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INTRODUCTION

Child development is the key concern today of all nations. The development of the human resource is possibly the most crucial variable in all developmental programmes. The qualitative development adopted by countries may be diverse but an efficient utilization of the human resource is a normative principle common to them all. This principle asserts that full development of the human resource must be the precondition of its efficient utilization. This cannot be left to chance, rather its foundations must necessarily be laid in the early stages of life. It is, therefore, the childhood that holds the potentials and sets the limits of future development of a society.

The recent advances in social and behavioural sciences have placed the child in a perspective of unprecedented significance. The care of the child is no longer subject to the wilful choices of parents, rather it has attained the status of a categorical importance.

Every nation, developed or developing links its future with the status of the child. The children in the age group of 0 - 14 years constitute a considerable
population of the human population. While mothers and children together make up over two third of the whole population, they are the most helpless victims of condition of poverty and are most vulnerable to natural and man-made calamities. In order to build up a healthy nation, it is recognised that the start has to be made at the formative stage through proper care of the developing minds, and bodies of the young children. The child is father of the man and the childhood lays down the lines of development. The growth of a human brain is 90 percent complete by the time the child is 4 years of age. Poor growth during these vital years, usually means that the child has not fully grown in his mental, emotional, physical and social potentials with which he/she is born.

Scientific researches have revealed that the child development is a very complex subject. The human organism is most complicated structure requiring a prolonged period of growth and development to fully manifest its potentialities. It needs conducive and congenial environment so as to develop into a full-bloom human being. A child comes into being not at the moment of delivery but at the moment of conception. Since then he needs to be provided planned care and socialization opportunities in order to attain a human status. He
needs to be nourished properly inside as well as outside the mother's womb. He is susceptible to the action of harmful microbes so he needs to be immunized against them. Further, his cognitive development may be hampered if his surroundings are stimulus-deficient and his emotional development may be constricted if love-warmth and security are denied to him.

Giving the child a best start in life begins before birth with the health of the mother. If the mother is healthy and is cared well during pregnancy by antenatal health checkup, nutritional support, control of anaemia, immunization for prevention of tetanus toxide and post-natal care, the chances of a healthy baby are maximum. After birth of a child, how well she cares for the baby during its first few months is equally important to the child's development.

In view of the gravity of the problem, the United Nations adopted a declaration of children's Rights which was revised in 1979, the year of the child, enumerating the benefits and rights to all children to develop fully and become able to make their contribution to the societies of which they are members. The rights include the right to adequate nutrition, quality medical care, free education, the right to special care of
handicapped regardless of race, colour, sex and religion. National policy for children was adopted on 22 August, 1974. The policy admitted the government responsibility to provide opportunities for the development to all children. Moreover, the fact that India administers the largest integrated child development Programme has not been able to solve this problem. It covers 16 million Children and 3.2 million mothers. The programme includes the confinements such as, Nutrition and immunization, health care, growth-monitoring and pre-school education.

The National Policy on Education, 1986 has given a great deal of importance to early childhood care and education (ECCE). It views ECCE as an important input in the strategy of human resource development, as a feeder and support programme for Primary Education and a support service for working woman of the disadvantaged section of society.¹ Realising the crucial importance of rapid physical and mental growth during early childhood, it stresses that every child should be assured access to the fulfilment of all basic needs. Child development can be realised only when the major impediments in its

process are removed, one such impediment is the child labour. In view of this, the government enacted certain legislations against child labour. The government banned the child labour under the Child Labour Prohibition and Regulation Act of 1986. The child (pleading of labour) Act of 1933 has prohibited pleading of child labour against debts owned by the parents and relatives. Besides certain legislations the constitution of India also guarantees the basic rights of children. Art 24 of the Constitution clearly prohibits the employment of children in factories.

The United Nations General Assembly also adopted a convention on the "Rights of the Child" and this came into force on September 2, 1990. To quote from the convention on the Rights of the child. Art. 1 says, for the purpose of the present convention, "a child means every human being below the age of 18 years unless, under the law applicable to the child, maturity is attained earlier".

Art. 4 says, state shall take all appropriate legislative, administrative and other measures for the implementation of the rights recognised in this convention.

Article 54, deals with a range of issues concerning child survival and development such as, civil rights and freedom, family environment and alternate care; basic health and welfare, education, leisure and cultural activities, child labour and child abuses and the role of media, whilevoicing their grave concern over the problem of child-labour.

The United States of America enacted various laws to discourage it and reduce it to the minimum. Through Harkins Bill has called for a ban on the import of items made by child labour. Similar bans are also in vogue in European Countries, especially in Germany and Switzerland.

Unfortunately, the problem has not attracted the attention of majority of the third world countries, including India to the extent it deserves. Child labour is not simply a labour rather it has given rise to a number of socio-economic problems. Gynaecologists are of the opinion that female child labour affects the general
physical and mental health of a child. They are malnourished with multiple deficiencies like calcium, vitamin A and iron, with the result they become anaemic and their growth is stunted. Female children when grow into adults can have increased incidence of operative deliveries. Ophthalmologists are of the opinion that degenerative myopia is higher in children engaged in carpet weaving. Psychologists are of the view that monotony of work, bad working conditions, maltreatment at the hands of employers lead to the development of a sense of hatred towards the work on the one hand and tension on the other.

Researchers have shown that the significant indicators of the development are the infant mortality rate, incidence of malnutrition, the morbidity picture and the female education.

Infant Mortality rate: A country's infant mortality rate is considered one of the most important indicators of its development. The infant mortality rate (IMR) of a society is also indicative of the health status of its children. The infant mortality rate in the age group of 0 - 1 in Japan and Sweden is 7 per 1000 births. 8 in Switzerland, 70 in China, the national rate of infant mortality in India is 120.
Incidence of malnutrition: About one third of the world’s poor population suffer from malnutrition caused by absolute shortage of food in the home. For them, food supplements can make the critical difference between health or death and no medical intervention can compensate for the lack of food supplements.

Low birth-weight babies (below 2500 gm) amount for about one-third of all infant deaths. The basic cause of the low-birth-weights in the developing world is malnutrition in the womb, mainly because the pregnant mother is malnourished. Research has shown that relatively low-cost food supplements of just a few hundred calories a day for chronically malnourished pregnant women could reduce infant deaths related to low-birth-weight by over 50 percent.

Morbidity: The major morbidity noticed among children are air-borne diseases like chicken pox, whooping cough, mumps, ordinary fever, cold cough etc. followed by water borne diseases like Diarrhoea, dysentery, typhoid etc.

Female Education: Children’s health is closely linked to mother’s level of education. Even within the same socio-economic group, children with more educated mothers have significantly better prospects for health and survival whether a mother will go for a tetanus
toxide or regular health check-ups for antenatal and post-natal care, depend upon her education than any other single factor.

Many countries of the Asian and Pacific have made significant advances in the provision for health care for women at all stages of the life cycle, but there remain marked inadequacies. General health care, maternal health care and treatment of complications from pregnancy and child birth-related problems are still very inadequate in many countries. Discrepancies in maternal death rates between developed countries of the west and the developing countries of Asia and the Pacific continue to be the highest among all public health indicators; although infant mortality rate in the region has fallen significantly owing to improved public health and child immunization programmes.

One of the main reasons of the high incidence of obstetrically difficult births and anaemia in women is poor nutrition and the excessive workload women and girls are made to bear from early childhood. Further, facilities for the treatment of infection toxemia and hemorrhage, which are the major causes of maternal mortality, are generally inadequate in many countries.
Health care programmes in India do not show remarkable change in the health status of Indian child. There are millions upon millions of children who die in their infancy, suffer from stunted physical and mental growth. The government of India since independence have included child related services as a part of national developmental plans and sponsored several schemes for the promotion of welfare and development of its children. But in spite of all these schemes the neo-natal mortality rate (death within one month of the birth) was highest in Uttar Pradesh and was lowest in Maharashtra and Kerala both in rural and urban areas. Researches have shown that out of 1000 children born, 77 die within a month. Nearly one-fifth of all deaths occur in the first week. It has also been observed that infant mortality is higher when the age of women at the time of marriage in below 18 years; 141 in rural areas and 78 in urban areas as against 85 in rural areas and 46 in urban areas where the age of women at the time of marriage in 21 and over. Similarly, it is higher where the mother is illiterate, 132 in rural and 81 in urban areas as compared to 64 in rural and 49 in urban areas where the level of education for mother is primary and above. \(^{(1)}\)

Need, importance and Relevance of the Study:

Inspite of the efforts made children are affected by poliomyelitis. A few die but the future of nearly all of them is shattered for want of a simple, in-expensive intervention by some one who knows enough and cares enough to take action. Moreover, in every two minutes there is a child death directly related to Measles, that is, two out of every 100. This is more severe in malnourished groups where the foetal proportion is 10 in 100. Not only this, there are other diseases like Tuberculosis, Diptheria, Pertusis, Typhoid which kill huge numbers of children and leave many more permanently affected with heart and brain damages. Such a sad situation is not only a burden on social conscience but also a drag on national development.

Equally important is the provision of services rendered by Government to women; both expectant and nursing mothers. In almost all the third world countries, advances have been made in the provision for health care for women at all stages of the life cycle, but there remain marked inadequacies. General health care, maternal health care and treatment of complications from pregnancy and child - birth related problems are still very inadequate. The incidence of
unwanted pregnancies, excessive work-load, lack of proper nutrition, and poor education mark the lives of majority of women, particularly those who are poor. Poor rural women are the most neglected of all groups.

In view of this, there is an urgency to make a follow-up study of the programmes launched by government to see to what extent the welfare services are available to children of all age groups, pregnant ladies and nursing mothers and to what extent they are able to utilize them. This attempt may lead us to arrive at some definite conclusions regarding the development of the child and mother. Secondly, our society is a stratified one, the composite of a number of classes and castes. Whether these different groups have access to these services and adopt them is of vital importance to examine.

Moreover, in the light of the research done so far, there is hardly any research study conducted in Kashmir on the child development and mother-care services that too on under-privileged groups. In view of this situation, the researcher got interested in investigating the problem of child-development and mother care services available to under-privileged groups in Kashmir.
Statement of the Problem:

A review of the programmes of child development in the last four decades indicates that the successive five year plans continue to give increasing attention to the needs of children. A variety of programmes were launched in the sections of health, nutrition, education and social welfare but these were not evenly distributed over all parts of the country. On the one hand one could achieve only limited coverages of child population coming from various sections of society and on the other to what extent the under-privileged groups in Kashmir could utilize these services assumes great significance in view of the social structure of our society. In view of this, the researcher planned to investigate the problem of child-development and Mother-care services for under-privileged groups. The title of the study thus is "Child Development and Mother care services for under-privileged groups in Kashmir - An evaluative study".

Definition of variables:

The variables included in the study are as under:-

1. Child Development
2. Mother Care
3. Integrated Child Development Services
4. Under-Privileged groups.

Child Development:

Development according to Anderson (1956) is not merely change in physical size or proportion of adding inches to inches or ability to ability, instead it is a complex process of integrating many structures and functions. Development, therefore, is a series of qualitative changes. There are many types of changes which take place during the process of development.

Recent researches have shown that the nine months of pregnancy are extremely valuable period for the subsequent development of the child. Development of most of the infants during pre-natal period is normal but it is also a fact that if something goes wrong prenately it is usually serious and permanent.

The stages of development in a child have been classified under the following stages for the present purpose:

1. Intrauterine life
2. Neonatal period
3. Infancy
4. Todlers

5. Pre-scholars.

Operational Definition:

For the present study, child development services have been operationally defined as the set of services (including in ICDS programme) extended to by the Govt and utilized by the target groups in Kashmir. The services that have been evaluated are given as under:

1. Supplementary nutrition

2. Immunization

3. Health check-up.

Mother Care:

While many countries of Asia and Pacific region have made significant advances in the provision for health care for women at all stages of the life cycle, there remain marked inadequacies: General health care, maternal health care and treatment of complication from pregnancy and child birth-related problems — are still very inadequate in many countries. Maternal mortality rates have increased in around 10 of the countries where data are available, while decreasing in
several countries. Discrepancies in maternal health rates between developed countries of the West and the developing countries of Asia and the Pacific continue to be the highest among all public health indicators, although infant mortality rates in the region have fallen significantly owing to improvement in public health and child immunization programmes.

One of the main reasons for the high incidence of obstetrically difficult and anaemia in women is poor nutrition of women and girls and the excessive work load women and girls are made to bear from early childhood. Furthermore, facilities for the treatment of infection toxaemia and hemorrhage, which are the major causes of maternal mortality, are generally inadequate in many countries.

As per India’s National report on World Summit on Social Development, Copenhagen March 1995, (1) the health facilities should reach the entire population by the end of the Eighth plan. The Health For All (HFA) Paradigm must take into account not only the high risk vulnerable groups, i.e., mother and child but must also focus sharply on the under-privileged segments within

the vulnerable groups. Health for the under-privileged may be the key strategy for H.F.A. by year 2000, a declaration which India is a signatory.

**Operational Definition:**

Mother care services has operationally been defined for the present study to include the following services: (in addition to the services included in the ICDS programmes).

1. Immunization
2. Supplementary nutrition
3. Health check-up.

**Integrated Child Development Services:**

Higher incidence of mortality and morbidity among children and mothers led to urgency in developing integrated and effective approach to meet the challenge. As such, integrated child development services (ICDS) scheme came into being. I.C.D.S. scheme, described as "India's gift to her children", is today the world's largest programme. It is the most comprehensive and holistic child survival and child development scheme for enhancing the health, nutrition and learning opportunities for pre-school children and their mothers by providing requisite nutrition-linked health services.
At the village level ICDS cares for children below six years of age. It also takes care of essential needs of pregnant women and nursing mothers residing in socially backward villages, areas of scheduled caste concentration, tribal areas and urban slums.

Its general objectives are:

1. To improve the health and nutritional status of young children up to the age of six years.

2. To lay the foundation for the proper psychological, physical and social development of children.

3. To reduce the incidence of mortality, morbidity, malnutrition and school drop-outs.

4. To increase the capability of mothers to look after the day to day health and nutritional needs of their children.

5. To achieve effective coordination of policy and implementation to promote child care and development.

The government of India started 33 ICDS projects on an experimental bases in 1976. In 1978 the programme was extended to 67 additional projects. It was by 1985 introduced in 1000 blocks, covering one fifth of the total number of blocks in the country. At present there are 3120 sanctioned ICDS projects in the country, benefiting 16.3 million children and 3.2 million mothers.
The types of services available for the target groups are:

1. **Expectant and Nursing mothers.**
   
   a) Health check-up.
   
   b) Immunization.
   
   c) Supplementary nutrition.
   
   d) Nutrition and health education.

2. **Infants and other children below 3 years.**
   
   a) Health check-up.
   
   b) Immunization.
   
   c) Supplementary nutrition.
   
   d) Referral Services.

3. **Children between 3 - 6 years.**
   
   a) Health check-up.
   
   b) Immunization.
   
   c) Supplementary nutrition.
   
   d) Referral services.
   
   e) Non-formal pre-school education.

a) Nutrition.

b) Health education.

I.C.D.S provides a package of inter-related services that includes:

1. Supplementary nutrition.

2. Immunization.

3. Health Check-up.

4. Treatment and referral services.

5. Non-formal pre-school education.

1. Supplementary Nutrition:

Today, an invisible malnutrition touches the lives of approximately one quarter of the developing world's young children. It quietly steals away their energy, gently restrains their growth, gradually lowers their resistance.

The third world's hunger is a hidden hunger; visible malnutrition is rare. And it is high time that the skin and bone image of the starving baby was replaced by a greater international understanding of
what child malnutrition really means. Malnutrition is primarily due to inadequacy of food of the right quantity and quality. In addition to inadequacy of food, infections and infestations play an important part in producing malnutrition.

To tackle the problem of malnutrition among children, many co-ordinated nutrition intervention strategies have been developed. In many developing countries supplementary feeding has been a major type of intervention.

Supplementary nutrition is an important component of the ICDS scheme. Supplementary nutrition means identifying and fulfilling the calorie and protein gap in the existing diets, avoiding cut-backs in the family diet, and taking other measures for nutritional rehabilitation.

Supplementary nutrition is given to needy children below six years of age and to nursing and expectant mothers from low income families. Generally speaking, the aim is to supplement the nutritional intake by about 300 calories and 8 - 10 grams of protein for children below the age of six years and about 500 calories and 20 - 25 grams of protein for pregnant women.
and nursing mothers. The supplementary nutrition is given for 300 days in a year. The type of food would depend on local availability, type of beneficiaries, location of the project, administrative feasibility etc.

Pregnant women and nursing mothers belonging to the families of marginal farmers or landless labourers, scheduled castes, scheduled tribes and other poorer sections of the community are enlisted for supplementary nutrition. Children below six years of age are to be identified and enlisted for supplementary nutrition on the bases of weight related to age or measurement of the upper mid-arm circumference.

Supplementary nutrition is an important approach for prevention and treatment of malnutrition among children. In the case of the very young child, the supplementary food should be reduced to a semi-solid form. There is also a need to recognise the fact that special foods need to be developed for pregnant and nursing women, culturally and psychologically acceptable to their family. Supplementary nutrition, during pregnancy affects the mother's own health status and the development of new maternal tissue to support reproductive functions, including foetal development and future lactation performance.
2. Immunization:

Immunization is the condition of being insusceptible or being protected against diseases by inoculation. Immunization is the term applied to the means by which specific immunity to micro-organisms is acquired by deliberate exposure to stimulus to which the body responds by manufacturing antibodies to protect itself against them.

Immunization is a very simple and effective way of gratifying reduction in the infant mortality and morbidity. A small dose of organism introduced into the body produces antibodies, as to increase the resistance to certain diseases; thus establishing effective immunity against patho-invaders. The individual who receives immunization achieves the degree of immunity sufficient to resist infection.

Children are more susceptible to diseases like diptheria, whooping-cough, polio, measles etc. though treatment of few of these condition is available but still the infant mortality morbidity remain quite high. These diseases can be prevented through immunization. We can successfully prevent diptheria, small pox, tetanus, whooping cough, poliomyelitis, measles, tuberculosis and typhoid.
The facilities for immunization are available at the hospitals, maternity and child welfare centres, dispensaries and primary health centres in urban and rural areas. But the target groups avoid seeking their services, with the results, utilisation of these facilities is either negligible or half hearted. But why the people still are reluctant to utilize these facilities?

The main reason can be that more than 80% of India's population lives in rural areas, obviously, the country is rural based - can not make any progress unless this section is developed. They are almost out of the reach of modern health care system, prefer to use traditional methods of diseases prevention. They fear that immunization will harm their children in some way or the other. Due to strong social, cultural and religious practices associated with disease, people refuse to take immunization and vaccination. They are illiterate and also ignorant about the importance of facilities available.

Lacunae in the services programme, improper follow-up, inability to maintain records, irregular schedule of vaccine supply, attitude of the service staff, ineffective vaccine (due to non-availability of cold-chain) may also prevent the participation of
Another reason, which may prevent mothers from getting their children immunized is that very often illiterate mothers are unwilling to bring their children for the second or third dose because of the temporary complications after the first dose given.

Mothers belonging to poor communities are always over-whelmed with work and have little time and energy to put into action. On top of that, poor transport, communication, illiteracy, absence of electricity, shortage of fuel and fodder, social security and the limited out-reach of health services, makes it obvious that immunization is not as easy as it seems to be.

3. Health Check-up and Referral Services:

The services included are:

i. Ante-natal care of expectant mothers.

ii. Post-natal care of nursing mothers and care of new-borns.

iii. Care of children under six years of age.

i. Ante-natal Care:

At the antenatal clinics apart from complete examination of the mother, serial recording of weight, blood pressure, haemoglobin and urine examination are
being done as a routine. Immunization against tetanus is given. Iron and folic Acid tablets along with supplements are given. Attention is paid to health education of mothers on hygiene and breast feeding. High risk mothers are identified during the ante-natal clinics, i.e. mothers with medical problems. Records of ante-natal care is being kept in antenatal card.

ii. Post - Natal Care:

As most of the mothers in rural areas deliver in their homes, therefore, only limited post natal care is possible. The post-natal clinic provides general physical examination of the mother with special reference to the condition of her breast, abdomen and other examination to ensure that she has regained her general health and is fit to resume her normal work.

iii. Care of children under six years of age:

For the care of children the following activities are included:

1. Recording of the height and weight with close watch over their nutritional status.
2. Watch over other mile - stones in the growth and development.
3. Provide all the facilities of immunization.
4. Provide general check-up every three/six months.
5. Provide treatment for the diseases like diarrhoeas, dysentery, respiratory-track infection, skin diseases and eye diseases.

6. Deworming against parasitic infections like round-worm, hook worm or thread worm.

7. Refer serious cases to the hospitals for specialized treatment.

4. Treatment and Referral Services:

Pregnant mothers and children, with different problems requiring specialized treatment are to be referred to the up-graded PHC/Sub-Division/District headquarters hospital as the case may be.

5. Non-formal Education:

Children of the age group 3 - 6 years have the benefit of non-formal pre-school education through the institution of Anganwadi, set up in each village and in each centre under an urban project. Non formal pre-school education in such project implies the organisation of pre-school activities for children below 6 years of age in each Anganwadi. These organisations are not aimed at imparting formal learning but help the child in developing desirable attitudes, values and behaviour patterns. Further-more they aim at providing environmental stimulation to the children.
Under-privileged Groups:

Non meaningful strategy of development was launched for socially dis-advantaged groups during the pre-independence period. As a result, this chunk of population could not keep pace with rapid strides taken by the socially privileged groups. But it was only in post independence era, the process of planned economic growth was initiated under the five year plan. It resulted in growing awareness of the imperative necessity of launching welfare schemes which aimed at extricating these unfortunate people from utter deprivation, hopelessness and depression.

The state was declared as a welfare state in which schedule castes, other backward classes and weaker sections of the society were given certain constitutional guarantees so that they could be at par with other.

Privileged strata of society, under SRO 126, some communities have been declared backward. The under privileged groups that have been taken up for the present study are as under:

1. Gujjar and Bakerwalls.

2. Doombs.
3. Moochi.
5. Gourkhandh.
6. Sweeper.
7. Shqcksaz.
8. Markaban.

**Delimitations of the problem:**

Since the child development and mother care services are mostly available through ICDS scheme, the present study was limited in line with these programmes, however, following specifications were made:-

1. All the six districts of Kashmir;

2. At least 360 children of 0 - 6 years of age group;

3. 180 expectant mothers, 180 nursing mothers, 50 medical officers and 90 school teachers were included in the sample.

4. Due precaution was taken while drawing the sample for each under-privileged groups.
Since there were no standardized tests available in the market, the investigator had to develop the data collection tools on her own with the help of background literature of UNICEF and expert guidance of experts.

Objectives of the study:

The following objectives have been framed for the present study.

1. To evaluate the supplementary nutrition programme of pre-school children.

2. To evaluate the supplementary nutrition programme of mothers.

3. To assess the immunization programme of children (0 - 6 years).

4. To assess the immunization programme of mothers.

5. To evaluate the health check-up facilities (pre-natal/post natal) available to mothers.

6. To study whether there is any linkage between Anganwadi pre-school children and their entrance to formal schools.