

Strategies for Children under Six

Children under six years of age need good nutrition, education and care in order to meet their full potential of health, well being and capacity for the rest of their lives. However, children under six (particularly those under two) and their needs rarely get any recognition in policies, programmes and budgets. Their feeding, development and care is assumed to be the responsibility only of the family.

Children are citizens with rights, and society has the responsibility for ensuring that they are given adequate and appropriate care. The only government programme that addresses the rights and needs of this age group is the Integrated Child Development Services (ICDS). The ICDS is supposed to address the health, nutrition and pre-school needs of all children below the age of six. However, the coverage of ICDS is quite limited, and the quality of the programme is also quite poor. “Universalisation with quality” is urgently required to protect the fundamental rights of children under the age of six.

In November 2001, the Supreme Court ordered the government to universalise ICDS. Further detailed orders were passed in 2004, which spelt out that ICDS should never be restricted to BPL families, and prohibited contractors from supplying nutrition to Anganwadis; instead it directed that funds should be spent by village communities, self-help groups and Mahila Mandals for “buying grains and preparation of meals.” The entitlements of children under six were further strengthened by the landmark Order of December 13, 2006, which ordered the government to ensure “universalisation with quality” within a time frame. The Order clearly states that **all ICDS services** (Supplementary nutrition, growth monitoring, nutrition and health education, immunisation, referral and pre-school education) must be extended to **every child under the age of six, all pregnant women and lactating mothers and all adolescent girls.**

The policy and programmes of the ‘restructured’ ICDS programme that is supposed to meet the nutritional, health, learning and development needs of children below six years of age, are in the process of being finalized. Any policy on Early Childhood Care and Development should focus on providing holistic and comprehensive care for children under six, and contain the following essential components:

- A **system of food entitlements**, ensuring that every child receives adequate food, not only in terms of quantity but also in terms of quality, diversity and acceptability.
- A **system of child care** that supplements care by the family and empowers women. Such care needs to also address their learning needs and must be provided by informed, interested adult carers, with appropriate infrastructure.
- A **system of health care** that provides prompt locally available care for common but life threatening illnesses. Such a system needs to address both prevention and management of malnutrition and disease.

Further early child care programmes should cater to the needs of the children of different age groups with different strategies. The three crucial age groups are:

- children 0 – 6 months of age – the period of recommended exclusive breastfeeding,
- children 6 months to 3 years – until entry into pre-school, and
- children 3 years to 6 years – the pre-school years, until entry into school.

Based on this framework, the following are the essential interventions required to be put in place:

1. **Universalised Maternity Entitlements.** Women need adequate nutrition and care, including health care, during pregnancy, after delivery and when they breastfeed. They need skilled counselling and support to begin breastfeeding within the first hour. During the six months of exclusive breastfeeding, they need to stay close to their children, at the risk of losing their wages. Therefore it is necessary to have maternity entitlements that include:

- Compensation for staying home to breastfeed the very young child at the risk of losing wages or affecting their economic status, on the lines of the “Dr. Muthulakshmi Reddy Maternity Benefit Scheme” in Tamil Nadu, where women are given cash support of Rs 1,000 per month for six months starting from the 7th month of pregnancy, for care during pregnancy and after delivery.
- Adequate nutrition during pregnancy and lactation, including good quality supplementary nutrition for pregnant and lactating mothers through the ICDS.
- Adequate access to quality health care services.
- Adequate access to skilled counselling and support for early initiation of breastfeeding and exclusive breastfeeding.

2. ***Exclusive Breastfeeding for children up to six months.*** ICDS and the Health System should mainstream providing skilled counselling and support for women to practice exclusive breastfeeding for six months through adequate training of frontline workers such as ASHA, anganwadi workers and ANMs. Mitani in Chhattisgarh have shown the way.
3. ***Skilled Counselling and nutritional support for children under three.*** Children require solid foods that are calorie-dense, including fats, after six months of age (complementary feeding). Nutritious and carefully designed take-home rations (THR) based on locally procured food should be provided as “supplementary nutrition” for children in this age group. Currently THRs are in the form of just grain – this is inadequate.

Also, THRs must be combined with nutrition counselling and nutrition and health education sessions for mothers and family members to ensure that children of this age group are given appropriate and adequate foods at home. Further, skilled counselling is also required to educate the family on the psycho-social and learning needs of the child.

4. ***Pre-school and hot, cooked meals for all children in the age group of 3 years – 6 years.*** Pre-school education is very significant in helping children to prepare for formal schooling. Pre-school education assists children both to enter school and to remain in the system. The ICDS must provide a centre-based play-school facility at the anganwadi with the workers trained in conducting preschool activities.

For these children a culturally acceptable, varied, adequate, energy meal that has multiple nutrients including micronutrients like Vitamin A and Zinc must be provided at the anganwadi centre. A hot cooked meal provided at a centre also has many benefits as it:

- serves as an incentive for regular attendance,
- promotes social equity,
- provides income support to poor households,
- acts as a form of nutrition education,
- tackles hunger and can contribute all nutrients required,

5. ***Day Care Centres or Crèches.*** Women across the country work long hours at paid and unpaid work, often starting to work very soon after delivery. They need support to provide adequate care and attention to their children. They need safe places or crèches, close to their work sites, run by trained workers, where they can keep their infants, and where their older children will receive hot cooked meals and health care.

Crèches must be designed to meet the varying needs of children of different age groups. Infants 0-6 months need to be breastfed on demand. Children 6mths-3years of age need 5-6 small but nutritious and energy dense meals a day. Children 3-6 years of age need 3-4 small but nutritious meals a day. All these children also require organized play and learning in areas that are safe, to help them develop adequate motor and learning skills appropriate to their age, acquire concepts, language, habits and develop relationships with peers and adults.

To begin with a model of anganwadi-cum-crèches can be introduced to provide this service in the village. This would mean that these centres are open full-time, with adequate staff, training and infrastructure. Existing crèche schemes such as the Rajiv Gandhi Crèche Scheme and provision for crèches under the NREGA must also be expanded and strengthened.

6. ***Second Anganwadi Worker for ICDS Centres.*** Adequate care of children under three, which includes skilled counselling on breastfeeding, nutrition and learning needs, combined with effective preschool education for children aged 3-6 years cannot be achieved without the involvement of two Anganwadi workers (along with the Anganwadi helper). The availability of at least two anganwadi workers at each anganwadi centre would make it possible for one of them to concentrate on providing the home-based services, while the other can provide centre-based activities such as pre-school. The helper would have a role to play in bringing the children, cooking and serving and keeping the centre clean.
7. ***Convergence between Health and WCD Department at all levels including provisioning of basic Health Care Services including Nutritional Rehabilitation Centres for highly malnourished children.*** Regular interventions like health screening and referral, growth monitoring, immunisation and de-worming must be carried out by the ICDS and health department together.

There are several factors that affect the nutritional status of children, including food and health factors. Tackling malnutrition effectively will require that the health department and the ICDS work together at all levels. The ASHA programme offers great opportunities for convergence provided:

- ANMs / AWWs and ASHA are trained and mentored together on tackling malnutrition.
 - Nutrition Rehabilitation Centres located at PHCs become the focal point of dealing with severe malnutrition.
 - Block and District level Health, RCH and WCD officials routinely monitor malnutrition together.
8. ***Investing in the ICDS workforce through training and capacity building.*** The training programmes should recognise pre-school education and nutrition counselling as essential components. Within the overall framework, training curriculum, material and approaches should be developed in a decentralised manner, to be appropriate to the specific state/district level. Anganwadi Training Centres should be allocated for capacity building in a specific region at the District or Sub-District level. A system for continuous field level support should be developed (for instance, identifying a relatively accessible Anganwadi centre and developing it as a local resource centre, where the supervisor/trainer can facilitate peer learning through monthly cluster-level meetings).
 9. ***Building in a comprehensive monitoring and evaluation system.*** A more robust, regular and independent monitoring and evaluation system, where workers are not forced to under-report malnutrition is needed. As things stand, the most reliable source of information on child nutrition is the National Family Health Survey (NFHS). However, the NFHS surveys have been conducted at intervals of 6-7 years. Further, these surveys are too small to produce nutrition indicators at lower levels of aggregation than the State level (e.g. the District level). Ideally, NFHS-type surveys should be conducted every five years on a scale that would allow the estimation of District-level health and nutrition indicators, and every year on a smaller scale. At the very least, national NFHS-type surveys should be conducted at intervals no larger than three years. Expert scrutiny of this issue is urgently required.

A high-level overseeing mechanism should be created which will serve as a strategic oversight, technical support and ensure convergence and accountability in the range of interventions concerned with child nutrition.

10. ***Improving governance and involving communities.*** Decentralisation is the key to reducing corruption. A decentralized approach is required, fostering participatory planning, community ownership, responsiveness to local circumstances, and the involvement of Panchayati Raj Institutions (PRIs). Key decisions, including decisions on recruitment and transfers should be taken locally. Procurement of food should be done at the village level without private contractors, as the Supreme Court has ordered. Medicine kits and Pre-School Kits should be procured locally. Monitoring and evaluation should also be carried out at the block and district level with the active involvement of PRIs.