UNDOING OUR FUTURE

Summary of the Report on the Status of the Young Child in India

FORCES: Forum for Crèche and Child Care Services

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The national secretariat of FORCES is currently housed at the Centre for Women's Development Studies, New Delhi

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Preface

FORCES (Forum for Crèche and Child Care Services), which completed in 2009 two decades of consistently advocating the rights of the young child and mothers, specifically focussed on the unorganised sector, is a national network of organisations that was set up in 1989 in the wake of the Shram Shakti Report (Report of the National Commission on Self-Employed Women and Women in the Informal Sector, Government of India, 1988).

Since December 2007, FORCES has actively participated in evolving the Alternative Citizens' Report to be presented to the UN Committee on the Convention on the Rights of the Child. FORCES used this opportunity to also prepare a status report on the young child for purposes of advocacy.

The area of ECCD (early childhood care and development) and its crucial significance for children has been neglected in discussions and policy analyses of the overall status of children, with focus on this area emerging only recently.

The major themes selected for this Report centre on a review of policies and programmes, resource allocations, education, health and nutrition, care services and the predicament of the girl child.

FORCES held four regional consultations — one each in the north, eastern, southern and the north-eastern parts of the country. While the southern states have performed well, the northern, eastern and north-eastern states show disturbing trends.

Our entire exercise was taking place at a critical period in the country's development, when many provisions of the State for the welfare of the people had already been whittled away due to major policy changes at the macro level. Specifically, the State's decision to withdraw from the sphere of social sector spending and to invite more private players, especially in the field of health and education, affected the vulnerable sections of society the most. This was manifested in the alarming figures of the National Family and Health Survey (NFHS) III in 2005-06 regarding the health of young children. While successive governments have failed to meet the proposed 6% spending (of the country's GDP) on education, its record in health is even more dismal.

Our country may not realise the MDGs by 2015 and on HDI, our performance is worse than many other economically weaker nations. As the country faces a crisis in both the agrarian and financial sector, the expectations from the government are heightened. While there have been some welcome steps taken by the government in its previous budget allocations, the role of advocacy-based networks like FORCES is to ensure that this does not remain confined to budgetary allocations alone but gets translated to concrete measures at the ground level.

Not all problems can be attributed to the government alone. Socio-cultural problems are also at work — preference for the male child, prevalence of caste feudal structures and attitudes and the deleterious impact of creeping commercialisation, among others.

The consultations also threw up possible remedies to the ECCD problems. Constructive suggestions led to a near consensus on the strengthening of the Integrated Child Development Scheme (ICDS) nationally, among other things.

The Report on the Status of the Young Child aims at highlighting the importance of the issue of ECCD, making this issue a crucial aspect of policy analyses, and pushing for improvements in the status of the young child in India.

Savitri Ray
National Co-ordinator, FORCES

Introduction

FORCES focuses on the very young child in the belief that this most crucial and formative stage in a child's development needs special and specialised attention. The perspective takes the holistic view that the status and destiny of young children is affected by and closely interconnected with the overall social, economic, political and cultural developments in the country and that the condition of the mother and the families of the children is an integral part of any assessment of the child's status.

The Report of the Working Group on Development of Children for the Eleventh Five Year Plan (2007-2012) also holistically takes a clear position against a fragmentary approach and advocates the integration of survival, development, protection and participation actions linking all aspects of children's well-being.

The non-negotiable recommendations of the Working Group cover the ICDS and Nutrition, Early Childhood Education, Child Protection and the Girl Child. The document argues for age-specific interventions.

In its Concluding Observations in its first Periodic Report, the UN Committee on the Rights of the Child expressed its concern at the decrease of government funds allotted to social services and expressed serious concern at the unavailability and/or inaccessibility of free, high-quality primary healthcare, the slow decline in Infant Mortality Rate (IMR), the worsening of the Maternal Mortality Rate (MMR), the low immunisation rate, high incidence of low birth-weight babies, the high number of children with stunting, wasting or who are underweight, the prevalence of micro-nutrient deficiencies and the low rate of exclusive breastfeeding.

Those included in the growth process have continued to benefit, others have not, and the condition of others has even worsened. Children are one of the critically affected groups, especially in the 0-6 age group, the most vulnerable age cohort, in which timely and effective interventions make all the difference. It is, therefore, useful to begin our review of the status and condition of children in the crucial 0-6 age group by looking at how the National Common Minimum Programme (CMP adopted by the United Progressive Alliance (UPA) government in May, 2004) addressed some of the critical issues affecting these young children, and the record of the government in fulfilling these commitments.

Reviewing the CMP record

Among its most direct and specific commitments to young children, the CMP committed the government to universal coverage under the ICDS. Addressing a larger age cohort of children, minus the very youngest, it promised a national nutritious mid-day meal scheme in primary and secondary schools. The CMP was committed to universal basic education and to increasing public spending in education to at least 6% of GDP, half of the allocation being spent at the primary and secondary levels. In the sphere of healthcare, it committed to spending at least 2-3% of GDP over five years with a focus on primary healthcare,

communicable diseases, the availability of life-savings drugs at reasonable prices, with special attention to the poorer sections.

The CMP also committed the government to a comprehensive medium-term strategy for food and nutrition security, and to long-term universal food security, "if found feasible". It promised to strengthen the public distribution system (PDS) particularly in the poorest and backward blocks of the country and to expand nutrition programmes "on a significant scale", particularly for the girl child.

Other commitments included protection of the rights of children, efforts to eliminate child labour, and to extend special care to the girl child. Further, it committed to ensure that at least one-third of all funds earmarked for panchayats would be for programmes for the development of women and children.

But the overall low priority given to the young child becomes evident from the fact that, in 2006-07, only 1.66% of the Union budget funds were allocated for children under six.

India presents a mixed picture reflective of the internal contradictions between the commitments made to the rights and interests of the marginalized (including children), and the continuation of a policy to promote liberalisation and globalisation. Policy commitments are yet to be backed by adequate allocations and expenditures.

The failure of the government to fulfil its commitment on the ICDS is a case in point, with this single most important programme for early childhood care and development still a long way off from universal outreach.

The National Family Health Survey (NFHS-III, 2005-06) shows there has been a clear deterioration in the nutritional status of children nationally. Between 1998-99 and 2005-06 the percentage of children under 3 who were wasted went up from 15.5% to 19.1%, and of children aged 6-35 months who were anaemic increased from 74.2% to 79.2%.

Recent exercises in child budgeting have shown an increase in outlays — from 2.2% of the Union budget in 2003-04 to 5.35% in 2008-09. Of the child-specific budget, the largest share is for education (72% in 2008) followed by ECCD (17% in 2008). But programmes for child protection or the girl child (including issues of the gender ratio) receive little priority in the budgets.

Issues that emerged from the Regional Consultations

The four regional consultations — one each in northern, eastern, southern and north-eastern India — showed distinct regional patterns with regard to the status and situation of the child, and access to child care services, the last obviously related to the overall social indices.

The northern regional consultation, which brought together participants from Uttar Pradesh, Madhya Pradesh, Uttarakhand, Haryana, Himachal Pradesh and Jammu & Kashmir, highlighted the poor state of ECCD services and issues of governance. It stressed the problems for young children arising from displacement due to the construction of power projects in the hill state of Uttarakhand, as well as the specific problems in Jammu & Kashmir related to its troubled political situation. An issue that was raised repeatedly was the role of panchayats in running anganwadi centres.

The Eastern regional consultation also highlighted the poor access to ECCD services, focusing on the problems of the anganwadi workers. Infrastructure development projects and their impact on livelihoods emerged as a crucial area of concern, particularly in Orissa. The participants from Jharkhand pointed to the lack of political will in implementing ICDS programmes, while spokespersons from West Bengal emphasised the problems of poor

infrastructure and political interference in the appointment of anganwadi workers. All participants talked of the problems related to the medium of instruction, especially with regard to tribal communities.

The Southern consultation showed the better performance of the ICDS programmes.

Kerala is known for the relatively better status of its women, with near universal literacy and low fertility rates and, of course, favourable general sex ratios. But it is also the state with high suicide rates among women and the young, high rates of unemployment and out-migration, and is now facing the disturbing problem of declining child sex ratios. The nutritional and educational standards in the tribal areas are very low; the ICDS scheme has poor reach in the tribal areas, both because of poor infrastructure and the use of non-tribal languages as the medium of instruction. Concerns were also raised over the 'communalisation of education'.

In Andhra Pradesh, the success of the ICDS scheme was largely attributed to the successful integration of the local communities in the functioning of the programme; the responsibility of monitoring and evaluation is entrusted to the Mothers' Committee members and the CRP (Community Resource Person), who are elected by village organisations to monitor the functions of anganwadi teachers.

Tamil Nadu is one state that has near-universal coverage, with 96% of the state population served by an anganwadi centre under the ICDS programme. The ICDS centres in Tamil Nadu receive food from the civil supplies department in contrast to other states where it is provided for from the market; this is one major reason for the better quality of food at the anganwadis. Tamil Nadu is the only state where each child beneficiary is given 3 eggs per week. The state ICDS runs an exclusive 'Nutritional Health Education Programme' and has, apart from the traditional monitoring system, a unique Village Level Monitoring Committee (VLMC) comprising retired teachers and village leaders. It regularly conducts various training programmes and disseminates information related to various health and nutritional issues at the village level. However, the reach of the services in the rural areas was found to be wanting.

The distinguishing feature of the ICDS in Puducherry is that anganwadis function directly under the state programme with the state playing a supervisory role which facilitates efficient delivery of services. The other feature is that 6% GDP had been utilised for educational expenditure and more than 200 schools for 0-3 years children have well structured curriculum for ECE (Early Childhood Education).

The devastating impact of the tsunami on the Andaman and Nicobar Islands can still be experienced, including the workings of the ICDS programme.

The consultation in the North-East was the first venture of FORCES in the region. This consultation was marked by the fact of the isolation of these states and their diverse levels of integration with mainstream India, their extremely different social and ethnic identities, the difficult terrain, the decades of ethnic and social strife and the distinct problems of poor migrants, many of them workers in the non-formal sector. Participants highlighted the decline in the status of children in the region as a whole, due to prolonged neglect of the region and also because of specific problems, such as the devastating floods that occur every year.

The problems of each of the North-Eastern states are closely interlinked. Thus, mining activities in Arunachal Pradesh, leading to the silting of the river bed of the Brahmaputra, is affecting the fertility of agricultural lands in Assam — this is leading to increased under-nutrition and malnutrition affecting children, pregnant and lactating mothers. While there is

no mortality due to starvation, hunger or nutrition related morbidity exists. The most affected are children in the rural areas. The construction of dams in the state of Arunachal Pradesh is also having adverse impact on the lands, lives and livelihoods of the people in the region.

Besides, due to continued strife and unrest of the last 40 years, a generation is growing up experiencing trauma, leading to aggressive behaviour among the young and the increasing prevalence of drugs. The impact of continued armed conflict on children was highlighted by speakers from Manipur. These have long-term consequences for women and children. The problem of fatherless children was highlighted by participants from Meghalaya, where the transformation of the matrilineal systems of inheritance and the consequent breakdown of its safeguards has had serious consequences for young children. The small border state of Tripura has its specific problems stemming from a deep divide between tribal and non-tribal communities. The specific problems of the medium of instruction for the tribal children were highlighted.

The prevalence of HIV/AIDS is a serious problem afflicting many of the states, like Manipur, Nagaland and Mizoram. This is closely linked to human and drug trafficking.

Critical Policy Issues

The critical policy issues discussed animatedly in the consultations related to:

- The role of the state and its role in providing the basic services of ECCD. There was consensus that the principal responsibility of the state in this regard has to be ensured and any attempt to pass on this responsibility to NGOs under the guise of public-private partnership should be opposed.
- The necessity of involving local self-government bodies in running anganwadis.
- The status of anganwadi workers needs urgent policy attention.
- The neglect of education in the ICDS centres along with the question of the medium of instruction.
- The situation of the girl child, specifically in the context of the declining child sex ratios is cause for alarm. The increasing prevalence of sex-selective abortions in this regard needs urgent national level policy intervention.
- Macro policies have significant impact on the ground level, on people's lives and opportunities; the changing government policies in the fields of health and education, specifically, have had a disastrous impact on the lives of young children.
- The need for factoring in the disastrous impact of development projects on the lives of communities and peoples was an urgent issue calling for intervention. It needs to be raised as a national issue.

Indrani Mazumdar
Vasanthi Raman
Savitri Ray

1 A Review of the Policies and Programmes of the Government of India for Children

C.P. Sujaya

The Concluding Observations adopted by the Committee on the Rights of the Child in its 35th Session (January 2004, produced in *Concluding Observations: India Committee on the Rights of the Child*, Thirty Fifth Session, CRC/C/15/Add.228, 26 February 2004, United Nations) touch on certain important policy issues. Some of these find resonance with policy statements articulated during the run-up to the Eleventh Plan.

The Constitutional principles — the Fundamental Rights as well as the Directive Principles of State Policy — are the bedrock of the democratic polity of India, promising equality and social justice to every citizen. Particular care and attention to children are embedded in the Directive Principles. Though the phrase 'inclusive growth' has been used frequently as a positive value, the evidence on the ground shows that some groups have been included in the growth process, but others have not, especially affecting children in the 0-6 age group.

The need to assess the impact of budgetary allocations on the implementation of children's rights and to disseminate this information widely is one of the important Concluding Observations made by the Committee (Paragraph 12 (b) in *Concluding Observations: India Committee on the Rights of the Child*, Thirty Fifth Session, CRC/C/15/Add.228, 26 February 2004, United Nations). The MWCD (Ministry of Women and Child Development) has presented its achievements in child budgeting (which was started in 2002-03) under the title 'Child Budgeting: Translating Outlays into Outcomes' — an echo of what the Committee indicated (Chapter 7 of the Annual Reports of MWCD 2005-06 and 2006-07, on child budgeting, are so titled; the title of the corresponding Chapter 7 in Annual Report 2007-08 is 'Child Budgeting: Improving Performance

in Allocations and Utilisation of Resources').

Translating budget outlays into positive outcomes for children is an immensely challenging task and calls for innovative thinking, restructuring of the implementation apparatus, use of sensitive indicators in the collection of information and data, as well as an operational framework on child rights in varied situations.

The relative priority given in the budget to children in the 0-6 age group depends to a certain extent on the allocations under the Eleventh Five Year Plan to the child sector. But a new and emerging area of concern, as voiced by the Committee, is the question of the impact of the child budget outlays on children. The struggle is now on two fronts — one is to get higher outlays for children as a whole and to ensure that the needs of the 0-6 age group are fully met. The other is to assess the 'outlays-outcome' equation.

The Committee has stressed the importance of a national co-ordinating mechanism to oversee the implementation of the CRC. The MWCD has created such a mechanism, but the Committee has noted that greater co-ordination is still required amongst the different bodies at *federal and state levels*. Keeping in view not only the federal structure of India but also the institutions of locally elected governments, it is necessary to look also at co-ordination at the *district, block and panchayat/municipal levels*. They have also to be brought within the purview of co-ordination, which is often ignored, as the governance structures in India are still highly centralised.

Also, these mechanisms should have adequate representation of civil society organisations committed to child rights, and they should be able to make an effective contribution to the proceedings of these coordinating bodies at all levels. The Committee has separately raised the issue of co-operation with NGOs which are '… partners … the State party should involve them in [a] more systematic and coordinated manner in all stages of … implementation, including policy formulation at the national, state and local levels …' (Paragraphs 19 and 20 in *Concluding Observations: India Committee on the Rights of the Child*, Thirty Fifth Session, CRC/C/15/ Add.228, 26 February 2004, United Nations). The main question arising from the Committee's observation is this: Is MWCD, as the nodal agency, able to carry out its coordination responsibilities?

Eight major parameters of the National Plan of Action for Children (reduction of IMR, CMR, MMR; universal access to safe drinking water and sanitation; elimination of child marriage; elimination of disability due to poliomyelitis; and a reduction in the number of infants infected by HIV/AIDS), finalised in 2005 with the approval of the Cabinet, are being regularly monitored at the Prime Minister's level. While the high-level monitoring speaks of the importance given to these indicators, it is difficult to access information about the actual monitoring process and methodology as well as the composition of the monitoring group and, more crucially, the outcome. The MWCD also prepared a list of indicators and circulated it to all States/ UTs and to the central ministries and departments concerned, who were also encouraged to send their views on the indicators. But information about this feedback is not available.

In such a vast country, with its social and economic variations and complexities, a purely centralised system of monitoring does not seem appropriate or functional. Those children who belong to the marginalized categories need special attention at the local level, and the shortfalls in their status — including less expenditure vis-à-vis outlays — need particular investigation.

The Committee has viewed the wide gaps and disparities in the rights enjoyed by different groups of children

as the most serious blots. While noting the special efforts made by the Government to improve the enjoyment of rights by children of marginalized groups, the Committee expressed concern that *children who do not belong to these groups* but who live in similar situations may not be receiving the same benefits.

The rights enshrined in the CRC are universal. While State parties may specially target those children who suffer from structural disadvantages, the CRC does not distinguish between *children* and *children*. This CRC core value of non-discrimination and the core values of the Indian Constitution of positive discrimination through 'special provisions' for children (Article 15(3)) are both based on the same universal value of the equality of human beings, though the CRC prohibits discrimination on grounds that are somewhat wider than those listed in Article 15 of the Indian Constitution. There is a difference in approach and strategy between the two, which has to be managed positively, in the best interests of the child.

The Indian State has to be careful that 'special provisions' do not lead to a counter-productive situation that thrives on difference and also respond to the special needs of marginalized children while ensuring their integration in society. Such an approach needs co-ordination between policies, legislative action and judicial interpretation, and a skilful combination of legal and non-legal interventions.

Questions that arise here are: Is it possible for the Indian Government to set a time schedule for providing rights to the dispossessed and vulnerable groups of children? Can the State apparatus hold the balance between universal rights whilst specially targeting those groups of children who do not enjoy these rights?

The ICDS is a case in point. Many MWCD reports have tended to argue that the priority in ICDS is children of marginalized groups, though the programme guidelines do not justify such an interpretation. The programme now has to move towards better targeting of the un-reached, while aiming at reaching every child in the 0-6 age group.

The Committee's anxiety over the State's failure *to reach the un-reached* spills over into its recommendations on data collection. It recommends putting in place a system consistent with the CRC and disaggregated by gender, age, social status, urban and rural location, etc., with emphasis on the excluded groups — a CRC-based data set. The information gathered is to be made publicly available and is to form the basis for drawing up programmes and policies for effectively implementing the Convention. This recommendation of the Committee is important as a crucial input in further improving the framing of child budgets, where at present the outlays, especially in case of non-child-specific programmes, are allocated without the availability of data on the number of children, including those of the excluded groups, who would be benefited. Such an initiative deserves the full support of all pro-child civil society groups.

The comparative status of under-privileged children in the 0-6 age group in vital indicators such as anaemia, infant mortality, vaccination status, registration of births, etc., as well as that of women (maternal deaths, ante-natal care, contact with health workers, assisted births, place of delivery,) shows very alarming disparities with other children. Besides the inequalities based on caste and community, the inequalities based on wealth, rural-urban location, religion, education status (including educational status of parents), age and higher parity (of women) are strikingly brought out in the data presented in NFHS III. A valuable lesson to be learnt is that while focusing on the un-reached and the excluded based on largely social and ethnic indicators, *the ranking in terms of wealth order* should not be dispensed with. The way data is presented can reveal the realities of the discrimination that children face in their daily lives.

Data can either highlight harsh truths or subsume them under different frameworks of presentation.

While state-wise presentation of data is essential for administrative considerations, there is now an emergent need to also present data disaggregated by the indicators and factors of social, economic and other types of discrimination. The recommendation of the Committee to create a CRC-based data set which would show up the various disparities and to give it wide publicity on a regular basis should become a non-negotiable component of compliance to the CRC by the Indian State. This would be a first step towards planning for inclusive growth as far as India's children are concerned. Such data may exist today, but they are scattered over various documents, ministries, institutions and time periods. A compact compendium should be profoundly revelatory not only on the issue of children but for inclusive planning in general.

This context — specifically, the need for special provisions to maintain equal standards and norms and for disaggregated data on the basis of various social indicators — leads to the problems in translating outlays to outcomes, 'non-institutional' factors playing a key role in preventing proper utilisation of funds available. The methodology of child budgeting, with a welcome focus on children's needs and rights, comes with a flaw of focusing only on child-specific programmes and policies, rather than on programmes from across the budget that both directly and indirectly affect children. Finally, the division of child budgets into four neat categories — development, health, education and protection — can also be problematic in that certain heads receive lower priority than is required, while the entire focus remains on the others.

The paper finally looks specifically at ICDS IV, keeping in mind the principle of universalisation, identifying problems in the approach of the MWCD and the architectural changes that must be brought in order to achieve such universalisation while focusing on children from vulnerable groups.

Gaps in outlays and expenditure

The attention now being given to the measurement of outlays on 'child specific' programmes has improved knowledge and awareness of the subject of investment in children. From 1998-99 to 2007-08, these direct outlays for children ranged from 1.98% to 5.08% of the Union budget (there have been appreciable increases in the outlays for the child in the period from 2004-05 to 2007-08). These are *outlays* — not *expenditure* — and are nowhere presented in terms of outcomes for the development of the child. As such it is a 'single-dimension' indicator of changes in State priority to children.

One cannot, therefore, make any statement on the adequacy of the outlays in relation to outcomes. The outcomes to which India has pledged itself are part of the World Fit for Children (WFFC), Millennium Development Goals (MDG) and Convention on Rights of the Child (CRC) commitments besides the Five Year Plan targets. These are very clear and unambiguous. What seems to be little known is the sufficiency (or otherwise) of the resource allocation for realising these commitments within a given time frame.

However, there seems to be evidence of fresh thinking within the Government. In addition to child budgeting being visualised as an analytic tool for assessing the budget priority for children, it is being seen *as a tool to examine whether children's programmes adequately reflect children's rights and needs*.

The 'Child Budgeting' exercise aims principally at an assessment of the *utilisation* of allocated provisions. For making improved utilisation a reality, the MWCD would have to go in for fiscal decentralisation, participation, transparency and accountability to democratise the process of

implementation. In order to focus on achieving a desirable outlay-outcome equation, *outcome indicators* will be formulated to assess the impact — both *intermediate* and *final.*

The MWCD began 'child budgeting' in 2002-03, an exercise that continues. One of the trends the Ministry noticed during 2004-05 was that *actual expenditures* were falling short of *budgeted outlays* (Annual Report, MWCD 2005-06. Given the widely accepted fact of insufficiency in most of the budget outlays for children, the *shortfall in expenditure over outlays* indicates a grave situation, which the Government itself accepts in its report. The reasons given by the MWCD for this situation are *lack of capacity to spend or to absorb funds*, delays caused by procedures, and slack implementation. A workshop convened by the Ministry noted the gaps between budget outlays and outcomes in key areas such as mortality, nutrition and education. It recognised that the lack of capacity to utilise funds was inhibiting the improvement of key indicators of child development. It acknowledged that the lack of optimal utilisation was due to 'non-financial' constraints (Annual Report, MWCD 2005-06, but failed to specifically delineate these.

When the adequacy of the budgeted funds is itself in doubt, the lack of institutional capacity to optimally utilise even these funds compounds the situation.

While rallying against inadequate public outlays and spending is totally justified, it should be accompanied by an equally vigorous campaign to relate outlays to outcomes through the building of requisite capacities.

The key is proper and effective utilisation of the budget outlays and not just expenditure that may not produce results. This is an issue that has not received the attention it deserves. It is a wide ranging subject and relates to the entirety of the governance structure and its functioning.

Child budgeting — the framework and the methodology

The MWCD justifies the use of what it calls the *ex ante* approach to child budgeting — that is, it selects those schemes as 'child specific' which directly aim at providing services or goods to children. It holds that it is not possible to invest the generous amount of time needed or to battle the limitations of inadequate information and data for an *ex post* approach. The *ex post* approach would require the identification of 'the proportion of children among all beneficiaries in each of the development programmes/schemes run by the Government' (Annual Report, MWCD, 2006-07).

The criteria adopted to define 'child specific' schemes and programmes can be faulted on more than one count. The example below is from the MWCD's annual report.

The budget outlay of the All-India Institute of Medical Sciences (AIIMS), which has one of the best neonatology units in the country, does not find a place in the child budget. The reason given for its exclusion from the child budget is that 'the policy underlying this public expenditure does not specifically aim for better outcomes for children' (Annual Report, MWCD, 2006-07, Chapter 7, paragraph 7.15). There may be many other cases where 'child specific' services and goods are part of a larger programme, where a part of the total budget is dedicated to children. Such systematic identification across the entire Government budget is a prerequisite for accurately determining the quantum of resources available for children and, more importantly, for quantifying the additional investments needed over the years to reach the set goals for the child.

This imperative of measuring the resources available for children *across the budget* (across ministries) brings the child budgeting exercise closer to a methodology that has been part of gender budgeting exercises.

The MWCD itself accepts that in the case of such important (non-child segregated) budgets as for the Accelerated Rural Water Supply Scheme and Total Sanitation Campaign, *how many children benefit are actually covered remains an unknown factor.*

Even if such data is available at an aggregate or consolidated level (national or state), it may not be readily available at the district and sub-district levels, where they are vital if local planning is to be facilitated through an outlay-outcome equation. The lack of small-scale local analysis and planning (at the level of the village and project) inevitably leads to concentration of planning and emphasis on public investment aggregates. The situation has not materially changed even after the 73rd Constitutional Amendment.

The larger question is whether attention should remain exclusively focused on increases and decreases in the outlays on child-specific programmes. There is a tendency to exclude sector outlays (such as environment and slum development, to name just two) which may not be categorised as child-specific but which are crucially important for children's all-round welfare and development. This raises another question: Has the Indian State been able to spend adequately even on social services, keeping in mind the acute need for such spending? All indications are that it has not.

Further, a systemic move towards greater empowerment of panchayats and community-based organisations — giving these bodies the physical, financial and other resources as well as the authority to implement, supervise, monitor and make crucial changes at the local level — can be at least as significant as numerical increases in budgetary outlays. To strengthen local communities and devolve powers to the elected panchayats, *and to make them more aware of the issue of children's rights and the CRC,* needs both financial and non-financial investments.

This is seldom seen as a child issue, and needs to be taken up by child lobbies.

Development, health, protection and education

The neat division of the child budget into the above four categories — development, health, protection and education — is not without subjective bias, which the MWCD itself acknowledges. The MWCD highlights the exceedingly low outlays for child protection. This segment has always received the smallest part of the child budget. Not only has the increase in allocations on child protection over the last few years been very small, its total size is also tiny; the increase for child protection has been from 0.027% of the total Union budget outlays for children in 2001-02 (revised estimates) to 0.034% in 2006-07 (budget estimates), and the total outlay under this head for 2006-07 is a minuscule 0.70%, less than 1% of the total Union outlays for children whereas the percentage outlays on the other three heads (development, health and education) are 17.72, 11.43 and 70.14 respectively (MWCD Annual Report 2006-07).

How big an outlay is needed to ensure rights to all children needing protection?

The disparities in resource allocation for child protection are long-standing. Looking at the size of the constituency of children who need protection, it is difficult to take a minimalist approach. The sub-group on child protection set up for the Eleventh Five Year Plan (2007-12) advocates both a *preventive approach* — going beyond conventional strategies built on advocacy, training and capacity-building, to proactively identify potentially vulnerable families — and a *protective* approach, not only dealing with situations 'post-harm' but investing in long-term protection strategies. This new perspective is quite different from the earlier one where 'protection' was understood in the more limited context of certain at-risk groups such as street children, working children, children under the juvenile justice system, victims of crime, differently-abled children, etc. There are two crucial questions here — first, the

availability of resources for the Eleventh Plan for child protection; and second, the presence of institutional capacities to deliver the services proposed in the new perspective on child protection.

From 2000-01 to 2004-05, the actual expenditure on child protection in the Union budget ranged between Rs. 67 crore and Rs. 147 crore whereas the sub-group recommendations for each of the five years of the Eleventh Plan is above Rs. 2000 crore Sub-Group Report on Child Protection).

Children in the age group 0-6: Universalisation and the ICDS programme

The flagship ICDS programme is now more than 30 years old. The first India CRC report (1997) reported that 1.8 crore children (in the 0-6 age group) were covered by the programme; as on 30 September 2006, the programme covered 5.43 crore children (Annual Report, MWCD, 2006-07). Reva Nayyar, who was earlier Secretary at the MWCD, commented during a recent seminar that of 16 crore children (the total number of children in the age group 0-6 years according to the 2001 Census), only 6 crore are registered under the anganwadi programme ('Brief Report of the National Seminar on Feeding the Child', February 2008, organised by the Swami Sivananda Memorial Institute, New Delhi).

The first India CRC report, even as it showed a coverage of 1.8 crore, claimed that the programme had been *universalised* in March 1996. The concept of universalisation used by the Government in the 1997 report was quite at variance with that used by the Supreme Court in its path-breaking orders in what is generally called the Right to Food case: PUCL vs. Union of India and Others, Writ Petition (Civil) 196 of 2001.

In concrete terms, 'universalisation with quality' would mean that (1) every settlement has an anganwadi centre, (2) all ICDS services reach all children under 6 and all eligible women and girls, (3) the quality of services is radically improved, and (4) priority should be given to disadvantaged groups, especially residents of scheduled caste/ scheduled tribe (SC/ST) hamlets and urban slums, in this whole process.

The limited context in which the word 'universalisation' was used in 1997 comes out in a concept note prepared for the Eleventh Plan by the MWCD (2007, 'ICDS -IV Project Concept Note (Revised)', 14 September 2007, Central Project Management Unit, MWCD, Government of India), where the observation has been made that *till the end of the Ninth Plan, the ICDS programme was expanded to cover all the blocks of the country, and that now (i.e., for the purpose of the Eleventh Plan) it is planned to universalise it.*

A comparative study of the status of maternal and child health at the all-India and state levels (Madhya Pradesh) are illustrative: Nationally, 81.1% children under age six are living in enumeration areas covered by an anganwadi centre, but merely 28.4% of these children have received any service in the past year. In Madhya Pradesh, 79.8% children under age six are living in enumeration areas covered by the centre but merely 43.8% have received any service in the past year (Vikas Samvad, 'Status of Child and Maternal Health in Madhya Pradesh and India — A Comparative Analysis').

One of the systemic defects is the time lag that occurs in making the anganwadi centres operational from the time they are sanctioned and funds provided. Though the number of ICDS projects was increased from 5,652 in 2005-06 to 6,284 in 2006-07, by the end of March 2007 only 5,829 projects were actually operational. Overcoming this blockage needs solutions by way of decentralisation of authority to the State, district, panchayat and community, other linked reforms and improvements, besides simplification of financial and administrative procedures.

Most of the suggestions in the concept note prepared by the MWCD on ICDS IV in the Eleventh Plan are conventional. It talks of decentralised management 'to integrate *health services, sanitation*

and hygiene, safe drinking water, gender and social concerns and child care behaviours' but stops short of detailing the authority and the powers of the panchayats in this respect. Genuine decentralisation and devolution of powers strengthens local government — which can (and should) *further improve its outreach to local communities through partnerships with community organisations and NGOs*.

The refusal to acknowledge this distinction results in equating elected bodies such as panchayats and municipal committees with NGOs and community organisations. The result is generally negative for all these bodies.

Some of the thinking in the concept note leads to disturbing conclusions. A policy perspective is presented in which *the very concept of universal coverage of services with special attention to marginalized and excluded groups seems to be in danger of being set aside*.

The World Bank has chosen 160 districts from eight states for intensive support in ICDS IV, with Andhra Pradesh chosen as a 'best practice' State, and the remaining 7 states chosen for the highest concentration of malnutrition. Though the concept note labels this as an instance of *better targeting,* there are several ramifications to this. Malnutrition in India, says the concept note, is concentrated in certain districts and villages. But the fact is that these districts and villages extend all over the country and are not confined to these 7 states. The concept note creates an artificial division *among* the *states* — some for focused attention in the new ICDS IV programme, including a 'best practice State' — as well as *within* the States by including some districts and excluding others. As such, this can hardly be called an instance of *better targeting*. Administrative units such as districts and states have been chosen; but communities, settlements and geographically and socially deprived areas have not been so chosen.

This concept note prepared by the MWCD deserves comparison with a framework for ICDS that is part of a larger paper on strategies for children under six years of age, prepared at the request of the Planning Commission. This has been put together by a 'Working Group for Children Under Six' (consisting of well known activists and experts on early childhood development), which looks at the overall situation of children of this age group (rather than in the specific context of ICDS), especially in the light of the latest NFHS survey. It addresses itself to the need for multi-sectoral interventions to remedy the situation. It finds that the ICDS alone cannot provide all the required facilities and services and suggests that it should be seen as one component, among others, of a comprehensive strategy for children under six. But it also sees the ICDS as having both the potential and the mandate to fulfil many of the multiple health, nutrition and educational needs of children under six years.

In contrast, the concept note for ICDS IV claims that the ICDS scheme would remain in the forefront of the Government efforts to achieve the *child nutrition-related Millennium Development Goals* — not only halving the underweight rates, reducing IMR and improving maternal health, but also reaching universal primary education and EFA and expanding ECCD, 'since malnutrition is closely linked to all of these MDGs …'.

The FOCUS Working Group lists the overall strategies for children under six as (a) food entitlements for children and maternity entitlements for women, (b) a system of child care that supplements care by the family and empowers women, and (c) a system of locally available health care for common but life threatening illnesses. The paper also presents a framework to deal with the specificities of the ICDS programme, within which its potential can be achieved.

One crucial restructuring of the programme suggested by the Working Group on Children Under Six is the

revision of the existing figure of 300 calories (in vogue since long ago) as the deficit to be made up through supplementary nutrition.

The concept paper of the MWCD on ICDS IV stops short of discussing certain 'hot' current issues critically relevant to the programme, such as food fortification and micro-nutrient supplements. The pros and cons of food fortification do not find a place in the paper. Food fortification has become a contentious topic in the country, even as the production of fortified foods is rising. The concept paper merely quotes from the Government Plan of Action for Nutrition, which recommends fortifying foods with micro-nutrients as one of the strategies to combat micro-nutrient deficiency (MND). It does not go beyond and engage with the post-globalisation situation.

Most important of all, the MWCD concept paper begins and ends with the ICDS. It does not grapple with the universe of the 0-6 age group in its entirety. It looks at this universe through the ICDS framework. It seems that the Ministry sees this concept paper as an exercise in planning for the development and rights of children under six for the entirety of the Eleventh Plan. It assumes that all the challenges posed by the MDG and WFFC can be met with an improved version of ICDS.

2 The Predicament of the Girl Child: To Be or Not to Be

Part I

The Social Context of the Missing Girl

Savitri Ray

The SAARC Decade of the Girl Child (1990-2000) has tragically been the decade when the Girl Child went missing at a rapid rate comparable to what happened in the 1980s with regard to the 'missing women'. Of the 1.2 crore girls born in India every year, as many as 30 lakh do not live to celebrate their 15th birthday. The 'disappearance' of girls has impelled activists, academics and policy-makers to shift attention to the declining child sex ratio (CSR).

The explanation that 'cultural biases' have led to the 'disappearance' of the girl child is both simplistic and inadequate. Such a generalisation diverts attention from socio-economic processes and contexts, and the effects of development policies and the broader State policies within which such cultural notions take form and substance.

Existing research veers between cultural and structural arguments. Colonial scholarship stressed the cultural basis, finding that the practice of female infanticide among the middle and higher level status groups in different castes was linked to status maintenance and dowry avoidance. Contemporary research has, however, shown how these so called cultural practices in colonial times were, in fact, the result of colonial rule — the 'masculinisation' of the colonial economy and the further alienation of women from property rights producing

the context within which dowry and son-preference became entrenched. However, caste still figures significantly in different ways in studies on the declining sex ratios in specific regions.

Surveys conducted by population research centres in several states found a direct correlation between the sex ratio and the number of registered ultrasound clinics. For instance, the more prosperous western part of Maharashtra accounts for 78% of the sonography clinics registered in the state. Not coincidentally, these are also the districts with very adverse sex ratios.

Recent studies have highlighted the combined role of globalisation, easier access to technology, factors related to labour practices, consumerism and the role of the educated urban middle class in impacting the sex ratio. These studies have questioned simplistic explanations regarding the sex ratio, and propose a more nuanced understanding of the disturbing trend.

Some studies have also suggested a strong correlation between female labour participation and juvenile sex ratios in India. It has been observed that where female labour participation is high (as in some southern states) there is always a high preservation of female life and where female labour participation is low (as in northern India) female children may or may not be preserved. It suggests that the economic contribution made to the family by a woman through her participation in the workforce is a significant factor that contributes to the viability of the girl child. Simultaneously, there are also indicators that increased female participation in the labour force affects child mortality adversely.

However, what is striking is that female foeticide is disturbingly high in urban areas as compared to the rural areas. The sharp decline in the urban female to male ratio among children cannot be explained by migration or biologically obtained high sex ratio at birth but clearly indicates female foeticide. Leela Visaria, in her study of sex selective abortions in the states of Gujarat and Haryana (2003, 'Sex Selective Abortion in the States of Gujarat and Haryana: Some Empirical Evidence'. New Delhi: Healthwatch Trust) shows that the preference for male children is higher among better educated people belonging to higher castes and land-owning families.

Other studies have tried to do away with urban-rural or north-south binaries and tried to explain cultural factors that determine sex-selective abortions. Set in Tamil Nadu and Haryana, Sayeed Unisha, Prakasam and Sinha's studies (Evidence of sex selective abortionsfrom two settings of India) stress that while the abortion rates are increasing in both states, the reasons for these are different. While in Tamil Nadu, women may be opting for abortions as a family planning method, in Haryana abortions are largely done as a result of son preference. However, the study still concludes that sex-selective abortions constitutes anywhere between 60% and 80% of total abortions.

Many studies point to the role of the powerful lobby of the fertility industry in USA (these include sperm sorting and pre-implementation genetic diagnosis) and of the reduced tariffs on technologies imported from outside. Sabu George (2005, CWDS campaign on female foeticide) points out the silent nod given to sex selection by multinational companies: "Corporations benefit from female foeticide. MNCs have made billions by selling ultrasound machines. The country has 15 companies selling these machines and there are many others, including those from Japan, waiting to enter the market." Domestic production of ultrasound scanners has also seen a dramatic increase.

While the access to reproductive technologies has been facilitated by the government, many studies lament the poor awareness and implementation around the Pre-conception and Pre-natal Diagnostic Techniques (PCPNDT) Act.

The fact that Christians have the most favourable sex ratios is partly due to the fact that the overwhelming majority of Christians are from scheduled caste and tribes communities, which have better sex ratios; the Sikhs have the most unfavourable sex ratios followed by the Jains.

Another disturbing finding is that there is a negative correlation between birth order and sex ratio. A study by the Christian Medical Association of India shows that in Delhi, the sex ratio at birth (SRB) for third children, when both earlier children are females, is a shocking 219 girls for every 1000 boys born. The desire for small families is also leading to an increase in the preference for sons.

Social Context of Female Foeticide in India

Since the deficit of women was first noted, there have been various hypotheses advanced to explain this and various factors have been identified. The possible reasons are under-numeration of women, out-migration of females and above all, greater excess of males at birth due to factors such as female infanticide and foeticide. While under-numeration and out-migration are valid reasons, the deficit due to them would be marginal. Female infanticide and foeticide can therefore be cited as being the main reasons for the 8% deficit of women that exists in the Indian population today. Sex-selective foeticide / abortion and infanticide aside, neglect plays a significant role in the culling of girls. Gender-biased health spending is also a significant factor in the death of girl children.

Recent trends, particularly the neo-liberal policies since the early 1990s, have compounded the already vulnerable condition of the girl child. Increased privatisation of healthcare has been encouraged by the government in line with policies of liberalisation. One outcome has been the reduced import duty on medical electronic equipment — from 43% in 2000 to 24% in 2005-06.

There is ample evidence to show that female foeticide has got a further boost from the technical innovations realised for different and more humane purposes. The growing use of ultrasound, often referred to as sonography, and amniocentesis tests have been deployed to determine the sex of the foetus. Since these technology services are expensive, they are more popular among those who can afford these.

After many studies and constant pressure group tactics, women's organisations were successful in forcing the government to introduce the PCPNDT Act but as is often seen in the case of government legislation, there seems a lack of political will to ensure its proper implementation. The delivery system is poor and with almost non-existent vigilance mechanisms, the Act has had minimal impact leaving much to be desired.

The Predicament of the Girl Child: To Be or Not to Be

Part II

Sex Selection as Genocide

Sabu George

Introduction

India sees widespread practice of sex selection and sex selective abortion (female foeticide). Recent data — from the National Family Health Survey (NFHS-III), District Level Household Survey (DLHS-3) and Sample Registration System (SRS) — indicate that sex ratios at birth are becoming more masculine since 2001. More girls were eliminated before birth in India in the past seven years than the number of Jews exterminated during the Holocaust. In the coming decade, India is likely to eliminate up to 10 lakh (one million) girls every year. Data for 2005-06 reveals that India and China together eliminate more girls annually than the number of girls born in the USA.

The social consequences of eliminating 10 lakh girls before birth every decade, particularly for the surviving women, are indeed catastrophic. Violence against women will reach unprecedented levels in the coming years. In China, after three decades of the 'one child' family, with extensive foetal sexing,

Table 2.1: Child Sex Ratio by Area and Census Year

Census	Total	Rural	Urban
1981	962	963	931
1991	945	948	935
2001	927	934	906

there is shortage of 32 million women in the under-20 age population as per the 2005 Census. There are gangs that kidnap young urban women to sell to rural areas and the widespread acceptance of the violence of sex selection has also created a flourishing market for kidnapped sons!

In 2001, a large number of states had less than 900 girls to 1000 boys (0-6 years), while four states (Punjab, Haryana, Himachal Pradesh and Gujarat) had less than 800. In 1991, none of the States fell in the category where there were less than 800 girls for every 1000 boys. As compared to 1991, there are fewer districts with a child sex ratio of more than 950 girls to 1000 boys.

Child Sex Ratio patterns from the Census of 2001

From the 1970s, feminist scholars and women's activists had warned of the impending possibility of large-scale and systematic elimination of girls before birth through the misuse of sex selection techniques; but the country at large ignored such forecasts. In fact, even when there were indications in the 1991 Census, the NFHS survey of 1992-3 (Punjab state) and others, scholars did not consider sex selection as a possible explanation. Civil society also largely ignored this with the exception of some short-lived campaigns like the Maharashtra Campaign of the mid-1980s.

The most visible impact this Campaign had was in terms of the enactment of the PNDT Law in Maharashtra, 1988, and, subsequently, the national law in September 1994. The virtual non-implementation of the law for six years is of course a blot on all of us who should have been pro-active much earlier.

Demographers Mari Bhat and Irudyarajan indicated in the late 1990s and early 2000s about the impending possibility of masculinisation of sex ratios at birth. The Census officials, particularly the Registrar General, Mr. J.K. Banthia, should be commended for the systematic analysis of the data, forthright recognition of the emerging genocide of unborn girls, and public advocacy of the adverse child sex ratio findings. This contribution of the Census 2001 officials is historic in that a Government body was willing to acknowledge the dimensions of an issue long neglected by even academics.

National and state level trends

The Census has acknowledged that child sex ratios (CSR), have decreased at a much faster pace than the overall sex ratio of the country after 1981. There were only 3 states/UTs with less than 900 girls for 1000 boys in 1991 but in 2001 there were 6 states. There has been a dramatic drop between 1991 and 2001 in CSR (0 to 6 years) in Punjab, Haryana, Himachal Pradesh, Delhi, Gujarat, Chandigarh and Maharashtra; Punjab has an alarming ratio of 798. The first private foetal sex determination clinics were established in these states and the practice of selective abortion of female foetuses became popular in the late 1970s and early 1980s. Karnataka, Tamil Nadu and Andhra also have shown a decline in CSR but the drops are less because the sex determination clinics emerged only a decade after they did in the North.

For India as a whole, the urban CSR has dropped twice as much as the rural (29 points vs. 15). This is because access to sex determination — and their utilisation — is greater in urban areas. Based on time trends in CSR data, Dr. Agnihotri who has pioneering work in this field argues that the initial drops are in urban areas, spreading to rural areas after many years, where it drops faster than the urban CSR once access to sex determination is no longer the limiting factor. For instance, in Punjab, which pioneered the private sex determination (SD) clinics from the late 1970s, today there is hardly any difference between the urban and rural. Over 25 years, sex determination has

been aggressively promoted by agents of medical professionals, with rural areas practising sex determination for over a decade.

District level trends

The best performing districts in CSR are in remote areas that have poor access to sex selection technology. Only 8 of India's 592 districts have more girls than boys and three of them are in Kashmir. Expectedly, the worst performing districts are all in Punjab and Haryana, the cradle of private SD clinics. But even in states like Jammu & Kashmir and Chhattisgarh, the presence of even a few machines, often less than 10 per district, was adequate to bring the CSR to less than 900.

History of sex selection in India

Foetal sex selection began in the 1970s in India. Amniocentesis was introduced by non-resident Gujarati medical entrepreneurs from USA. The first published scientific paper (by All India Institute of Medical Sciences scientists), in 1974, proudly advocated sex determination as a boon to Indian women. Following concerns raised by activists, the Government of India banned such tests in Government hospitals in 1978, following which sex determination facilities were established by the private sector. The first such clinic in North-West India came up in Amritsar in 1979; clinics were soon set up in other parts of Haryana and Punjab; these appeared in Maharashtra

Table 2.2: Comparative Child Sex Ratio Distributions District-wise by SC, ST and General

Ranges	SC	ST	General
Less than 800	11	23	32
800-849	20	8	37
850-899	79	38	95
900-949	184	102	230
950-999	252	278	191
1000+	24	91	8
Total (ex-J&K)	570	540	593

The Sample Registration System (SRS) provides the most recent data on sex ratio at birth data for India. Despite mandated registration of births and deaths, the actual registration is far from satisfactory overall. To generate reliable and continuous data on these indicators, the Office of the Registrar General initiated the SRS from 1969-70, which currently covers 1.4 million households constituting over 70.1 lakh population. The limitation of SRS is that it yields only estimates. Three-year data is pooled together to reduce the statistical variance of the sex ratio at birth estimate for the bigger states.

The sex ratio at birth of 901 suggests that 51 girls are eliminated before birth for every 1000 boys. The female infant mortality rate in 2007 was such that 56 girls died for every 1000 live born girls in the first year of life.

Traditionally, the most dangerous phase for a woman has been infancy. But the greed of unethical doctors has made the foetal stage as dangerous as infancy for an Indian woman. The sex ratio at birth (SRB) for an urban Indian girl — at 891 — makes the risk higher than for her rural counterpart and higher than the female infant mortality rate (IMR, at 39); thus, there is a 56% higher risk for an urban Indian girl of being eliminated in the womb as compared to dying in the first year of life.

in the early 1980s. The CSR in Punjab dropped from 925 to 874 (girls per 1000 boys) over the inter-censal period 1981-1991. The first systematic analysis on the declining sex ratio at birth from hospital data was published in 1994 by the Christian Medical College (CMC), Ludhiana.

The Government of India Response: Enactment of Pre-Natal Diagnostic Techniques (PNDT) Act, 1994

In 1994, Parliament enacted the PNDT Act to prevent the misuse of prenatal sex determination. Though this Act came into force from January 1996 it was not implemented. The Rules framed in 1996 were such that these did not cover 95% of ultrasound machines, thus making a mockery of the 1994 Act.

Following a Public Interest Litigation (PIL), filed in February 2000, the Supreme Court directed the Government of India and the states, on May 4, 2001, to ensure strict enforcement of the PNDT Act. It also directed the Government to amend the Act to strengthen implementation and enlarge its scope to cover emerging sex selection technologies. Subsequently, the Government took steps to implement the Act, registering over 20,000 clinics in the first two years (2001-2003, as opposed to 600 when the petition was filed in 2000) and seizing more than 500 unregistered machines; several hundred cases were filed for various violations of the Act.

The Ministry of Health & Family Welfare (MoHFW) prepared a comprehensive set of amendments to the original PNDT Act, 1994 and Parliament passed the Amendment Bill in December 2002. The salient features include, among others: Inclusion of pre- and post-conception (sperm and embryo) methods as sex selection measures; Mandating registration of ultrasound machines and maintaining records of scans; and Enhancing penalties for violations of the Act.

Adoption of amendments harmonised our laws with the provisions of the several international covenants — like CEDAW and CRC — to which India is a signatory.

As of October 2008, 34,793 clinics were registered under the Act. However, the practice of ultrasound is not yet regulated. The proliferation of ultrasound scans is a matter of concern since the most common use of the scan machine is for foetal sex determination. Annually, 6,000 ultrasound machines are sold (as per industry sources), while the registration is barely 4,000 annually. This suggests that the registration has slackened since 2003, following the closure of the litigation in the Supreme Court.

Going by the data, it appears that one case is filed for every 10,000 sex determination crimes. We are here not even talking about ultimate legal convictions. Given the nature of trials in the lower courts, the rates of convictions are very remote. The first conviction of a doctor was in the year 2006. Later, the District Court overturned this conviction!

The failure of the Union Government

There is evident lack of seriousness on the part of the Union Health Ministry to implement the PNDT Act. The most serious problem in implementation has been the Ministry's decision to give the Medical Officers the responsibility to regulate ultrasound clinics while allocating power to the District Collector! Apart from the dichotomy, the Collector already has enormous responsibilities — and little relevant technical understanding — which means the virtual marginalization of the PNDT Act.

Further, the Health Ministry has not convened the Central Supervisory Board for the past 18 months (the obligation is once every six months). Thus, there is no systematic monitoring of the states' performance in the implementation of PNDT Act, and no consolidated reports as directed by the Supreme Court. After the

Union Minister of Health unilaterally announced, in 2008, that the Ministry of Women & Child Development would handle all responsibilities under the Act, many State Supervisory Boards and District Advisory Committees have stopped being active as has the National Inspection and Monitoring Committee. In 2006, the Committee was not allowed by vested interests to inspect notorious clinics in Meerut; the Union Health Ministry allowed such gross contempt for the law to go unchallenged.

This long period of indifference has led to the non-functioning of the mechanisms at the state level. Registration levels have fallen and very likely the re-registration of clinics due in 2007-8 may be affected (clinics are given licenses for five years; several thousand were first registered under the pressure of the Supreme Court).

Hope for the future: Possibilities

Few civil society groups have taken Governments to task for their fundamental failure to ensure the rights of millions of missing girls to be born. The exceptional efforts within the Government and the civil society give us hope that the law can be implemented and that there are civil society initiatives that show promise and together they can make a difference in ensuring that girls have the right to be born. There have been a few people in the Government at various levels who have indeed been concerned. These include District Collectors in Khammam/ Hyderabad, Morena/Shivpuri, Shivpuri/ Mandsaur / Rewa, who have demonstrated the potentialities of the law across the period of 2002 to 2009. There have also been notable efforts by Vatsalya in Madhya Pradesh, the Campaign Against Sex Selective Abortion (CASSA) in Tamil Nadu and the Voluntary Health Association of Punjab (VHAP), among others.

The discourse in the media and in sections of the country on declining sex ratios at birth in the recent years, post-2001 is encouraging. However, there are few effective actions to counter the formidable public campaign by medical professionals to promote and legitimise the practice of sex selection. Unethical practitioners are employing agents, motivating local quacks and at many places employing even functionaries of the State health system (ANMs) and the anganwadi system to reach out to potential clients.

Conclusion

Of the 600-plus districts in the country, only in a few there is likelihood of any improvement. But in a vast majority of the districts one can expect substantial declines. The overall picture is dismal. We see remarkable consistency among the findings at various levels (National, State, District and sub-District). The response of sex ratio to variables like urban/rural, prosperity and caste are all on expected lines. The declines in CSR are consistent with our knowledge of the practice of sex determination (when SD was initiated, availability of scan machines, presence of mobiles). All this provides causal evidence of the role of sex selection in the rapid declines in child sex ratios in most districts where it has occurred.

3 Health and Nutrition of Children under Six

Mira Shiva

India is among the most malnourished countries when it need not be so. According to the Human Development Report (HDR), India's Human Development Index (HDI) ranking was 128 in 2007, 126 in 2006 and 127 in 2003, 2004 and 2005. The International Food Policy Research Institute (IFPRI) ranked India 94th in 2007 on the Global Hunger Index. According to the NFHS-III report, 21.5% infants born in India are Low Birth Weight babies; however, HDR 2007 gives a figure of 30%. Though the IMR has shown a 1% annual decline between 1998-99 and 2005-06, it is still unacceptably high.

With a high economic growth rate of 8%, the health and nutritional status of children in India was expected to improve significantly. But the poor nutritional status of children, which actually worsened in some places, clearly showed that to improve the nutritional and health status of children, their mothers required measures which gave priority to *public health and nutritional security* rather than trade interests. Economic growth that is accompanied by inequities does not translate into a better situation for all.

Denial of basic determinants of health, food, and safe drinking water often results in malnutrition, acute repeated and prolonged untreated infections. This is compounded by poor access to healthcare services, health illiteracy and overall lack of awareness about health hygiene, poor sanitation and transport facilities, and low purchasing power. Together, this leads to high mortality rates for children.

Among the several causes of infant mortality, is maternal and infant *malnutrition*. The averages, however, do not reflect the extreme gaps. In view of poor birth and death registration and the seasonality of certain diseases, many deaths of the vulnerable sections in un-reached areas are not even reported.

Schemes directed to improving the nutritional status of pregnant mothers such as the National Maternity Benefit Scheme (NMBS) — where pregnant women from below poverty line (BPL) households are given Rs. 1000 to meet their nutritional requirements — are also not implemented properly. The Janani Suraksha Yojana is meant to promote institutional deliveries for mothers from the BPL category.

The disparities between rich/poor and rural/urban and amongst people of different castes and religions are significant, and contribute to the nutritional status of the children in these areas. Gross gender disparities amongst underweight children worldwide are highest in South Asia. The need for disaggregated data by gender, social and economic inequalities becomes extremely important in order to identify vulnerable and affected sections to be able to take action to prioritise their health needs.

Diarrhoea, the major killer: Acute diarrhoea continues to kill a large number of children and is closely linked to poor access to or unavailability of safe water. Falling water levels, dried water sources and floods make access to safe drinking water worse.

In cities contamination of water by sewage has spread diarrhoea and faecal infections, such as typhoid, paratyphoid, cholera, hepatitis, amoebiasis, and helminthiasis.

A number of child deaths are due to diarrhoea-related dehydration. According to the World Health Organisation (WHO), only 50% of acute diarrhoea cases have been treated with oral re-hydration solutions (ORS), either home-made or from packets that cost between Rs. 6 and Rs. 10 per litre commercially (low-cost packets are supposed to be available free under the National Rural Health Mission, NRHM).

With 80% healthcare in private hands and poor quality of care, diarrhoea deaths occur even on reaching healthcare facilities. About 80% of medical care sought in slums is from unqualified medical care providers; however, their services are continued to be sought as they are accessible, affordable and, while they often create complications, often actually do provide relief.

Alongside the worsening access to safe drinking water, the poor have worse access to good quality food. Spiralling food prices, loss of livelihoods, decreased purchasing power and climate change, have together resulted in droughts and floods and forced migration that has increased vulnerability to malnutrition and infection.

Malnutrition: About 40% of the world's malnourished children live in India. NFHS III data shows that 46% of children under 3 are underweight, (deficit in weight for age), 38% are stunted, (deficit in height for age), and 19% are wasted, (deficit in weight for height). India is home to 40% of all low birth weight babies in the world. Malnutrition among Indian children is worse than in Sub-Saharan Africa.

Malnutrition affects not only physical growth, but also cognitive potential, and increases vulnerability to infection, resulting in poor health throughout life. Not only are these children at higher risk of dying early in life, but "… the survivors are liable to have an impaired immune system. These surviving children may also suffer a higher incidence of such chronic illness such as diabetes and heart disease."

About 80% of children in the age group 6-35 months are anaemic; also, the increase in childhood anaemia, which is not restricted to the poor, is alarming. Reasons for this include maternal anaemia, late and inadequate complementary feeding, inadequate intake of iron-rich foods due to lack of nutritional awareness, helminthiasis intestinal worm infestation, repeated diarrhoea due to unsafe drinking water and poor sanitary conditions. The rising price of food items is definitely

Table3.1: Early Childhood Mortality Rates by Background Characteristics

Neonatal, postnatal, infant, child and under-five mortality rates for the five year period preceding the survey by background characteristic and residence, India 2005-06, and for NFHS-II and NFHS-I

Background Characteristics	Neonatal Mortality (NN)	Post neonatal Mortality	Infant Mortality	Child Mortality	Under-five Mortality
URBAN					
Education					
No Education	38.2	23.1	61.3	21.4	81.4
<5 years complete	39.9	13.4	53.3	6.5	59.4
5-7 years complete	31.4	16.7	48.1	7.5	55.2
8-9 years complete	25.8	5.4	31.2	4.7	28.7
10-11 years complete	16.2	8.3	24.5	4.3	28.7
12 or more years complete	19.4	4.2	23.6	4.7	28.2
Religion					
Hindu	30.9	13.3	44.3	10.9	54.7
Muslim	21.6	13.9	35.5	9.6	44.8
Christian	11.3	5.0	16.3	9.4	25.5
Sikh	*	*	*	*	*
Buddhist/Neo-Buddhist	*	*	*	*	*
Other	*	*	*	*	*
Caste/Tribe					
Scheduled Caste	35.0	15.7	50.7	15.5	65.4
Scheduled Tribe	29.0	14.8	43.8	10.4	53.8
Other Backward Class	26.4	15.8	42.2	12.9	54.5
Other	27.5	8.6	36.1	6.2	42.1
Wealth Index					
Lowest	39.4	25.4	64.8	29.2	92.1
Second	40.8	21.6	62.4	21.5	82.5
Middle	32.0	17.8	49.8	16.4	65.3
Fourth	31.3	14.9	46.2	8.0	53.9
Highest	21.1	6.3	27.4	5.6	32.8
Total	28.5	13.0	41.5	10.6	51.7
NFHS – 2	31.7	15.4	47.0	16.9	63.1
NFHS – 1	34.1	22.0	56.1	19.6	74.6
RURAL					
No Education	47.0	24.1	71.1	27.8	97.0
<5 years complete	50.5	18.6	69.2	15.8	83.8
5-7 years complete	35.8	14.4	50.1	13.3	62.8
8-9 years complete	35.1	11,6	46.7	6.1	52.5
10-11 years complete	35.0	10.5	45.5	3.0	48.3
12 or more years complete	20.0	9.6	29.6	2.3	31.8
Religion					
Hindu	43.3	19.7	63.0	20.9	82.5
Muslim	40.1	20.3	60.4	23.1	82.2
Christian	42.0	12.8	54.8	12.9	67.0
Sikh	34.3	11.7	46.0	8.7	54.3

Buddhist/Neo-Buddhist	(36.7)	(10.0)	(46.6)	(17.3)	(63.2)
Other	44.7	42.0	86.7	49.2	131.7
Caste/Tribe					
Scheduled Caste	49.6	21.4	71.0	25.6	94.7
Scheduled Tribe	40.9	23.0	63.9	38.3	99.8
Other Backward Class	42.1	19.1	61.1	18.7	78.7
Other	38.1	17.5	55.7	13.3	68.2
Wealth Index					
Lowest	48.8	21.9	70.7	32.5	100.9
Second	44.9	24.2	69.2	22.8	90.4
Middle	41.2	19.4	60.6	13.8	49.1
Fourth	32.4	9.9	42.3	7.1	49.1
Highest	24.3	9.2	33.6	2.7	36.2
Total	42.5	19.7	62.2	21.0	82.0
NFHS – 2	46.7	26.6	73.3	32.8	103.7
NFHS – 1	52.9	32.2	85.0	37.6	119.4
TOTAL					
Education					
No Education	45.7	24.0	69.7	26.9	94.7
<5 years complete	48.4	17.6	66.0	13.8	78.8
5-7 years complete	34.5	15.1	49.5	11.5	60.5
8-9 years complete	32.0	9.5	41.5	5.6	46.9
10-11 years complete	26.9	9.6	36.5	3.6	40.0
12 or more years complete	19.6	6.3	25.9	3.9	29.7
Religion					
Hindu	40.3	18.2	58.5	18.5	76.0
Muslim	34.1	18.2	52.4	18.6	70.0
Christian	31.5	10.1	41.7	11.6	52.8
Sikh	35.9	9.7	45.6	6.8	52.1
Buddhist/Neo-Buddhist	43.0	9.8	52.8	17.1	69.0
Other	43.3	41.4	84.6	50.4	130.7
Caste/Tribe					
Scheduled Caste	46.3	20.1	66.4	23.2	88.1
Scheduled Tribe	39.9	22.3	62.1	35.8	95.7
Other Backward Class	38.3	18.3	56.6	17.3	72.8
Other	34.5	14.5	48.9	10.8	59.2
Wealth Index					
Lowest	48.4	22.0	70.4	32.3	100.5
Second	44.6	24.0	68.5	22.6	89.6
Middle	39.3	19.1	58.3	14.4	71.9
Fourth	31.9	12.1	44.0	7.5	51.2
Highest	22.0	7.2	29.2	4.8	33.8
Total	**39.0**	**18.0**	**57.0**	**18.4**	**74.3**
NFHS – 2	**43.4**	**24.2**	**67.6**	**29.3**	**94.9**
NFHS – 1	**48.6**	**29.9**	**78.5**	**33.4**	**109.3**

Source NFHS-III, Chapter 7, Infant and child mortality.

a contributory cause; the cost of vegetables and fruits has spiralled and green leafy vegetables like *bathua* and *chaulai*, which grew wild in the wheat fields, are now labelled weeds and sprayed with weedicides. These are vanishing from the diets of urban and rural people.

The processing of rice and wheat negatively affects the availability of the existing nutrient. Polishing of rice and milling of *atta* superfine burns away certain essential amino acids. There is a need to address such de-nutrification processes at a policy level.

To improve child nutrition levels, the Ministry of Health sees its role as dealing merely with micro-nutrients, such as iron, folic acid and vitamin A (see minister's reply to a Lok Sabha question on January 2, 2008). The MWCD issued guidelines for Infant and Young Child Feeding and the National Nutrition Policy (1993) and the National Plan of Action for Nutrition (1995); the National Nutrition Mission was set up in 2003.

Breastfeeding: Only 23% babies are breastfed within the first hour of birth and 46% exclusively breastfed for the first six months as recommended. Exclusive breastfeeding meets daily nutritional needs and provide protection against diarrhoea, pneumonia and sepsis during the neo-natal period. Starting breastfeeding within an hour of birth contributes to decreasing neonatal mortality by one-third. If all babies were exclusively breastfed up to 6 months of age, 13%-15% of all under-five deaths could be prevented. Appropriate complementary feeding from the seventh month onwards would prevent and decrease childhood anaemia and also the risk of death by approximately 6%.

The Food Crisis and Corporate-Friendly Solutions

As the world faces a serious food crisis, corporate solutions to this crisis are being aggressively pursued. One such solution, the Global Alliance for Improved Nutrition (GAIN), clearly states as its objectives "expanding markets in developing countries" and "creating regulatory friendly environment", the focus remaining on markets rather than on substantive issues of health and nutrition. It does not address the root cause of the present food crisis – unjust agricultural and trade policies.

The food crisis is closely linked with policies and agreements pursued by institutions such as the World Bank and the World Trade Organization. A shift to non-food crops for the purpose of exports as part of the Structural Adjustment Programme (SAP) has accentuated the crisis. The increasing trend of appropriation of multi-crop fertile land for SEZs (special economic and export zones) and other industrial projects backed by corporate-friendly policies has put greater pressure on land available for agriculture.

Major policy shifts that have repercussions for the nutrition of mothers and children by influencing food availability ad affordability at the national level are the:

- Introduction of the Seed Act, 1988, which allowed the entry of multinational corporations in the seed sector, such as Monsanto and Cargill.

- Introduction of the Food Safety and Standard Act (FSS Act), which attempted to repeal the Infant Milk Substitute, Feeding Bottles and Infant Food (Regulation of Production, Supply and Distribution) Amendment Act 2003. However, the IMS Act was retained following protests by child health and child rights groups.

- Introduction of the National Biotechnology Regulatory Authority Act, which is in the process of being finalised. This Act, while promoting the growth of the biotechnology industry, would ironically also be responsible for "Safety" and "Regulatory" aspects.

Table 3.2: Stunting/ Wasting/ Underweight among Children under 3 in India and Major States

India/ Selected States	Key Indicators			
	Children under 3 who are stunted (%)		Children under 3 who are wasted (%)	
	NFHS III[a]	NFHS II[b]	NFHS III[a]	NFHSII[b]
India	38.4	45.5	19.1	15.5
Assam	34.8	50.2	13.1	13.3
Bihar	42.3	54.9	27.7	19.9
Chhattisgarh	45.4	57.9	17.9	18.5
Gujarat	42.4	43.6	17.0	16.2
Himachal Pradesh	26.6	41.3	18.8	16.9
Jammu & Kashmir	27.6	38.8	15.4	11.8
Jharkhand	41.0	49.0	31.1	25.4
Karnataka	38.0	36.6	17.9	20.0
Kerala	21.1	21.9	16.1	11.1
Madhya Pradesh	39.9	49.0	33.3	20.2
Maharashtra	37.9	39.9	14.6	21.2
Orissa	38.3	44.0	18.5	24.3
Punjab	27.9	39.2	9.0	7.1
Rajasthan	33.7	52.0	19.7	11.7
Tamil Nadu	25.1	29.4	21.5	19.9
Uttar Pradesh	46.0	55.7	13.5	11.2

Source: (a) NFHS III Fact Sheet (2005-06), (b) NFHS II (1998-99)

The aggressive promotion of processed foods for children manufactured by food corporations eyeing the child food market through ICDS and Mid-Day Meals is a matter of concern. Foods such as Furtox Corn Syrup, Doritos from GM corn, snacks loaded with sugar and salt have resulted in malnutrition of another kind — obesity, hypertension and even juvenile diabetes.

Probiotics: Trials are being undertaken for 'Probiotics' on children under 6. Since exclusive breastfeeding for 6 months is recommended, there is little justification for this. Probiotic is being aggressively sold commercially. The rationale for promoting this is the presence of the scientific-sounding 'Lactobacillus', despite it being found *naturally* in yogurt. This is similar to the aggressive sale of glucose with Vitamin D while Vitamin D is freely available in abundant sunlight.

Fortified Food and Micronutrients: While there has been an extremely aggressive sales pushing for fortified foods and micronutrients there has been a conspicuous absence in attention given to locally available nutritive food options. This includes the need for education about the nutritive value of foods such as *ragi mandua* (finger millet), which is rich in calcium at 344 mg per 100 gms; *amaranth (ram dana)*, which is rich in calcium at 397 mg per 100 gms and protein at 4 gms per 100 gms; and drumstick leaves, fenugreek, *chaulai,* and *bathua*, all rich in iron (National Institute of Nutrition, 2007).

Pesticides and chemicals

Children have a right to a non-hazardous, chemical-free environment, food and water. But there have been numerous cases of exposure to excess quantities of chemicals, resulting in gruesome deaths and serious body malfunctions. The endosulphan case of Kerala, for example, resulting in the birth of congenital malformed babies was caused by repeated aerial spraying of cashew nut plantations resulting in contamination of water sources. The plight of the second-generation victims of the Bhopal Gas Tragedy due to poisoning by Methyl Iso-Cyanate (MIC) is another case in point.

Children are more vulnerable than adults to these toxins, even in small doses, since their organs are still developing.

Medicines and children

While the number of private hospitals and nursing homes has increased, services are also being expanded under the NRHM, government healthcare centres, and anganwadi centres to address child health issues.

Most medical problems of children are infection-related — fever, diarrhoea, acute respiratory infection, malaria, measles, fungal skin infections, impetigo, etc. The majority of medical care providers for children (especially in the urban slums, rural and tribal areas) have not received any training in paediatric care. Among others, problems of misdiagnosis and irrational use of potent drugs arise. Moreover, many medicines do not have paediatric doses and. Cough syrups with heavy doses of antihistamines and certain antibiotics contraindicated for children continue to be given to them. The repeated and irrational use of antibiotics results in antibiotic resistance. This issue of the Rational Use of Medicines for children was recognised as an area of concern by WHO, and a resolution related to this was passed at the World Health Assembly in 2007.

The use of drugs known to cause teratogenic effects in foetuses continues.

The newer viral fevers along with the older ones continue to be undiagnosed or misdiagnosed by local doctors, as blood tests to diagnose viral fever are very expensive and only available in a few select national institutes. Thousands of children have died of Japanese Encephalitis and Plasmodium Falciparum in recent years, with these fevers becoming endemic in many areas. The increasing resistance to anti-malarial drugs has not been recognised adequately as a major public health issue.

Small pox vaccine undoubtedly contributed to the wiping out of small pox. Several other essential vaccines — BCG for the prevention of milliary and bone TB, DPT for the protection against diphtheria, pertussis (whooping cough) and tetanus, polio drops to prevent polio paralysis and vaccine against measles — have become part of the national Universal Immunisation Programme (UIP).

The so-called 'suspension' of three vaccine producing public sector units (the Central Research Institute, Pasteur Institute of India, and BCG Vaccine Laboratory) has been a cause of great concern to the public health community. The entry of private players followed the 'suspension'; after initially agreeing to supply the vaccines at the same rates as the PSUs, these later asked for a 60%-70% increase in vaccine prices.

The 'suspension' also resulted in shortages of the essential vaccines, with the Parliamentary Standing Committee on Health stating, in February 2008, that there was a shortfall of more than 10 crore doses in 2008-09. The Health Ministry reported in July 2009 that there had been a decline of 10% in target achievement for immunisation in 2008-09 as compared to the average of the last three years.

Conclusion

The health and nutrition needs of children in the country are not being addressed with the required seriousness. Unjust international trade regimes have made the present and future of children even more vulnerable – be it in their right to food, water, medicine, medical care, survival, shelter or peace. There is a growing collaboration with corporate interests in the decision-making process, as the government, corporations and others have come together to take decisions on the presumption that the market knows best and competition is good for growth and development.

Self-reliant options are being systematically destroyed and dependencies created as basic needs are being denied.

The issue of child health goes beyond distribution of polio drops and Vitamin A to ensuring complete immunisation routinely, ensuring availability of safe nutritive affordable food, rational use of medicines and vaccines, rational medical care and comprehensive primary healthcare, safe water, safe environment and protection from health hazards.

4 Rethinking Childcare in the Changing Socio-Economic and Political Scenario

Neetha N.

Introduction

In the context of changes in the family structure and the entry of women into paid work outside the home, the care of young children is now acknowledged as an integral component of Early Childhood Care and Development (ECCD). With increasingly more women entering the labour market and the increased prevalence of nuclear families have generated an increased demand for quality substitute care for young children.

In the absence of adequate provisions for childcare, households rely on various unsatisfactory measures for their childcare requirements. Often, small children are either left to themselves or with older siblings. Given the patriarchal norms, the caregiver is generally herself a young child who needs care and protection but is kept away from school to take care of her siblings. Alternately, many women carry their children to their worksites and leave them in unsafe conditions. Some rely on informal arrangements with neighbours or relatives, and a few on paid domestic workers.

The social and political economy of care

The common social understanding is that childcare is a family responsibility, especially that of women. Within the State policy framework, there is little explicit thought on childcare. It is assumed that family structures are in place and that women/ mothers are present, ready and able to undertake this work. Childcare is considered a private, familial, and female responsibility and practice.

Thus, the issue is either absent in most discussions on child development or mentioned as an issue of working mothers.

Formulations of social policy and labour rules come closest to any State-sponsored action on childcare. Only where the State is an employer or through anti-poverty programmes such as the National Rural Employment Guarantee Act (NREGA), does it address extra-household care facilities in its rules, institutionally or through funding. The Integrated Child Development Services (ICDS) programme, designed specifically for the welfare of children under 6, gives little or no attention to aspects of childcare.

Yet, the demand for childcare services is growing — evident in the mushrooming of market-based private childcare institutions such as day-care centres and pre-nursery schools. These have also mushroomed in rural areas. The demand is also indicated by the growing demand for hired domestic workers (whose numbers have grown more than three-fold between 1999-2000 and 2004-05).

The services of private day-care services and hired domestic workers are out of the reach of many women due to the huge cost involved. Furthermore, the quality of these services — with uninformed and unqualified staff and inadequate infrastructure — is rarely standardised.

Effective day-care services are essential to support both mothers and young children. As a protective measure, childcare addresses issues such as child labour and child abuse. If appropriate and good childcare services are available, children grow healthy, both emotionally and physically. There are many studies showing that proper early childcare encourages school-going. Proper childcare services also release older children, especially girls, from the task of sibling care.

Policy and State interventions

The need for childcare services has been emphasised in various government documents such as the National Policy for Children, 1994, National Policy for Education, 1986, National Policy for Empowerment of Women, 2001 and the National Plan of Action for Children, 2005. The Parliamentary Standing Committee on Demand for Grants for the year 2002-03 has also pointed out that all sections of the society should be allowed to avail of the services of crèches. The National Common Minimum Programme also emphasises enhancement of childcare and development services in the future.

The Factories Act, 1948 lays down provisions for crèches in every factory employing more than 30 women workers. The *Beedi* and Cigar Workers (Conditions of Employment) Act, 1966, the Plantation Labour Act, 1951, the Contract Labour (Regulation and Abolition) Act, 1970, and the Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979 or 1980 also stipulate provision of crèches for women workers. The Plantation Labour Act, 1951, allows time off for women workers to feed children. The Building and Construction Workers Act (Regulation of Employment and Conditions of Work), 1996 and National Rural Employment Guarantee Act, 2005 also provide for crèches for children below 6.

In India, more than 94% of women workers are engaged in the informal sector, and thus are beyond the purview of many of the labour laws. Even in cases where labour laws are applicable, poor implementation is an issue, with the majority of women workers being denied any maternity benefits or childcare facilities.

In pursuance of the priority objectives of the National Policy for Children, 1974, a Central Sector Scheme was started in 1975 to support voluntary organisations in setting up crèches for children of working/ailing mothers.

Administered by the Central Social Welfare Board (CSWB), it was designed to provide a safe environment for children through healthcare, sanitation, nutrition, play materials, cradles, beds and the provision of a supervisor in every crèche, targeting poor working mothers in the unorganised sector (with children in the 0-6 age group and a family income of less than Rs.12,000 per month). The total number of crèches set up under the scheme nation-wide was 12,470, catering to about 350,000 children. The scheme was merged with the Rajiv Gandhi National Crèche Scheme for the Children of Working Mothers in 2005-06.

In 1993-94, the National Crèche Fund was set up by the Department of Women and Child Development, with a corpus of Rs.19.9 crore, to assist registered voluntary organisations to run crèches. By 2005-06, 1,805 crèches were set up. Additionally, assistance was to be given to voluntary organisations/ mahila mandals (women's groups) to convert 10% of existing anganwadis to anganwadi-cum-crèche centres; however, this scheme has been a non-starter.

In 2005-06, both the crèche and day-care schemes were integrated into the Rajiv Gandhi National Crèche Scheme for Children of Working Mothers (implemented through the CSWB) and two national voluntary organisations, the Indian Council for Child Welfare (ICCW) and Bharatiya Adimjati Sevak Sangh (BAJSS). The Scheme provides crèche services to children in the 0-6 age group, with supplementary nutrition, emergency medicines and contingencies, linked with other health and nutrition programmes, especially anganwadi centres. User charges at Rs. 20 per month per child are collected from families below the poverty line and Rs. 60 from other families; it is estimated that 50% of the children using the service are from BPL families. The income eligibility limit for user-families has recently been enhanced from Rs 1,800 per month to Rs 12,000.

Apart from these direct interventions for childcare, national child development programmes such as the ICDS and the ECE component under SSA also address, implicitly (since children spend part of the day in the anganwadi centres or schools), the care requirements of children under 6. The function of a crèche is not part of the ICDS mandate. Though the anganwadi centre functions as a day-care facility at least for a few hours, it serves only children above 2 and is open generally for only 4 hours. However, the new National Programme for Education of Girls at Elementary Level (NPEGEL), which has been added to the SSA to encourage girls' education at the elementary level, has components for childcare services. Under this, provision is made for two childcare centres per cluster run by the community in areas where there is no government childcare centre. Each centre opened under the NPEGEL is given a recurring grant of Rs. 5,000 and non-recurring grant of Rs.1,000 per annum to strengthen existing local ICDS centres, and an honorarium for anganwadi workers running the centres for extended hours to match school timings.

Private and non-governmental initiatives

While there has been no exhaustive survey on the private sector role in pre-primary/nursery schooling and day-care or crèche services, it is estimated that the number of children enrolled in such centres was about 10 million in 2005 (Sub Group Report on Early Childhood Education in the Eleventh Five Year Plan, 2008). These private initiatives, which were mainly in the urban areas nearly a decade ago, are gaining momentum in semi-urban and even rural areas.

Childcare services provided by voluntary or non-governmental organisations have a marginal role, especially in socially and economically backward areas and among migrant labourers. Some NGOs also run mobile crèches. In addition, some institutions

Table 4.1: Status Report of the ICDS

Month Report	State/Ut	LCDS Projects											
Statement Indicating State Wise Number of ICDS Projects and Anganwadis AWCS) Sanctioned and Operational As on 29.02.2008													
		ICDS Projects					**No. of Anganwadis**						**No. of Mini-AWCS Sanctioned**
		Sanctioned Upto 31.03.2005	Sanctioned During 2005-06	Sanctioned During 2006-07	Total Sanctioned Upto 31.3.2007	Operational As On 29.2.2008	Sanctioned Upto 31.3.2005	Sanctioned During 2006-07	Total Sanctioned Upto 31.3.2007	Operational As On 29.2.2008	In VIII Plan	During 2006-07	Total As On 31.3.2007
2/08	Andhra Pradesh	363	13	9	385	385	56539	7843	73944	69611	4211	3409	7620
02/08	Arunachal Pradesh	58	21	6	85	85	2359	1240	4277	4277	0	0	0
02/08	Assam	196	23	4	223	223	25416	5007	37082	36849	0	0	0
04/07	Bihar	394	144	7	545	394	60813	560	81088	80211	0	0	0
02/80	Chhattisgarh	152	6	5	163	158	20289	5500	34937	29355	836	1483	2319
02/80	Goa	11	0	0	11	11	1012	100	1112	1112	0	0	0
02/80	Gujarat	227	33	0	260	260	37961	2695	44179	43104	0	0	0
02/80	Haryana	116	12	9	137	137	13546	833	17192	17192	0	252	252
02/80	Himachal Pradesh	72	4	0	76	76	7354	0	18248	18248	0	0	0
05/07	Jammu & Kashmir	140	0	0	140	129	18772	6711	25483	16409	0	0	0
10/07	Jharkhand	204	0	0	204	204	24171	1243	32097	31074	0	0	0
02/80	Karnataka	185	0	0	185	185	40301	2646	54260	54260	0	405	405
11/07	Kerala	163	0	0	163	163	25393	3464	32115	32115	0	0	0
01/08	Madhya Pradesh	336	31	0	367	367	49787	9914	69238	68306	2250	0	2250
02/08	Maharashtra	372	44	35	451	416	62126	9877	84867	75741	1881	7490	9371
12/07	Manipur	34	0	4	38	37	4501	3120	7621	7621	0	0	0
01/08	Meghalaya	32	7	2	41	41	2218	209	3388	3195	0	1234	1234
02/08	Mizoram	21	2	0	23	23	1361	90	1682	1682	0	0	0
02/08	Negaland	54	2	0	56	56	2770	159	3194	3194	0	0	0
02/08	Orissa	326	0	0	326	326	34201	4217	41697	41697	1708	3111	4819
02/08	Punjab	142	6	0	148	148	14730	2748	20169	20169	0	0	0
12/07	Rajasthan	257	17	4	278	278	35821	1510	48372	48363	0	2681	2681
12/08	Sikkim	5	6	0	11	11	500	0	988	988	0	0	0
02/08	Tamil Nadu	434	0	0	434	434	42677	1539	47265	47265	0	3168	3168
02/08	Tripura	40	11	3	54	54	3874	1257	7351	7351	0	0	0
02/08	Uttar Pradesh	834	1	62	897	889	106059	13170	150727	146785	0	0	0
02/08	Uttarakhand	99	0	0	99	99	6658	1872	9664	8834	0	2676	2676
01/08	West Bengal	358	58	0	416	411	57540	17512	92152	87665	0	0	0

and corporate organisations also have day-care centres or pre-school schools. Apart from these institutionalised forms of private childcare services, there has been a phenomenal growth in the number of domestic workers in recent years.

Adequacy and implementation issues

Initiatives to address childcare requirements — by the public, private or voluntary sectors — are clearly inadequate. The Rajiv Gandhi National Crèche Scheme does not provide an adequate number of crèches for the childcare requirements of even just the women in the informal sector.

Studies have also pointed out the sorry state of affairs of existing crèches. Crèches run by the voluntary sector with grant-in-aid in residential localities are ineffective, mostly because of the abysmally low level of funding, lack of awareness about the purpose of a crèche, and lack of guidelines, training and supervision. Poor funding makes it practically impossible to provide even basic needs, such as the salaries of workers, and basic amenities such as water, space and toilet facilities. The timings that the centres are open bear no relation to the hours of work of the mothers and are functional for only 3-4 hours, thereby defeating the purpose of the programme.

Though crèches are mandated by law in different sectors like mines, plantations, and factories, very few crèches exist and many are non-functional. A major reason for the failure is the exclusive financial and managerial responsibility placed on employers to provide crèches. There is no shared responsibility, no guidelines and no mechanism for supervision. Crèches have never been on the list of priorities of the Labour Department and there are no attempts to monitor whether crèches are established by employers. Given the new economic policy and trends, with the size of manufacturing units on the decrease, the possibility of having factory units with 30 and more women workers has also been reduced. This has diluted the importance of the Factories Act regarding the provision of crèches for working mothers.

Recent social audits of NREGA highlight the neglect of crèche/ childcare facilities at the worksites, though young women constitute a considerable proportion of beneficiaries under the programme. This was found true even in states that have otherwise a good record of other social/childcare programmes such as Tamil Nadu.

Thus, with neither regulation nor mandated registration, women are compelled to accept childcare services with no assurance of quality.

Emerging concerns

Childcare should be the focus and not viewed as an add-on to programmes for education and nutrition. To address the rights and meet the needs of children, a comprehensive strategy is required which should plan specifically to cater to the care requirements of various age groups, such as 0-6 months, 6 months-3 years and 3-6 years. While provision of maternity entitlements is the only solution to address the care requirements of the first category, ICDS (anganwadi-cum-crèche schemes) and crèches at workplaces could meet the care requirements of children younger than 3 years of age. *The care of children in the age group 3-6 could be made part of pre-school education programmes where a crèche facility should be made available for the entire day.*

The Rajiv Gandhi National Crèche Scheme should be expanded. As per the NSSO 61st Round Survey, 1999-2000, there are around 149 million women in the workforce, of which a large proportion are in the reproductive age group. Day-care support services are an essential requirement for these women. To meet the requirements of children of migrant workers and those in the informal sector, there is a need to strengthen various forms for mobile services/ crèches (with flexible time and space). Flexibility should be extended to allow new and different

institutions, such as labour unions, self-help groups and community based organisations, to run crèches. *Thus, the existing crèche facilities need to be expanded exponentially.*

ICDS, the only agency that can reach children in all localities, should play a major role in childcare services. *Universalisation of ICDS must go beyond mere provision of food supplementation to comprehensive early childhood care.* The National Policy on Education (NPE), 1986 and the Programme of Action (POA), 1992 had also recommended the conversion of anganwadi centres into anganwadi-cum-crèches in a phased manner. Though, under the scheme of the National Crèche Fund, there was provision for conversion of 10% anganwadi centres into anganwadi-cum-crèches, the initiative ended with the merger of the NCF with the Rajiv Gandhi National Crèche Scheme. Thus, overall, the policy recommendations of the NPE and the POA remain unimplemented. Provisions to fulfil these aspects need priority. *Further, the day-care/ crèche component should be included in all pre-education, primary/ elementary education programmes.*

Additionally, there is need to improve the quality of services offered under various programmes. This calls for *setting up minimum standards of care and protection for all crèches/day-care centres and other institutions providing care services.* Further, there should be strict monitoring of services, transparency and accountability. There is also need to undertake a comprehensive survey at the national level, covering various models of childcare institutions, such as private crèches (home-based as well as institutional), voluntary sector crèches (government-aided as well as others) and those working under statutory provisions. Such a database could help in framing appropriate policies and establish regulatory and monitoring mechanisms.

Conclusion

It is imperative to recognise the importance of early childhood care within the context of a society. The need to allow for the full development of a child is paramount for a society. And, it is in this context that a comprehensive and holistic approach to childcare needs to be taken, an approach that recognises the need for maternal labour entitlements, proper institutional care for children below 6, and a comprehensive plan that looks at all aspects of early childhood care. And, it is in this context that one must continuously focus on improving the quality, access and capacity of schemes for the provision of early childhood care.

5 Status of Early Childhood Care and Education in India

Asha Singh & Neelam Sood

Introduction

Linguistically interactive, mentally stimulating, socially responsive and emotionally supportive environments make for optimal growth, presenting a scientific argument for Early Childhood as a period of significance.

The National Policy for Children, 1974, the National Policy on Education, 1986 and the National Plan of Action, 1992, as well as the Integrated Child Development Scheme (ICDS) have arisen from recognition of the role of ECCE in overall human development. Though India has seen an increase in investment in Early Childhood Care and Education (ECCE) over the past decade, the sector is still struggling to obtain the levels of financial and other support needed for quality and quantity in programming.

Global perspectives on ECCE

Early intervention in the child's development process can go a long way in improving a child's intellectual, social and physical abilities. A growing body of literature has shown that investing in pre-school education makes good economic sense by providing improved life choices for the children and benefits for the families. The Education-for-All Goals set in 2000 at Dakar have become the backbone of international efforts in education, placing ECCE at the centre of educational debates.

The Indian context

Among the early pioneers of ECCE programming in India are Gijubhai Badheka and Tarabai Modak of Gujarat and Maharashtra, respectively, while Maria Montessori's work contributed to the establishment of some ECCE centres around her didactic philosophy.

The Government recognised the importance of early childcare in the National Policy for Children, 1974. The State also committed to "progressively increase" childcare services. The ICDS, launched in 1975, took the logic further, expanding services to 10.11 lakh centres (2008), benefiting 16,685 lakh children under the supplementary nutrition programme and 330 lakh children between the ages of 3 and 6 years through pre-school education. The National Policy on Education, 1986, emphasised ECCE as "a crucial input in the strategy of human resource development, as a feeder and support programme for primary education and also a support service for working women." And the Constitution of India commits, in Article 45, that: "The State shall endeavour to provide Early Childhood Care and Education to all children until they complete the age of six years". Thus, ECCE is a constitutional commitment, not just a "justiciable" right of every child in India.

More recently, the National Council of Educational Research and Training (NCERT) set up an exclusive Focus Group to deliberate, reflect and conceptualise curricular goals in the field of ECCE. Part of the five-yearly review of the National Curricular Framework (NCF), the position paper on Early Childhood Education, released in 2005, is a critical commentary on issues of threat, precarious social realities and policy implications. The refreshing feature of this document is the conflict resolution and solution-oriented approach in the form of descriptive guidelines for the curricular framework. The inclusion and presence of some objectives and the philosophy of classroom processes makes the document particularly useful for practitioners and educators.

Emerging trends/policies

The Eleventh Five-Year Plan puts "development of children at the centre of the plan" with recommendations based on a rights-based, holistic and integrated framework for ECCE. Among its various recommendations is the setting up of *crèches*, renewed stress on *alternate care for abandoned and destitute children* (including foster care and adoption) and improvements in the ICDS programme.

Current trends

Most State-run and many private fee-paying ECCE centres are overcrowded, have poor teacher-to-student ratios with little individual guidance and routines. In the absence of any regulation, these are mushrooming, often without any attention to quality.

Till the NCF 2005, State documents had no formal descriptions of a *curricular framework* to define educational goals or govern the transactions in ECCE. Each individual and group could devise classroom processes and content as wished, a freedom that has both strengths and weaknesses. A curricular framework gives direction to create harmonious blends in accordance with principles of child development that are based on an understanding of children as constructors of knowledge, not passive receivers of information. But India also has a multiplicity of social contexts, language, religion and socio-economic influences that have deep influences on children's responses to a school setting, structure and even absence of structure.

Providing easy access for ECCE to children, especially from disadvantaged communities, remains an elusive target. The services vary across anganwadi centres, NGO-operated balwadis, crèches, pre-primary sections attached to government and private schools. The Report of the Sub-Group on ECCE in the run-up to the Eleventh Plan found that while the average enrolment is between 20% and 30%, none of the major states has even half of their children in pre-schools. Though enrolments under public and private services have increased in the past 10 years, more than 70% of the child population in the eligible age group continues to remain un-reached.

As per the District Information System for Education (DISE) of NUEPA which presents a database (2005-06) of information collected from schools, the ratio of enrolment in pre-primary classes to the total enrolment in schools is as low as 6.94%, though this figure is a bit higher in urban areas in comparison to rural areas, and higher in privately-managed schools than in government schools. Nationally, of the total number of children in the 3-6 age group, the MWCD, in its report 'ECCE: An Overview', found that barely 19.64% children were covered under ECCE programmes in 1996-97. While the coverage of children, especially under ICDS, has increased substantially since then, it has not yet managed to break the 30% ceiling.

Issues in ECCE services

The question of age: The age of entry into pre-school centres and schools in India varies for different education providers, though the government-stipulated age is either 5 or 6 across states. This throws up questions regarding the right age-grouping for ECCE services and overlap between school and pre-school services.

Questions about curricula: The formidable challenge is to provide high-quality early childhood education programmes; this involves a curricula that preserves indigenous patterns such as multilingualism. The education structure must also allow family/community involvement. Broadly defined needs serve as a frame to guide curricular content and the nature of ECCE, based on principles of child development. In order to maximise impact, the planning and provision of early childhood and primary education programmes need to take into account three important principles of child development: (a) Child development is a continuous and cumulative process; (b) Health, nutrition, educational and psycho-social development are all synergistically interrelated; and (c) The child's development will be optimised if the programmes address not only the child but also the child's overall context.

The curriculum and teaching-learning materials must take into account traditional systems, practices, materials, foods and other systems, including childcare practices.

The 2005 National Curriculum Framework advocated socially relevant and meaningful learning that goes beyond the textbook. Most importantly, NCF promoted an ideology towards how to view children as active constructors of knowledge rather than mere receivers of information. The curriculum must be age appropriate, rounded, play-based, integrated, experiential, flexible, and contextual.

Nature of a child's needs: Children need positive experiences to attain desirable developmental goals, experiences that introduce a healthy orientation. Professionals must think about the goals of the teaching-learning experience and about environments that permit children *freedom from undue adult restraints, nurture happiness of individual achievement, inculcate the ability to adapt and become a member of a collective*.

Besides fashioning sound notions of child development, caregivers must look for local indigenous ways of care-giving, feeding and healthcare. The Working Group for Children Under Six, in 2007, recommended the following essentials as components of ECCE: (a) quality food as an entitlement; (b) a system of childcare that supplements care by the family and empowers women; and (c) a system of healthcare that provides prompt locally available care for common but life-threatening illnesses; this must address both prevention and management of malnutrition and disease.

Training and capacity-building: Social demographic variability poses unique challenges for the childcare facilitator or the pre-school teacher (who determines the quality of the service delivery) in the setting of Indian diversity. Some steps have been taken to train ECCE workers to become more professional. Capacity-building

occurs at many levels — from colleges offering courses in ECCE under 'Home Science' programmes, to Master's level courses to training for field workers. However, most training programmes do not provide sufficient exposure to the wealth of local knowledge and skills. The National Council of Teacher Education has developed guidelines for training of ECCE personnel. The National Institute of Open Schooling (NIOS) also has a vocational course in ECCE and the Indira Gandhi National Open University (IGNOU) offers several courses dealing with young children. NCERT and NIPPCD also offer direct courses for students in ECCE and Guidance and Counselling of young children. The participation of ECCE teachers through the SCERTs is also rapidly increasing.

Research: Building an understanding of children and childhood: In India, research occurs in the form of micro-studies as well as large-scale macro-inquiries across states. Apex organisations like NIPPCD and NCERT engage in macro-studies to understand issues of access retention and resource distribution. In a study by the NCERT in eight states (Maharashtra, Rajasthan, Karnataka, Bihar, Tamil Nadu, Madhya Pradesh, Uttar Pradesh and Goa), short-term benefits were seen in enrolment, academic and social preparedness for formal schooling. Interestingly, the impact of ECE was greater in girls than in boys (NCERT, 1993). A 1992 study by NIPPCD, covering ICDS in 98 districts, also projected the positive role played by ECE in promoting enrolment, reduction in dropout rates and greater retention in primary schooling.

Development of tools

Through micro-studies and macro-investigations, certain tools culturally appropriate for Indian settings have also been developed. Use is also made of assessment tools devised in other settings. Some of the scales and assessment measures that have guided research in the country are the Developmental Assessment Scale for Indian Infants (DASII), and Vineland's Social Maturity Scale and Portage Checklist.

Regulation of private sector providers

Nursery schools of a great variety can be found in rural and urban areas. Most of these run like mini-schools and emphasise formal education. Currently, there is no regulation of nursery schools and no mandate for registering these. Thus, these mini-alphabet industries do not follow any norms for infrastructure, water and sanitation facilities, space for indoor and outdoor activities, adult-child ratio, availability of materials and, above all, sensitive teachers with adequate training and empathy for young children. In the absence of any regulatory system and any database on the number of such institutions, it is difficult to plan and estimate the coverage of young children.

The EFA Global Monitoring Report 2007 recommends that it is necessary to "establish regulations and monitoring systems that apply equally to the full range of public and private settings. Limited regulation of the private sector can negatively affect access and quality, especially for the most vulnerable and disadvantaged.

While a case is often made for public-private partnerships, experience has shown that this has only meant giving a free hand to the private sector. While there has been a huge increase in the private sector (for profit) schools in India recently, it is not possible to assess their efficiency, quality, equity and other impacts due to lack of transparency.

Sound database for planning: For effective planning and management of service delivery, and performance monitoring and accountability, a sound database is necessary. A necessary step in policy-making and implementation of ECCE services is "developing an integrated, comprehensive data system for early childhood".

Conclusion

India has one of the largest intervention programmes dealing with children in an integrated manner. However, the focus on health and nutrition has often been at the cost of a 'whole child' approach to ECCE. The National Policy for Children and the forthcoming formation of the National Commission for Children must ensure that the emphasis in ECCE is on ensuring equity and quality, allowing for diversity and plurality in teaching methods and content and attention to the needs of children.

6 Public Expenditure, Budgets and Children under Six

Denny John

The National Common Minimum Programme (CMP) of the United Progressive Alliance currently in government has set ambitious targets related to key public spending — raising investments in education and health to 6% and 2-3% of GDP, respectively, over the next five years, focusing mainly on primary healthcare. The National Rural Health Mission (NRHM) was launched on 12 April 2005.

Economic growth and social sector expenditure

India has, in recent years, moved decisively to a higher economic growth plane. GDP growth, at market prices, has exceeded 8% every year since 2003-04. However, such economic growth rates have not led to improved human development indices. As per the Global Health Development Report (HDR) 2007, India ranks 128 among the countries with medium human development, out of 177 countries of the world as against 126 in the previous year. In terms of Gender Development Index (GDI), India ranks 113 out of 157 countries.

The zero count for HDI rank minus GDP rank of India is indicative of a similar rank in terms of gender development and human development. This underscores the need for a greater focus on this area of development planning, including budgetary allocations.

Budgetary allocations for social sector expenditures have increased, measured both as a proportion of aggregate government expenditure and as real expenditure (i.e., at constant prices) since the 1990s. But government expenditure on social services (measured as a proportion of GDP) has not seen much change — expenditure on the social sector increased from around 0.71% of GDP in 1996-97 to

1.1% of GDP in 2006-07. This increase in the Union Government spending represents just under 0.4% of GDP, which is inadequate if we take into account the acute need for greater public resources for the social sectors as also the worsening fiscal health of the states over this period.

However, in 2006-07, only 1.66% of the funding in the Union Budget was allocated for children under six. In 2000-01 it was as low as 0.88%. Expenditures are even lower. From 2000 to 2005, the average expenditure on government schemes for the young child was only Rs. 208 per child per year. In 2004-05, only 0.95% of the Union Budget expenditure was on programmes for children under six. In 2000-01 it was as low as Rs. 151 per child (Rs. 2,476 crore), and in 2004-05 it rose to Rs. 288 per child on these programmes (around Rs. 4,724 crore), which too is inadequate. The cumulative expenditure on these seven programmes shows that in 2000-01 it was as low as 0.88%. In 2006-07, it had risen to 1.66%. The low priority given to the young child becomes even more evident when funds are analysed as a percentage of the Union Budget.

The Ministry of Women and Child Development (MWCD) commissioned the Society for Applied Research in Education and Development to compile the expenditure on children during 1993-94 to 2002-03 at the Central and State levels. The study found that:

- The increase in total expenditure on children from 1993-94 to 2002-03, cumulatively for Centre and states, is 257%. The share of state governments is significantly higher than Central level interventions, being more than 85%. In the case of ICDS and nutrition, the share of the Centre is less than one-third.
- There is an increase in expenditure on children as a percentage of GNP from 2.66% in 1993-94 to 3.26% in 2001-02.

The proportion of provisions for child development in the total expenditure of the Union Government has increased to 0.87% in 2008-09 (BE) from 0.42% in 2004-05 (BE).

Sector analysis: Budget for children

The Budget for Children (BfC) in the nine years ending 2006-07 has been 3.4% of the Union Budget. Of every Rs. 100 allotted to children, Rs 63.09 has been for education, Rs 19.31 for health, Rs 16.62 for development and 99 paise for protection. From 2000-01 to 2004-05, social sector expenditure has been an average of 10.81% of the entire budget. Within this, children have received an average of 22.38%. Within BfC there is growth of 18% in health, 27.3% in development, 18.3% in protection and 28.2% in education.

An average growth of 25.4% in the overall budget for children is primarily due to increased allocation for the education and development sectors in 2005-06 and 2006-07. Increased allocation in this case is directly related to SSA, the Mid-day Meal Scheme and ICDS; this increase was preceded by an amendment to the Constitution, large-scale public protests and orders of the Supreme Court. The Budget figures of

Table 6.1: BfC as Percentage of Union Budget

	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	Average
BE	2.4	2.3	2.4	2.5	2.8	4.1	5.2	4.8	4.98	3.4
RE	2.1	2.2	2.1	2.2	2.8	4.2	4.67	4.42	-	3.08

Source: Expenditure Budget Volume II, various years

Table 6.2: Summary of Expenditure by States and Centre for Children (Rs. crore)

Year	t	%	States Amount	%	Total Amount
1993-94	1,003.29	5	19,447.51	95	20,450.80
1994-95	1,944.14	8	22,605.82	92	24,549.95
1995-96	2,769.31	9	28,853.81	91	31,623.12
1996-97	3,268.28	9	32,021.30	91	35,289.58
1997-98	3,919.94	10	36,218.00	90	40,137.95
1998-99	5,147.27	10	44,541.28	90	49,688.56
1999-2000	5,565.19	10	52,676.56	90	58,241.75
2000-01	5,986.30	10	56,573.78	90	62,560.09
2001-02(RE)	6,859.39	10	61,043.80	90	67,903.19
2002-03 (BE)	8,911.04	12	64,156.53	88	73,067.57

Source: Child Budgeting, Chapter 7, MWCD Annual Report 2004-05

2008-09 show that the allocation for the Mid-day Meals and SSA together in 2007-08 rose by 6.3%.

Focus on children under six

Census 2001 puts the number of children in the 0-6 age group at 158 million, or approximately 15.2% of the total population. Of these, 75.95 million are girls and 81.91 million are boys, making for a sex ratio of 927 females per 1,000 males. A significant proportion of these children live in an economic and social environment that impedes physical and mental development — poverty, poor environmental conditions, poor sanitation, disease, infection, inadequate access to primary healthcare, inappropriate child caring and feeding practices, etc. The Technical Group on Population Projections has projected (based on estimations that an Indian child born today can expect to live four years longer than a child born in 1991) that, in 2016, about 25 million infants would need immunisation services and 72 million pre-school education services.

The child development continuum passes through five sub stages, namely, pre-natal to one month, one month to three years and three to six years, followed by two sub stages corresponding to primary education.

The government is implementing seven 'schemes' for children under six: ICDS; Early Childhood Education; Rajiv Gandhi National Crèche Scheme; National Nutrition Mission; Reproductive and Child Health; Strengthening of National Immunisation Programme and Polio Eradication; and Child Adoption.

The Integrated Child Development Scheme (ICDS) under Ministry of Women and Child Development): States have received full Central support for the cost of all components of the ICDS programme except supplementary nutrition, for which, from 2005-06, they receive assistance for upto 50% of the expenditure. The rise in BfC allocations has almost entirely been due to increases in allocations under the ICDS scheme.

Rajiv Gandhi National Crèche Scheme for Working Mothers (under Ministry of Women and Child Development): There was 100% increase in the budget for this scheme in 2006-07 (BE); the allocations fell to Rs 96 crore in 2008-09 (BE).

Reproductive and Child Health (under Ministry of Health and Family Welfare): The overall allocation for RCH increased almost by 53% in 2008-09 as compared to 2007-08 (BE).

Strengthening of the immunisation programme and eradication of polio (under Ministry of Health and Family Welfare): The budgetary allocation for immunisation and the eradication of polio takes a substantial portion of the total child health component. (On average, the polio immunisation programme received 76% of the total budgets for immunisation in 2005-06 to 2008-09). However, in 2008-09 the allocation for pulse polio immunisation fell to Rs. 1,042 crore from Rs. 1,289.38 crore in 2007-08.

National Nutrition Mission (under Ministry of Women and Child Development): After an allocation of Rs. 0.03 crore from 2005-06 (BE), there was a steep rise in the year 2007-08 (BE) to Rs. 0.09 crore. That allocation has remained constant till year 2008.

Improved public finance mechanisms

According to the Economic Survey 2007-08, while the gross-GDP ratio, which has stagnated in the 8%-10% range for more than a decade, increased to 11.4% in 2007-08 (BE). The proceeds from indirect taxes have also increased from around 5.4% of GDP to 6.08% during the period. Given the demand-constrained economy (given the high percentage of poor populations) this is a regressive form of public finance mechanism.

Huge amounts of resources are forgone every year on account of various tax exemptions. The total revenue estimated to be forgone in the central tax system alone for the year 2007-08 is around 7.2% of GDP. Some of this could go into social sector financing, such as child care and development.

Improving systems for early childhood care and development

The following systems would be required to provide comprehensive early childhood care and development: (a) maternity entitlements to ensure proximity of mother and child during the first six months as well as adequate care to both mother and child; (b) breastfeeding, IYCF and nutrition counselling and support services to families; (c) community based day-care services or crèches; (d) pre-school centres; (e) supplementary nutrition; and (f) healthcare services — predominantly community-based — with institutional backup.

The current allocation for the ICDS is only around one rupee per child per day (on average, for all children under six). This level of expenditure is utterly inadequate to ensure effective and universal programmes. It is estimated that there are currently about 14 crore children under six in the country, of whom 10 crore live in rural areas and 4 crore in urban areas (including 1 crore in urban slums). Allowance has to be made for the fact that not all parents may wish to enrol their children in the local anganwadi. Assuming that about 75% of children in rural areas and urban slums are enrolled, the budget estimates are for 8 crore children under six. Of these 8 crore children, 10% (0.8 crore) would be enrolled in anganwadi-cum-crèche centres.

Given these assumptions, the proposed plan of action would cost around Rs. 33,000 crore (at 2006-07 prices) in the reference year, including 'recurrent costs' of Rs. 30,000 crore per year. If the Indian economy grows at 8% per year on average during the Eleventh Plan, this financial requirement will represent about one half of 1% of India's GDP five years from now.

Reducing child mortality will require

multiple complementary interventions. These include access to safe water, better sanitation facilities, and improvements in education, especially for girls and mothers. Also needed are awareness-building programmes as there is a strong relationship between child mortality and mothers' literacy.

Strengthening of healthcare and immunisation programmes

Health being a state subject, financing is primarily by the state governments. Resource allocation to this sector is influenced by each state's fiscal situation. Budgetary allocations to the health sector during 2003-04 declined from 7.02% in 1985-86 to 4.97% in 2003-04. All states levy user charges for services in secondary and tertiary level hospitals in the public sector, which account for 2% to 3% of the total health budget.

There are issues related to both underutilisation of funds and inadequate coverage. During 2003-04, the greatest under-spending was in the health sector — amounting to 22.41% of the budgetary allocations for children. Approximately 22% of the money for World Bank Assisted ICDS-II/JH/APER projects remained unutilised as well as about 34% of the money remained unutilised for the ICDS Training Programme, Project Udisha. The problem of under-utilisation is rampant at both the Central and state levels. The state of Maharashtra has been able to utilise less than 25% of the amount allocated for public health. Under the NRHM, the Centre had allocated Rs. 671.14 crore for Maharashtra in 2007-08, of which Rs. 310.52 crore was released.

There is also need to look into alternative health financing strategies through sliding-scale mechanisms, community health financing and social insurance systems to ensure access to curative services, including maternal and child care.

If India is to stay committed to achieving the National Health and Population Policies in 2010 and the Millennium Development Goals in 2015, the National Commission on Macroeconomics and Health (NCMH) had in 2005 recommended that public spending be increased from the current level of 1.3% to 3% of GDP in the next few years. Government would require a five-fold increase in the budget — or Rs. 1 lakh crore at the rate of Rs 1,160 per capita per year — if it is to be the sole provider of a comprehensive package of services consisting of preventive, promotive and curative services. For assuring equitable access to secondary care and reducing the financial burden on households, considering India's diversity and disparities, a careful blending of social health insurance, community-based health insurance and limited and well regulated private health insurance is recommended.

Private household expenditure on health is nearly four to five times higher (around Rs. 85 per capita) than government health expenditure. Health insurance coverage is still rare and caters only to a small minority. Hospitalisation frequently results in financial catastrophe, especially in the absence of risk pooling mechanisms. A 2001 World Bank study on India concludes that out-of-pocket medical costs (estimated to be more than 80% of the total medical expenditure) alone may push 2.2% of the population below the poverty line each year. Studies have shown that medical costs are the third highest cause of indebtedness in most households. As per the NSSO (60th round), 6% of the population did not visit a health facility due to high cost. There is a need to assess the contribution of healthcare utilisation and costs to the increase in poverty and to look into alternative health financing mechanisms.

Conclusion

A public budget is a comprehensive statement of government finances, including expenditure, revenues, deficits and debt. It is the government's main economic policy document

and indicates how the government proposes to use public resources to meet policy goals. Given the fact that children in the 0-6 age group make up approximately 15.2% of the total population of the country but receive only 1.03% of the total Union Budget, substantial increases in public investment are needed to improve their physical and mental condition. If this country is to maintain its economic growth at the present rate it needs political will and resource commitments to ensure the well-being of children under six for a better tomorrow.

Glossary of Abbreviations

AIIMS	–	All-India Institute of Medical Sciences
ANM	–	Auxiliary Nurse-Midwife
ARWSP	–	Accelerated Rural Water Supply Scheme
BAJSS	–	Bharatiya Adimjati Sevak Sangh
BE	–	Budget Estimates
BfC	–	Budget for Children
BPL	–	Below Poverty Line
CASSA	–	Campaign Against Sex Selective Abortion
CEDAW	–	The Convention on the Elimination of Discrimination against Women
CMP	–	Common Minimum Programme
CMR	–	Child Mortality Rate
CRC	–	Convention on the Rights of the Child
CRP	–	Community Resource Person
CSR	–	Child Sex Ratio
CSWB	–	Central Social Welfare Board
DASII	–	Developmental Assessment Scale for Indian Infants
DISE	–	District Information System for Education
DLHS	–	District Level Household Survey
ECCD	–	Early Childhood Care and Development
ECE	–	Early Childhood Education
FSS Act	–	Food Safety and Standard Act
GAIN	–	Global Alliance for Improved Nutrition
GDI	–	Gender Development Index
GDP	–	Gross Domestic Product
HDI	–	Human Development Index
HDR	–	Human Development Report

ICCW	–	Indian Council for Child Welfare
ICDS	–	Integrated Child Development Services
IFPRI	–	International Food Policy Research Institute
IGNOU	–	Indira Gandhi National Open University
IMR	–	Infant Mortality Rate
IMS Act	–	Infant Milk Substitute, Feeding Bottles and Infant Food (Regulation of Production, Supply and Distribution) Amendment Act 2003
IYCF	–	Infant and Young Child Feeding
MMR	–	Maternal Mortality Rate
MWCD	–	Ministry of Women and Child Development
MDG	–	Millennium Development Goal
MoHFW	–	Ministry of Health & Family Welfare
NCERT	–	National Council of Educational Research and Training
NCF	–	National Curriculum Framework
NCMH	–	National Commission on Macroeconomics and Health
NFHS	–	National Family Health Survey
NIOS	–	National Institute of Open Schooling
NIPPCD	–	National Institute of Public Cooperation and Child Development
NMBS	–	National Maternity Benefit Scheme
NPE	–	National Policy on Education
NPEGEL	–	National Programme for Education of Girls at Elementary Level
NNM	–	National Nutrition Mission
NNP	–	National Nutrition Policy
NREGA	–	National Rural Employment Guarantee Act
NRHM	–	National Rural Health Mission
NUEPA	–	National University of Educational Planning and Administration
ORS	–	Oral Re-hydration Solutions
PCPNDT Act	–	Pre conception and Pre Natal Diagnostic Techniques Act
PDS	–	Public Distribution System
PIL	–	Public Interest Litigation
PNDT Act	–	Pre-Natal Diagnostic Techniques Act, 1994
RE	–	Revised Estimates
SAP	–	Structural Adjustment Programme
SC	–	Scheduled Caste
SEZs	–	Special Economic and Export Zones
SSA	–	Sarva Shiksha Abhiyan
SRB	–	Sex Ratio at Birth
SRS	–	Sample Registration System
ST	–	Scheduled Tribe
TSC	–	Total Sanitation Campaign
UIP	–	Universal Immunisation Programme
UPA	–	United Progressive Alliance
VHAP	–	Voluntary Health Association of Punjab
VLMC	–	Village Level Monitoring Committee
WFFC	–	World Fit for Children
WHO	–	World Health Organisation
WTO	–	World Trade Organisation