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Founder Editors: RAJ & ROMESH THAPAR

Caring for children

DIPA SINHA

ONLY a society that cares for its children, especially the very young, can be said to be truly developed. Our society has failed its children, rendered them unprotected and ignored their basic rights; they are in any case voiceless and do not constitute a vote bank. Our newborn children, toddlers and those who can barely talk or express themselves, the 0-36 month olds, not only live precarious lives but have limited access to institutional care and government systems.

Clearly, the state of our children is not something we can be proud of. Although there have been improvements in the last 50 years, we are way behind compared to developed countries, as also in relation to our own targets. As many as 63 of every 1000 children 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. 2.42 million children under the age of five die annually and there are 60 million underweight children under age-five (A. Gupta and J.E. Rhode 2004).

Despite this the condition of young children is rarely debated in the public domain. The fact that as many as 50% of children under-five are underweight is neither an issue for our political parties nor something that can destabilise governments. Worse, the public has tolerated such an appalling condition. Despite so many children dying preventable deaths each year, there is no expression of public shock or outrage.

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), tasked with 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 yet to be taken up in a whole-hearted manner. Nor is it a universal programme covering every village and municipality. While there are 14 lakh habitations in the country, the ICDS project area covers only about six 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 discusses the experience of MV Foundation in mobilising communities to protect the rights of the young children and to demand from the state what is due to them. This programme is a recent one and thus the observations made are not conclusive.

The MV Foundation,[1] drawing on its experience with children's right to education, began working on the issue of children's health in eight mandals[2] of Ranga Reddy district.

Initially, data was collected on every birth that took place in the village each month and the prevalent practices of delivery and childcare. It was found that almost 50% of the women delivered at home and that infant mortality was very high. When these figures were compared with PHC statistics, it emerged that the government did not report most deaths.

More disturbing was the fact that even when eight to nine children died in a month in a mandal, there was total indifference. It did not become an issue of concern for anyone in the village – neither the gram panchayat, the anganwadi centre, nor the community found it important to discuss this issue. At best people sympathized with the family. Invariably, it was seen as a personal issue and not something that required any social action.

Meetings were held at the village and mandal level where this data was shared with the entire community to discuss how each of these deaths could have been prevented. This entire exercise was also to help create an environment where the community felt responsible for the well-being of the children born in the village. It was then decided that the gram panchayat should review the condition of all children in the village every month along with all the concerned government functionaries such as the anganwadi worker (AWW), the ANM (auxiliary nurse midwife) and the school headmaster.

Members of youth groups and mother's committees among others, also attended these meetings in the village. Consequently, in about 50 villages, each month the ANM and AWW along with the sarpanch and the ward members now review the number of children they immunized, whether supplementary food was reaching the children, details on whether any children died during the month and so on. They even discuss cases where families did not cooperate, refused to get their children immunized or were unwilling to take the supplementary nutrition provided at the anganwadi centre. The gram panchayat along with others then visits these families and motivates them to access the 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 in delivering services. For instance, in Sheriguda, the ANM explained that she was not doing antenatal 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 and the material stored in the godown was shifted to a corner in the gram panchayat office.

In village Ervaguda, Shankarpally mandal, there were recurrent complaints that the AWW was not maintaining the growth charts for all children. The AWW in response pointed out that there were rats in the centre who were eating away all her registers because of which she was unable to maintain any records. The gram panchayat then pooled resources and bought a steel *almirah* for the anganwadi centre. In many villages there were complaints that the ANM was not available while she in turn claimed to be making the requisite number of visits. As a result, there is a public announcement made (with drum beats – *dappu*) the previous evening, informing everyone about the ANM's visit and asking parents to get their children immunised and checked-up. Such issues are now being tackled at the village level with government departments and the community coming together.

More importantly, through meetings with the gram panchayats and campaigns in the village regarding the health of newborns and young children, what was so far seen as a

private issue concerning only the family, and even within the family just the mother, has now become a concern for the entire village. In village after village ceremonies are held where the sarpanch gives out birth certificates to all children below age two. Once the backlog is covered in an institutionalised manner, all children in the village are given birth certificates as soon as they are named. For the sake of the certificate, families are 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 – a shift from the earlier position where if a child died it was considered the mother's *karma*. Now when a child is born the entire village welcomes the newborn with pride.

It is in such an environment that the specific issues of each child are taken up. The families are informed and motivated to avail the services available to them from the ICDS and health department. Through review meetings the community exercises pressure to ensure that the ANM comes regularly and the anganwadi centre functions.

While it was comparatively easier to get people to access immunization and register births, 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 receive 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.[3] The strategy evolved to address the issue of malnutrition was based on the age of the child – different for those in the age group of 0-6 months and those in the age group of 7-24 months.

It is recommended that children be exclusively breastfed during the first six months. It is also often assumed that this does not concern 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, they must be breastfeeding their children for as long as possible. However, a study conducted by the Breastfeeding Promotion Network of India in 49 districts of India showed only 39.7 % of children in the age-group of 0-6 months were exclusively breastfed. Although the survey did not cover Ranga Reddy district, the situation there was not very different.

The problem exists at two levels. One is that the babies are fed pre-lacteals like honey or sugar water and newborn babies are sometimes not given any milk for almost three days, literally starved the first few days after birth. Sometimes, after the pre-lacteals, another woman and not the mother feeds them. 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, as did everyone around them, 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 begins, loosing out on the mother's colostrum that has micronutrients, especially vitamin A and anti-bodies.

The MV Foundation held meetings with pregnant women and their mothers-in-law on the importance of exclusive breastfeeding, explaining why it is important to start immediately and to exclusively breastfeed. Others, such as members of women's self-help groups and mothers' committee members, were invited for these meetings. Their real worry was that the child would not have enough if she were not given some pre-lacteals. They were convinced about not giving anything else and see if the baby would be all right.

With repeated meetings and home visits many families were convinced. Subsequently, as soon as there was a delivery in the village, the volunteer checked 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 apprehensions about the poor being stubborn and unreceptive were invalid. If their fears are addressed patiently without insulting them and mothers told that this is the right thing to do, they have the capacity to listen and be reasonable.

They have never been told that it is important for the baby to be fed by the mother herself within an hour after birth. Even in cases of hospital delivery, including 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, and the entire science of it.

Second, the greater problem is to encourage mothers to continue exclusive breastfeeding later in a proper manner. It is well known that the mother must be relaxed and give exclusive attention to the baby while feeding. This is almost impossible as the mother is so tied up with work, never given free time to just relax and enjoy her child and learn to feed her, be with her and understand her needs. This is not seen as at all necessary. 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 prescribes gripe water and colourful tonics claiming these would make her a healthy child.

At this stage the only intervention of the ICDS centre is to provide supplementary food for lactating mothers in the village. There is no motivating/educating the mother and the family on exclusive breastfeeding, despite many aids and books on how to do it. How on earth is a 14-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 is aware?

In mid-2004, the ICDS ran a campaign on exclusive breastfeeding and all AWWs were instructed to conduct special activities to educate the community on breastfeeding. As part of this campaign a rally was organised 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 working in the fields.

The ICDS must take up this responsibility with greater earnestness and follow up with each 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.

It is recommended that supplementary feeding be started for a child only when she is seven 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 external feeding while continuing to breast feed. This is again rarely done in a systematic manner, mainly because nobody knows that it is important.

It was seen that there was no particular age at which the community thought that the child should be given external feed. It is usually when the child begins to move around and pick things to eat herself. The practice is to feed the child out of the adult's plate if she happens to crawl by when the adult is eating. If the child cries then she 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, eats 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 accounting for what the child should be given – how many times a day, and in what form. They start with biscuit packets, available for Rs 2, which only kill the child's appetite. Some spend a lot more money to starve their children. In every case where the baby was being fed expensive supplementary foods such as Cerelac or Horlicks that are available in the market, it was seen that none in the family new the right quantities in which the feed is to be mixed. When the baby should be fed about 5-6 spoons of the powder during each feed, it was seen that only one spoon was given. Again, not because the family is poor but because it has not been told of another way in which it can be done.

Added to this is of course the problem of the mother not having time for her children. If she has 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, then she would have no time to cook, wash, clean and go out to work.

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

Poor families are as concerned about their children and their well-being as anybody else. 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 it.

It was decided that each volunteer would identify one or two malnourished children in her own village for follow up. The purpose of this exercise was to gain confidence in dealing with malnutrition as 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 linking them to the anganwadi centres. Time was spent with each family telling them about what could 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 cereals and pulses 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 drawn in, made to share in the responsibilities of feeding the child. When the mother was out at work, another member of the family took on the responsibility of feeding the child. Now when the

mother is feeding the child, the family appreciates that she should be given ample time and not be called for some other task.

Bringing about this change was not easy. When our volunteer began initial visits, the family wanted her 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 that all it required 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 herself. Once the parents saw that the child was actually eating they took over and the volunteer decreased the number of visits. She would still visit them everyday to ensure that they continued to feed the child. She even motivated them to wash their hands before and after feeding, to bathe the child everyday and to generally maintain cleanliness.

Soon, everyone could see the change in the child. These children became more active and social, looked healthier and began to put on weight. Children suffering from grade IV malnutrition are now in grade III and those in grade III to grade II. Those who did not have the strength to stand can now hold onto the wall and stand. Those who only clung to their mothers are now playing with other children.

The anganwadi worker was involved in this entire process, often accompanying the volunteer on her visits to the family. The AWWs agreed to bring the weighing machine to the house of these children and weigh them every 15 days. They even gave these children extra rations and showcased them with pride to their supervisors.

Simultaneously, the growth monitoring of all children was regularised. Dates on which weight of children below three would be measured were fixed and the panchayat took on the responsibility of announcing 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 malnutrition 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 and asked how it was possible. The mother of the child shared what they had done with others. The activist also visited other homes and and explained to them how it was possible for their children to be healthier.

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

Anuradha Rajivan advocates a third approach, which is knowledge-based. It is necessary for people to be knowledgeable about food and non-food factors that influence nutrition status in order to combat malnutrition. Similarly, Arun Gupta also argues for a shift from a food-based approach to an approach that corrects inappropriate feeding practices.

The MVF experience also advocates an approach that is akin to the knowledge-based or 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 can 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 exist a culture of giving time to children. This can happen when the community recognises the needs of young infants and children and is made 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.

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 governmental agencies, inform them and, wherever necessary, bring pressure on them to deliver services. The gram panchayats, as elected local bodies, have to play an important role in reviewing the functioning of all the departments that work for children in their area and bring the inadequacies in the system to the notice of the staff and bureaucracy.

The ICDS programme will, of course, have to play a crucial role in achieving this. Currently, the anganwadi centres cater to only a section of children below six years in the village, 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 makes it impossible for her to do anything efficiently. This sends out an incorrect message to the community.

Some changes that have been recommended, such as separating pre-school education activities from nutrition and health initiatives, decreasing paper work, expanding ICDS to cover all children in all habitations, and so on, are urgently needed. However, these changes will become effective only when the community is mobilised to think about children and their rights. As long as this is not done, all we will see are supply side programmes that do not reach the people.

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Footnotes:

1. The MV Foundation is a voluntary organization working on the issue of child labour and children's right to education since the last 14 years. The MVF is currently present in 6000 villages of Andhra Pradesh.

2. 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.

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