

Infant Survival: A Political Challenge

In a democracy, every child must be regarded as indispensable and the government must be accountable for the deaths of children and mothers. Unfortunately, the issue of children's health seldom finds space in contemporary political discourse in India. The process of ensuring that every child is taken care of as a matter of right involves societal pressure through public action and democratisation of all public institutions.

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In the Indian context, for the poor, the safe delivery of a healthy child and the survival of both mother and child cannot be taken for granted. A political regime that tolerates iniquitous access to health and nutrition and has little care for the respect and well-being of its infants and mothers, is not fully democratic. The process of ensuring that every child is taken care of as a matter of right involves societal pressure through public action, and democratisation of all public institutions. It can be achieved only when the newborn child is welcomed and taken care of. It is a reflection of the country's normative framework, its legal framework, its institutional framework, its power balances and priorities. In this sense, survival of the child and the mother is an indicator of the health of the system.

Normative and Constitutional Framework

Among the poor, both in rural and urban India, pregnancy and delivery are fraught with risk. The mother's health or even the child's survival does not cause anxiety, despite the fact that the child and mother may or may not survive. There is a silent resignation to fate, despite all the advances in medicine. This attitude, cutting across classes, is so pervasive and there is general indifference. When the child dies, consolation is drawn from the fact that not all is lost; the mother can give birth to more children, there is always another chance. Such an attitude is compounded among

the poor where the lives of infants are precarious, and parental instincts are numbed in the struggle for survival.

Absence of a normative framework that supports the well-being of women and children is bound to adversely impact the manner in which the state takes up its responsibility towards mothers and infants. The infant mortality rate in India is 67 per 1,000 live births; 47 per cent of children are malnourished; there are 60 million underweight children under the age of five; and 67 per cent of pre-school deaths are associated with malnutrition. In absolute numbers, there are as many as 2.42 million malnutrition deaths under the age of five each year.¹ The maternal mortality rate is 540 per 1,00,000, which is unacceptable by any standards.² When the data are further disaggregated on the basis of birth, socio-economic status, caste and gender across the country, analysis reveals that several districts and blocks in the country have alarming statistics on infant and maternal mortality, almost on par, if not even worse, than countries in sub-Saharan Africa. Bangladesh fares better than India with regard to both infant mortality and maternal mortality rates.

This is a "hidden" disaster, larger in scale than the tsunami of December 2004. In a true democracy, every child must be regarded as indispensable and the government must be held accountable for the deaths of children and mothers. Continuous failure on this account has to be perceived as a threat to the nation's progress. It is in the process of responding to the most vulnerable, the pregnant

women, poor mothers and infants in their weakest moments that democracy is tested.

The Constitution of India recognised how crucial children's well-being was to the functioning of India's democracy when it stated "that the state shall direct its policy towards ensuring that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment".³ Article 45 of the Directive Principles of State Policy assured that children up to 14 years of age would be covered under free and compulsory education. However, the recent 86th amendment and introduction of Article 21A, making education a fundamental right for all children in the age group 6-14 years, does not provide for children in the 0-6 years age group. By not including children in this age group it compromises on guaranteeing them their rights.⁴

Policy and Institutional Framework

India's first comprehensive policy for children was adopted in 1974 through its National Policy for Children which assigned to the state the responsibility to provide adequate services to children both before and after birth; to ensure full physical, mental and social development; to set up Integrated Child Development Services (ICDS) centres, balwadis and day care centres run by voluntary agencies with government assistance, and pre-primary schools run by state governments, municipal corporations and other agencies. The provision of maternal and child health services through primary health centres and sub-centres and other agencies was also adopted. Subsequently the National Policy on Education, 1986 viewed early child care and education (ECCE) "as an important input in the strategy of human resource development, as a feeder and support programme for primary education

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and as a support service for working women of the disadvantaged sections of the society". ECCE involves the total development of the child, i.e., physical, motor, cognitive, linguistic, emotional, social and moral.⁵ A target was set that 70 per cent of all children in the 0-6 years age group must be covered by the year 2000. Today, in 2005, only about one fourth of such children are covered by the ICDS, which is the only programme that reaches out to children in this age group. The programme covers 3.41 crore children in the 0-6 years age group as on March 2004 which is around 22 per cent of all children in that age group.⁶

In 1992 India became a signatory to the UN convention on the rights of the child. In the same year, the national plan of action incorporated expansion of early childhood development activities including appropriate low-cost family and community based interventions. It also made a commitment to reduce by half severe and moderate malnutrition among children under-five years of age between 1990 and 2000, a reduction in incidence of low birth weight babies and control of vitamin A deficiency and its consequence.⁷ A decade later, in the Tenth Five-Year Plan (2002-07), it set out to achieve universalisation of ICDS in all the 5,652 blocks of the country.

The institutional arrangement to concretise the policy objectives is the ICDS under the women and child welfare department. Healthcare to be delivered through the health department is expected to take care of pregnant women, prenatal and post-natal care and children at the village level. It is envisaged that a well-oiled, institutional coordination between the two departments would enable a proper utilisation of the services, material and other supplies. The ICDS programme relies on the front-line functionary, the anganwadi worker, to realise the policy-maker's dream of a society that respects women, takes care of adolescent girls, gives them dignity and space, rectifies gender imbalance, ensures safe delivery of the infant and maintains the nutritional status of children until s/he reaches six years of age. She is also expected to maintain the data that feeds into the statistics of the government on births, deaths, growth of children, records for supplies of food, educational material and lists of women who could access the innumerable schemes for issuance of doles, stipends, and other "schemes".

Any new idea or agenda for action is seen to be delivered by the anganwadi worker. For all the responsibilities assigned

to her, she is neither professionally trained nor paid even the minimum wages according to law for her services. Further, she has layers of officials supervising and monitoring her work at the block, district and state levels. There is a huge administrative edifice, its clerks, officials, researchers, institutions operating at the national level and consultations at the state, national and international levels all directing their attention on what "more" could be added as activities to the anganwadi worker's already overflowing timetable.

Political Parties

Those who are better endowed have access to their entitlements to health, seek private care and are ensconced in the support they receive. They can pay for it. On the other hand, the poor require institutional care and support. They require the investments of the system, which must not calculate the costs for keeping the woman and child alive. To do so is not easy, as they have to compete with more powerful forces whose priorities are not necessarily that of ensuring survival of the child.

Children's health seldom finds space in contemporary political discourse in India. A perusal of the election manifestos of all the political parties for the 2004 general elections shows that most of the manifestos carried only one-liners and a token statement. The Congress pledged to raise the public spending on health to at least 2-3 per cent of GDP, and promised that the ICDS will be universalised with a functional anganwadi in every settlement, especially for children below six years. The TDP vowed to keep maternal mortality at 0.5 and child mortality at 15 though it was not explicit on how it is going to do so. The CPI (M) acknowledged that the public health system was in a state of disarray and argued that the trend towards privatisation of health services should be reversed. In addition to increasing the expenditure on public health to 5 per cent of GDP, it intended to provide a primary healthcare infrastructure that would include a national community health worker scheme to deliver basic health services at the habitation level. The CPI mentioned that it would have a network of primary health centres with sufficient stocks of medicines and create adequate staff, provide for free and compulsory universal education, guaranteed for all children up to the age of 14 years as well as free and hygienic midday meals, and bring about legislation

to check sexual abuse of children. The CPI(ML) too remarked in its manifesto about the systematic neglect of the health sector, about how only the elite afford state-of-the-art medical facilities while the poor and middle classes are denied quality medical treatment. The BJP targeted a reduction of India's infant mortality rate and the under-five mortality rate by spending more on prenatal and post-natal healthcare programmes. Low cost health insurance schemes and providing essential drugs at affordable prices have also been mentioned in the manifesto.

At the moment there are no fundamental differences of opinion among parties. There are no contentious issues; practically all of them across the spectrum of political ideologies suggest programmes which are alike, without disturbing the balance of interests and power. There is no doubt that unanimity among political parties is necessary for ensuring that the state meets its obligation towards infant and maternal care. However, the issue has never come up for serious discussion and debate, and political parties have seldom thought through the programme, working out the intricacies. A consensus on the broad need for such programmes, without thinking through the nitty-gritty of implementation is unlikely to achieve much.

During the parliamentary sessions between 2003 and 2004 out of 28,227 questions that were raised in the two houses of Parliament "only 843 questions, a mere 3 per cent were child focused (Lok Sabha, 424 and Rajya Sabha 419) and out of this only 11 per cent related to the health of children in the country".⁸ None of the questions exhibited passion or political commitment. They were mechanical, without the intensity a crucial issue such as this deserves. It is clear that it is an issue considered insignificant in electoral calculations.

Emerging Conflicts to be Resolved

Healthcare is not yet a political issue on which there are alignments of forces and discussions regarding policy matters. The real issues that cause tensions and conflict have not even emerged. Genuine implementation of ICDS and related services would disturb the division of work in the family resulting in bringing gender imbalances to the fore. It would require modalities to resolve intra household conflict, making it acceptable for women to be treated with respect. It would also mean relieving the girl

child of the drudgery of work, not allowing her to get married at an early age, protecting her from exploitation, trafficking, bondage and sexual abuse. A functional ICDS programme would free the girl child of responsibilities for younger siblings and encourage her to join school and continue to study without any disruption at least until class X. This would mean equipping the entire force of the government, its police, labour, revenue, education, health, women and child welfare, social welfare and justice departments to deal with every instance of violation of the girl child's right to education, breaking the nexus of relationships both formal and informal that serve to perpetuate violence, both physical and mental. It is a commitment that demands that we do not calculate costs but do with pride the work of ensuring the dignity of children, especially girl children.

A wholehearted political commitment would also expose the quality of services rendered by the registered medical practitioners (RMP) and local quacks; there is need to devise mechanisms to regulate their activities and resolve tensions that emanate from their resistance to accountability, and monitoring by authorities. An ethical code of conduct must be enforced among medical practitioners, with proper scrutiny of records and transparency in delivering health services. The impact on other services, lab technicians, pharmacists, RMPs and their linkages with private healthcare systems must also be brought to light. That none of these issues have even come up could be an indicator of how ineffective the existing services have been at the local level.

Yet another area of conflict that would emerge if the programme is taken up seriously is the structure of authority operating on the anganwadi worker. This leaves little scope for the anganwadi worker to dialogue with her superiors. False data regarding the status of malnourishment in her area, or the data on infant and maternal mortality is repeatedly submitted. Almost everyone concerned with planning for infant and maternal care knows that the data is usually an underestimation. There is seldom an effort to create processes and conditions that allow the truth about the status of children to be acknowledged by authorities. Correcting the structures that obfuscate the flow of information is also a political issue. Unless the local bodies and the community see the importance of accurate and reliable data, it would be difficult to circumvent this.

The potential conflict areas at a macro level would emerge more fully once there is more vigorous debate on the modalities for concretising delivery mechanisms. For example, we can anticipate a debate on whether the country can afford millions of trained professionals to take care of its children; over the very need for professionalisation of early childcare services. The issue of linkages between the public and private service providers, and whether they need to be regulated is also potentially contentious. The issue of investments in paramedics and community health workers, versus professional support to the poor has also not emerged in public discussion. There has also not been any major increase in the budgets allocated for early childcare and women's health. The National Advisory Council estimated that tripling the coverage and doubling the unit costs, at the very least, would be required for universal coverage of ICDS. This implied raising the annual budget allocation for ICDS from Rs 1,600 crore to Rs 9,600 crore. On the other hand, the central government, in its budget for 2005-06, increased the amount towards ICDS from Rs 1,490 crore (revised estimates 2004-05) to Rs 3,142 crore (budget estimates 2005-06) which may even be construed as a violation of Supreme Court order.⁹

These are only some of the areas of tension and conflict one envisages. It would require intense political debate and discussion to resolve them. At present, political parties seem content with homilies and the mere presence of a lonely and overworked anganwadi worker. It is only in the actual process of reaching out to every child, pregnant woman and adolescent girl that the politics behind such programmes will become more explicit.

The fact is that taking care of infants, adolescent girls or pregnant women is not just another sop or welfare programme, but central to the functioning of democracy. It is in the struggle for the right to health that structures of domination and power unfold. These rest on values that are deeply entrenched in the system. As they unfold it is evident that they are linked to the entire state apparatus and the structures that gain from the appalling health condition of infants and mothers.

Public Action and Democracy

Accessing all that is promised by the state, engaging with it and exerting pressure for the fulfilment of its commitments is the

starting point for public action in a democracy. In the Indian context, the legal framework is an expression of the states' commitment; setting norms for society and binding the state to its commitments are also within the realm of the courts. In other words, the legal instruments could set the principles for public debate and discussion, and concretise the translation of law into actual practice.

At present there are certain legal instruments derived from the labour legislations pertaining to factories act, mines and plantations, construction workers, etc, which mandate that crèches must be provided. In reality they "hardly exist".¹⁰ There are not more than 23,000 crèches, "whereas 8,00,000 crèches are needed to cater to approximately 220 million women working in the informal sector and in dire need of childcare services".¹¹

The Supreme Court has also issued orders that the ICDS should be universalised to cover all settlements in the country, reaching out to every child under six years of age, mother and adolescent girl with supplementary nutrition. Universalising ICDS in accordance with the Supreme Court directive would mean increasing the number of ICDS centres by almost three times from the present six lakh anganwadi centres to the required 17 lakh. Public action alone would bring pressure on the state to concretise these obligations and also expose the lacunae in the details of such policy instruments.

For the provision of the necessary physical infrastructure and for professional support, there are no legal instruments binding the state, though these are essential services that should be taken for granted. There is no legal process by which the poor woman in labour can complain about the non-availability of the doctor or even a trained midwife. There is no law that mandates the state to provide for all the services and procedures any woman can demand in a primary healthcare centre, subcentre or a general hospital. There is no law that would take punitive action because children in a village have not been immunised for months together, because of the absence of an auxiliary nurse midwife (ANM). The absence of such a legal framework is an indication of the state's indifference.

Public action is premised on an intrinsic faith in the system and its capacity to respond. To mobilise communities to access health systems is to anticipate public action. The indifference of the system in

providing immediate redressal is often tolerated because it does not cause grave loss like the loss of lives. An apathetic and dysfunctional health system however can lead to great agony. To urge more people to access a public health system that is woefully inadequate may expose people to risk. On issues such as access to education, one can afford to have a child pushed out of school and work towards re-enrolment. There is some damage to the child, but it is not irrevocable. This is hardly the case with health. It is in this context that there is a dilemma in insisting that the poor utilise inadequate health services.

Holding political leaders and public bureaucracies morally responsible for apathy, harm or wrongdoing is significant in maintaining the accountability of the government. In a democracy it is imperative that citizens exercise such pressure. In a representative democracy, citizens are themselves ultimately morally responsible for the actions of their government. Mechanisms that integrate officials, governmental organisations and individual initiatives to bear a collective responsibility for the effective functioning of a democratic political system are still immature in the Indian context.

Public action involving local institutions and local bodies, and large support structures at the state and national levels, enabling the community to question, negotiate and bargain with authorities to deliver services would pave the way for enhancing every child's access to the ICDS, and making it an institution for protecting the rights of children aged 0-6. This would involve participation of people in decision-making processes, and thus democratising public spaces. ICDS too must be seen as a site for the contestation of power.

Democracy is nurtured only when, through public action and pressure, the system begins to perceive violence and is compelled to bring about substantial change in favour of children's right to health and well-being. Every malnourished child challenges the edifice of anti-democratic forces and alliances. **END**

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Notes

- 1 Arun Gupta, Jon E Rohde, 'Infant and Young Child Under Nutrition', *Economic and Political Weekly*, December 4, 2004.
- 2 *Human Development Report 2004*.
- 3 Article 39(f), Directive Principles of State Policy, Constitution of India. [http://](http://www.crin.org/docs/resources/treaties/crc.37/FORCES_New_Delhi_India.pdf)

- 4 www.crin.org/docs/resources/treaties/crc.37/FORCES_New_Delhi_India.pdf
- 5 Government of India, Ministry of Human Resource Development, 'National Policy on Education-1986-Programme of Action'.
- 6 Arjun Singh, Minister of Human Resource and Development's reply as quoted in Enakshi Ganguly et al, *ibid*.

- 7 Enakshi Ganguly et al, 'Says a Child...Who Speaks for My Rights', HAQ-Centre for Child Rights, p 9.
- 8 *Ibid*, p 4.
- 9 <http://www.haqcrc.org>, 'Resource Allocation in the Union Budget 2005-06: Is It Sufficient to Fulfil the Rights of India's Children?'
- 10 http://www.crin.org/docs/resources/treaties/crc.37/FORCES_New_Delhi_India.pdf
- 11 *Ibid*, FORCES.