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Putting Children in the Centre of Public Health Debate

The 14th World Congress on Public Health took place in Kolkata in February 2015. Hundreds of public health leaders and experts from around the world and across India attended. We took this opportunity to present the most challenging public health problems we face in India in sessions called 'global consultations'. Participants helped elaborate the problems and discuss how to address them. We report here on one of several topics discussed.

Consultation on: 'Are We Putting Children in the Centre of Public Health Debate'

Key questions raised:

1. Do the policies and programs taken up by various government departments in India for children take into account the social determinants influencing the outcomes expected from these programs?
2. Are there effective mechanisms and defined protocols to ensure that the programs meant for improving children's health complement each other in reaching the tools defined in the programs?

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3. How does the 'one size fits all' kind of program fit in with diverse social, cultural, economic realities of various regions?
4. Are the funds allocated under these programs commensurate with the needs identified?

Protection, health, education, nutrition, safe water, and hygiene are basic rights for all children (as for adults). Yet children in the South Asian region face difficulties that hamper their survival and development, and prevent full realisation of their rights and potential.

India is home to 20 per cent of the world's child population, aged 0–4 years, with about 27 million children added to the population every year. India's population is going through fundamental demographic changes. Over the coming decades, birth rates will continue to drop and young people (10–24 years of age) will soon constitute the largest section of the population (larger than the current cohort of children aged 0–9 years).

Children bear a shocking and disproportionately large burden of death and disability. About 1.83 million children die before they reach their first birthday.¹ The percentage share of infant deaths to total deaths in rural areas is 15.8, and 9.7 per cent in urban areas.² Approximately half of the under-5 deaths in the country can be attributed to only four groups of diseases: respiratory diseases, diarrhoeal diseases, other infectious and parasitic diseases, and Malaria.¹

The world's largest number of adolescents (243 million out of the total 1.2 billion) reside in India. They (aged 10–19) also represent one fourth of India's population. Adolescence is a time when gender roles diverge sharply. Girls and boys experience adolescence in very different ways. Apart from physical maladies, adolescents have additional deprivations. They are largely excluded from decisions that affect them, have limited access to information on issues affecting their lives, and lack spaces and opportunities to acquire and share knowledge, and to participate actively in decision-making processes. Adolescents are largely invisible as citizens. Gender-based discrimination has far-reaching implications for health and nutrition of girls and women.

Given that health of a population is multidimensional, and crosses the traditional boundaries between sectors, it would be unfair to blame only providers of health services for the dismal state of this age group. Health is influenced by water quality, sanitation facilities, and living conditions, including connectivity, food security, employment opportunities, environmental exposures, socio-cultural beliefs, and above all income. Increasing the health budget alone may not lead to the desired outcome. Nonetheless such increases, given our current low level of public spending on health (about 1 per cent of Gross Domestic Product), are necessary in the extreme.

Poverty and Exclusion

An estimate published by the Planning Commission of India indicates that 37.2 per cent of the population of India (41.8 per cent in rural areas and 25.7 per cent in urban ones) lived below the poverty line in 2009.³ The method they adopted for drawing the poverty line and fixing the percentage of population below it has been hotly contested by academicians and social activists. Terming India a 'Republic of Hunger', Professor Utsa Patnaik has shown that the annual per capita consumption of grains actually declined from 177 to 155 kg in a span of 5 years (1998–2003) to levels prevalent during the Second World War, a period characterised by famine, food shortage, and rationing.⁴ The health situation is far too complex to be explained by count of poverty dimensions alone. In India, caste, gender, religion, and location all play roles in determining access to health care for the below poverty population, including the children. Approximately 100 million children in India are in the poorest wealth quintile.

One half of all the poor children in India belong to the 'Scheduled Castes' and 'Scheduled Tribes' (official designations given to various groups of historically disadvantaged people in India) and they continue to be at a substantial disadvantage in terms of Millenium Development Goals (MDGs) 1, 2, 3, 4, 5, and 7.¹ Analysis of National Family Health Survey II data on prevalence of anaemia, treatment of diarrhoea, infant mortality rate, utilisation of maternal health care, and childhood vaccinations among different caste groups in India also shows that the Scheduled Castes, Scheduled Tribes and other marginalised groups bear a much larger burden of these ailments.⁵ It's not as if the importance of social determinants is not recognised. The High Level Expert Group on Universal Health Coverage, set up by the Planning Commission of India, is the group that makes four specific recommendations for 'linking' the major government programmes that influence the health outcomes of an area. These include programmes on food security, water, sanitation, and social protection.⁶

Unfortunately we have yet to witness any urgency on the part of the authorities to take up these recommendations.

Key Indicators of Child Health in India

<i>Parameter</i>	<i>Status</i>
1. Child Sex ratio (Census 2011)	914
2. Maternal mortality ratio (Sample Registration System December 2013)	178
3. Infant mortality rate (Sample Registration System October 2012)	44

4. Anemia (National Family Health Survey III – 2005–2006)	69.5% (children 6–59 months)
5. Underweight (National Family Health Survey III – 2005–2006)	42.5% of children under 5 years [35.6% of women in the age group of 15–49 years are chronic energy deficit (measured in terms of Body Mass index {Wt (kg)×Ht (m ²)}]
6. Low birth weight (National Family Health Survey III – 2005–2006)	22% of newly born children (below 2.5 kg)
7. At least 1 antenatal checkup (UNICEF Coverage Evaluation survey 2009)	89.6
8. ≥3 antenatal checkup (UNICEF Coverage Evaluation Survey 2009)	68.7
9. Full antenatal coverage (Women who received three antenatal checkups, one tetanus toxoid injection and consumed 100+iron folic acid tablets) (UNICEF Coverage Evaluation Survey 2009)	26.5
10. Institutional delivery	72.9
11. Skilled birth attendance (delivery by doctor, auxiliary nurse midwife/nurse/lady health visitor) (UNICEF Coverage Evaluation Survey 2009)	76.2
12. DPT ₃ (diphtheria, pertussis, tetanus) vaccine (UNICEF Coverage Evaluation Survey 2009)	71.5
13. Measles vaccine (UNICEF Coverage Evaluation Survey 2009)	74.1
14. Full immunization (children (12–23 months) receiving one dose BCG (Bacillus Calmette-Guerin), three doses of DPT(diphtheria, pertussis, tetanus)/OPV (oral polio vaccine) each and one measles vaccine) (UNICEF Coverage Evaluation Survey 2009)	61.0
15. DPT (diphtheria, pertussis, tetanus) booster dose (children aged 18–23 months who received DPT booster dose) (UNICEF Coverage Evaluation Survey 2009)	41.4
16. Vitamin A first dose (UNICEF Coverage Evaluation Survey 2009)	64.0
17. Early initiation of breast feeding (<1hr) (UNICEF Coverage Evaluation Survey 2009)	33.5
18. Oral rehydration therapy or increased fluids for diarrhea (among children <2 year of age who had diarrhea in preceding 2 weeks) (UNICEF Coverage Evaluation Survey 2009)	53.6
19. Care seeking for acute respiratory infection (ARI) in any health facility (among children <2 year of age who had ARI in preceding 2 weeks) (UNICEF Coverage Evaluation Survey 2009)	82.6

Nutrition

Unfortunately we don't have access to any current data on nutrition levels of children from the National Family Health Survey III. The figures as revealed by the National Family Health Survey II were quite daunting. About 20 per cent of children under-age five in India were wasted, 43 per cent underweight, and 48 per cent stunted. In terms of numbers that means about 54 million children under 5 years in India are underweight – about 37 per cent of the total underweight children in the world. Twenty-five million children under 5 years are wasted, and 61 million are stunted. Worldwide that amounts to 31 per cent and 28 per cent of wasted and stunted children, respectively.¹

The Integrated Child Development Services (ICDS) programme is currently fully occupied with the task of providing supplementary nutrition, and in very few cases, pre-school education. Not enough attention is given to improving child-care behaviour and to educating parents on how to improve nutrition using the family food budget – both interventions that are highly cost-effective and part of the original design of ICDS. It would be simplistic to attribute malnutrition to the under-functioning of the ICDS programme alone. A holistic understanding of malnutrition challenges demands a close look at the role of disease conditions shaped by water and sanitation, and by public health measures. Comparing the findings of National Family Health Surveys II and III shows that nutritional outcomes have improved for the richer households.

Whereas the proportion of children stunted in the bottom quintile went down from 60 per cent in 1992–93 to 53 per cent in 2005–06, the corresponding drop was from 35 per cent to 21 per cent for the top quintile. The difference is even starker for the proportion who were underweight, where almost all the improvements are concentrated in upper-income groups.⁷

But regional inequalities may also 'dwarf inequalities in household background. A poor, illiterate Dalit labourer in Kochi or Chennai is less likely to suffer from short- and long-term illnesses and has greater access to medical care than a college-educated, forward-caste, large landowner in rural Uttar Pradesh. Social inequalities matter, but their importance is overwhelmed by state and rural–urban differences.⁷

Gender Bias

India continues to have a serious problem of gender bias in childcare (reflected for instance in much higher mortality rates and lower school

participation rates for girls than for boys). New manifestations of the bias have appeared in the recent past. For example, sex-selective abortion means the female–male ratio in the age group of 0–6 years (hereafter the ‘child sex ratio’) has been going down over time, and in the last decade it has fallen further, from 927 girls per 1000 boys in 2001 to 914 girls per 1000 boys in 2011. Identifying 540 as a cut off ratio for male–female proportion at the time of birth by European standards, Prof (S) Amartya Sen and Jean Dreze has shown that:

We can draw a dividing line to cut India into two halves, with the states in the west and north of India (with clear evidence of sex-selective abortion) being separated from states in the east and south (without such evidence). The former group – with female-male ratios below 940 per 1000 – include Punjab, Haryana, Gujarat, Himachal Pradesh, Uttarkhand, Rajasthan, Uttar Pradesh, Maharashtra, Madhya Pradesh, Jammu & Kashmir and Bihar, whereas the ones with ratios above 940 per 1000 are Assam, West Bengal, Kerala, Jharkhand, Chattisgarh, Odisha, Andhra Pradesh, Tamil Nadu and Karnataka. The state of Odisha fails to qualify in the latter list marginally, with a female-male ratio of 934 per 1000, even though – like the other states in the east and the south – Odisha has a higher female-male ratio than every major state in the north and the west.⁸

Impact of Domestic Violence on Children

Apart from physical causes, analysis of the NFHS III data has also revealed an association between multiple incidence of domestic violence in the previous years with anemia and underweight in women and a suggestive association with child under nutrition. ‘Domestic violence increases psychological stress among Indian women (12, 13), and witnessing maternal domestic violence increases psychological stress among children (14). Psychological stress increases oxidative stress (15–18) and metabolic levels (19), risk factors for anemia and underweight. Domestic violence could also increase the risk of poor nutritional outcomes through environmental circumstances such as the withholding of food by abusive family members’.⁹ Another analysis of National Family Health Survey II data attempts to quantify the incidence of domestic violence and concludes that about one-fifth of ever-married women in India, with interstate variations, are beaten or physically mistreated by their husbands.¹⁰ According to the National Family Health Survey III, 37.2 per cent of the women experienced violence after marriage.¹¹ Government has now put in place an institutional

mechanism to deal with domestic violence; the outcomes of these efforts are yet to be measured.

It has been argued that poor quality water and sanitation leads to a high prevalence of diseases like diarrhea, which in turn retards food absorption and affects nutritional outcomes. Because the disease climate is a function of broader environmental conditions, it affects both the rich and the poor, and weakens the benefits of income and associated ability to buy more food of higher quality. According to National Sample Survey Organisation (NSSO) estimates, during 2012, 38.8 per cent and 89.6 per cent households in rural and urban India, respectively, had access to an 'improved source' of latrine, with Kerala having the highest (96.9 per cent) and Jharkhand, the lowest (8.9 per cent) proportion of households¹². However, 50 per cent of the population still practice open defecation (66 per cent rural and 13 per cent urban).¹³ The picture is somewhat better with regard to water. During 2012 in rural India, 88.5 per cent households had an improved source of drinking water while the figure was 95.3 per cent in urban India.¹²

Resource Allocation for Children

The Government of India has recently put forward a separate statement on the Child Budget (Statement 22), as a part of its annual expenditure Budget Statement. The Programmatic allocations listed in this statement, however, include the amount proposed to be allocated to across union territories and centrally administered areas. The budget statement for 2014–2015 lists 89 such programmes. Analysis undertaken in 2011 showed there were 73 budgeted programmes meant for the children: 9 programmes on survival and health, 15 on development including nutrition, 7 on elementary education, 16 on secondary education, 14 covering elementary and secondary education by other ministries, 11 on child protection.¹⁴

The average of spending on children by decade increased from about 2 per cent of the total Union Budget during 1990–2000 to a little over 4 per cent during 2001–2010. There is no regular pattern of increase or decrease in the children's share in respective state budgets.¹⁴ The average share of budget allocated to children in the Union Budget between 2000–2001 and 2008–2009 was 3.75 per cent.¹⁴ In 2013, 4.64 per cent of the total Union Budget was for programmes on children. Compared with 2012–2013 the total Union Budget had risen by 11.7 per cent, while the increase in allocations for children rose only 8.7 per cent.

The Union Government put forth a National Policy for children in 2013 that promises a 'rights based, long term, sustainable, multi-sectoral, integrated, and inclusive approach for the overall and harmonious development and protection of children'.¹⁵ But the amount of funding earmarked for

implementing the policy hardly matches the promise. As a commentator observed 'there is a shortage of 0.54 lakh *Anganwadi* centres (AWCs), and a shortage of 1,92,388 Anganwadi workers, that is, 14.08 per cent of the total sanctioned strength', and 'Annual Budgets 2012–2013 (budget estimate (BE)) and 2013–2014 (BE) allocated 15 850 crore and 17 700 crore, respectively, for the ICDS (child survival and development)' which 'are far less than the 36 600 crore (annual) as has been projected by the Twelfth FYP'.¹⁶

The Government of India, NGOs, and international agencies support a wide range of programs for adolescent girls and, to a lesser extent for boys. These programmes cover nutrition and health. Each government scheme for adolescents focuses on a specific target group (by age and sex). Budgets for these schemes are inadequate and the reach, access, and coverage of adolescent health, nutrition and non-formal education programmes are poor at block-level. No mechanisms exist to facilitate convergence among various schemes for adolescents. There is also a need to analyse the allocation and use of budget of the adolescent component under various flagship programmes.

Resource Utilisation

We also need to look at whether the nation is able to make optimal use of the inadequate resources available for ensuring the rights of the children. Unfortunately, there has been no visible evidence of the key departments are moving out of their 'silos' to ensure that they complement each other's initiatives. The Ministry of Women and Child Development and the Ministry of Health and Family Welfare (MoHFW) are key partners in helping young child grow into healthy adults. But there are many instances where these two agencies throw the responsibility to each other for early child interventions, especially those related to malnutrition. For example, ensuring breastfeeding, one of the key activities to reduce infant mortality, does not generally feature among the priorities of a key counsellor for young mothers, the Anganwadi worker (AWW – the frontline worker for the Integrated Child Development Services (ICDS), which is an Indian government welfare programme which provides food, preschool education, and primary health care to children under 6 years of age and their mothers. These services are provided from Anganwadi centres established mainly in rural areas). Instead, children seem to come into the domain of the ICDS only after attaining the age of 6 months.

Apart from this problem, the leadership in these two key ministries has inadequate understanding of issues in the domain of their counterparts. Therefore even with 'over 50 per cent of infant and young child mortality' being 'linked directly to malnutrition', there is 'lack of child nutrition expertise

and leadership in the child health division of the MOHFW'.¹⁷ That there is something quite not right with the way the programmes are implemented is also borne out by the fact that the Central expenditure on social sector programmes has more than doubled from Rs. 13 15 283 crore in 2007–2008 to Rs. 28 35 873 crore in 2012–2013 without proportionate improvement in the indicators. Unfortunately, process related issues do not feature in the discussions around effectiveness or otherwise of the government programmes.

Lessons from Neighbours

In their latest work, *An Uncertain Glory: India and its Contradictions*, Amartya Sen and Jean Dreze had poignantly delineated, with evidence, how India has been falling behind its neighbors in social indicators despite its phenomenal economic growth in the last few decades. They observed that:

Only 16 countries outside sub-Saharan Africa had a 'gross national income per capita' lower than India's in 2010: Afghanistan, Bangladesh, Cambodia, Haiti, Kyrgyzstan, Lao PDR, Moldova, Myanmar, Nepal, Nicaragua, Pakistan, Papua New Guinea, Tajikistan, Uzbekistan, Vietnam and Yemen. India has, by the choice of our cut-off point, the highest GDP per capita in this particular group, with the rank of being number 1 among these 17 countries. Its rank in this group is an inglorious 10th for life expectancy and child mortality, 12th for female literacy and mean years of schooling, 15th for access to improved sanitation and DPT immunization, and absolutely the worst in terms of the proportion of underweight children (among the 13 countries in this group for which child undernutrition data are available).⁸

India's economic growth has not translated into improvement in the social indicators; rather while this country was busy with its focus on growth, our neighbours have overtaken it in the area of human development. In 1990, India had the second-best social indicators in South Asia, next only to Sri Lanka, and presently it is perhaps down to the second worst, barely above Pakistan. Bangladesh is a case in point:

With per capita GDP half as high in Bangladesh as in India, and public expenditure a mere 10 per cent or so of GDP in Bangladesh (again about half as much as in India)" this country "has *overtaken* India in terms of a wide range of basic social indicators, including life expectancy, child survival, enhanced immunization rates, reduced fertility rates.⁸

For sanitation, more than 90 per cent of households in Bangladesh had access to some sanitation facilities compared to almost 50 per cent of households in India that practised open defecation in 2011. How did Bangladesh achieve this? Dreze and Sen feels that the 'roots' of their social achievement lies to a great extent on women's empowerment. Bangladesh have almost double India's rate of women's participation in the workforce – brought about by greater female literacy and education. This has empowered women and Bangladesh has made excellent use of this avenue in reaching its social development targets. This endeavour have been helped by flourishing non-governmental organisation (NGO) activities, even though the overall size of public expenditure on health there is still very low and many of the governance issues that have plagued India's health-care system also seem to apply to them.

Nepal is another intriguing case. Despite its political and governance problems, it is also catching up with, and in some aspects almost overtaking India, even though its per capita income is just below one third of that of India. Sen and Dreze had also compared India with the other members of the Brazil, Russia, India, China so called 'BRIC club' to show that Brazil, Russia and China are far ahead of India in social development.

Intentions and Implementations

As a report published by five international NGO's on Child Friendliness of Governments in South Asia shows, the Government of India was indeed quite serious in putting together a framework for child protection. The report observed:

India has been the most successful country in the region in terms putting in place a General Measures of Implementation-based framework for the realisation of all the rights of the CRC.¹⁸

But putting the framework in place alone may not be adequate. The report goes on to show that 'countries which have done well in putting in place an enabling structural framework overall have not necessarily been able to ensure good education, health and protection outcomes for children'.

India needs to be more serious in order to bring back children to the centre of public health deliberations and, more importantly, actions.

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