he/she was not given some pre-lacteals. They were convinced to try not giving anything else and see if the baby would be all right. With repeated meetings and home visits many were convinced. Subsequently, as soon as there is a delivery in the village, the volunteer would go and check whether the baby was being breastfed. In about 80% of the deliveries that were followed up in this manner the baby was not given any pre-lacteals and was fed colostrum. It was found that all the arguments that the poor are stubborn and would not listen were just not true. If their fears were addressed patiently without insulting them and they were told that this was the right thing to do they had the capacity to listen and be reasonable.

They have just not been told ever that it is important for the baby to be fed by the mother herself within one hour after birth. Even in cases of hospital delivery, including in private hospitals, the doctors do not educate the family that the baby can be breastfed immediately after birth. It is expected that people, especially women, automatically know how to breastfeed, when to start breastfeeding, and the entire science of it.

Secondly, it is seen that the much larger problem is to encourage mothers to continue exclusive breastfeeding later in a proper manner. It is well known that it is important for the mother to be relaxed and give exclusive attention to the baby while feeding. This is almost impossible as the mother is so tied up with work all the time and there is pressure on her from everyone to always be busy. She is never given the free time to just relax and enjoy her child and learn to feed her and be with her and understand her needs. This is not seen as something that is necessary at all. It is not as if the family does not care for the child but they just do not know how important these things are for the growth and development of the child. Instead they take the baby to the doctor/RMP who will then prescribe gripe water and colourful tonics to the baby saying these would make her a healthy child.

At this stage the only intervention of the ICDS centre is to provide supplementary food for 6-8 lactating mothers in the village. There is no motivating/educating the mother and the family on exclusive breastfeeding. There are many aides and books to do this but

it is not done. How on earth is a fourteen-year-old illiterate mother to know that she must exclusively breastfeed her child till the baby is six months old, when it cannot even be assumed that a well-educated older woman would know?

In mid-2004, the ICDS had a campaign on exclusive breastfeeding and all AWW were instructed to conduct special activities to educate the community on breastfeeding. As a part of this campaign, all that was done was to organise a rally in the village with school children holding placards encouraging breastfeeding. This too, at a time when most of the adults had left home and were at the fields, working.

Must not the ICDS take up this responsibility with greater earnestness and follow up with every case of a new born baby so that mothers are taught to breastfeed and the society too understands the value of giving her time to be with the baby in these crucial six months.

#### **Above six months -- Complimentary Feeding -- When and how?**

It is recommended that supplementary feeding be started for a child when she is 7 months old. After six months it is believed that breast milk is not sufficient for the child and this is the right age to start on her external feeding while continuing breast feed. This is again something that is not done in a systematic manner. It is not done because nobody knows that it is to be done.

It was seen that there was no particular age at which the community thinks that the child should be given external feed. It is usually when the child begins to move around and pick things to eat himself/herself. The practice is to feed the child out of the adult's plate if he happens to crawl by when the adult is eating. If the child cries then he is given breast milk.

There are very few households where the child is purposefully fed in a different plate before he learns to eat on his own. Till then, the child has to eat biscuits, drink tea, eat from the elders' plates and there were even cases where the mother sprinkled some rice on the floor so that the child would learn to eat!!

At the same time there is no count on what the child should be given – how many times a day, what form – nothing. They start with biscuit packets, which are available for

Rs.2, which does nothing but kill the child's appetite. Some spent a lot more money to starve their children. In every case that was found where the baby was being fed expensive supplementary foods such as Cerelac or Horlicks that is available in the market, it was seen that none in the family knew the right quantities in which the feed is to be mixed. When the baby was to be fed about 5-6 spoons of the powder during each feed, it was seen that the baby was being given only one spoon. Again, this is not so much because the family is poor but because they have not been told that there is any other way in which it can be done.

Added to this is of course the problem of the mother not having the time for her children. If she were to mix feed and feed the child five times a day in a manner in which she would have to pursue the baby to eat even if she refused then she would not have the time to cook, wash, clean and go out for work. .

The ICDS provides one kind of food for all children in this age group, and another kind of a more nutritious powder for children who are in grade III and grade IV malnutrition. There is no explanation given on whether this is enough, should the child be fed anything else, how many times a day should this be given and in what form. There have been instances where the parents have not fed the child anything else once they got powder from the AWW, which is actually not enough for the entire day. Further, when some children have diarrhoea when they eat this food, even other mothers stop feeding the child Anganwadi food. Again there is no one who will tell them what the right practice is when something like this happens.

Poor families are as concerned about their children and their well-being as anybody is. However, they are deprived of the capability of knowing what they should do to keep their children healthy. As mentioned before, when the entire community believes that the child will eat when he wants to and there is no reason to give it any special attention, the child loses out on nutrition that is available in the house because she has still not learnt to demand for it.

### **Making it Possible**

It was decided that each volunteer would identify one or two malnourished children in his/her own village and follow up with them. The purpose of this exercise was

to gain confidence in dealing with malnutrition and also to showcase to the community that children can be healthier without having to spend money on tonics and commercial foods.

With these children there was an intervention at two levels – addressing feeding practices within the family and also linking them to the Anganwadi centres. Time was spent with each family telling them about what can be fed to the child from what is available at home. They began with feeding the children semi-solid food made at home with a mix of the cereals and pulses that were available at that time. The entire family was involved in this process and the focus was not just on what should be fed but that feeding the child should be an activity that the family thinks about and gives time for. The father and grandparents were also involved in this process. They also shared in the responsibilities of feeding the child and the grandparents stopped buying biscuits and *murukkus*. When the mother was out at work some other member of the family took on the responsibility of feeding the child and when the mother was feeding the child the family now understood that she should be given time to do it and not called for some other task.

Bringing about this change was not easy. When the volunteer initially began visiting the family, they wanted him to take them to a doctor and give them some medicines/tonics to make the child healthy. The volunteer insisted that this was not necessary and that the child could become healthy by just being fed what was available at home and all that this would require was some time from the family. When the family argued that the child would not eat and that they had tried doing so before, the volunteer began visiting that family three times a day and feeding the child himself. Once the parents saw that the child was actually eating they took over and the volunteer decreased the number of times he visited them. He would still visit them everyday to ensure that they continued to feed the child. He even motivated them to wash their hands before and after feeding the child, to bathe the child everyday and to generally maintain cleanliness.

Soon, everyone could see the change in the child. These children became more active, more social, looked healthier and of course began to put on weight. Children who were in grade IV are now in grade III and those in grade III are now in grade II. Those

who did not have the strength in their legs to stand are now holding on to the wall and can stand. Those who clung to their mothers are now playing with other children.

The Anganwadi worker was involved in this entire process. Every once in a while the volunteer would take her along to visit the family. The AWWs agreed to bring the weighing machine to the house of these children and weigh them every fifteen days. They even gave these children extra rations and showcased with pride these children to their supervisors.

Simultaneously, the growth monitoring of all the children was also regularised. Dates on which weight of children below three would be measured were fixed and the panchayat took on the responsibility of making an announcement of these dates every month making it known to everyone that it was time to take their child to the Anganwadi Centre to find out how she was doing. With others taking interest in the Centre, the AWW was also enthused to explain to the mothers what grade their child was in and whether she was growing properly.

As there was a noticeable change in the child who was being followed up others came up and asked how it was possible. The mothers of this child shared what they did with others in meetings. The activist also visited houses of other children and told them how it was possible for their children to be healthier with just what was available at home.

## **Conclusion**

Over time different approaches have been evolved to combat malnutrition. There has been a shift from a drug-based approach that understood malnutrition as the shortage of certain nutrients that could be overcome by administering tablets/syrups with the deficient nutrients to a food-based approach. The latter argues that where the total quantity of food consumed is inadequate, malnutrition could be substantially reduced if only people ate more and better than what they normally did (Rajivan.A.K, 2004).

Anuradha Rajivan advocates a third approach, which is the knowledge-based approach. It is necessary for people to have knowledge about the food and non-food factors that influence nutrition status in order to combat malnutrition. Similarly, Arun

Gupta also argues for a shift from the food-based approach to an approach that corrects inappropriate feeding practices.

The M.V.F experience also argues for an approach that is close to the knowledge-based approach or the feeding-practices approach. It shows how providing nutrition education to the family in an environment where the well-being of young children becomes a public issue could contribute to combating malnutrition in an effective and sustainable manner. While it is absolutely essential for families to learn how and what to feed their children, it is also important that there exists a culture of giving time to children. This can happen when the community recognises the issues of young infants and children and is responsible for the protection of child rights. Such an approach encourages the entire family to share the responsibility of feeding children and makes it possible for women to be provided all the support and leisure to participate, as they should in taking care of the child.

In a way there has to be a societal response that expresses concern about the status of young children and their rights leading to an institutionalised form of collective action to interact with the governmental agencies, inform them and wherever necessary bring pressure on them to deliver services. The gram panchayats, being the elected local bodies too have an important role to play in reviewing the functioning of all the departments that work for children in their area and bring to the notice of the staff and line in the bureaucracy the inadequacies in the system.

The ICDS programme would of course have to play a crucial role in achieving this. Currently the anganwadi centres cater to only a section of the children below six years in the village, they are poorly staffed and have inadequate resources. The quantum of tasks that the AWW is expected to perform and the number of registers she needs to maintain make it impossible for her to do anything efficiently. All this sends out a very non-serious message to the community.

Some changes that have been recommended by many such as separating the pre-school education activities from the nutrition and health initiatives, decreasing the paper work, expanding ICDS to cover all children in all habitations etc are urgently needed. However, these changes would be effective only when the community is mobilised to

think about children and their rights. As long as this is not done, any innovations will only be supply side programmes that do not reach the people.

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