Rocky Road
to Realisation Of
Child Rights in Karnataka

A Collection of Essays

Edited by

R.Padmini and Satish G.C.

KCRO
KARNATAKA CHILD RIGHTS OBSERVATORY

unicef for every child

CRC30 CONVENTION ON THE RIGHTS OF THE CHILD

ROCKY ROAD TO REALISATION OF CHILD RIGHTS IN KARNATAKA

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FOREWORD

It is my pleasure to present this book of articles, “Rocky Road to the Realization of Child Rights in Karnataka,” on the 30th anniversary of the Convention on the Rights of the Child (CRC).

In the three decades following the adoption of the CRC, inspite of an exploding global population, we have reduced the number of children missing out on primary school by almost 40 per cent. The number of stunted children under five years of age dropped by over 100 million. Three decades ago, polio paralyzed or killed almost 1,000 children every day. Today, 99 per cent of those cases have been eliminated.

However, poverty, inequality, discrimination and distance continue to deny millions of children their rights every year. 15,000 children under five still die every day, mostly from treatable diseases and other preventable causes. We are facing an alarming rise in overweight children, but also girls suffering from anemia. The stubborn challenges of open defecation and child marriage continue to threaten children's health and futures. Whilst the numbers of children in school are higher than ever, the challenge of achieving quality education is not being met. Conflicts continue to deny children the protection, health and futures they deserve. The list of ongoing child rights challenges is long.

Thirty years ago, world leaders united around a common cause and adopted the CRC, that helped transform children's lives. Thirty years on, child rights have not changed, they have no expiry date. But the children of today are facing a new set of challenges and global shifts that were unimaginable to their parents. Our climate is changing beyond recognition. Inequality is deepening. Technology is transforming how we perceive the world. And more families are migrating than ever before. Childhood has changed, and we need to change our approaches along with it.

So, as we look back on 30 years of the Convention on the Rights of the Child, we should also look ahead, to the next 30 years, and reflect on the issues of greatest concern to children today and begin working on twenty-first century solutions to twenty-first century problems.

I am therefore happy to note that the articles written by experts in this book cast a critical eye on the status of child rights in Karnataka and offer pragmatic recommendations to fulfil those. I hope that this document will serve as a valuable reference for policy makers and planners in Karnataka. UNICEF reiterates its commitment to the state in its endeavor to create a better world for the children.

Meital Rusdia

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Preface

This volume, conceptually speaking, has been in the works for several years. The situation of the children of and in Karnataka, as indeed those of/in the country and any state, needs periodic review and updating. However, such reviews are rarely to be found in the public domain, especially at the State level. When the Karnataka Child Rights Observatory [KCRO] was launched in 2008, it decided to take up this task for this state, and make it a periodic exercise. It was conceived as being based upon both secondary and primary data, using sample surveys and field data available with academics and NGOs across the state.

However, this idea never saw the light of day as it was overly ambitious – in terms of available field practitioners who were also skilled in data collection and analysis, or if they were to be found they were not free or interested to take up the task; academics were also focussed on other topics and studies. Further, funds for the massive exercise were not forthcoming.

Hence we revised our sights and settled for a review of the situation of children in the state based on secondary data and the analysis of experienced practitioners and academics that together would reflect the status, problems and suggestions on solutions or way forward across the various aspects of child rights.

We contacted a number of persons pre-eminent in the field of child rights/development/welfare but we could not obtain the agreement of all those we reached out to – again, some were too busy, some not interested, and so on. Our final list did, however, have a number of experts and we hoped to complete our project by the National Child Rights Day 2014.

Our deadline has had to be postponed for one reason or the other: While some authors were very prompt and turned in their articles by the original deadline given to them [for which we thank them heartily], others needed prodding and reminding several times; some needed a few revisions, which even if small, got delayed often; and for some areas of Child Rights, we just could not get any prospective authors! This was a major source of delay as we hunted for appropriate writers for some topics for quite some time.

Yet another problem was that the book was envisaged as being put out in both Kannada and English; to that end, we encouraged the authors to write in whichever of these two languages they preferred, but found later that translations were a big hurdle. Outsourcing them did not solve the problem, especially for Kannada to English. In fact this step has proved the biggest hurdle to the completion of the project.

Printing such a volume, in which many articles contained multi-coloured illustrations, charts, maps and tables, has been yet another hurdle that we finally decided not to cross. In this digital age, the document can be seen, downloaded and if needed, sections printed out by any interested reader, and the richness of the illustrations will not be lost.

So, finally, here is the end product, nowhere as comprehensive as we originally envisaged, and varying a good deal in approach, style, length and depth. Some are data-

embedded, and some have steered clear of data, by and large. Such diversity in a volume of contributions by many authors is natural – the result is a kaleidoscopic picture. Unfortunately, the coverage of this book does have many gaps which is a disappointment. However, this lacuna only strengthens our resolve to close these gaps as well the next time around, which may be after about five years. When we do so, we would hope to better other aspects of the book also.

This is a beginning and like all beginnings, imperfect, but hopefully it contains both informative and analytical sets of insights into the situation of children in Karnataka. The reader's feedback will help us in moving forward to the next stage in our endeavour to portray it more vividly and comprehensively next time.

I would like to thank UNICEF Hyderabad for its support to this exercise.this digital age, the document can be seen, downloaded and if needed, sections printed out by any interested reader, and the richness of the illustrations will not be lost.

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I would like to thank UNICEF Hyderabad for its support to this exercise.

R.Padmini

Managing Trustee, Child Rights Trust, Bengaluru.

A Note on Topicality of the Articles

As explained in the preface, articles in this volume span a period of five years. Obviously those written at the beginning of this period could only refer to and use data and qualitative information available at that time while those written towards the end could access later versions of these. There can thus be two valid objections to the publishing of this document: one that the earlier articles are outdated; and the other that earlier contributors have been disadvantaged by their timely submissions.

As the section below will show, sadly, that the first accusation is not borne out as it reveals that for most indicators, the status of Karnataka's children has not improved significantly, and in some cases, has actually worsened. This stagnation or reversal therefore nullifies the second caveat too.

While one could have asked each of the contributors to update their data or to add a few comments at the end of their articles, our experience of delays on our first attempts at revision or correction has prevented us from taking that path. Hence this note points to whatever key changes the recent data show up, and comments on them, including any known or expected advances or stagnation or regression in any indicator or sector. Most of the recent data are from 2014-15, i.e., the end of the MDGs and the beginning of the SDGs, giving us a summary view of the attainment of the MDGs and a baseline for the SDGs.

In October 2019, alarming reports of even worse positions of the National Hunger, and Child Survival, Health, and Nutrition, indicators have hit the headlines. How far these levels are reflected in the various states is not known, but the outlook cannot be expected to be too rosy, especially in view of the economic downturn, joblessness, high pollution levels, water crisis and other climate change issues, that are already evident in many areas across the country.

Changes in key indicators in the recent past [As per data from MDG, SDG, RSOC, CNNS, CBI and CAG reports; also recent global indices].

Poverty

Both Karnataka and India poverty levels have declined more than MDG goals had stipulated [halving since 1990 to India [I]-21 and Karnataka [K]-18 as against goals of 24 and 28] but the present status and the SDG goal of eradication by 2030 seem difficult as per recent statistical anecdotal evidence such as economic slowdown; increased joblessness, rising inequality, etc.

Mortality and Morbidity

Under 5 Mortality: MDG goal was to reduce 1990 levels by 2/3 and these were not achieved [I – 49 actual vs. 42 goal; and K – 36 vs. 31] [NFHS 4]. Will the SDG goals of 25 be achievable?

While IMR is not included in the global goals, they were included by India. The results were I – 40 vs.27; K- 31 vs. 23. Alarmingly, NFHS 4 shows increases to I- 50 and K - 32 [slightly higher]. This indicator again looks difficult to show impressive improvements by 2030.

Measles: Universal vaccination was the MDG goal. The coverage was 89% but K achieved the goal even earlier. By NFHS 4, both had come down to 81% and 82% denoting backsliding.

Malnutrition

Underweight: MDG underweight figures were 33 and 26 % respectively of below 3 year olds in India [I] and Karnataka [K] as against goals of 26 and 24, but NFHS 4 has 36 I and 35 K for below 5 years. Hence one can surmise there was no major change by 2015, though one cannot directly compare the two sets of figures. However, preliminary data from the CNNS [Comprehensive National Nutrition Survey, 2016-18] shows that 33% <5 year olds are underweight nationally; hence the downward trend continues, albeit slowly. [CNNS State-wise figures are not yet available].

Stunting: 48 against goal of 39% and K: 42 vs. 35 in the MDG report indicating that the goal was not expected to be reached in either case. However, with NFHS 4 showing levels have declined to 38 and 36 respectively, the situation has improved a bit. Now CNNS has 35% stunted nationally; so again there is downward trend. Yet, there are disturbing discrepancies as stunting is higher in rural areas and among the poorest. The SDG goal is not clearly specified [It is to reach "internationally agreed goals for stunting"], which is not useful for targetting and estimating India's chances of reaching the goal.

Wasting: The NFHS figure was 21%; it is now 17% nationally.

Anaemia: The level was as high as 59% in NFHS 4, while CNNS shows 41% of 'pre-schoolers', 24% of school-age children and 28% of adolescents as anaemic. Hence, this improvement is reassuring.

Thus there are indeed improvements on many counts in child health and nutrition, [disallowing for the problem of comparability across different surveys], but except for anaemia, they are not large and perhaps not significant. Moreover there are huge inter-state discrepancies apart from those noted above; and worrying backsliding also.

Literacy & Education

The MDG literacy target was 100% while the achievement in 2015-16 was 75%. Enrollment in primary school was universal but sharply dropped by middle or upper primary school level. SDG aims to reach universal secondary school completion, minimum level of learning, full access to ECD; vocational education etc. - all call for huge strides. India's new education policy also emphasises these aspects but the gaps are still very large.

Water and Sanitation

As of December 2017, only 44% of rural habitations and 85% of government schools and anganwadis could be provided access to safe drinking water, only 18% of rural population were provided potable drinking water by piped water supply and only 17% of rural households were provided household connections," said the CAG report, Nov 27, 2018.

Proportion of urban population not covered by proper sanitation was 63% as per a CBI 2011 report. With the Total Sanitation Campaign's metamorphosis into Swach Bharat,

the access to toilets has increased tremendously, but attitudes and usage are still not moving at the same pace. Rural safe sanitation facilities are yet to transform villages and all areas in urban locations into ODF ones.

There have been some very important new schemes that have not been evaluated or their outcomes quantified, such as the Maternity Entitlement Act, the National Food Security Act , the special provision of Iron for school children, but in any case the effects of any innovations typically will not be seen so soon after their initiation , not to mention the problems of under-budgeting or partial implementation that some of them have faced.

In conclusion, this review of the status of the available various indicators of children's wellbeing as compared to those available and used in the articles in this volume shows that the latter are not really out of date or irrelevant. They also serve as baseline figures for the next review, especially the SDGs. The qualitative and analytical aspects of the articles have also an enduring relevance.

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Acronyms

AIDS/HIV	Acquired Immunodeficiency Syndrome / Human Immunodeficiency Vir
AIIMS	All India Institute of Medical Sciences
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ARSH	Adolescent Reproductive and Sexual Health
ASER	Annual Status of Education Report
ASHA	Accredited Social Health Activist
AWCs	Anganwadi Centres
AYUSH	Ayurvedic, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BBMP	Bruhath Bengaluru Mahanagara Palike
BCC	Behaviour Change Communication
BCG	Bacille-Calmette-Guerin,
BEO	Block Education Officer
BF	Breast Feeding
BIRDS	Birth and Death Registration System
BMI	Body Mass Index
BMRF	Bala Mandir Research Foundation
BP	Blood Pressure
BPL	Below Poverty Line
BSUP	Basic Services to Urban Poor
CACL-K	Campaign Against Child Labour - Karnataka
CAG	Comptroller and Auditor General
CBR	Crude Birth Rate
CBSE	Central Board of Secondary Education
CCL	Centre for Child and the Law
CCRU	Collaborative Child Response Units
CDR	Crude Death Rate
CD-SDG	Child Development - Sustainable Development Goals
CECED	Centre for Early Childhood Education and Development
CED	Chronic Energy Deficiency
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CES	Coverage Evaluation Survey
CHC	Community Health Centres
CICL	Children In Conflict with the Law

CII	Confederation of Indian Industry
CNCP	Children in Need of Care and Protection
CO	Carbon Oxide
COPD	Chronic obstructive pulmonary disease
CRC	Convention on the Rights of the Child
CRP	Cluster Resource Person
CRPC	Chronic Poverty Research Centre
CRS	Civil Registration System
CRT	Child Rights Trust
CRVS	Civil Registration and Vital Statistics
CRY	Child Rights and You
CSA	Child Sexual Abuse
CWC	Child Welfare Committee
CWO	Child Welfare Officer
DB	Decibels
CUM/C/Yr	Cubic Meter Consumption per Year
DCPU	District Child Protection Unit
DDT	Dichlorodiphenyltrichloethane
DHFW	Department of Health and Family Welfare
DHS	Directorate of Health Services
DIET	District Institute of Education and Training
DISE	District Information System on Education
DLHS-RCH	District Level Household & Facility Survey - Reproductive & Child Health
DPT	Diphtheria-Pertusis-Tetanus
DWCD	Department of Woman and Child Development
ECCD	Early Child Care and Development
ECCE	Early Childhood Care and Education
EmOC	Emergency Obstetric Care
ENNMR	Early Neonatal Mortality Rate
ER	Emergency Room
FIR	First Information Report
FNB	Food and Nutrition Board
FRU	First Referral Unit
GDP	Gross Domestic Product
GER	Gross Enrolment Ratio
GIT	Gastrointestinal Tract
GoI	Government of India

GoK	Government of Karnataka
GP	Grama Panchayath
GSP	Generalised System of Preferences
HB	Hemoglobin
HDI	Human Development Index
HH	Household
HR	Human Resource
HRF	Hippocampus Reading Foundation
HUNGaMa	Hunger and Malnutrition (Report)
I & B	Information and Broadcasting
ICDS	Integrated Child Development Schem
ICMR	Indian Council for Medical Research
ICPS	Integrated Child Protection Society
ICSE	Indian Certificate of Secondary Education
ICT	Information Communication Technology
IEC	Information Education and Communication
IFA	Iron Folic Acid
IFPRI	International Food Policy Research Institute
ILC	International Law Commission
ILO	International Labour Organisation
ILR	Implantable Loop Recorder
IMNCI	Integrated Management of Newborn and Childhood Illness
IMR	Infant Mortality Rate
IQ	Intelligence Quotient
ISK CON	International Society for Krishna Consciousness
IUGR	Intrauterine Growth Restriction
IYCF	Infant and Young Child Feeding
JJ Act	Juvenile Justice (Care and Protection) Act
JJB	Juvenile Justice Board
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
JSSK	Janani Shishu Suraksha Karyakram
JSYJ	Janani Suraksha Yojana
KCRO	Karnataka Child Rights Observatory
KDLWS	Karnataka State Drug Logistics and Warehousing Society
KHDR	Karnataka Human Development Report
KHPT	Karnataka Health Promotion Trust
KRWSSA	Karnataka Rural Water Supply and Sanitation Agency

KSCPCR	Karnataka State Commission for Protection of Child Rights
LCD	Average Daily Per Capita Water Consumption
MCH	Maternal and Child Health
MCTS	Mother and Child Tracking System
MDG	Millennium Development Goals
MDMS	Mid Day Meal Scheme
MIS	Management Information System
MMR	Measles, Mumps and Rubella
MMR	Maternal Mortality Rate
MLD	Millions of Litres per Day
MNRC	Modified Nutrition Rehabilitation Centre
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MPR	Monthly Progress Report
MPW	Multi-Purpose Worker
MWCD	Ministry of Woman and Child Development
NABARD	National Bank for Agriculture and Rural Development
NBSU	New Born Stabilisation Unit
NCERT	National Council of Educational Research and Training
NCLP	National Child Labour Project
NCPCR	National Commission for Protection of Child Rights
NCRB	National Crime Record Bureau
NER	Net Enrolment Ratio
NFHS	National Family Health Survey
NFSA	National Food Security Act
NGO	Non-Government Organisation
NIMS	National Institute of Medical Statistic
NIPCCD	National Institute of Public Cooperation and Child Developmen
NIP	Network for Information on Parenting
NIP-K	Network for Information on Parenting- Karnataka
NLSIU	National Law School of India University
NNMB	National Nutritional Monitoring Bureau
NNMR	Neonatal Mortality Rate
NPAC	National Plan of Action for Children
NRC	National Register of Citizens of India
NREGA	National Rural Employment Guarantee Act

NRHM	National Rural Health Mission
NRLM	National Rural Livelihood Mission
NSSO	National Sample Survey Organisation
NULM	National Urban Livelihood Mission
OOSC	Out of School Children
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salt
OSCC	One Stop Crisis Centres
OT	Operation Theatre
PCB	Polychlorinated Biphenyls
PDS	Public Distribution System
PHC	Public Health Centre
PLHIV	People Living with HIV/AIDS
PNC	Post-Natal Care
PNR	Peri-Natal Rate
PO	Probation Officer
PoA	Power of Attorney
POCSO	Prevention of Children from Sexual Offences
POP	Persistent Organic Pollutants
PPCIUD	Postpartum Intrauterine Contraceptive Devices
PPTCT	Prevention of Parent to Child Transmission
PTR	Pupil-Teacher Ratio
PU	Pre-University
RBSK	Rashtriya Bal Swasthya Karyakram
RGNCS	Rajiv Gandhi National Crèche Scheme
RIDF	Rural Infrastructure Development Fund
RMNCH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RSBY	Rashtriya Swasthya Bima Yojana
RSOC	Rapid Action Survey on Children
RTE	Right To Education
RTI	Reproductive Track Infection
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SC	Schedule Caste
SCF	Save the Children's Fund
SCLP	Special Committee on License Portability
SDMC	School Development and Monitoring Committee

SDP	Skill Development Programme
SHG	Self Help Group
SICHREM	South India Cell for Human Rights Education and Monitoring
SJPU	Special Juvenile Police Unit
SJSRY	Swarna Jayanthi Shahari Rozgar Yojana
SLI	Standard of Living Index
SNP	Supplementary Nutrition Programme
SOP	Standard Operation Protocol
SPAC	State Plan of Action for Children
SRS	Sample Registration System
SRTT	Sir Ratan Tata Trust
SSA	Sarva Shiksha Abhiyan
ST	Schedule Tribe
STI	Sexually Transmitted Infection
TLM	Teaching Learning Materials
TT	Tetanus Toxide
U5MR	Under Five Mortality Rate
UBR	Universal Birth Registration
UDHR	Universal Declaration of Human Rights
UHA	Universal Health Assurance
UKG	Upper Kindergarten
UNCRC	United Nations Convention on the Rights of the Children
UNICEF	United Nations Children's Fund
UT	Union Territory
VAS	Value Added Services
VHND	Village Health and Nutrition Day
WHO	World Health Organisation

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STATUS OF CHILDREN'S HEALTH IN KARNATAKA

- Dr. Avita Rose Johnson

Maternal and child health outcomes are a sensitive indicator of the country's health system and how society treats its most vulnerable members. Improved maternal, newborn and child health benefits individuals, families, communities and societies, while generating huge economic returns. India has made impressive progress in the decline of maternal and child mortality.

India has realized impressive gains in child survival over the last two decades, working towards achieving the Millennium Development Goal (MDG) 4-which aims to reduce Under-Five Mortality (U5MR) by two thirds by the year 2015. However, India still has 1.7 million children dying under the age of 5 years, one million of whom are newborns. Only six states, namely Kerala, Tamil Nadu, Maharashtra, Punjab, Himachal Pradesh and West Bengal are likely to achieve the goal by 2015.

Improving maternal and child health and survival are central to the achievement of National Health goals under the National Rural Health Mission (NRHM) and the 12th five year plan (2013-2017). The focus is now on key high impact interventions with special emphasis on poor performing geographies, targeting the first 1000 days window of opportunity between pregnancy and the first 24 months of life, which is critical to a broader life cycle approach.

This document discusses child health in Karnataka under the following headings:

1. Causes of neonatal and child mortality
2. Maternal and demographic factors influencing child health
3. Key child health indicators in Karnataka
4. Measures taken by the government to improve child health
5. Current gaps in child health services
6. Recommendations

1. Causes of Neonatal and child mortality:

As per WHO 2012 estimates, the causes of Child Mortality in the age group 0-5 years in India are Neonatal causes (52%), Pneumonia (15%), Diarrhoeal disease (11%), Measles (3%), Injuries (4%), and Others (13%). The major causes of neonatal deaths are infections such as Pneumonia, Septicemia and Umbilical Cord infection; Prematurity i.e. birth of newborn before 37 weeks of gestation and Asphyxia i.e. inability to breathe immediately after birth that leads to lack of oxygen.

2. Maternal and demographic factors influencing child health:

NIMS, ICMR and UNICEF Report 2012 “Infant and Child Mortality in India: Levels, Trends and Determinants” has listed the following maternal

and demographic determinants of child health.

a. Education: Children born to mothers with at least 8 years of schooling have more chances of Survival. Infant mortality rate (IMR) and under five mortality rate (U5MR) among children born to illiterate mothers have been consistently higher than those born to mothers with any education. However, the association between maternal education and child mortality becomes significant only when maternal education exceeds 8 years of schooling. For example, children born to mothers with at least 8 years of schooling have 32% lesser chances of dying in neonatal period and 52% lesser chances in the post-neonatal period, as compared to the illiterate mothers.

b. Age: Children born to adolescent mothers are at higher risk. Both IMR and U5MR are highest among mothers under 20 years of age. The effect of the low age of the mother on mortality is highest during the neonatal period (79% higher).

c. Spacing between childbirths: There is a consistent and significant impact of birth intervals less than 24 months on child survival. For example, a child born within 24 months of the previous child has 68% higher risk of dying within the neonatal period and 99% higher risk of dying in the post-neonatal period.

d. Maternal Nutrition Status: Mortality among children born to malnourished or anemic is higher. Analysis of the National Family Health Survey (NFHS)-3 data showed that neonatal mortality among children born to mothers with low Body Mass Index (BMI) (<18.5) was slightly higher than those with normal BMI (18.5-24.9). Anaemia was associated with 26% higher neonatal and 16% higher post-neonatal mortality rates.

e. Attendance at childbirth: Deliveries attended by traditional birth attendants at home have higher neonatal mortality (27.2 per 1000 live births) as compared to hospital deliveries and (25.5 per 1000 live births). Post neonatal mortality is also higher among infants delivered by traditional birth attendants at home (16.8 per 1000 live births) as compared to those born in hospitals (8.1 per 1000 live births).

f. Social and Economic Factors: Economic status (as measured by Standard of Living Index or SLI) maybe low, medium or high. The under 5 mortality rates are 98.6 per 1000 live births for Low SLI, 79.8 for medium SLI and 48.3 for high SLI. Social Group - a child born to a scheduled caste family has 13% higher risk of dying in the neonatal period and 18% higher risk of dying in the post-neonatal period, as compared to others. Similarly, a child born to a scheduled tribe family has 19% higher risk of dying in the neonatal period and 45% risk of dying in the post-neonatal period. This disparity between the mortality rates experienced by children in different socioeconomic groups may be explained by the difference in awareness, attitudes and access to health services, as well as other factors like maternal education, housing and nutrition which have a direct bearing on child health.

g. Sex of the child: Typically males have higher mortality rates than female at any period of life, owing to the biological advantage conferred upon females. In India, however, IMR among girls has become equal to that among boys. Though girls have lower mortality in the neonatal period, they have higher mortality than boys thereafter and throughout their childhood indicating that gender inequality exists. Under-5 mortality among girls is 80.4 per 1000 live births, while it is 73.3 per 1000 live births for boys.

h. Environmental Factors: Neonatal mortality and under-5 mortality rates are consistently lower among children living in families who accessed drinking water from a safe source as compared to those who accessed drinking water from an unsafe source (Adjusted hazard ration of 0.98 for neonatal mortality and 0.91 for under 5 mortality, after controlling for maternal and foetal risk factors). Similarly, the IMR and U5 mortality rates are consistently lower among children living in families with access to an improved toilet as compared to those who do not have such an access.

3. Key child health indicators in Karnataka

Table 1.1: Current Child Mortality Rates:

Per 1000 live births, as per SRS 2012	Total	Rural	Urban	India	MDG 2015 Target
Infant Mortality Rate	32	36	25	42	28
Neonatal mortality Rate	23	29	12	29	–
Early neonatal mortality Rate	20	24	11	23	–
Perinatal mortality Rate	33	40	20	28	
Under -5 mortality rate	37	40	31	52	42
Low birth weight %, as per NFHS-3	18.7	–	–	22	

Though Karnataka has a better infant mortality rate than most of the rest of India, it has yet to achieve the MDG- 4 goal for reduction of infant mortality by 2015. Karnataka is lagging behind the rest of the country in perinatal mortality rate (table 1.1).

Fig 1.1: State-wise Comparison of Infant Mortality rates in India

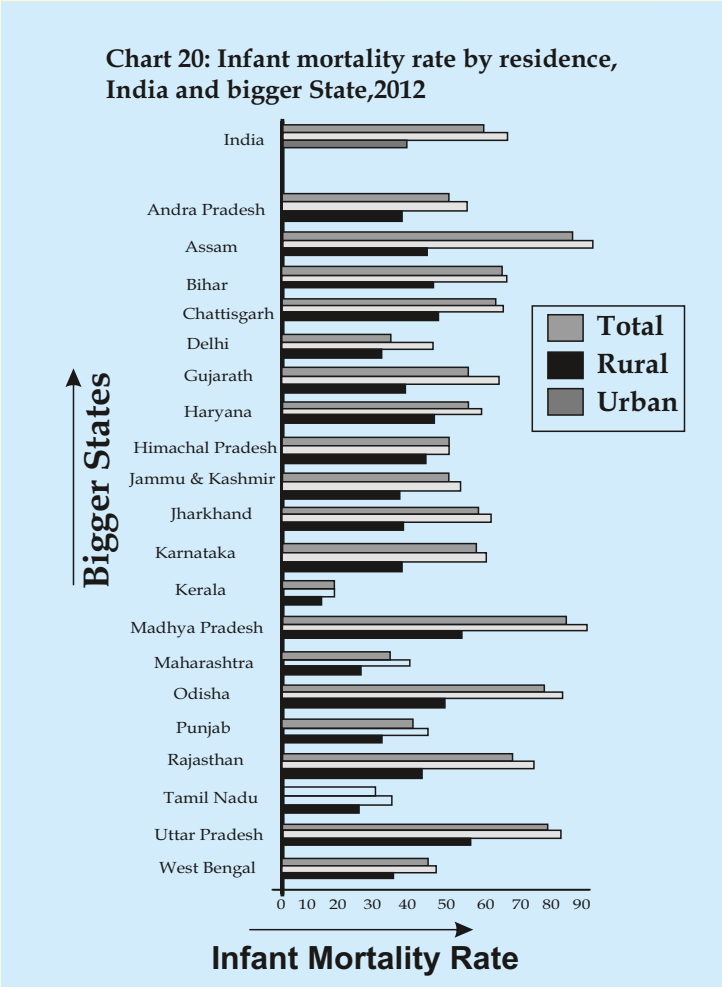

Fig 1.2: State wise Comparison of Under five Mortality rates in India

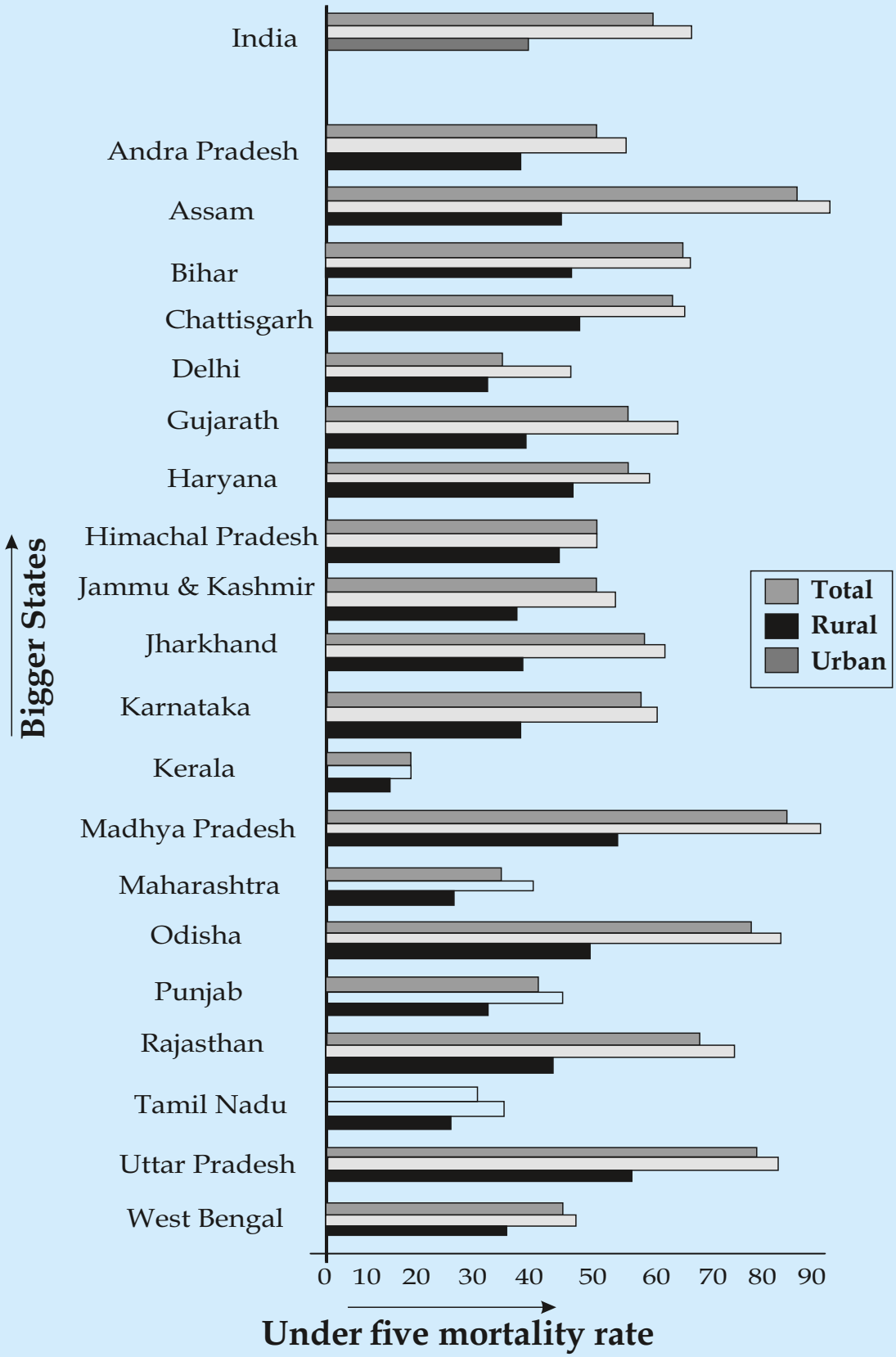

Table 1.2: Current Status of Key Determinants of Child Health Survival in Karnataka:

S No.	Indicator	DLHS - 4 (2012-13)
1.	Literacy rate	75.2%
2.	Sex ratio at birth (males per 100 females)	97
3.	Access to improved source of drinking water	92.3%
4.	Access to improved toilet facility	51.2%
5.	Current use of Family planning methods	62.5%
6.	Pregnant women who received full antenatal care (3 ANC visits, 1+ TT and 100 + IFA tablets / syrup equivalent)	49%
7.	Pregnant women with anaemia	64.6%
8.	Institutional delivery	89%
9.	Delivery by a skilled health personnel	92.3%
10.	Fully immunized children (BCG, 3 doses DPT, 3 doses of Polio and Measles)	77.6%
11.	Initiation of breast feeding within one hour of birth	65.6%
12.	Exclusive breast feeding for at least 6 months	25.7%
13.	Introduction of complementary feeds between 6-9 months	63.6%
14.	Children with diarrhoea in last 2 weeks who sought advice treatment	77%
15.	Children with diarrhoea in last 2 weeks who received ORS	56%
16.	Children with ARI in last 2 weeks who sought advice / treatment	87.8%
17.	Children under 5 years with anaemia	75.9%

In the state of Karnataka, only half of all pregnant women receive full antenatal care (3 ANC visits, 1+ TT and 100 + IFA tablets / syrup equivalent). Anemia among pregnant women and children under 5 years is high (64.6% and 75.9% respectively). Full Immunization for children aged 12-23 months is lagging at 77.6%. The rate of Exclusive breast feeding for at least 6 months is very low (only 25.7%) and only two thirds of infants are weaned at the appropriate age of 6-9 months and just a little over half of all children with diarrhea receive ORS. Only half the population has access to a toilet facility (Table 1.2).

4. Measures taken by Government of India to improve child health

The Government of India has identified 8 High Priority Districts in Karnataka, which are lagging behind in terms of health indicators and other development indicators: These are Bagalkot, Bellary, Bijapur, Gadag, Gulbarga, Koppal, Raichur and Yadgir. Efforts in maternal and child health are being focused mainly on these 8 high priority districts, with the implementation of RMNCH+A programme.

RMNCH+A is a comprehensive strategy adopted by NRHM, based on lifecycle approach for improving maternal and child health outcomes. RMNCH+A stands for Reproductive, Maternal, Newborn, Child and Adolescent Health. The Plus is included to bring focus on adolescence as an important stage of life where key interventions should be made and also means that services in the homes and community should be linked to those provided in health facilities, at primary, secondary and tertiary level with adequate linkage for referral both ways.

RMNCH+A is based on the evidence that maternal and child health cannot be improved in isolation as adolescent health and family planning have an important bearing on the outcomes. RMNCH+A strategy encompasses use of basic principles of public health & management besides implementation of high impact interventions across the continuum of care : 1) critical life stages 2) preventive, primitive and curative services 3) various levels of health facility and the community.

RMNCH+A interventions are implemented across the maternal and child Continuum of Care, following the idea that a healthy adolescent will grow to be a healthy mother, who will give birth to a healthy child. The Government of India is focusing on certain high impact RMNCH+A interventions, which are to be implemented with high coverage and high quality through NRHM.

Table 1.3: Key Interventions in RMNCH+A

5 X 5 Matrix for High Impact RMNCH+A Interventions
To be Implemented with High Coverage and High Quality

Reproductive Health	Maternal Health	Newborn Health	Child Health	Adolescent Health
Focus on spacing methods, particularly PPIUCD (postpartum intrauterine device) at high case load facilities Focus on interval IUCD at all facilities including subcentres on fixed days Home delivery of contraceptives and ensuring spacing at birth through ASHAs Ensuring access to Pregnancy Testing Kits ("Nischay Kits") and strengthening comprehensive abortion care services. Maintaining quality sterilization services and strengthening comprehensive abortion care services.		Early initiation and exclusive breastfeeding Home based newborn care through ASHA Essential Newborn Care and resuscitation services at all delivery points Special Newborn Care Units with highly trained human resource Community level use of Inj. Gentamycin by ANM in treatment of neonatal sepsis	Complementary feeding, IFA supplementation and focus on nutrition Diarrhoea management at community level using ORS and Zinc Management of pneumonia Full immunization coverage Rashtriya Bal Swasthya Karyakram (RBSK): screening of children for 4Ds'(birth defects, development delays, deficiencies and disease) and its management	Address teenage pregnancy and increase contraceptive prevalence in adolescents Introduce Community based services through peer educators Strengthen ARSH (Adolescent Reproductive and Sexual Health) Clinics Rollout National Iron Plus Initiative including weekly IFA supplementation Promote Menstrual Hygiene

5 X 5 Matrix for High Impact RMNCH+A Interventions
To be Implemented with High Coverage and High Quality

Reproductive Health	Maternal Health	Newborn Health	Child Health	Adolescent Health
Maintaining quality sterilization services.	and child deaths for corrective actions Identify villages with low institutional delivery & distribute Misoprostol (for medical abortion) to select women during pregnancy; incentivize ANMs for domiciliary deliveries			
Health Systems Strengthening Case load based deployment of HR at all levels Ambulances, drugs, diagnostics, reproductive health commodities Health Education, Demand Promotion & Behavior Change Communication Supportive supervision and use of data for monitoring and review, including scorecards based on HMIS Public grievances redressal mechanism; client satisfaction and patient safety through all round quality assurance				

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5 X 5 Matrix for High Impact RMNCH+A Interventions
List of Minimum Essential Commodities

Reproductive Health	Maternal Health	Newborn Health	Child Health	Adolescent Health
FP commodities: Tubal Rings, IUCD 380-A, IUCD 375 Oral Contraceptive Pills,(Mala-N), Condoms Emergency Contraceptive Pills (Levonorgestrel 1.5mg) Pregnancy Testing Kits	Injection Oxytocin Tablet Misoprostol Injection Magnesium Sulphate	Injection Vitamin K Mucous extractor Vaccines - BCG, Oral Polio Vaccine (OPV), Hep B	Oral Rehydration Salt (ORS) Zinc Sulphate Dispersible Tablets Syrup Salbutamol & Salbutamol nebulising Solution Vaccines - DPT, Measles, OPV, Hep B JE (19 States),	

-Nischay Tablet Mifepristone (Only at facilities Conducting Safe delivery)			Pentavalent Vaccine Syrup Vitamin A	

Cross cutting Commodities as per level of facility

- Iron & Folic Acid (IFA) Tablet, IFA small tablet, IFA syrup
- Syrup /tablets: Paracetamol, Trimethoprim & Sulphamethoxazole, Chloroquin and Inj. Dexamethasone
- Antibiotics: Cap /Inj. Ampicillin, Metronidazole, Amoxycillin; Inj. Gentamycin, Inj. Ceftriaxone;
- Clinical /Digital Thermometer; Weighing machine; BP apparatus; Stop Watch; Cold box; Vaccine carrier; Oxygen; Bag & mask testing equipments for Hemoglobin, urine and blood sugar

5 .Current gaps in child health services

In 2013, UNICEF (AP& Karnataka) in collaboration with the Department of Community Health, St. John's Medical College, conducted a Gap analysis of the RMNCH+A program in the 8 high priority districts of Karnataka which are lagging behind the rest of the districts in maternal and child health indicators: Bagalkot, Bellary, Bijapur, Gadag, Gulbarga, Koppal, Raichur and Yadgir. A sample of government health facilities were surveyed in various taluka of these districts and government health functionaries were interviewed.

RMNCH+A Gap Analysis of High Priority Districts of North Karnataka

Gaps Identified at District level

- Good infrastructure at District Hospitals
- Large numbers of general cases are seen by specialists, because of lack of Medical Officers. This puts an unnecessary burden on specialists, whose time and effort can be utilized better.
- The proportion of sanctioned posts in urban areas is not matching the population as per norms, especially ANMs. This is because even though the urban population is expanding, there is no subsequent increase in the staff for covering urban populations.
- Training is not always translated into practice.(eg:PPIUCD). This is because there is a lack of supportive supervision and hand-holding in the district. There is no mentoring for the junior or inexperienced staff.
- Staff Nurses lack training in NSSK, PPIUCD, F-IMNCI, FNBC, blood storage, IYCF counseling, SAM.
- Overall, the Routine Maintenance of equipment is poor. Annual maintenance Contract (AMC) for all major instruments\ are not available (essential equipment like ILR is waiting for repair.)
- Computerized inventory management not present
- High risk pregnancies and sick neonates are being transported under JSSK but number of referrals of high risk pregnancy and delivery and high risk newborns to the

district hospital is high because the FRU is not "fully functional" (lack of Obstetrician, Blood storage, Pediatrician and functional NBSU at FRU)

- Admission of SAM children to the NRC is not happening adequately. Children who are identified as SAM are not being referred to the NRC for admission and follow up. Staff at the NRC needs to be trained in managing SAM.
- JSY/ JSSK entitlements not displayed appropriately in ANC /PNC wards/clinics.
- Maternal death review being done regularly but actionable points needs to be followed up.
- Infant death review needs strengthening

Gaps Identified at First Referral Unit (FRU)/ Community Health Centre (CHC) level

- Some of the FRUs are not "fully functional" due lack of either specialist trained in EmONC (Emergency Obstetric and Newborn Care) or lack of Blood storage facility.
- In the many FRUs, specialist vacancies are an issue. Obstetrician, anaesthetists and pediatrician posts are vacant, inspite of attractive remuneration package offered.
- No blood banks in FRUs. Some FRUs even lack Blood Storage facility due to lack of staff trained in Blood safety and storage.
- No NRC/MNRC in most FRUs.
- Some NBSUs are not functional due to lack of Pediatrician.
- Staff quarters not adequate for all the staff at FRU.
- Many of the existing quarters not habitable. Regular maintenance of staff quarters is not happening.
- Shortage of Group D workers in FRUs
- Some of the Medical officers have not been trained in NSSK, EmOC, Blood storage, IYCF counseling, SAM, PPIUCD.
- Staff nurses require training in NSSK, FIMNCI, PPIUCD, Blood storage, IYCF counseling, SAM, RTI/STI, PPTCT, use of Zinc
- No mechanism for staff from the periphery to request for training.
- Overall, the Routine Maintenance of equipment is poor. Annual maintenance Contract (AMC) for all major instruments are not available (many places, essential equipment like OT lights are waiting for repair, some Essential equipments like ILR, Radiant warmer and OT lights are not functioning .)
- All equipments are available but sometimes are redundant because lack of specialist.
- One FRU had no Inj Mag Sulph and one FRU was not storing Inj Oxytocin in the refrigerator.
- Normal deliveries are conducted in all FRUs as per expected, but C-section is not happening in many of the FRUs, leading to burden on District hospital.
- Maternal death review follows up inadequate. No infant death review happening.
- Line listing of severely anemic pregnant women not being done.

Gaps Identified at PHC level

- PHCs are built on IPP model in many places and are generally well maintained.
- Staff quarters not adequate in some places, not habitable in some.
- Most PHCs do not have separate wards for males and females.
- The number of PHC Medical officer and ANM posts are not matching with the population covered. Population has increased in some PHC areas, but the staff has not correspondingly increased.
- Medical officers and Staff nurses have not been trained in NSSK, EMOCs, Blood storage, IYCF counseling, SAM, PPIUCD, on use of Zinc. No mechanism for staff from the periphery to request for training.

- Some PHCs which cover a larger population, or receive larger number of OPD/IPD patients find that the budget for drugs that is allocated to them is inadequate to meet their needs.
- Overall, the Routine Mwaintenance of equipment is poor. Annual maintenance Contract (AMC) for all major instruments are not available (many places, essential equipment like Radiant warmers are waiting for repair.)
- Normal deliveries are conducted in all PHCs as per expected
- Staff nurses are trained but some are not confident in handling sick newborns and infants
- ARSH clinic attendance among adolescents is poor.
- Line listing of severely anemic pregnant women not being done.
- PHCs are well connected with FRUs by 108 service, but transport from home to facility and back is lacking
- Though there are well displayed IEC materials in FRUs and PHCs, there is a lack of relevant IEC in many antenatal clinics or post natal wards regarding Breastfeeding, Immunization, Family planning, JSY and JSSK Entitlements

Gaps Identified at Community / Household level

Adolescent girls

- IEC for ARSH Clinic at school level is required.
- Sanitary napkins are available but no demand from the community, because of poor quality
- Poor awareness of ARSH clinics among adolescent girls

Antenatal women

- Birth Preparedness among antenatal women is inadequate. Knowledge of danger signs is very poor. Though most

Postnatal women

- For postnatal mothers, there are issues with receiving JSY payment prior to discharge. Women who did not have ration card could not avail the benefit.
- Mothers are not aware of JSSK entitlements.

Mothers of children aged 0-6 years

- Knowledge among mothers regarding home available fluids for diarrhea, ORS and Zinc is poor.
- Knowledge among mothers regarding danger signs of pneumonia is poor.
- Handwashing practices among mothers is poor.

6. Recommendations to fill the Gaps and overcome Bottlenecks in Child Health and Survival in Karnataka

A. Human Resources

- Medical Officers can be appointed at District hospital and FRUs, since there is a large number of general cases seen daily in the OPD. This will reduce burden on specialists.
- Specialist recruitment in FRUs – Obstetrician, Paediatrician, Anaesthetist - to be hired aggressively with difficult area allowance in high priority districts.
- The number of sanctioned posts of ANMs in urban areas should be increased to match the population covered.

B. Capacity Building

- Doctors trained in EmOC can be appointed in the absence of an obstetrician
- EmOC, Blood storage, SAM and PPIUCD training for all MOs in FRUs.
- ANMs and ASHAs require training on the

use of Zinc and ORS.

- Refresher trainings to Staff nurses on SBA, F- IMNCI in mentoring pattern.
- Supportive Mentoring for Staff nurses, to improve the initial management of high risk pregnancies and for handling sick newborns and infants. Mentoring program, which started as Sukshema project from KHPT has indeed improved the practice of partograph and systematic case sheet filling in PHCs. This should be continued.
- Trainings to AYUSH doctors are needed on NSSK and F-IMNCI.
- Staff Nurses need training in NSSK, PPIUCD, F-IMNCI, FNBC, IYCF counselling, SAM
- MO and Nurses at the FRU to be trained in blood storage and blood safety.
- Subcentre ANMs require training in NSSK, IMNCI, HBNC, RTI/STI, use of Zinc
- There should be a linking of the training of staff with the service register at district and state level.
- There is should be individual database of capacity building in the district and state.

A. Infrastructure

- Blood storage facility to be made fully functional in FRU.
- Annual maintenance Contract (AMC) for all major equipment is required.
- Relevant IEC material should be displayed in antenatal clinics and post natal wards regarding Breastfeeding, Immunisation, Family planning, JSY and JSSK Entitlements.
- Computerized inventory management should be put in place
- Staff quarters to be repaired/ maintained wherever required and new staff quarters to be built where there is shortage

B. Service Delivery

- Maternal and Infant death review should be followed with clear and concise corrective measures and subsequent monitoring mechanism and not as a fault finding exercise. Actionable points need to be followed up
- Quality of ANC at the subcentre needs to be improved. It should be stressed to the ANM that antenatal care does not mean 3 visits, 2 TT and100 IFA alone. At the subcentre, She MUST screen for high risk pregnancy – monitor weight, fundal height, measure BP, measure Hb, check urine for albumin and sugar, ask and look for danger signs, ensure Birth Preparedness in the mother and counsel her for family planning.
- Essential and basic equipment for blood sugar estimation, for urine albumin and sugar, BP apparatus and adult weighing scale should be functional. Non functioning essential equipment at the subcentres should be replaced if they cannot be repaired.
- Line listing of severe anemia cases needs to be maintained at Lab and followed up.
- MCTS system should be used for generating monthly due list for the ANM.

C. Community Level

Antenatal women

- ASHA and ANM should use VHND platform to improve Birth Preparedness among antenatal women, the importance of identifying transport well in advance as a part of birth preparedness, knowledge of danger signs in pregnancy, PPIUCD, and also awareness of various maternity benefit schemes like JSY and JSSK entitlements.

Postnatal women

- ASHA should generate awareness regarding transport reimbursements from home to facility and back. Posters of JSY and JSSK entitlements should be prominently displayed in postnatal wards to make women aware of these benefit schemes.

Mothers of children aged 0-6 years

- VHND platform can be used to improve Knowledge among mothers of infants and young children regarding Handwashing practices, use of ORS and Zinc in diarrhoea and regarding danger signs of pneumonia.

Adolescent Health

- IEC for ARSH Clinic at school level is required to improve awareness about ARSH clinics.
- Schools should be informed correctly about WIFS protocol with Blue IFA

W.A.S.H

- Clean drinking water must be made available at all health facilities.
- Separate toilets for males and females in all health facilities should be provided.
- Handwashing practice among mothers of infants and young children should be improved through BCC activities by ASHA using VHND platform.

Nutrition

- VHND should be a platform to promote nutrition among antenatal mothers with focus on cheap, locally available foods. Nutrition demonstration by ASHA and Anganwadi worker at VHND can be done.
- Nutrition education to Adolescents at schools can be done by ANM and ASHA. Emphasis on locally available nutritious food and avoidance of pre-packaged /junk food.
- SAM children identified at the periphery should be referred to the NRC or MNRC

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HEALTH SYSTEMS AND SERVICES - CONCERNS FOR IMPROVING CHILDREN'S HEALTH

- Asha Kilaru

Improving child health requires improving health systems (the way health care is organized and financed), health care (involving human resources, diagnostics, treatment, etc.) and health-seeking behaviour (how and why people seek or do not seek care). This paper broadly discusses some of the concerns in the current health system in India in terms of improving health care access for poor children and acknowledging recent changes that appear to be politically popular and seem likely to be sustained regardless of party dominance in the central government. Some of the key concerns include: An increase in user fees at government hospitals, the growing arrangements between the private sector and government to provide care to the poor, and the development of conditional insurance schemes as a way of providing access to secondary and tertiary care for the poor - all in the context of a historically prevalent model of vertical programming for care and low budgetary allocation.

Progress in child health is embedded in improving population health overall and in the development of a culture of health care quality that integrates health conditions and life stages instead of fragmenting services and treatment. The same systems of health care serve children as well as all other members of the population. Accesses to good quality health services are necessary for all ages. In other words, the supply of good quality affordable care must increase, as must its demand – the measure of how much people want and access health care. It is accepted that improved supply will increase demand, especially in resource poor settings. In such settings, it is often easier to define supply improvement than to define efforts to improve care-seeking. Supply improvement must of course go beyond the “bricks and mortar” of infrastructure and be attentive to specific components of diagnosis, treatment, respect and cost. Furthermore, these services need to include preventive care, health promotion *and* curative care.

Interventions to change health-seeking behaviour are tricky and need to be multi-pronged. Health-care seeking behaviour is more complex and influenced by

economic, cultural and social factors, as well as individual characteristics such as personality and family up-bringing. Health is not achieved through health services alone, as safe water, sanitation, clean environmental surroundings, food and nutritional security, etc., are also important. This paper deals with one key contributor to good health – health services.

Health service delivery, from the point of view of the user, is determined by the quality and extent of care available in hospitals and health centres. From the perspective of a family seeking care for a child, these services are highly fragmented. Whether urban or rural, health services are delivered in a health system that requires people to access treatment from health centres located in different areas (often far away). Furthermore, treatment is arranged through disease schemes based on national (and not necessarily local) priorities. Insurance programmes to improve access to care for the poor that recently have been instituted across the country are often disease and/or procedure focussed and administered by different government departments and agencies. While these may increase health-seeking because those who could not afford care now can register for some coverage, this system does little to provide entitlement to a comprehensive continuum of care individually or at a household level.

In terms of accountability and integration of services, the rural population accesses a public-sector system that less fragmented than urban health systems. Nearly all hospitals and services fall under the Department of Health and Family Welfare and not multiple authorities. Karnataka however, has a separate Medical Education Department, which operates 12 of the 30 district hospitals in the state so some rural areas will have hospitals run by both departments. People access care in primary health centres for health problems involving general medicine for all populations, maternal and child care for non-complicated care (e.g. normal birth, immunization, family planning, etc.), and care under any of the several national disease programmes, such as tuberculosis. The primary health centres provide referrals to secondary and tertiary hospitals. While this is logical in concept, ease of access is still a desired goal that is yet to be achieved. Barriers involve distance to hospitals, quality of care, poor supply of medicines and out-of-pocket expenditure through user fees as well as illegal payments that are incurred for consultation, medicines from government and private dispensaries and government and private diagnostic services. It is well-known that government hospitals often prescribe medicines and instruct individuals to purchase these “outside” at private pharmacies and certain diagnostic tests are ordered that are not available within the hospital so patients rely on their families to take them to private diagnostic centres. Services for complex, chronic and/or rare conditions often do not even exist in the government tertiary care hospitals. When they do, such tertiary care centres are often stand-alone public sector, large hospitals that serve entire states and regions (for example Kidwai Cancer Hospital or the National Institute of Mental health and Neuroscience, both in Bangalore). To address this gap, the government has developed insurance schemes and empanelled private providers and/or hospitals. Problems associated with this approach are discussed later.

The urban system is a web of services and hospitals that lack administrative coherence. Government hospitals under different government departments and programmes exist in the same urban centre, with little joint planning and coordination. Mostly accessed by low-income persons, few are aware that different levels of government (state, local) and different departments within a level manage individual hospitals within a city. Bangalore illustrates this complexity very well, with both state and local government operating primary health centres, and different departments within the state government managing secondary hospitals and tertiary care hospitals. This administrative heterogeneity results in different user fees, incompatible eligibility requirements for free services, and a tendency to avoid accountability for patient welfare.

Furthermore, insurance schemes and medical care schemes are not necessarily seamless between hospitals and during worsening or changing medical conditions within for a given person. Imagine the difficulties a family faces for example, with a sick child, taken to a primary health centre and given free treatment under a particular scheme, not recovering at home, taken back to the centre and referred to a secondary or tertiary hospital where they either have to enrol again in the scheme at this location or pay in full (some amount upfront) for care. Serious conditions such as carcinomas would be treated in some hospitals only, most of which are autonomous and services here are not free even for BPL patients, only discounted. Often, prescribed medicines are only available in external dispensaries and diagnostic tests in external labs, especially for out-patient care. Insurance schemes, while promising free treatment for the procedure itself, do not cover follow-up care or medication once the patient is discharged. Distance is also a factor, with most empanelled private hospitals located in Bangalore. For families of sick children, the burden of travelling to Bangalore and staying there for the duration of the treatment is huge. Furthermore, children and older persons require outreach care – home visits and care coordination. There is little evidence that such services are widening beyond “screening” camps for the initial identification of persons who may need treatment. Private institutions undertake these screening camps because of the financial incentives involved in identifying people who need procedures that the hospitals get reimbursed to provide. In contrast, there are no incentives for important components of care, such as outreach.

Under the National Rural Health Mission (NRHM), a number of schemes have been introduced for maternal and child care, such as Janani Shishu Suraksha Karyakram (JSSK), which provides cashless care for delivery, starting at home (pick-up during labour) till 30 days after birth for mother and child. The advantage of this scheme is that it covers the continuum of care and has merged various programmes and schemes to ensure full coverage. The disadvantage is that it is provided in only a few government hospitals and, especially in urban centres, do not provide full coverage because of hospitals being run by other departments. For example, in Bangalore, transportation from home is not covered in most cases and patients still incur costs from diagnostic tests. Yet, this is a great improvement on benefit schemes such as JSY and Madilu because they cover several other aspects of care.

Insurance schemes such as RSBY and VAS, which cover children's diseases at the secondary and tertiary levels respectively, are less accessible. Patients have to be identified through field staff, screening camps

etc. and treatment is covered only for specific conditions and again often not for follow up care after the first episode or hospitalization.

While existing schemes are fragmented, state governments can play a huge role in shaping access and coverage. For example, Kerala has used RSBY, the NRHM scheme Rashtriya Bal Swasthya Karyakram (RBSK) and others to provide free comprehensive health care for all children (under 18). Instead, Karnataka has introduced schemes such as Bhagyalakshmi (a financial investment for girl children), Balasanjeevini (tertiary care for BPL children), eggs and milk for malnourished children through the Women and Child Welfare Department without linking them to the Health Department's schemes. In urban areas, the shortage of Anganwadis leads to a poor uptake of these schemes as well.

In addition, there are chronic problems that affect health services in Karnataka

- Acute staff shortages – doctors (Medical Officers and specialists), nurses, technicians
- Out of the 1,124 sanctioned specialists' posts, 900 posts are vacant for over two years now (paediatricians included)
- Medicines availability – shortage of children's medicines: syrups, antibiotics, even ORS (oral rehydration solution)
- Free treatment for poor not always implemented
- In Vajpayee Arogyashree and other insurance programmes, travel for only one family member is covered. Follow-up not covered
- IGICH ventilator example – ventilators ran out, so hospital rented them. Patients incurred huge costs
- Coordination between Health and Family Welfare and Women and Child Development departments still have gaps, often pronounced in urban areas

Will current trends of plugging access gaps with insurance and treatment schemes continue? What can we expect from the new national government in terms of availability of health services? The central government has plans to dramatically expand the private health sector. The Press Information Bureau, Government of India, Ministry of Health and Family Welfare released the following headline on 27th August 2014.

Universal Health Assurance to galvanise Health Care sector

Dr Harsh Vardhan tells CII to prepare for "next revolution"

The article reported comments by the Union Health Minister that India's health care sector would undergo "unprecedented growth" and that the Modi government's Universal Health Assurance (UHA) programme will make medical care affordable for the poor, thereby causing an "explosion" of demand. It is important to note that these remarks were made at the Confederation of Indian Industry (CII)'s 8th Health Insurance Summit. While the details of UHA are being worked out through a series of 'expert' committees, the minister has outlined some aspects, such as the free availability of 50 essential drugs, widening the government-paid health insurance cover and premiumed health insurance for everyone else. They envision large growth in the already fast-growing private sector. The minister also promised that widespread corruption would be addressed through a strong regulatory body and demanding transparency, using information technology to achieve this. Small and medium enterprises will be given special advantages in the health care sector and the "government will become the biggest marketplace for buying and selling of health care goods and services". Other critical issues such as increasing the doctor population ratio, and

training more people in diagnostics and medical technology were flagged. Significantly, AYUSH will be given greater prominence because these systems of medicine have a holistic view of health. The government also plans to add medical colleges to all district hospitals to their campuses. While some of these points sound promising for improving the availability and capacity to provide quality health care in the country, the emphasis on the private sector is worrying. Furthermore, the new government has defines health assurance as "an assurance that people receive an essential package of required and quality health services without suffering financially by having to pay for such services." package approach is contrary for such service. " An essential package approach is contrary to truly universal health care which includes all necessary health care and excludes only elective care.

Furthermore, it does not appear that truly universal health care, with one system of delivery and one system of payment, funded through direct taxation, will evolve. It is early to tell, but an expansion of government-backed insurance to finance health services from the private sector for the poor is likely – essentially an expansion of current trends. Will the problems of fragmentation, the lack of a continuum of care from primary to tertiary for all conditions except those that are rare, and effective health preventive and health promotion services be addressed? If it is to be addressed to achieve better child health, it needs to be addressed for all. It is imperative that the public health community, the medical community, and civil society raises their voices at this juncture to ensure that these systemic problems are addressed in a way that will bring improvement in health services and not an increasing set of barriers after an initial "invitation" into the health care system through the schemes and insurance programmes mentioned.

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3

HEALTH SITUATION OF CHILDREN AND ADOLESCENTS IN KARNATAKA – AN OPINION

-Edwina Periera

Karnataka as a state has achieved improved health indicators over the past decades. However, Karnataka is one state where, because of the progressive districts, the abysmal state of the northern region of the state is invisible.. The 2011 census puts the population of Karnataka at 61.13 million with 31.06 million males and 30.07 million females. Of this 37.55 million were in rural areas. The rapid rural-urban migration is also responsible for significant differences in population densities between rural and urban areas. The share of small villages in rural population has been shrinking while that of villages with population above 5000 has been increasing. Children under six constitute 11.21%.of the population in Karnataka according to the 2011 Census.

Health and development are two sides of one coin:

Health and development are two sides of one coin. Over my 25 years of work in public health, this fact was reinforced by the addressed of several health challenges. I cite two examples to highlight this point.

Firstly, an example of reducing malarial deaths among children in Bissam Cuttack in Odisha. The name Bissam Cuttack means 'fort of death'. It was derived from the fact that the railway line across here took 50 years to build since most workers fell prey to malaria. Tribal families here never named their new born babies till they crossed one year of age, lest they die of malaria. In Odisha, around 85% of the cases reported are due to falciparum malaria (pf)[1]. The challenges of operational difficulties increases the risk of malaria in remote, rural, tribal, inaccessible, forested and forest fringed areas. In 1998, Orissa (with a share of less than 4 per cent of all-India population), had accounted for 28.6 per cent of the detected cases of malaria in India (two million) and 62.8 per cent of all malarial deaths in the country.[2] One of the pilots to address malarial deaths was undertaken by the Christian Hospital, Bissam Cuttack under the leadership of Dr John Oommen. He demonstrated that malarial deaths could be reduced by 50% in malaria prone Bissam Cuttack. He used evidence

based data to ensure people and children sleep inside mosquito nets. The mosquito nets were bought by the tribal self help group program and soaked in Deltametrine twice every year during the tribal festivals. The poverty alleviation development programs helped with the buying of mosquito nets making the program sustainable. The use of the tribal festivals and dance as an occasion for dipping the mosquito nets in insecticide was far more effective than dry formal health education. This pilot was scaled up across Odisha and then India subsequently.

This case study demonstrates the inextricable link between health and development as two sides of one coin.

The second case study is related to living positively with HIV infection. At INSA-India, we sought to enlist the participation of children living with HIV infection in strengthening positive living i.e. children living with HIV infection have the opportunity to live healthy, normal lives. Child parliaments were formed in two institutional and two community based programs looking after children living with HIV. As a result of the child parliaments, adherence to the medications that keep them healthy, ART, was ensured. The child's right to treatment was linked to the child's responsibility to take the medications regularly. In practice, health and development actions cannot be separated.

Can we learn from addressing HIV and AIDS?

Indian political parties contesting for elections in Karnataka repeated the list of promises made to children in the last two elections (2004 and 2009). They promised children of ending malnutrition, improving quality in primary education, preventing child abuse and child labour; building toilets; preventing female foeticide; protecting the girl child, upholding the rights of children with disabilities; etc. The Indian National Congress, in its 10 years' regime succeeded in passing a few child centered Acts. But, in its current manifesto it has accepted India is yet to solve problems of malnutrition and building toilets. BJP aims to bring down child and maternal mortality rate. It envisages strengthening the National Health Mission and providing clean potable water to arrest epidemics. But all these assurances speak of political parties looking at child health from the lens of health alone.

In the present context, with child participation as a Right children have, there is a need to establish forums for children at various levels to reach out to the Government and express their needs and aspirations. But, so far, no party has made any attempt in this regard.

Although HIV was first seen as only a health issue, it very soon was mainstreamed into other sectors and Ministries. Today HIV is a chronic condition, which Denis Brown, former UNAIDS chief of India calls a “chronic non communicable disease.”

Is there scope for child health to follow a similar trajectory of multi-stakeholder involvement across health and development sectors in Karnataka today? It is the parents and guardians that control when a child gets immunized, when they visit hospitals and what they eat. The parents could be found across sectors, making a good argument for mainstreaming child health. But first, one must acknowledge then, that health and development ARE two sides of one coin.

Why is there child malnutrition still?

There has been too much rhetoric on the poor state of child health. Look at malnutrition deaths, for example. It is a well known fact that between April 2009 to August 2011, 2689 malnourished children died in the district of Raichur itself. Another 4531 children are suffering from severe malnutrition in Raichur, as of the last count in 2011. Sadly, this was admitted by officials including the Hon'ble Chief Minister Shri Sadananda Gowda. A country is defined by the way it treats its most vulnerable - its children. Plain lip service during election and other times cannot be the response to the years and years of child neglect, poor detection and sustained responses, poor food intake and hunger experienced by children resulting in malnutrition related deaths. Not one or two but over 2500 deaths of children attributed to malnutrition is a shame for the state.

Under Supplementary Nutrition Programme, supplementary nutrition provided (per day) is as follows:-

- 500 calories of energy and 12- 1 8 grams of protein to 0-6 year's children
- 600 calories of energy and 18-20 Gms. of protein to pregnant women/lactating mothers /adolescent girls
- 800 calories of energy and 20-25 Gms. of protein to severely underweight children as a supplement to their normal intake.
- Unit cost of milk supplied to Anganwadi children raised from Rs 4.60 to Rs. 6.00
- *150 ml milk is provided to all children from August 2013*
- *Rs. 4 worth of milk/egg is provided to all severely malnourished children*
- *Health Checkup is being conducted once in 2 months*
- *27 Modified Nutrition Rehabilitation Centers and 30 Nutrition Rehabilitation Centers are started in the State to treat the Malnutrition Children.*

A grave problem like malnutrition cannot be cured by simplistic health centric treatments. It requires the active participation of food security, health services and poverty alleviation to work hand in hand with non-corrupt common visions to ensure that no child in Karnataka is malnourished. Factually, in spite of the attention by courts and government functionaries to the problem of malnutrition in Raichur district and city, malnutrition continues to receive a simple bandaid response. In the Annual Plan for 2013-2014, the Chief Minister has announced that 30 kgs of rice at Rs 1/-kg would be provided to BPL families[3]. He added that the increased concern for malnutrition has egged the Ministry to provide milk to children in anganwadi and schools on alternate days.

Key causes for malnutrition in the state.

The root causes of the issues of malnutrition have yet to be tackled with the new state government now in place. Diarrheal diseases are one of the root causes of malnutrition. Unsafe drinking water is just one cause of such diseases. The Annual Plan

for 2013-2014 proposes to set up water purification systems similar to that piloted in Gadag in another 1000 villages. Is that enough? Tackling malnutrition requires a comprehensive response.

Firstly, Poverty is a twist between having an earning to spending it on paying back loan interests, medical bills and alcohol leaving very little for food for the family. Poverty is also a twist between joblessness with the growing mechanization of agriculture and fickle weather discouraging agricultural work. Poverty is a twist also between migrating from rural to urban locations with very real homelessness, very little space to generate self income generating programs, own food produce, and paying higher costs for urban wants. The ultimate outcome of these twists is child malnutrition with lack of funds to purchase nutritional healthy foods that children need.

Secondly, the community. Small hamlets are disappearing in Karnataka. Villages with over 5000 population are the average. In the fight for minimal resources, the child loses out. It is a fact rarely questioned that a Pepsi is more available in poor communities than free safe drinking water. Growing globalization forces both men and women to work leaving children in crèches, child care centres and Anganwadis. Also even while poverty is showing a decrease, inflation erodes the purchasing power of families.

Thirdly, the word '***supplementary***' feeding is not understood by parents, who then depend on just this food for the child. Supplementary means 'in addition to' what food they get at home. However, in majority of cases, the supplementary meal is **the** meal a child has. “Many children come hungry to school and wait eagerly for the mid-day meal served” is the cry of several teachers in schools. “But why do they not have breakfast. Is it because they cannot afford to?” I asked. “Their mothers work as domestic workers. The mothers leave home at 5am and do not return till after the children return home from school”. While children have a Right to Food, that Right cannot be met by only the government. The parents have to own their responsibility too.

Fourthly, food shortages are a significant cause of malnutrition in children. Even in the 2013-2014 Annual Plan, Karnataka is seeking help from Chhattisgarh and other states in order to honour the Rs1/kg 30 kgs per BPL family per month.

Fifthly, the health system imposes the vertical functioning that limits the health system to stay within the boundaries of health care. Key causes like poverty alleviation cannot then be tackled comprehensively with an individualized family plan. Malnutrition in Raichur was identified years before the children died of it. While newspaper sources cited abject apathy as a significant cause, we would like to delve deeper. Job descriptions aside, historically health personnel face rigid red tape processes to themselves take corrective innovative actions for local specific malnutrition redressals. Today, even as decentralization is surfacing, and PHC and CHC are answerable at Panchayat levels, the mindset at both ends – the community and the health personnel- has to change. A system exists through the growth monitoring process for all children below 5 years of age. The individual child card captures significant data for a comprehensive response, in time.

However, poor accountability for the work required to be done cannot be amplified better than with the statistics of children dying of malnutrition in the state. The response is much better now though than when the cases in Raichur surfaced in 2011.

Sixthly, privatization of medical care is increasing and communities tend to trust their medical needs to private health facilities. Although the government has schemes like the Rashtriya Swasthya Bhima Yojana for 98 lakh BPL families, medical costs impoverish families. Further, the scheme is not perceived as trustworthy since it is marred by delays in enrolment, training and reimbursement of hospitals. In some cases, the data stored in the smart cards do not match patient information. In other cases, the beneficiary names or fingerprints are incorrect, forcing the hospitals to collect payment from patients for treatment[4]. Karnataka's health indicators have much to deliberate on. Is the child the last priority of an adult world hankering for money, power and space?

As per Indian laws, children are both private and public responsibility. But the tendency for the government to put the responsibility on the migrant parent, and the parents to look on for hand-me-downs from the government has meant that children keep getting hungrier, hungrier and then eventually die. There are an estimated 93 thousand migrants in Karnataka. Even as migrant flows are observed from rural to urban areas there are challenges and inability of census to capture the larger picture of seasonal and distress migration. Not one or two, but over 2500 malnourished children dead in one district itself. It leads to good introspection. Yet today, indicators of child health tell its own story.

The prevalence of anemia in the state is over 70%. Simple actions in school health to ensure sanitary toilets (so that worms do not feast on the blood of children), iron supplementation, nutritious food (just greens, jaggery and Ragi are rich in iron) and regular checks could take care of the problem. Ensuring that the Primary/Urban Health Centres do the jobs they are supposed to do is crucial.

Where are the doctors?

In Karnataka, PHCs are facing a dearth of doctors. A recent report cited Chikmagalur district where eighteen Primary Health Centres (PHCs) in the district are facing dearth of doctors. In addition, the routine cases with common ailments are attended by paramedical and other auxiliary paramedical staff due to absenteeism among doctors. However, the cases with serious complications and which require indoor health care services are not attended by PHCs due to non-availability of diagnostic facilities. Few PHCs are found to be equipped with the requisite combination of complementary facilities including the post of a lady doctor. Consequently, we have seen that non-utilization of PHCs services has resulted in wasteful expenditure of scarce resources, wherever such infrastructure was created.

Table 3.1. Key indicators of child health:

Sl.No	Key indicators of child health	Present status in Karnataka
1	Infant mortality rate Rural Urban	58/1000 live births 69/1000 live births 24/1000 live births
2	Under 5 Mortality Rate	69.8/1000 live births
3	Neonatal Mortality rate	37.1/1000
4	Crude birth rate (CBR)	22.3 /1000 population
5	Crude death rate (CDR)	7.7 /1000 population
6	Nutritional Status of children Severe Moderate Mild - Under Nutrition Normal	 6.20% 45.40% 39% 9.40%
7	Percentage of children fully immunized	60%
8	Anaemia among children (6-35 months)	70.6%
9	Dropout rate of girls	16% at primary school level 46% at middle school level
10	Literacy rate	67.04% M-76.29% F - 57.45%
11	Child Sex Ratio (0 - 6 years)	949

Where are the medicines?

Even when doctors are present, the challenges of PHCs with poor infrastructure and staff shortage are leading to child mortality. To compound this, Community Health Centres (CHC) and Primary Health Centres (PHC) had empty pharmacies. Over 3,000 health institutions did not received drug supplies during 2007-12, according to the Comptroller and Auditor General of India (CAG) audit. The responsible institution for ensuring drug supply to health centres is the Karnataka State Drug Logistics and Warehousing Society (KDLWS). The CAG audit found that KDLWS did not have any evidence to show that 3,093 health institutions in the state received drug supplies during 2007-12. (There is no data for 2013). Its scrutiny also revealed that 2,360 PHCs and CHCs with sub-centres, 277 PHCs and three CHCs were denied drug supplies in this period due to ineffective monitoring by the Society. The report said, "This evidently affected delivery of healthcare services to the needy public." The report further quoted that health department officials agreed that delays in supply were common.

Where is the equipment?

For the past few years keen attention was brought to the fact that most of the infant mortality deaths happen during delivery or first month of life. Neonatal care needed to be improved. The neonatal home based care kit prepared by the Ministry of Health and Family Welfare has helped many a village health worker to respond to babies in critical condition too far out of reach of a medical facility. But let us re-wind to the birth of the child. Questions burning are the capacities of PHCs to provide and use **sterile** equipment for deliveries. Sterile equipment is possible if the necessary autoclaves are in good condition and use. In many a walk to a PHC in Karnataka, one can see women with normal deliveries being prescribed antibiotics as a precaution against infections. We do know that the sterilizers or autoclaves are in poor condition for several months and hence sterilization of equipment for deliveries is compromised.

How good are the checks?

A system whereby there is a continuous check on the equipment of the PHCs from the district levels and higher is a dire need linked to reducing the IMR in our state. Causes for high IMR continue to be documented as

- Lack of awareness about universal immunization
- Inadequate antenatal care
- Non-institutional delivery
- Malnutrition
- Anaemia in children
- Low weight birth

When we have the know how, why can't we reduce IMR?

The author respectfully, acknowledges that no other institution but the PHCs and the governmental health functionaries reach out to every part of the state's health. There is a system in place – the potential of which is not completely exploited for child health. The government system of recruitment of health personnel ensures that qualified personnel are appointed to the job. This may not be assured in a private clinic, where it is not unknown for compounders and others to run clinics. In our many interactions with health personnel, we do know that in our state, if the health personnel are committed,

the work in that PHC is exemplary. The health of children depends on this fact. So, while the services provided are very person-driven, miracles happen. If not, even with systems of monitoring in place, a laissez faire culture sets in, which poses the greatest disadvantage to children. There needs to be a way to ensure that standard of care in the way countries like Vietnam, poorer than India, manage it. In Vietnam, a country which uses 6.6% of its GDP on health, the IMR was 19.61 per 1000 live births. The IMR and Child Mortality rate are sensitive indicators of the health of children. In India IMR is 64 per 1000 live births (2011) and in Karnataka it is 58 per 1000 live births. One wonders then how is it that a China or a Vietnam progresses faster than India in reducing under 5 child deaths. Is it that Karnataka faces more inequities in than Vietnam? Simple measures like increased access to public health services, such as women's health, child health, immunizations during pregnancy, water and sanitation, health education, nutrition, environmental sanitation, control of communicable and non-communicable diseases and drugs for endemic diseases are key to reducing IMR.

Further, in Karnataka, the Backward Regions Grant Fund was implemented in Bidar, Chitradurga, Davangere, Gulbarga and Raichur. Yet, inequities exist between the poor and the rich; create a greater gap in the demand for health services, adversely affecting children health.

When the necessary **standard of care** is not provided, people's trust in the government health system falls and even the poor are often seen to knock on private practitioners and quacks doors, much to their peril .Medical costs are paid up through taking loans from money lending sharks at exorbitant interests, creating the vicious circle of debt and bondage. The health of children is vulnerable when debt and bondage impoverish families.

Health of the adolescent

Karnataka's capital city Bangalore is the suicide capital of India for adolescents today. It has been so for some time now. Yet within the state, interventions to ensure counselors in schools are absent. Mental health of children is not an acknowledged need until the child manifests 'deviant' behaviors. Adolescents face challenges due to their critical changes in five dimensions of their lives viz., changes in their physical, social, intellectual, spiritual and emotional dimensions. In tune with this, the ARSH programme in the state coupled with the free distribution of sanitary napkins did create a dent to retain gender parity in schools. Yet this program is not without its challenges. The ban on sex education in Karnataka in 2007, while bridged, is once again facing doubting waters with the Union Minister's comment on value education and culture. The importance of sex and sexuality education for adolescents with life skills is critical to address the health and development of adolescents and children of the state. Further, while gender parity in schools is good in Karnataka, the absence of toilets in high schools is a clear reason for school dropouts among girls.

Child sexual abuse is a reality

Child appropriate sex education strengthens a child's protection against sexual abuse. The MWCD study of 2007 revealed that 54% children in India reported being sexually abused. Only 7% reported the sexual abuse to anyone, since the perpetrator was a known trusted member of family or friend. A person the child trusted. After several years, the Prevention of Child

Sexual Offences Act, 2012 (POCSO, 2012) is now in place, opening the way to penalties for child sexual abuse. However, the Indian myth about 'if we do sex education, then children will experiment' and the secrecy about sex makes it difficult for children to express their experience of child sexual abuse. What language can children use? The parts of the body abused are 'forbidden words' in the dictionary of a child. Hence, even though POCSO, 2012 is there, its enforcement is a challenge from a child-perspective, unless there are adequate trained counselors.

Systems development for protecting children

No child care centre, be they for health, education or development, have mandatory child protection policies and programs. The child's voice is neither invited, nor listened to. When they face sexual abuse, who do they report to? **According to the World Health organization, preventing violence is definitely a public health agenda**. Yet, although Bangalore had some pilot programs for addressing domestic violence where women and children were the survivors and the UN agencies have a Safe City program[5], the child experiencing violence is a grey area in the programming. Then what about the children of migrant workers, Devadasi and other excluded communities?

We know that abusers use opportunities of employment and stay to abuse children sexually. These could be places the child trusts viz., the home, school, tuition class, games filed, hospitals etc. Yet, presently, there is no hospital in Karnataka that proactively protects children through developing and implementing a child protection policy. Further, only four hospitals in Bangalore have a child response unit for taking care of children reporting sexual abuse.

Mental health of children - a dire need

Children in Karnataka, as in pan India are treated as 'property' of parents. Child abuse and exploitation are 'normal' disciplining processes; notwithstanding the fact that children experiencing violence are more prone to use violence themselves or it impairs their overall physical and emotional health. INSA-India has the opportunity to train link workers to recognize and deal with child abuse. Yet, the crying need is for counselors in the health centres, since if children or their mothers go to yet another place specifically for counseling, the violence at home would accelerate.

In addition, in a recent national study on substance abuse among children *by state, Karnataka reported the highest number of children with alcohol abuse.* The study titled 'The Assessment of Pattern and Profile of Substance Use among Children in India' commissioned by the National Commission for Protection of Child Rights (NCPCR) was conducted by the All India Institute of Medical Sciences (AIIMS) and the National Drug Dependence Treatment Centre, New Delhi. The alcohol abuse rates among children in Karnataka were found to be 88.9%. This highlights the dire need for wellbeing enhancement services that promote the mental health of children in Karnataka. Presently no curriculum promoting mental health, in schools, nor counselor support is available in most schools. “If a counselor is placed in the health centres, then women and children experiencing domestic violence have access to mental health care” said a doctor working on domestic violence redressals. However, substance abuse, de-

addiction and rehabilitation counseling is a tertiary service delivery in Karnataka.

Key recommendations

Key recommendations for the strengthening of child health care through PHCs and UHCs include the following:

- Commitment is needed. To ensure the functioning of primary health care institutions and the medical and paramedical staff in PHCs, there is an urgent need for the enforcement of the systemic mechanism of supervision, monitoring and review. This will help improve the quality of health delivery system. Ensuring optimum use of public resources benefits the child's health.
- The creation of the National Urban Health Mission is promising for improving child health. Decentralized management with accountability of the health team for the health of children in their area is required. Filling of vacant posts is a dereliction of state's duty to its people, especially the children.
- The mainstreaming of child health in other sectors will bring about a paradigm shift in the addressal of child health. It worked for addressing HIV.
- A holistic approach to primary health care system needs to be adopted which should strive to integrate the allopathic system of medicine with Indian systems of medicine. Allopathic treatment and medicines are becoming increasingly unaffordable. Using generic formulations brings down the cost of medications. Child friendly formulations are a dire need. Children with tuberculosis require such child friendly medications urgently.
- In order to bring down IMR, an adequate number of lady doctors to attend to deliveries are required for posting in the rural areas. In their absence, paramedical staff especially the Nurses should be provided refresher training on obstetrics/gynecology so as to enable them to facilitate institutional deliveries. Ironically, the intensive training in midwifery that nurses receive to legally conduct deliveries is not recognized nor utilized enough. Commitments that all child related service centres will develop child protection policies and programs should be made. Such policies and programs will bring about a catalyzing change to ensure that the Child is focused upon (instead of profits etc) and recognize the child as a human being with Rights that are paramount.

The existing PHCs should be equipped with essential infrastructure and diagnostic facilities which will help increase the utilization rate. Besides medicines should be made available in PHCs especially for those who are living below the poverty line.

Promising steps:

All of the above paint a very stark picture of children's health in Karnataka. But there have been great initiatives by the government, schemes for institutional deliveries, training for health workers, the ARSH that need to continue. It is without doubt that there is low priority given to children in the healthcare system. In a study by the National Commission for Protection of Child Rights (NCPCR), it was found that

public hospitals are over-burdened by 150%-200% patients over capacity, while private hospitals are using less than 10% of their EWS (economically weaker sections) beds for children. The study resulted in the creation of 10 beds in every district level hospital for children[6]. This is one small step thanks to NCPCR for focusing on children's health.

The largest government and UNICEF health sector input for operationalising IMNCI (Integrated Management of Neonatal and Childhood Illness) clinical protocols in the community and the health facility was in the focus district of Raichur. A total of 2016 (100%) Health and Nutrition workers in the district are implementing IMNCI to ensure newborn and sick children receive quality health care. This needs to be scaled up through the state.

If only every health personnel did the job they were supposed to do, and reports were well responded to consistently, because children have a right to development and survival, a right to participate and be protected! If only all the stakeholders across development and health joined hands with the vision of 'healthy children make for healthy communities', concrete steps can be taken. If only child health was mainstreamed across all sectors as a priority! We have the knowledge and the technology to do so. As the government and adults, we have the power to do so. This is Karnataka's children's Right to Survival.

1. http://www.nrhmorissa.gov.in/
2. National Malaria Eradication Programme Report ,1998
3.http://www.planning.kar.nic.in/Speech_(CM)_Book.pdf
4. http://www.thehindu.com/
5.http://www.unwomen.org
6. http://timesofindia.indiatimes.com

Edwina Periera: 35 years in public health, gender, sexuality, wellbeing, and child safety, with the vision of every child growing to his/her full potential happily. Formerly, Program Director-Training in International Services Association (INSA-India) and Executive Director of Child First Foundation. She works independently presently.

4

NUTRITION IN CHILDREN- FOCUS ON KARNATAKA

-Dr. Maya Mascarenhas

1. Overview of malnutrition in India
2. Causes of malnutrition
3. Response so far
4. Current situation
5. Suggestions for way forward
6. Case study of Myrada's work in malnutrition

"When you see in places like Africa and parts of Asia abject poverty, hungry children and malnutrition around you, and you look at yourself as being people who have well-being and comforts, I think it takes a very insensitive, tough person not to feel they need to do something." – Ratan Tata

Malnutrition has been defined as "Lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat, Malnutrition is a condition that results from eating a diet in which nutrients are not enough or are too much such that it causes health problems. The nutrients involved can include calories, protein, carbohydrates, vitamins or minerals

Malnutrition limits development and the capacity to learn. It also costs lives: about 50 percent of all childhood deaths are attributed to malnutrition. In India, around 46 percent of all children below the age of three are too small for their age, 47 percent are underweight and at least 16 percent are wasted. Many of these children are severely malnourished (NFHS -3 survey report)

The prevalence of malnutrition varies across states, with Madhya Pradesh recording the highest rate (55 percent) and Kerala among the lowest (27 percent). Malnutrition in children is not affected by food intake alone; it is also influenced by access to health services, quality of care for the child and pregnant mother as well as good hygiene practices. Girls are more at risk of malnutrition than boys because of their lower social status.

Malnutrition in early childhood has serious, long-term consequences because it impedes motor, sensory, cognitive, social and emotional development. Malnourished children are less likely to perform well in school and more likely to grow into malnourished adults, at greater risk of

disease and early death. Around one-third of all adult women are underweight. Inadequate care of women and girls, especially during pregnancy, results in low- birth weight babies. Nearly 30 percent of all newborns have a low birth weight, making them vulnerable to further malnutrition and disease.

Although malnutrition is prevalent in developing countries, it is rarely cited as being among the leading causes of death. This is due in part to the conventional way that cause of death data are reported and analysed. In many countries, mortality statistics are compiled from records in which a single proximate cause of death has been reported.

Malnutrition is a complex phenomenon and it is both the cause and effect of poverty and ill-health, and follows a cyclical, inter-generational pattern. While pre-school children are one of the most nutritionally vulnerable segments of the population, the cycle of under- nutrition begins much before the birth of the child. Nutrition during the first five years has an impact not only on growth and morbidity during childhood, but also acts as a determinant of nutritional status in adolescent and adult life. Moreover, the crucial period is birth to two years when maximum growth takes place and any deprivation at this stage, both nutritional and care related in development would be difficult to remedy later.

The WHO Integrated Management of Newborn and Childhood Illness (IMNCI) initiative is based on the premise that combining efforts to promote the appropriate case-management of serious infectious diseases with nutritional interventions, immunization programmes, and other disease prevention and health promotion activities will be more effective in decreasing child mortality than implementing any one of the components alone. This is an important observation that requires the service providers to integrate services to the child in order to make a significant impact on the health and nutrition of the child. Unfortunately, though IMNCI training was conducted in several districts of Karnataka, this has not been followed up or implemented in the field.

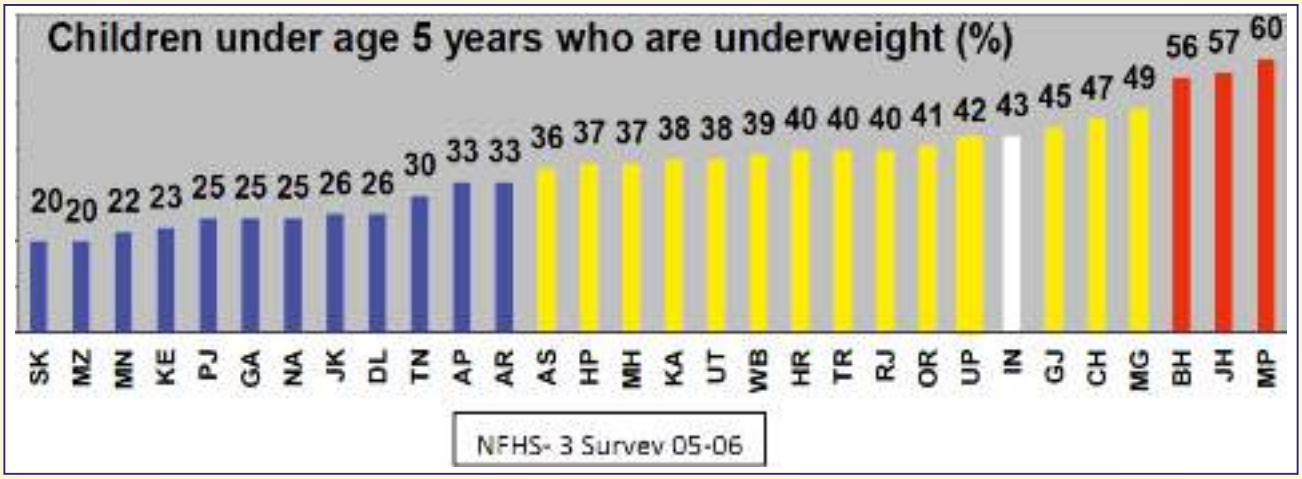
Malnutrition in India has been described as a “silent emergency” by the World Bank Report. It also reported that the rate of malnutrition cases among children in India is almost five times more than in China, and twice than in Sub-Saharan Africa.

For the past nine years, the government in India has not collected national-level data on nutrition as the last National Family Health Survey conducted in 2005-06, showed that 42.5 percent of children under the age of 5 were underweight.

To tackle the problem of malnutrition, Congress-led government had restructured the Integrated Child Development Services (ICDS) programme. The revised programme focused on providing supplementary foods to pregnant women, nursing mothers and children under three years of age. It also worked towards improving mothers' feeding and caring practices as well as promoting immunization and growth monitoring of children among people. Restructuring has involved putting the ICDS program in mission mode from the 12th plan onwards, starting with 200 districts. Other features include increased budget allocations for supplementary nutrition from Rs. 4/- per day to Rs. 6/- per day for normal children and from Rs. 6 to Rs. 9 per day for severe malnourished children. In addition, there would be a special focus on the early learning component of the ICDS and added human resources.

Fig 4.1: Situation of Malnutrition in India

The State wise break up of Malnutrition in India as per the NFHS – 3 reports is as below in Fig 4.1:



According to the report by the Ministry of Statistics and Programme Implementation - Children in India 2012 - 48 per cent children under the age of five are stunted (too short for their age), which indicates that half of the country's children are chronically malnourished. The report states that malnutrition is higher among children whose mothers are uneducated or have less than five years of education. Similarly, the percentage of underweight children in lowest wealth index is three times higher than of those in higher wealth index.

In Karnataka, the situation is not much better. In fact, in some indicators it is worse the national average.

Table 4.1: Situation of Malnutrition in India and Karnataka

	India	Karnataka
Children < 5 years with stunting	48%	44%
Children < 5 years with severe acute malnutrition (SAM)	23%	18%
Children < 3 years with anaemia	79%	84%
Exclusive breastfeeding < 6 m	46%	58%
Pregnant women with anaemia	58 .7%	63%
Women with malnutrition	49%	51%

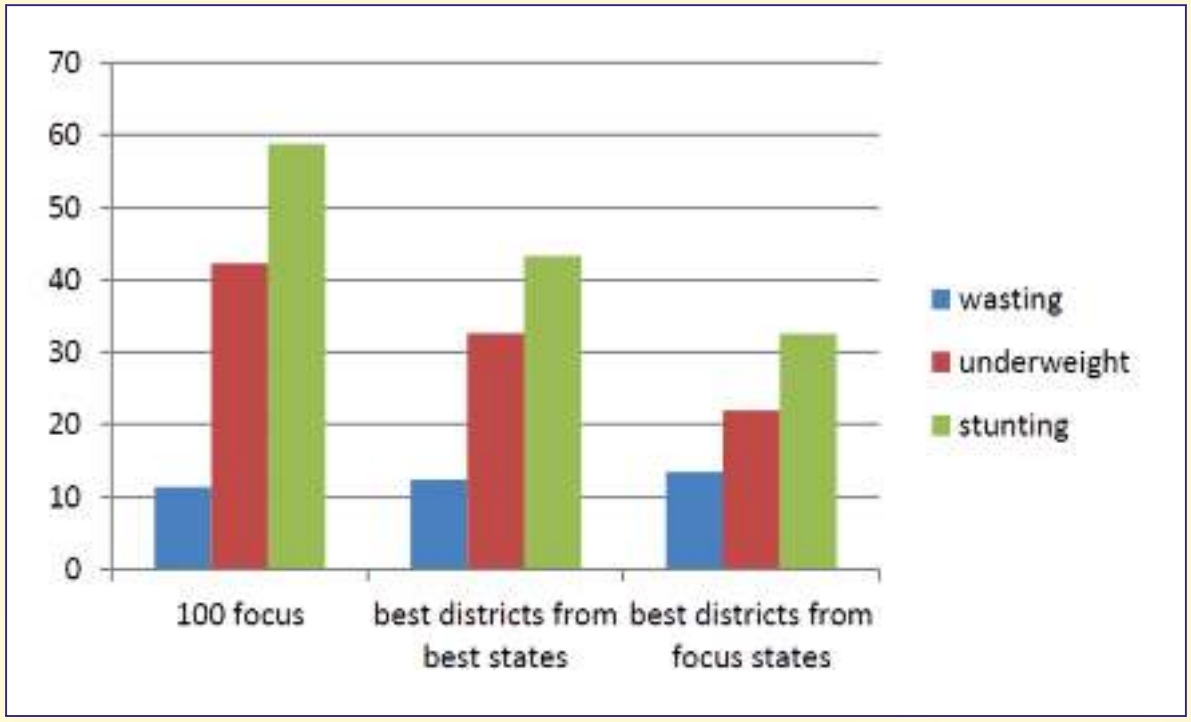
Source: NFHS -3 survey report

1. 38% are underweight, which takes into account both chronic and acute under nutrition.
2. Children in rural areas are more likely to be undernourished; but even in urban areas, more than one-third of children under age five years suffer from chronic under nutrition.

70% of children between the ages of 6 and 59 months are anaemic. This includes 29 percent who are mildly anaemic, 39 percent who are moderately anaemic, and 3 percent who suffer from severe anaemia. Children of mothers who have anaemia are more likely to be anaemic.

Further, according to the HUNGaMa (Hunger and Malnutrition) report prepared by Naandi Foundation in 2011 that covered 112 districts across 9 states in India, 42.5 per cent of children under five years of age are underweight (low weight for age), 58.8 per cent are stunted (low height for age), and 11.4 per cent are 'wasted' (low weight for height).

Fig 4.2: Prevalence (%) of moderate and severe malnutrition 0-59 months



Source: HUNGaMa Report 2011.

Though the HUNGaMa Survey was done more than 5 years after the NFHS -3 survey, the rate of malnutrition still seems high. It must also be noted that the former survey was done in 112 special districts in high focus states largely based in North India. However, that is no excuse for the fact that, despite knowing the burden of malnutrition in 2005 itself, not much was done to rectify the situation.

Recently, the National Nutrition Monitoring Bureau, Hyderabad conducted a 7 state study on malnutrition. The table 2 describes the state wise prevalence of under nutrition, highlighting that the reduction in Karnataka numbers are better than the pooled average of the studied states, but are still below other neighbouring states.

Age and gender break up for malnutrition

Some of the other findings of the NNMB survey for Karnataka:

a. Trends show that there has been a significant decrease in the household food intake in Karnataka. It has reduced by 137 Gms in the past 4 decades. This strengthens the theory of a “food gap” being the most important cause of malnutrition.

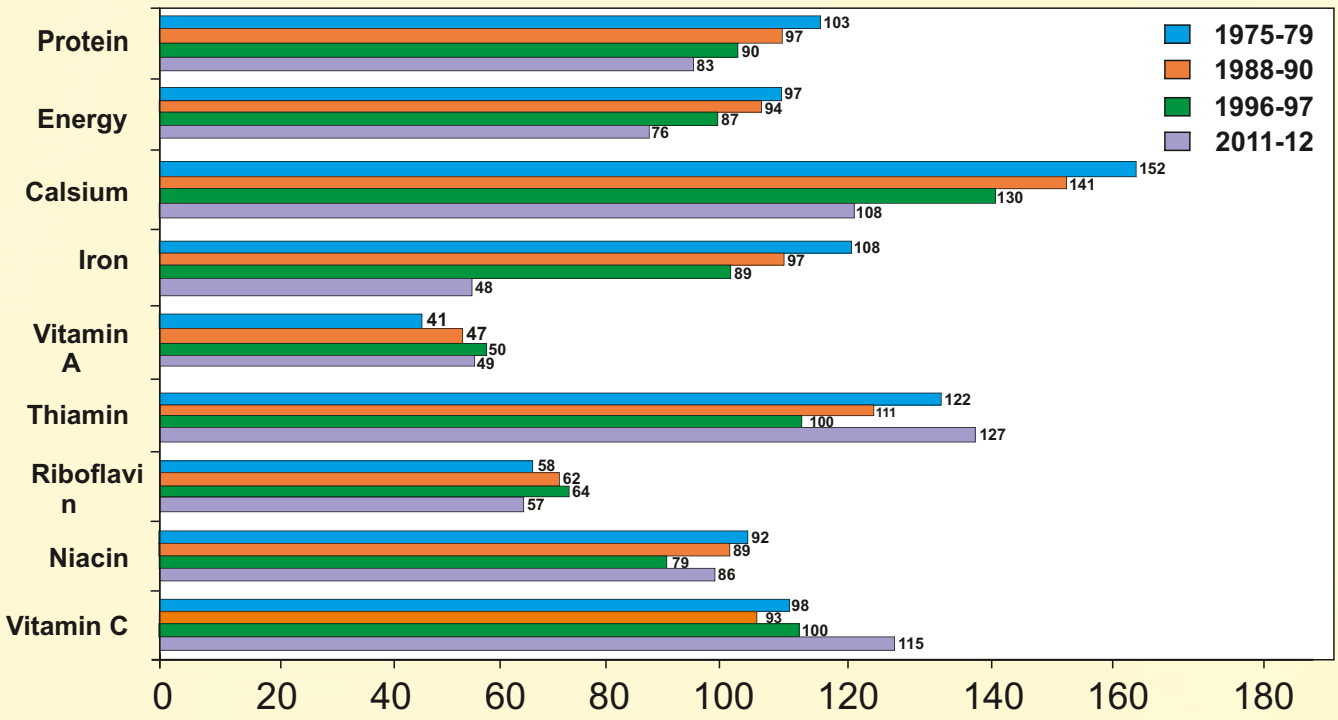
b. There is also an overall decrease in the calorie and protein intake for children in India.

Table 4.2: Nutrition Status of Children

State	Underweight	Stunting	Wasting
Kerala	20.8	23.4	16.4
Tamil Nadu	28.6	21.7	26.4
Maharashtra	31.5	43.9	15
Andhra Pradesh	31.7	42.9	14.1
Karnataka	**35.6**	**36.7**	**20.7**
West Bengal	35.6	40.6	21.4
Pooled	37.7	***41.3***	***22.3***
Orissa	40.3	47.3	18.2
Uttara Pradesh	47.8	44.9	31.7
Gujarat	48.4	54.9	27.7
Madhya Pradesh	51.4	48.7	33

Source: NNMB Technical Report Series No. 26

Fig 4.3: Trends in Nutrient intake for children over 4 decades - a 7state study



Source: NNMB Survey 2012

Table 4.3: Age and gender wise and severity break up of malnutrition in children in Karnataka

Age	Severe %	Moderate %	Normal %			
	Male	Female	Male	Female	Male	Female
0-12 months	6.4	7.1	17.9	20	73.1	69.4
12-36 months	12.5	12.6	31.5	23.2	55.4	63.7
36-60 months	14.7	15.6	37.3	33.5	47.3	49.7
0-60 months median average	12.1	12.7	31.1	26.6	55.8	59.4

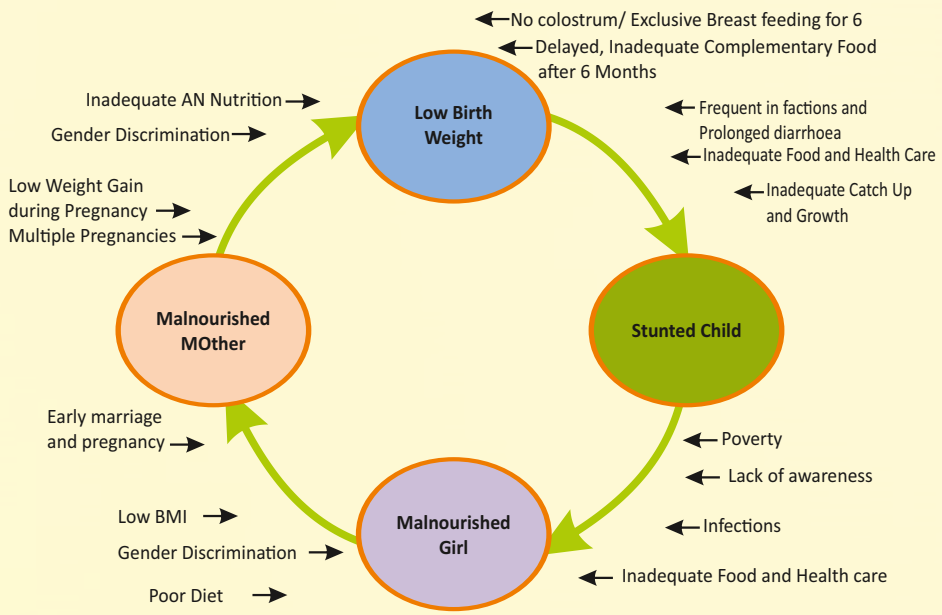
Source – NNMB Survey 2012

The table 3 shows that infants are largely within normal limits of nutrition – largely a factor of breastfeeding. However, as the child grows the risk of malnutrition increases. This is significantly more in girls with severe malnutrition.

Cyclical nature of Malnutrition

This is a problem that begins much before birth. Unless interventions are planned for the adolescent girl and young mother, there will still be low birth weights and malnutrition in children. The diagram below describes the cyclical nature of malnutrition (Fig 4.4)

Fig 4.4: Cyclical nature of Malnutrition



Causes of Malnutrition

Malnutrition is a very complex health problem. No single factor can be attributed to this issue.

Common causes of under nutrition are as follows

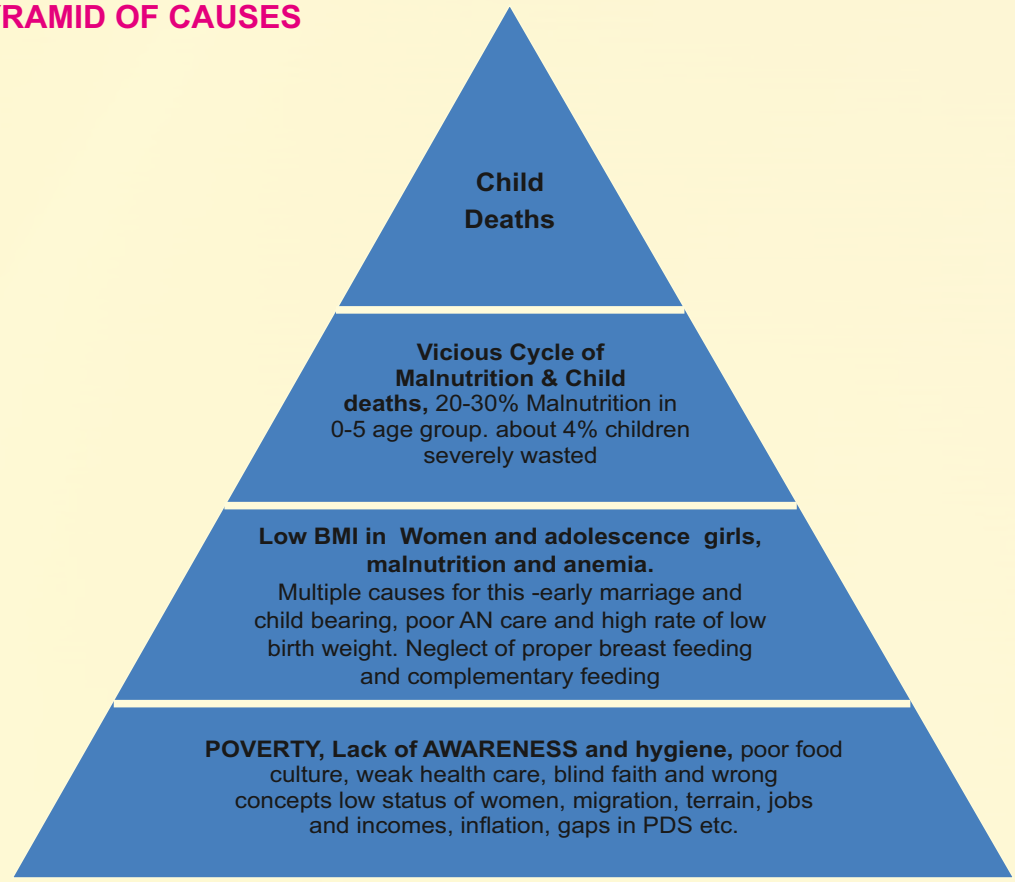
1. **Inadequate quantity of food**: food shortages may be acute (sudden/sharp) or chronic (long-lasting) and arise as a result of poverty, natural disaster (e.g. flood or drought) or conflicts, which may lead to the displacement of people from their homes and disruption of food supplies.
2. **Inadequate quality of food**: people may not have access to the variety of foods that will provide all the necessary vitamins and minerals in their diet. People may also lack the knowledge needed to make sound choices about the food they eat or provide to their children.
3. **Infections**: these may reduce appetite, increase energy and nutrient utilisation (e.g. to fight infection) and limit the ability to absorb or retain nutrients (e.g. as a consequence of diarrhoea and/or intestinal parasites).

The causes for malnutrition could be categorized into immediate causes, other causes and broader causes.

- **Immediate causes**:
  a) Poverty
  b) Lack of knowledge of nutrients and require amounts for different age groups.
  c) Lack of time: care givers out at work
  d) Infrequent feeding and poor breastfeeding practices.
  e) Wrong cooking and food preparation practices inappropriate to developmental stage of child
  f) Frequent infections due contaminated drinking water and poor environmental sanitation.
- **Other causes**:
  a) Early marriage/ pregnancy
  b) Inadequate birth spacing and higher birth order
  c) Cultural beliefs (not feeding colostrums; incorrect weaning practices)
  d) Poor personal hygiene
  e) Children starting off with a handicap – low birth weight; underweight girl child
  f) Maternal malnutrition
- **Broader causes**:
  a) Crop failures
  b) Quality of crops
  c) Migration
  d) Illiteracy
  e) Food and agricultural policies

Another way of describing the causes is looking at how important they are to causing malnutrition. The base of the pyramid is the set of root factors that finally lead to malnutrition. Unless all these areas are tackled, we will continue to be plagued by the consequences of malnutrition, and will not be able to achieve the Millennium Development Goal of "halving hunger" by 2015.

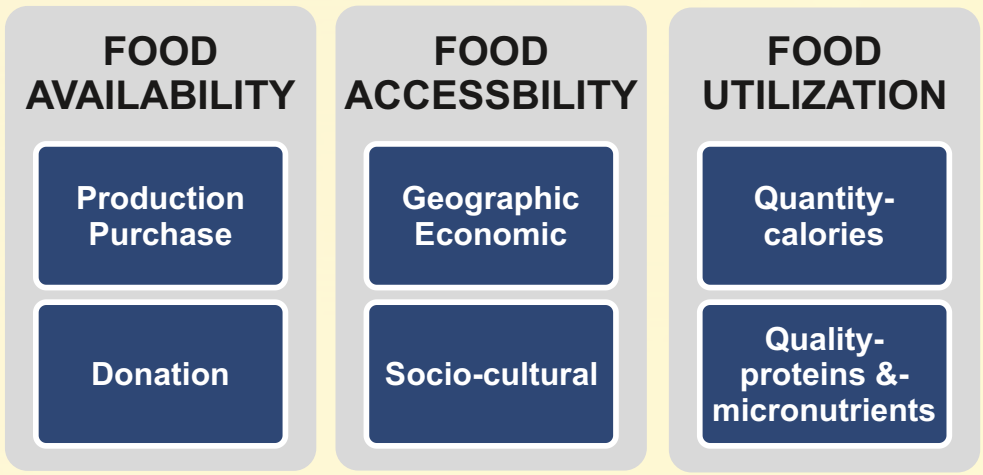
Fig 4.5: PYRAMID OF CAUSES



Malnutrition is largely a consequence of food and nutrition insecurity, although the underlying reasons leading to this are many. Food security can only be guaranteed if all three components: food availability, food accessibility and food utilization are adequately addressed in the community.

Food security is defined as a state when all people at all times have both physical and economic access to sufficient food to meet their dietary needs for a productive and healthy life. Three distinct, but inter-related aspects of nutrition security include food availability, food access, and food utilization. Each of these has an impact on the nutritional status of the community and the most vulnerable groups – the child below 5 years.

- *Food availability* is considered achieved when all individuals have sufficient quantities of food consistently. They can get this food through household production, other local outputs, commercial imports, or food assistance.
- *Food accessibility* is not only a factor of economic resources to access, it also depends on the geographic and socio- cultural issues that enable or impede regular access to food.
- *Food utilization* is the actual biological use of food, where both the quantity and the quality of the food eaten, along with potable water are considered important elements.



India's response so far

Government of India Action on Nutrition

- Commitment to reduce malnutrition and low birth weight through national and state level policies
- Use of community based approach to address malnutrition and child development
- Provision of Vitamin A and iron supplementation to address damage caused by vitamin and mineral deficiencies.

Several plans and policies have been drafted and operational zed since Independence with a direct objective of improving the nutrition status of children and others.

Some of the direct programs of the government that impact on nutrition are:

1. ICDS
2. Nutrition program for Adolescent Girls: Sabala; Kishori Shakti Yojana
3. Nutrition Advocacy and Awareness: General Programs for Food and Nutrition Board (FNB)
4. Follow up for action on National Nutrition Policy 1993
5. Ministry of Health and Family Welfare Programs
   a. National Iron Plus Initiative
   b. Vitamin A supplementation program
   c. National Iodine Deficiency Disorder Prevention Program
   d. Mid-day meal program for schools

Indirect programs impacting nutrition

1. Department of Agriculture
   a. Increased food production
   b. Horticultural interventions
2. Food Public distribution system
   a. Targeted PDS
   b. Antyodaya Anna Yojana
   c. Annapurna Scheme
3. Rural and Urban Development
   a. Food for work program
   b. Safe drinking water alleviation program
   c. NREGA
   d. NRHM
   e. IMNCI

National nutrition goals were set up (see table below) for the 11th five year plan (2007-2012). It remains to be seen how far they have been achieved.

Reduce prevalence of underweight children below 5 years to 20%
Eradicate prevalence of under nutrition in children above 5 years
First hour breast feeding rate to increase to 80%
Exclusive breastfeeding rate to increase to 90%
Complementary feeding rate at 6 months of age to increase to 90%
Reduce prevalence of anaemia in high risk groups to 25%
Eliminate Vitamin A deficiency in children below 5 years
Reduce Iodine deficiency problems to less than 5%

Here is a description of action taken in Karnataka Vis a Vis the various programs for addressing malnutrition

1. INTEGRATED CHILD DEVELOPMENT SCHEME

Currently, 61187 AWCs and 3331 mini anganwadi centres are functioning in 204 ICDS projects in the State, covering all the 175 taluks (181 rural projects & 12 tribal & 11 urban projects). During 2013-14, 56.21 lakh beneficiaries availed benefits under the scheme.

The GOI is reimbursing 50% of the expenditure incurred by the state government for SNP. Supplementary nutrition is provided to the beneficiaries under the ICDS programme with revised feeding norms of 500 calories of energy and 12-15 gms of protein to 0-6 years children, 600 calories of energy and 18-20 gms of protein to pregnant women/lactating mothers/adolescents girls, 800 calories of energy and 20-25 gms of protein to severely malnourished children as a supplement to their normal intake, as envisaged in the schematic guidelines. Supplementary nutrition is given for 300 days in a year at a cost of Rs. 6.00 per beneficiary per day for normal children and Rs. 7.00 per beneficiary per day for pregnant/nursing mothers/adolescent girls and Rs. 9.00 to severely malnourished children in 12 districts as per GoI revised unit cost and in remaining 18 districts Rs. 6.00 per beneficiary per day for normal children and Rs. 5.75 per beneficiary per day for pregnant/nursing mothers/adolescent girls and Rs. 6.90 to severely malnourished children

Under Ksheera Bhagya scheme 6 months to 6 yrs children is provided 150 ml milk for 3 days a week (15 Gms skimmed powder and 10 Gms sugar)

- Severely malnourished children are provided egg for 4 days and 200 ml milk for 2 days, children who do not consume egg are provided 6 days milk.
- Moderately malnourished children of 5 backward districts viz., Bidar, Gulbarga, Raichur, Koppal and Yadgir are provided egg for 4 days and 200 ml milk for 2 days, children who do not consume egg are provided 6 days milk.

Recent visits to the field in Bidar, Gulbarga, Yadgir and Raichur district revealed that the Anganwadis have revised their menus. Skim milk powder is being distributed and given as milk three times a week to all children. It is not clear if the severe malnutrition children below 3 years get this milk as they do not attend the anganwadi. Eggs are not being distributed in most places except in Devdurg, Raichur through a tribal development program.

Construction of Anganwadi Buildings

A good building is the basic infrastructure to be provided for the smooth functioning of the anganwadi centre under ICDS, especially for indoor activities for anganwadi children and sufficient space for outdoor activities.

Out of 61187 Anganwadi centres and 3331 Mini AWCs functioning in the State, 38686 anganwadi centres have their own buildings, 1473 AWC function in Panchayat buildings, 4256 AWC function in community halls, 242 AWC function in Yuvak mandals & 142 in Mahila mandals, 975 AWC function in temples, 4379 AWC function in schools, and 10954 AWC run in rented buildings and 3410 AWC run through other alternative arrangements.

Based on the availability of funds and land, the AW buildings are constructed with assistance from NABARD under RIDF scheme, under SDP, with Departmental funds and funds from other schemes.

i) Construction of Anganwadi Buildings (NABARD assistance):

Considering the imperative need of providing buildings to run anganwadi centres, NABARD is extending financial support in the form of loan for their construction. In the construction of buildings, NABARD share is 85% and 15% is borne by the GOK .The GOK has to refund the loan to NABARD within 7 years.

2013-14 NABARD:

During the year 2013-14 Rs.82.00 crores budget has been allotted for Anganwadi building construction under RIDF scheme of NABARD works.

1. In second stage under RIDF 19 NABARD has sanctioned grants for construction of 713 buildings with matching grants from MNREGA/Gram Swaraj/One time assistance from GoI. Rs.5574.76 lakhs has released to Zilla Panchayat for construction of only 664 buildings.
2. As explained above during 13-14 out of the total amount of Rs.7200.00 lakhs released for 800 buildings, only Rs.6948.60 lakhs for 769 buildings has been drawn.

ii) AW building construction under Special Development Programme:

According to Dr. Nanjundappa report on Regional Imbalances, 114 backward taluks have been identified as backward, more backward and most backward taluks. These are given priority in construction of AW buildings under special development programme.

During 2009-10 and 10-11 remaining grants of Rs.279 lakhs has been released for sanctioned 131 buildings. Administrative approval has been given under Special Development Programme by releasing Rs.1737.30 lakhs grants for construction of 257 buildings with matching grants from Gram Swaraj scheme. Under SDP administrative approval has been given for construction of 40 buildings. State Govt share of Rs.2728.32 lakhs grants has been released and matching grant of Rs.3.375 lakhs per centre will be provided by GoI.

Rs.369 lakhs has been released for construction of 120 buildings under 4 pilot projects for which sanction was approved during 2012-13. Rs.3000.00 lakhs grants has been allocated in the budget under SDP during the year 2013-14, out of this Rs.2613.34 lakhs has been drawn.

iii) Construction of Anganwadi Buildings with Departmental funds and other Contributions:

During 2013-14 in Zilla Panchayat scheme under department wise programme Rs.1649.90 lakhs budget has been allocated for maintenance of anganwadi buildings, Rs.1700.05 lakhs additional budget has been released. This budget may be diverted for purchase of fan/electricity/ repair of 2643 buildings.

Meeting medical expenses for severely malnourished Children

During 2007-08 a new scheme was introduced by the Government of Karnataka wherein Rs. 750/- is given to each severely malnourished child for meeting medical expenses and for therapeutic food as per doctor's prescription so as to improve the child's health and bring it to normalcy. For 2013-14 Rs. 407.61 lakhs has been spent for assisting 54348 severely malnourished children to meet the medical expenses.

During 2010-11, a sub scheme under the main scheme namely **Bala Sanjeevini** was conceived and implemented. This scheme covers BPL families wherein 0- 6 yr children who are registered in AWC and suffering from acute diseases requiring tertiary treatment are treated free in 26 selected hospitals in the State.

2. NATIONAL NUTRITION POLICY 1993

The National Nutrition Policy (1993) advocates a comprehensive inter-sectoral strategy for alleviating all the multi-faceted problems of under/malnutrition and its related deficiencies and diseases so as to achieve an optimal state of nutrition for all sections of society but with a special priority for women, mothers and children who are vulnerable as well as 'at-

risk'. Of the two major problems of macro and micro-nutritional deficiencies that the women, mothers and children suffer from, while the former are manifested through chronic energy deficiency (CED), the latter are reflected in Vitamin A, Iron and Iodine deficiencies.

There has not been any revision to the National Nutrition Policy, but there is provision in the recent Food Security Bill 2013 that address nutrition

3. FOOD SECURITY BILL 2013

Section 5 and 6

5. (*1*) Subject to the provisions contained in clause (*b*), every child up to the age of fourteen years shall have the following entitlements for his nutritional needs, namely:-

(*a*) In the case of children in the age group of six months to six years, age appropriate meal, free of charge, through the local *anganwadi* so as to meet the nutritional standards specified in Schedule II:

Provided that for children below the age of six months, exclusive breast feeding shall be promoted;

(*b*) In the case of children, up to class VIII or within the age group of six to fourteen years, whichever is applicable, one mid-day meal, free of charge, everyday, except on school holidays, in all schools run by local bodies, Government and Government aided schools, so as to meet the nutritional standards specified in Schedule II.

(*2*) Every school, referred to in clause (*b*) of sub-section (*1*), and *anganwadi* shall have facilities for cooking meals, drinking water and sanitation:

Provided that in urban areas facilities of centralised kitchens for cooking meals may be used, wherever required, as per

the guidelines issued by the Central Government.

6. The State Government shall, through the local *anganwadi*, identify and provide meals, free of charge, to children who suffer from malnutrition, so as to meet the nutritional standards specified in Schedule II.

Nutritional Standards: The nutritional standards for children in the age group 6 months to 5 years, age group 3- 6 years, pregnant and lactating mothers required to be met by providing "Take Home Ration" or nutritious food hot cooked meal in accordance with the Integrated Child Development Services Scheme and the nutritional standards for children in lower and upper primary classes under the Mid-day Meal Scheme are as follows:

Table 4.4 Nutritional Standards

Sl. No.	Category	Type of meal	Calories (kCal)	Proteins (gm)
1	6m – 3 years	Take home ration	500	12-15
2	3- 6 years	Morning snack and hot cooked meal	500	12-15
3	Malnourished 6	Take home ration	800	20-25
	months - 6 years			
4	Lower primary classes	Hot cooked meal	450	12
5	Upper Primary	Hot cooked meal	700	20
6	Pregnant and lactating meals	Take home ration	600	18-20

4. HIGH COURT COMMITTEE TO MONITOR MALNUTRITION: 2011-2012.

In response to a public litigation regarding cases of severe malnutrition and related deaths reported in Raichur district, the High Court set up a monitoring committee under the chairmanship of Justice N.K.Patil to review the situation of malnutrition in the state and suggest recommendations. The department of Women and Child Development was asked to set up special sub committees to assist them in the formation of appropriate guidelines. At the same time, there was the discovery that the supplementary nutrition foods were produced and sold by a private company, against the Supreme Court rules. This unearthed a series of decisions that finally resulted in the High Court Monitoring Committee making detailed field visits and suggesting detailed recommendations.

On studying the status of malnutrition, the department reported varying numbers in reported cases over the months, as is reflected in this table below. In some districts, the variation was obviously not accurate. Under- reporting by the field was also a reason for this.

Table 4.5: Status of malnutrition in Karnataka in 2011-12.

Sl. No.	District	Aug. 2011	Sept. 2011	Oct. 2011	Nov. 2011	Dec. 2011	Jan. 2012
1	Bagalkot	8957	7801	7279	4773	4083	2925
2	Bangalore (U)	456	388	400	351	402	459
3	Bangalore (R)	475	398	317	343	356	375
4	Belgaum	7016	6604	6307	6122	6244	6128
5	Bellary	6411	4710	4710	4543	4807	5045
6	Bidar	659	685	678	671	759	806
7	Bijapur	8983	5297	4844	4948	4316	3843
8	Chamaraj nagar	459	507	613	581	650	674
9	Chikkaballapur	1364	1333	1233	1230	1216	1077
10	Chikmagalur	590	592	578	568	585	587
11	Chitradurga	2746	2380	2490	2498	2782	2598
12	Dakshin Kannada	969	888	879	893	858	870
13	Davangere	3724	2300	2285	1656	2286	2168
14	Dharwad	3230	3094	3046	3003	3027	2982
15	Gadag	2765	2740	2613	3038	2531	2424
16	Gulbarga	1153	1249	1288	2019	2980	3006
17	Yadgir	451	444	444	501	947	965
18	Hassan	458	471	442	457	416	381
19	Haveri	4537	4225	3946	3836	3705	3532
20	Kodagu	144	150	145	168	214	170
21	Kolar	1058	1044	903	855	788	814
22	Koppal	4085	3000	4019	4081	3898	3752
23	Mandya	688	742	688	681	612	636
24	Mysore	1097	1097	1090	1073	1172	1176
25	Ramanagara	233	248	260	264	248	233
26	Raichur	4531	4685	7507	8397	8110	7343
27	Shimoga	1059	1049	1071	1077	1091	1174
28	Tumkur	1483	1408	1409	1423	1390	1396
29	Udupi	338	310	302	293	319	322
30	Uttara Kannada	1486	1190	1117	799	772	711
	Total	**71605**	**61029**	**62903**	**61142**	**61564**	**58572**

Source: Report submitted by DWCD, GoK, 2012

Some of the key recommendations included:

a) Getting an accurate picture of the burden of malnutrition in the state through proper weighing and recording of all children in the state.

b) Ensuring that all malnourished children were examined by a medical team through special health camps organised once in 2 months on fixed dates.

c) Improvement in infrastructure especially related to cooking, water, electricity and sanitation

d) Improved menus taking into account district specific variations.

e) Regular monitoring by the department

f) Effective inter sectoral coordination through convergence of duties between departments.

CURRENT SITUATION IN INDIA

1. The majority of children with malnutrition (55.00%) is in the age group of 4-6 years.
2. The highest numbers of malnourished children are from the ST category (46.25%)
3. There is a strong correlation between the literacy of mothers and malnutrition. 90% of mothers of malnourished children were found to be illiterate.
4. Most of the families with affected children were Nuclear Families (67.50%)
5. Majority were from below the poverty line (56.25%)
6. 45% of the malnourished families were in dry land areas.
7. 48.75% of malnourished children were female and remaining was male.

The results highlight the centrality of poverty in influencing malnutrition outcomes and also in explaining the observed disparity in malnutrition among the population groups. That the poor and the vulnerable sections of the Indian population shoulder the disproportionate burden of child malnutrition is one of the key findings, arrived at. Apart from poverty and socioeconomic inequality, the sublime importance of other proximate determinants and program outreach is underscored in the emerging results, notably maternal education and improved access to maternal and child health care reducing the incidence of low birth weight babies being born.

WAY FORWARD

"A national programme in Mission Mode is urgently required to halt the deteriorating malnutrition situation in India, as present interventions are not adequate. A comprehensive strategy including detailed methodology, costing, time lines and monitor able targets will be put in place within six months".– Arun Jaitely- July 2014 Budget speech

While we wait for this to materialize, there are several suggestions that the state can take forward to improve the situation at an urgent pace.

1. Do a situational analysis district wise of the current numbers of both severe and moderate malnutrition
2. Set up a monitoring committee to review the status every month. Fill up all vacant positions of supervisors and mid-level managers to strengthen the local monitoring system.
3. Finalise the child data base that tracks children every month.
4. Go on campaign mode to increase awareness on importance of

breastfeeding, balanced diet, hygiene etc.

5. Ensure that all children identified with either severe and moderate malnutrition are reviewed in detail every month and followed up with specific nutrition interventions, regardless if they come to the anganwadi or not.

Other suggestions

- Provide safe drinking water and health care facilities.
- Anganwadis to be sanctioned for all remote settlements.
- State Governments should make available medical kits, toilet facilities, and drinking water in all ICDS projects.
- Look at the intergeneration cycle and involve ASHAs and other frontline workers in the field.

Case study of Myrada's response to malnutrition in Bidar

Improving nutrition status and livelihoods of vulnerable women and children through MY NUTRI MIX – a macro and micro nutrient supplement

Myrada, with support from WelthungerHilfe (WHH), initiated a project in Bidar, North Karnataka to address nutritional insecurity in women and children. This project is being implemented in 64 villages of Bidar – an area defined as backward – with features of illiteracy, high migration patterns, large no. of tribal communities etc.

The key objective of the project is to equip families with the knowledge and skills to improve the nutritional security of their women and children.

Two key strategies adopted in this project are:

a) Using a 5 step tracking tool to identify and follow up all children with malnutrition

b) Production of an energy dense nutrient supplement through women in SHGs – thereby improving livelihoods as well as encouraging change in dietary behaviour of children.

With these strategies and activities in place, Myrada first made a line list of all children below the age of 5 years with the help of the anganwadi centres and workers. Details regarding their age, weight and height were taken. These were compiled and the children were divided into three groups; normal weight for age, moderate malnutrition and severe malnutrition.

TREAT AND TRACK TOOL

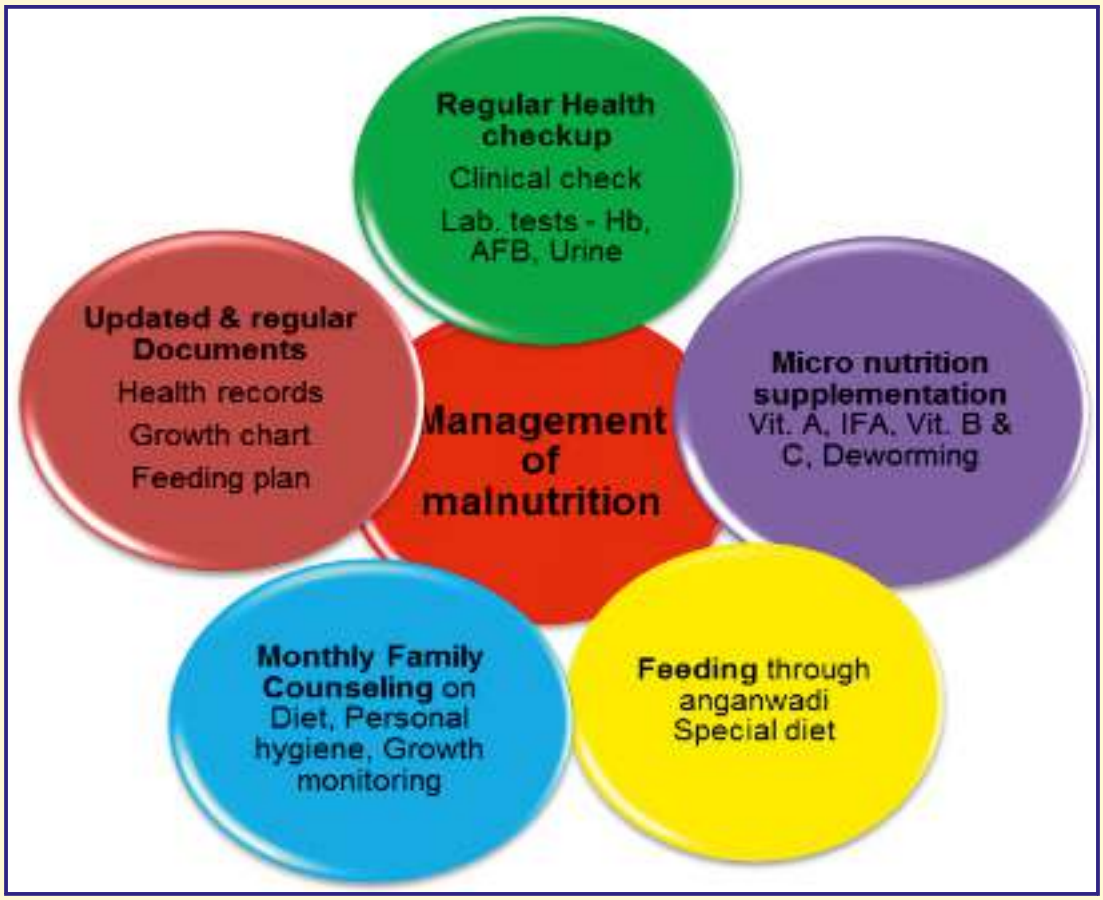
A specific "track and treat plan" was made for the children identified with malnutrition, and this has been simplified into the "5 steps to manage malnutrition" model. The diagram below describes the 5 steps.

Step 1: Regular Health check-up: This is required monthly for moderate malnutrition; bi- monthly for severe, and is done by the PHC medical officer. If required, s/he will refer upwards. Along with the health check-up, children with severe malnutrition should have their Haemoglobin test (for anaemia), and Mantoux test (for Tuberculosis) done.

Step 2: Micronutrient supplementation and prophylaxis: All children identified with malnutrition need to have the following medicines regularly:

a. Vitamin A – once in 6 months
b. IFA (20 mg) – 100 days recheck HB; if still anaemic; continue for another 100 days
c. Vitamin B complex - daily for 6 months
d. Albendazole (> 1 year: 200 mg; 2-5 yrs: 400 mg) – once in 6 months.

Fig 4.6: Malnutrition track and treat plan



Step 3: Feeding through special diet in anganwadi: While Myrada has tried to influence the ICDS to introduce a special menu for children with severe and moderate malnutrition over and above the regular SNP (supplementary nutrition program), the state has introduced egg 4 times a week and milk twice a week for children with severe malnutrition. In addition to this, Myrada has initiated the My- Nutrimix distribution to children with severe and moderate malnutrition. This mix is prepared by local SHGs and sold to the families with children with malnutrition. It is expected that these children will use this mix for at least 6 months till they come into the normal weight for age range and replenish some of the body stores of iron and other nutrients.

Step 4: Monthly counselling of the mother and family: - this is done on a one to one basis for all mothers with children with severe malnutrition. The topics covered are balanced diet, sources of protein and calorie rich foods, personal hygiene, importance of following the growth chart etc. A special flip book was made for this purpose and is being used by the anganwadi workers and CRPs.

Step 5: Regular documentation: - this step is stressed so that anganwadi workers can follow up all children regularly. In our 6 months experience of tracking, we found that,

while around 50% of children with severe malnutrition improved, a few moderate and normal weight children fell into the severe category. It is therefore very important to monitor all children monthly. Also, the anganwadi workers have been trained to use the community growth charts once a quarter with the parents – to show them how their child fares in comparison with others – this is expected to stimulate awareness and interest in their child's growth.

This track and treat package was used to handle the food utilization arm of nutrition security.

PRODUCTION OF MY NUTRI-MIX

One of the interventions in the Nutrition security project implemented by Myrada, with the support of WelthungerHilfe is the production of My Nutri mix (a high calorie, high protein, and micronutrient rich, ready to use powder mix).

My Nutrimix is a high calorie high protein powder mix containing wheat, groundnut and jaggery; and gives 405 Calories and 13.gm protein per 100 gm of mix. This is made by local SHG women, which is also a livelihood activity for them. Production costs around Rs. 46/- per kg (minus labour) and is sold at Rs. 60 per kg.

Initially, Myrada trained a few SHGs in Ratkal, Gulbarga to produce My-Nutrimix in 2012. They started production of the same and distributed to the severe malnutrition children in Bidar. As the project progressed, this mix was being ordered and used by Biocon project in Bagalkot as well as in Chintakitaluk of Chikkaballapur.

From September 2012, one SHG in Wadgoan, Bidar, was trained and started producing this mix. Initially, they were producing around 200 packets (500 gm each) a month for severe malnutrition children only.

Currently, they are producing around 1500 packets a month. They are selling this mix to children with severe and moderate malnutrition; as well as to the general public who is interested in using it for their families.

Fig 4.7: My Nutrimix

Fig 4.8: Nutritional Mix

Table 4.6: Composition of Nutri-mix

Item	Quantity
Wheat: (roasted, ground into powder in mill)*	300 gm
Groundnut (roasted; husked, ground in mixed)	125 gm
Jaggery (pounded to powder by hand)	75 gm
TOTAL weight of one packet	**500 gm**

* Wheat can be substituted with same amounts of either Ragi or Jovar. **(Fig 4.9)**

Table 4.7: Nutrient value

	Per 100 gm	Per 50 gm
Calories	55.4 mg	200
Protein	405	6.7 gm
Iron	13.5 gm	2.6 mg
Vitamin A	5.2 mg	25.3µ g
Calcium	50.6 µg	22.7 mg

Preparation:

This mix can be used to make porridge or a laddu.

Porridge: 3 tbsp. (50 gm.) of the mix is mixed with about 50 ml of cold water. This is then poured into about 150 ml of boiling water and stirred till the mixture becomes thick. One can add a little milk to the boiling water (100 ml water + 50 ml milk). There is no need to add sugar as the mix contains jiggery.

Laddu: Each laddu can be made by mixing the powder with a little warm water and moulding into a laddu shape. 50 gm of mix can make 2 big laddus.

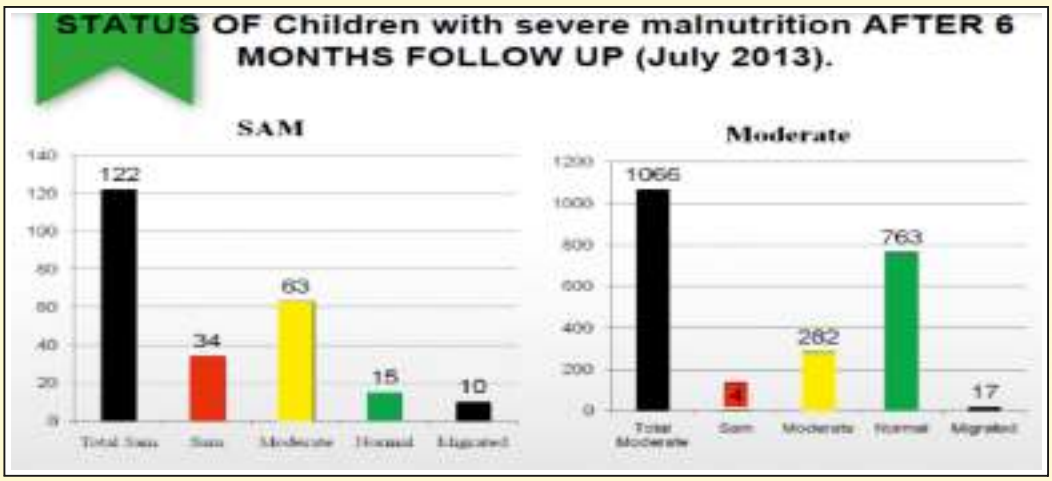
Children with severe malnutrition need 100gm of the mix per day in two divided portions (once in the morning and once in the evening), while children with moderate malnutrition need 50 gm only once a day.

Table 4.8: Cost Analysis

The cost and sale value of this mix is as follows:

Sl. No	Particular	Quantity	Rate /kg	Cost per Kg My Nutri mix
1	Wheat	300 gm	26	8.00
2	Groundnut	125 gm	80	10.00
3	Jaggery	75 gm	35	3.00
4	Roasting		0.5	1.00
5	Grinding (Electricity)			2.00
6	Packing			1.00
7	Sealing of Packet			0.50
8	Printing of cover label	2 Side print		1.00
9	Transport Charges			2.00
10	Labour Charges			7.00
11	Actual cost			35.00
12	**Total sale value**			**60.00**

Fig 4.10. Severe Malnutrition Before and after



On an average, if one SHG makes around 1500 packets per month (7 women working only 5days in the month), the total amount the SHG will spend is Rs. 36,750/-. Each of the 7 women earns Rs.1179 per month doing this activity (Rs. 236 per day for 5 days per month). This includes Labour charges towards preparation of Nutri Mix is Rs. 3.5 per packet (7 women works for 5 days in a month gets total Rs. 5250/- each member will get Rs. 750 per month) and Rs. 2 net profit on preparation of each packet goes to their common fund (Ex: 1500X2=3000 per month)

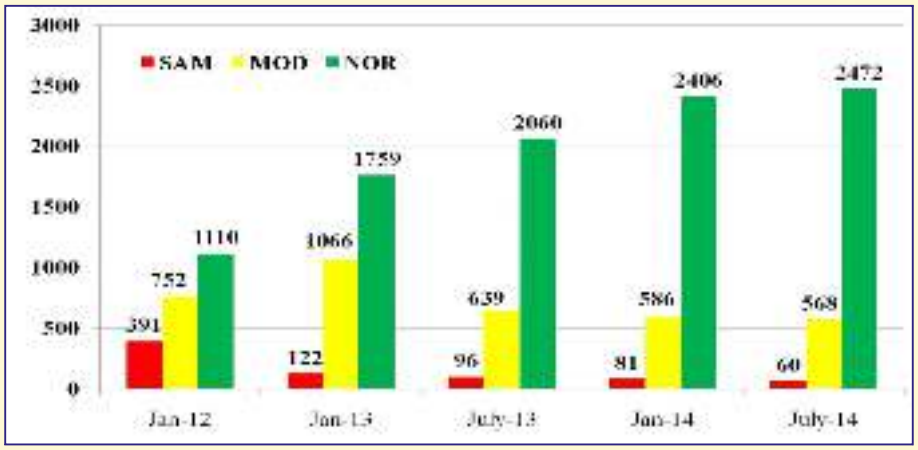
Following the introduction of these 2 strategies, Myrada has been tracking the progress of the children identified with malnutrition over 6 month's periods. The Fig. 10 describes the most recent cohort tracked.

These results are very promising. Out of the total of 122 children with severe malnutrition identified in January 2103, only 34 of them were still in the same category after 6 months. Most of them had shifted to moderate and normal status by July 2013. For the 1066 children who started off as moderately malnourished, 763 of them shifted to normal status in 6 months.

From feedback through group discussions with the parents, they attributed this improvement to the counselling given to them during the home visits and the My Nutri mix powder.

The graph below clearly explains the significant gains made in this project over time. This reflects the success of the tracking tool used by the project and the importance of the 5 step formula (Fig 4.11)

Fig 4.11: Improvement in Nutritional Status



Over the past 30 months (January 2012 - July 2014), we have reduced the total number of children with severe malnutrition from 391 to 60 (from 17.3% in January 2012 to 1.94% in July 2014. In addition, the number of moderately malnourished children has come down from 752 to 568 (from 33.3% to 18.3%. Concurrently, the number of children in the normal weight for age range has increased from 1110 to 2472 (from 49.2% to 79.8%). This is a remarkable reduction in the prevalence of malnutrition.

1. Strengthening and Restructuring of Integrated Child Development Services Scheme - Press Bureau of India link: http://www.pib.nic.in/newsite/erelease.aspx?relid=87949

Dr. Mascarenhas: A community medicine and pediatric specialist working in rural health and development for past 30 years; special focus on mother and child; experience in planning, monitoring, evaluations, training. Member of state planning and monitoring committees for child malnutrition and several health programs under NRHM

5

FUTILE FOOD SCHEMES BY GOVERNMENT FOR UNDERPRIVILEGED

- Y. Mariswamy

Malnutrition among children is the biggest drawback for our country's social system as nearly 15 lakh children below the age of one year are dying because of malnutrition. It is a national and international problem and the same is alarmingly high in the state of Karnataka. We don't need to do any new research to state the fact that about 50% of children are suffering from severe malnutrition as it has already been proven. The situation is so rampant not just in Mumbai- Karnataka or Hyderabad-Karnataka but also in other districts of the state including the state capital. But the state government is projecting the situation in a lighter manner highlighting it as a tiny problem that exists only in the northern parts of the state. But according to the National Family Health Survey, the number of children suffering from anaemia in the state is quite high with 83.9% when compared to that of our neighboring states with 79.6, 72.7 and 56.1 in Andhra Pradesh, Tamil Nadu and Kerala respectively.

Lack of intake of nutritious food, fat, protein and starch in the regular diet are the foremost reasons for malnourishment, anemia and weakness.

The ruling Government is not in a secure condition to provide food security to its citizens despite being an independent nation for about 67 years and a democratic country for 64 years. 42% of the Indian populations are below poverty, estimates of The World Bank. We constitute 27% of world's malnourished people. India has 40% of children aged below 18 but the government has just put forward a food policy which is 'futile' for its citizens as it is framed unscientifically keeping eye on the vote banks and favoring the poor. Hence according to these schemes, the poor have become the beneficiaries not the citizens of the country.

According to government, pediatricians, and nutritionists, early marriage, lack of hygiene, heredity, open defecation, not having milk, curd, vegetables, fish – meat etc are the imperative reasons for children suffering from malnourishment and anemia eventually leading to death. Though all these aspects contribute to malnutrition of children, they can't be considered as exclusive reasons. Malnutrition among children is not just a health problem pertaining to the medical field;

it's fundamentally a social and economical problem. We can witness the direct relation between malnutrition and improper distribution of wealth and hierarchical caste system, for about 90% of Children and women belonging to scheduled castes, scheduled tribes, backward and religious minority communities are worst hit by malnutrition.

To provide adequate nutritious food to children below the age of six, from infancy to f maximize physical and mental health and to develop the personality traits of children by providing pre-school education, ICDS has come into force in 1974. But the Integrated Child Development Scheme has miserably failed to meet its core objectives; as a result we are coming across children with severe malnutrition across the like in Somalia.

Prior to 2012, our state government was supplying readymade food packets which were unfit to be eaten even by the animals, from a Tamil Nadu based company called Cristy Fried Gram Industry to Anganwadis, against the Supreme Court order. The contract was made to be withdrawn by the state government after the rigorous movement by Samajika Parivarthana Janandholana. Soon after the state government submitted an affidavit to the High Court stating it would provide fresh food to Anganwadi kids, considering the local food habits as recommended by the Justice N K Patil committee. But in reality the state government has never kept its promise. At Anganwadis throughout the state Rice-Sambar, Puliyogare, Lemon rice made out of Rice are served to Anganwadi children even keeping aside the concept of providing the food that are eaten locally. Pediatricians and Nutritionists opine that due to high intake of calories prevailing in rice, Children are more prone to becoming Diabetic at very young age. Hence they recommend replacing rice with locally available millets like Ragi, wheat, Jovar, corn along with vegetables. But in reality, even at a microscopic view we will not be able to trace any pieces of vegetables in the food provided to them!

Toned milk is the best supplement for the healthy growth of children below the age of 6yrs. But the Milk supplied under Ksheera Bhagya is not toned. Since three to four years, SPJ has been lobbying with the state government urging to provide Egg or Banana to all those children who come to Anganwadi centres. Keeping its eyes closed at this best practice of neighboring states, government is blindly providing egg only to children who are severely/ moderately malnourished either at Hyderabad – Karnataka region or in other parts of the state. And most of the time the distribution of egg is done irregularly to Children with high / moderately malnourished children at Hyderabad – Karnataka region.

In the name of distribution of eggs to children, about Rs. 57 lakhs had been misused by the officials of Department of Women and Child Development during Jan-Mar 2014. In this regard SPJ submitted a memorandum on August 1st to Minister, Women and Child Welfare urging the suspension of the officials and a probe against the corruption in distribution of eggs since 2012. But till now we have not received any response from the govt. In the midst of all these, distribution of sprouts like horse gram or green gram to children, which is conducive to child nutrition, should be undertaken..

Rs. 6/ is the grant spent by the Govt per day to supply nutritious food to each child who visits an Anganwadi, constituting fuel and transport expenditure Meanwhile one need not explain more about the bad quality of the ingredients supplied to Anganwadi; a mere visit to the nearest Anganwadi will reveal the fact!

Mid Day Meals Schemes –MDMS - is yet another important Government scheme pertaining to children. A central govt scheme has been implemented under the name

Akshara Dasoha by the state Government. The scheme's specialty lies in serving the food even during holidays in drought hit areas. Under this scheme, Education Department has given the food chart instructing to provide Rice- Sambar, Lemon Rice, Bisibele Bath, Pongal both for Middle and High school students. But most of the schools in the state are providing only Rice and Sambar, which is making children feel bored to eat. Here the children are denied of their Right to food of their choice.

About 93 NGOs including ISKCON, Adhamya Chethana, etc., have agreed to provide mid day meals to both middle and high schools covering 10.68 lakh children in the state. But a research by SICHREM, an organization for Human rights, highlights that the food supplied by the NGOs are of poor quality and have become the means to mint the money in the name of service. Hence on June 14th 2012, SICHREM submitted its report to the General Secretary, primary and secondary education department and urged the department not to outsource the service providers for the implementation of the scheme. Moreover the food prepared by the ISKCON doesn't use Onion and Garlic to cook and they use Vanaspathi instead of Oil; through this ISKCON is trying to impose its food culture on children, is it not the violation of Child Rights? Though ISKCON is receiving both local and foreign funds under the banner of Akshaya Pathre Foundation apart from government funding; we don't come across any filed documents on this, states the 4th review committee in its report. Adhamya Chethana samsthe is misusing the government funds granted for MDMS and other government schemes for their political wellbeing. Some NGOs despite receiving the funds from government for MDMS, they are publicizing the projects as being run solely by the concerned organization. Upon agreeing to the demands made by the Swamijis from prestigious Mutts to stop supplying of Eggs in middle and High schools (applicable only to BBMP P.U. colleges), the then BJP- Janatha Dal coalition government withdrew the supply of eggs in MDMS. This action led to alarming increase in malnutrition level among children. Distribution of Milk, Egg or Banana to those who don't eat egg along with MDMS is still practiced in our neighboring states like Andhra, Tamil Nadu and Telangana. On March 18th, 2013 MDMS's 4th review committee recommended the education department to follow the same pattern in the state. Despite all these recommendations, even the ruling state government is paying least attention towards this. In the midst of all these, the only relief is supply of powder Milk, thrice a week under the scheme Ksheera Bhagya.

By the way, the grant given by the central government to be spent on each child per day, which also includes fuel and transportation expenditure, is only Rs. 5.60.

Article 21 in the constitution ensures Right to life with dignity, includes Right to Food. Article 39 (1) says better opportunities and amenities should be provided by the government to all children to ensure healthy development and article 47 directs the state to take responsibility of increasing life style and nutritional levels among children and to develop holistic health. In order to perform this primary duty, the state government should allot sufficient funds in its budget.

Another important scheme pertaining to government food scheme is PDS- Public distribution scheme. (I will not speak about the loopholes that exist in the scheme, as they are already under discussion). Under this scheme in the state we have around 98.35 lakh beneficiaries. Anna Bhagya which is also synonymous with Akki Bhagya covered under this scheme, supplies rice ranging between 10-30 kgs depending upon the number in the family. State should aim at providing Ragi, maize, corn and other locally preferred food grains to keep the scheme alive and to ensure 'Hunger free Karnataka'.

According to government rules the fair price shops should function 26 days a month, hence they should come up with idea of distributing vegetables, fruits, milk meat and other groceries under the same roof.

To eradicate malnutrition among children and adults absolutely there is no need for any government to come up with new schemes or policy. These policies should be treated as constitutional duty rather than treating them as schemes meant to fill the stomachs of the poor. At the same time schemes should be reviewed scientifically to meet the needs of the citizens so that malnutrition in the country is brought down after providing the food and other necessary aspects at low cost that are nutritious. Otherwise on one hand the schemes would continue to remain futile; on the other hand pave the way to bump up to the personal benefits of the perpetrators

Mariswamy Y., Former member of Karnataka State Commission for Protection of Child Rights (KSCPCR); Director, Samaja Parivarthana Janandolana (SPJ)

6

CHILDREN AND ENVIRONMENT

- Dr. H. Paramesh.

Introduction: The Director General of W.H.O Dr. Gro Harlem Brundtland coined the world health day theme: 2003 "Shape the future of life: Healthy Environment for children". The children of today are the adults of tomorrow, they deserve to inherit a safer, fairer, healthier world. There is no task more important than safeguarding their environment.

Children are the future citizens of this world and decision makers and keepers of this planet. However, we are burdening them with pollution in their environment like (1) physical environment, (2) biological environment by the physiologic interaction with innumerable chemicals, pesticides, fertilizers and toxins, and (3) the social environment in which the day-to-day circumstances of living as well as regulation that may affect their day-to-day well-being.

The vulnerability of children to environment pollution begins with exposure in the mother's womb, e.g. drugs, tobacco smoke and lead, and they are affected and suffer because they breathe more air, consume more water, more food and absorb more toxic chemicals per unit of body weight in comparison with adults.

Challenges to Children's Health and Development:

The major challenges are 1) The driving forces 2) Global environmental changes. The driving forces includes:- population growth, rapid urbanization, rapid globalization, new industrialization, poverty and inequity, non-sustainable consumption and transboundary chemical transport. The global environmental changes are – climate change, Increased ozone at troposphere (ground level) and decreased ozone at stratosphere (10km above ground), loss of biodiversity, increased use of biotechnology, desertification, deforestation and forest fires. They contribute to environmental degradation and our children are more disproportionately affected now and in future.

Nearly 352 million children between the ages of 5 years and 12 years engage in economic activities; 50% of these children work in hazardous occupations with poor hygienic conditions, which adversely affect their growth and development, safety and future health. Nearly 30% of global burden of disease can be attributed to environmental

factors. Thirty-six percent of the overall disease burden is due to modifiable environmental risk factors in the age group of 0-4 years and 34%among children of 0-14 years.

Environmental pollution:

The key environmental pollution problems that affect our children's health vary from affluent to non affluent countries and they are –

1. Air pollution
   Outdoor air pollution
   Indoor air pollution
2. Water pollution
   Surface water pollution
   Ground water pollution
3. Chemical pollution
   Persistent organic pollutants (POPs)
4. Noise pollution
5. Exposure to radiation

The windows and timing of exposure to pollutants have different impact as shown in Table - 6.1

Table - 6.1: The environmental pollution affects womb to tomb.

2 weeks of gestation	• Less prone for teratogenic effect Prenatal death can happen
3 - 8 weeks of gestation	• Major morphological abnormalities
9 weeks onwards	• Minor Morphological abnormalities Physiological aberration

Outdoor Air Pollution:

The major contribution for outdoor air pollution is from automobile emissions. Some of the facts for air pollution on respiratory health are -

- ❖ Children of heavy traffic schools suffer from more asthma and it further increases in lower socio economic children.
- ❖ Urban children suffer more asthma than rural.
- ❖ Asthma is increased in summer season in 15 years 2% to 28%.
- ❖ Traffic police suffer more than non traffic police
- ❖ Slow traffic 10km/hr produce 6 times more CO than at 75km/hr.
- ❖ Asthma visits to ER increased by 100% during Diwali
- ❖ Allergic Rhinitis increased 22.5% to 27.5% between 1994-99.
- ❖ Chronic cough – Under 18 is 8% 1994 – 10.2% in 2010
  – Under 5 is – 4.95%
- ❖ Children living 1000ft from a freeway at birth had 2 fold increases in Autism.

The above data are shown in figures 6.1 to 6.6

Fig – 6.1: Trends in Asthama Prevalence 1979-2004 (P<0.05)

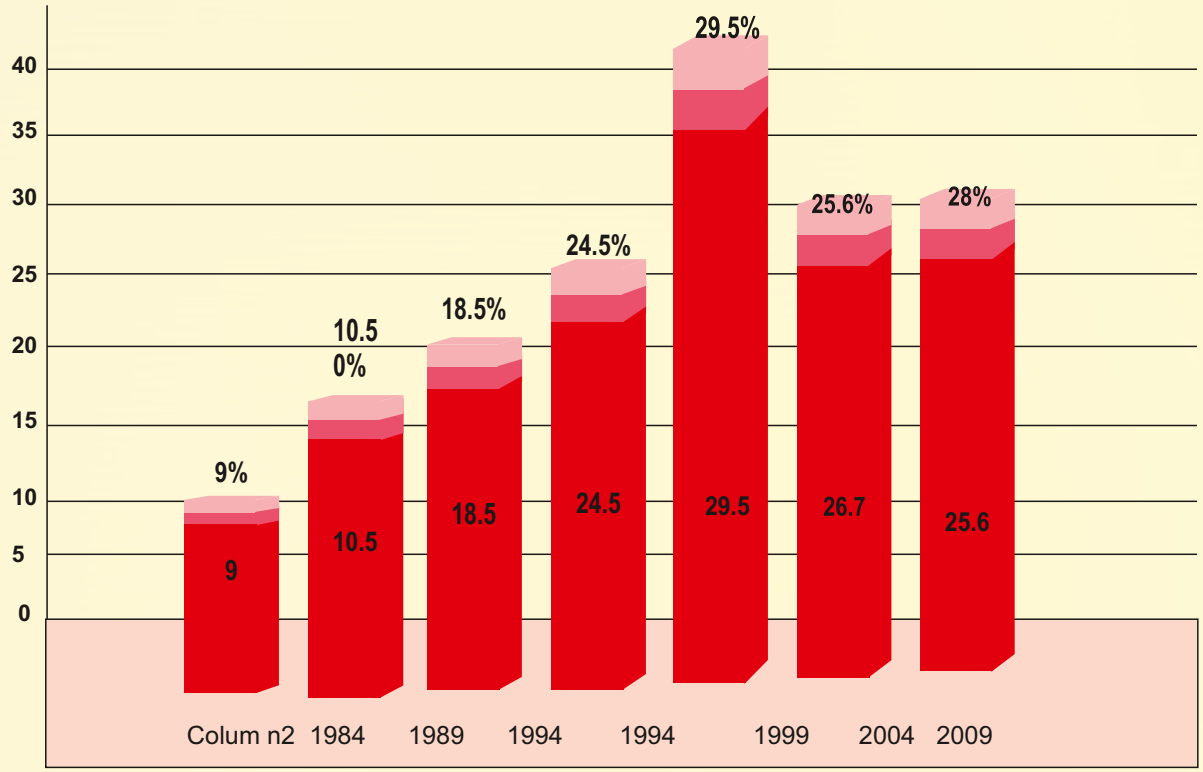


Fig –6.2: Prevalence of Persistent Asthma 1994 - 2004 (P<0.0058)

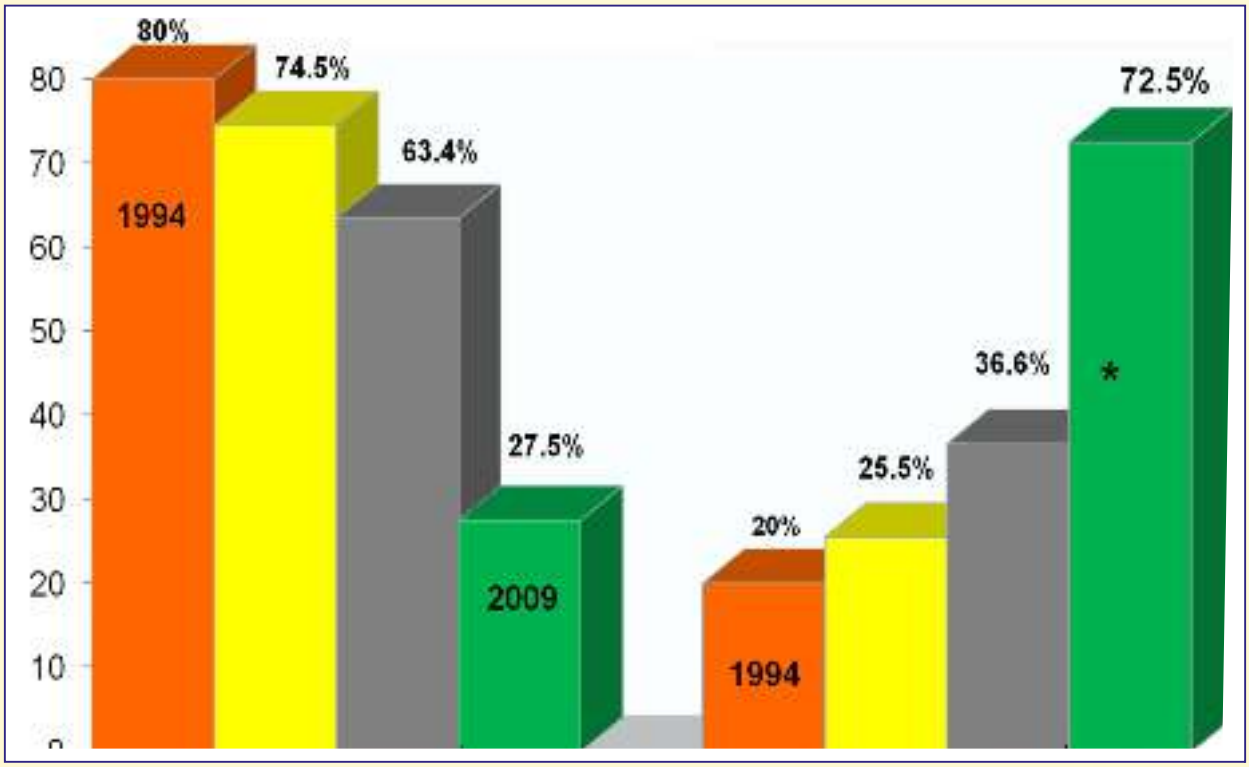


Fig – 6.3: Heavy Traffic in school areas

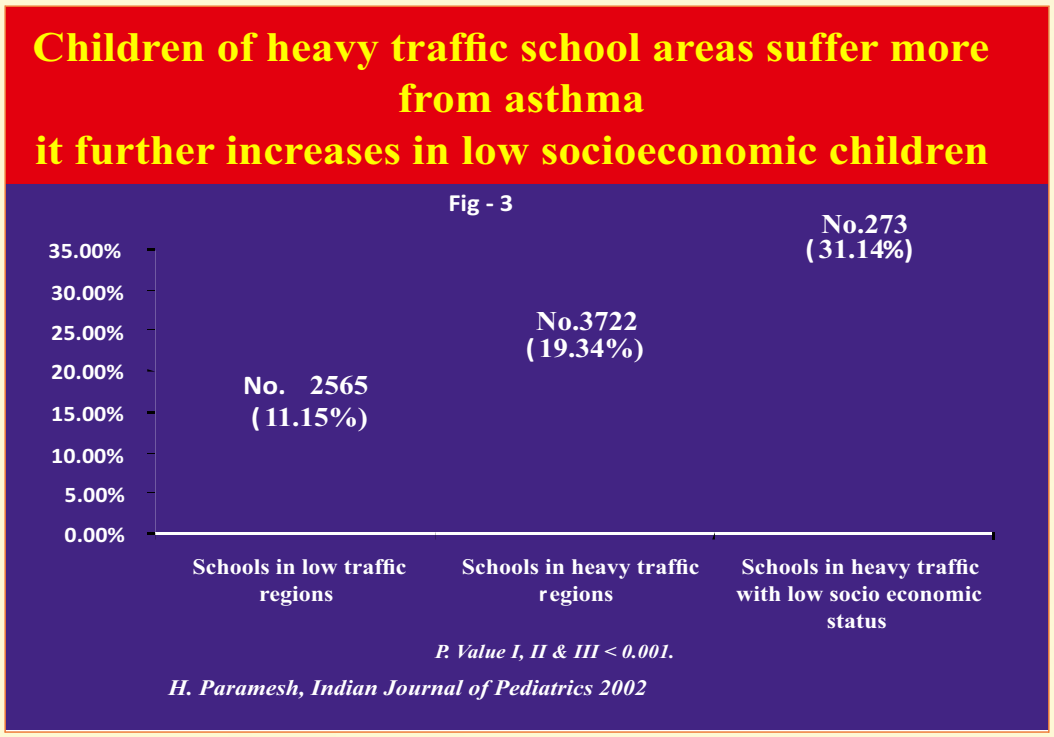


Fig 6.4: Changing Seasonal Pattern of Asthama Episodes

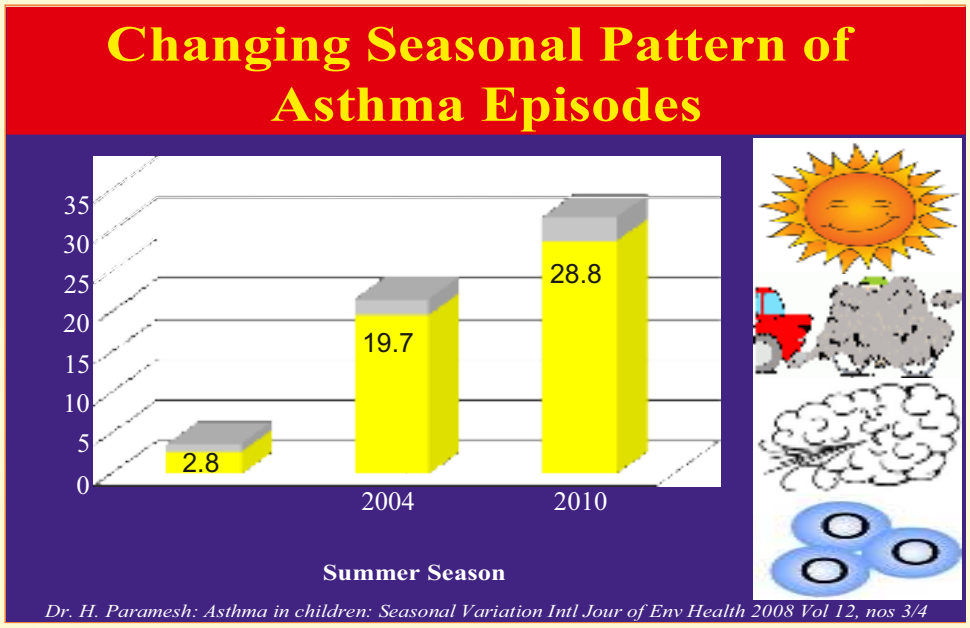


Fig 6.5: Air Pollution and Traffic Police

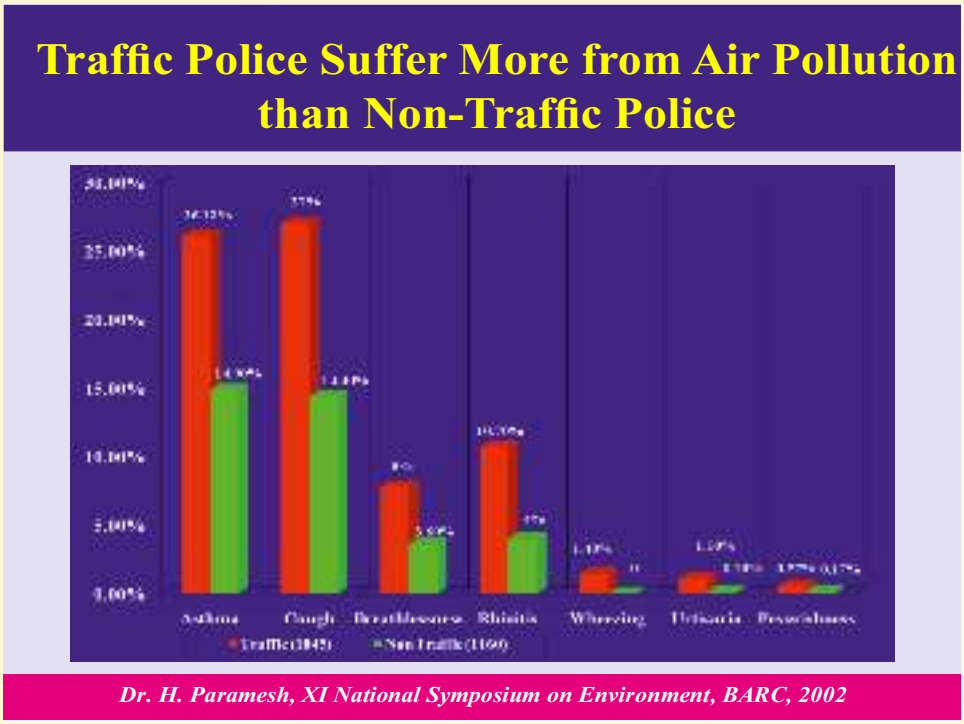
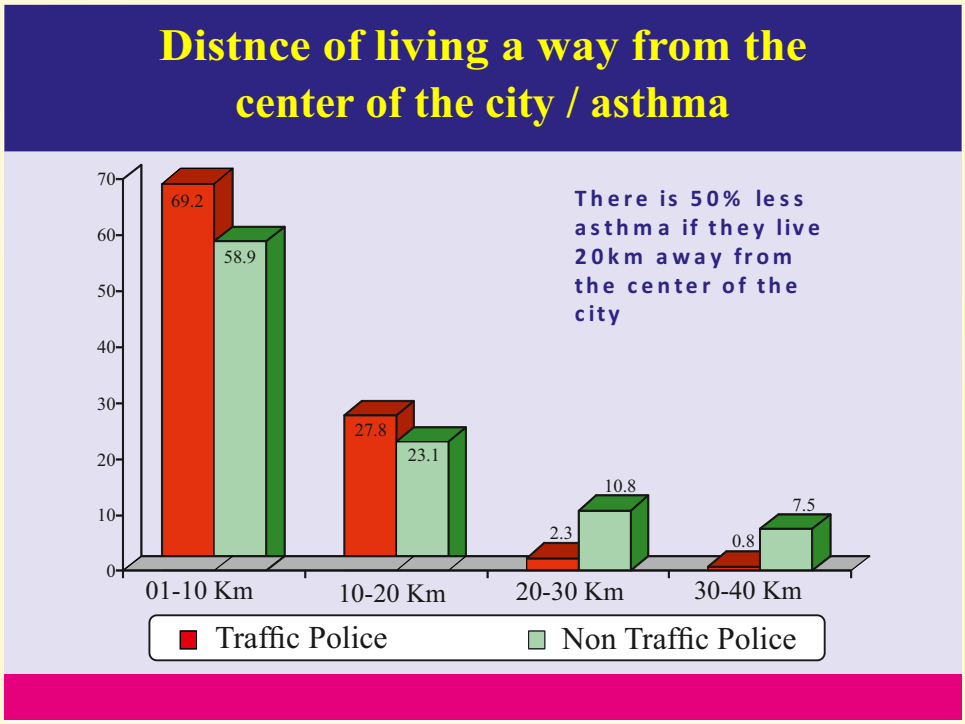


Fig – 6.6: Distance of living away from the center of the city / asthma



Source- H.Paramesh, IX National Symposiumon Environment 2002

Indoor air pollution:

Some of the facts on indoor air pollution are –

- Use of Bio fuel in ill ventilated huts changes the sex ratio of asthma.
- Prevalence of asthma in well ventilated house is 8% in ill ventilated house 42.7%.
- Cow dung cake as cooking fuel 48.8%, Electricity 1.2% in asthma prevelence
- Single parent smoking 22.8% Non smoking 08.8%
- Mosquito coil produces nearly 75-100 cigarettes equivalent carbon monoxide and particulate matter.
- Single room dwelling with agricultural waste as cooking fuel has 10.5 fold increasing incidence of Pneumonia.

The above data are given in figures 6.7 to 6.10

Fig – 6.7: Ventilation and Asthma

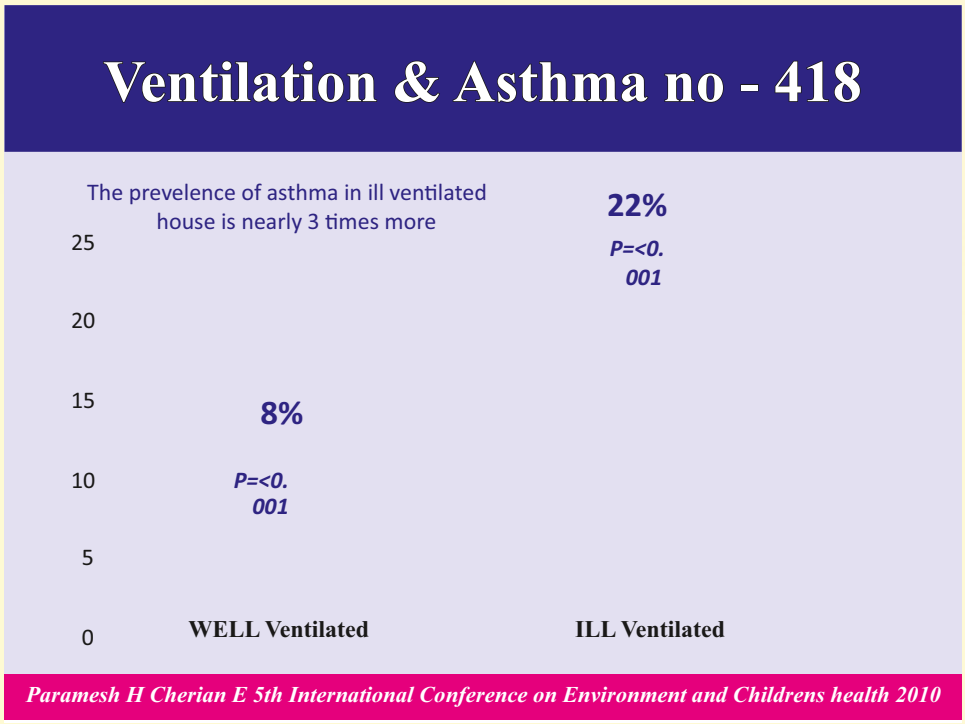


Fig – 6.8: Cigarette Smoking Parents v/s Asthma prevalence in Children

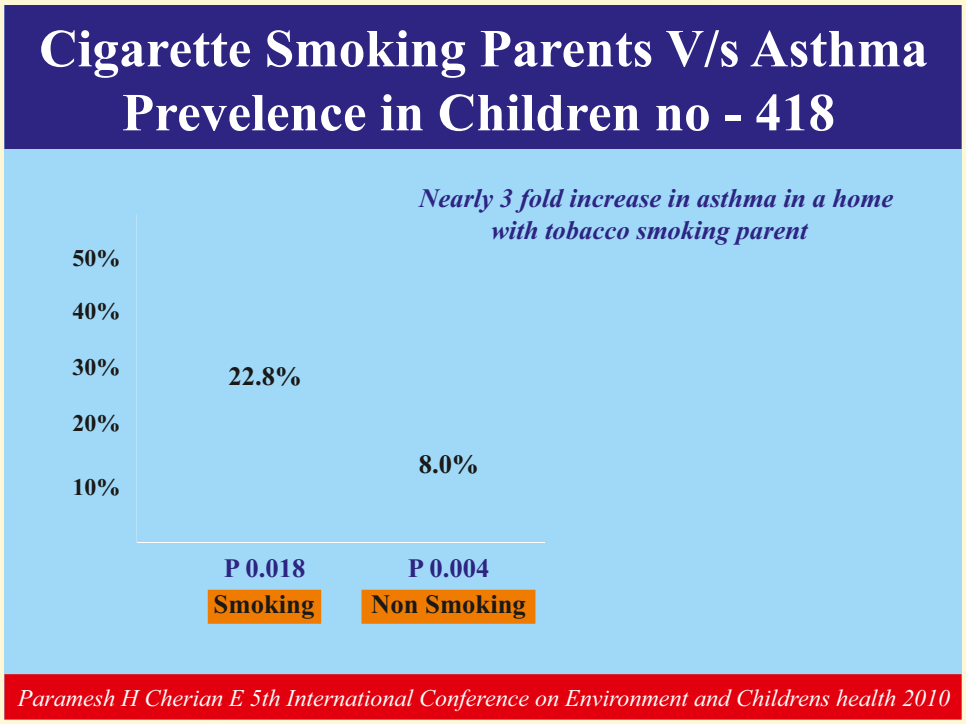


Fig – 6.9: Cooking Fuel V/s prevalence of asthama in children

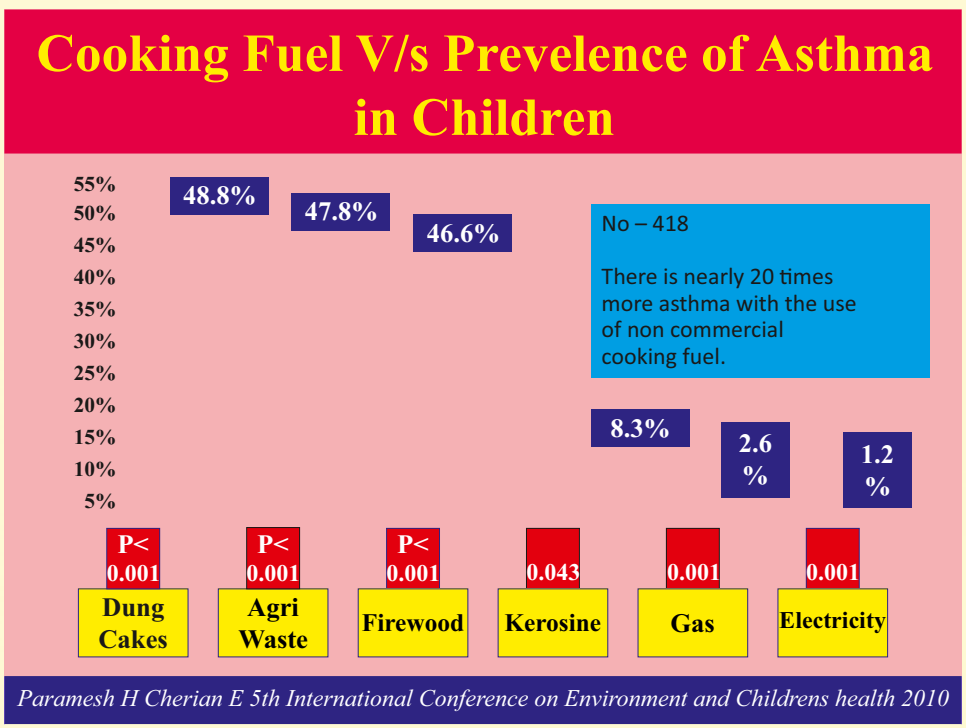
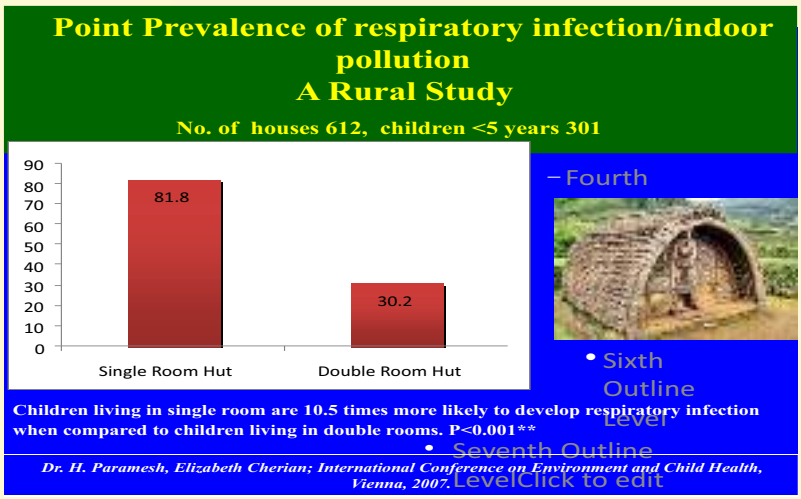


Fig – 6.10: Single room dwelling with agricultural waste as cooking fuel has 10.5 fold increasing incidence of Pneumonia.



- India supports 1/6th of world population; 1/25th of water resources and 1/50th of worlds land.
- Our allotted water need is 170cum/c/yr is comparison to >3600cum/c/yr in North America. By the end of 21st Century, 18% of people lack safe drinking water and 40%, lack adequate sanitation. The future fights are going towards water.
- I just want to quote the example of our city of Bangalore, a rapidly growing city in the world. The problem of water scarcity is tremendous.
- The water requirement for 9 million people of Bangalore is 135/L/C/D (National building code of India) is = 1215 MLD. The water available from (Cauvery + Arkavaty rivers = 810+ 184 MLD and ground water 200 MLD), total of 1194 MLD. We have shortage of 21 million Litre/day.
- The water borne diseases, water washed diseases, Vector borne diseases will increase in future. Among the vector borne disease **malaria** will resurface and **Dengue** fever has increased over 30 time for the past few decades. Knowing the magnitude the 2014 W.H.O theme is vector borne diseases.
- In addition we have to be aware of **chemical contamination** of water like – Arsenic, Fluoride, Lead, Mercury, Nitrates, Volatile organic compound as shown in table - 6.2

Sanitation is a major concern for India. One gram of human excreta contains – 10,000,000 viruses; 1000000/bacteria; 1,000 parasite cysts and 100 parasite eggs. According to official India's Sanitation programme, by 2022 every one should have an access to toilets in the house. It is heartening to know that Sikkim and Haryana are the best states with improved rural sanitation. Unfortunately the existent toilets are defunct and used for storage purpose in Jharkhand, Chhattisgarh, Bihar and U.P.

Table – 6.2: Chemicals Contaminating Water and Their Effects

Chemical	Mechanism	Ill effects
Fluoride	Affects 6 Million Children less than 14 years	Dental fluorosis
	Drinking water with more than 1 mg fluoride/liter	Skeletal fluorosis
		Non-skeletal fluorosis
Arsenic (As)	Ingesting water with As content more than 0.01 mg/liter over a period of 5-15 years	Skin rashes, hyperkeratosis Cancer of lung, bladder, kidney
Mercury	All mercury in India imported, used in equipments, batteries and thermometers	Major health effects; Psychological, GIT cramps, colitis
	Poisoning occurs by ingestion and inhalation	Persistent cough, emphysema, asthma, sinusitis Excessive perspiration Alzhemer's disease, parkinson's disease, autism also reported
Nitrites	Seepage from septic tank, pit latrines and organic manures into ground water	Ingestion of water with more than 45 mg/L of nitrites – “blue baby syndrome”, meth hemoglobinemia Chronic ingestion and in cancer

Lead	Ingestion of water from lead pipes, food containers, paint and insecticides	Lead level more than 10mg/dL in blood: Progressive GIT, hematologic, peripheral and central nervous system involvement
	Inhalation of polluted air from leaded petrol, battery storage, crystal glass, ceramic glazes, enamel jewelry, plastic and rubber stabilizers, surma, vermillion	Anorexia, abdominal pain, vomiting
		Anemia, blue fine in gums Headache, seizures, altered sensorium Peripheral neuropathy Behavioral disturbances Lower IQ, poor school performance

Chemical pollution

Persistent Organic Pollutants (POPs)

They are man-made organic pollutants, and are the most dangerous and hazardous compounds synthesized.

They include pesticides, industrial chemicals, chemicals used in consumer products and byproducts of certain manufacturing and combustion process. They have long half lives and hence persist in the environment for years or decades. They bioaccumulate and penetrate the food chain thus, polluting and exposing all living things.

They disperse universally and travel in air, water currents and living organisms. Most POPs are lipophilic and remain in fat tissue, not well metabolized or excreted, even small doses ingested daily accumulate to measurable amounts over time. They are endocrine disruptors, mimic, modify or block the actions of naturally occurring hormones as listed in Table 6.3 prenatal exposure of pesticides negatively affects fetal growth like smaller head circumference and shorter birth length.

The major sources of human exposure are food, soil, indoor environment, toys and other objects, air and leaching from medical products. The important organic chlorine pesticides developed after dichlorodiphenyltrichoroethane (DDT) and widely used after world war will include aldrin,

dielrin, endrin, chlordane, heptachlor, indane and pentachlorophenol. They helped a great deal in agriculture, which helped the world economy. Once adverse effects due to their persistence and accumulation in the environment became known, most uses were discontinued. Endosulfan played havoc on the life our children which should be banned at any cost.

Table – 6.3: Hormonal effect of persistent organic pollutants

Persistent Organic Pollutants	Hormonal ill effect
DDT, dieldrin, endosalfan, methoxychlor PCBs – alkyphenols, phthalates, mycotoxins,	Estrogenic
Phytoestrogens	
Dioxins, PCBs, phytoestrogens	Antiestrogenic
Vinclozolin	Antiandrogenic
PCBs, Dioxins	Antithyroid

Abbreviations: DDT, Dichlorodiphenyltrichloethane; PCBs Polychlorinated biphenyls;

Noise pollution:

The noise pollution is known to affect 800 million people globally. Hearing loss is the result of cumulative effect of noise. 2.7% of population of India is deaf. Deafness is more common in rural children. The source of noise is form Industrial area, Transport and community noise. The noise level at 80 decibel is annoying 110 decibel is results in discomforts 135 decibel is painful. The recommended noise level at urban residential area is 35-40db; urban business 40-45db; rural area 25-30db and hospitals 30-35db.

In addition excess noise during pregnancy affects the fetus. Prematurity, IUGR; increased need for oxygen for ventilated premature babies, stress response, sleep disorders, poor school performance.

Economic Burden:

COPD	-	48.306 Cr by 2016
Asthma	-	13,528 Cr by 2016
Antihistamine drug cost	-	1,000 Cr by 2016

Note: *Only 7% of health budget allocated to Children who constitute 50% of Population*

Sanitation

Tardy Sanitation	-	2.4 Trillion
Health related loss	-	1.75 Trillion
Diarrhea <5yrs children	-	824 Billion
Per capita annual loss	-	2180 Rupees

School Environment:

W.H.O. & UNICEF want to create Health Promoting Schools. Healthy school environment directly improves children's health and effective learning and school act as an example for the community. Students learn about the link between environment and health and enact in their own homes.

The School environment has 2 important components.

1. Physical Components of healthy environment.
2. Psycho – social environment.

1. Physical Components of Healthy Environment

a) Provision of basic necessities:

- Shelter
- Water
- Light
- Ventilation
- Sanitary facilities
- Emergency medical care
- Food
- Warmth

b) Protection: Biological Threats:

- Molds
- Unsafe water and Food
- Vector borne diseases
- Venomous animals, Rodents etc

c) Protection from Physical Threats

- Traffic and transport
- Violence and crime
- Injuries
- Radiation

d) Protection: Chemical threat:

- Air Pollution
- Water Pollution
- Waste

2. Healthy Psycho – Social Environment of School

- Should be warm, friendly and rewards learning
- Should promote co operation rather than competition
- Facilitates supportive, open communications
- Avoids physical punishments, bullying, harassment, violence.
- Promote Non – Violence interaction on the playground, in class, among staff and students
- Equal opportunity to all gender and democratic approach

The positive social environment in school can influence the behaviour of students, mental health and well being of young people and finally improve learning out come.

60% of American adults had troubled and abusive childhood environment. Those children experience higher risk of depression, cardiovascular diseases, diabetes, cancer, substance abuse and prime time death.

Radiation Hazards

Radiation is the emission of energy (as electromagnetic waves) or particle matter from unstable atoms. Some types of radiation are harmful to life while others, such as heat energy and light radiating from the skin, are beneficial.

Source of radioactive substances: Natural sources of ionizing radiation are the most common, and include cosmic rays from space and radioactive minerals. In sources areas, the gas radon found in soil, rocks, building materials and granite stone are highly radioactive.

Artificial sources of ionizing radiation include X-ray machines, radioactive isotopes used in diagnosis and treatment and nuclear reactors

Radiation hazards to health depend on the dose duration of exposure and organs exposed.

Remedial Measures for Air Pollution:

- Control of outdoor and indoor pollution
- Control of environmental tobacco smoke
- Use of clean fuels for cooking
- Avoiding overcrowded houses, classrooms
- Construction of proper houses with good cross-ventilation and sunshine. Use Vaastu based on Vedic mathematics
- Interior decoration to suit the environment

- Drying of mattresses, pillows and blankets in the sun once a week
- Use of indoor plants and exposing them to sunlight once a week
- Control of cockroaches, better garbage disposal
- Control of automobile exhaust fumes.
- Lon-term urban transport planning
- Certification of in-use vehicles
- Car pooling, traffic management
- Monitoring of air quality
- Identifying of hot spots in the city
- Coordination of various municipal and utility services
- Use of better technology to reduce emissions
- Alternatives for fossil fuels
- Education of children, society and policy makers on the adverse effects of air pollution

Remedial Measures for Water Pollution:

- Education of public about use of safe drinking water, toilet hygiene
- Use of water filters
- Use of deflouridation plants
- Prevention of waste production and pollution
- Prevention of waste from various sources entering water
- Protecting the source of water does not ensure that the water people drink will be bacteria-free. There are many cases of water that was bacteria-free source getting contaminated during transportation, storage and consumption. Hence, it is essential to educate the community.
- Water storage at home should be covered
- Avoid using dirty hands or implements to fetch water
- Drinking water can be purified by chlorination, boiling, slow sand filters and solar disinfection.

Remedial Measures for Noise Pollution:

- Effective noise control programmes in industries and use of protective aids.
- Plantation of trees near schools, hospitals, public offices and libraries to reduce noise by 6-10db
- Residential zones planned away from main roads, factories, airport and railways
- Perforated plywood and other porous materials to be used for office floors or ceilings
- Implementation of noise control regulation by automobiles, social and religious functions and prayer halls.

Key Principles of United Nations Convention on the Child Rights.

We have to adopt the key principles of United Nations convention on the rights of the child like –

- Best interest of the child to be a primary consideration in any legislation
- They have the rights to survival,

development, freedom of expressions of their views

- Access to information of benefit and protection from injurious information
- Protection from violence, abuse and neglect.
- Right to highest attainable standard of health in that country
- Right to adequate standard of living
- Protection from economic exploitation.

Conclusion:

The environmental pollution is growing uncontrolled. We are not doing enough to curb this menace. Let us all pledge ourselves to do more. We must recognise the environmental risks to our politically powerless children and assume responsibilities for preventing them because we hold our future in our hands – and it is our children.

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7

PROGRESS TOWARDS KARNATAKA'S GOALS FOR CHILDREN

- Dr. R. Padmini

Introduction

The year after the Convention on the Rights of the Child [CRC] was unanimously adopted and almost immediately signed by all countries except two, the world's leaders met at the Global Summit for Children and decided to aim at a set of goals through a global Plan of Action for the Child. This was to be adapted in a National Plan of Action [NPAC] by each country; further to be followed by sub-national plans of action [SPACs] in large countries.

India accordingly prepared its five year NPAC in 1992 and updated it in 2005 while Karnataka adopted its SPAC in 1993 and updated it in 2003 [for 7 years]. However, neither of these plans was actually referred to nor were the set targets used as yardsticks, milestones or goals in any subsequent government document or discussion that was made public or carried out with the public. In 2012, DWCD shared a draft of the next SPAC with a few NGOs who pointed out so many drawbacks in it that it was withdrawn and a consultative process was agreed upon to work on a new draft. To date, this process has not moved or has been fragmented without the necessary direction from the nodal department.

The MDGs

The UN meantime adopted two other sets of global goals, the Millennium Development Goals [MDGs] in 2000 and the World Fit for Children [WFFC] goals and action plan in 2003. While the former has gained universal importance, the latter has been mostly ignored. The MDGs were to be adapted by each country[1] to reflect its own situation. India endorsed its version in the 11th and 12th five year plans. This note discusses Karnataka's progress towards these goals and adds some comments on key nuances in this progress.[1]

India adapted the global MDGs and set itself 8 MDG goals, 12 targets (out of the 18) and 35 indicators.

Goal 1: Eradicate Extreme Poverty and Hunger

Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

The percentage of people below the national poverty line has already narrowed down to a level less than half of its position in 1990 [48%], in 2011-12 itself [22%], at all India level and both rural and urban areas, ahead of the MDG target year of 2015 [MDG India Country Report, 2014, GoI]. Karnataka does even slightly better than the nation as a whole. However, comparing it with the other South Indian states/UT, its reduction from the 1990 level to the expected level in 2015 is by 2/3 while the rest will have reduced their proportions by 4/5 or even more. Also, its rate of decline in the past decade is poorer than many states as its ranking shows- it has dropped from 18th place to 21st [ibid]. The states that have the lowest PHCR are Goa and Kerala [both below 10% while the worst are Chattisgarh, Jharkand and Manipur [between 36 and 40%].

Fig 7.1: Poverty Head Count Ratio - Likely achievement of states vis-à-vis MDG target

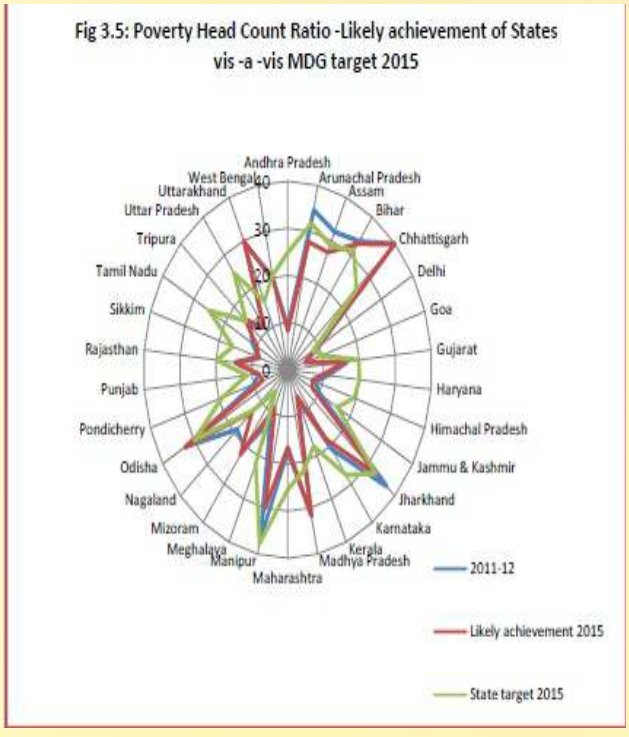


Fig 7.2: Poverty Head Count Ratio - States & Uts 2011-12

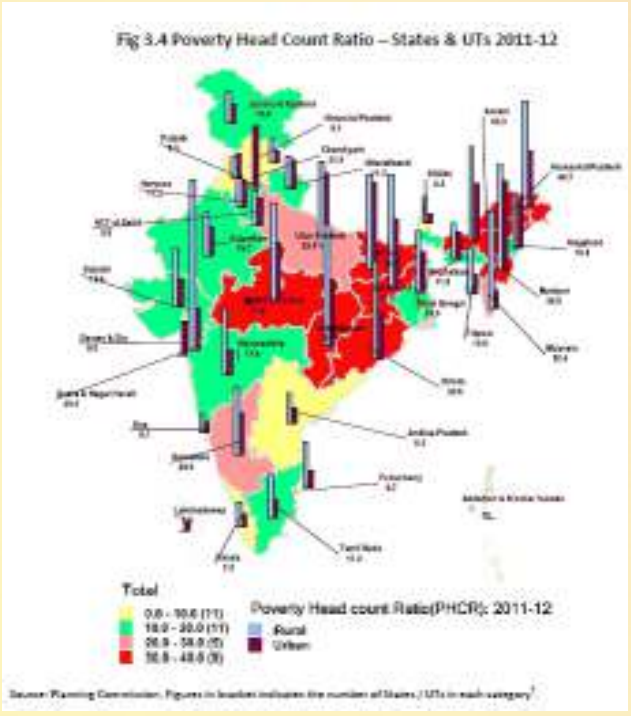


Table 7.1: Poverty Head Count Ratio (Tendulkar Methodology)

States	1990	Likely achievement 2015	Target 2015
Andhra Pradesh	49.74	8.27	24.872
Karnataka	55.11	18.29	7.5517
Kerala	35.51	18.29	17.76
Tamil Nadu	50.20	6.15	25.10
Puducherry	38.27	7.25	19.14
India	47.80	20.74	23.90

A caveat may be raised regarding the indicators used to determine poverty reduction: the UN target of a minimum of a dollar a day is so low that it is not even a measure of deprivation let alone overall poverty. Secondly, the Tendulkar methodology adopted recently in India did allow for some more realistic measure of poverty than the earlier methods but still does not allow for some basic needs such as rent, healthcare, fuel, transport, clothing etc.

Thus in Bengaluru today, the official minimum wage ranges from Rs. 180-Rs. 230 for an unskilled labourer. On the other hand, taking basic needs including nutritious food, “shelter, clothing, education, health, fuel and recreation into consideration, the Sixth Pay Commission arrives at a monthly minimum of Rs 9,337 and a daily minimum wage for a government employee across the country that the 15th ILC and the SC translated to Rs 359.12 for a family of four at 2009 prices. This makes it about Rs 90 per capita/day and around Rs 1,30,000 per year for a family of four” [Chamaraj, 2011]

Further, eligibility criteria for various schemes and subsidies vary; for PDS, it was 17,000 for urban and 12,000 for rural family which is far below the minimum wage. Thus a number of families that are said to be BPL do not receive many of their entitlements. Properly speaking, India's poverty line should be in sync with a periodically updated minimum wage as per the methodology worked out by the 15th ILC/SC, by which yardstick the proportion would be much more for the country and several states.

Thus we must sadly note that India's target of halving the number of poor people may be achieved only with some juggling with definitions of poverty lines; while, on the other hand, Arjun Sengupta's study or the ILC calculations give us much higher estimates.

Moreover, according to a presentation made by Dr. Tanweer Fazal in 2013, the estimates of national poverty reductions both overall and more so among the main minority group [Muslims] and SCs and STs are not so optimistic as in the above report. According to this presentation, the national BPL level was just below 30% in 2009-10, which means there has been a steep downward decline to 22% by 2011-12 or just two years

later, which begs explanations. Further probes into such rapid changes including methodological questions seem warranted.

As for the minorities and vulnerable groups, the corresponding rates in 2009-10 are given separately for rural and urban areas: Muslims 36 - r, 34 – u; SCs – 42 and 34 respectively and STs – 47 and 30 respectively. Such figures clearly indicate the typically worse-off situation of these groups compared with the overall averages.

Another issue of concern is chronic poverty defined by the Chronic Poverty Research Centre [CPRC] as the persistence of poverty during the lifetime of an individual/household and passed on for generations. This pattern is specially evident in tribal and/or forested areas and is higher in some states than the national average. While Karnataka as a whole is not among these states, its tribal/forested areas may fall into this group and thus this vicious cycle needs to be specially targeted. [CPRC India, 2011].

Another measure examined by the Planning Commission, the Poverty Gap Ratio, that gives the gap among the poor between the mean consumption and the poverty line, has declined in the state as in many states from 2004-05 to 2011-12. When compared to the national figures but not by any large margin. The report does not give state-wise figures for the share of the poorest quintile in consumption expenditure; the national figures show a decline for urban and a mixed result for rural areas depending on the indicator used, and all of them are less than 10% [i.e., the lowest quintile or 20% of the population account for less than 10%]. If Karnataka follows this trend, that is another worrying aspect.

Target 1.B: Achieve full and productive employment and decent work for all, including women and young people

India did not include this target amongst its goals.

Target 1 C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger - India has taken this as target 2.

Per capita calorie intake and children's weight for age and other related indicators are the most commonly used measures for this target.

Per capita calorie intake has declined by 6% from 1993-94 to 2009-10 both in rural and urban areas of the country, and even more if the 1983 level is taken as the benchmark. Yet, it is better than the abysmally low level in 2004-05. The patterns for the different nutritional components vary with the share of proteins having grown and that of fats shooting up [The Hindu, 2014 a]. Hence, the implications of these changes are unclear but overall the picture is worrying - When compared with the Planning Commission's norm of 2400, the rural intake is only 2099 Kcals, and the urban 2058.

NFHS also has what could be a proxy indicator, the BMI [Body Mass Index] of adult women and men. Karnataka has only about 50% women and 60% men in the desirable range; 30% of the former are underweight and nearly 20% are obese; among the latter, 25% are underweight and 15% are obese. There are more underweight persons in rural areas than in urban centres, while the

reverse is true for obesity. With such a large number of underweight women in the reproductive age group, the ill-effects on the growth and development of the foetus is likely to be large, as can be seen in large proportion of low birth-weight babies, and other nutri-deficiencies in new-borns. This is a factor that must be attended to for the health and productivity of the adult population also.

The recent IFPRI Global Hunger Index [GHI] however places India at a better rank in its latest ranking [from 63 to 55 among 76 countries] with its score declining from 31-18, and moves its hunger status from the category of alarming to serious concern. [Livemint, 2014 & the Hindu, 2014 b].

This improvement has been attributed to the slew of poverty reduction and other pro-poor measures as well as the sharp increase in economic growth during the first decade of the new millennium. In this context, the reduction in budgets for the social sector schemes such as MNREGA, PDS, ICDS, etc. is cause for serious concern. Similarly the move to shift land use from agriculture to other purposes with easing of laws and safeguards in land acquisition will exacerbate the decline in production of food grains especially pulses and thus can lead to greater malnutrition.

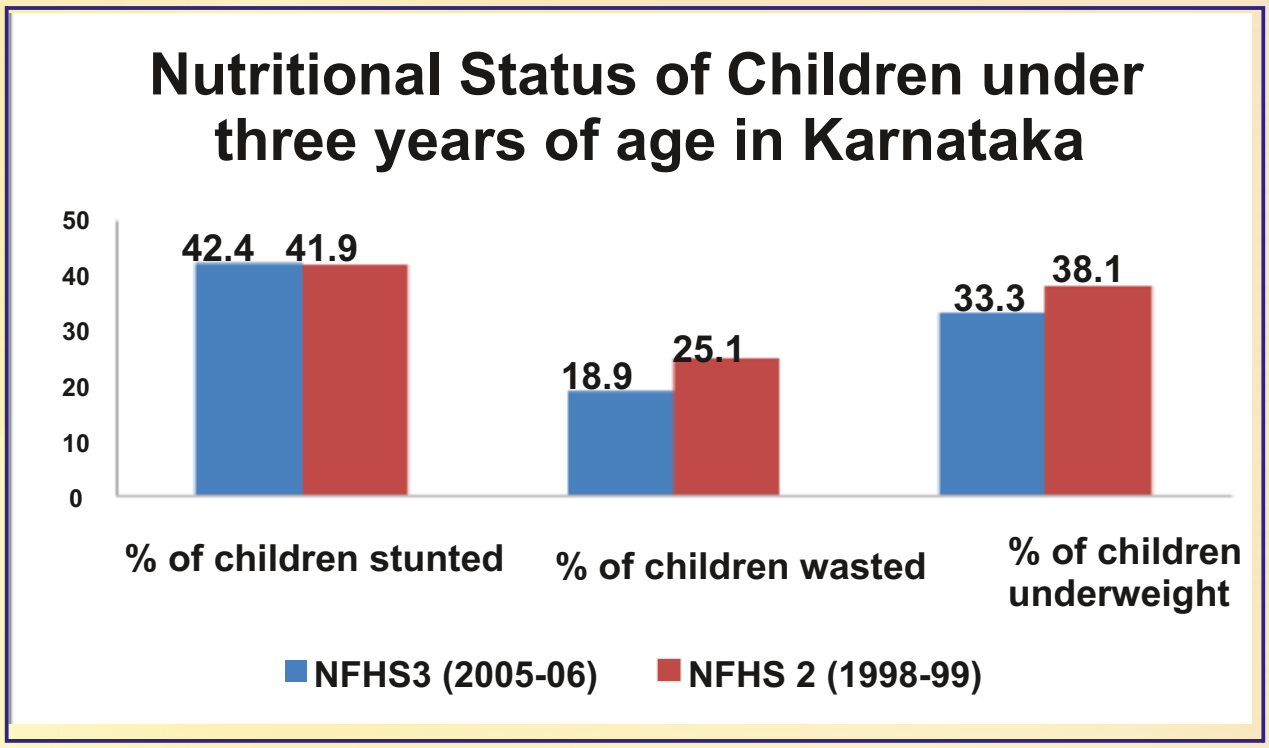
Table 7.2 uses data and extrapolations based on the 2005-06 National Family Health Survey [NFHS], and according to these, India will not reach the MDG target of halving its underweight incidence of 1990 by 2015 [While the MDG target is given for the under five age group, the data collected periodically by NFHS is for the under three age group, but this is acceptable as most of the growth and development of the child occurs within this period]. The extrapolations also revealed that the scenario was not an optimistic one for most southern states except TN. Karnataka in fact does better than AP or Kerala in terms of rate of decline and closeness to its MDG target and so the state's overall progress could perhaps even be spiked to reach the MDG target.

ii. Prevalence of underweight children under-five years of age: Child Malnutrition in Karnataka

Table 7.2: Underweight children under 3 years

States	1990	Likely achievement 2015	Target 2015
Andhra Pradesh	44.41	25.59	22.21
Karnataka	48.28	25.59	24.14
Kerala	22.25	20.54	11.12
Tamil Nadu	42.88	18.06	21.44
Puducherry	NA	NA	NA
India	**52**	**32.85**	**26**

Fig: 7.3: Nutritional Status of children under 3 years of age in Karnataka



The chart 7.3 clearly shows that the problem of child malnutrition in Karnataka has been multi-dimensional: not only were a third of our children under three, the most crucial period for child development, underweight [low weight for age], but 42% were stunted [low height for age], and 19% were wasted [low weight for height]. Worse, the proportion of children had actually gone up marginally from 1998-99 to 2005-06! On the other hand, while the underweight and wasted proportions had declined, they were still very high.

Recently however, a Rapid Action Survey on Children (RSOC) was carried out in 2013-14 that has shown remarkable progress on many child-related indicators including nutritional ones such as the proportion of underweight children in the country declining sharply from 40% in 2005-06 (NFHS 3) to 29% in 2012-13 (ROSC). ROSC was carried out on lines similar to NFHS and thus data can be compared to previous set from NFHS. The official report of this national survey has however been withheld so far. But some highlights have been released through the press and reveal a remarkable turn of improvements that amount to the country having reached key targets a year or more earlier than the deadline. As state-wise data can only be gleaned from colour coded maps published in the media, one can only make out that Karnataka also has recorded a drop in the proportion of children underweight from 33% to 25-30%. Stunted also declined nationally from 48 to 39% in the State. Thus the decline in the state was less dramatic than the average for the country.

Fig 7.4: Stunted Children

Recent national figures publicised elsewhere are:

- % Population undernourished fell from 26 to 17 from 1990 to 2014;
- % undernourished children declined from 56 to 31; and
- % under-five mortality from 13 to 6 (1-5 (Yrs)
- However, the MDG India report,

  key indicators were causes for alarm:
- Vitamin A deficiency among children - 62% ['03]; and

Some interesting and puzzling data from NNMB report on rural diets, 2012, include a higher rate of malnutrition among young boys than girls. Specifically, "The overall prevalence of underweight, stunting and wasting among boys of > 5 years was 45.1%, 44.3% and 22.5%. While the corresponding figures for girls were 41.4%, 41.9% and 21.5% respectively.

The same report reveals some anomalies in Karnataka, which is among the top in consumption of pulses and millets, and has about the highest calorific energy intake; yet, it has among the highest rates of anemia and Bitot spots (indicative of Vitamin A deficiency). This might be due to poorer consumption of vegetables.

Examining data that compares the economic status and GHI score for the states, Karnataka was among the states that

performed worse on this indicator than its economic status and growth indicated, while states like Kerala and Punjab fared better than their economic indicators would warrant.

Anaemia among pregnant women– 54% ['11]

Serious Situation in Karnataka: The State erupted in 2011-12 with reports of the infamous starvation deaths and malnutrition rates among children under six in Raichur district that hit the media headlines, and an ensuing PIL led to the High Court forming a committee to investigate and recommend actions to alleviate IMR and Malnutrition among children of this age group in the entire state, as there were indications that the problem was not confined to that district alone. The data obtained by this committee and their analysis together indicate that young child malnutrition is indeed a major problem in the state. [GoK 2012] Consolidated Recommendations of the Committee Constituted by the State Government to Address Child Malnutrition and Infant Mortality in Karnataka, GoK, January 2012] The state government had admitted to 1.2 million malnourished children [Down To Earth, 2012]. Actions taken upon the report included better rations for children in AWCs, regular health and nutrition camps in health centres, the unearthing of scams in the provision of food and snacks in ICDS with resulting shake-ups in government departments, and other very needed nutritional monitoring and rehabilitation systemic changes, but it is difficult to say if the situation has improved enough on the ground.

Malnutrition has many facets. Looking at anaemia first, a shocking 83% children were anaemic in the state, which had the third worst record among states/UTs on this indicator in 2005-06. Further, the situation worsened since 1998-99 when it was 79%. Why this was so and what the position now needs urgent investigation. The key aspects of child malnutrition, Underweight, Stunting and Wasting had shown some improvements: 33, 42 and 18% respectively in 2005-06; down from 39, 42 and 25% in 1998-99 and 46, 48 and 24% in 1992-93.

There are several related aspects that need to be probed, given that malnutrition is impacted by multiple causes and interacts with them in various ways: what is the income level of the families of malnourished children; the health and nutrition status of the mothers during and before pregnancy; what was the mother's age when she got pregnant; what kind of breastfeeding practices did they follow; what is the sex breakdown of the malnourished children; were they enrolled in an anganwadi or other young child centre and were they regularly receiving health inputs and nutritional supplements appropriate to their nutritional status, if they were under three: and if they were between three and six years of age, were they regular attendees at such centres; what do the growth charts show and if they do indicate malnourishment, what actions were taken to arrest/reverse this status; what is the birth order of the child and what is the birth interval between her/him and the preceding and following child [if any]; what kind and amount of foods did the child get; what is the sanitation and hygiene situation of the family/community/centre; etc., etc.?

On the other hand, it is apparent that there is so much disparity among the state's districts that one needs to examine what the progress in them has been. Unfortunately, the various sources available in the public domain does not give district level data for malnutrition indicators but DLHS does give district-wise information on practices relevant to nutrition such as breastfeeding, vitamin A provision, etc. and hence one can use them as proxy indicators for nutritional status with caveats as applicable.

Breastfeeding within one hour of birth as recommended by child nutrition experts is practiced by less than half the mothers in the state, with the range of a low of a quarter in Gadag to a high of almost 70% in Dakshina Kannada district [DLHS-,RCH 2007-08]. The trend from 1990 to 2005, according to NFHS survey is an upward one which is good news. [NFHS did not give district-wise data till 2015-16] but provides urban-rural breakups as well as by level of mothers' education]. Direct comparison of data from any two different sources is not valid; and the state figures in these cases can be very different. Still keeping this caveat in mind, the general scenario can be gauged].

Exclusive breastfeeding, according to NFHS 3, is less than 60% and the urban rate [54] is lower than the rural [60]. But according to DLHS-RCH, it is only 36%, with Bangalore Urban at only 19 while Bagalkote is at 62.

Continued breastfeeding with complementary other foods from 6 months to 2 years is almost universal in many districts of the state, and thus the average is also so. The impact of this good practice will probably manifest itself in some years. Overall, though, there is obviously a lot of headway to safeguard the newborn, infant and toddler. The concept of the first thousand days beginning with conception to the 2nd birthday of the child as being the most crucial for the child has to be taken very seriously at all stages of planning and programming.

Concerned NGOs have been lamenting the lack of strong media streaming of key messages and expert as well as homey counseling on child, maternal and adolescent girls' nutrition matters. However, there is a welcome change on both TV and radio of late, with shorts on breastfeeding within one hour of birth, exclusive breastfeeding, ways of avoiding iron-deficiency anaemia, etc. Hopefully, this is not a one-off campaign; as such messages are rarely absorbed and acted upon in the short run.

GOAL 2 : Achieve Universal Primary Education

India has chosen three indicators for this goal:

Net Enrolment Ratio [NER]; The proportion of children starting grade 1 that reach grade 5; and the literacy rate of 15-24 year olds.

The estimates of NER in Primary Education as revealed by the District Information System on Education (DISE) data show that it has improved from 83% in the year 2000 to over 99.89% in 2010-11 for the country as a whole.

The DISE data further shows the country has achieved cent percent or more GER [gross enrolment ratio] for children in the primary schooling age of 6-10 years ahead of

2015.

The Karnataka position mirrors the national picture very closely, but what is surprising is that Kerala shows a much lower rate of enrolment increase in each of the last three years for which data are given. A possibly higher enrolment of underage or overage children there could explain this strange phenomenon partially, but even the GER in that state is much lower than in the other South Indian states. A certain amount of lack of data from private schools, unevenness of out of school surveys, inflation of enrolment to bolster demands for funds and staff, etc. are all known confounding factors. The reliability of the data in the various states and in the country as a whole is itself clouded in doubt due to such unexpected patterns.

The proportion of children entering Grade 1 who reach Grade 5 nationally was 87% in 2011-12, up from 76% in 2008-09, and in Karnataka it was 94% in 2011-12, up from 89% in 2008-09.

What is evident to the naked eye in any urban or rural area is the considerable number of children out of school on any given school day, whether among migrant children in urban areas, or those from agricultural families. Child labour in garages and agricultural fields, or mining and cash crop areas is still rampant.

The 2012 ASER report on the state gives the out of school rate as just under 2 % for the mandatory 6-14 age group. The definition of dropout allows a lot of leeway for counting a child absent upto 6 months as an attendee and so this loophole might account for such low out of school numbers (The state has apparently recently revised the definition to include those absent for more than a few days – so, perhaps, dropout data hereafter will reflect this). Further, while the reported dropout rate is less than 1% in the 7-10 year age group, it goes up to over 3% in the 11-14 age group, with the rates being higher for girls than for boys in both age groups

Absenteeism is a major impediment to realising the full potential of schooling. ASER has recorded observed attendance of both students and teachers on days of the visit of its investigators and found it be a gratifying 89% of students and 94% of teachers of primary school classes and 83% and 88% respectively of the entire elementary level classes. However, this may not give the full picture as it is known that children may turn up for the first part of the day when the attendance is marked and then absent themselves for either the rest of the day, or turn up around the mid-day mealtime. Either way, they lose out on part of the lessons.

The MDG report gives the progress on youth literacy rather than adult literacy, and this indicator is expected to reach its target of 100% by 2015, with the 2001 Census showing 76% and NSSO [2007-8] 86%. The male-female and the urban-rural gaps are narrowing too. Karnataka is among the states that perform better than the country as a whole, but only slightly so.

Table 7.3: GER and NER in South Indian States

	GER			NER		
States	Boys	Girls	Total	2008-09	2008-10	2010-2011
Andhra Pradesh	99.68	99.38	99.53	79.39	71.99	99.85
Karnataka	105.22	104.12	104.53	98.61	99.23	99.85
Kerala	91.38	91.48	91.43	65.28	65.48	66.33
Tamil Nadu	111.01	112.56	111.76	99.38	99.15	98.15
Puducherry	104.02	102.27	103.57	5.19	86.7	85.98
India	**115.33**	**116.69**	**116.01**	**98.59**	**98.28**	**99.89**

(Source: MDG progress report 2013, GoI)

There are a number of other factors that make for a good education, however that is defined. The norms prescribed by the RTE Act seem not to have been fully attained by Karnataka – for example, usable toilets in general are found only in 60% of schools and girls' toilets in 54%. The lack of an usable toilet is known to be a major factor in dropping out of girls especially as they reach puberty [upper primary or middle school level age].

Beyond the classroom, it is noted that library books were being used by children only in 55% cases. Similar observations about computers, the condition of playgrounds, ramps for physically challenged children, are not recorded in the report.

As for minimum learning achievements, ASER 2012 found that even in standard 5, only about less than half the students in rural Karnataka could read a 2nd standard text, and another quarter could manage a 1st standard text, while the rest [over a quarter] could not manage even that. The proportions rose to three quarters in standard 7 for ability to manage a 2nd standard text and nearly 14% to manage at least a 1st standard one.

Interestingly the rates for private schools are not much better over the last few years than for government schools; nor do those students who are tutored privately vastly outrank those who are not. Sadly, the trends over time are not inspiring.

Further, only 20% in the 5th standard could manage subtraction and 20% more could also divide, while the remaining 40% could not do neither. By standard 8,these first two proportions had climbed to 30 and 50.

Private school students fare much better in arithmetic than government school ones. Otherwise the patterns are the same as for reading.

It is a pity that no MDGs were set for such indicators that give a more rounded assessment of learning achievement and school and student performance than mere enrolment as looking at them clearly brings out the gap between the spirit of the goal and the situation on the ground

Goal 3: Promote Gender Equality and Empower Women

Gender Parity Index 2011-12

Assessment of the progress towards this goal is again hampered by the choice of a few indicators and lack of many other key indicators, such as related to health, protection and participation in many areas that affect women.

The first indicator chosen for this MDG goal is gender parity in schools in which aspect, Karnataka has an almost perfect score, bettering even Kerala's average for classes 1 to 10.

Table 7.4: Gender Parity in School Enrolment

States	I-V	I-X	I-XII
Andhra Pradesh	1	1	0.99
Karnataka	0.99	1	1
Kerala	1	0.98	1
Tamil Nadu	1.01	1.01	1.02
Puducherry	0.98	0.96	0.98
India	**1.01**	0.97	**0.96**

The other indicators do not concern children, but it seems that female participation in wage employment has gone down in the final of three years under review in Karnataka as well as a few other states. This is a negative trend. The proportion of women in Parliament has barely risen in the past 12 years, from less than 10% in 1991 to over 11% in 2013. The state MDG reports should give the ratios in the state legislature.

Table: 7.5: % Share of Females in Wage Employment

States	2004-05	2009-10	2010-11
Andhra Pradesh	23.5	23.1	22.9
Karnataka	20.9	22.6	20.9
Kerala	27.4	29.3	30.8
Tamil Nadu	25	25.6	32.5
Puducherry	20.6	24	24
India	**18.6**	**18.6**	**19.3**

Goal 4: REDUCE CHILD MORTALITY

- **Reduce by two thirds, between 1990 and 2015, the under-five mortality rate**

Table 7.6: U5 Mortality in South Indian States

States	1990	Likely achievement 2015	Target 2015
Andhra Pradesh	100	40	33
Karnataka	94	36	31
Kerala	33	11	11
Tamil Nadu	97	20	34
Puducherry	NA	NA	NA
India	**125**	**49**	**42**

Both A.P. And Karnataka, as also the country as a whole, are likely to miss hitting the target for reduction of under-five mortality in Goal 4 as per the latest official progress report, while T.N. and Kerala will meet or even exceed it.

As for reduction of infant mortality, only T.N. will make it among the southern states.

Thus Karnataka, like India, will fall short with reference to these key indicators among the MDGs.

Other causes for concern are that U5MR is higher for female than male children in all states, and there is also a large gap between rural and urban areas.

Fig 7.5: U5MR Likely achievement vis-à-vis target 2015

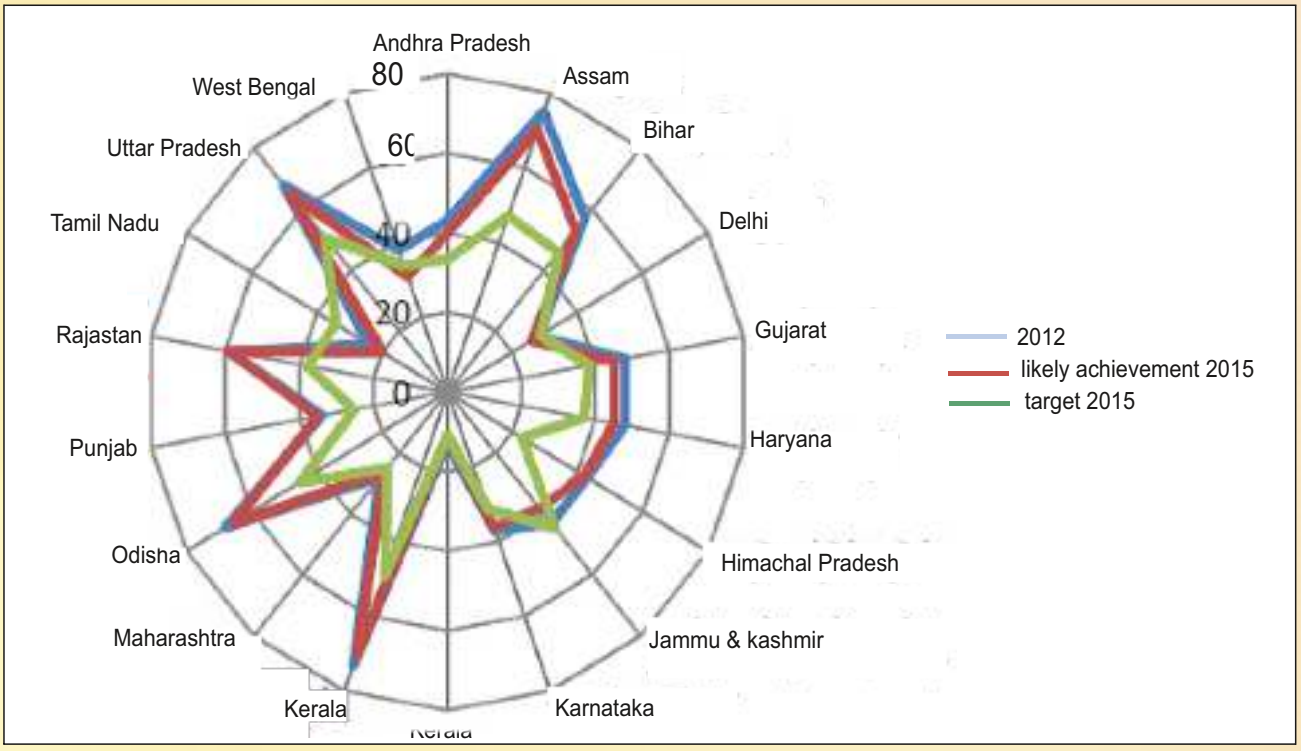
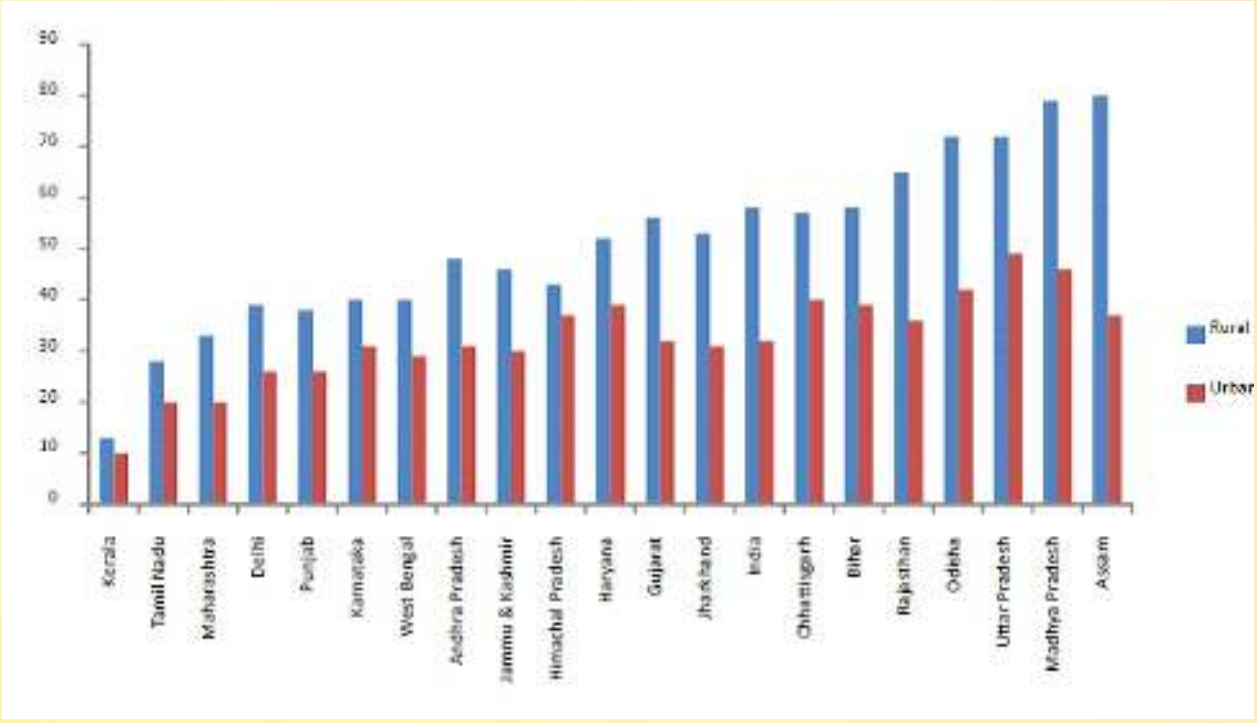


Fig 7.6: U5MR by place of residence -2012



Infant Mortality Rate: The MDGs do not have a target for IMR in addition to U5MR, but India added it, which is a good move as most child mortality occurs within the first year of life.

Table 7.7: Infant Mortality in South Indian States

States	1990	Likely achievement 2015	Target 2015
Andhra Pradesh	70	41	23
Karnataka	64	31	23
Kerala	13	11	5
Tamil Nadu	61	19	20
Puducherry	NA	NA	NA
India	**81**	**40**	**27**

These trends are based on the 2013 SRS [Sample Registration Survey] results which also show that rural area decline in IMR is more than urban decline. Also, IMR of males [30] is lower than that of females [32] and this difference is slightly more in urban areas [22 and 26] respectively] than rural ones [33 and 35] [The Hindu, 2014 d].

Fig 7.7 also shows the fertility trends and the progress towards demographic transition in each major state.- Karnataka has already achieved it [1.9 live births per woman, as against the required 2.1] while India can do so by 2020.

Earlier data from the Karnataka Human Development report [KHDR] of 2005 shows the wide disparities among districts, with Dharwad having the highest IMR of 67 and Dakshin Kannada having the lowest [and 16 districts being higher than the state average of 55 while 11 of them went above 60].

It is known from NFHS 3 [2005-06], Karnataka report that out of 55 deaths among every 1,000 live births that occurred before the age of 5 years, the bulk 29-occurred within the first month of life (neonatal mortality), and 43 in the first year of life (infant mortality). Further, ENNMR or early neonatal mortality rate [deaths in the first week] was 60% of IMR, as per KHDR '05. With the reported fall in IMR, it would be useful to know if this problem has been cracked open and has been a key cause in this fall. In any case, the focus should continue to be on such issues to enhance the first right of every child. Notably the decline has been steeper in rural areas than in urban ones, indicating perhaps improvements in either rural services or awareness or living standards or combinations

of these. As for gender disparities, female IMR declined from 81 to 44 [45.7%] from 1990 to 2012, while male IMR declined slightly more, from 78 to 41 [47.4%].

Measles India has taken into consideration other health indicators such as measles immunization that help in tackling infant and child mortality and morbidity; this is an important subsidiary indicator of U5 Mortality.

Fig 7.7: Fertility trends in India

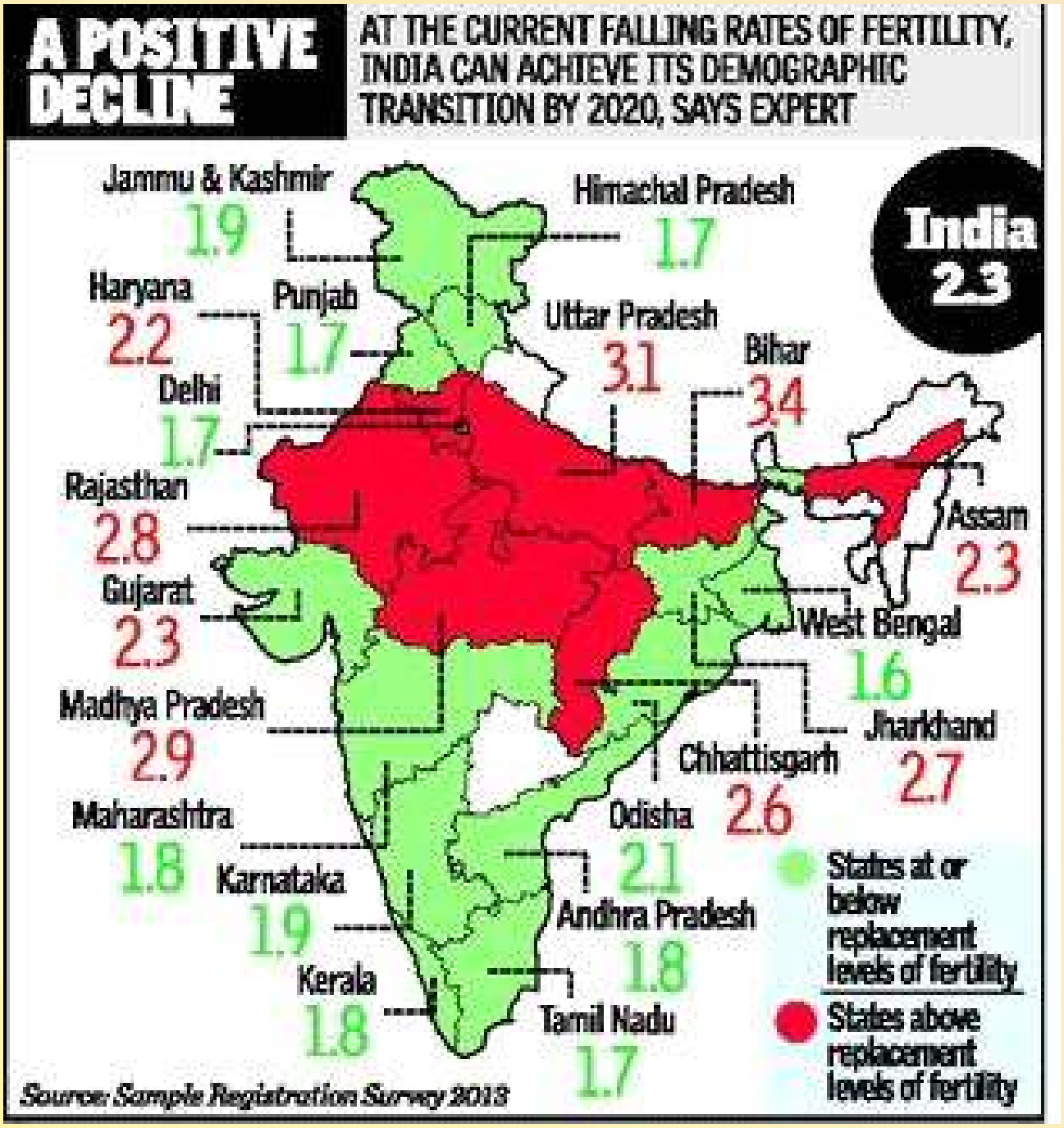


Table 7.8: Percentage of one year old children immunized against Measles

States	1992-93	Likely achievement 2015	Target 2015
Andhra Pradesh	53.7	100	100
Karnataka	54.9	100	100
Kerala	60.5	100	100
Tamil Nadu	71.5	100	100
Puducherry	N.A.	100	100
India	**42.2**	**89.06**	**100**

As table 7.8 shows, the estimated cent per cent coverage of measles immunization in all the South is very impressive but what about other important challenges posed by various sources of child mortality and morbidity – especially Diarrhoea and ARI? While their incidence is difficult to measure, they are not impossible to estimate and both NFHS and DLHS have shown that the recommended therapy of the former, ORS, is given only in 31-41% cases, though the majority of children who suffered from a bout of diarrhoea are taken to a health facility at some point. Whether this is a good practice or not depends on the timing of the visit, the therapies such as ORT [giving any form of ORS] used at home before visiting the health facility and the diet of the child while ill.

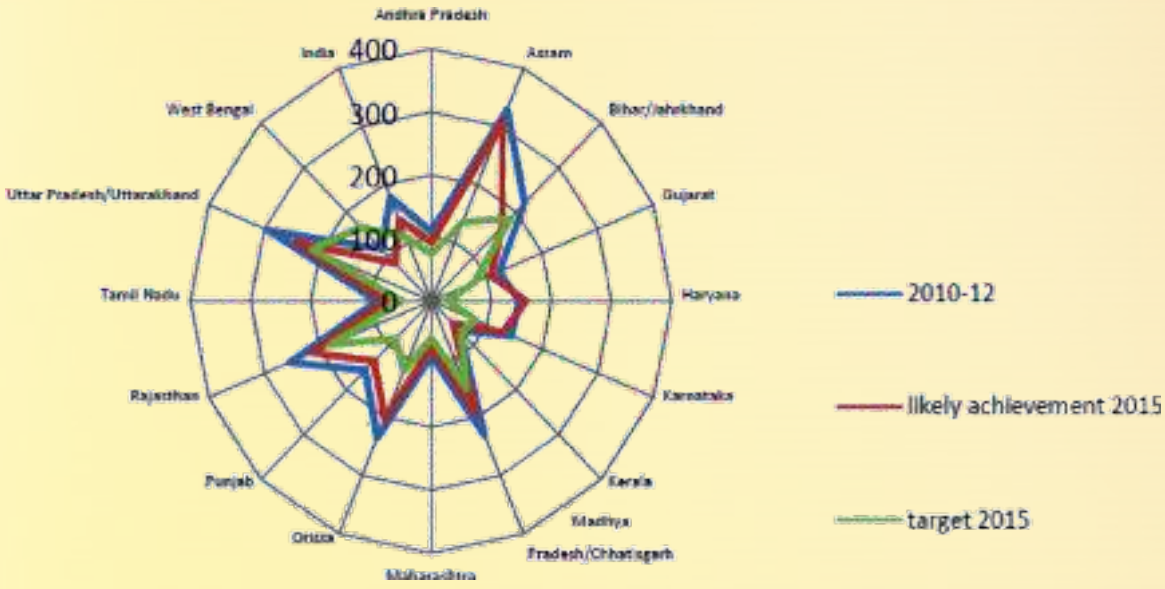
A healthy and well-nourished pregnant woman, right delivery, breastfeeding and weaning practices are other key prerequisites for lowering infant mortality and should be measured. Breastfeeding practices have been discussed above, while the poor health and nutritional status of women and safe deliveries are looked into below. None of these are satisfactory. Thus, as in the case of malnutrition, child/infant mortality and morbidity are affected by multiple factors that are found wanting in the state, as in the country as a whole, with wide disparities among districts.

Goal 5: Improve Maternal Health
Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
Table 7.9: MMR in South Indian States

States	1990	Likely achievement 2015	Target 2015
Andhra Pradesh	298	93	74
Karnataka	316	129	79
Kerala	279	50	70
Tamil Nadu	197	76	49
Puducherry	NA	NA	NA
India	**437**	**140**	**109**

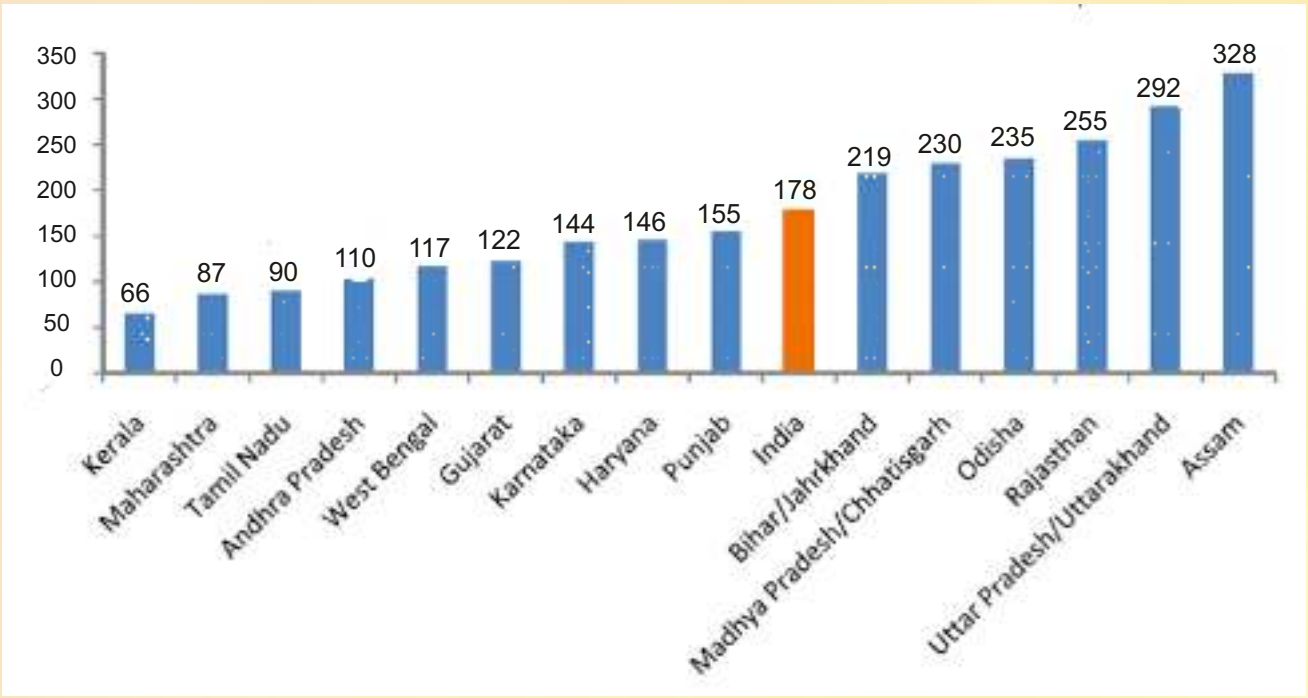
India has recorded a 59% decline in MMR in the past 22 years since 1990. Yet, it is almost definitely likely to miss the MDG target of 2/3 reduction. Only Kerala among the South Indian states is likely to achieve [and even whizz past the MDG target for maternal mortality. Karnataka will reach less than 2/3 of its target of 129 maternal deaths per one lakh live deliveries as against a target of 79, rather similar to India that will reach only 140 as against the required 109. Thus, it is among the middle-level performing states.

Fig 7.8: MMR Current status, likely achievement vis-à-vis target 2015



Data shows that the age group 20-24 years recorded the highest percentage of maternal deaths [39%] in the period while previously; it was the next age group, 25-29 years.

Fig 7.9: Maternal Mortality Ratio 2010-12



· Achieve, by 2015, universal access to reproductive health – Safe delivery is important for both reduction of infant as well as maternal mortality. The national figures leapt from 48% to 76 % from 2002-2003 to 2009 [the surveys were different though]. Further increases are expected to be marginal due to shortage of trained personnel.

Table 7.10: Percent of deliveries assisted by skilled health professionals (%)

States	1992-93	Likely achievement 2015	Target 2015
Andhra Pradesh	48.9	100	100
Karnataka	46.6	97.81	100
Kerala	90.2	100	100
Tamil Nadu	69.3	100	100
Puducherry	NA	NA	NA
India	**33**	**77.79**	**100**

It is strange that only Karnataka among the southern states will fall short of achieving cent per cent coverage of safe delivery, when A.P. that was just a bit above it earlier will do so. However, while DLHS 2002-03 revealed that only half the deliveries in the state were safe, with the levels being lower in Uttara Karnataka, the welcome trend is that this rate rose to more than 2/3 by 2007-08. If the trend continues, the state may well approach close to the target. Still, it is worrisome that almost half the districts, predominantly in the north of the state, are below the state average. The status of some key indicators that underpin maternal health has improved over the years nationally, but there are still some yawning gaps, especially in full ANC and consumption of IFA tablets.

Once again, the question is whether we should not be looking at certain other important indicators, for example the average BMI of adult women, which as mentioned above, is below normal in Karnataka. Half the women in the reproductive age group and 60% among pregnant women were anaemic in 2005-06 according to NFHS; more alarming still, this proportion has risen from 42% and 49% respectively in 1998-99! Whether other health problems of women have been largely alleviated also are issues. Hence, unless these trends in women's poor health and nutrition are halted, rather reversed, the goal of attaining reductions in maternal mortality may not be achieved and not be really meaningful for either maternal or child well-being.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

The prevalence of HIV/AIDS in the country's population declined from 0.45% in 2002 to 0.27% in 2011. While the rate was higher among males [0.32%] than females [0.22%], the picture among states is diverse, with some high prevalence states having notable declines but some other low prevalence states experiencing increases. Karnataka had the fifth highest level of prevalence at 52% [double the national level]. The prevalence among youth [15-24 years] was 0.11% in 2011 among both males and females. Information on estimated deaths from AIDS reveals that children account for 7% of them. The total mortality was high in 2011, and next only to A.P. On the other hand, the number living with HIV/AIDS, which has recently shown a slight decline, is segregated between adults and children. Out of 21 million PLHIV [people living with HIV], 7% were children. New HIV infections declined from 2.96 lakhs in 2000 to 2.74 lakhs in 2011, of which infections among children accounted for 0.22 and 0.16 lakhs respectively. Karnataka is once again amongst the high prevalence states. For this indicator too, the state has the second highest number in the south, after A.P.; and far higher than the next state, T.N. There is no benchmark figure for 1990 or any year soon after that date so no trends can be observed.

The state's population and child population are both less than in TN, yet incidence of both HIV/AIDS deaths and PLHIV are higher than in that state. This is worth looking into.

Table 7.11: Estimated deaths from AIDS, 2011

States	Estimated deaths from AIDS 2011
Andhra Pradesh	31347
Karnataka	12514
Kerala	1738
Tamil Nadu	8582
Puducherry	24
India	147729

Table 7.12: No. of people living with HIV/AIDS – 2013

	Adult	Children	Total
Andhra Pradesh	125979	5996	135575
Karnataka	86874	5902	92776
Kerala	7531	399	7930
Tamil Nadu	65759	3454	69213
Puducherry	NA	NA	NA
India	597052	35345	632397

Malaria

Child mortality and morbidity due to malaria must surely be an important issue, but again no breakup between children and adults is available. For the population as a whole, the state is midway among the South Indian states and the only one reporting any deaths, albeit a very small number. With data only from a recent year, trends and extrapolation is not feasible on this indicator too.

The report does not give any figures about T.B.

Table 7.13: Malaria cases and deaths – 2013

	Malaria cases reported	Deaths
Andhra Pradesh	13351	0
Karnataka	10170	5
Kerala	1370	0
Tamil Nadu	13075	0
Puducherry	103	0
India	693006	285

Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Table 7.14: Percent of households with access to improved drinking water

States	2008-09		2012	
	Rural	Urban	Rural	Urban
Andhra Pradesh	92.5	89.1	91.9	97.5
Karnataka	95.1	96.9	95.1	96
Kerala	69.8	82.3	29.5	56.8
Tamil Nadu	96.8	89.2	94	95
Puducherry	100	96.5	100	95.3
India	90.4	93.9	88.5	95.3

Tables 7.14 and 7.15 reproduced here from the government report do not give the baseline [1990] data on either drinking water or sanitation but data from other sources show that India's improved drinking water coverage was only almost 70% in 1990 and by 2010 had climbed to over 90%, tap water being at 40% [Fazal, 2013]. Coverage in the state has basically hovered near the cent per cent mark in both urban and rural areas and has been stagnant between 2008-09 and 2012.

However, the KRWSSA report of 2006 acknowledges that access alone is not the answer as it finds a number of serious water quality problems in almost the entire state [fluoride, arsenic, etc.].

Another important issue is that 'Access' can be interpreted in various ways from just the physical location and distance from a household to consideration additionally of frequency, amount, social barriers, etc. These aspects are difficult to measure but nonetheless must be taken into account.

Table 7.15: Percent of households with access to improved sanitation

States	2008-09		2012	
	Rural	Urban	Rural	Urban
Andhra Pradesh	34.2	86.8	44.5	91
Karnataka	23.7	86.4	28.4	87.7
Kerala	93.4	97.2	96.9	98.8
Tamil Nadu	25.2	79.9	33	86.6
Puducherry	34.6	85.7	52.6	93.6
India	31.9	85.3	38.8	89.6

The Fazal paper shows that the national sanitation coverage rose from 18 to 34% in the same period. Karnataka was worse off than the national average in rural areas in 2008-09 and has even deteriorated in urban areas with respect to national coverage by 2012, with over 70% and 12% respectively not having a toilet on their premises.

Though sanitation coverage in a few districts of Karnataka is over 80 per cent, in many districts of North Karnataka it is below 20 per cent [UNICEF, 2011].

Other environment indicators are not included among the MDG goals, which is a major drawback in view of their increasing importance, especially for children. For example, the air quality in Indian cities has recently acquired notoriety for shaving off a few years from one's life but what has been ignored for years is its increasing deleterious impact on child health with increases in asthma and other respiratory diseases.

Conclusions

A rapid summary of the Indian and Karnataka situation/progress in aiming for the MDGs reveals a mixed scenario. A number of the targets are likely to be met by end 2015, with some having been already achieved as both the MDG report itself and RSOC data indicate but there are some significant ones that are not and for almost all of them, there are disparities, caveats on the measures, or disturbing trends.

Table 7.16 is a summary of the main points of this clouded picture.

Item	Likely Achievement by 2015 vs. Goal – India & Karnataka	Remarks
I.1a: Halve Proportion of Poor	·**On Track:** India – 21 vs. 24 % State – 18 vs. 28%	Definitions &methodologies tweaked; prevalence of r-u, regional &group disparities,chronic poverty; share of consumption of poorest quintile less than half fair level; etc
I.1b: Full &productive Employment	N.A	N.A
I.1c: Halve proportion of hungry	Slow or off-track [1] Calorie intake declined by 6% from 93-94 to 09-10; rural intake 2099 kcals, urban 2058 vs Planning Commission norm of 2400. [2] Underweight <3 years - State: 26 vs 24%; India: 33 Vs 26 % (RSOC results- State-25-30; India-29%) Stunting: State-42-35%; India 48-39%)	[1] Recently, India has slightly improved its rank in Global Hunger Index. But problems exist in the details, e.g., low BMI among women and even men. [2] Even if State makes huge strides to achieve goal, underweight is only one, though a key, indicator of malnourishment. State has 80%+ anaemic children &50%+ anaemic women; problems like low birthweight, poor breastfeeding &weaning practices, worsening stunting causes for concern. Some key reasons given for improvement in nutritional status of the population and of children in particular are the various social programmes and benefits that have recently been implemented and/or improved, but the latest budget and trends in programme restrictions will have the opposite effect and thus nullify or even reverse the gains made with such difficulty.
MDG 2 on track -Target 3: 100% completion primary schooling – 100% NER; all entrants in grade 1 reaching grade 5; % literate 15-24 year olds.	1- NER 100% 2- GER 100% 3 -Literacy: 100% General literacy rate: T=75.36, M=82.47, F=66.01	Target 3 is measured by the second indicator rather than the first, but in any case the State has around cent per cent enrolment already. It has also nearly full completion of primary

Item	Likely Achievement by 2015 vs.Goal– India & Karnataka	Remarks
MDG 6: Combat HIV/AIDS, Malaria etc. target 7:halt &reverse HIV trend	On track	
% HIV prevalence -w 15-24 yrs	Decline from 0.31 in '08 to 0.27% in '11; 0.62 to 0.52% youth – 0.11% [state]	Karnataka is among the states with higher prevalence rates and hence further declines must be sought.
MDG 7 -Ensure environmental sustainability		
Target 9: sustainable development policies & programmes; reverse losses to environment	Moderately on track	Unclear how this statement can be made, with rapid increases in deforestation, water shortages, air pollution in urban areas, etc. Many policies detrimental to sustainable development and a good environment are being promulgated also.
Target 10: Halve % without safe d. water &basic sanitation	On track for water; slow for sanitation	
% HH with d. water access - 94 u; 79 r	98 u; 96 r; 96 u; 95 r	Access is not the only issue. Poor quality whether high bacterial content or fluoride, arsenic, iron, etc.; irregularity and infrequent availability – there are manifold problems that plague the state as well as India.
% HH without sanitation -16 u; 47 r	10 u; 61 r; 12 u; 72 r	Surprising that state is worse off than the country. Reasons need to be investigated and used to tackle different problems with specific solutions each.

Item	Likely Achievement by 2015 vs. Goal – India & Karnataka	Remarks
		school of those entire enrolled in grade 1, but one needs to bear in mind that primary schools are typically in the vicinity of a child's home and that there is a "no fail" policy till class 8 in the state. Another point is that absentees were not counted as such or included among dropouts even if absent for 89 days – thus a number of dropouts were missed out. Other issues such as being present only at mid-day mealtime, fudging of records also vitiate the data. What is clear is the steep decline in enrollment in grade 6, due to distance, the pull of alternative options for older children – work, marriage, etc.
MDG 3: Gender Parity	on-track	This goal seems achievable, if not already achieved, for the educational targets.
Ratio g to b in primary education -1	1 [both country and state]	
Ratio g to b in secondary education -1	No information re country; state = 1	
Ratio g to b in tertiary education -1	ditto	
F: m literacy ratio 15-24 yr olds	1[for youth literacy] – India and state	
50% Share of wage non-agricultural employment	23 % [India] state – no information	This has been included in this note only to indicate the future options that girls might have.
MDG 4 – Reduce Child mortality; target 5: reduce by 2/3	moderately on track. [figures below are for India first; state next]	Unclear how it can be said India is on track to achieve this MDG. Even the latest data that the Rapid Action Survey has thrown up do not indicate good enough progress on infant or child mortality.
U5MR -42; 31	49;36	Karnataka mirrors the national situation in lagging behind this target. District disparities and between males and females are worrying.

IMR – 27; 23	40; 31	ditto
Measles Immunization 100%	89; 100	This is a good showing for the state. It will imply continuous drives to persuade parents to bring their 9 + month old children, especially girls, for vaccination. Lack of attention to targets and progress in diarrhoeal disease and ARI reduction must be deplored, as they are major causes of young child morbidity and mortality.
MDG 5 -Improve Maternal Health; target 6: reduce MMR by 2/3	Slow or off-track	Despite large gains made over recent decades, this is a serious shortcoming. Need to be addressed.
MMR – 109; 79	140;129	Apart from reasons often cited of problems during ANC, delivery and PNC, the deplorable health and nutrition status of adolescent girls and women, early marriages and pregnancies, lack of rest during pregnancy, short birth intervals, etc.
Births with skilled attendants – 100%	78; 98	Unclear why the state cannot achieve 100% births with skilled assistance.
MDG 6: Combat HIV/AIDS, Malaria etc. target 7:halt & reverse HIV trend	On track	
% HIV prevalence -w 15-24 yrs	Decline from 0.31 in '08 to 0.27% in '11; 0.62 to 0.52% youth – 0.11% [state]	Karnataka is among the states with higher prevalence rates and hence further declines must be sought.
MDG 7 -Ensure environmental sustainability		
Target 9: sustainable development policies & programmes; reverse losses to environment	Moderately on track	Unclear how this statement can be made, with rapid increases in deforestation, water shortages, air pollution in urban areas, etc. Many policies detrimental to sustainable development and a good environment are being promulgated also.

Target 10: Halve % without safe d. water &basic sanitation	On track for water; slow for sanitation	
% HH with d. water access - 94 u; 79 r	98 u; 96 r; 96 u; 95 r	Access is not the only issue. Poor quality whether high bacterial content or fluoride, arsenic, iron, etc.; irregularity and infrequent availability – there are manifold problems that plague the state as well as India.
% HH without sanitation -16 u; 47 r	10 u; 61 r; 12 u; 72 r	Surprising that state is worse off than the country. Reasons need to be investigated and used to tackle different problems with specific solutions each.

Overall, one can conclude that Karnataka does not fare as well as it should, given its development image, in attempts to reach key goals for children that are included either among the MDGs or needed to achieve them. Even where the extrapolations seem to veer towards an overall state achievement, the disparities among its districts and between rural and urban areas do not augur well for such achievement in most of them. The MDGs are not perfect or sacrosanct in the effort to achieve child rights, but they offer useful yardsticks en route to that goal. Both the government and civil society need to take off from where the MDGs stop and ask searching questions as to why the goals are still so distant in many cases and how they may be quickly achieved and sustained.

In some cases such as nutrition, remedies are directed rather too late in the process or as single blitzkrieg type of strategies when a multi-pronged sustained approach is needed. In others, such as safe drinking water, quality and true sustained access is not given adequate importance. In all, IEC is running mostly on tired old lines, and is afforded far less budget and attention than it needs. Creating awareness and through it a robust demand and response system that is geared to the specific local problem configuration are needed rather than the present one strategy-fits-all approach.

Resource Constraints, be it in financial allocations or personnel, or in materials and equipment, both initially and as replacements and improvements, are often to blame. The

role of the many social policies, laws and schemes in impacting on children's welfare and development is seen in those directly concerning children like ICDS, RCH, RTE, ECCD, ICPS or NRHM but that of the ones more indirectly impinging on them such as the NFS act; MGNREGA; Indira Awas Yojana; NRLM and NULM, to name some, is not fully appreciated. There has been a tendency to cut budgets or slash some aspects in many of these. That these moves come in the way of the smooth development of children who are the nation's supreme assets, and are a denial of their own human rights, is a very sorry commentary on the country, its political and social mores.

Truly, if one looks at the child holistically, and her/his needs at each stage of the life cycle, a systematic strategy can be devised and accordingly, programmes and budgets to deliver all the rights of every child in the state. Such a strategy must be non-negotiable. When will it be so? Will it ever be so – that is a question we are answerable to, the powers that be more than the rest but in even a small measure, each of us.

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1. Since this paper was written, MDGs have given way to SDGs or sustainable Goals for Development]. However the paper sticks to the discussion on MDGs, with an addendum on SDGs as there is still very nominal progress on them, and no study or report on attainments towards their goals.

   Similarly though new data have become available, they have not been used in the text to update figures as this is end of a specific period, whose data can further be used as benchmarks for the SDG progress.

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8

SEX RATIO IN KARNATAKA

- Satish G.C.

Ever since the first census of India started in 1881, revealing that India's sex ratio [or the number of females to every thousand males] was as low as 953, the issue of sex ratio has been a very important concern and matter of discussion. Many policies and programs have been implemented to improve the ratio, but even after many decades, it's very disappointing that the desired result has not been achieved. This report discusses the issue of sex ratio in Karnataka. All the data used for this analysis in the report is as per 2011 census. The detailed analysis of the facts, reasons for this statistics and possible solutions are not discussed here, however' it is left to the discretion of the society, policy makers, sociologists etc.,

The sex ratio of a community or population indicates the status of women in it; and it also depends on various factors like the educational, economical, social and cultural scenario of that particular place.

Sex ratio varies from state to state and district to district. It also varies across the different age groups and different communities. So along with the overall sex ratio, different aspects of sex ratio like sex ratio among children, in different districts, in different age groups are discussed here. The sex ratio in different age groups is really alarming.

2011 population of Karnataka

As per details from Census 2011, Karnataka has a population of 6.10 Crores, an increase from the figure of 5.05 Crore in the 2001 census. Total population of Karnataka as per 2011 census is 61,095,297 of which male and female are 30,966,657 and 30,128,640 respectively. In 2001, total population was 52,850,562 in which males were 26,898,918 while females were 25,951,644. The total population growth in this decade was 15.60 percent while in previous decade it was 17.25 percent. The population of Karnataka forms 5.05 percent of India in 2011. In 2001, the figure was 5.14 percent.

Out of the total population of the state, 16 percent of the people live in the capital city Bangalore, which is also the largest city in the state; less than 1% of the total population is in Coorg district; except Coorg and Chamarajanagar districts, there are more than 10 lakh people living in every district of the state. During the last decade, there is a considerable rise in the population in all the districts except Chikkamagaluru district.

Of the total population of Karnataka state, around 61 % live in the rural areas and 39% in the urban areas. Considering the fact that the rural population was 65% and urban population was 35% in 2001, it's evident that, there is a rise in the population of the people living in the urban region in the last decade.

Similarly, 17 percent of the total population comprises of people belonging to schedule caste (rural=20%: urban=13%) and 7% belonging to schedule tribe (rural=9.1%; urban=3.5%). Bellary district alone has about 11% of people belonging to schedule caste.

General Sex Ratio:

The Sex Ratio in Karnataka is 973 for 1000 males as per the 2011 census, and has increased since the last census of 2001 in which it was 965 per 1000 males and in 1991 it was 960 per 1000 males.

Table 8.1: Decadal Sex Ratio

	2001	2011	Increase
Total	973	965	8
Rural	979	977	2
Urban	963	942	21

However, though the State Government has taken up several initiatives, the increase in sex ratio is very minimal. There are many reasons for these sex ratios. There is an argument that there is a high death rate among women due to the inaccessibility to health and nutrition in a society where men get the more prominence. However, if we consider the statistics of the state, the death rate among men is more than the death among women. Similarly, it's a known fact that there are lots of men who migrate to cities in search of jobs and education and live alone. In such cases, there would be a huge difference in the percentage of men to women in cities like Bangalore.

If we consider some of the districts, there are more women than men in districts like Udupi (1094), Dakshina Kannada (1020) and Hassan (1019) whereas we find the completely opposite scenario in Bangalore urban (916); Bangalore rural (946) and Haveri (950). In 9 districts, the sex ratio is lesser than the average sex ratio of the state. We find that some districts with high literacy rate have good sex ratio but there are a few exceptions like Bangalore, Dharwad etc. Similarly, Raichur district which has a low literacy rate has comparatively good sex ratio (983)

The statistics in the Karnataka Census 2011 reveal that the state is improving well with respect to the sex ratio compared to the data in the census done in 2001, like Chikmagalur (+24); Coorg (+23); Chamarajnagar (+22); Dharwad (+22); Mysore (+21); and Dhavangere (+21) The sex ratios in the scheduled caste and scheduled tribe groups are better than the average sex ratio of the state. This is in contrast to the literacy rate scenario, where the literacy rates of the scheduled caste and scheduled tribe are less than the average literacy rate of the state. The average literacy rate stands at 75, whereas the literacy rate of scheduled caste is 65 and the same of scheduled tribe is 62. Though the

female literacy rate is lower compared to the average rate and still holding a better sex ratio, it can be said that women are treated with importance in these communities.

Discrimination among children:

The UNCRC of 1989 (India ratified this international convention in 1992) and The National Child Policy 2013 define 'Child 'as a person below the age of 18 years.

Sex ratio in 0-6 age group:

Generally, 'The Primary' sex ratio is considered at the time of conception and 'The Secondary' sex ratio is taken as at birth. Usually latter is higher than former due to higher biological vulnerability of male foetuses, 3-37 per cent more male foetal deaths take place over female foetal deaths. The 'Tertiary' sex ratio what we have discussed here is very much influenced by physical, social and economical aspects.

According to WHO (World Health Organisation) if there is no human intervention in this natural process, for every 1000 females, there would be 1040-1070 males at birth. However as said above, due to various reasons the chances of death of the male foetus are more compared to the female. This is the reason why we hardly see any difference in the primary and secondary sex ratio (considering the still birth) but the gender discrimination and low status of women in our society has always influenced the sex ratio

Decadal 0-6 years sex ratio in Karnataka and India

Since the last few decades the sex ratio of the state in the age group of 0-6 is higher than the national sex ratio, but there has been a decline in the ratio for the state between 1961 and 2011 (by 39 percentage points), while on the whole there is a decrease of 62 in the national level. However the general sex ratio has gone up over the last few decades, there has been a marginal rise in the state during 2001-2011 in the general age group.

Table 8.2: 0-6 Age group Sex Ratio

Year	Karnataka	India
1961	987	976
1971	978	964
1981	974	962
1991	960	945
2001	946	927
2011	948	914

Comparison of sex ratio in 0-6 age group out of total population of Karnataka

It is clear that the child sex ratio is lower than the sex ratio as a whole. The primary reason considered for this is female infanticide. Many legislative measures have been taken up by government to overcome this, sex detection test is declared illegal in the year 1994 and the act was enforced throughout the country in the year 1996. Unfortunately even with these measures we don't find any significant improvement in the decreasing child sex ratio. It is also observed that, the cities and

Table 8.3: % of 0-6 population out of the total

	2001	2011
Total	13.59	11.72
Male	13.72	11.87
Female	13.45	11.57

Table 8.4: 0-6 Sex Ratio in the Rural –Urban areas

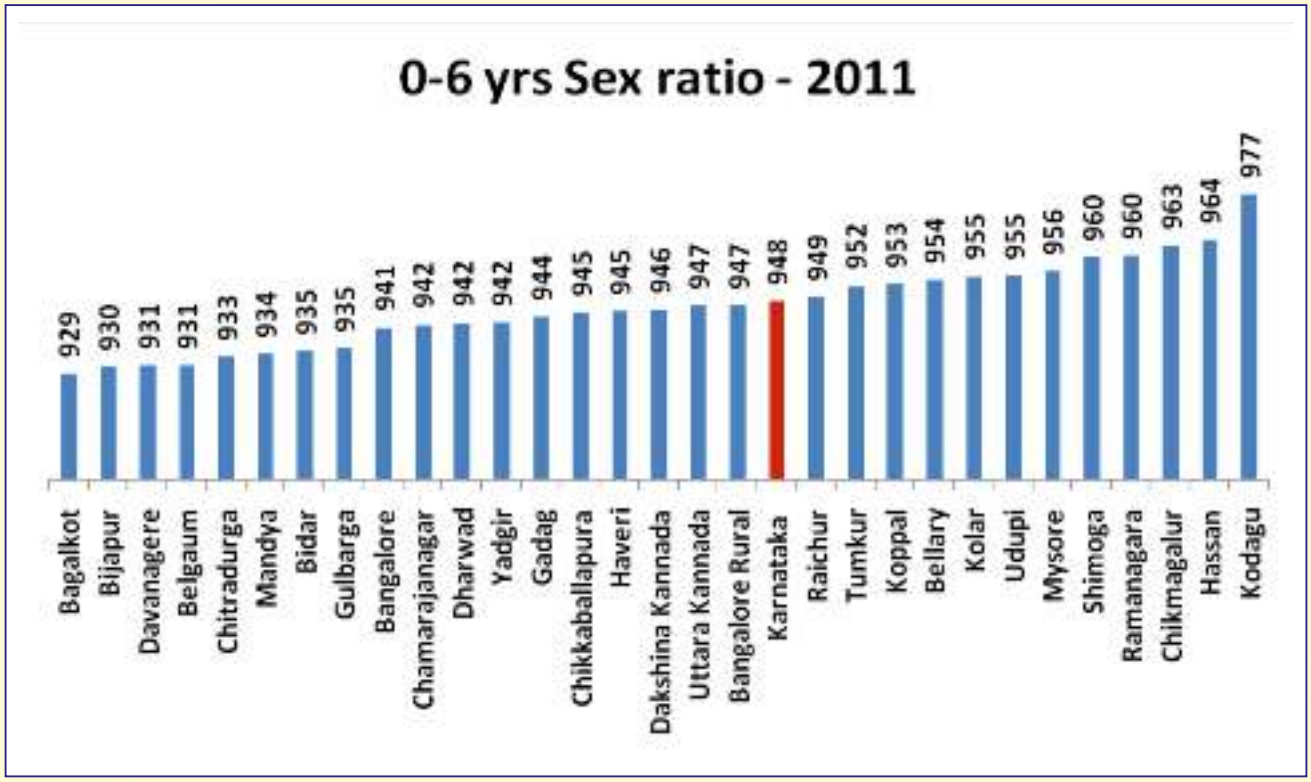
	2001	2011
Total	946	948
Male	949	950
Female	940	946

towns with higher literacy rates show a low sex ratio among children. The awareness of and accessibility to sex detection system in towns and cities has led to this problem. So, the child sex ratio is better in rural areas compared to urban areas (except last decade).

Out of the total population of the state, the percentage of children in the age group (0-6) is 11.72. This percentage was 13.59 in 2001. The number of female children has gone down compared to male children.

In the period from 2001 to 2011, the sex ratio among children in age group 0-6 has improved marginally. Interestingly the sex ratio in the 0-6 age group in increased more in urban areas when compared to rural areas. It can be assumed that the factors like improving literacy rate, government's policies towards women, initiatives like Bhagyalakshmi Yojana, intervention of non-government organizations have yielded fruit in the last decade.

Fig 8.1: District wise sex ratio



District wise Sex Ratio among children

If we look at the sex ratio in the age group of 0-6 in the districts, the highest sex ratios are found in Coorg (977), Hassan (964) and Chikkamagaluru (969). The lowest sex ratios are recorded in Bagalkot (929), Bijapur (930), Davanagere (931) and Chitradurga (933) districts. In 18 districts, the sex ratio in the age group 0-6 is lower than the average child sex ratio of the state (Fig 8.1).

Sex ratio in different age groups:

If we separate the children below the age 18 into different age groups, there are several things which come up. In rural areas, the sex ratio in the age groups 0-4 and 5-9 are higher than the average sex ratio in that age

group. However, in the age group 10-14 and even more strikingly in the 15-19 age group, the rural levels are less than the state average.

Table 8.5: Sex Ratio in Different Age Group

Age group	Total	Rural	Urban
0–4	954	955	952
5–9	944	946	939
10–14	941	938	946
15–19	915	891	957

Child marriage can be considered as one of the reasons for this low sex ratio in those two age groups and other reasons might be malnutrition, inadequate health facilities, dowry harassment, and/or premature motherhood.

If we consider the overall sex ratio of the state in comparison with the sex ratio in Scheduled Caste and Scheduled Tribe, in all age groups the sex ratio in these communities is better than the average sex ratio of the state, except in the age group of 15 – 19. As mentioned before, the factors like child marriage, death due to teenage pregnancy and malnutrition, lack of health facilities and human trafficking might be the reasons for this scenario. In other age groups it is higher may be because of lack of affordability of sex selection, less stress on son preference among them as girls too work in the fields and pastures etc.

Table 8.6: Sex Ratio in Different caste groups

Age group	Total	SC	ST
0–4	954	969	970
5–9	944	958	962
10–14	941	947	956
15–19	915	908	905

Though the state is improving in aspects of Education, Health, Literacy, Woman empowerment, these improvements are not reflected in the sex ratio among children. For example, Dakshina Kannada district which has a higher literacy rate records a low sex ratio in the age group 0 – 6compared to the average sex ratio of the state. Similarly, districts like Bellary and Koppal which have lower literacy rate, have recorded better children sex ratio compared to the average children sex ratio of the state. Though Human development can be based upon Education, Health, per head income, it is incomplete without an equal sex ratio. So sex ratio should be considered in the backdrop of changing social and economic progress.

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9

BIRTH REGISTRATION – STILL AWAITING TO TAKE ITS PLACE IN KARNATAKA

-Rashmi. G.M.

1. Introduction :

Every Child is born with Every Right to a name and identity, but there are numerous numbers of children who either do not have their births registered or have yet been given their names. Without birth registration children are more prone to be excluded from essential services such as education, health care and protection. India signed and ratified the UNCRC in the year 1992, through which the Govt. has committed to protect, realize children's rights, also has agreed and committed to hold itself accountable in front of the international community. The vulnerable and marginalised children whose births are not being registered are the ones who belong to the below poverty line (BPL) families, slum dwellers and the children of migrants who wander from one place to another very frequently without having any basic amenities. An unregistered child will be more attractive target either ***"Pushed or Pulled"*** for a child trafficker and does not have even the minimal protection that a birth certificate provides against child marriages, child labour, to prove whether he/she is a child / adult. In later life the unregistered child may be unable to apply for a passport or formal job, open a bank account and get a driving licence or a marriage certificate.

Article-7 of the 1989 United Nations Convention on the Rights of the Child (UNCRC)

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and. as far as possible, the right to know and be cared for by his or her parents.
2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

In India, an estimated 26 million children are born every year of which about 10 million go unregistered.
Source: UNICEF report -2010

According to the report released by UNICEF – 2010 it states that "The current registration level of births in India is about 58%. The state disparities in registration coverage (ranges from over 90% to under 30%). While some states like Kerala, Tamil Nadu and Gujarat have registration rates of over 90% others lag behind. The low performing states (Uttar Pradesh, Bihar, Rajasthan, Andra Pradesh and Madhya Pradesh) reports registration rates as low as 11%. These five states also

accounts for approximately one quarter of all children born every year in India".

The equity gap holds the mirror on the effective implementation of Acts and Laws at the grass-root level. Critical challenges and operative sustainability is one of the ways to make children and community realise their rights and duty bearers to ensure efficient State Services. When analysing the trend of birth registration of children in Karnataka (1979 - 2011), elevation in the process could be appreciated but still there are children who are unreached and several areas which are untouched. With this let's look forward for improving birth registrations and tackling inequalities present at various layers of the communities. Sensitising the target groups of all levels requires comprehensive, multi-sector and multi-dimensional interventions and responses.

Note 1: An effective Civil Registration and Vital Statistics (CRVS) system helps secure an individual's legal identity and tracks the major life events such as birth, adoption, education, immunisation, marriages, divorce, death and cause of death (Tracking system of every individual) is required. The statistics produced further should be made used for essential planning, measuring and monitoring the process of development. This is also strongly linked with equity and inclusive development. ***(This paragraph is a summary of Mr.Vasudeva Sharma's speech at the conference of Universal Birth Registration, 24th June 2011)***.

The Registration of Births, Deaths and Still Births is compulsory and free under the registration of Births and Deaths Act, 1969. According to the law it is mandatory duty of the household to report the occurrence of any live birth or still birth or death. In case of births and deaths in a hospital, nursing home or other such institution, the Medical Officer in charge or any person authorised by him; in respect of births and deaths in a jail, the jailor in charge ; in respect of births and deaths in hostel, boarding house, choultry or other such institution, the person in charge thereof; in respect of any new-born child or dead body found in the public place, the headman or other corresponding officer of the village in case of a village and the officer in charge of the local police station are designated as persons responsible to report their occurrence to the concerned local Registrar. As per Karnataka Registration of Births & Deaths Rules, 1999 (with effect from 1.1.2000), all births, still births and deaths are to be reported within 21 days of its occurrence to the Registrar/Sub-registrar of the concerned local areas.

The national legal framework for registration is the 1969 Registration of Births and Deaths Act and registration services are decentralised spreading across 28 States and 7 Union Territories with more than 200,000 registration centres. 98% of these centres are in the rural areas and about 2% are in urban areas. The Registrar General, India is the central authority for unifying and coordinating the registration work in the country and at the state level. State has a Chief Registrar of Births and Deaths who has the overall responsibility of coordinating, unifying and supervising the work of registration. The Chief Registrars are required to submit an Annual Report on the Working of the Act along with an Annual Statistical Report to their State Governments and to the Registrar General, India. The local registration centres are managed by Registrars and Sub-Registrar of Births and Deaths who are the grass-root level functionaries from either the Health

Department or the Local Self Government Department (Panchayat Department).

Births and deaths are the two most important vital events in the life of an individual and for the society as a whole. Based on the data collected under the Civil Registration System on registered births and deaths, this section presents the trend in the level of registration, vital rates and other related indicators, at both the State and National level.

Birth Registration:

- The number of reported registered births has more than doubled in the year 2010 as
- compared to 1981 (increased to 21.4 million in 2010 from 8.6 million in 1981).
- The share of registered births total estimated births under SRS is increasing year by year
- which in result shows the significant improvement in birth registration.
- The share of male registration is more than the female for registered births.
- Share of Institutional births in total registered births has increased to 65% during 2010 as
- compared to 56% during 2009. 35% of the total registered births are non–institutional in the year 2010. It is based on information received from 23 States/UTs.
- The level of registration of births has increased from 58.0 per cent in 2000 to 82.0 % in 2010.
- 14 States/UTs have achieved the target of cent per cent level of registration of birthsduring 2010.
- 10 among 19 major States have crossed the level of registration of births of 90 present. These States are Assam, Gujarat, Haryana, Karnataka, Kerala,Maharashtra, Odisha, Punjab, Rajasthan & Tamil Nadu.
- After excluding 2 most populous and poor performing States namely Bihar and Uttar Pradesh, the level of registration of births comes out to be 91.6%.
- The birth rate worked out to 18.1 per thousand populations during 2010 as compared to 22.1 from SRS birth rates.
- The gap between the birth rates based on CRS and SRS is narrowing down over the year which is a good indication of improvement in the functioning of CRS.
- Birth Rate reported under CRS in some of the better performing States namely Assam, Gujarat, Kerala, Maharashtra and Punjab is on higher side that of SRS birth rate. This difference may be due to the fact that SRS estimates are based on the usual residence while events registered at the place of occurrence irrespective of the place of residence under CRS.
- The Sex Ratio at Birth for the year 2010 comes out to be 857.
- Highest Sex Ratio has been reported by Assam (1244) followed by Karnataka (1025) during 2010.
- Lowest Sex Ratio has been reported by Bihar (323) followed by Manipur (770). This is due to poor netting of events especially female in Bihar.

Source:Vital Statistics of India Based on the Civil Registration System 2010.
CRS: Civil Registration Rates, SRS: Sample Registration System (Table 3)

Table 9.1: Trends of Birth Registration in Karnataka.

Vital Births from 1971 to 2011			
Year	Births Registered	vital rates of birth	% of CRS rates to SRS rates
1971	469226	16	50.5
1972	484616	16.1	51.1
1973	463130	14.94	51.7
1974	435353	1374	49.1
1975	453444	13.97	50.4
1976	454851	13.68	46.4
1977	459473	12.92	48.2
1978	427336	12.22	42
1979	455668	12.82	44.7
1980	460295	12.68	45.9
1981	466387	12.56	44.4
1982	480337	12.66	45.4
1983	406812	10.51	36.1
1984	439892	11.14	36.8
1985	484334	12.03	40.6
1986	564500	13.65	47.4
1987	564015	13.4	46.4
1988	641846	14.98	52.2
1989	673287	17.68	63.1
1990	780496	17.61	62.9
1991	792291	17.65	65.6
1992	827188	18	68.5
1993	860471	18.34	71.9
1994	886320	21.6	86.7
1995	996077	20.34	84.4
1996	1028112	20.54	89.34
1997	1031329	20.17	88.86
1998	1042256	20	90.67
1999	997649	18.68	83.78
2000	1009716	18.68	83.78
2001	1017224	19.51	87.88
2002	973653	18.85	85.29
2003	1001749	19.31	88.58
2004	988520	18.82	90.05
2005	1007868	18.51	89.85
2006	1046531	18.95	94.28
2007	1046424	18.95	95.23
2008	1082450	19.3	97.47
2009	1076383	19.05	97.69
2010	1071518	18.29	95.26
2011	1108562	18.72	99.47
Source: CRS Annual Report 2011:Karnataka CRS: Civil Registration Rates SRS: Sample Registration System			

Karnataka State - General response of the public: In Table 9.2 we can state that response from the public is steadily on rise, birth certificates are now in demand in the Grama Panchayat, BBMP and municipality office for fulfilling the formalities of Bhagya Lakshmi Schemes, schools for admission and death certificates for all personal claims. Slowly sturdily the publicity measures are also yielding significant results since the last decades. The table on vital events registered from1971 to 2011 indicates the extent of Registration of births. The percentage of Civil Registration System (CRS) rates to Sample Registration System (SRS) rates are provided in the table-9.2.

Table 9.2: District wise Registered Births and rates of Karnataka State (Urban & Rural)-2011

	District	Birth	
		Registered	Rate
1	BAGALKOTE	48759	23.2
2	BANGALORE (R)	9292	11.3
3	BANGALORE (U)	146105	13.9
4	BELGUAM	96159	19.7
5	BELLARY	54319	22.2
6	BIDAR	40487	24.2
7	BIJAPUR	61009	27.3
8	CHAMARAJANAGARA	13733	15.1
9	CHIKKABALLAPURA	17918	14.2
10	CHIKMAGALUR	17366	14
11	CHITRADURGA	27130	17.1
12	DAKSHINA KANNADA	38335	16.4
13	DAVANGERE	37149	19.5
14	DHARWAD	39537	19.5
15	GADAG	22567	19.9
16	GULBARGA	49277	29.8
17	HASSAN	26445	15.1
18	HAVERI	30117	20
19	KODAGU	8300	14.9
20	KOLAR	21667	15.4
21	KOPPAL	32610	25.4
22	MANDYA	22280	13.7
23	MYSORE	49105	15.7
24	RAICHUR	31689	19.7
25	RAMANAGARA	13547	14.1
26	SHIMOGA	33555	17.4
27	TUMKUR	41075	17
28	UDUPI	19928	17
29	UTTARA KANNADA	26425	17.8
30	YADGIR	32677	28.7
	STATE	1108562	19

The registration records are primarily useful for their value as legal documents and secondarily as the source of vital statistics. Civil registration as a source of vital statistics is relatively less expensive, as the statistics generated from the registration records are the by-products of an essential administrative process. The registration records can also generate current and continuous statistics, which can be more accurate than any other method of data collection. The reliability of the statistics obtained through the registration system depends much on the completeness and promptness with which events are registered and the accuracy of the information in the registration records. The improvement in the system of registration of births and deaths is critically dependent on how much importance is attached to the data on births and deaths by the respective States and District administrations. Besides, the level of awareness among the public about the utility of birth/death certificate also plays a crucial role.

Vital statistics generated through registration records enable estimation of the size, structure and geographical distribution of the population for the current year except for migration. Vital statistics also enables the projections for future years on the basis of probable trends of fertility and mortality as derived from a study of these factors and their interactions with social, economic and other demographic factors. The vital statistics data generated through an effective Civil Registration System is of immense use for formulation of various development and welfare programmes/ schemes. Civil Registration data can act as an objective source for allocation of financial resources at State and District level. The Civil Registration data acquires paramount importance in the wake of 73rd and 74th amendments to the constitution of India, as it can provide data at local level for micro level planning, monitoring and evaluation of schemes. At national level the vital statistics data generated through Civil Registration is quite useful for medical research and in the study of sex ratio, mortality and morbidity rates and also in the study of causes of deaths.

The coverage of Civil Registration in the country, the data generated from the Civil Registration System has been compared with corresponding estimates provided by the Sample Registration System. The data under Civil Registration is based on place of occurrence and Sample Registration System is by the place of usual residence of mother. It will not be out of place to mention that although the registration data continues to be deficient due to not reporting of the events for registration or not being registered, and also due to non-reporting of the registered events to the Districts Registrar's office in time by the local registration units, the silver lining is that the overall level of registration across the States / Union Territories (UTs) largely show an upward trend (Table 9.3)

Table 9.3: Vital Statistics of India based on the Civil Registration System 2010, New Delhi

India/ States/ Union Territories	Rural			Urban			Total		
	Male	Female	Person	Male	Female	Person	Male	Female	Person
India	**4406784**	**3647232**	**11071902**	**5029477**	**4439836**	**10358432**	**9436361**	**8087068**	**21430434**
States									
Andhra Pradesh	241002	239499	480501	360614	351606	712220	601616	591105	1192721
Arunachal Pradesh	7057	5368	12425	13647	11038	24685	20704	16406	37110
Assam	216056	262657	478713	110545	143530	254075	326601	406187	732788
Bihar	763785	267401	1031186	195223	42141	237364	959008	309542	1268550
Chhattisgarh	90952	83800	174752	74324	66006	140330	165276	149806	315082
Goa	4297	3773	8070	6796	6302	13098	11093	10075	21168
Gujarat	277229	254997	532226	420638	374440	795078	697967	629437	1327404
Haryana	123078	106270	229348	173250	142022	315272	296328	248292	544620
Himachal Pradesh	48721	44804	93525	21776	19418	41194	70497	64222	134719
Jammu & Kashmir	34242	31987	66229	41595	37561	79156	75837	69548	145385
Jharkhand	134019	113243	247262	103674	92246	195920	237693	205489	443182
Karnataka	164500	188086	352586	364744	354188	718932	529244	542274	1071518
Kerala*	113755	104154	218153	168256	160528	328811	282011	264682	546964
Madhya Pradesh	325504	298096	623600	510134	471995	982129	835638	770091	1605729
Maharashtra	379426	315208	694634	665456	577637	1243093	1044882	892845	1937727
Manipur	6771	3869	10640	9321	8526	17847	16092	12395	28487
Meghalaya	37102	34045	71147	8445	7511	15956	45547	41556	87103
Mizoram	5677	5378	11055	7541	7156	14697	13218	12534	25752
Nagaland	13480	11983	25463	10712	9094	19806	24192	21077	45269
Odisha	216566	200631	417197	184915	164948	349863	401481	365579	767060
Punjab	113602	90970	204572	164712	138381	303093	278314	229351	507665
Rajasthan	450775	377890	828665	497973	418419	916392	948748	796309	1745057
Sikkim	1308	1326	2634	2987	2803	5790	4295	4129	8424
Tamil Nadu	159163	156415	315578	391403	358290	749693	550566	514705	1065271
Tripura	10505	10382	20887	9796	9828	19624	20301	20210	40511
Uttar Pradesh	0	0	3017642	0	0	889092	0	0	3906734
Uttarakhand	27569	24470	52039	45749	38408	84157	73318	62878	136196
West Bengal	421639	393521	815160	249265	230899	480164	670904	624420	1295324
Union Territories									
A & N Islands	1428	1358	2786	1563	1436	2999	2991	2794	5785
Chandigarh	149	131	280	13141	11544	24685	13290	11675	24965
D & N Haveli	1708	1595	3303	1608	1405	3013	3316	3000	6316
Daman & Diu	601	520	1121	1514	1409	2923	2115	1929	4044
Delhi	13192	11569	24761	175930	158772	334702	189122	170341	359463
Lakshadweep	335	340	675	0	0	0	335	340	675
Puducherry	1591	1496	3087	22230	20349	42579	23821	21845	45666

*: Kerala includes cases of sex not reported in person so does not match with the addition of male and female.

4. Current project/ programmes / policy/ act/ rules pertaining to birth registration in Indian Constitution:

Acts / Law and other instruments related to Birth Registration in India: (Table 7)

- **Civil Registration Act, 1837**
- **Citizenship Act, 1955**
- **The Registration of Births Registrations in India, 1969.**
- **United Nation Convention on the Rights of the Children, 20th Nov 1989 (Article - 7)**
- **National Policy for Children – 2011**
- **Millennium Development Goals**

5. Field level attempt (Govt. / Non Govt. / Pvt. Initiatives) at lateral, multi-lateral levels with positive or negative outcomes and the learning throughout the process.

Government of India's Innovative Ideas to attract citizens to register births and deaths (BIRDS):

Govt. of India launched BIRDS in Jan 2008, BIRDS is a software built as per the uniform and updated guidelines of Registrar General of India (RGI) for registering births and deaths in the country online. Citizens can download unsigned copy of birth/death certificate from website. The Head office of Directorate of Health Services (DHS) monitors birth and death registrations through website. The system generates statistical reports required by RGI in prescribed formats. Facility for other Govt. offices like RGI, Civil supplies department, Elections department, Transport department etc., to download birth and death records periodically from website, including downloading of data in XML format is also available. There is a workflow based system in website for changes in birth records, NOC etc., This system has been implemented in all 91 registration centres in the UT, Health centres of DHS. The number of records in BIRDS is 2.5 lakhs.

Note: Similarly even BBMP has introduced a method of registering births online.

Plan India – A supporting / Funding Agency creativity to promote Birth Registration: Plan India, a child centred development organization launched Universal Birth Registration campaign in the year 2006 with the theme ***"Count Every Child because Every Child Counts"*** to achieve 100 % registration of births in India. It is aimed to advocate birth registration as first right of the child. The campaign has significantly contributed in creating awareness about birth registration in districts of Rajasthan, Karnataka, Andhra Pradesh, Maharashtra, Tamil Nadu and New Delhi.

Plan India has played a crucial role in promoting birth registration and certification through its Universal Birth Registration campaign with 52 NGO's across 173 blocks in 27 districts in 7 states. The program has also supported initiatives to reach out to Children in Difficult Circumstances.

With the efforts of Plan India over 4, 67,000 children have been registered, 200 grama panchayat in partner states have achieved 100% current birth registration level.

Plan India worked towards increasing the national impact of its programs by working closely with the Office of Registrar General India, UN agencies and other national and international non-government organizations, and media agencies. It has also been working with civil society, government, panchayat leaders, community based organization / Self Help Groups and youth alliances to generate awareness and increase demand for registration.

Plan India started this project at an initial level with a goal of achieving a distant dream, grass root level experience, has given this campaign a high level of credibility. The campaign has been very successful – thousands of children have been registered, including children living in difficult circumstances. Plan India regards birth registration as a tool in preventing other child rights violations- a simple and yet first step in ensuring Child Rights to identity. Plan India continues to be committed to ensuring that every child gets his/her first right to an identity."

Child Rights Trust's –NGO : Initiatives to succeed, achieve and to bring best practices on registering births in the communities :

With the support of Plan India, New Delhi, CRT gave a drive to expand the awareness through campaign since September 2010. The focal points of the project are:

a) To intensively campaign for birth registration with the various target group such as ANMs, AWWs, teachers, concerned departments etc.

b) To organize the vulnerable group such as parents, youths and children to have their children's birth registered so that 100% birth registration is achieved.

The project is implemented in two wards of Bangalore (Yeshwanthpur and Yelahanka) which consists of three communities in each ward. The grass root level operations are performed in partnership of our organization's networking NGOs such as Paraspara Trust and SAMA foundation, since they have been working in the area and have established relationship in the community.

The programmes and activities that were carried out during the project period are giving direct impact on the awareness of Birth Registration and its importance. Some of the activities / programmes conducted at the intervention areas are as follows:

- **Situational Analysis**: Situational analysis study was conducted to assess the awareness of birth registration among the community. The total numbers of houses reached in the community were two thousand eight hundred.
- **Birth Registration Camps:** These camps are organized involving line departments in which certificates were issued. There is an effort to sensitize families on birth registration as well as the process involved. Totally it was possible for us to reach about one thousand five hundred children during the process.
- **Street Play Shows:** Street Play had direct impact on public since the activity involved play way method. It was easier for the people to mentally internalize the issue. This activity enabled the people to know the importance of birth registration. Five thousand seven hundred people were sensitized at various locations of the community.

- **Child Participation Programmes:** These Programmes particularly strengthened children to register and internalize the concept of UBR through drawing and essay competitions. Two thousand five hundred children took part at different events which were held at the school premises.
- **Development of Innovative IEC Materials and Distribution:** Posters, handbills, sticker play its own important role and method of communication. These were constantly pasted and distributed at all meetings and activities of UBR. Approximately five thousand people were reached in this process.
- **Wall Writings:** The necessity and importance of UBR and the process are written on walls of the community.
- **Meeting with Self Help Groups, lactating mothers, expecting mothers:** These are the significant people who are effectively carrying and taking forward the message with them and spreading the essence of birth registration in the community. At six communities totally two ninety participants were reached.

Capacity building for the Service Providers: The role of service provider is very essential in order to promote the birth registration. Capacity building programmes were organized to involve line departments and raise the level of co-ordination and Co-operation among service providers. ANM, AWW and teachers were some of the target groups who were sensitized and the total number of reached are two hundred and twenty people.

(**source:** http://planindia.org/about-plan/media-centre/news/plan-india-celebrates-the-success-of-universal-birth-registration-campaign/?searchterm=birth%20registaration)

Photo 1. Chidren of Yelahanka (Ambedkar Nagara) community facilitated and provided with Birth Certificates Photo 2. Mr.Vasudeva Sharma, Exective Director, CRT addressing the gathering on the importance of birth registration and its uses. Photo 3. Children at Sharif Nagar (Yeshwanthpura) community participating during the survey process. Photos by –Rashmi.G.M, CRT, 2011

Photo 1 .Mr.Sathyanarayana rao.SN, collecting data on BR during the survey at Chikkabammasandra of Yelahanka, Bangalore.Photos by – Rashmi.G.M, CRT, 2011 Photo 2. Street Play : Ms.NAgamani and Mr.Nagaraja.B.G addressing the gathering on the importance of birth registration and its uses.Photos by – Rashmi.G.M, CRT, 2011 Photo 3.Ms.RAshmi.G.M, Project Assistant ,CRT Attempting to speak to the people in community about Birth registration through Street Play. Photo By –Sathyanarayana Rao, CRT, 2011

6. Effects

When births / deaths go uncounted and their causes are not documented, governments cannot design effective public health policies or measure the impact. According to several critics and public health planners' statement "Civil registration is something that all developed countries have, and that developing countries need". Information on births and deaths by age, sex and cause is the cornerstone of public health planning.

Civil registration systems are the most reliable source of statistics on births and deaths and causes of death. If we don't have a well-functioning civil registration system then we will have only approximate ideas on the numbers of children but not the accurate one.

The majority of couples (55%) do not obtain marriage certificate from the civil registrar office. 75% of the children from these couples do not have a birth certificate. (Plan India report) (Table-8)

- In India, an estimated 26 million children are born every year of which about 10 million go unregistered. (Unicef report 2012)
- Yet the births of nearly 230 million children under the age of five worldwide (around one in three) have never been recorded. (Unicef Report 2012)
- India has 10.12 million child labourers aged between 5 to 14 years (National Census 2011).
- Roughly 50% of all working children are girls (CRY website states data from govt. report)

- In India the child sex ratio is at the lowest it has ever been with just 914 girls for every 1000 boys (Census, 2011)
- Girls in India have 61% higher mortality than boys at the age of 1-14 years (NFHS-III)
- In India 47 out of every 1000 live births do not complete their first year of life ((Sample Registration System - SRS, 2011)
- Nearly 45% girls in India get married before the age of eighteen years (NFHS III)

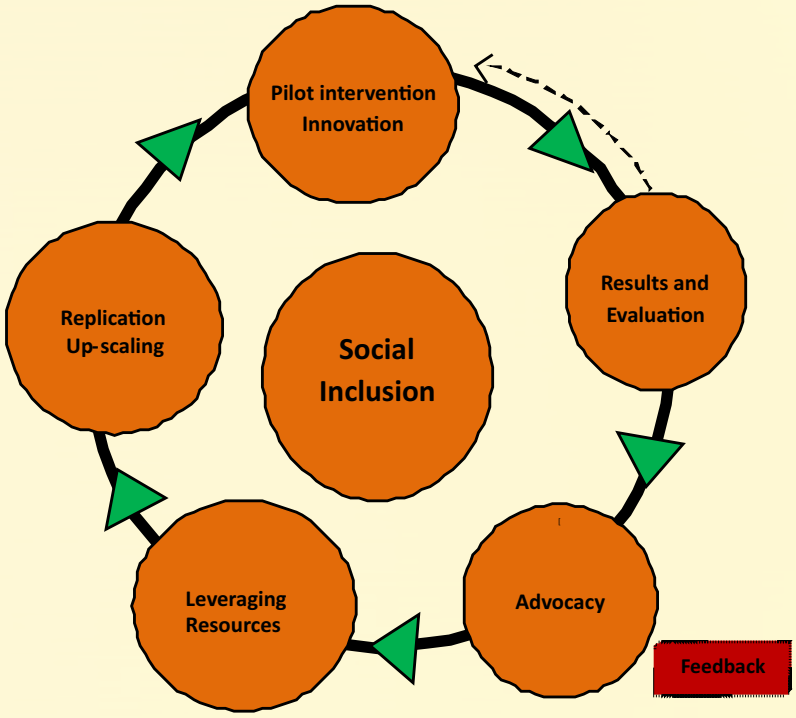
  The statistics affirm that children are accorded a low priority in National policy and governance decisions.
- In general, at the national level, the number of girls enrolled in all levels, i.e. primary, secondary and higher education is less than their counterparts. However, the female-male ratio in education has been steadily improving over the years. In primary education, the GPI ratio has gone up from 0.76 in 1990-91 to 1.00 in 2009 - 10 showing 31.6% increase and in secondary education the increase is from 0.60 in 1990-91 to 0.88 in 2009-10 thereby showing 46.7% increase. (Children of India 2012)
- It is alarming that, in 2011, the Crimes against children reported a 24% increase from the previous year with a total of 33,098 cases of crimes against Children reported in the country during 2011 as compared to 26,694 cases during 2010. (Children of India 2012)
- A total of 113 cases under prohibition of Child Marriage Act 2006 were reported in the country out of which highest were reported in West Bengal (25), followed by Maharashtra (19), Andhra Pradesh (15), Gujarat (13) and Karnataka (12).(Children of India 2012)
- A large number of Juvenile crimes (SLL) were reported under Gambling Act (14.77%) followed by Prohibition Act (10.7%). Cases under 'Indian Passport Act' and 'Forest Act' have registered a sharp decline of 66.7% each, while cases under 'Prohibition of Child Marriage Act' and 'Immoral Traffic (P) Act' registered sharp increase of 200% and 50% respectively. (Children of India 2012)

7. Replications & Scaling up possibilities

The following cycle can be kept as a model through which any practitioner / a duty bearer could promote good planning , evaluation and documentation of results for pilot interventions; advocacy for scaling up and policy influence using the evidence of documented good practices and innovations ; strengthening of partnerships and leveraging of resources for expansion and sustainability of the pilot approach; and eventually replication of the pilot intervention to deliver impact on a larger scale.

Note: Social inclusion is not a separate entity in the process of piloting and scaling up model, but emphasised as an underlying theme throughout the entire process.

Fig 9.1: A theory of change for moving from pilot intervention to scaling up can be represented as follows



A theory of change from moving from pilot intervent ion to scaling up can be represented as follows. **Source: UNICEF India's Country Programme Action Plan 2008 -2012 (Table-9)**

8. Issues still pending- not addressed/ new/emerging issues/problems

Invisible children: More than one third of children are not registered at birth, Could a new governance indicator bring some changes?

These children will join earlier generations who were also denied such access, simply because their parents or care takers did not sustain the capabilities to register births and ensure that everyone are counted. The failure to register children is widespread across Karnataka (Villages, Grama Panchayts, Municipalities, Metro Politian Cities).

Birth Registration is not a new issue on our govt's development agenda. Section seven of the 1989 convention on the rights of the child clearly states that all children have a right to be registered. But more than 23 years later India is showing only a little priority and progress. Keeping birth registration as a base there are several other issues that are bothering the lives of children (Child marriages, child labour system, Juvenile delinquency, flesh trading of female girl children, child mothers etc).

"By 2030, all children born in India will be registered at birth (Vital Statistics of India

based on the Civil Registration System 2010, New Delhi). What actions will be taken if this goal is broken down? Who is accountable?

Note: One of the biggest challenges in promoting birth and death registration in our society is the low priority rendered to the work on registration.

9. Suggestions – general & specific

The low priority manifests itself in number of ways that could hamper the smooth functioning of the birth and death registration system, for e.g., very low or no budget allocation, lack of inter-departmental coordination (NAVAGRAHA – DWCD, EDUCATION, RDPR, STATISTICS,POLICE, PLANNING etc..), no regular monitoring and supervision and lack of awareness about the need and importance of registration etc..

The value of birth registration as a fundamental human right needs to find focus . Birth registration is the starting line, and everything possible must be done to give every child the best start in life. Hence there is a need for considerable work to be done before every child in the country which can claim the right to a legal identity.

We have a responsibility now to find new ways of tackling the challenges we have not yet overcome, to reach the children we have not yet reached, and to put equity and children's rights at the centre of an agenda of action for all children. Studies show that when we design policies and programs not around the easiest to reach, but around the hardest to reach, we can achieve more results. The Government has several good plans to operate and collect statistics related to Birth registration. It presents examples of progress and good practice but still to focus on areas of action and which are as follows:

Focus areas for action 1. Political commitment; 2. Public engagement and participation; 3. Coordination; 4. Policies; 5. Legislation and implementation of regulations; 6. Infrastructure and resources; 7. Operational procedures, practices and innovations; and 8. Data quality, production, dissemination and use of vital statistics.

10. Conclusions:

This paper is an attempt to look at progress made towards realizing the child's right to birth registration with particular attention to the ***"Situation of children in Karnataka".***

A review of data has indicated that considerable progress is seen in the performance within Karnataka (since 1971 to 2011). Birth registration practices and many of the associated national laws continue discrimination against already marginalised sections of society and reinforce broader socioeconomic disparities. Currently, as per our field intervention and conversation our team had seen that many of whom cannot access government services and face the risk of exploitation and abuse of their rights. For example, asking money and involving themselves in corruption to issue bith certificates is one of the black mark on the system. Many slum dwellers have to bribe the middle man four times the charge priscribed by Govt. to obtain the birth certificates (500 Rs. – 1500 Rs).

This paper is a representation of the current scenario with regard to address the situation and barriers to birth registration in

Karnataka. The targets cannot be achieved unless the rights of children and human rights made realised in future.

More research and trainings should be conducted in order to sensitise the target groups to make them understand on the concept and also to render effective services depending on their sectors.

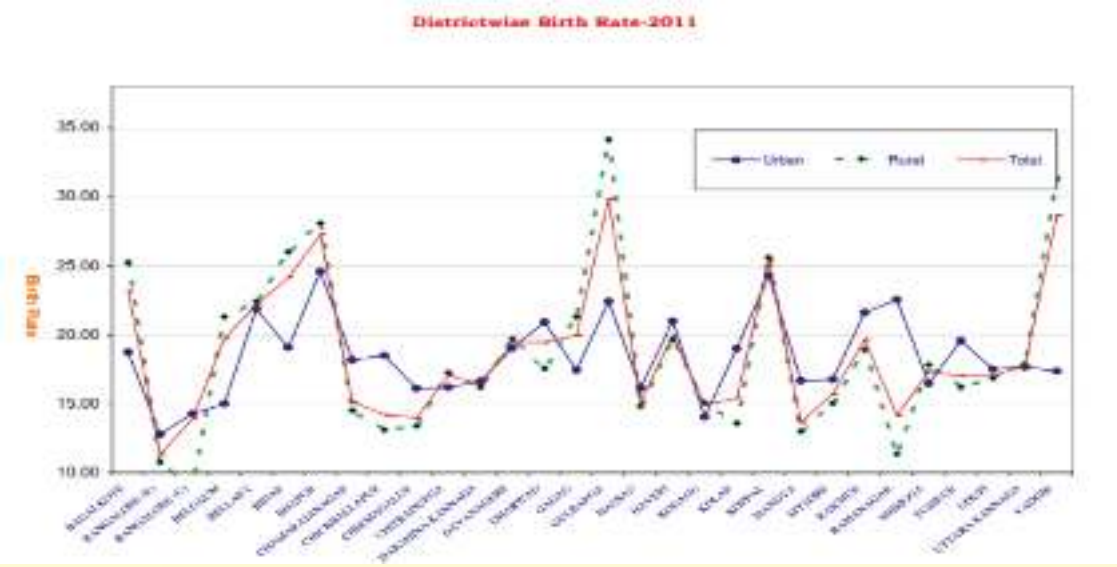
Table 9.4: BBMP, Number of Live Births registered by place of birth-2013

Table No.	Area Code	District	Registration of Birth by place of occurrence		
			Male	Female	Total
B1	20	Blr CC	57507	37425	**94932**
B2	20	Blr CC	55768	36574	**92342**

Table 9.5: BBMP, Live births by sex & month of occurrence 2013

District	Live births by sex & month of occurrence													
Blr CC		Months												
	Sex	Jan	Feb	Mar	April	May	June	July	Aug	sep	Oct	Nov	Dec	Total
	Male	3387	5695	8137	5587	4569	5142	4534	4215	4865	3841	4204	3331	**57507**
	Female	2935	3502	2989	3472	3557	2816	2725	2792	3326	4139	3414	1758	**37425**
	Total	6322	9197	11126	9059	8126	7958	7259	7007	8191	7980	7618	5089	**94932**

Fig 9.2: District wise Birth Rate 2011: Government of Karnataka, Chief Registrar of Statistics Annual Report-2011; Births and Deaths Act 1969.



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10

STATUS REPORT ON ECCD IN KARNATAKA

- Dr. Usha Abrol

THE CONTEXT

Early childhood refers to the period from conception to 6 years. Developmentally this is the most crucial period of human life having long term implications for all aspects of development. In other words the foundations for later development are laid during this period. The pace of development in these years is very fast .Recent research in the field of Neuroscience has shown that "critical periods" for some of the competencies which are important for lifelong learning &development, are located during this period (Karoly et.al, 1998). Due to rapid neural connections, the growth & development of brain during this period is very fast making this period critical in human life. The early experience of children & the stimulation they receive are very important for forming synaptic connections in the brain. Sometimes home environment cannot provide this stimulation due to many factors like poverty, negligence, ignorance, parental absence etc .Research within India &abroad has shown that ECCE can make significant impact in terms of compensating these deficits (NCERT 1994).

The status of children below six years in age is a significant indicator of the development of a Country/State. According to the Census 2011 the total population of Karnataka is 61,130,704 out of which11.2 percent (68,55,801) is the population of children below six years of age. Age wise population breakup is given in table 10.1.

An overview of status of children as reflected from census data, Govt reports &research studies is given below.

2. Health &Nutritional Status of Children

The first three years are important from the viewpoint of survival &health of the child, as well as development of brain which in turn is affected by mother's health &related factors. The indicators like Infant Mortality Rate (IMR), nutritional status, health status etc indicate the situation of children in any society.

2.1 Infant Mortality Rate (IMR)- is the most sensitive indicator of child health. The current IMR in Karnataka is 35 per thousand live births which is less than the all India IMR of 44 (SRS 2011).

Table-10.1: Age- wise population of children in Karnataka (Census 2011)

Age	Persons	Males	Females	Female % of the total
0	690113	355631	334482	48.47
1	941371	485254	456117	48.45
2	1062841	545423	517418	48.68
3	1120971	568359	552612	49.30
4	1127298	582809	544489	48.30
5	1138754	588059	550695	48.36
6	1100752	565423	535329	48.63

The State has made a steady progress in this regard as reflected by steadily declining trend of IMR from 65 (NFHS1:92-93) to the current rate of 35. The main reason for declining IMR is the improvement in the Maternal & Child health (MCH) services in the State. More than 90 percent of women are receiving ante-natal check-up and a majority of deliveries are taking place in institutions (86.4%). However almost one third (31%) of the mothers did not receive any postnatal care (CES 2009).

2.2 Maternal Health-Mothers health has a direct bearing on the health of the Children. Anaemia is a major health problem of women in Karnataka. As per NFHS-3 more than half the women in the age group of15 to 49 years have Anaemia, 34.4 have mild Anaemia ,15 percent have moderate & 2 percent have severe Anaemia. The situation is further aggravated by the fact that only 52.7 %pregnant women received IFA tablets & of those who received only 43.9percent consumed them this has a direct impact on health of the children born to these women (CES-2009).

The data on BMI is indicative of the nutritional status of women. In the State some 10percent women are at risk so far as the height of women is concerned but as regards to thinness or acute malnutrition almost one third of the women (35.5 %) in the age group of 15 to 45 were classified as thin (BMI Below18.5).

However when it comes to health services for women especially from socio-economically disadvantaged sections of the society the situation is not very good. A fact finding committee of experts during their field observations found that in some parts of Karnataka, especially Hyderabad-Karnataka region & urban slums, many pregnant & nursing women suffer from malnutrition. The Committee also found that pregnant & nursing mothers are not getting adequately the benefits due to them i.e., “take home ration”, IFA tablets etc. (Prevention of Malnutrition of Children in Karnataka, Report of the Core Committee Chaired by Justice NK Patil, 2012).

2.3 Nutritional Status of Children

The three standard indices of physical growth that describe the nutritional status of children are-height for age (stunting), weight for age (underweight or not) & weight for

height [wasting]. Though the nutritional status of children has shown improvement over the years 41%of the under 3s were still underweight, 44 %were wasted & as many as 51 percent were stunted at the time of NFHS-3 (2005-06).

The Integrated Child Development Services (ICDS) a flagship programme for children below 6 years has a systematic programme for regularly weighing the children &maintaining the growth records. According to the current ICDS records presently 71 % children have normal nutritional status, 28% are moderately malnourished & a small number (one percent) are severely malnourished requiring hospitalization & intensive care. These trends however are reflecting the nutritional status of only those children who are registered with the ICDS programme. Though they cover the majority of child population.

Though the percentage of severely malnourished children is small, in absolute numbers there are 51,453 children in this category (DWCD-MPR, 2013) requiring intensive care & hospitalization.

Minor differences are seen among boys & girls. Slightly more number of girls are severely malnourished than boys. The following table also shows that the children in 3 to 6 years age group are more malnourished than those below three. The differences in age & gender however are too small to draw any definite conclusion (table 10.2).

Table 10.2: Severely Malnourished Children in ICDS as per the Growth Monitoring Records (DWCD, MPR-2013)

Nutritional grade	Boys Below 3	Girls Below 3	Boys Below 3	Girls Below 3
Normal	72.13	71.97	68.48	68.17
Moderate	26.83	26.68	30.18	30.14
Severe	1.04	1.35	1.34	1.69

A lot of differences are seen among districts with respect to prevalence of severe malnutrition ranging from less than 1 percent to 2.87 percent. The percentage of severely malnourished is highest in Koppal (3.11) followed by Dharwad (2.62), Gadag (2.48) & Raichur (2.05) & Bellary (1, 97).

In the ICDS Programme there are provisions for early identification & treatment of severely malnourished children. The Core Committee, based on the data provided by the DWCD & their own observations, concluded that the scheme adopted by the State Government to identify, medically asses &treat the severely malnourished children enrolled in the ICDS does not appear to be adequate. There are still a good number of severely malnourished children not registered with ICDS; the Government does not have any system for identifying, medically, assessing & treating them. (Report on Prevention of Malnutrition in Karnataka, 2012, pp 25-26).

Comprehensive Master Plan Report on Prevention of Malnutrition of children in the State of Karnataka.

In response to a PIL a high level nine member Committee has been constituted in 2012, under the Chairmanship of Hon'ble Justice NK Patil, Karnataka High Court to examine the status of malnutrition in the State & suggest a plan of action to address the problem.

Measures Taken for Severely Malnourished Children

The severely malnourished children, though small in numbers, are a matter of concern to the Department of Women & child development (DWCD). Subsequent to the recommendations of the Core Committee on Prevention of Malnutrition of Children in Karnataka Chaired by Justice NK Patil (2012) a number of measures have been initiated to take care of severely malnourished children by the two concerned departments, i.e., DWCD & DHFW.

Measure to manage severely malnourished children

- A scheme- Bal Sanjeevini - has been started to help the families of severely malnourished children.
- An allocation of Rs 750/- has been made for each severely malnourished child to meet the cost of therapeutic food & medicines.
- The severely malnourished children between 0-6 years, registered with the Anganwadi, suffering from acute diseases requiring tertiary care are treated free in twenty selected hospitals.
- An allocation of Rs 50000/- for the neonates & Rs 35000/- for children below six has been made to help the children who need hospitalization.
- Nutrition Rehabilitation Centers are being set-up in every district under NRHM to take care of severe underweight children requiring medical attention.

It is hoped that with these interventions the situation of severely malnourished children will improve considerably.

2.2.2 Breast Feeding Practices

One of the reasons known to affect the nutritional status of children is faulty/inadequate Infant Feeding Practices. The data on this aspect show that though as many as 96 percent of the mothers were giving breast feeding [BF] to their new born the other IYCF (Infant &Young Child Feeding) practices followed were not so good. As shown in the following table only 38 percent of mothers started BF within the first hour. Exclusive breast feeding was not followed by almost one third of the mothers. Giving water, other milk &other food along with breast milk was reported by almost one third of the mothers (table 10.3).

Table-10.3: IYCF Practices

Sl. No.	Breast feeding practices	Percentage of mothers
1	BF within an hour	38.2
2	BF within one day	77.5
3	Giving colostrums	90.0

Percentage of children by type of food received during the first 6 months

1	Breast milk	Water
2	237.8	96.0
3	Other milk	33.2
4	Other food	27.3
	Duration of breast feeding	3.98 months (median)

Source-Coverage Evaluation Survey, 2009, UNICEF

2.4 Immunization Status

According to DLH-3(2007-08), 77 percent of the children between 12to 23 months of age have received full immunization comprising BCG, three doses of DPT & Polio &measles immunization. Less than one percent children (0.7 %) are unimmunized in the State

3. Pre -school Education in Karnataka.

The main requirement during the period 3 to 6 years is guided & organized experience in a safe & protective environment so as to enhance cognitive, language and socio-emotional development, while ensuring the needed health and nutrition of the child. This period continues to be highly vulnerable to environmental influences & parenting practices.

In a scenario like India, where more & more women are entering in to work force & support of joint family system is dwindling it has become imperative to put the young children in an anganwadi/preschool /day care center. Pre- school is accepted by increasing number of people, as the first step in the ladder of education and preparedness for primary education.

The Key issues underlying the development of children between 3 to 6 are- access to preschool, quality of services & policies & programmes to meet the developmental needs of children in this age group, while continuing attention to their health, nutrition and protection needs.

3.1 Access to Pre-school

There has been a steady increase in the Gross Enrolment Ratio (GER) for the pre primary Education in the last twenty years, from 3 percent in 1991 to the current GER

being at 55 percent (UNESCO-2010) indicating that more &more children are receiving preschool education now. Although the progress is good still about 30 million children are not getting any type of preschool exposure in India. ECCE in Karnataka as well as in rest of the country is being provided through three channels; public, private & NGO. Public programmes are planned for the disadvantaged groups whereas private fee paying preschools are catering to middle & upper socio-economic classes. A few models providing preschool exposures through balwadis are being implemented through some NGOs but their number is very small.

The data on number of preschools &children enrolled in them is grossly inadequate & fragmented in the absence of any regulatory system prevailing in the State .While this information is available in the Government programmes through regular reporting systems, the same for children availing preschool education from private institutions is not available to get a holistic picture.

3.1.1 Public Sector Programmed for Pre-school Education

The public sector programmes for preschool education include the following;

1. Integrated Child Development Services (ICDS) -ICDS is the largest provider of ECCE to the children below six years especially those from poorer sections of the society. A package of six services is provided through ICDS Anganwadis (AWCs) including health care, nutrition & preschool education. In Karnataka there are 64518 AWCs operative all over the State providing Pre- school exposure to 1763376 children (DWCD MPR 2013). Thus almost half the child population between 3 to 6 years (52.38%) is registered with ICDS Anganwadis for preschool education. The number of children having

Table 10.4: Number of Children receiving services from ICDS

	Age group of beneficiaries	Services	Numbers	Percentage
1	Children 0 to 3 years	Nutrition, Health care, Growth monitoring	2085785	54.67
2	Children between 3 to 6 years		1763376	
3	Total No. of Anganwadis	Nutrition,Health care, Growth Monitoring & pre -school education	64518	52.38

The universalization of ICDS programme has certainly contributed to the growing number of children getting preschool exposure. However, the expanded coverage is more in terms of geographical coverage than number of children. There are still hamlets & small villages which do not have an Anganwadi & poorest of the poor who usually live in such areas is not getting preschool education. Recently the concept of mini AWCs has been introduced which provide nutrition & health care to children but preschool education is almost nil in these mini AWCs. There are 3331 such mini anganwadi in the State (DWCD, 2013). Though the access to PSE for the poorer section has increased there are still some children who do not have access to AWCs because of the norm of 40 preschool children in one AWC, due to which many children are left out in the densely populated villages.

Despite the increase in the number of Anganwadis the average enrolment of preschool children in the in AWCs has been decreasing as seen from average attendance in the AWCS, from 33 in 2005-06 to 27 in 2011.

3.1.2 Rajiv Gandhi National Crèche Scheme (RGNCS)

The second major scheme providing ECCE in the public sector is Rajiv Gandhi National Crèche Scheme for working women to provide services for custodial care, nutrition, health care & early stimulation to children above 3 years. The Scheme was started in 2006 to help &support the working women from poorer sections of the society. This is a Central Government scheme giving grants in aid to the NGOS to provide Crèches for women from weaker sections. About 8 million children all over the country are getting services under this scheme.

Some 46415 children were getting services from1490 Crèches under the scheme in Karnataka (Annual Report MWCD 2010). However poor monitoring, administrative bottlenecks & lack of provision for training of staff are some of the constraints of the programme.

3.1.3 Pre-primary Sections Attached to Primary Schools

Pre-school sections attached to primary schools are another channel for providing preschool education to children between 3 to 6 years. Some 2 million children are getting education from these preschools all over the country.

In Karnataka, 8.6 percent of the primary schools have a pre-primary section attached to them providing preschool education to children between 3to6 years. The number of pre-primary sections attached to primary schools is higher in Southern States as compared to other parts of the Country. In South also this number is highest in Kerala (36.5) followed by TN (17.9), Karnataka (8.6) & AP (6.7). (Source-DISE, 2009-2011)

3.1.4. Sarva Shiksha Abhiyan (SSA)

ECCE centers under SSA areas providing preschool to 5 million children through 0.80 million centers all over the country. Following table 10.5 shows the details;

Table 10.5: Coverage of ECCE under Various Programmes

Programmes	No of Centers in millions	No. of children in millions	Source
Integrated Child Development Services(ICDS)	1.08	72	MWCD, Annual Report 2009-2010
Rajiv Gandhi National Crèche Scheme for Working Women	0.03	0.08	MWCD-2011
Pre-primary sections Attached to Primary Schools	0.04	0.02	MHRD-2011
Sarva Shiksha Abhiyan	0.08	0.5	NCERT National Focus group on ECCE 2006
NGO Services for ECCE	Not Available		
Private initiative	0.22	10	MWCD, Annual Report 2009-10 Chapter-4, pp48-49

Source-Early childhood Education in India a Snapshot, ECCD Brief, CECED, Ambedkar University, Delhi.

3.2 Preschool Education in Private Sector

In terms of scale next in order after ICDS is the private sector which is steadily expanding its outreach encompassing rural & tribal areas too. Data trends from rural sector indicate a distinct increase in the number of private institutions providing preschool education & more enrolment in them (ASER, 2010). It is estimated that some 10 million children are getting preschool exposure from private sector. (GOI, MWCD, Annual Report 2009-10). Due to the absence of a licensing policy it is difficult to assess the coverage of the private sector preschools. They provide preschool education through nurseries, kindergartens & pre-primary classes in private schools .There is not much systematic information on numbers & quality of education in these institutions. The quality of preschool being imparted through these institutions is open to question. In some cases the preschool offered can be counter- productive for the developing child & can be described as 'MIS- education' (Kaul-1998, CECED, 2012).

The data also show that more & more 5 year olds are going to private schools.

Table10.6 suggests that a majority of children are leaving the AWCs by the age of 5 years. The number of 5 year old children enrolled in LKG/UKG &private schools (13.36+34.08) is much more than those going to AWCs suggesting a movement towards private schools even though the AWCs are planned to keep the children up to 6 years. This trend could be attributed to parents desire to start formal education as soon as the child becomes 5 years old or due the entry age at primary school being 5 years in Karnataka or even a pull factor from private schools which are mushrooming everywhere as commercial ventures. The parents' desire to have the children learn English that is either the medium of communication in the private centres or emphasized in them and hardly used or taught in the public sector ones is another reason for growing demand for private schools (table 10.6).

Table-10.6: Enrolment of 5 & 6 Year old Children in Various Institutions

	Institution	5 Year olds attending (%)	6 year olds attending (%)
1	Anganwadi	17.36	2.5
2	LKG/UKG	13.36	4.45
3	Govt.schools	34.08	54.21
4	Private schools	32.46	36.42
6	Others	1.29	1.38
5	Not going any where	2.46	2.05

(Source-ASER, 2010)

Though ASER data is based on rural population it provides a glimpse of the status of ECCE in the country. The role of private parties may be much more in urban areas.

4. Quality Issues in ECCE

The main purpose of the ECCE package is to promote the overall development of children in the domains of physical, cognitive, language & socio emotional development and make the children ready for school at the school entry time though it is heartening to note that more & more children are getting preschool education the empirical evidence shows that impact of ECCE exposure depends on the quality of services provided in the preschool. Transaction of good quality ECCE programme results in improved learning achievements in children. Significant benefits of participation in ECCE programme in terms of rates of retention in primary school to the extent of 15-20 percent were reported (Kaul, Venita, NCERT). In a study of Anganwadis in Bengaluru where an NGO-Akshara Foundation was providing interventions to improve the quality of ECCE, significant gains in learning levels of children were reported (Akshara Foundation, p 29).

A comprehensive longitudinal study by CECED highlighted the main features of ECCE programme being imparted in three

types of institutions; Anganwadis, private preschools & NGO run preschools known for their good practices as illustrated in table 10.7.

Table-10.7: Three Models of ECCE

Anganwadis	Private preschools	Other centers
Limited infrastructure with some play & leaning material	Relatively better infrastructure but little learning aids	Limited infrastructure with contextually relevant play & learning material
Mixed group of children with appropriate student -teacher ratio	Homogeneous group of children with high teacher-student ratio	Flexible weekly & monthly plansAge appropriate planned
Formal teaching with some opportunity for free play, songs & rhymes, creativity & social interaction	Fixed weekly schedule supervised Formal teaching with rote memorization	Age appropriate planned activities for development of concepts, language social skills, fine & gross motor skills &creativity

Source: CECED, Ambedkar University, Delhi, 2012.

The study suggests some dimensions which reflect quality of an ECCE programme. These include; a well planned, flexible, context specific programme schedule, age-wise grouping of children, non formal methods of teaching & adequate infrastructure &teaching learning material.

4.1 Quality of ECCE in ICDS Anganwadis- Potential Not Utilized!

The ICDS being the biggest provider of ECCE to children between 3 to 6 years proposes to give an integrated programme of preschool for 3 hours every day. However the field observations show that it is not happening in most of the Anganwadis. In a study of the 37 AWCs it was observed that in 22 AWCs little meaning full preschool activities were going on. The toys & other material were meager (The Young Child in Karnataka, A Status Report, FORCES, 2004). A Social Assessment of ICDS undertaken by IIMB in 2001, covering 241 Anganwadis also pointed out that the preschool was not satisfactory. The Center for Child & the Law, National Law School University of India, Bangalore, worked with some of the AWCS in Bengaluru to bring about change in ECCE. They found that preschool was limited to a few songs & stories, a child friendly environment & play way methods were missing. Recognizing the workload of the AWWs as a constraint they provided the AWCs with an additional worker (Balshakhi) to provide support to the AWW on experimental basis.

Recognizing the constraints of the AWWS &workload another NGO Belaku Trust introduced the concept of gelathi (a trained community worker) to support the AWW. Need for more preschool & play material was emphasized in this experiment Belaku Trust 1995). A recent study of Anganwadis in Kolar Dist also reported that parents had high expectations from Anganwadis for education of their children but preoccupation of the AWWs with the Supplementary Nutrition Programme (SNP) & other tasks did not allow her to focus on preschool (Nagaraj - 2014).

The work of some agencies with Anganwadis suggested that the AWCs have potential for imparting good quality ECCE. Work of an NGO, MAYA with Anganwadis of Bangalore since 2005, focused on low cost Montessori material, multi-intelligence pedagogy & decentralized on the job training of AWWS as some of the strategies to improve the quality of ECCE in ICDS. Subsequent to the success of their intervention the inputs were expanded to include many more AWCs.

Another field experiment undertaken by Akshara Foundation to improve the quality of ECCE in ICDS showed significant improvements in the learning levels of children by providing meaningful teaching-learning material (TLM), training & supervision of the AWCs (Bangalore's Education Profile, 2009-10, Akshara Foundation).

Most of the above mentioned work with ICDS Anganwadis suggests that nothing much is happening in the Anganwadis towards ECCE but whenever efforts were made to improve the quality of ECCE the outcome in terms of increased attendance, learning in children & parental satisfaction was high. As regards the learning outcomes in the AWCs, the practice of assessing the child's learning in the AWC is not there making it difficult to remark on the outcomes of ECCE package

However the studies conducted elsewhere as well as in Karnataka show that interventions to improve the quality of ECCE programme in the Anganwadis by way of capacity building of AWWs, provision of teaching learning material & supervision has made a significant difference in the learning levels of anganwadi children. In one study, based on the assessment of some 30000 children it was found that after their intervention, language skills improved by almost 25% from 55% in the pretest to 80% in the post test. The test scores in the domain of intellectual development also showed an increase of almost 28 %. The pre-academic or school readiness scores showed an improvement in reading, writing & mathematics skills in that order (Bengaluru Education Profile, Akshara Foundation, 2009-10, pp 18 to 26).

Although research studies provide a good perspective on quality of ECCE in the Anganwadis most of them are based on small samples or confined to only one or two geographical areas. The ICDS programme per say does not have any provision for assessing the learning achievements &other quality issues in the ECCE in Anganwadis. The Monthly Progress report provides information only on attendance of children.

4.2 Quality of ECCE in other ECCD Programmes

Currently CECED is carrying out a longitudinal study in partnership with the ASER Centre to explore the quality aspects of ECCE programmes in different settings in three States-Assam, Andhra Pradesh & Rajasthan. The initial results are showing a significant increase in participation of children in ECCE programmes. However learning outcomes in terms of school readiness levels of children, which is the main objective of any ECCE programme, are very low primarily because of poor quality of ECCE curriculum across public, private & NGO sectors (CECED, Ambedkar University-an ongoing study). The quality of preschool education being transacted in private schools is difficult to assess due to their being unregulated. A wide range of private preschools exist in Karnataka from one room schools to high end franchisee based schools. Since there is no regulatory mechanism or standards prescribed by the State, their number &quality is open to guess.

5. Policy Framework for ECCE

The ECCE has never received so much attention as in the recent times as reflected by various initiatives taken by National & State Governments. Some of these major initiatives are given below;

Right to Education (2009)

Section 11 of the RTE states "With a view to prepare the children above the age of three years for elementary education and to provide early childhood care & education for all the children until they reach the age of six years the appropriate Government may make necessary arrangement for providing free preschool education for such children".

International Commitments

India is a signatory to the Convention on the Rights of the Child (CRC-1989) and Education for All (EFA). Dakar Frame of Reference (2000) & Moscow Framework for Action (2010) all reiterate the importance of ECCE an urge the Governments to take measure to improve ECCE.

National Early Childhood Care & Education (ECCE) Policy-

The ECCE Policy framed in 2013 is an expression of commitment of GOI to provide integrated services for the holistic development of children. It has been adopted with the following Resolution.

The Resolution -

"The Government of India has had under consideration a National Early Childhood Care & Education (ECCE) Policy to reiterate the commitment to promote inclusive, equitable and contextualized opportunities for promoting optimal development and active learning capacity of all children below six years of age after due consideration and approval, National Early Care and Education (ECCE) Policy is hereby adopted (GOI, MWCD, 27 September 2013)

India is home to 158.7 million children between births to 6 years. The policy lays down the way forward for a comprehensive approach towards ensuring a sound foundation for children acknowledging the synergistic relationship between health,

nutrition, psycho-social & emotional development of the child.

The Policy specifies the non-negotiable standards for ECCE to ensure quality in ECCE services.

Non negotiable Indicators for all ECCE Programmes

- An ECCE programme of 3 to 4 hours duration
- A classroom measuring atleast35 square meters for a group of 30 children
- Adequately trained staff
- Age & developmentally appropriate child centric curriculum transacted in mother tongue
- Adequate developmentally appropriate toys & learning material
- Safe drinking water
- Child friendly toilets
- Separate space for cooking Food
- Immediate health services-First aid kit
- Caregiver child ratio one to 20 for children between3 to 6 &1to 10 for those below three.
- The Policy ensures a regulatory mechanism for quality ECCE. Under the Policy a National ECCE Council has been formed followed by a directive to form State ECCE councils within a period of three years. The Council will take care of issues related to regulation/ registration/accreditation of all ECCE services.

Restructuring of ICDS Programme - The restructuring of ICDS in Mission mode already on ground, will also ensure quality of Anganwadis of ICDS the biggest provider of ECCE services in the country by sanctioning additional human & financial resources towards improved infrastructure, adequate TLM & capacity building of the Anganwadis worker. The Karnataka APIP 2013 also envisages many measures to improve the quality of ECCE services towards making Anganwadis a focal point for promoting overall development of children & enhancing their learning capacity in later years. Some concrete actions towards improving the quality of ECCE in Anganwadis as a result of ECCE Policy & restructuring is seen in terms of increased hours of Anganwadis till 3:30 pm as compared to earlier timings till 1pm,dedicated 3hours of preschool education, assessment of child's progress, revision of curriculum as directed in the ECCE Policy, etc. These measures are likely to change the image of anganwadi from" feeding centers to "joyful learning centers" in the community.

Conclusions

The status of children in early childhood age in Karnataka presents a mixed picture of achievements & failures. On the one hand the children in Karnataka are better off than those in some other parts of the country as reflected by many indicators like IMR, Immunization, nutritional status, school enrolment, etc. On the other hand there are many gaps so far as quality indicators like school readiness, learning achievements performance of AWCs & related indicators are concerned.

An unique feature of Karnataka is district level variations in almost all Human Development Indicators including those

related to young child. The IMR, Nutritional status, access to ECCE all show wide district wise variations. The Restructuring of ICDS addresses these variations on priority basis by identifying "high burdened" Districts & sanctioning additional financial &human resources for them on priority basis (Karnataka, APIP-2013). However so far quality of ICDS services, especially preschool education is concerned, they are not very good in most parts of the State.

Though hard data about the ECCE in private sector is not available but the mushrooming of private nurseries, LKG/UKGS, increasing number of vans /buses on roads carrying small children suggest an unprecedented invasion of private institutions not only in urban areas but also in remote rural /tribal areas & more so in urban slums, of not only big cities but also small townships. The decreasing number of children in Anganwadis especially those 4+ in age suggests their movement towards formal education in Government schools & private schools. Though it is heartening to note the increased levels of enrolment of children at preschool level, the quality of preschool being received by these children is not known. The critical importance of a regulatory mechanism cannot be overemphasized in this context. The adoption of the ECCE Policy is a welcome step at this juncture.

If the commitments in the policy are implemented with sincerity, ECCE has a great future in the State as well as the Country as a whole. The first & foremost being the formation of a State Council on ECCE. However the effectiveness of the policy may require many systemic & administrative reforms. The past experience has shown that policies if not implemented properly do not make any significant dent in the situation.

The increasing awareness of the significance of early childhood & developmental needs of children among planners & parents is also a positive sign. Emphasis on creating more awareness among parents about the right kind of preschool for children is a need of the hour so that they do not pressurize their children into formal teaching at an early age.

The field studies however suggest a concern about the curriculum for ECCE programme especially in ICDS which still caters to almost 50percent of the child population between 3 to 6 years in age, capacity building of the teachers & AWWs in child appropriate classroom transactions and availability/adequacy/suitability of teaching-learning material.

So far as Karnataka is concerned the Women & Child Development Department has taken some concrete steps towards strengthening the ECCE in ICDS like increasing the timing of Anganwadis from 9:30 AM to 3:30 PM to support working women as well as to give 3 hours dedicated time to ECCE, formulation of a curriculum based on developmental needs of children &steps to provide relevant/adequate teaching/learning material & improvement in infra-structure. However capacity building of AWWs in effective classroom transaction, accountability towards preschool education, monitoring/mentoring & on the job guidance

from supervisors, a system for assessment of child's learning do some gap areas need attention. The DWCD has also shown a positive approach towards allowing the NGOs to experiment innovations for improvements. The lessons learnt from these experiments need to be included in the system & replicated to the entire network of Anganwadis in the State.

The adoption of National ECCE Policy is also a welcome step. Formulation of a State Council on ECCE at the earliest will go a long way to implement the policy & regulate ECCE programmes in the State & achieve the vision of making Anganwadis vibrant joyful learning centers for this important human resource in their formative years.

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11

PARENTING THE CHILD.. A JOY AND A CHALLENGE!

-Dr. Veda Zachariah

When one looks at a happy, carefree, bubbly child we are attracted to her and interact instantaneously. I also wonder how many of us stop to appreciate and acknowledge her parenting that has contributed to her present state.

What is 'parenting'?

When one hears the word 'parenting', we instantly think of a relationship between a child and her parents. Although it is essentially that, we often tend to forget the roles played by extended family, friends and siblings (especially in the Indian context). The long list would also include crèche workers, pre -school teachers, anganwadi workers and other child care professionals. In effect anyone who interacts with a young child is playing a 'parenting' role. This establishes the fact that 'parenting' is not a role played exclusively by parents.

In today's world, most young mothers are dependent on substitute care while they are working to augment the family income or pursuing their career. They could be professionals or daily wage earners who are totally dependent on child care workers in the absence of support at home. On an average a young child spends at least 6 to 8 hours daily in child care, besides family members. This is evident by the number of pre-schools mushrooming everywhere with extended working hours.

There is a misconception that 'parenting' is natural and that all parents are equipped with the knowledge to 'parent'. This includes parents themselves! On the one hand, they may know what to do, but are unable to do so due to paucity of time. Many do not know what to do and are constantly consulting others or the internet. But the reality is that, most parents learn 'parenting' on the job! Then there are some parents who depend heavily on their parents for help and guidance. Besides all the above reasons there is one more factor to consider in the Indian context; the fact that Indian society has changed due to rapid socioeconomic development over the past few years. This situation has exposed the child to newer aspirations. As a result 'parenting' is not as

simple as it used to be! Often parents and children do not see eye to eye. In all these various situations the parents try to do their best and often succeed.

The poor underprivileged parent may or may not have access to help and guidance and often rely on their own knowledge and experience. They also have the additional burden of coping with the daily stress of life while parenting.

Most parents think of 'parenting' as a necessity during a particular phase of a child's life and that it will not be so demanding once the child begins school. This is not so and parents have to realize that they need to acquire new skills along with refining old ones all through the child's life! In fact some skills learnt to deal with young children can come in handy when 'parenting' parents! In other words parenting is not necessarily downwards (parents to their child) but can also be upwards (by parents to their elderly parents).

'Parenting' skills at different phases

The parenting skills required at different phases of a child's life are varied and challenging. 'Parenting' begins in the womb. The emotional well being of a pregnant mother has a positive impact on the child in the womb. Recent studies have confirmed this fact. Therefore some of our traditional beliefs like keeping a pregnant mother happy with positive and pleasant thoughts during pregnancy are not to be disregarded.

An infant requires her needs of feeding, toileting, sleeping to be attended to on a regular basis. She also needs to be reassured when insecure and cuddled to feel wanted and loved and pacified when upset and crying. In other words her physical and emotional needs are to be met without fail. Parents also need to understand that her language development occurs only when they begin to talk to her as a baby. In India babies are fed, clothed and made to sleep; not much communication by way of talking happens! Her health and nutritional needs get attended to during her visits to the doctor.

In the Indian context, babies are always close to the mother when they are newborns and for a while later. But the new Western concept of looking at a baby as 'being an individual' has made some parents opt for separate baby cots and rooms, for those who can afford to do so. This idea of 'being an individual' will help develop her sense of independence later. Parents today have the choice to follow what they want for their child.

However, there is another aspect of 'parenting' at this stage which involves stimulation of the neuronal pathways in her brain by exposing her to sights, sounds and experiences. In many homes this is done naturally but at times neglected for lack of knowledge, want of time and stress on the family members. At this point of time of rapid growth and development the child's needs are constantly changing and can be demanding on the parent. The child needs to explore as she is curious about all things. Time during this phase is precious as the brain is being imprinted with experiences that will help shape the future and we cannot afford to lose it! This critical phase lasts from birth to six years.

At six years, the child, who has developed physically and acquired a number of skills, is raring to go to school. She hones her earlier skills and acquires new

ones in an environment away from home. She is physically active, willing to learn, cooperative and inquisitive at all times. Her psychosocial skills are developing along with her reading and writing skills. At this stage instilling a sense of discipline and order is of prime importance. The early schooling years lays the foundation for learning.

The adolescent period for the child is traumatic, turbulent and enjoyable. In this phase a young child grows to become a gawky teenager and later turns into a confident young adult. This transformation is intimidating, worrying and pleasurable –all at the same time! At this time the young teenager tries to establish her identity, forge her independence, develop her intellect, learn about integrity and develop a sense of intimacy. The parenting skills required during these turbulent times are challenging for the parent!

Case study

Sheela and Raju are parents of three young children. Bina is 10 years old and has a younger sister Tina who is 6 years old and a brother Ravi who is 3 years old. Raju works as a carpenter and Sheela as a domestic help. She leaves home early by 7 am to work in three houses in order to be home by noon. The girls go to a nearby school and Ravi is with the grandmother at home. When Bina returns she has to take care of Ravi till her mother has finished all the household chores. Sheela has time only to bathe and feed her son as she has to cook, wash clothes and clean the house. The only time she actually spends with Ravi is when he is ill. Raju works very hard to keep the family from going hungry. On some days he has a drink on his way back from work and becomes unpleasant at home. Sheela has to put up with his drunkenness as she has no choice.

Bina has been more of a 'parent' to Ravi than Sheela or Raju. What about her parenting?

Why talk of 'parenting' today?

Why is 'parenting' in the limelight today? Parents have been 'parenting' through the centuries, so why the concern or worry now? In the past young parents relied heavily on their parental support and also lived with extended family. Today most families are nuclear and without parental support. Young parents relied on the wisdom and knowledge of elders. Parents now turn to experts, media, and internet for advice that is often not appropriate and conflicting. Society had a collective responsibility for the child in the past; these days everyone is out to exploit the child. Nowadays, parents are stressed out balancing their jobs, family and children as both of them are employed to provide for the needs of the family. Parents today face numerous challenges that did not exist in the past which in effect leaves very little time or thought for 'parenting'. Finally, the effect of lack of proper parenting is visible very often in the children's behavior or attitude in schools and colleges today.

Case study

Arvind and Geetha is a young couple with a two year old son, Anirudh. They are both software engineers working in a multinational company. Their work is stressful and demanding. Geetha has just joined work after a break in her career. They are a nuclear family with no help at home. Like any other couple they have ambitions and have set goals to achieve.

Anirudh is left at an expensive play school from 8.30am to 6pm. The school takes care of all his needs till evening. Most mornings Anirudh is cranky and upset to leave home early and therefore is often not even bathed. In the evenings he is asleep and cranky when Geetha picks him up. The only quality time the parents are able to spend with him is on weekends. Sometimes they feel that they do not know Anirudh and that he is more attached to the child care worker in the play school. But on every occasion they ask the caregiver what their child learnt that day and often the reply is that he cried a lot that day. Geetha is very eager to be a good parent and Arvind too. What is their parenting dilemma?

What needs to be done.

A systematic approach to create awareness to parents about good parenting practices from the birth of their child needs to be institutionalized. Child care services need to be enriched with adequately trained persons on parenting practices. Anyone who interacts with a child needs to know that they are playing a 'parenting role'.

The medical and childcare professionals who check the health of the child need to emphasize not just the physical health but also the psychosocial health of the child. When the child is in school, parents focus only on the physical and cognitive development of the child and express satisfaction when the child achieves good results. However it is equally important to see that the child has developed healthy friendships, has good communication skills and self confidence. This aspect of child's development is often taken for granted and not encouraged as it should be.

Parents of young children need to be made aware the importance of early childhood stimulation for the optimal development of their child.

Regular awareness programs on parenting and trained community mothers as guides will help the young parents in the community.

Fathers are encouraged to be with children and even given leave in the West. In India if fathers are involved in childcare it is not appreciated and even considered derogatory! The parenting experience should involve fathers, at every phase, even with young children.

Another aspect is to promote cuddling and hugging as important non-verbal communications. In our culture it is considered inappropriate behavior and we do not encourage this even with children! But it has been proven that many a time a hand over the shoulders of one feeling sad, is more comforting than a dozen words.

To sum it up, parenting should be looked upon as a joyful activity and not as chore to be done. The reward of effective parenting is visible in the child almost instantaneously- like the happy, bubbly child we all like to see! Promotion of Good Parenting Concepts and Practices:

In 1997, the Bala Mandir Research Foundation (BMRF) Chennai, introduced the concept of 'Parenting the young child' with the use of visual aids in the form of a flipchart called the 'Learning through Play calendar' to a group of people (mainly staff of NGOs). The NGO group consisted of people engaged in different activities like disability rehabilitation, de-addiction programmes, preschool education and education of street children and people engaged in health education. In all an estimated 3,000 families have been reached through NGOs in TN, Karnataka, Gujarat and Maharashtra. In the process, the Network for Information on Parenting

[NIP] was established with BMRF as the secretariat. BMRF also got the support of UNICEF for a multi-year project to train a large number of ICDS workers in these concepts and approaches.

The training was spread over two phases with a period of six weeks between them. In the initial phase the concept of 'parenting' was introduced and participants internalized it. In the second phase they actually learnt how to use the visual aids i.e. 'the learning to play calendar' which was available in the local language as well. This training was highly appreciated and valued as it gave an insight as to, how to communicate age appropriate messages to parents through effective visuals. In 1999, BMRF started using a Canadian 'Learning through Play' calendar that was found very useful in conveying the multi-dimensional concepts of young child development though the pictures in it being Canadian, were not easily identified with by trainees. Later, these calendars were indigenized with both South and North Indian versions.

A review of the NGOs, done in 2007-08 revealed that although the participants (those who participated in the training) had internalized the parenting messages and had personally changed their behavior accordingly in many cases, however many had not been very successful in communicating the messages to other parents in their communities. Only those NGOs engaged with young children and a few others, had actually incorporated the concept and planned effective programs in their areas of operation.

A Recap of Activities done in Karnataka

The initial work in Karnataka was done by BMRF or NIP from Chennai. The materials for the work were translated into Kannada. Subsequently, a group of individuals who were interested in taking the concept forward formed the Karnataka unit of Network for Information on Parenting in Bangalore [NIP-K]. The group has since trained a number of individuals from NGOs and some of them have directly been involved in conveying the parenting concept to various communities. The members of the network through their individual organizations have reached out to anganwadi workers (especially in rural areas), ASHA workers, primary care givers of children, and also a number of parents belonging to all sections of society. In Kolar and Tumkur districts training has been imparted to the concerned anganwadi workers and the parents.

One significant program through the network has been the training of staff from SRTT (Sir Ratan Tata Trust) involved with the reviving efficient functioning of the Anganwadis and primary schools at Yadgir, in North Karnataka. The SRTT staff in turn trained the

ICDS staff in their project. Along with another NGO these groups covered two very backward districts of the State.

Training has also been imparted to ICDS trainees at NIPCCD and to Bala Sevikas of the Karnataka State council for Child Welfare. Individual members have been taking the parenting message forward through their organizational work in their own communities. However, despite all the above efforts much more needs to be done and the network is open to new members and new collaborations.

(Note: Written by Veda Zachariah with inputs from Lakshmi Krishnamurthy and Hema Srinivas - members of Network for Information on Parenting –Karnataka)

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12

STATUS OF PRIMARY EDUCATION IN KARNATAKA

- Nagasimha G. Rao

It is a fact that that those who were fighting with the slogan 'Education is Power' and demanding 'Education to be a fundamental right of all human beings' were at least somewhat relieved by the enactment of the Right of Children for Free and Compulsory Education Act of 2009. With the enactment of RTE Act the education activists all over the country thought that the dream of every children in the age group of 6-14 in the country would be in full time schooling, and in a safe environment, the atrocities on children will end, child labor will be significantly reduced and child marriages will end and every right of every child will be upheld. But the reality is yet to be seen. The situation is not much changed.

It is true that millions of children who were out of school were identified and brought to school. In Karnataka, the State Commission for Protection of Child Rights launched a state wide movement titled, 'My Steps towards the School'.

The Department of Education, which was claiming that only 14,000 OOSC (Out of School Children) was forced to change its statistical figures. Hundreds of voluntary organizations joined hands to bring out-of-school children to schools and enroll them. At the same time millions of parents became aware of the fact that children should not be out of school, and that children should be sent to school. But primarily a question pops up, is mere enrolment of children to school is going uphold the right to education? Children should get confident by acquiring knowledge, they should get an idea that education is going to facilitate in overall development of the personality. But is the education given by our system is providing opportunities for all-round development of children?

To find out what kind of education is provided by our teachers in schools, the Karnataka State Gnana Ayoga had set up a system. When the review of the learning abilities of children in 6th standard was conducted it was found that they cannot reach the text book of 3rd standard, if ten

words are given in dictation there will e mistakes in six words, they lack creativity, etc.

The State Policy Commission has said that what children need is not just right to education, but right to learn. Education without quality is waste, education is also an indicator of human development, literacy is a major component in all development measurements. The ASER – Annual School Education Report, released in December 2017, has revealed some alarming facts, (a survey of leaning abilities of children). The survey in 2017-18 involving about 28, 323 children has examined the learning abilities of children and also the teaching abilities of teachers. The data outcomes of the survey has opened the eyes and mind set of the educators, teachers on the learning abilities of the children and the capacities of the teachers in schools. Children in the age group of 6 to 14 years have right to education, they are expected to be in schools. What happens to them after 14? Will they continue schooling or go to work? The ASER survey when examining the kind of skills our children have acquired has shown that 51% of our children are not in a position to read a text in their own mother tongue. They cannot name the capital city of their state and country and cannot do simple addition.

A look at the national budget, reveals that substantial amount is earmarked for education. India's higher education is supposed to be equating with international standards, but the ASER report has shown that the primary education is at the lowest levels. After ASER, NFHS-National Family Health Survey 2015-16 report has shown that 81.4% urban below six years girl children are in preprimary system, only 63% below six rural girl children are enrolled into preprimary education. In Bangalore, 84.9% of girls go to school in urban areas. It is a well-known fact that it is the girls who are away from schools. Again, it is believed that when girls are schooled it is equal to a family being educated. But inspite of bringing girls to schools, if they are not educated, whom should we point at as the reason for the same. Are teachers not teaching appropriately or do we need to bring changes in the text books? What needs to be done?

According to a recent newspaper article, 80% of teachers do not like their career. On various occasions when discussed with the teachers on the issues of poor learning achievement, they have come up with following.

1. Not able to compete with non-government schools (so called private schools).
2. Parents are enrolling their wards to non-government schools due to the RTE 25% reservation.
3. There is too much work for teachers, there is shortage of teachers.
4. Education is becoming privatized.
5. Teachers' creativity has no value!
6. There is harassment and high handedness by the departmental officers.

Teachers often pour out with such complaints and grievances. RTE TaskForce is hounoring outstanding teachers every year. Some of the teachers who have received the honours are the teacher in

Gajendra Ghada, who walks up to the school on a hilltop and brings children to save the school on a day to day basis. Another teacher who is wheel chair bound reaches out to school in Betagery every day to encourage the other teachers to run the school. Such teachers with their commitment are a few promising examples to see that if teachers have love and affection to the children and to their profession, they can certainly achieve a lot.

Children's Education in Karnataka and 25% reservation

The Education dept in Karnataka is worried-the reason, around 534 schools had to pull down their shutters due to lack of enrolment. In about 9503 schools there are only on an average 20 students in grades 1 through 7. It is predicted that this situation will only worsen in the coming years. Authorities in the education department are hard pressed to find the reasons for this situation and trying to find answers too. Last year, 146 schools were closed without students in the state. The report, published in The Hindu newspaper in June 2015, has pushed not just about the Department of Education, it worries parents about education. Are parents not sending their children to government schools? There is a need to find out why parents have lost faith on government schools. A deeper study of these issues in the education and right of children to A deeper study education in Karnataka may reveal some more facts.

The Right of Children for Free and Compulsory Education Act 2009'came into force in India from 1-4-2010.But the Act was not immediately implemented in Karnataka. The conflict between the state and the centre and the lack of political will lead to the delay. The state government had put forward several conditions to implement the Act in the state (one can understand the difference of opinion between the two as the state was ruled by BJP and in the centre Congress).

The key issue was funds! The state and central share in the implementation of the Act was 50% and 50%. (Several states had disagreed with this). But after several rounds of negotiations among the states and 65% and 35% share was accepted between the centre and the state respectively. The act went into effect in June 2012.

At this juncture a report shook the people of Karnataka. It was a report presented by R Govinda Committee. A committee under the chairmanship of Professor R Govinda was appointed to provide recommendations on improving the school education in the state. The committee apart from several recommendations also advised to close down 12,470 Kannada medium schools.

It was a paradox that in the same year when the Govt. is working to implement RTE, the Govt. was also advised to close down certain number of schools as there are no students in them. Several NGOs working in the field of education and educationists then were involved in a two-pronged activism- one to oppose the recommendations given by Govinda Committee and the second is to pressurize the Govt. for the implementation of RTE 2009

Facing intense opposition by several groups and committees, the Govt. finally made a promise that there is no proposal to

close the schools but merge the management. This for a relief to the campaigners and they sighed that they saved around 6000 schools. But just then there was another attack on the RTE. A non-governmental school in Bengaluru circulated a letter to the parents of the children studying in the school (opposing the proposition of Sec 12.1.c) RTE free seat children from poor background are going to spoil the school environment and it may affect the education of your children. So oppose RTE'.

This instigated many parents to write directly to the Education minister and also send series of emails demanding to withdraw the RTE Act which is going to have negative impact on their children. The whole incident took an ugly turn and the then Minister for Human Resource Department had to intervene into the situation and warn the school authorities for this kind of move and stand. But this incident left a big blow to the enforcement of the RTE. Debates started about the status of Non-government school, government school, government education, non-government education, etc.

Many disturbing and varied responses were recorded in this background. It is actually in Govt. schools. Normally this would provide an excellent learning environment. But this self-certifying statement by Govt. is not always true. In spite of these statements and questions, the RTE came into force from 2012-13 academic year in Karnataka. But the dream of free and compulsory education continued to be in question.

In the beginning of 2013-14, the High Court of Karnataka in a writ petition expressed its doubts about the out of school (OOS) children statistics provided by the Department of Education. The Education dept had submitted that only 53,000 children are OOS. The court ordered the dept. to find out all the children who are OOS with the help of NGOs and put all such children back to school immediately.

A survey conducted with the NGOs revealed that lakhs of children are OOS. In this background the question and hope of 'compulsory, free and equal education to all children' seem to be impossibility, with the closing of Govt. schools, expensive private school education and the lack of understanding of the RTE Act.

At this juncture we need to analyse the impact of the Supreme Court directions on the issue of minority schools. In 2011-12 managements of a few Minority Schools approached the Supreme Court that the RTE 25% reservation provision goes against the Constitutional rights of such managements under Articles 30 & 31. The court referred to the culture / language / customs provisions of the minorities and declared that such schools need not have to abide with RTE Act provisions.

A close look at the order dictates that the madrasas run by Islamic organisations and convents run by Christian monks do not come under RTE Act. But many institutions used the orders of the court to their convenience by trying to get minority status to their schools. One need to observed that in Karnataka, prior to 2009 the govt. had defined that if all the management members of a school belong to a minority community, only then such schools should be declared as a minority school.

2011-12 – If there are more than 75% of students are from a single religion it is a minority school. 2014-15 – If there are around 25% of the students belong to a single religion then it is a minority school.

In the midst of all the above three there are 'minority language schools' too. The minority schools listed in the Education dept website are as per the pre 2009 definition. Who decides these minority schools? Central Govt., State Govt., Wakf Board, Panchayat.

In Karnataka there are about 7000 schools who have applied for minority status. If all these schools get the desired status, then the RTE Act will lose all its meaning in Karnataka.

The conflict in the name of language is at its peak in the state. Those who are against Hindi welcome English. Similarly, those who fight for Kannada also turn to English when it comes to their own children's education. The debate on which is the best medium Kannada or English is a never ending conflict in Karnataka.

The RTE Act insists that children should be taught in mother tongue. Article 30 of the UNCR 1989 also suggest about mother tongue be the medium of instructions and education. But parents think that if children are given English education they can be better educated. Similarly, non govt. schools think that with English medium schools one can earn more money, then the govt. which has given permission to run English medium schools and the Kannada activists who demand for Kannada medium education- all these have not given the expected results. Who decides on the language of medium of instructions to our children? The Supreme Court in 2014-15 in its judgment suggests that it is the parental prerogative to decide on the medium of learning their children.

It's a pity that parents without any knowledge of English are opting for English medium for their wards and force them into the so-called Convents rather English medium schools.

Recently at Mudhol in a workshop a teacher sighed as follows: 'in govt. schools children learn with a smile and for non govt., schools parents send their children with a smile'

Between 2014-15, 2015-16 Govt., has reached the stage to close down hundreds of schools due to lack of children. The Govt., has bought time by changing its stand every now and then to be or not to be – to close or not to close. For govt. it has become a practice to blame 25% for lack of children in its schools. Parents end up in non-government schools with the 25% reservation. With the following statistical data it is evident that the govt., schools may have to be closed.

Is RTE 25% a necessary?

"At least 25% reservation should be provided to children coming from disadvantaged / financially disadvantaged in unaided schools says Section 12.1.C of the RTE Act". For these 25% admissions, the government reimburses the fees to the non-government schools which provide the reservation! Non-government schools shall not charge these children for anything - textbook, uniform, or any other service! The

wish of the Act and the 25% reservations is that let the children belonging to poorest of the poor families get educated in the neighbourhood schools – whether it is a Govt., or non Govt. school. It is the social commitment of the non govt. schools with higher facilities than the govt. schools to provide free education to children belonging to poor background. This 25% reservation has the intention of levelling the society. There was not publicity to the 25% reservation in 2012-13. The NGOs with the knowledge of this provision created awareness among the parents in their vicinity. in the midst of all confusions several parents were motivated to apply under the provisions and some children got admissions rather 'seat' in such non govt. schools.

Table 12.1: Children enrolled in Non Govt., schools with RTE 25% reservation

Year	No. of students enrolled
2012-13	49,259
2013-14	73,440
2014-15	92,543
2015-16	1,00,067
2016-17	97,991
2017-18	1,09,001
2018-19	1,19,678
Total	**3,13,233**

The minimum standards prescribed by our Govt. to allot a seat under RTE 25%

1. Family annual income should not be more than 3 lakhs
2. Caste certificate
3. Income certificate
4. Photograph of the child
5. Birth registration of the child
6. Address proof

[from 2017-18 it is compulsory to provide the Aadhar card of the child and of parents]

There is further reservation for certain categories within this 25% reservation that is meant for SC-ST children, children with disabilities, children of migrant families, HIV affected children, children of farmers who have committed suicide, children of 3rd gender, etc. The process of selection has changed from year to year. Now selection of children for this 25% reservation is done online

Benefits of RTE reservation

For parents

As per the Sec. 12.1c. of RTE Act, the un- aided schools should give 25% reservation to the children coming from financially disadvantaged families. Some parents who are benefited from this respond as follows:

- Our children, who are poor, can go to a non-government school that only the rich children thought of.
- We can also send our children to CBSE, ICSE and Central schools.
- There is a school in the ward where the house is located. It is good

Benefit to government

- Improved access to education for underprivileged children (social

integration)

- Non-government schools which are unaided from the government should wait for the government grant for children enrolled in the 25% reservation, which gives the government exclusive powers over the non-government schools.
- Non-governmental schools must submit an annual audit report to the government so that the government can monitor the financial affairs of non-government schools.
- It can be clearly seen that the government is shifting its responsibility to non-government schools

The benefit to non-government schools

- Rs 16,000 comes from the government per child to educate who are enrolled in 25% reservation.
- As no officer from the government pays any official monitoring visits to schools, schools can extract money from the parents in the name of uniforms and textbooks, although children are enrolled under 25% reservation quota.

25% Reservation is a boon to Money-Making Schools

In the past six years we have observed he following under the 25% reservation business:

- In the first two years reservation was given to really poor families. but after the Online system has come, most poor parents have stopped going for applying for the 25% reservation
- As the seat selection is done by lottery, parents have concluded that it is only luck that decides 25% reservation.
- Children enrolled under 25% are charged for textbooks, uniform, karate, dance, tour, transportation to school etc. Even if the parents complain about the same govt. is not responding.
- In many schools children enrolled under 25% are seated separately. Discrimination is a violation of children's rights.
- While the minority schools declare that the RTE Act is not for them, several schools are attempting to get minority school tag.

Problems arising out of 25% reservation

- Many parents who enrolled their wards at the entry level, with 25% reservation – L KG and / or U KG have decided to shift their children to Govt., schools as they cannot bear the fees.
- Some parents have filed cases against the schools and are making trips to the courts.
- Parents have formed RTE Parents Association, Right to Education Trust and are organizing protests on a day to day basis against non govt., schools and education dept.
- There is increasing unrest about 25% reservation as it is seen as a main reason for the down fall of govt., schools
- RTE 25% has also paved way for

corruption. The school management of unaided schools, middle men and the education dept officers has taken bribes.

- With the ambition to get a seat in Non Govt., schools under 25% parents are also getting indulged in altering the birth certificates, changing the house address, providing false caste certificates, income certificates, bribing the officers, etc.

Has the 25% reserved really affected the government schools?

Over the past seven years, government schools have been in the process of closing. At the same time many non-government schools have started afresh. Along with this there is roaring campaign for 25% reservation. Some non-government schools have even promoted the reservation, as the 25% reservation refund of fees is guaranteed. The opposition levelled by the association of non govt. schools is not seen now!

Reports from the education department make it clear that parents tend to enroll their children in non-government schools. As there are no English medium LKG and UKG in government schools, parents who decide that their children can develop only with English medium are enrolling their children in a non-governmental school. This has created a void in government schools, with less or no children in govt. schools and a very good pretext to pull he shutter down of the Govt. schools.

Non-governmental schools advertise in many ways about the facilities and education available in their schools, advertise in the media, conduct home visits to attract the parents and children. At the same time govt. has failed to attract parents to Govt. schools due to the dilapidated school buildings, lack of teachers and facilities. How can parents send their wards to such schools?

There are 48571 government schools and 19593 non govt. schools in our state. Over 3000 schools are under minority tag and do not entertain 25% reservation. In the remaining schools 25% reservation can accommodate 1.5 lakh. of children. The government has failed even to attract the rest of the children government schools. If the govt. give sufficient and the right publicity by developing basic facilities in schools and also give education about the provisions of mid-day meal, scholarships, milk, shoes, free tuition, pottery, etc., it can certainly attract substantial number of children to govt. schools. But looks like the govt., has decided to stop thinking on these lines. As a result those who are fighting and advocating to retain govt. schools and for common schooling, equal education are not getting the expected results.

Table 12.2: Enrolment of children and differences

Year	Non govt. (unaided schools)	Govt. schools	Aided schools
2015-16	36.51 lakhs	47.45 lakhs	15.14 lakhs
2016-17	38.93 lakhs	46.50 lakhs	14.29 lakhs
Difference	+ 2.42 lakhs	-95 thousand	-85 thousand
	Non Govt. schools – enrolment to 1st standard		Enrolment to class 1st in Govt. schools
2006-2007	3.15 lakhs		7.69 lakhs
2017-18	5.27 lakhs		4.99 lakhs
Difference	+2.12 lakhs		-2.70 lakhs

(Academic Report of the Department of Education)

Is the 25% reservation really free?

RTE TaskForce was initiated in the year 2002 basically to protect the parents who had enrolled their wards under the 25% reservation (Sec. 12.1.c of the RTE Act 2009) and to protect such children from any kind of discrimination. The RTE TaskForce is a consortium of several NGOs and also got support from parents.

Parents of children who are enrolled under 25% have been facing several problems from the beginning.

Parents of these children have been paying fees for uniforms, textbooks, computer education, etc., as and when the schools have charged them.

They have lost hopes on the Govt. and its officers as there is no response from the govt. for any complaints made to them.

The non govt. schools who have taken 25% reservation are making money from both the sides – getting the subsidy from the Govt. and also charging parents for various purposes.

Many parents have paid more than 1 lakh as fees under several categories in these so called non govt. schools.

The school authorities are not giving receipts for the fees collected and thus there is no tangible evidence to take the issue to the courts.

The RTE TaskForce has conducted a study on these and has shared the findings with the Education dpt., KSCPCR and the media.

Objectives:

1. To understand the financial situation of parents who have enrolled children in a non-government school through RTE 25%;
2. To find out in what ways non-government schools take money from parents;

3. To share the findings of the study with the Department of Education, KSCPCR , parents and the media;
4. To submit the findings of the study as recommendations to KSCPCR and Government.
5. To provide evidence on how the non-government schools have become business centres in the name of education.

Limitations:

The study faced several obstacles:

1. Most parents did not cooperate with the study because they felt that it would disturb their children's education.
2. Parents are not aware of how much money they are paying each year as non-government schools do not provide any kind of documentation for the money they have taken.
3. Lack of awareness of 25% reservation in districts other than Bangalore.
4. We had to confine our study to 100 parents, as rest of the parents either not cooperating for the study or they do not have any information, although the TaskForce wanted to reach out to 500 parents

Location of study:

The main district we chose for our study was Bangalore Urban district. The reason is that no other district in the country (as per our knowledge) has seen such widespread struggle to popularize R.T.E 25% reservation. The study thus got confined to Jayanagara, JP Nagara, Basavanagudi, Hanumanthanagara, Kurubarahalli, Laggare, Koramangala, Indiranagara, Kengery, Banneraghatta, Nandini layout, Frazer town, Lingarajapuram and such areas where normally poor parents are located and those who volunteered to provide the necessary data.

This study was supported and conducted by members of R.T.E. TaskForce.

Parent's Background:

Occupation

Out of the total households that the study collected data, 10 percent of the fathers are employed in private establishments. About 14 per cent were small time traders and the remaining 76 per centre laborers (most of whom are auto drivers, car drivers)

Overall, only about 14% of children's mothers are employed in some form (private employment = 2 percent; wage labor = 12 percent). The remaining 86 percent of mothers are housewives.

Table 12.3: Occupation of parents

Type of occupation	Father's occupation (%)	Mother's occupation (%)
Private Employee	10	2
Business	14	0
Coolie	76	12
Housewife	0	86
Total	**100**	**100**

Family size

About half of the families (around 46%) have 4 members in the family. 28% families have 5 members; 12% families have 3 members and 8% of the families have 6 members and lastly 6% of the families have 7 members in their families.

Table 12.4: Size of the Family	
Family size	%
3 people	12
4 people	46
5 people	28
6 people	8
7 people	6

Most families, (86%) have only one bread winner that being the father.

Family Annual Income:

Of the total households in which data was collected, only 96 households reported their annual income. Most of them (63 per cent) have an annual income between Rs. 20,000 - 50,000. The annual household income of 18 per cent is Rs 10,000 - 20,000, while the annual household income of less than ten thousand in 4 percent families.

Table 12.5: Family Annual Income	
Annual Income (RS)	%
>10000	4
10000 - 20000	18
20000-50000	8
50000 - 1 lakh	63

Details of children enrolled in a non-government school under the Right to Education Act: Of the total children enrolled under RTE quota 68% are girls and 32% are boys in the 4 to 11 years bracket.

Table 12.6: Enrolment details	
Year of enrolment	%
2012-13	17
2013-14	20
2014-15	23
2015-16	26
2016-17	14

In the 2012-13 academic year 17% of children and in 2015-16 academic year 23% of children and in 2016-17 academic year 14% of children have been enrolled to Non Govt. schools under the RTE Quota.

Of the total number of children enrolled under this provision, 92% of parents have informed that they have paid for their child's education in some form or the other.

Table 12.7: Reason for payment	
Text book/uniform	%
Text book/uniform	31
Insistence of the school	61

Only 8 % of parents said they never paid to the school for the education purposes.

Of the total number of parents who paid fees to schools 61% of parents have said that they paid on the insistence of the school. 31% of parents have paid for textbooks / uniforms, and 8 % of parents said they paid for school maintenance.

Here is the quantum of money that the parents have paid to schools in different years.

Table 12.8: Quantum of money paid by the parents

Out of a total 92 parents who were paid, only

Year of enrolment	Number of parents that have paid fees	Quantum of fees Rs.
2012-13	17	4,07,790
2013-14	19	2,83,825
2014-15	20	5,45,000
2015-16	24	2,22,660
2016-17	12	1,65,175
Total	**92**	**9,32,835**

37 (40 per cent) said that the school has issued a receipt for the payment. The rest have not received any kind of proper receipt for the fees paid by them. But 65% parents have said that they are aware of the fact that the children enrolled under 25% reservation have a right to free education in the schools!

Complaint:

Of the total number of parents who have paid for the school, only10 have said that they had complained to the BEOs about the schools demanding for fees. 14 parents have approached BEOs, education Dept and the KSCPCR.

Of the 24 parents who have complained, only 5 have received some response from the concerned.

Quantum of money/fees for child's education:

Of the total 92 parents who have paid the school, 46 % of parents (42 people) said they are willing to pay in the coming days and it is inevitable.

Almost all parents have no idea about what would be the cost to get their children complete their 8th stand education in Non govt. schools under RTE Act. However, those who answered the question said they would estimate around Rs. 30,000 to Rs. 2 lakhs.

School Development Committee:

From the respondents to our study it is found that only in 62% of the Non Govt. schools there are parent's associations or School Development Committee.

Again only 62% of the parents have said that the information elicited from them can be converted into a complaint and be shared with the authorities.

Finally ....

The 25% reservation is a boon given by the Govt to children from poor families. With appropriate supervision, this fantastic social equalizer dream can be realized.

Nagasimha G. Rao: Director, Child Rights Trust: Convener, RTE taskforce
He is involved in training of UNCRC and acts related to children, network building and preparation of resource material from 17 years.

13

CHILDREN'S LIBRARIES IN KARNATAKA

- Nagasimha G. Rao

Indian culture reveres books as gods and naturally considers libraries as temples of books. It was difficult to think about libraries everywhere when education was not that important in society. During the time of British occupation, education began getting more importance over a period of time and various other dimensions of education were also shaped. Libraries welcomed socially minded people to look into the books to understand diverse opinion about issues, collection of information, critiquing on issues, etc.

It is said that Nalanda University, had the world's biggest library. The library revolution started in India in 1951. Public libraries were initiated then with modern technology and systems adopted from UNESCO. Libraries were initiated in Karnataka too and in 1965 Karnataka Public Libraries Act was passed. As per this Act several libraries were started in various parts of the state. As there were libraries in every nook and corner and specifically in every taluka centre, it attracted book lovers and gave opportunities for publishers to bring out new titles. In the initial stages the government had no idea of starting separate or specific libraries for children. Books for children were kept in a corner of general libraries and called as Children's section. In most libraries, books for children would get mixed up with other books and even if there was a separate section for children in Public Libraries, one hardly found children in such a set up.

Ms. Kalyanamma is a pioneer who realized the need for having a separate library for children and started the same in Bengaluru. Ms. Kalyanamma is the person who cared for children and started the famous 'Makkala Koota'. Apart from cultural and creative activities, Makkala Koota had the distinction of starting a library for children in 1940 itself. It is said that the Makkala Koota had child friendly environment and children could take their book and sit anywhere in the surroundings to read. In 1960, the library was reorganized and had thousands of child members. Even today the library is active and is a model to many such groups.

The Karnataka government started a special library called 'Indira Priyadarshini Children's Library' in Cubbon Park, Bengaluru. Although the library had child friendly environment, it was criticized a lot.

Karnataka Knowledge Commission made some attempts to revive it in 2011. But, even now not many children visit the library. (Unfortunately the Government has a wine trading centre next to this children's library!) When there came a time that one could find less and less of children's libraries, Hippocampus Reading Foundation introduced a scientific method attract children to books and libraries.

Why Children's Library?

If we do not inculcate the habit of reading to children, we cannot think of them developing into human resource of the country. Children cannot get adequate information and knowledge only by reading school textbooks. Books help in developing creativity, visualizing something new. One can identify various kinds of developments during childhood. Playing with various things, examining them, listening, attempting to draw and write, are all part of their development. In this stage, i.e., if books are introduced to three year olds, they get attached to books. Along with this if everyone develop a mini library is their houses, it reinforces the habit of reading.

Even now, many do not have the habit of buying books. There are quite a lot of people who consider buying books as a waste of money. If a house does not have books and elders who cannot narrate stories to children, the capacity of a child to imagine becomes limited.

Apart from highlighting the importance of survival, protection, development and participation rights of children, the UN Convention on the Rights of the Child, in its Article 17, directs the state and the concerned to provide appropriate and suitable information to children. But, it is sad fact that systems to provide information to children are not deep rooted in our society. There are magazines, books for children. But, there is no credible system that provides comprehensive information to children. Similarly, we do not have adequate number of children's libraries in comparison to the child population. It is estimated that for every 30 children there should be about 200 different books-books with colourful pictures, activity books, comics, books meant for very young children and books where children could just see and get to know something also should be there. Such books would encourage more children to come to the libraries.

It has always been said that India is a country of villages. In most of the rural areas, library is confined to the Grama Panchayat office. A small room with the board 'library' may have some newspapers. The Right to Education Act 2009 prescribes that every school should have a children's library. As per the Act there are libraries in every school. But, a very important question is that, whether the books in such libraries are in tune with the spirit of having a children's

The Rural Children's Library in Chakaleti has 3D books and has attracted children to the books. The pictures in the books come 'alive' when you concentrate and see them. Children get thrilled by this experience. Information about such books travel very fast from child to child and many children come to get that experience and they take up membership in the library.

It was in 2012-13 that Government of Karnataka initiated closing down Govt., Kannada medium schools, due to lack of enrolment. A school in Ajjampura village in the midst of forests in Chamarajangara district was also one such school which was closed. As a result children from Ajjampura had to walk for about 8 km to reach Rampura School. Some dropped out as they were scared walk through the forest and in midst of wild animals. Almost in the same time, Mobility India, an NGO started a library at Rayakeri just a km away from Ajjampura with the help of CRT. Children who have left schools are now regulars at the library and it has become an alternate school for them.

library or not? SSA grants Rs. 10,000/- every year to schools to procure books for children's library. But, one would hardly find any teacher who would have the idea of what kind of books should be brought for children. Selection of books for children is an issue associated with psychology of child development.

Hippocampus Reading Foundation – Scientific libraries.

With an aim to establish, 'creative libraries' Hippocampus Reading foundation was started in 2004 in Tamil Nadu and Karnataka. With their research on children and books for children, Hippocampus has developed a scientific method and formula titled GROW BY READING to facilitate children to inculcate the habit of reading. The purpose of this formula is to grade and segregate published books keeping in mind the age of the children and their capabilities of reading and understanding the content of the books. Books are indexed in different sections with a colour code.

1. G: Green
2. R: Red
3. O: Orange
4. W: White
5. B: Blue
6. Y: Yellow

These colour codes not only group books, but also the level of the reading capacity of the children.

Green indicates those books which are meant for children, who have the capacity to identify and recognize 'pictures' or drawings. Children observe pictures and understand the story. In the subsequent stages, words are introduced and sentences are brought in and the number of pictures would reduce. Finally the 'yellow' stage where there would be no pictures and that might be a novel. These stages also help in understanding the capabilities of the children to understand the contents of the books. This method has also shown that if we provide books that are in tune with their grasping capacity, they develop an interest to read more books and increase their ability in understanding more content.

For this, all the books in the library have to be 'graded' with the colour code. As mentioned earlier along with the books, children are also grouped as per their level of reading. Every month children are screened to mark their progress from grade to grade. Once children reach the Yellow stage, they would have developed a capacity to read any kind of books. [This may vary from language to language]. It is observed that once children reach green level, they put some extra effort to reach the yellow level. This also indicates that their learning levels have changed. Hippocampus which is conducting training to librarians from government schools and NGOs, is also involved in publishing books for children. Hippocampus even visits the libraries and gauges the effectiveness of their training. They also have instituted awards for best libraries.

Libraries and children's books

As mentioned earlier Hippocampus Reading Foundation has identified books for children in six stages. But, in the open market it is very difficult to procure books for children in the age group of 3-5 years [Green stage] and 5-7 years [Red stage]. It is true that it is a big challenge to visualize stories, write and bring out books for them.

As reported by KIDS, Dharwada an NGO that runs Rural Children's Libraries, has recorded that the teachers have identified and reported that the children who are regular to the libraries have shown positive signs in their learning capacities too. The librarians have also said that there is a healthy competition among children to reach 'yellow' level.

There are very few writers and publishers who have taken this challenge. It is true that not many translations are

available now a days either. To narrate a story with only pictures, both the story teller and the artist have to work together. Or the illustrator would be the writer too. Hippocampus has published some books translated from English. But, they have retained the same pictures or illustrations. As the pictures are not very familiar to our children rather, the pictures are very western or alien our children have a little difficulty in relating with them. After several researches conducted by 'Pratham' another group, they have found that children relate to the books very soon, if the pictures and the content of the books are in tune with the culture and surroundings of the children. The books brought out by Pratham are not very expensive and are meant for children in the Green and Red stage. Pratham is bringing out books with a motto, 'books for all children' and it is a nonprofit initiative. Although some publishers like Sapna Book House and Navakranataka have made some attempts there still a big vacuum in this field.

Magazines like Chandamama, Bombe Mane, Balamithra, Putani, which were available in the market abundantly were meant for children, and they were books in the Blue stage. There are novels, drama, story collection, translations, etc., but not many books which are meant for beginners.

Innovations

Saranga Trust's libraries, Bengaluru:

Ms. Hema Srinivasan has initiated 'mobile libraries' in the village of Gorur Taluk, Hassan district. PUC students take books from the centre to villages and there would be young children who would be waiting for the arrival of the books. They return the books taken in the week before and take new books. It is heartening to note that the adults in the villages are now demanding that they too need such a facility. Mobile libraries are a boon to the children who otherwise cannot reach the libraries in taluka head quarters. Such a facility will be of great help for many children with disabilities or children who are not allowed to travel to far off places to reach the libraries.

Chakaleti Rural Children's Library

Chakaleti Rural Children's Library was initiated in 2011 with the support of Child Rights Trust in the village. In the last five years the library has been identified as a centre that has given abundant opportunities for children to participate and has been identified as a library 'run by children for children' by Hippocampus and has received an award in this regard. In this library children grade the new books as well the children according to their capacities. The library which started with only 30 members is now brimming with 150 members. With the experience of this success, Rural Children's libraries have been initiated in the districts of Bellary, Chitradurga, Dharawada and Chamarajanagara.

Some publishers

- Akshara Prakashana,
- Navakarnataka
- Sapna
- Book Worm

Nagasimha G. Rao: Director, Child Rights Trust: Convener, RTE Task Force; Has been involved in training of UNCRC and Acts related to children, network-building and preparation of resource material since the past 18 years.

14

INSPIRING JOURNEY OF THE KATHE BUTTI

- Hema Srinivas

Saranga Trust in partnership with Hippocampus Reading Foundation started library programme in 2007.

Hippocampus Reading Foundation (HRF) was the knowledge partner who trained us and also introduced us to the concept of running libraries with minimum requirement to the underprivileged children.

Saranga Trust had adopted the government primary schools in 18th cross and 6th cross, Malleshwaram from 2005 onwards to implement learning activities in school through innovative ideas. During the course of interaction, one very disappointing fact came to be noticed was, the children were not able to read Kannada, in fact even in class 6th and 7th, they could not even identify the letters properly.

At that point, we were introduced to GROW BY READING programme of Hippocampus Reading Foundation, which was entirely to motivate children to read through well illustrated story books and interesting activities. What made us take this concept was mainly, it did not require any library room, and fancy stuff. All it required was creative skills, interest in storytelling to the children with a few story books in a bag. .

As we had no clue about how to get good illustrated Kannada books, they introduced us to the well illustrated Kannada titles published by NBT, CBT, Tulika etc.... It was really a very effective method to motivate children to take a book, and try to read. We very soon realized, it was helping them to read their text books also better. The feedback from the teachers was also very encouraging because of this positive effect on their academic performance. That was the beginning of our very interesting journey of the Granthalayas.

In 2008, we thought of taking this to the rural children. In fact, it is all the more important for them, because they hardly get to see, feel and enjoy reading such well illustrated story books.

We have moved forward, keeping the basic idea of HRF as it is, but developed our

own methodology to suit our needs, trying to make it as simple, low cost yet very effective programme.

At first, we introduced it to Gorur government primary school .But, the idea was to introduce in more number of villages. We had to find a way to do it effectively without much expense.

First we created a central Granthalaya to store story books for lending. Very soon, we developed our own way to conduct this programme cost effectively. Saranga Trust has been supporting education to girls and boys in villages around Gorur to continue after 10th standard. One day, one of these scholars asked about this library, and wanted to know whether she can also do it in her village. That was the beginning of our Kathe Butti Granthalayas concept. About 7 students offered to do this voluntarily, and they felt very proud about the fact that they were doing something for the development of children in their own villages.

Since then, instead of getting salaried librarians, we used our own college going scholarship students whoever who is interested in this to conduct the activities. All of us were also part of this to guide them, inspire them. Sometimes, it was these students from very poor families who inspired us with their innovative ideas and enthusiasm in reaching out to the children. .

We trained them on the basics of how to run a Granthalaya, the activities which should be introduced, etc… Those who are naturally very creative did extremely well, added new ideas and made it more holistic.

We created a central storing place. Each one of these scholars would come and collect 30-40 story books from there once a month, carry them in a bag (Basket) to their village. Initially they started gathering their village children near their house and introduced them to story books, games, recitation, narrating stories etc.…

Slowly, they started conducting in their village government schools, so that more number of children enjoyed this and also, it was a very value added programme for their academic learning the teachers welcomed them.

To make it more interesting, we included conducting children day events, competitions in storytelling, reading, art and craft, sports; and gave them all prizes for participation.

Later we introduced projects where they have to read stories related to the project topic, and also collect information from other sources. So the children, who till then were not looking at news papers, started reading to collect information, they started asking questions to collect information. They were also supposed to create their own drama scripts related to their project and perform.

Because of this project, in 2011, children collected information on birds, made models, displayed art and craft work, danced and performed a drama entirely on birds. So, when Ms, Shantha Nagaraj, Kannada writer. Conducted a quiz, the children were not only giving answers; they could also give some explanations to certain answers. This inspired her to write a story book on “Kagajjana nyaaya” and released the book in our Gorur Kathe Butti center in 2013 November. .

Having successfully spreading the passion for reading, we have now extended our Granthalaya activities towards creative writing.

1000 children participate in workshops, discussions, reading story books and illustrating them, writing their own imaginary stories etc..... We are giving them the new experience of publishing their work in our children magazine called—Saranga Kathe Butti Granthalaya Makkala "Kuhu Kuhu" Pathrike.

We have so far published 3 issues, and it has been one of the very thrilling experiences to see the joy of the children when they receive the pathrike. Seeing their names and photos in print media is always a very exciting thing for any age group. Now the rural children are enjoying owning a pathrike, and enjoying all the activities just like any other child in the world.

The pathrike is like a library (one kathe Butti) itself, it has all the ingredients , stories to read, create art work, articles to read, writing their own imaginary stories, quiz, puzzles, an activity to do on craft, to practically learn science concepts, etc… and some useful information relevant to social causes . At a time, Kathe Butti is reaching to 1000 children through this "KUHU KUHU"

We are planning to spread this to different rural areas selecting each time 1000 rural children to participate in this innovative creative activity.

This has no boundary, it can go anywhere, reach out to any number of children. But this is not as simple as running Kathe Butti Granthalayas, because of the printing cost to print each issue is involved.

We hope the journey of the Kathe Buttis will continue reaching to many more children, and if somebody who can take this concept forward to reach many more children and introduce in their field, it is very satisfying to us.

Hema Srinivas: Counsellor and Trainer on Parenting. Founder, Saranga trust through which "Kathe Butti Granthalaya" was developed to create interest in children for reading and writing in Kannada through creative activities; also the free magazine publication, "Kuhu Kuhu" – For the children by the children; supports young girls psycho-socially and financially in their education; Member of the Network for Information on Parenting – Karnataka.

15

CHILD PARTICIPATION IN KARNATAKA – A FEW EXPERIENCES

–Vasudeva Sharma N .V. and Nagaraja B.G.

India has acceded to and ratified the UN Convention on the Rights of the Child (1989) in the year 1992. By this, India has promised the Indian child and the UN that it would uphold the survival, protection, development and participation rights of all children in the country. As part of the Indian republic, the state of Karnataka too has the obligation of accepting and upholding the UNCRC.

Child Participation

Child welfare and development programmes by the government like the health, education, protection, nutrition programmes and prevention of child mortality etc. are highly visible, whereas participation is not. The reason may be because of the fact that participation is an abstract concept and it cannot be quantified or compared with another variant. To identify child participation, we need to scrutinise interventions in every sector. In Karnataka, however, a few effective attempts of child participation can be identified as a result of the joint efforts by the Government and NGOs.

Art 12 of the UN CRC directs that it is the responsibility of the adults and the society to 'respect children's opinion'. Along with this, the Convention says that it is the duty of the adults to provide appropriate information to children so that they can form their own opinion. For this to be implemented, the Convention guarantees Right to Education (Art 28 and 29); Right to appropriate information (Art 17). Along with this, the Convention guarantees the right to express one's own opinion (Art 13); right to associate (art 15) and right to privacy (art 16) to emphasise the right to expression or opinion and right to participation.

However, it is not enough just to say that children's opinions will be honoured. When we analyse the various articles of the UN CRC, it throws up several situations that compel the adult society to provide opportunities for children to participate. For example, in the implementation of the Juvenile Justice Act, everyone who come across children in need of care and

protection; children in contact with law and children in conflict with law should facilitate the process in such a manner that it does not hinder the child's right to participate.

In this context, we cannot forget 'non-discrimination' and `the best interest of the child' that are the basic principles of child participation and the concept of child rights. It is a reality that in a country like India, due to the existence of caste, religion, class, language and the parental background, many adults, even those individuals entrusted with the responsibility of delivering services to children do discrimination that hinders the right to participation.

Children in Karnataka

As per 2011 general census, Karnataka has a total population of 6.10 crores. In that, the population below 18 years of age is 2.07 crores (32 %). In this, the urban child population is 73 lakhs (35%) and rural child population is 1.34 crores (65%)

As per the recent Govt statistics primary school enrolment rate is 99.85 %, and in this 12.51% of children have continued their education beyond 8th standard. In 61,187 Anganawadis and 3,331 mini anganawadis, 37,71,495 children are enrolled. 83.4 lakh children in primary (1 to 8th standard); 17.66 lakh children in high school (9th and 10th std) and 6.77 lakh children in college education are enrolled.

Table 15.1: Child Population & School Enrolment

Sl No.	Age groups	Child population			Sex Ratio	Enrolled in education			
		Male	Female	Total			Male	Female	Total
1	0-3	20.48	19.56	40.04	955				
2	4-6	16.27	15.29	31.56	939	Pre primary			
3	7-14	45.58	43.05	88.63	944	Primary	43.07	40.37	83.44
4	15-16	1.95	10.79	22.75	902	High school	9.2	8.46	17.66
5	17-18	12.76	11.53	24.72	903	College	3.31	3.46	6.77
	Total	**107.04**	**100.22**	**207.7**	**936**	**Total**	**55.58**	**52.29**	**107.87**

A large number of children are also enrolled in various residential hostels in Karnataka. The Government is running hostels under various categories for backward communities and castes, and for minority children in almost every taluk in every district, either directly or indirectly by providing grants.

In spite of these facilities, a large number of children are out of the education system or dropouts. There is no information available about the number of children in private and NGO run pre-primary schools. More importantly, there is no system at present to control or direct them on this.

Government either directly or in coordination with NGOs (educational institutions, religious institutions, etc) is also running hostels for educational purposes. Along with this, destitute cottages and homes for boys and girls are run by the Dept. of Women and Child Development and educational programmes are going on in these institutions. Over and above this, fit institutions (certified by Child Welfare Committees and DWCD) also keep children in need of care and protection for temporary as well as long term care and provide opportunities for their education and development.

Social Welfare Department also runs various hostels, residential school in all taluks of the state. There are also sports hostels in the state to encourage sports. Along with this, various NGOs with Govt, local and foreign support [religious institutions also] run educational institutions and hostels for children. A majority of these are run by either Trusts or Societies. However, it is ironical that they are called as 'private educational institutions!'

Similarly, for the benefit of children of minority communities, several religious and non govt organisations are running children's homes. They normally provide residential accommodation for education and skill training.

Child participation and a few legislations in India

We need to identify the concept of child participation from the Constitution itself. As children are 'Indian citizens', children also have the Constitutional provisions of 'participation and right to express' [Art. 19(g) A]. As a result, children already have the right to participate. In India, adult franchise, the right to vote comes into force only after an individual attains 18 years. As a result, there is an argument that children have no right to participate, they cannot vote. So, when children cannot vote, they have no say in other areas too!

There is hardly any recognition for child participation in families, schools, public places or in homes for children. Many a times when children are narrating something, most adults hardly pay attention to them. Adults do not know the skill of looking at the face and eyes of children and respond to their feelings. At the same time, adults normally expect the children to tell everything quickly (adults have no time!). Most children do not know the art of telling something in one go. They need time. Children may not possess such vocabulary. We also do not know the method to convey to the child that we have heard her/him and asking simple questions without hurting the child and getting information.

As a result, the adult mind set is fixed with 'what is there to discuss with children? After all what could children say? What do they know? We adults know everything.' The work towards child participation is largely to educate the adults to respect children's views. So, rather than telling children that they have the right to participate, we have to take up campaigns in the midst of the adult world that they need to understand children's feelings and expressions.

The National Policy for Children 2013 is said to have imbibed the essence and language of the UN CRC. The Policy seems to have given equal importance to child survival, protection, development and child participation. In its preamble, the NPC highlights that the opinions of children, particularly of girls and children in difficult conditions have to be taken into consideration keeping in mind their age and understanding[1]. In the same manner, while detailing on the need for advocacy for the implementation of the policy, it says, (5.3) that there should be systems for Children to express their views on anything that influences their life[2] and reach their voices to the concerned[3].

Perhaps it is time now that we stopped ourselves from having a separate slot for child participation in our discussions and programmes. During the 1990s, there was a need to specifically point out and adhere to child participation. But now, we have entered an era where child participation has become an integral part of all child development programmes and processes. We now need to identify and recognise areas where child participation has become part and parcel of the processes and areas where we still need to create a space for child participation.

A few statutes where child participation is integrated

It has to be reiterated that except for the Constitutional provision for 'expressing your opinion' (to children also), there is no other separate law that governs the aspect of participation. But, in a few acts that are in operation now, child participation and child's opinion has become mandatory.

For eg., the Juvenile Justice (Care and Protection) of Children Act 2000/2006 specifies that 'the CWC and the JJB have to take the opinion of the child before making any decision about the children'. Very importantly, children have the freedom to decide whether he/she is willing to go back to their families/parents or not and give reasons for the same. The Board or the Committee has to give a patient hearing on this, record the same and then take the next steps. On similar lines, in the adoption process, the courts have to record the opinion of the child (if the child has attained the age and maturity to respond to such queries) whether he/she is willing to live with the adopted family. The recent Protection of Children from Sexual Offences (POCSO) 2012 Act has given very clear status for child participation. Priority has been given to record the statement of the child in distress. Although we cannot see direct indications for child participation in the RTE Act 2009, issues such as no corporal punishment, no entrance exams to enrol into schools, no exams and no detention policy can be recognised as child participation issues.

As per the Karnataka RTE rules, there should be two child/student representatives in every School Development Monitoring Committee (SDMC) and every school has to display information about Child Rights and the ChildLine 1098 board for the benefit of the students.

Child Participation in Karnataka

Child Participation in Karnataka is visible in the form of Child Rights Grama Sabhas, urban ward sabhas, child rights parliaments, children's panchayats, child

rights clubs, school meena sangha (clubs), conducting rural children's libraries and in discussions to lobby with political parties and the government to consider child rights issues in their programmes and manifestos.

Child Rights Grama Sabhas

Between 2003 and 2006, Child Rights Trust conducted a field action research in 15 Grama Panchayats in Bellary District. The objective of the study was to find out to what extent, 'the grama panchayats are sensitive towards child rights issues and what do the Grama Panchayats know about children'. The study also included the objective to orient the GPs about what kind of information they need to keep and take up actions to uphold the rights of children locally. Over the three year period, the field workers visited Anganwadis, ANMs, schools and other service providers in the GP level as well as the GP members to get secondary data about the children. The field workers also made house to house visits and collected child centred data, met the youth and also had group discussions with children. [This action research was initially supported by Child Rights & You (CRY) and later by EveryChild.]

This research showed that most GPs did not have specific information about children (2003-06) and there was no interaction or coordination between the various child centred service providers like the Health, Women and Child Development, Rural Development and Panchayat Raj, Police, Labour, and the Education departments and the grassroots level people's representatives and officials. Child Rights Trust organised meetings with representatives from the above mentioned departments along with youth groups, NGOs and GP elected members and shared the findings of the action research (2005-06). These meetings were almost like mini Grama Sabhas, but on children's issues. The data and facts about the status of children in the GP level led to several discussions, both positive and negative. While a few accepted the facts, most departments blamed one another and the parents. In many GPs, child representatives prepared and presented wall magazines and posters on their situation and demands. Several GP presidents and members passed resolutions to correct the system at their level. In Hagaribommanahalli and Kudligi taluk, grama panchayats came forward to pay the rent for anganwadi buildings, to construct compound wall and to provide drinking water for schools

Child Rights Trust shared this experience with Mr. V. P. Baligar, then Secretary to Government, RDPR in August 2006. In a meeting called 'Manthana', the whole experience was presented to the senior officials of the department. Based on its experiences, CRT suggested that to discuss and take up positive and affirmative steps to uphold rights of the children at the GP level, there is a need to hold Child Rights Grama Sabhas regularly. On the basis of this suggestion, the Government issued a circular in 2006 instructing every GP in Karnataka to conduct one day Child Rights Grama Sabha in the month of November every year with the participation of children, adults, NGOs and representatives of concerned departments. It also directed that the GP has to take up measures to solve issues which can be addressed with local resources or decisions

and other issues should be included in the action plan and presented to the Government.

As per the information available during 2013-14, out of 5,660 GPs around 70 to 80 % of GPs have conducted Child Rights Grama Sabhas and have reported to the government. In all these, as evidence, they have also given photographs, newspaper reports and minutes with signatures of child participants. However, in all these cases, one cannot come to the judgement that there is meaningful child participation. Nevertheless, the process of including children has opened a new chapter in meaningful child participation. Several NGOs across the state are taking a major role in conducting pre meetings with children and facilitating the process of child participation to raise the value of child rights grama sahbas.

A few case studies are recorded here to give a glimpse of the issues that are raised in the Child Rights Grama Sabhas, providing an opportunity for child participation and articulation.

- Lack of facilities in schools, specifically, lack of subject teachers (particularly science, maths, social); school supplies reaching schools very late; locals littering the school premises; abusing the school toilets; having waste disposal and manure units and poultry farms near the schools etc., which cause problems for children.
- Lack of medical staff and doctors in health centres, taking money even from children in government health centres, lack of medical supplies, irregularities in immunisation and problems in supply of nutritious food and improper recording of child mortality etc.
- Child marriages, child labour, missing children, trafficking, violence on children by parents, employers and sometimes in schools, sexual abuse of children and discrimination and deprivation of services to children with disabilities, delay in providing scholarships, hostel facilities etc.
- Bad condition of village roads, irregular supply of electricity and drinking water in villages, lack of bus facilities, non availability of school stationery material in the village shops, non-existence of foot bridges to cross river lets etc., and particularly trouble created by alcoholics.

Some NGOs have successfully conducted Children's Panchayats in some districts by conducting elections amongst children and electing child representatives. Similar to Child Rights Grama Sabhas, recently Child Rights Ward Sabhas were also conducted in a few wards in Bengaluru.

Child Rights Parliaments and Interaction with the Chief Minister of the State

Child Rights Parliaments conceived and organised by members of the Karnataka Child Rights Observatory (KCRO) in all the districts of Karnataka has created a new wave among child rights

activists. This is a congregation of child representatives at the district level once a year (since 2006) organised by the district level members of KCRO. Taluk Child Rights Parliaments are held every year since 2014 and child representatives from these Parliaments come to the district level meet. Children suggest their representatives in whom they have confidence that they would articulate their issues effectively. In many districts, departments of education, welfare and DWCD have joined hands in organising district level meetings of children. In the whole process, about 1,500 children from rural and urban area take part in this parliament. Karnataka State Commission for the Protection of Child Rights also supported series of programmes during the year 2014 – 15.

To conduct these meetings, KCRO has developed a specific methodology and KCRO members follow the same process. Initially, children are given an orientation about the status of children in the state and then the district with simple statistical data and real cases. Later, children sit in small groups and discuss about the situation of children in their district and list out the needs and present them in the larger congregation.

In many districts local people's representatives take part in the District Child Rights Parliaments and give a hearing to the issues raised by children and respond. Many members of the Karnataka State Legislators' Forum for Child Rights are taking part in these meetings.

Child representatives selected at the district level take part in the State level Child Rights Parliament held in Bengaluru. The state level Child Rights Parliament held since 2006 is getting very good publicity and importance. Children sit in groups to discuss the problems faced by them and put together a state level list to be presented before the Government. Since 2011, Child Rights Parliament is coupled with interaction with the Chief Minister of the State at Vidhana Soudha. These children representing children from the whole of Karnataka State not only present the situation and demands of children, but also present some cases directly to the Chief Minister. Successive governments have taken these consultations seriously and have promised action. In the coming days, KCRO is trying to convince the Government to conduct this meeting on its own initiative and institutionalise the process.

School child rights Clubs, School Parliaments and Meena Sanghas

Child participation is seen in School Child Rights Sanghas, School Parliaments and Meena Sanghas in schools run by the state. With student representatives, these sanghas organise regular meetings, identify problems and discuss them with the school authorities and SDMC for solutions. Although one can see children's representation and importance in them, as there is a formal structure for these groups, they too have their own limitations.

These sanghas are active wherever the coordinating teacher is active. These sanghas have taken lead role in demanding proper facilities in schools, identifying school drop outs and bringing them back to school, informing authorities about possible child marriages and preventing them, etc. All these are very good developments. But, there is a

limitation to running these activities within the control of the school authorities. More often than not, they are restricted from mentioning anything about the difficulties they face within the school system. Many a time, a student representative is there in the SDMC for namesake. Mostly these members do not get any chance to speak for children and flag their issues.

In 2009, a student from a Government High School in a village in Arasikere taluk, Hassan district raised his voice against the abusive teachers in the school's Child Rights Sangha. The sangha questioned the physical abuse by the teachers. But the school authorities and SDMC denied the whole incident. The school also threw those students out. The Karnataka State Commission for the Protection of Child Rights intervened along with the local CWC and conducted an enquiry to provide justice to children.

On the lines of the School Child Rights Clubs, there are Legal Awareness Clubs too in schools. These clubs function under the district judge as per the directions given by the state Chief Justice. But due to lack of appropriate curriculum, lack of training to teachers/coordinators, these clubs are functioning only for namesake.

Conclusion: The science and process of child participation is not as simple as we talk about the right to survival, protection and education. Karnataka Child Rights Observatory and CACL-Karnataka are conducting consultations with children during every election and giving a list of their demands to the political parties. Several organisations and networks concerned with child rights are conducting consultative processes with children and are presenting alternative reports to the UN on the implementation of CRC in India. In 2003, when State Plan of Action for Children (SPAC) was drawn up, a wide range of consultations were conducted with children. All these are just a few attempts at realising child participation in the state. Child participation is not deep rooted in Karnataka. In some places, children are just brought on to the podium or taken out in a procession and then declared as child participation! There is a need for having continuous education and orientation on child participation with individuals, organisations and committees, boards and commissions who are directly or indirectly working with children.

1. National Policy for Children 2013, 3.Guiding Principles, (xii)
2. Ibid Advocacy and Partnership 5.3
3. Ibid Advocacy and Partnership 5.3

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THE JUVENILE JUSTICE SYSTEM CRITICAL GAPS AND CHALLENGES FACED BY JUVENILE JUSTICE BOARDS & CHILD WELFARE COMMITTEES RECOMMENDATIONS FOR CHANGE

- Neena P. Nayak

Introduction

The Juvenile Justice (Care and Protection of Children) Act enacted in 2000 and amended in 2006 and 2011 defines the 'child' as a person below eighteen years of age and provides for a separate justice delivery system. It includes both Children In Need of Care and Protection (CNCP) and Children who Come in Conflict with Law (CICL) and is a very progressive law in the country for their care, protection, treatment and rehabilitation of children. CNCP includes working children, children engaged in begging, children living on streets, victims of child marriage, child victims of physical/ sexual abuse, trafficked minors, mentally/ physically challenged children, children affected by HIV/ AIDS, children who are missing or have run away from home, children who have been abandoned or neglected, children harmed by natural disasters or man-made disasters like armed conflicts, earth quakes, floods, child labour, street children, child trafficking etc. while CICL includes children who have engaged in deviant or criminal activities such as theft, drug and substance abuse, participation in gangs, rape, murder, etc.

The Act provides for two competent bodies, the Juvenile Justice Boards (JJBs) for CICL and Child Welfare Committees (CWCs) for CNCP to cater to the needs of an estimated 40% of India's children or 170 million children who by GoI's own admission are vulnerable to or experiencing difficult circumstances. 80% of cases who come before CWCs hail from 21.9% of our population who live below the poverty line and struggle for survival with no access to social security measures. These children are mostly illiterate, school dropouts and have no access to acquiring skills to sustain themselves. Consequently, they run the risk of being caught in the nexus of exploitation, neglect and abuse. A small percentage of these children enter the JJ system as CICL

and according to NCRB reports of 2011, 87% of those who do, belong to impoverished families who earn less than Rs.50,000 per annum with no access to safe housing, clean drinking water and in many case even a square meal a day.

Taking cognizance of the precarious situation of this vulnerable child population, the JJ Act aims to uphold the dignity of such children deeming it the State's responsibility to provide appropriate care and protection by catering to their needs and rights. It calls for adoption of a child-friendly approach in the adjudication and disposition of child cases and has put in place separate processes and infrastructure for addressing the two categories of children. It eliminates the criminalization of children mandates that institutionalization and custodial treatment of children must be the last resort and focuses on family and community based rehabilitation.

The police have a key role to play within the JJ system. The JJ Act and State rules endorse the establishment of Special Juvenile Police Unit and appointment of Child Welfare Officers in each Police Station to handle CICL with sensitivity and compassion and also divert those who have committed minor crimes away from the JJ system. Regular orientation and capacity building programmes for the police continue to be arranged but have not yielded too different results.

The Model Rules of 2007 has attempted to further strengthen the above and instills child centric rehabilitation, family restoration and family and community based alternative care options such as Adoptions, Sponsorships and Foster Care for children through appropriate procedural and operational guidelines and provisions. States are expected to frame their own individual State Rules and many have done so with the Karnataka JJ Rules having been brought out in 2010.

To support and strengthen the implementation of the JJ Act, in 2009-10, the Ministry of Women and Child Development, Government of India introduced the Integrated Child Protection Scheme (ICPS), a comprehensive centrally sponsored scheme through the State governments /UT administration for promoting the well being of children in difficult circumstances as well as reduction of vulnerabilities to situations and actions that lead to abuse, neglect, exploitation, abandonment and separation of children from parents.

The ICPS provides preventive, statutory care and rehabilitation services to CNCP and CICL as defined under the JJ Act and financial support to State governments/UT administration on pre-defined cost sharing financial pattern. Structures and services to set up include Service Delivery Structures (State and District level Child Protection Societies and Units), Statutory Support Structures (CWCs and JJBs in every district) and Care Support and Rehabilitation Services (Emergency Outreach services for children through Childline, Open Shelters in urban and semi urban areas and family based non-institutional care through sponsorship, foster

care and adoption).

Allocation for the Scheme under the XII Plan period was Rs. 2,350 crores with all States/Uts having signed the MoUs for implementing the ICPS. For the year 2013-14, a sum of Rs.265.38 Crores had been sanctioned with the number of beneficiaries reached being 74,983. For the period 2013-14, Karnataka was sanctioned 2299 lakhs.

Legal framework

The genesis of the JJ Act is the Constitution of India (as prescribed in article 15 (3), article 39 (e) and (f), articles 45 and 47); the UN Convention on the Rights of the Child, 1989 ratified by India in 1992; the UN Standard Minimum Rules for the Administration of Juvenile Justice, 1985 (the Beijing Rules); the United Nations Rules for the Protection of Juveniles Deprived of their Liberty, 1990; UN Guidelines for the Prevention of Juvenile Delinquency, 1990 (The Riyadh Guidelines); UN Standard Minimum Rules for Non-custodial Measures, 1990 (The Tokyo Rules); and many other international conventions/treaties and instruments

The National Policy for Children brought of 2013 further enumerates a vibrant policy framework for catering to every aspect of the developmental needs of CNCP and CICL while recognizing that such children have equal right to learning, knowledge and education. It acknowledges the State's responsibility to secure theses right through access, provision and promotion of required environment, information, infrastructure and services towards the child's development to his/her fullest potential. It also commits to ensuring special protection measures for CICL.

Child Welfare Committees

Child Welfare Committees (CWCs) under the JJ are the final district-level authorities to deal with matters concerning CNCP. They have been given an immense responsibility for positively impacting the lives of CNCP to secure their ultimate rehabilitation through various institutions established under law including facilities for institutional care. Each Child Welfare Committee consists of a Chairman and 4 Members (including one women member) who are executive appointees drawn from civil society. They are to function as a Bench of Magistrates with powers equivalent to that held by a Metropolitan Magistrate or, as the case may be, a Judicial Magistrate of the first class as conferred by the Code of Criminal Procedure (CrPC) 1973 (2 of 1974).

The various functions and powers of the CWC are presented in Section 25 of the Model Rules and are as follows:

1. Take cognizance of and receive children produced before them
2. Decide on matters brought before them
3. Reach out to children being in difficult circumstances and who are not in a position to be produced before them with support from the District Child Protection Unit or State Child Protection Unit or the State Government;
4. Conduct necessary inquiry on all issues relating to and affecting the safety and well being of children

5. Direct the Child Welfare Officers (CWOs) or Probation Officers (POs) or non-governmental organizations to conduct social inquiries and submit reports to them
6. Ensure necessary care and protection, including immediate shelter to such children
7. Ensure appropriate rehabilitation and restoration, including passing necessary directions to parents or guardians or fit persons or fit institutions in this regard, in addition to follow-up and coordination with District Child Protection Unit or State Adoption Resource Agency and other agencies
8. Direct the Officer-in-charge of children's homes to receive children requiring shelter and care
9. Document and maintain detailed case records along with case summaries of every case dealt by the Committee
10. Provide a child-friendly environment for children
11. Recommend 'fit institutions' to the State Government for the care and protection of children
12. Declare 'fit persons'
13. Declare a child legally free for adoption
14. Keep information about and take necessary follow-up action in respect of missing children in their jurisdiction
15. Maintain liaison with the JJB in respect of cases needing care and protection
16. Visit institutions where children are sent for care and protection or adoption at least once in three months to review the status of children therein and suggest necessary action
17. Monitor associations and agencies within their jurisdiction that deal with children in order to monitor their well being
18. Co-ordinate with the Police, Labour Department and other agencies involved in the care and protection of children with the support of District Child Protection Unit or State Child Protection Unit or State Government
19. Liaison and network with non-governmental organizations for any of the above, including conducting social inquiries, restoration and rehabilitation, as and when required
20. Maintain a suggestion box to encourage inputs from children and adults alike and take necessary action.

Some limitations to the powers of the CWC include:

- A quorum of at least three members including Chairperson is required to pass an order
- CWCs have the power to declare a child legally free for adoption after following provisions in law. However, they do not have the powers to place a child directly in adoption.
- In matters relating to the custody of children in matrimonial conflicts, CWCs cannot pass orders for the child's custody as such powers are vested with the judiciary. CWCs can intervene in such matters and provide for the care and protection of the child.

Challenges faced by Child Welfare Committees

This JJ system in Karnataka has since its inception encountered several challenges and limitations, one of the primary issues being its inability to reach out pro-actively to children and consequently, only a miniscule number of CNCP enter the Juvenile Justice System. Listed below are some key challenges

1. Inadequate administrative and infrastructural support

- CWCs report that there are no systems in place for proper registering and recording of cases, listing cases for hearing, summoning parties, undertaking home inquires, etc. in spite of provisions in the ICPS due to lack of adequate administrative hands and provision of proper orientation and training of designated staff who are not always cooperative, speedy disposal of cases is hampered. Further, proceedings get stalled and delayed at CWCs without access to working tools such as computers, printers, storage equipment for recording case proceedings and support of full time data entry operators.
- Drinking water, adequate furniture to conduct sittings; separate room for interviews and meetings; play/waiting area for children; toilets for use by CWC Members and public not made available for all CWCs.
- A transportation facility to undertake visits to institutions and pro-actively reach out to CNCP within the district etc has not been considered inspite of repeated requests.

2. Limited Sittings and Constrains impeding execution of responsibilities

- CWCs without exception are located at district head quarters. Irrespective of the vastness of districts, case overload there is only one CWC per district except at Bengaluru where for a child population of about four million there are three CWCs. However though the CWCs here have been established to serve different geographical locations, yet the venue of sitting remains in the southern part of Bengaluru within the Social Welfare Complex where the Homes are located which does not make them easily accessible to public and CNCP in other parts of the expanding city.

3. CWC Members Lack Knowledge and Skills and Poorly Empowered

- CWC Chairpersons and Members often are not familiar with the provisions within the JJ Act and other child centric legislations and their own role, power and how to exercise them.
- Selection process not stringent and many appointees come in with little motivation. Under the Protection of Children Against Sexual Abuse Act 2012, they are expected to provide necessary rehabilitation support and extend the services of a Support Person to provide hand holding to the

child victim while they go through the criminal justice system. However, CWCs have little knowledge on the subject and how to intervene in such matters.

4. Dismal status of child care institutions

- Personalized care, access to education, health and psycho-social services for children and provision of adequate hygienic living space with proper sanitation are services missing in most of JJ Homes and NGO run institutions. Abuse and violence within the Homes are issues which get repeatedly reported by children and about which CWCs are unable to intervene.
- Many constructive provisions to oversee the functioning of institutions provided in the JJ Act and the Model Rules such as District/ City Advisory Boards, District Child Protection Units, State/ District/ City Inspection Committees, and Special Juvenile Police Units have either not been constituted or are defunct in a vast majority of districts.

5. Efforts at family strengthening minimal

- Poverty, break-upof families, death and chronic illness of parents are all prime causes for neglect of children of children but unfortunately in spite of having several poverty alleviation programmes which provide social security to such families, they are unable to access same due to poor administration, corruption etc.

6. Poor monitoring of the JJ System

- Internal monitoring by CWCs them selves and external monitoring High Court JJ Committee and State Legal Service Authority and review of implementation of the law by Karnataka State Commission for

  Protection of Child Rights are yet to take off with the seriousness it demands particularly since resources are now made available under the ICPS but poor governance has limited quality and reach of this law to the last CNCP.

7. Child Participation not a priority

- CNCP are rarely consulted on matters related to planning their future, running of the child care institution as child participation as an approach rarely gets any importance due to heavy workload or lack of sensitivity of adults interacting with CNCP including the CWC Members and personnel in Home and in DCPUs.

8. Standard Operating Procedures not in place

- Lack of prescribed procedures in the Act or the Rules for management of cases (Standard Operating Procedures) leads to delays in case disposal. Limited understanding and experience of handling cases leads to resorting to inefficient/ inappropriate practices.

9. Failure to file FIRs in case abuse cases and police non-compliance

- CWCs have a responsibility required by law to facilitate the filing of FIRs by the police when they come across offences against children punishable under law including cases of some missing and child labour cases .

10. Inadequate publicity about role and function of CWCs

- Due to lack of awareness among the general public about the role, powers and functions of the CWCs, referral of children is minimal in most districts. Whom and where to take a child victim of abuse and exploitation is unknown to most persons including functionaries of government departments resulting in children continuing to live on the streets; found begging; harassed by traffickers and brokers; abandoned; engaged in labor; forcibly married etc.

11. Lack of access to Resource Directory impeding access to services

- Information on available community resources such as details of various government schemes and entitlement of children not available to all CWCs in the form of a Resource Directory thereby restricting their optimal utilization for the welfare of children. Officers of various govt. departments at the state, district, taluka, hobli and gram Panchayat level which have child centric schemes such as Social Welfare, RDPR, Education, Revenue, Labour have little knowledge about the JJ Act and its provisions and consequently, there is minimal co-operation forthcoming to CWCs

12. Paucity of professional services

- CNCP who enter the JJ system in a majority come from difficult circumstances and exhibit behavioral problems, drug addiction etc. which make it increasingly difficult to manage them and keep them engaged in stimulating activities. Without adequate number of mental health professionals, probation officers etc, for providing counseling support, undertaking home inquiries, preparing care plans, providing access to educational and vocational programmes and involving the families and children themselves, these support services remain only on paper to the detriment of children entering the JJ system.

- Legal aid is also not readily available to families of CNCP as such is required for claiming child maintenance from deserted spouses and filing for inheritance by HIV affected orphans

13. Language constrains

- Communicating with children speaking in languages other than Kannada as with children of migrant workers or those trafficked from other States results in poor quality intervention and unsatisfactory

disposal at the cost of the child's best interest.

14. No provision for safety and security of CWC members

- Members have expressed fear for their lives too as a few have received threatening calls and attempts to assault them particularly while undertaking inquiries and participating in rescue of child labour in collaboration with government, NGOs and Childline.

15. Honorarium insufficient and payments inordinately delayed

- Remuneration of CWCs has been retained at Rs.500 per sitting though the ICPS has raised the same. Payments are almost always delayed by several months which can be very de-motivating.

16. Poor Convergence and Inadequate Networking of Services

- Networking between govt. departments and civil society organizations is lacking at all levels. Each functions as an island of intervention resulting in overlapping of services in certain geographical areas and huge gaps in certain remote /inaccessible areas.
- Linkages with District Administration, Karnataka State Commission for Protection of Child Rights, Childline Emergency Services etc to strengthen interventions and supportive services for CNCP and CICL yet to gain priority

17. Poor Data Management , lack of MIS and use of Information Communication Technology (ICT)

- CWCs receive large number of referrals and cases can be very varied requiring individualized intervention. For lack of systems to adequately document and analyze the cases, there is tardy disposal and failure to put in place preventive strategies for action.
- Further, though there are various levels of monitoring put in place such as the Karnataka High Court JJ Committee, State Legal Services Authority, Karnataka State Commission for Protection of Child Rights to improve the functioning of CWCs and JJBs active engagement with the JJ System is not forthcoming.
- The JJ System has also failed to make use of ICT to improve its functioning and build linkages with other service providers both State and non-State.

18. Juvenile Justice Fund not accessible to CWCs

- There are many needs of CNCP presented before CWCs that require financial support such as travel costs for parents visiting from far off districts, emergency medical care, fees for specialized courses etc. Release of financial support often need to be arranged at short notice for which there is no provision causing great inconvenience to CNCP and a feeling

of helplessness amongst CWC members is passing the right directions

Juvenile Justice Boards

Juvenile Justice Boards (JJBs) are the competent authority in every district before whom CICLs are presented. The Act states that there shall be one or more Juvenile Justice Boards in every district, which shall be constituted by the State Government and consist of a Metropolitan Magistrate or a Judicial Magistrate of the first class, as the case may be, and two social workers of whom at least one shall be a woman. They shall function as a bench and have the powers conferred by the Code of Criminal Procedure 1973 (2 of 1974).

The JJB's role is not to inquire into the guilt of any child presented but look at why the juvenile committed the offence and to redeem him and to put him on the right track. The JJ Act therefore provides for options of liberal bail, community service, counseling, supervision, probations, paying a fine and sending repeat offenders or those whose security may be at risk or those who have committed heinous crimes to a Special Home or Place of Safety as a measure of reformation in their behavior.

The proceedings before the Board are to be conducted in a non- adversarial environment while ensuring due process guarantees such as right to counsel and free legal aid. The process of the enquiry is to enable juveniles realize where they have failed and to offer support for rehabilitation and follow-up so that they can become responsible citizens of society. It mandates no disqualification attached to conviction after a reasonable period of time, prohibits death penalty or life imprisonment or commitment to jail for CICL and forbids joint trials with adult offenders.

The functions of the JJB are detailed under the Rule 10 of the JJ Model Rules 2007 and are as follows:

- Adjudicate and dispose cases of juveniles in conflict with law;
- Take cognizance of crimes committed against children such as exploitation, abuse etc as listed under section 23 to 28 of the Act;
- Monitor institutions for juveniles in conflict with law and seek compliance from them in cases of any noticeable lapses;
- Deal with non-compliance on the part of concerned government functionaries or functionaries o voluntary organizations I implementing the law, inaccordance with due process of law;
- Pass necessary directions to the district authority and police to create or provide necessary infrastructure or facilities so that minimum standards of justice and treatment are maintained in the spirit of the act;
- Maintain liaison with the CWC in respect of cases needing care and protection;
- Liaison with JJBs in other districts to facilitate speedy inquiry and disposal of cases through due process of law;

- Send quarterly information about juveniles in conflict with law produced before them, to the district, state child protection unit, the state government and also to the chief Judicial magistrate or chief metropolitan magistrate for review under sub-section (2) of Section 14 of the act;
- Initiate age determination of CICL presented before JJBs where found necessary
- Take suitable action for dealing with unforeseen situations that may arise in the implementation of the Act and remove such difficulties in the best interest of the juvenile;
- Any other function assigned by the State government from time to time relating with juveniles in conflict with law.

Challenges faced by Juvenile Justice Boards

Though the number of CICL who enter the JJ system are negligible compared to CNCP, however the JJBs face immense challenges too in executing their responsibilities. Several of the challenges they face are similar and have not been repeated.

1. Minimal Administrative and Infrastructural support

- Though provisions has been made within the ICPS, yet JJBs report they do nothave adequate infrastructure to keep files and documents often resulting in Probation Officers and Police attending hearings carrying files to and fro. Basic work tools have not been provided for efficiently processing cases such as computers, printers, storage equipment for recording case proceedings and the assistance of a data entry operator etc.
- Drinking water, adequate furniture, separate room for counseling, waiting area, toilets are facilities rarely made available.

2. Sittings not reaching all districts

- The venue of JJBs sittings is expected to be within the Observation Homes located at district head quarters but instances of hearings continuing to be held in Prl. Magistrate's chamber is often reported.
- While the JJB at Bengaluru works for three full days a week, in the districts weekly sittings are held for barely 2-4 hours per sitting thereby delaying the disposal of cases.
- With Observation Homes not present in 13 districts, JJBs must periodically move to other districts within its jurisdiction to attend to cases as this would facilitate attendance of CICL who have been discharged.

3. Lack of empowerment, skill and knowledge building of JJBs

- Inadequate knowledge and capacity building of Prl. Magistrate and Members and protection personnel working in the DCPUs and Homes for CICL has resultedin near total failure in

rehabilitation outcomes for CICL. The JJ Act states that a Metropolitan or a judicial magistrate with special knowledge or training in child psychology or child welfare shall be appointed as Prl. Magistrate of the JJB and if such a Magistrate with special knowledge or training is not available then the State Government shall arrange for the training on the same for the appointee. However, not all magistrates have been provided training and frequent transfers also made this difficult. Further, due to lack of proper orientation and training of staff there is inadequate documentation of proceedings of the JJBs too leading to delays in disposal

4. Inadequate number of Homes

- In Karnataka there are only seventeen Observation Homes with almost all Homes catering to two districts. Further there is only one functioning Special Home run efficiently by an NGO and one After Care Home for the whole State. Transporting CICL for hearings puts a huge strain on human and other resources.
- The pathetic functioning of Observation Homes with poor infrastructure, unclean and unhygienic living space and lack of stimulating programmes for CICL all lead to boredom, discomfort and aggression resulting in indiscipline and violence within Homes as has occurred in 2012 and even later in the Observation Home at Bangalore. Untrained and inadequate number of caretakers and professional assistance to offer personalized care, failure to segregate CICL according to age and seriousness of offences committed are reasons for poor outcomes for children entering these Homes.

5. Lack of Correctional Services

- CICL require very intensive and individualized correctional services to enable them return to mainstream society as responsible citizens but this is grossly lacking within the system though Section 15 of the JJ Act provides for various diversion options. There is only one Probation Officer per district who also has to serve adult offenders and he is unable to do justice to the responsibility. Further, services of mental health specialists like psychiatrists/psychologists and counselors to work with children and assist with preparation of care plans for rehabilitation and mainstreaming of every CICL have not been provided and not always available in the districts. Providing access to education and vocational training according to age and ability with the intention for improving career prospects and mainstream CICL is also not a priority.
- Further, shockingly CICL who involved in serious crimes such as murder, attempt to murder are released within 3-5 days from the Observation Home without undergoing any correctional

therapy which is not only harmful to society but also to themselves

6. Efforts at family strengthening absent

- Working with families and helping then access poverty alleviation programmes and also providing counseling and supporting them to help their children wean away from anti social behavior is completely lacking to the detriment of CICL who are discharged

7. Large pendency

- As per law all inquiries are to be completed within four months and in special cases within six months and only in exceptional cases extended further. However, in most JJBs particularly the one in Bengaluru, there remains a huge pendency even of non-serious cases for nearly 4-5 years. Several of the CICL whose cases are pending cases are have crossed the age of 18 years and are gainfully employed but continue to face the harassment of appearing periodically before the JJB thus hampering their rehabilitation.

8. Participation of CICL in proceedings and rehabilitation not prioritized

- JJBs are not child friendly with child participation unheard of. Alleged CICLs who appear for hearings are often made to stand till the hearings are over, cross-questioned in a hostile manner with the Bench speaking together and rarely is concern exhibited regarding the neglect and exploitation the CICL may have experienced in the past.

Recommendations

Investment in child protection and development in India remains a low priority in spite of commitments made by the State through legislation and policy articulation. Lofty intentions such as stated in the National Policy for Children 2013 and even the flagship Integrated Child Protection Scheme simply do not get adequately translated on the ground. The mounting cases of school drop-outs, poor enrollment, child abuse, child trafficking, malnutrition, child labour, girl child neglect, child marriage all seem to vindicate the hypothesis that the plight of children in India has remained largely neglected. This callous approach towards children could be so as they are voiceless and do not form a part of the political vote bank.

Fortunately, advocates of child rights in the country are far from remaining mute spectators to the spectacle of indifference towards our “most specious asset”. The National Commission for Protection of Child Rights comprising generally of experts drawn from civil society and their counterpart in States and UTs, child rights activists and civil society organizations have taken up the matter with the seriousness it deserves by raising cudgels with the powers that be to take the human rights based approach to promoting the well being of children. Several research studies have been undertaken by these parties to gain a comprehensive understanding of system discrepancies and gaps in implementation of laws, policies and

schemes and to develop strategies on how best to address operational obstacles and come up with procedural reform all of which have been documented. Several of these reports have included recommendations relating to the implementation of the JJ Act and highlighted the need for systemic reform and collaborative operational delivery through improved governance to achieve the intended outcomes of the JJ legislation. Highlighted below are recommendations drawn from these reports and personal experience.

1. Adequate administrative and infrastructural support

- JJBs and CWCs must be provided adequate space, furniture, child friendly atmosphere, waiting area, toilets etc. Computers, printers, storage facilities are also a necessity to facilitate administration.
- Dedicated bench clerks to put up cases, case workers to assist with file management are all in short supply though prescribed by law and provided for by the ICPS. This must be made available to CWCs.
- An operational manual for the administrative wing of CWCs and JJBs is also a necessity as it would facilitate generation of correspondence, issuing of orders to various stakeholders such as the Police, Institutions, Probation Officers for follow-up and seeking compliance reports.
- Transportation or travelling allowance to enable CWCs reach out to children in all parts of the district and to conduct ground level inquiries and inspection needs to be provided.

2. Ensure Venue of Sitting CWCs is commensurate with need

- CWCs and JJBs must also consider holding sittings at locations which are known to be high vulnerable areas for child neglect, exploitation, abuse and crime across the entire district such as railway platforms, schools, prisons, remote villages, inner city areas which maybe distant from the regular sitting venue. Support of CHILDLINE and DCPUs could be mobilised to assist with holding these sitting
- Frequency of sittings should be tri-weekly as proposed under the ICPS and held and for a minimum duration of six hours per sitting which could include field visits.

3. Need for Empowering CWCs and JJBs

- Paucity of skill sets and knowledge on child protection issues needs to be offset. Though there are new and progressive laws like the JJ Act, RTE Act 2009, POCSO Act 2012 skills and knowledge to implement them is very limited. There is an urgency to build capacities and offer training to sensitize the protection work force including probation officers, welfare officers, social workers, counselors, legal aid under the ICPS and care takers, police security personnel etc. on care, protection and rehabilitation of children with a rights based perspective.

- CWC Members need intensive orientation and training in the area of alternative care services. This should include field visits to well run adoption and foster care agencies; interaction with adoptive and foster parents; adoptees and foster children. CWC Chairpersons could nominate two members selected on basis of interest and experience to gain expertise in this field.
- Regular orientation and training programmes for officers at all levels of the Departments of Women and Child Development, Social Welfare, Education, Labour and Employment, Rural Development and Panchayat Raj, Youth Affairs and Sports, Police etc. is also important as it would ensure a right based approach to responding to needs of CNCP and CICL.
- CWCs also have a responsibility under the Protection of Children against Sexual Offences (POCSO) Act, 2012 to provide supportive services to child victims. They need to work in close collaboration with police as reports on all complaints filed under POCSO Act are to be brought to the notice of CWCs for their intervention where found necessary.
- Selection of Chairperson of CWCs and Members of CWCs and JJBs must be a rigorous process as envisaged in the JJ Act. This would ensure that experts and public spirited individuals with appropriate qualifications, competence and sensitivity occupy these positions and serve with dedication. Thorough background checks of prospective of appointees must be undertaken to prevent abuse of power /authority.

4. Quality Standards in Functioning of Child Care Institutions must be ensured

- CWCs and JJBs must insist that a Child Protection Policy is in place in all child care institutions and the DCPUs need to take on the responsibility of monitoring its implementation. The recent draft prepared by civil society groups in Bengaluru and accepted for consideration by the State should be the starting point.
- Monitoring the registration status of child care institution under Sec. 34.3 of the JJ Amendment Act 2006 by the State is also a responsibility that CWCs can take on as it could then track all admissions and discharges from child care institutions and promote non-institutional alternatives for children. It is particularly important that for older children, options such as residential schools/hostels run by the Dept. of Education/Social Welfare are explored as they are not “custodial” in nature as with JJ Homes and easy contact with families can be maintained.
- CWC Chairpersons could nominate one or two members on rotation basis to routinely visit JJ Homes and Fit Institutions in their jurisdiction to

record their observations and make recommendations on the finalization of care plans for children, review health and psycho-social status, cleanliness and hygiene of JJ Homes and the functioning of Children's Committees.

- The JJ Act and the Model Rules have in-built monitoring mechanisms such as District/ City Advisory Boards, District/ City Inspection Committees, Management Committees and Children's Committees within institutions and the government should be pulled up by the CWCs and JJBs if they are not functional and taking their responsibility seriously.

5. Strengthening families

- Active efforts are required to be made by DCPUs under the guidance of CWCs and JJBs to link impoverished families of CWCs and JJBs to various poverty alleviation schemes of the State which would provide social protection and economic empowerment. Such collaborative interventions and referrals could raise family's ability to assume full responsibility for their child.

6. Internal and External Monitoring must be institutionalized

- Internal CWC/JJB review mechanisms and external monitoring are vital for the efficient functioning of these competent bodies.
- Some CWCs have one or two Members in rotation during sittings reviewing old cases and looking into administrative issues, reporting, data management etc. Delhi CWCs have set aside one day a week to together undertake this exercise
- At the district level, the District Legal Services Authority under the guidance of the District Judge could oversee the review mechanism and forward proceedings to the High Court JJ Committee.
- Quarterly review of pendency of cases is CWCs and JJBs by the High Court constituted JJ Committee would improve performance. Directions could be given to hold Lok adalats periodically to clear JJB cases and to the State to extend necessary support to these statutory bodies.
- The State Legal Services Authority under the guidance and supervision of the High Court JJ Committee issue quarterly reports with performance ratings on a scale of 1-10 of individual CWCs and JJBs based on specific evaluation criteria.
- Karnataka State Commission for Protection of Child Rights constituted under the Commissions for Protection of Child Rights Act 2005 and CWCs and JJBs could build a collaborative interface to resolve functional and administrative problems they are facing in executing their responsibilities.

7. Child Participation must become a priority

- Child participation as a rights based approach must become part and

parcel of all interventions with children especially in Homes and while preparing care plans and arranging rehabilitation programmes

8. Standard Operating Procedures to be finalized for use by CWS and JJBs

- Maharashtra, Odisha and Delhi for instance have in place SOPs standardizing all proceedings and procedures followed by CWCs. Karnataka needs to have SOPs for both CWCs, JJBs and the Police too as this would articulate and guide the management of cases from entry to disposal. For CICL it would include categorization of offences, clarity on inquiries, diversion, restoration and rehabilitation and for CNCP specific need based rehabilitation interventions which are family and community based. Constant review of procedural and operational processes should be undertaken to ensure they are focused on community based rehabilitation and family restoration.

9. Adequate publicity about role and function of CWCs

- Advocacy on the role and function of CWCs must gain priority to promote the universal reach of the JJ Act. DCPUs need to disseminate this information through multiple media (flex banners, posters, hand bills, public display at schools, district, taluka and gram Panchayat levels of administration, police stations, bus stands, airports, train stations, market places, and stickers on public transportation/hoardings in public places, ticker tape on TV channels) using allocated resources. Planned awareness camps through Supervisors and Anganwadi workers under the ICDS, ANMS and ASHAs working under the NRHM, announcements/interactive programmes over AIR and other radio channels should also be explored to raise issues such as child marriage, child labour, trafficking of children etc.
- CWCs need to also consciously move to all corners of the District including gram Panchayat and villages so that they are more accessible to children in need of care and protection and their families. A close collaboration between CWCs and District/ Block/ Village level CPUs can be hugely beneficial in connecting CNCP to CWCs.
- CWCs and DCPUs could also work proactively by making unannounced visits to all locations CNCP are housed or provided services or where there is likelihood of them being neglected/ exploited such as residential care services, pediatric sections of district, taluka hospitals, PHCs, hostels run by Social Welfare Dept., JJ Homes, schools, residential schools run by Depts. of Education and Social Welfare, work sites etc.
- A voluntary forum of various JJBs and CWCs in Karnataka which meets periodically and shares case studies and experiences via the internet or a

Newsletter would facilitate cross-learning, sharing of good practices and for enhancing advocacy efforts to provide improved services for CNCP and CICL. Inclusion of grassroots based NGO would provide ground level data in various geographical locations on problems and concerns of CNCP.

10. Need for Resource Directory to enhance Networking

- DCPUs must complete district needs assessment and resource mapping and present this information as district Resource Directories to CWCs and JJBs to be used as ready reckoners for making referrals for CNCP and CICL respectively presented before them. This would facilitate access to need based services such as schooling, special services for disabled children, and accessing cash transfers such as disability pension, sponsorship support and residential care, scholarships, vocational and apprentice training etc for children's rehabilitation and mainstreaming into society.

11. Services of Professionals must be made available

- DCPUs must make available experienced counselors and other professional support to each CWC and JJB so that mental health issues which generally plague CNCP and CICL are compassionately handled and resolved.
- A panel of trained lawyers must be constituted by the Karnataka Legal Service Authority and made available during sittings of JJBs and CWCs and also to provide free legal aid to families who require the same.

12. Translators must be provided when necessary

- Considering the CNCP and CICL hailing from different parts of the State, country and some from neighboring countries are presented before CWCs and JJBs, DCPUs must constitute a panel of translators with appropriate linguistic skills in different languages to facilitate case management at both CWCs and JJBs. Such translators could be on call after their credentials are approved and they sign a Confidentiality Agreement

13. Provision for safety and security of CWC members

- Security guards must be posted outside CWC sittings and police must be requested to CWC Members during field visits

14. Sufficient honorarium and timely payments

- Delays in disbursement of honorarium and raising it to Rs.1000/ per sitting should be considered as it can otherwise leads to de-motivation and frustration amongst CWC members.

15. Convergence and Networking with allied bodies to be strengthened

- CWCs and JJBs must engage with

various departments of the government as well as civil society organizations, Trusts, Societies and religious bodies so that access to welfare and poverty alleviation schemes and services form part of the rehabilitation package for families of CNCP and CICL. Such support would go a long way to strengthen families own their ability to raise their children.

- The Deputy Commissioners as the District Administrative heads must include the Chairpersons of CWCs in their district monthly review meetings and provide an opportunity for the CWCs to share their reports related to inquiries conducted related to child rights violations, visits made to State run services (hostels, Anganwadis, schools) with district and taluka level officers. Coming from a statutory body, reports of such violations would receive a serious ear by the concerned authorities and provide a platform to build linkages to strengthen relief and rehabilitation measures for CNCP.
- District administration should also issue clear instructions to all stakeholders concerned to respect and implement the CWC orders as they are judicial bodies conferred with powers under the JJ Act as the "final authority" for the disposal of all cases related to the care, protection, treatment, development and rehabilitation of children.
- WCs could also build stronger linkages with Childline services located in several districts of Karnataka and reachable through the southern grid call centre to serve as a reporting mechanism for child rights violations.
- Active collaboration of CWCs and JJBs with Karnataka State Commission for Protection of Child Rights in the area of generating awareness about child rights issues and responding to complaints would also tremendously benefit CNCP.

16. Need for Improved Data Management, MIS and use of ICT

- CWCs and JJBs are required to submit monthly reports. However, they need to go further and collate, analyze and categorize all complaints of child rights violations to come up with recommendations for policy articulation, plan intervention strategies, convergence of services etc. Possible ways to achieve this could be through simple non-time consuming templates which would also ensure uniformity throughout the State and mobile/web-based applications which can promptly be pulled up with request commands and save decision making time. Referrals to CWCs/JJBs from different stakeholders in remote locations can also use such applications for presentation of children before CWCs/JJBs to avoid travel.
- Use of ICT and setting up collaborative and interactive child protection website

with Management Information System (MIS) to collect records centrally at the District, State and Central levels involving all relevant stakeholders within child protection systems including CWC, JJB, SJPU, DWCD, DSW, DoL, DoH, DLSA/ SLSA/ NALSA etc. is a necessary tool. MIS that is resource-friendly and cost-effective would make available all relevant child protection data and information within a single space, prevent loss of records due to damage of paper files, prevent duplicity of efforts, enable efficient coordination and cooperation amongst the various child protection stakeholders, ensure transparency, and encourage innovative strategies/ best practices. The website could also serve as a platform for sending requests/ queries/ advice/ complaints, all of which can be automatically recorded in a specially designed and easy to refer format.

- The website could serve as a Resource Directory and include all relevant and regularly updated details such as district-wise lists of names and contact details of CWC and JJB members, sitting venues and timings, lists of child care institutions and community child related services; quantitative quarterly reports; child-related Government schemes, child-related laws etc. This would greatly enhance the functioning of the JJ System at the District and State level which can be shared at the National level. The website needs to be linked with the Ministry of Women and Child Development's 'Track Child', the Ministry's missing and found child national portal.

17. Filing of FIRs and SOP for police interaction with CWCs

- DCPUs and Karnataka State Legal Services Authority must organize training for Special Juvenile Police Units (SJPUs) and CWOs in police stations and orders must be passed by Director General of Police to follow directions issued by CWCs in relation to CNCPs such as filing of FIRs, tracing of missing children, escorting children back to their homes etc.

18. Juvenile Justice Fund

- There is an urgent requirement to consolidate this Fund as CNCP and CICL presented before CWCs and JJBs often require financial support to meet pressing needs. The State must provide clarity on child eligibility and procedures for utilization of resources by CWCs and JJBs at the earliest.

Acknowledgements:

1. CHILD WELFARE COMMITTEES IN INDIA -A comprehensive analysis aimed at strengthening the Juvenile Justice System for children in need of care and protection, March 2013. (National Commission for the Protection of Child Rights-2013)
2. Towards streamlining implementation of processes and measures pertaining to children in need of care and protection: a study of child welfare committees in Delhi' (Haq, 2012),
3. Functioning of Child Welfare Committees in Karnataka' (Baburaj, 2010),
4. Report of the Study on Status and Functioning of Child Welfare Committees in Tamil Nadu' (SCOPE India & Thozhamai, 2011),
5. A Study on Child Welfare Committees in Selected States of India - NCT of Delhi, Karnataka and Uttar Pradesh' (Kamath, 2009), 'Study on functioning of Child Welfare Committee in West Bengal' (Ghosh, 2011), and
6. A study of the role and functioning of the Child Welfare Committees in Maharashtra: Opportunities and challenges in strengthening the Juvenile Justice System' (Shekar & Vora, 2010).

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17

THE STATE REQUIRES TO BE FREED FROM THE SCROUGE OF CHILD LABOUR MENACE

- Vasudeva Sharma N.V.& Vani Kanti

In the midst of several for and against debates, the Child Labour (Prohibition and Regulation) Act 1986 is now amended. The new name for the Act is The Child and Adolescent Labour (Prohibition and Regulation) Act 1986. With this, the Govt can claim that India has risen to the level of international standards and responded to some objections about non-implementation of Article 32 of the UNCRC[1]. This also means that around 10 crore adolescents (in the age group of 14-18 years) have been brought under the legal protection[2]. This amendment also includes the long-standing demand by NGOs and various campaigns to consider child labour from the right to education perspective. The Govt is now ready to respond to the ILO Convention 182 to release children from the worst forms of child labour. However, the new amendment to the Act, in contrast to this prohibition of employment of children up to 18 years in hazardous sectors, along with some promises also raises some serious questions (allowing children to work along with family business/enterprises before and after school hours and during holidays).

***CRC Article 32* Child Labour / Economic Exploitation**

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.
2. States Parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, States Parties shall in particular:

   (a) Provide for a minimum age or minimum ages for admission to employment;

   (b) Provide for appropriate regulation of the hours and conditions of employment;

   (c) Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

After India acceded to the UNCRC in 1992, the Govt had not taken immediately any significant measures to address issues pertaining to children. Interestingly, while taking part in the historical signing of the

Convention, India had reservations (as per Article 51, UNCRC) to the provisions of the Article.32 that dealt with child labour or economic exploitation of children[3]. The UNCRC Committee has been suggesting to India several times to withdraw this reservation and to take a comprehensive participation in the Convention[4]. It is now time for India which has completed 27 years (In 1992 India ratified the UNCRC) of signing the UNCRC to withdraw the reservations and declare that the country has accepted the Convention in totality. For this, the State Governments and NGOs and other civil society organisations have to pressurise the Centre across the nation. Several State Commissions for Child Rights also have to take part in this movement to pursue the central government to take action in this direction.

Combating Child labour

While discussing about the child labour situation, it becomes inevitable to discuss the systems that are expected to prevent child labour and also various Acts and programmes that prohibit child labour and provide rehabilitation, as well as about the various campaigns that advocated for ending child labour.

The earlier Act of 1986 had given a limited list of areas/fields to prohibit employment of children. But it is a fact that children continued to work in several hundreds of areas all around us. As a result, the people in the campaign against child labour have been raising their voice and demanding that the Govt. not to have several absurd acts banning child labour in selected fields like motor vehicles act, factories and boilers act, ports and ships act, etc., but instead to have one Act that prohibits employment of children in all sectors.

In the 1990's there were several campaigns throughout Karnataka against child labour. Hand in hand, the Campaign against Child Trafficking and the Campaign for Right to Education were also in full swing. All the three campaigns had a common agenda: protection of children and right to education. To realize right to education, ending child labour was the key. Hundreds of organisations and volunteers were involved in rescuing and releasing child labour from the working situation and taking them to special short stay camps and enrolling them in mainstream schools after a bridge programme.

The 1992 verdict by the Constitutional Bench of the Supreme Court headed by Justice Jeevan Reddy in the Unnikrishnan Vs. State of Andhra Pradesh, has declared that 'children below 14 years have the right to education' and armed the NGOs with new vigour to take the campaigns further[5].

NGOs who were making use of the not so effective provisions of the Child Labour (Prohibition and Regulation) Act 1986 also made use of the Central government's National Child Labour Project (NCLP) and the State Government's State Child Labour Project (SCLP) and various projects supported by UNICEF and ILO in the mission to rescue child labourers. Several funding or support agencies (e.g. CRY, ILP, TdH Germany/Netherlands/ Sweden, NOVIB, OXFAM, HIVOS, Save the Children, Bread for the World, Concern India, CCF/ChildFund, EveryChild UK, TATA Trust, FORUT, PLAN International, etc.) also supported the child labour eradication projects. During this period, as per the reports presented by the NGOs and also by the Education Dept. of the Govt., lakhs of children got enrolment in mainstream schools or were re enrolled and found a new start.

The verdict given by the Supreme Court (1996) in the M.C. Mehta vs State of Tamilnadu, was a boosting shot in the arm of NGOs who were engaged in the campaign against child labour. There were several obstacles and practical difficulties in the implementation of the order: nobody should employ children in hazardous sector as per the CLPRA 1986; if children are engaged in hazardous labour they have to be rescued and rehabilitated and the owners/employers must be fined and that money should be used in the rehabilitation of the rescued children, etc. But this particular judgment also gave a new hope to the campaigners.

Hundreds of child labourers who were rescued and given educational and vocational training as a part of the rehabilitation in the 90's by APSA, Bengaluru, are leading independent lives now. Similarly the efforts of KIDS, Dharawada; SNEHA, Ballary; PADI, Mangaluru; CWC, Udupi; RLHP, Mysuru; Ujwala, Vijayapyra and BOSCO, REDS, YMCA, MAYA, Mythri Serva Seva Samithi, Bengaluru have resulted in providing new life to lakhs of child labourers with education, vocational training and in enabling them to lead a happy life. With the Bachapan Bachao Andolana and CACL, there were several rounds of 'March against child labour' in the 90's. SATHI which started around 1992 in Raichur initiated an innovative method of rescuing and providing counselling to the children on railway platforms to get into education and back to their families that gave a new dimension to prevent child labour and trafficking of children to labour. Mahila Samakhya, Karnataka with its innovative project facilitated thousands of girls to get released from the clutches of labour.[1]

In the last decade UNICEF with its innovative projects of working with the district administration at Kalburgi, Magadi, Davanagere, Koppala and Bengaluru and ILO in Chamarajanagara and Bidar conducted studies on the situation of child labour and initiated field work that gave special impetus to face the employers of child labourers and take-up rehabilitation activities.

Several plans of action were released on the implementation of child rights by Central and some State governments (1992 and 2013). The Labour Dept of the Karnataka Govt, with the support and guidelines of ILO, within the limited scope of the Child Labour (Prohibition and Regulation) Act 1986 had prepared a 'State Plan of Action to Combat Child Labour' (2001) and had declared that the state would be made child labour free by 2007. The PoA had earmarked Rs. 6 crores per year to realize the plans within 2007. At the time of preparing this PoA, then Commissioner of Labour Mr. Lukose Vallathrai had conducted several rounds of consultations with NGOs. That was an appreciable and welcome move.

But there were objections about the PoA that was released immediately after the transfer of Mr. Lukose Vallathrai, under the leadership of the new Commissioner and released by the then Chief Minister of Karnataka S.M. Krishna (2001). For the implementation of this POA the Labour Dept had constituted a separate Resource Centre and a state level advisory committee. But, the same POA was reviewed and renewed even in 2014-15, but never received the promised crores of rupees for the implementation. This historical truth reveals volumes about the political will of the Govt to implement the POA. As a result, the much-heralded State Child Labour Project (SCLP) that is supposed to work with the participation of NGOs is still limping to achieve any results.

Apart from this, both State and Central Govt sponsored programmes that worked with NGOs in conducting child labour rehabilitation schools have been marred from the beginning, with several reports and complaints about delay in sanctions, selection of NGOs, reporting, evaluation, etc. Reports about corruption involved in releasing funds to groups have

only resulted in doubting the whole project and its objects. The scheme also has an impossible uphill task of identifying and rehabilitating only child labourers found and listed in hazardous sectors. That means, if a below 14 years child was found and listed by the Labour Dept (as per the 1986 original Act), the NGO in the project should make efforts to release only such a child, file case against the employer and enrol the child in the 'bridge school'. But, in reality in most of the bridge schools run by the NGOs it is very difficult to find children from only the designated group. The reasons for this are several. Firstly, there are no proper surveys at all. As per the Govt. figures, large number of child labourers are not found in hazardous sectors. Secondly, only a few children are rescued from such hazardous sectors and cases filed. Having said this, another common-sense question pops up. In some districts in Karnataka there were a greater number of child labour schools. But, in those districts, there were no recorded evidence to indicate proportionate number of child labourers in hazardous sectors. It's an unsolved puzzle as to how the concerned officers were sanctioning child labour schools in these districts and also sanctioning grants to them. A similar question can be raised about the 'Open Shelters' run by NGOs with the support of DWCD.

A close look at the budgetary allocations by Govt of Karnataka to combat child labour from 2007-2014 reveals a different picture. To combat child labour in 2007-08 and 2009-10 Govt had ear marked Rs. 350 and 450 lakhs respectively. In the later years although the allocations touched Rs. 600 lakhs in 2011-12, the overall budgetary allocations hovered around an average Rs. 450 lakh for the purpose of eradicating child labour. In the reports by the Govt. there are references on what is the achievement of the Govt., but there is confusion on how many child labourers have been rescued and rehabilitated as well as figures on how many children have been prevented from becoming child labourers. After 2013 there is not much change in the budgetary allocations to the sector. The reasons could be that project allocations are made without taking into consideration the field realities.

17.1: Karnataka Budget (extracts)

Head: Rehabilitation of Child Labour Account: 2230-01-103-6-01 (All Rs .in lakhs

Account		Revised		Budget	
Plan	Non Plan	Plan	Non Plan	Plan	Non Plan
2011-12		2011-13		2013-14	
	450		600		470
201--11		2011-12		2013-13	
	400		600		600
2009-10		2011-11		2013-12	
	450		400		600
2008-09		2011-10		2013-11	
	500		450		400
2007-08		2011-9		2013-10	
	350		350		450

Fall in child labour numbers

Compared to 2001 (Census) in 2011 the child labour numbers have come down. In 2001, in the age group of 5-14, there were 1,26, 66,377 child labourers. This came down to 43,53,247 in 2011[6]. Apart from Kerala, compared to the 1991 status, in 2011 along with AP (76%) the numbers in Karnataka (75%) have come down. This we can attribute to the concerted efforts by several NGOs (with the support of both national and international support including Govt schemes), campaigns, awareness programmes, education activities, etc.

17.2: Decadal Variation in Child labours

Sl No.	State	1991	2001	2011	Decline % from 1991-2011
1	Andhra Pradesh	16,61,940	13,63,339	4,04,851	76%
2	Karnataka	9,76,247	8,22,615	2,49,432	75%
3	Tamil Nadu	5,78,889	4,18,801	1,51,437	74%
4	Kerala	34,800	26,156	21,757	38%
	All 35 states Total	**1,12,85,349**	**1,26,66,377**	**43,53,247**	**62%**

The National Sample Survey 66th Round (2009-10) on Employment and unemployment, reveals a very interesting aspect about child labour. The report records that in the age group of 5-14 only about 42,38,372 children are working in India. A comparison of the four southern states indicate that in Kerala a very low number of children are working (2,765). In AP although it is very high (2,34,665), in Karnataka it is a little less (2,26,497) and in Tamil Nadu, only 17,351 child labourers are found. As this survey includes agriculture labourers too, we can find more number of child labouers in rural areas.

(Some of these figures are less than the census figures even though they include agricultural labour too - such anamolies need to be probed).

Table 17.3: Child labours in South Indian States

		Rural			Urban			
		Boys	Girls	Total	Boys	Girls	Total	Grand Total
1	Andhra Pradesh	88156	110191	**198347**	20767	15548	**36315**	**234662**
2	Karnataka	89796	113429	**203225**	20793	2479	**23272**	**226497**
3	Tamil Nadu	0	13880	**13880**	3471	0	**3471**	**17351**
4	Kerala	1182	0	**1182**	0	1583	**1583**	**2765**
	All 35 states Total	**2511101**	**1727271**	**4238372**	**546897**	**198602**	**745499**	**4983871**

But, as per the reports of the Govt, in Karnataka there are only a few thousands of child labourers. The Rapid random NCLP survey on Child labour conducted in 2011 in Karnataka found only 47,000 child labourers in 6-14 age group.

Campaigns and the results

In 1997, Campaign Against Child Labour (CACL) had conducted a state level campaign at Magadi, near Bengaluru. The campaign representatives had congregated after a monthlong state level jatha against child labour through street plays and interactions with the communities. Back then, Magadi town was notorious for employing children in silk twisting industry and this particular campaign was to oppose the employment of children in the industry. On the basis of a newspaper report about the programme one Mr. Shriram Babu filed a PIL in the Karnataka High Court questioning the Govt on its inability to eradicate child labour. When the case was under trial, CACL impleaded itself and provided available statistics and other case studies on the incidents of child labour in Karnataka. As a result, in 1997 the But, as per the reports of the Govt, in Karnataka there are only a few thousands of child labourers. The Rapid random NCLP survey on Child labour conducted in 2011 in Karnataka found only 47,000 child labourers in 6-14 age group.

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NGOs under the leadership of CACL – K, again presented the existence of large number of child labourers in silk filatures, silk twisting works in Magadi, Ramanagar and Kolar to Govt through several rounds of discussions, research, publications, case studies etc. But it was not accepted by the authorities. The CACL took Mr. Lukose Vallath Rai, the then Labour Commissioner and some of his senior officers to Magadi in 1999). The other officers had no idea about the places that they were visiting. The officers were shocked to see children engaged in several hazardous works in various factories. Many factory owners gave no heed to the words of the officers and either just ignored them or got into verbal duels with the senior officers. The local labour officers got to know about the visit by the team of officers only at a later stage. It is important to

note that the Labour department started looking at the child labour situation with critical note only after this historic visit.

Similar to this incident there are several rescue operations by NGOs, ChildLine, Labour Department and in recent times by the District Child Protection Units (DCPU) of children from West Bengal who were working in gold smithy in Bengaluru (2002); rescue of children from Tamil Nadu engaged in fishing at Shivamogga; rescue of children engaged in brick making and bag manufacturing, e - waste recycling, plastic recycling, fish packing, farm work, poultry, etc. In most of these incidents, children are mostly trafficked. In such incidents, along with other Acts, Bonded labour liberation Acts was also used to rehabilitate them.

Child Labour in Karnataka: Recent situation

In Karnataka there are 34% children below the age of 18 years (2.77 crore children against 6.11 crore total population)[7]. Among them, children below 14 years were said to be protected as per the CLPRA (prior to 2016). That means, these children should have been in schools and learning. But as per 2011 Census, in Karnataka there are about 2,49,432 child labourers in the age group of 5-14 years. These child labourers are found to be working in hazardous and non-hazardous sectors excluding agriculture and agriculture related sectors. The Govt is giving this statistical information again and again in the question hour in both legislative assembly and council for the past several years!

In 1990s CACL was claiming that there are about 10 lakh child labourers in Karnataka. The Govt was refuting this. The NGOs were doing a simple calculation by comparing the number of children who were enrolled in schools and the number of children who have dropped out and adding to it the number of children who are never enrolled. By this they had found about 10 lakh children out of schools. This the NGOs have been holding since 2000. The Campaign had filed the same report in the Karnataka High Court when it was called for.

In 2013, Ms. Kathyayini Chamaraj, of CIVIC, an NGO, had informed the High Court that even after the implementation of The Right of Children for Free and Compulsory Education Act 2009, several lakhs of children are out of schools. She also had pleaded with the court to direct the government to bring back all the dropped out children to schools.

Very importantly in Karnataka, that too in North Karnataka, lakhs of children are engaged in agriculture and agriculture related works during various seasons (sugarcane, cotton, paddy, pulses, sun flower groundnut, etc.). But the other agricultural and commercial crops including floriculture, seeds-of vegetables are in demand for child labour all over the year. Over and above this, as the existing labour is not enough, every day thousands of children are brought from neighbouring state Telangana (erstwhile Andhra Pradesh). But it's an open secret which the administration is not aware of (sic) to take action. It's a bunch of crimes against children: child trafficking, educational rights are denied, children are engaged in spraying pesticides, sowing, pollination, harvesting, etc. All these are clearly forced labour and bonded labour. But, as there is no coordination among concerned officials of various departments and the district administration, they either never file cases or file flimsy cases against the perpetrators.

As per 2011 Census reports in Karnataka in the 5to 14 age group 2,49,432 main workers and 1,36,600 co-workers were there. Around 31,870 children were said to take any work if offered to them. Can anyone ignore this fact? But, in the census data, there is no account of thousands of child labourers who have come from other states or those who have been trafficked for labour.

The passing of Juvenile Justice (Care and Protection of Children) Act 2000 (later 2015) came as an empowering instrument in the hands of the campaigners against child labour.

Under the definition of children in need of care and protection, almost all kinds of child labourers, children pushed into begging, children loitering around railway stations, children out of schools, etc., could be protected, file cases and if required produced before district CWCs. As per the provisions of the Act, ChildLine 1098, NGOs, any public spirited individual, police and any officers could identify children in need of care protection and produce before the CWCs. Since 2002-2003, till recently, all over the state, lakhs of children have been protected and produced before several CWCs and they have been facilitated in their rehabilitation. For example, in Bengaluru during 2003-04, with cooperation between UNICEF and Govt of Karnataka a campaign was initiated to protect 'children in domestic help'. The project helped 450 children, and most of them were girls[8].

It has to be noted that most of the children who were protected in this special drive were children brought from other states. Attempts were made to bring these cases under the purview of the offence of child trafficking. In similar projects undertaken in Kalaburgi, Davanagere and Raichur, CLPRA, JJ Act and Abolition of Bonded Labour Act were used to protect the child labourers. Very significantly, children who were brought from Andhra Pradesh and engaged in agriculture, particularly in cotton seeding have been rescued and rehabilitated in their respective states.

In similar projects undertaken in Kalaburgi, Davanagere and Raichur, CLPRA, JJ Act and Abolition of Bonded Labour Act were used to protect the child labourers. Very significantly, children who were brought from Andhra Pradesh and engaged in agriculture, particularly in cotton seeding have been rescued and rehabilitated in their respective states.

One needs to understand that these could be achieved because of the following: Campaigns, district level projects, Govt programmes concentrating on rural areas, implementation of various Acts to end child labour; residential programmes providing accommodation and education to rescued children run by NGOs and Govt. We can also attribute the following as reasons for reduced number of child labour.

- the continued public education through media news and articles,
- child labour prevention programmes that were taken up through training on the Acts and provisions in the various rehabilitation programmes to be provided within the vicinity or

community of the children, and also repatriating the children to

their original village, district or state,

- continued lobbying and advocacy with the concerned Govt departments, allocations from the departments for the rehabilitation programmes, positive pressure created by the legislators all led to develop positive thinking towards prevention of child labour.

The Education Dept (post 2000) is into systematic work of identifying non-enrolled children and those who are dropping out of schools or who are on long leave from schools (Out of School Children) and bringing them to schools. To support this the Education Dept has issued orders recognising certain officers as 'Attendance Authority'. If children are absent for a long period (more than 6 days), school teachers have to visit the families and look out for the children and bring them to the schools. If they fail to get the children back to schools, teachers have to inform the Block level officers about the efforts they have done. The block level attendance authority continues to follow up with the children and bring them to schools. This basically involves attempts to prevent child labour, child marriage, child trafficking, etc. But, apart from all these efforts, a look at the situation of child labour today in Karnataka reveals that a large number of children are from other states. This also indicates that there is still great demand for child labourers.

When we review the Governmental efforts in combating child labour, one finds either simplified statements or complicated calculations hurled with statistics and reports of a few pilot projects to prove that there is no child labour. In a few experiments or pilot programmes one could find some kind of results with the coordination of a few Govt departments. But, in most of the districts, it is only the labour dept which is addressing issues pertaining to child labour. The CALPRA 1986 notifies under Sec. 17 certain officers as Child Labour Officers (officers of taluk level from all the departments have been designated), but most of them do not attend to child labour cases. In spite of this, the District Child Protection Committees constituted under the ICPS-Integrated Child Protection Scheme, have made some attempts in addressing the child labour issue in the districts – identifying, enrolling, rescuing, rehabilitating, etc. They are even making efforts to produce rescued child labourers before the CWCs.

As per a circular issued by the Rural Development and Panchayat Raj Department (2006), every GP has to conduct Child Rights Grama Sabha each year to address the issues of children locally. These also include protection of children from child labour situation. Supporting this, the GPs have constituted Child Protection Committees and have taken up measures to combat child trafficking for child labour as well. This has also helped in preventing children dropping out from schools and entering the labour force.

The Child Rights Commission, constituted as per an Act passed in 2006, has a role in conducting district level reviews with the officers and taking up measures to protect children from child labour.

With this discussion, the authors propose the following measures to be taken to combat child labour in Karnataka.

1.Prevention of children entering labour market: Government and the concerned stakeholders have to do some serious thinking on the obstacles children are facing in entering into and continuing in full time schooling and to take up measures to iron them out. They should prevent children coming from other states in search of labour and provide education and training opportunities and repatriate them to their original places with the cooperation of the concerned states.

2. Reaching the root issues of the problem: There should be concerted efforts with the collaboration and participation of Govt and Non-Government agencies to develop ideas on rescue and be prepared for the consequences of rescuing and repatriation, etc. They need to take up long term rehabilitation programmes that include rescue and release of child labourers, law enforcement, justice, protection, follow up and rehabilitation. Also the existence of child labour should be seen as an indicator of lack of development.

3. Eliminating child labour: Information in the form of public education should reach everyone who is employing children and violating the law and who may employ children in future. There should be widespread education/awareness about the existing legal instruments, punishment; and such public awareness should be continuous.

In spite of public education and information dissemination, knowing fully well that employing children is an offence, even now some people's representatives, govt officials, police personnel, advocates and even the so- called thinkers, media representatives, etc., put forward the issue of 'poverty' and support child labour. They have to be educated about the fact that the children are citizens and have every constitutional right as citizens. Secondly, they need to move forward and start accepting that child labour is not just mere a social issue, but a development indicator and having child labour is preventing development. In the current situation all are gearing up to take up sustainable development goals and so have to end child labour by considering it as a development indicator.

On every June 12th while observing International Anti Child Labour Day successive chief ministers and labour ministers keep announcing that the state would be free of child labour either in the next 10 or 20 years, without mentioning the reality! The biggest requirement today is for the Government, society, NGOs, corporate sectors and political parties to take a hard look at the realities in pockets and sectors and act accordingly with a micro-level approach.

ಮುಖ್ಯಮಂತ್ರಿ ಸಿದ್ದರಾಮಯ್ಯ ಭರವಸೆ

2017ರ ವೇಳೆಗೆ ಬಾಲಕಾರ್ಮಿಕ ಮುಕ್ತ ರಾಜ್ಯ

ನಿಮ್ಮ ಪತ್ರಿಕೆಗಾಗಿ ಬೆಂಗಳೂರು

ಕರ್ನಾಟಕವನ್ನು 2017ರ ವೇಳೆಗೆ ಬಾಲ ಕಾರ್ಮಿಕ ಮುಕ್ತ ರಾಜ್ಯವನ್ನಾಗಿ ಮಾಡಲಿದೆ ಎಂದು ಮುಖ್ಯಮಂತ್ರಿ ಸಿದ್ದರಾಮಯ್ಯ ತಿಳಿಸಿದರು.

ಕಾರ್ಮಿಕ ಇಲಾಖೆಯು ಕೋಲಾರ ಬಂಗಾರಪೇಟೆಯಲ್ಲಿ ಗುರುವಾರ ಮುಖ್ಯ ಕೈಗಾರಿಕೆಗಳಲ್ಲಿ ಬಾಲ ಕಾರ್ಮಿಕ ಪದ್ಧತಿ ವಿರೋಧಿ ದಿನ' ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ಅವರು ಮಾತನಾಡಿದರು. "2012ರ ವೇಳೆಗೆ ಕರ್ನಾಟಕ ಬಾಲ ಕಾರ್ಮಿಕ ಮುಕ್ತ ರಾಜ್ಯವಾಗಿ ಬೇಕು. ಆದರೆ, ಅದು ಸಾಧ್ಯವಾಗಲಿಲ್ಲ. ಈಗಲೂ ಆಗಾಗ ಒಟ್ಟಿ, ಬಡ ಕಾರ್ಮಿಕರಿಗೆ, ಮೋಟಾರ್‌ಗಳಲ್ಲಿ, ಪಟಾಕಿಗಳಲ್ಲಿಗಳಲ್ಲಿ ಮಕ್ಕಳನ್ನು ಬಡಿಸಿ ಕೆಲಸ ಕ್ರಿಯವುದನ್ನು ಕಾಣುವುದು. ರಾಜ್ಯ ಕಾರ್ಮಿಕ ಇಲಾಖೆ 2017ರ ವೇಳೆಗೆ ರಾಜ್ಯವನ್ನು ಬಾಲ ಕಾರ್ಮಿಕ ಮುಕ್ತ ಮಾಡಬೇಕು. ಅದಕ್ಕೆ ಎಲ್ಲರ ಸಹಕಾರವನ್ನು ಬಯಸುತ್ತೇನೆ," ಎಂದರು.

"ಕೇಂದ್ರ ಸರಕಾರದ ಬಾಲ ಕಾರ್ಮಿಕ ಕ್ರಿಯಾ ಯೋಜನೆ ಅಡಿಯಲ್ಲಿ 17 ಜಿಲ್ಲೆಗಳನ್ನು ಹಾಯಿಯಲ್ಲಿದೆ. ಅದರಂತೆ ರಾಜ್ಯ ಸರಕಾರ ದಿನ ದರಂ ಕ್ರಿಯಾ ಯೋಜನೆಯೊಂದನ್ನು ಸಿದ್ಧಪಡಿಸಿ ಇದರ ಅಡಿ 13 ಜಿಲ್ಲೆಗಳನ್ನು ಹಾಯಿ ಮಾಡುವ ಉದ್ದೇಶ ಇದೆ. ಬಾಲ ಕಾರ್ಮಿಕರಿಗೆ ಪುನರ್ವಸತಿ, ಗುರುತಿಸಲ್ಪಡದ ಪಟ್ಟಿಯಲ್ಲಿ, ಅವರನ್ನು ಮರಳಿ ರಾಷ್ಟ್ರೀಯ ಮುಖ್ಯವಾಹಿನಿಗೆ ತರುವ ಪ್ರಯತ್ನ ಮತ್ತು ಸಮಾಜದಲ್ಲಿ ಉಪ್ಪಡುವ ಪಡೆ ಗಣನಾಗಿ ರೂಪುಗೊಳ್ಳುವುದು ಇದರ ಮುಖ್ಯ ಉದ್ದೇಶ," ಎಂದರು.

"ಬಾಲ ಕಾರ್ಮಿಕರನ್ನು ಮರಳಿಸಿಕೊಳ್ಳುವುದು ಮಾತ್ರವಲ್ಲ, ಪೋಷಕರಿಗೆ ಒಳ್ಳೆಯ ಉದ್ಯೋಗ ಕೊಡಿಸುವ ಕೆಲಸವೂ ಆಗಬೇಕು. ಆಗ ಮಾತ್ರ ಬಾಲ ಕಾರ್ಮಿಕ (ನಿಷೇಧ ಮತ್ತು ನಿಯಂತ್ರಣ) 1986ರ ಕಾಯಿದೆ ಜಾರಿಯಲ್ಲಿದೆ. ಅದರ, ಇದರಲ್ಲಿ ಹೆಚ್ಚಿನ ಒಟ್ಟು ಅಪರಾಧವನ್ನು ಮತ್ತಷ್ಟು ಬಲಗೊಳಿಸುವಂತೆ ಕೇಂದ್ರದ ಮುಂದೆ ಒತ್ತಡ ತರಲಾಗುವುದು. ಅಲ್ಲದೆ, ರಾಜ್ಯ ಪರಿಷ್ಕೃತ ಇಂತಹದ್ದೊಂದು ಕಾನೂನು ಜಾರಿಗೆ ತರಲು ಇಚ್ಛಿಸಿದೆ ಎಲ್ಲಪಕ್ಷಗಳ ಬಗ್ಗೆ ಅಭಿಪ್ರಾಯಗಳು ಬಂದಿಲ್ಲ ಸಚಿವರೊಬ್ಬರು ತಿಳಿಸಿದರು.

"ಬಾಲ ಕಾರ್ಮಿಕ ಪದ್ಧತಿ ನಿರ್ಮೂಲನೆಗೆ ಕೇಂದ್ರ ಮತ್ತು ರಾಜ್ಯ ಸರಕಾರಗಳು ಇಷ್ಟವು ಕ್ರಮ ಕೈಗೊಳ್ಳಬೇಕು. ಕಂದಾಯ 14 ವರ್ಷದೊಳಗಿನ ಎಲ್ಲ ಮಕ್ಕಳಿಗೆ ಕಡ್ಡಾಯ ಶಿಕ್ಷಣ ದೊರೆಯುವಂತೆ ಎಸ್ಸೆಸ್ಸೆಲ್ಸಿ ಪೂರ್ವದವರೆಗೆ ಶಿಕ್ಷಣ ಮತ್ತು ಉಚಿತ ಪಡೆದ ಜಾರಿ ತರಬೇಕಾಗಿದೆ. ಮಕ್ಕಳು ಶಿಕ್ಷಣದಿಂದ ವಂಚಿತರಾದರೆ ಈ ದೇಶದ ಆಸ್ತಿಯೂ ಸಾಧ್ಯವಿಲ್ಲ, ಪೂರಾಹಾರ ಹಾಗೂ ಎಷ್ಟು ಹೊಂದಿದ ಅವರು ಮಕ್ಕಳನ್ನು ಶಾಲೆಗೆ ಕಳುಹಿಸಬೇಕು," ಎಂದು ಹೇಳಿದರು.

ಸಚಿವ ಟಿ.ಬಿ. ಜಯಚಂದ್ರ ಅವರು "ರಾಜ್ಯ ಬಾಲ ಕಾರ್ಮಿಕ ಕ್ರಿಯಾ ಯೋಜನೆ ಜಾರಿ ರಾಷ್ಟ್ರೀಯ ಬಾಲ ಕಾರ್ಮಿಕ ಕ್ರಿಯಾ ಯೋಜನೆಯ ಮೂಲಕ 2001ರಿಂದ ಇಲ್ಲಿಯವರೆಗೆ 1,09,751 ಬಾಲ ಕಾರ್ಮಿಕರನ್ನು ಪುನರ್ವಸತಿಗೊಳಿಸಲಾಗಿದೆ. ಬಾಲ ಕಾರ್ಮಿಕರನ್ನು ನೇಮಿಸಿಕೊಂಡಿದ್ದ ಮಾಲೀಕರಿಂದ 1.03 ಕೋಟಿ ರೂ. ಪರಿಹಾರ ವಸೂಲಾಗಿದೆ. ರಾಷ್ಟ್ರೀಯ ಬಾಲ ಕಾರ್ಮಿಕ ಯೋಜನೆಯಡಿ 17 ಜಿಲ್ಲೆಗಳಲ್ಲಿ 107 ಶಾಲೆಗಳಿದ್ದು, ರಾಜ್ಯ ಬಾಲ ಕಾರ್ಮಿಕ ಯೋಜನೆಯಡಿ 26 ವಿಶೇಷ ತರಬೇತಿ ಶಾಲೆಗಳು ಕಾರ್ಯನಿರ್ವಹಿಸುತ್ತಿದೆ. ಪ್ರತಿ ಶಾಲೆಗೆ 50 ಮಕ್ಕಳ ಪುನರ್ವಸತಿಗಾಗಿ ನಿಗದಿಪಡಿಸಿ ಅನುದಾನವನ್ನು 9 ಲಕ್ಷ ರೂ.ಗೆ ಮಿತಿಗೊಳಿಸಲಾಗಿದೆ," ಎಂದರು.

"ಬಾಲ ಕಾರ್ಮಿಕರ ಪುನರ್ವಸತಿಗಾಗಿ ರಾಜ್ಯ ಸರಕಾರ ಬಜೆಟ್‌ನಲ್ಲಿ ಕೋಟಿ ರೂ. ಒದಗಿಸಿದೆ. ಜೊತೆ ಜಾಗೃತಿಯಿಂದ ಮತ್ತು ಬಾಲ ಪದ್ಧತಿಗಳಲ್ಲಿ ಅಂಗಾಂಶಗಳಿಂದ ಕಾರ್ಮಿಕ ಸಂಸ್ಥೆ ಅಧಿಕಾರಿಗಳಿಂದ ಸಹಿಗೆ ಮಕ್ಕಳ ಕ್ರಿಯಾ ಯೋಜನೆ ಜಾರಿಗೆ ತರಲಾಗಿದೆ. ಪ್ರತಿಷ್ಠ ಅಧಿಕಾರಿಯೊಂದಿಗೆ ಕೆಲಸ ಮತ್ತು ರಾಯಚೂರು ಜಿಲ್ಲೆಗಳಲ್ಲಿ ಸಹಿಗೆ ಬಾಲ ಕಾರ್ಮಿಕ ಯೋಜನೆ ಜಾರಿಗೆ ತರಲಾಗಿದೆ," ಎಂದು ವಿವರಿಸಿದರು.

ಬಾಲ ಕಾರ್ಮಿಕ ಪುನರ್ವಸತಿ ಕೇಂದ್ರಗಳಲ್ಲಿನ ಎಸ್.ಎಸ್.ಎಲ್.ಸಿ ಮಕ್ಕಳಿಗೆ ಅತಿ ಹೆಚ್ಚಿನ ಅಂಕ ಗಳಿಸಿದ ವಿದ್ಯಾರ್ಥಿಗಳನ್ನು ಸನ್ಮಾನಿಸಲಾಯಿತು. ಸಚಿವ ಆರ್. ರೋಷನ್ ಬೇಗ್, ಕಾರ್ಮಿಕ ಇಲಾಖೆ ಸರಕಾರದ ಅಪರ ಮುಖ್ಯ ಕಾರ್ಯದರ್ಶಿ ಟಿ.ಎಂ. ವಿಜಯಭಾಸ್ಕರ್, ಕಾರ್ಮಿಕ ಆಯುಕ್ತ ಡಾ.ಡಿ.ಎಸ್. ವಿಶ್ವನಾಥ್, ಆದರ ಕಾರ್ಮಿಕ ಆಯುಕ್ತ (ಆಡಳಿತ) ಜೆ.ಟಿ. ಮಂಜುಳಾ ಮತ್ತಿತರರು ಉಪಸ್ಥಿತರಿದ್ದರು.

ಈ ನಡುವೆ, ನಿಮ್ಮ ಬಾಲ ಪತ್ರಿಕೆ ವಿರೋಧಿ ದಿನದ ಅಂಗವಾಗಿ ಸ್ವಾತಂತ್ರ್ಯ ಉದ್ಯಾನದಿಂದ ಕಂಠೀರವ ಕ್ರೀಡಾಂಗಣದವರೆಗೆ ಜಾಥಾ ನಡೆಯಿತು.

1. ಕಾರ್ಮಿಕ ಇಲಾಖೆ ಕೋಲಾರದ ಬಂಗಾರಪೇಟೆ ಕ್ರೀಡಾಂಗಣದಲ್ಲಿ ಗುರುವಾರ ಹಮ್ಮಿಕೊಂಡಿದ್ದ 'ನಿಮ್ಮ ಬಾಲ ಕಾರ್ಮಿಕ ಪದ್ಧತಿ ವಿರೋಧಿ ದಿನ' ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ವಿವಿಧ ವಿದ್ಯಾರ್ಥಿಗಳು ಪಥಸಂಚಲನ ನಡೆಸಿದರು.
2. ಕಾರ್ಯಕ್ರಮದಲ್ಲಿ ವಿದ್ಯಾರ್ಥಿಗಳು.
3. 4. ಮಕ್ಕಳ ವಿವಿಧ ಮನರಂಜನಾ ಕಾರ್ಯಕ್ರಮಗಳು.

1. UNCRC 1989, Article 32 Child Labour/Economic Exploitation
2. Census 2011
3. India's only statement (The Government did not say whether this is a declaration or a reservation) when it ratified the CRC was about working children : While fully subscribing to the objectives and purposes of the Convention, realising that certain of the rights of Child, namely those pertaining to the economic, social and cultural rights can only be progressively implemented in the developing countries, subject to the extent of available resources and within the frame work of international co-operation; recognising that the child has to be protected from exploitation of all forms including economic exploitation; noting that for several reasons children of different ages do work in India; having prescribed minimum ages for employment in hazardous occupations and in certain other areas; having made regulatory provisions regarding hours and conditions of employment; and being aware that it is not practical immediately to prescribe minimum ages for admission to each and every area of employment in India - the Government of India undertakes to take measures to progressively implement the provisions of Article 32, particularly paragraph 2(a), in accordance with its national legislation and relevant international instruments to which it is a State Party. - RESERVATIONS TO THE CONVENTION ON THE RIGHTS OF THE CHILD: A Look at the Reservations of Asian State Parties (1994), International Commission of Jurists, GENEVA, SWITZERLAND

4. 2004 UN CRC Committee Concluding Observations 1999
5. Supreme Court 1992
6. Analysis of budgetary allocations of several years
7. Census of India 2011
8. Census of India 2011
9. Suchitra Rao, Release of Domestic Child Labourers, Joint efforts by NGOs, UNICEF and Government of Karnataka, 2016

Vasudeva Sharma N.V. M.S.W.; Executive Director of Child Rights Trust and State Convener of KCRO; President, Karnataka Association of Professional Social Workers and Executive Committee Member of India Network of Professional Social Workers' Association; Former Member, KSCPCR and CWCs with special interest in the implementation of JJ Act and RTE Act.

Dr. Vani Kantli: Ph.D.; State Program Coordinator, Bachpan Bachao Andolan, Bengaluru; Former Child Welfare Committee (CWC) Member, Bengaluru Urban, and Childline Nodal Coordinator, Bengaluru city.

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REPORT ON CHILD SEXUAL ABUSE IN KARNATAKA: SITUATION, MEASURES IN EXISTENCE, THE GAPS, STANDARDS, AND STEPS TO BE TAKEN.

-Dr. Shaibya Saldana

Situation till 2014: With the implementation of the POCSO Act from November 2012, there has been a marked focus of media, government departments and the public at large on the issue of child sexual abuse. Over the last 3 years the following has been seen in Karnataka state

1. Increase in reporting of cases of child sexual abuse, primarily where the offender is not a relation, i.e. school staff, neighbour, stranger
2. Increase of reporting in the media, both print media and TV channels
3. Community action: protests, marches and campaigns for improved safety of children
4. Formation of community and parent associations and forum for prevention of CSA
5. Seminars and panel discussions organised by various media houses and organisations on child protection policies and processes
6. Setting up of KSCPCR in Bangalore for Karnataka state
7. Under JJ act, setting up of CWCs and JJBs which are functioning as per rules
8. Designation of specific police officers for CSA management (CWO order by DG IGP, Karnataka State police)
9. Training of police officers in the processes of POCSO Act (GSP-KSP)
10. Dissemination of information to health officials regarding POCSO Act and Ministry and Health and Family Welfare (MoHFW) guidelines regarding management of cases of sexual violence
11. Setting up of special courts for trial of cases of sexual violence against children
12. Capacity building of prosecutors and judicial officers on processes of POCSO Act
13. Setting up of District Child Protection Units in every district in Karnataka under ICPS
14. Government order for setting up of One Stop Crisis Centres (OSCC) in every district hospital
15. Training and formation of Collaborative Child Response Units (CCRU) in few medical colleges in Bangalore, Mangalore and Belgaum
16. Increase in NGOs associated with Childline in 17 districts in Karnataka
17. Resource centres available e.g. NIPCCD, CCL in NLSIU, GSP trainers, CRT, KCRO, Etc

Further action:
A. Preventive:

Area of concern	Measures in existence	Gaps	Action to be taken
Community awareness: -General public -Schools and institutions working with children	- Few posters in schools on corporal punishment - Erratic DIET training for government teachers and staff on child safety policies - Sporadic talks by NGOs on child sexual abuse	Implementation of RTE w.r.t. abolishing corporal punishment in schools Reduction of school drop out Sexual violence in schools	Training for teachers Recruitment policies Background checks or police verification SDMC training on child sexual abuse issues
Parent awareness	Nil	Understanding dynamics of abuse and personal safety measures required at home and school Fear and lack ofconfidence in police and legal processes	Parenting classes Talks by police officers at schools for parents and students
Children's personal safety knowledge	Sporadic talks by NGOs on child sexual abuse	Inability to recognise, resist and report CSA	Personal safety classes for students as part of the curriculum
Adolescent risky behaviour	Nil	In adolescents, there is a lack of understanding of their own feelings, their developing sexuality, their impulsive behaviour and their need to break adult rules	Adolescent education programmes Vocational training for 14 -18 year old Creating social spaces safe for adolescents
	Few NGOs working in different regions	Inadequate understanding of different dynamics Lack of data pertaining to children	Comprehensive data collection on issues related to children

Area of concern	Measures in existence	Gaps	Action to be taken
Religious fundamentalism in Dakshin Kannada			
Sponsorship and foster care systems for children	Sporadic, inadequate and unstructured schemes by DWCD	Poor implementation of schemes Lack of knowledge by public regarding these schemes	Posters and programs regarding schemes Systematic implementation at village level Involvement of Information and Broadcasting Ministry
Child care programs at village / taluka level	Sporadic, inadequate and unstructured schemes by various departments	Top-down approach in implementation of schemes for children	Decentralisation of child care schemes
Convergence between departments	Multiple schemes on child protection by different departments	Each department creates schemes, sends notifications to their own departments without informing other departments, hence duplication of efforts and absence of programs in some areas	Working committee on children with mid-level officials from concerned departments to discuss schemes and evaluate before implementation. Interdepartmental notifications for information to other departments

B. Early Reporting and Systemic Response to sexual violence against children:

Area of concern	Measures in existence	Gaps	Action to be taken
Community awareness on mechanisms of reporting	Public campaigns on child sexual abuse by DWCD, Police and education depts.& I & B Dept.	Inadequate knowledge of reporting in community	Sustained and repeated public campaigns on CSA by ICPS functionaries
Private medical doctors knowledge of CSA and methods of reporting esp due to mandatory reporting under POCSO Act 2012	Few seminars on CSA diagnosis and management for private practitioners by medical state and national level organisations/ federations	Lack of knowledge of private medical personnel	Sensitisation of doctors through medical association
Medical management of child who has experienced and	GO has been circulated by DWCD Few district-level OSCC are functioning with	Each district does not have a fully functional OSCC Location and allotment	Implementation of OSCC: Designated location in district hospital
level of sexual violence	deputed staff	of space not according to Govt. officials No training for medical staff No SOPs or protocols for OSCC	SOPs and protocols formation Recruitment of exclusive staff for OSCC Training of staff
Police response to cases of sexual violence	SJPU Gender Sensitisation Program, Karnataka State police Police training regarding POCSO Act	Inadequate sustained training Lack of specialised police officers Insufficient police personnel	Increase in recruitment of police personnel

Safety of child & family after reporting	Response by CWC and JJB	Lack of individualised care plans for children Lack of trained social workers	Standard individualised care plans
Prosecution and legal aid for cases of sexual violence	Allocation of prosecutors for each case	Lack of knowledge of laws governing children Insensitive and gendered management of child abuse cases	Training of public prosecutors on laws governing children Designation of specially trained and senior public prosecutors to cases of children
Establishment and functioning of Special courts for children	Notification of specific courts in Bangalore and each district to function as a special court for children Police are informed regarding the courts	Judicial officers are unaware of recent changes in laws and processes governing cases of sexual violence against children	Training of judicial officers Establishment of child-friendly, survivor-sensitive and legally acceptable courts following the guidelines of POCSO Act and JJ Act in each district
Rehabiliation of children who have faced abuse	Victim compensation funds allocated by government Schemes to ensure survivors can continue schooling and normalisation of activities	Lack of dissemination of information regarding government schemes to community, child protection agencies and district administration	Dissemination through posters, circulars, in government offices, schools, panchayat offices regarding schemes for children
Victim compensation	Inadequate and poorly implementable schemes Lengthy processes for obtaining compensation	Corruption and harassment in obtaining compensation Humiliating processes for obtaining compensation	Single window mechanism for victim compensation

Reporting in media	Guidelines for media on reporting of cases of sexual abuse	Media does not follow the guidelines of confidentiality regarding reporting of cases of sexual violence against children	Action by CWC and KSCPCR on media institutions
Data on Child sexual abuse	State crime Records bureau Police data Data with various agencies ICPS data	Incorrect data collection and entry Incomplete data entry Poor analysis of data Wrong data entered due to need to meet targets in programs	State system for data collection Training of data collection staff regarding nomenclature, systems and data management Need for professional data analysis

Dr. Shaibya Saldanha: Obstetrician- gynecologist and a sexuality activist with a focus on child rights. While continuing her clinical practice of 25 years, she trains stakeholders (medicos, counsellors, police, lawyers and judges, and the community at large) in setting up child protection systems in the state. Founder of Enfold Proactive Health Trust,

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CHILD MARRIAGES IN KARNATAKA

- Satish G.C.

Any child, whatever its social, economical and cultural background, has the right to care, protection, education, development and joyful childhood. These rights are clearly articulated in our constitution and several international conventions that India has accepted. So in child marriages, the child is deprived of its health and educational rights and undergoes violence, exploitation and misuse. Hence child marriages should be considered as a severe violation of child rights.

Child marriages especially marriages at very early ages a seriously affect the lives of both boys and girls, but the extent and types of problems are more in girls.

The existing evil of child marriage is not only in our state and country but also in many backward and developing countries. Child marriage means marriage before attaining the maturity. In India, according to Child Marriage Prohibition Act 2006, any marriage carried out below the age of 18 years for girls and 21 years for boys, is defined as child marriage.

There is universal acceptance to prohibit child marriages in the world through international conventions. Our country also prohibits the child marriages, but the system still exists.

Salient features of Child Marriage Prohibition Act 2006

Whoever performs, conducts, directs any child marriage shall be punishable with rigorous imprisonment one year to two years or a fine of one lakh rupees or both;

- *To handle the child marriage cases Child Marriage Prohibition Officers are appointed;*
- *The petition may be filed at any time but before the child filling the petition completes two years of attaining majority;*
- *While issuing decree of nullity of marriage, both parties can return, the money, valuables, ornaments and other gifts received on the*

occasion of the marriage by them from the other side.

- *Court can make a direction about girl child maintenance and residence.*
- *Children born from child marriage should be considered as legitimate child.*
- *Court has the power to give injunction to child marriages.*

Causes:

It is very difficult to give a particular reason for child marriages. It varies from state to state, district to district. But in general, child marriages are justified in the background of financial, social and cultural background of the society, but the parents and family play an important role. In the majority of the cases, parents and elders of the family perceive girl child marriage as a responsibility as well as a prerogative rather than considering the best interest of the child.

One can identify the major reasons for this in our country. They are illiteracy, ignorance about serious consequences of child marriage i.e. health problems, hindrance to education, curtailing of childhood rights and lack of maturity of the girl to face marriage; ignorance about the prevalent law prohibiting the practice, ignorance regarding the importance of education of children; socio-cultural and religious practices, morality, emphasis on virginity, fear of molestation/eloping/rape, dowry, pressure from the community, lack of will to enforcement of law etc. In general the main reason is male dominated society and low status of girl child.

Consequences:

Child marriage affects children adversely. It destroys the child's development and growth and enjoyment of childhood joyfully. It not only affects the lives of the children but also has a long term harmful impact on the society in total.

According to NFHS 4 (Table 31) the highest percentages of miscarriage and still births occur among girls in the age group of 15-19 years. Similarly they have less awareness about ORS than women.

International and National Commitments on Child marriage:

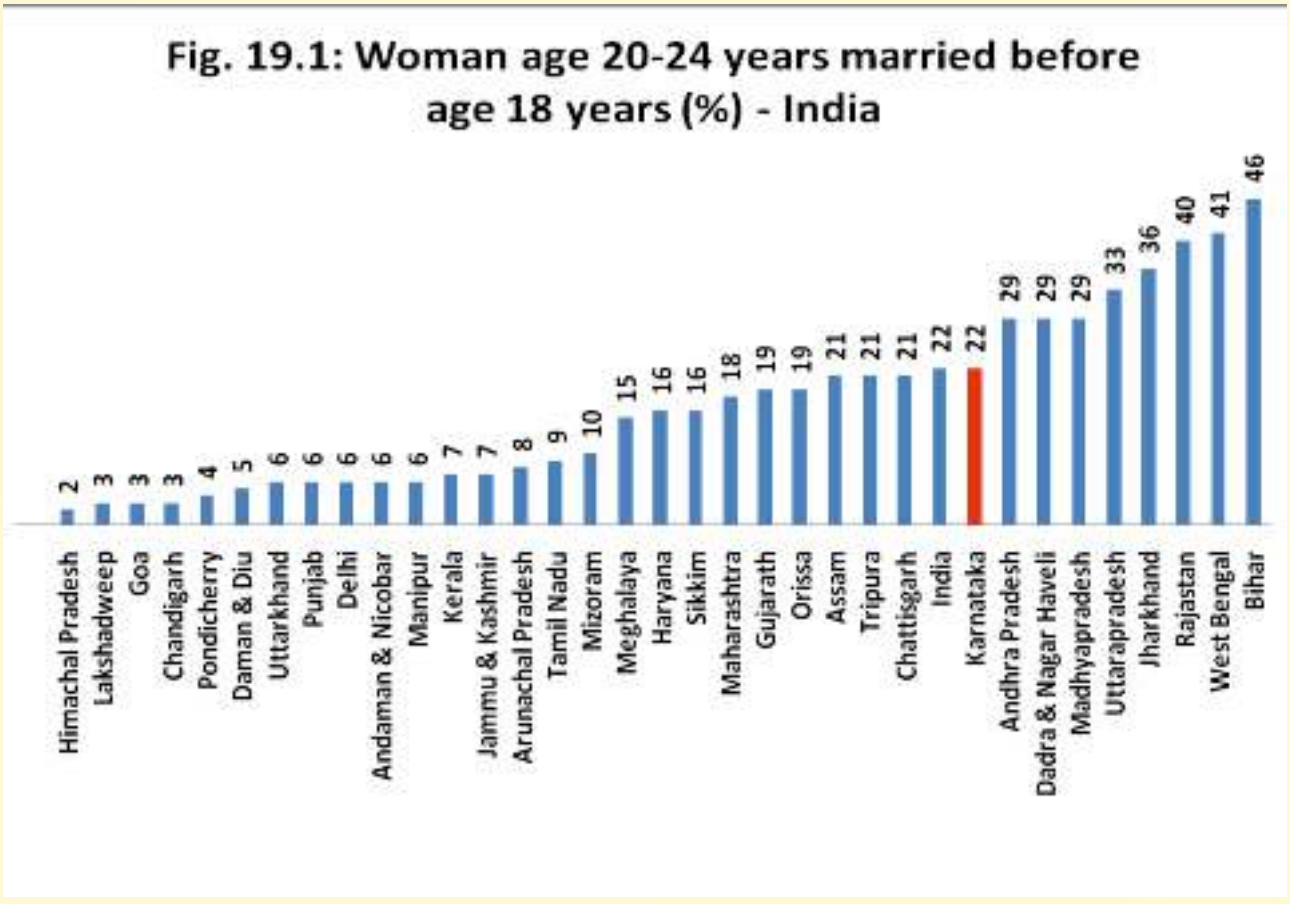
- The Universal Declaration of Human Rights 1948 – Article 16;
- Convention on the Rights of the Children 1989 for which India is signatory on 1992 – Article 19,24,28 and 34;
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 1979;
- Millennium Development Goals;
- Convention on Consent to Marriage, Minimum Age for Marriages, 1964
- Child Marriage Restraint Act, 2006
- Compulsory Marriage Registration Act, 2006
- Juvenile Justice (Care and Protection) Act, 2000
- Prevention of Dowry Act, 1961
- Free and Compulsory Education Act, 2009
- 11th Five Year Plan (2007-2012) – calls for 'compulsory registration of marriages, and verification of age at the time of marriage'
- National Policy for Children (2005) – It aims to abolish child marriages within 2010 (section 6.1.4 and 7.1.3)

Child Marriage in India

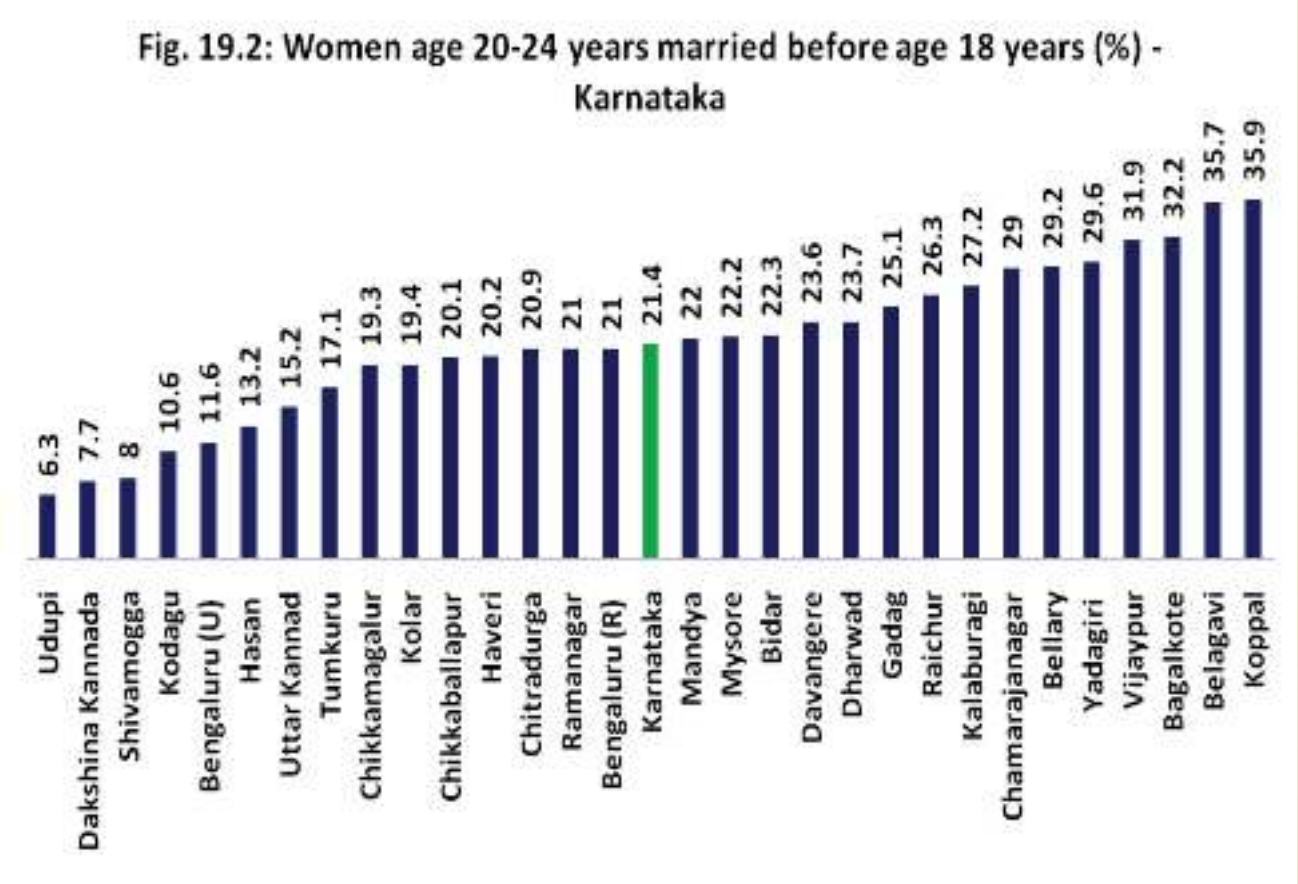
According to National Family Health Survey 2015-16, nearly 21% of women (aged 20-24 years) in India said that they were married before the age of 18 years. In eight states the prevalence of child marriage is more than the national average. In Karnataka, the prevalence of child marriage is 22% and is almost equal to national average

The state's average is down from 42% to 21% during the period of 2005-06 to 2015-16. Also Nine percent of men age 25-29 years got married before the legal minimum age of 21, down from 15 percent of men in NFHS-3.

Looking at the above figures leads one to believe that child marriages have drastically decreased in the country and state. But the gap between the two surveys is ten years and the sample size used in both the surveys is not equal, which might affect the accuracy of the data. That is perhaps why it seems very low.



Child marriages in Karnataka



Within Karnataka, there are wide discrepancies among districts. Koppal district has recorded highest in the state (36%). In almost all north Karnataka districts, the prevalence of child marriages is high. In 15 districts of the state, the prevalence of child marriage is more than state's average.

Government, NGOs and communities have made several efforts to combat child marriages but still it is a common practice in the state.

To find out the extent to which the practice is in vogue in the state and suggest ways and means to root it from the society, the Karnataka High Court directed the state government to form a committee. The state government formed one under the chairmanship of Hon'ble Justice Dr. Shivaraj Patil. This committee has organized consultations in several parts of the country ant discussed with experts and handed over the 'Report on Prevention on Child Marriages in the State of Karnataka' to the state government. In this report it made three major recommendations. They are:

1) Creation of awareness on the consequences of child marriage to prevent its occurrence;
2) Reformation of the legislative and

legal framework, including amendment to the existing Prohibition of Child Marriage Act 2006 and state rules.

3) Effective implementation of Prohibition of Child Marriage Act, 2006 by addressing the constraints and hurdles.

Even though Government has implemented several programmes in line with this recommendation, it has not yet come out with an action plan in this regard. To prohibit child marriages completely in the state, it is necessary to formulate an action plan and implement the same within the prescribed time limit. If so, convergent action by all experts, NGOs, the community, children, elected representatives and concerned departments is necessary.

Some recent developments:

Karnataka State government has amended the Child Marriage Prevention Act in 2017. According to this amendment:

- Every child marriages solemnised on or after the date of coming into force of the Prohibition of Child Marriage (Karnataka Amendment) Act, 2016 shall be void abinitio.
- The offenders will be punishable with rigorous imprisonment of not less than one year which may extend upto two years including women.
- The police officer shall take cognizance of an offence committed in his jurisdiction under this act, suo motto.

With all the efforts of government and NGOs to stop child marriages, still the system exists. In this background some of the organisations are working on education, sexual reproductive health rights, counselling, life skills aspects of early married girls in the selected districts of the state. In the recent meeting the DWCD officials, the department has accepted that there are lot of early married girls in the state and it has formed a committee to analyse the situation of early married girls in the state.

Legal enforcement:

- Justice Ashok B. Hinchigeri, In his Judgment in the case of Ms. Seema Begaum D/O Khasimsab vs State of Karnataka on 26 February, 2013 dismiss the petition to allow child marriage under Muslim Personal Law (Shariat) Act 1937.
- Justice Madan B. Lokur & Deepak Gupta, Supreme Court, New Delhi in their judgment said that “sex with minor girls even in the relationship of marriage is considered as rape” i.e. these cases were considered under POCSO.

These two judgments are considered as milestones in legal enforcement in preventing child marriages in the country and state as well.

Satish G.C.: Director, Child Rights Trust, Bengaluru; Incharge of research wing. Involved in research and analysis of various child related issues, training and translation of various child related acts from English to Kannada.

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CONSEQUENCES OF LACK OF WATER AND SANITATION FACILITIES ON RURAL UNDERPRIVILEGED FAMILIES- AN EXPERIENCE OF MYTHRI SARVA SEVA SAMITHI

-Harish Babu

Water and sanitation are the fundamental rights of Human beings, states the U.N. It is only through these fundamental facilities that a man can execute his activities with ease and that also gives him power to work. More the power to work, higher the rate of elimination of poverty, this in turn helps to bring below poverty families to mainstream. Only by this can we ensure remarkable development in social health. It is depressing to notice that these facilities are far from reaching the beneficiaries, thus the statements are merely statements.

The projects that were implemented after Independence for the improvement of Water and sanitation conditions are still in practice. But due to lack of implementation and the casual attitude among the officials, about 70% of rural population are denied these facilities (source: a study conducted by Mythri Sarva Seva Samithi in 2013 among 13 villages of Doddaballapur Taluk). Since 10 years, Mythri Sarva Seva Samithi is working in all the Gram Panchayat of Doddaballapur Taluk to persuade the families to have better water and sanitation facilities in their vicinity. In this regard we have become successful in providing these facilities for about 38,000 families.

Our learnings, experience and challenges during this long journey are being shared here. A primary survey conducted by us reveals the fact that about 80% of the families are deprived of the supply of potable drinking water; hence these families are dependent on street hand pumps and private water suppliers. Fetching and storing water has become the responsibility of women in every family. The child also shares these tasks as the exact time of supply of the water at street taps by the local government is not certain.

Even if the water is supplied through street taps, about 15-20 families are dependent on a single tap; and each family is able to fetch a maximum of 4-5 pots of water and collecting the water becomes a day long affair as the force of the water supplied is very

minimal. And this has become a tough task especially for working women as they are forced to take leave to fetch the water which in turn will have an adverse effect on their work and earnings.

If the women are the sole bread earners of the family, the responsibility of fetching water automatically will be shifted on to children. As a result children are not able to attend school on time and this is having an unfavorable effect on their educational progress. Following are the crucial elements that were revealed upon interaction with children in the locality

"Every day I go to school, but not on time because the time of supply of water is not fixed, hence I will have to wait for about 2-3 hrs in a queue. Moreover I will have to walk a long way to reach the school which is a Km. away as there is no transportation facility. I am unable to concentration on studies as fetching water and walking all the way to school tires me a lot. As a result I am not able to excel in studies like other students".

Following are the issues which we came across during our interaction with the women.

"Squabbling with neighbors has become routine, apart from waiting in a queue for long hours leading to breakdown of relationships. Since the supply the water is limited to one hour, every house in the street will not get sufficient water; in such a case it is a waste of time to wait for the whole day leaving undone the work and other household work. Sending the children to school on time, nurturing of small kids, cooking and cleaning the house become difficult tasks. In case if the supply of water from the street tap water is stopped, we are forced to go to the neighboring fields for which we walk about 2 KM spending around 2-3 hrs a day. Some landlords speak foul language; this is against the self respect of us poor people. Still we have to fetch the water pacifying them. It is tiring both physically and mentally to fetch for about 20-25 pots of water which every family is in need of.

"Sometimes it so happens that we are left with no option but to shell out money from our pockets to purchase water from private water suppliers. Some families shell out about Rs. 250-300 every month which gives no guarantee as to the quality of water supplied by them".

Citing the problems, opinions expressed by a few of the beneficiaries of projects run by our organization during interaction with them:

"We are a family of four people; I work as a cook in Jalapa School in Doddaballapur. My husband runs a cycle garage, my son is a car driver and my daughter is studying in 9th std. By 9 am we are all out of the house and for the entire day none of us are at home.

"In this situation it becomes difficult and a huge challenge for us to fetch water every day. Once in 8-10 days we take a bath whereas my son wishes to take bath every day. Once in 15 days water was supplied by the Gram Panchayat for which the time is not stipulated. If one is at home during the time when it was released, one has to wait hours to get 5-10 pots of water. In the process of fetching the water, one has also to fight with others, each claiming she is ahead of the others in the queue.

"We do walk to areca nut fields which

are about a mile away from Village to fetch just 4-5 pots of water, after seeking the permission from the owners, who have refused us anymore. Sometimes we give Rs. 2/- to private vendors for every pot of water. Despite all these efforts, we used to hardly get enough water for household activities. Due to this my daughter is neither attending the school on time nor able to concentrate on her homework. And several times teacher has warned me to send my daughter to school on time. At the same time most of the time I used to go late to my work, where I was supposed to be present by 8 am.

"We just passed the days in distress, as we were not in a condition to afford to get water supply connections to our homes. But I felt amazed after knowing from my neighbor about the financial support given by Mythri to get the connection at our doorstep. Whether to trust this organization or not was the confusion I had. Once, to meet the Mythri representatives I had taken off from my work. During the interaction with them they explained to me the project which they were running and with their support today we have a water connection at our home; and are leading a trouble-free life

"It is easy to collect and store enough water as the water comes to our door step. Usually the supply of water starts from 6 AM and it's easy to collect water and store the water for about a week, even if the municipality supplies water once in a week. Now we are able to collect 10-15 pots of water without much difficulty. And my daughter goes to school on time, my son takes bath every day as he wished to before and we take baths once in two days and are keeping ourselves clean. Now we are able to maintain good health and peace of mind. Above all, my elder daughter has come home seven months pregnant, and the tap connection has relieved us from the worry of getting adequate water at the time of her home delivery.

"Never thought that even we can afford to have a tap of our own at home… this convenience has become a reality thanks to Mythri; we are very happy and we wholeheartedly thank Mythri for this."

Gowramma, Kodigehalli

Kodigehalli Gram Panchayat,

Doddaballapur

The vicinity in which we are working is water scarce and ground water is almost depleted. Even after digging till about 1200-1300 ft deep we hardly get any water. Even if the water is available, the water is unfit either to drink or use for domestic purpose. When tested we found that the water was hard, contains fluoride, and nitrite beyond the normal level. Usage of this water eventually leads to ill effects on health.

In order to overcome these problems, local governments should own the responsibility. Especially when the following issues are improved, problems pertaining to water can be reduced:

- Systemic maintenance of water supply system
- To inculcate the technology required for the reinstallation of depleting groundwater. Ex: Collection of roof water, refilling of bore well water,

refilling of wells-ponds and lakes

- To test the quality of water an making it compulsory to treat the water if necessary
- Revenue based water supply management such as systematizing water supply system, tariff collection.

Water and sanitation are like two faces of the same coin. About 80% of diseases can be prevented if supply of drinking water and sanitation plans is implemented properly. But the primary survey conducted in our project area reveals that about 50% of the families are denied a sanitation facility. The reasons are that under Nirmala Bharat Abhiyan, it is the responsibility of every gram panchayat to provide a toilet facility to every family which has not been implemented properly. Due to lack of awareness about the govt. projects and lack of interest among the govt. department, the projects are not being implemented properly.

At the community and household levels, we come across an attitude wherein having a a toilet at home is not considered as priority, sometimes due to lack of financial backup in families or lack of space they are not able to construct a toilets despite having a mind set to have a toilet at home. Due to this, women and children are becoming the victims of various problems. Here are a few important issues that are observed in our project area:

Open defecation at the outskirts of the village or on agricultural land is common among villagers. As a result, skin and respiratory related diseases, malnutrition and spread of infections among women are growing at high rate. Apart from this, despoiling of the fields by open defecation is a problematic practice that strikes at the dignity of women, elderly persons, adolescent girls and disabled persons.

In this regard we tried to understand more about the feelings of women and children towards open defecation; and the following came up:

For evaluation of the projects in our project areas, our project team visited Shikaripura in Doddaballapur, a poor, largely Muslim, area. Family of Naveen Taj is one among the families residing in the area.

We visited their home and interviewed them, since they had constructed a toilet under the Water and Sanitation project. During the interview Parveen explained her family situation stating “we are a family of 11 members with 3 male, 5 female and 11 kids. It is quite difficult to run the family with the income generated by our men; hence we women roll bidis at home”.

Answering our question, “why did you get the interest to construct a toilet”, Ms. Parveen said, “Since beginning we wished to have a toilet at home but collecting Rs 8000/- at once was of great difficulty for our family. As a result we used go out in search of bushes to defecate either early in the morning or late night. These days it has become difficult to defecate openly as buildings are constructed extensively. With people moving around, it is difficult to squat and again to get up for defecation, as also shaming

“Secondly, my children are small; I have to wait for my children to go to sleep and then go out, otherwise it would have been a difficult task for us to keep them calm. Thirdly,

my mother- law is aged and finds it difficult even to walk. Even in this situation she was forced to go out for defecation. Even after experiencing all these troubles, we were unable to gather the amount for construction of a toilet. But in this situation we constructed a toilet at home with the financial support and information from Mythri and with the permission of family members.

"And now the toilet in our home has brought us both pleasure, and respect. If we now remember the past and horrible days we get goose bumps. Now I need not worry about leaving children at home". She thanked our organization for solving her problems. After listening to this we felt happy for successfully implementing the objectives of the project.

A nineteen year old told us that Sujathamma, resident of Karanala village, Doddaballapur taluk had constructed a toilet on the demand of her daughter, Lakshmi, for which she took out a loan. We assisted them with financial support. Lakshmi, who returned home from colleges, spoke to our team members with joy, when we visited the project area. The reason for her happiness was the financial support given by our organization for construction of the toilet. Following are the feelings shared by her ….

"We were going out to defecate before construction of the toilet at home which was a matter of shame and of unspeakable anguish. I used to never invite my friends to my home as they might make fun of us as we had no toilet facility.

"We were incapable to construct the toilet for various reasons. My brother-in-law had taken back my sister, who had come home for delivery to his place, due to unavailability of a toilet at *home. This incident made us feel embarrassed and pushed us to a helpless state but aroused our determination to construct a toilet in our home.*

"During the Nairmalya awareness programme I was told about the project run by Mythri in our home town. Then I persuaded my parents to construct a toilet at home which became a reality with the support from Mythri. Now, I don't hesitate to invite my friends to home or even if any of relatives visit my home, it is comfortable for them to stay, unlike before".

The joy of constructing a toilet at Lakshmi's house was seen in her words and joy in her face. On this note we bid good bye to Lakshmi, thinking this project can solve the problems of many such families.

On the whole, lakhs of families are denied water and sanitation facilities and are forced to face problems. It is only through proper implementation of the water and sanitation programme by government, NGO and community development centres that people in rural areas can lead a healthy and contented life.

Since six years we are working in Doddaballapur taluk covering 26 Grama Panchayat with an emphasis on supply of drinking water and construction of toilets in each household. Our aim is to create awareness and provide financial support for people to get access to these services. Through rainwater harvesting, construction of a toilet and drinking water connection and other projects, about 31000 people belonging

to 7000 families have been benefitted since 2008.

Government institutions have played a major role in the success of the project. During 2008-09 Mythri was selected as an agency to create awareness on sanitation and community organization among rural people, Government officials and other stakeholders by the Chief Executive officer of the Bengaluru Rural Zilla Panchayat. As a result we were able to develop a good rapport with the officials of Grama panchayat and elected representatives, this paved the way for expansion of our project area in Doddaballapur taluk

Taking advantage of this, in association with Anganwadi workers (Department of Woman and Child development), Asha Workers (Department of Health), Panchayat Development Officer and elected representatives, we are helping the poor families to get access to water and sanitation facilities.

To create awareness among rural people several informative and communicative methods are in use, which include:

- Movie on water and sanitation (audio-visual projections during evening, power point presentation and documentary films)
- Awareness through Photographs
- Distribution of Posters, Brochures, Flip charts and pamphlets
- Formation of water and sanitation committee and fortnightly visits to the villages for proper implementation of the project Home visit and sharing information in groups
- Street play and sharing information through auto campaigns
- For more information on our water and sanitation visit

  http://panchatantra.kar.nic.in/stat/

Harish Babu: Has 20 years of experience working for vulnerable groups, including women and children, especially in water, sanitation and waste management. State resource person on many aspects of this sector; including campaigns, community mobilization and advocacy. General Secretary/ Associate Director of MSSS since 1999.

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URBAN KARNATAKA's CHILDREN

- Dr. R. Padmini

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* * * * *

Introduction

India's population is about a third urban, and Karnataka's nearer two-fifths While urban-rural breakdowns of various child-related indicators are available at the national level and sometimes at the state level for some indicators in the latest round of NFHS - 4, 2015-16 - these are not at all available for specific urban areas. District level data are also not found in all surveys but when they are and where a large city covers an entire district, this problem can be overcome by using that district as a proxy for the city, as in the case of Bengaluru Urban. Some sample surveys have given some data for Bengaluru as one of the major Indian cities, and these are useful. But such data are not available for other urban areas in the State. Finally and most importantly, there is no disaggregated data within a city, and hence the problems of the vast differences between low-income and slum areas and the other areas are hidden, giving a false sense of complacency about the situation in the former on key issues.

This paper seeks to look into whatever data is available about urban Karnataka, Bengaluru and other urban areas, and within them, from the perspective of child rights and the goals for children. Since time series data is sparse, comparisons between the state and the national, as well as other key states, between urban areas if available, will be undertaken. Where urban- rural data are available, comments will also be made about the rural rates, as relevant.

Sources such as the Census, NSS, SRS, NFHS, Education statistics, ASER, Hungama, SCF and others will be drawn upon. Specific studies and reports on the State's towns will also be looked into for case studies and area-specific data.

Now that the United Nations and all countries including India have adopted the Sustainable Development Goals [SDGs] to be reached by 2030, we need to check how urban Karnataka is faring with respect to these goals. [There are 17 SDGs and 169 targets. Here, we can examine the trends and probabilities of reaching those goals for which we have urban-specific data].

General Situation in the State's Urban Areas

In Karnataka as per Census 2011, the urban population under 18 years was 37% of the total population of under 18 years as against 32% in Census 2001. (Census 2001 & 2011)

The State's urban population under 15 years as per NFHS 4 [2015-16] was 24% of the total as against 31 in 2005-6.

Karnataka has for several decades been close to or even mirrored the National statistics with many of its child-related indicators being close to the latter's. Table 1 shows the comparison between Karnataka and India with urban and rural breakdowns for several indicators [NFHS 4 has provided this breakdown for the first time]. The following comments focus on those where the difference between either the state and country or that between urban and rural is large enough to merit attention and also on indicators that are significant by themselves.

Poverty

Various national estimates of the poor range from as low as 11% to 26%, but the Commission on Enterprises in the Unorganised Sector [Arjun Sengupta report] stated that 77% of India's population were living on less than Rs. 20 p.d.]

Around 2008, the estimates of poverty were with the inter-state range for urban poverty being from 2% in J & K to 43% in Odisha [Rural levels were similar]. At that time, with almost a third of the population being urban and nearly a quarter of them being BPL, the urban poor were 5% of the total population while the rural poor were nearly 20% [Padmini, 2008].

According to a World Bank Report, about 14% of the urban population was poor as against 25% of rural population. Other reports give widely disparate estimates for the country's poverty rate, not always disaggregated by urban and rural. It must be noted that there is much methodological change across time and source, but it seems that a fifth or so of our population are poor, but also that there was a downward trend from 2005-2015.

Despite schemes like SJSRY and JNNURM's BSUP, poverty and lack of access to decent employment, basic

amenities etc., in urban areas are noticeable on an anecdotal level. The rule that 40% each of the 18% special component plan set aside for SCs and STs should go to education, economic development is not honoured. These funds are generally under-spent.

Multi-dimensional poverty, as measured by the Alkire-Foster index and similar measures, comprises of the different types of poverty, not just income poverty but that due to access to basic amenities and services. This needs to be studied in both urban and rural areas.

Despite the proportion of the poor declining between 2004-05 and 2011-12, the gap between the poor and the rich has risen for the first time in rural areas in about 35 years and to an all time high in urban areas.

Inequality, computed from the National Sample Survey on household consumption expenditure for 2011-12 is measured by the Gini coefficient. In rural areas, the coefficient rose to 0.28 in 2011-12 from 0.26 in 2004-05 and to an all time high of 0.37 from 0.35 in urban areas [Jha].

Ahluwalia, the Deputy Chairperson of the Planning Commission stated in 2011/12 that in equality had risen in the country including sharply in urban areas of most states. Oxfam (2018) records further increases in inequality in both urban and local areas, as evidenced by India's Gini ranking - 53/127 countries; and its Gini Coefficient - 36.8 [global range being 24.7 [Denmark] to 74.3 [Namibia]

- Overall, richest to lowest decile [10% of population] income ratio was 8.6; 20% ratio -5.6., I.e. top 10% of the population were nearly 9 times richer than bottom 10%; top 20% were nearly 6 times as rich as the poorest 20%.
- India's HDI ranking is now 128th among 177 countries.
- Thus, while its GDP growth has been impressive, this has not been shared equally or led to social development adequately. Recent estimates put the richest 1% having 28% of the total income in India.

The Child's Health Status

IMR, U5MR and NNMR

Karnataka's IMR [28] is definitely lower than the country's in both areas, and its urban rate [19] is much lower that its rural rate [33] and than the national one of 29; overall, it has come down from 43 a decade ago and from 60 in 1990 [the 2015 target was 30]. While the SDGs do not include a specific IMR target, it is important to track it as most U5MR occurs in this period. Similarly most IMR is in the first month of life - NNMR or neo-natal mortality rate. Unfortunately, NFHS 3 gives the perinatal or first week plus stillbirth figure of 26 in urban Karnataka and not the NNMR figure. So while NNMR definitely has come down, it is unclear by how much.

The difference between urban [24] and rural [38] within the state is also considerable for U5MR, and it is large between the state [32] and national [50] levels for both areas together. Here the decline of the overall state level since the last NFHS survey [55] is noteworthy, while it has just missed the target of 31.

2013 SRS [Sample Registration System] results which also show that rural area decline in IMR is more than urban decline. Also, IMR of males [30] is lower than that of females [32] and this difference is slightly more in urban areas [22 and 26] respectively] than rural ones [33 and 35] [The Hindu, 2014 d].This difference is also seen in ENNMR [Early Neonatal Mortality rate -or deaths in the first week of life]

These data and trends may indicate that realising the State's urban equivalent of the SDG national goals of 12 for NNMR and 25 for U5MR by 2030 may be within reach.

Infant Mortality can be broken down into perinatal [PNR], Early neonatal [ENMR] and neonatal [NNMR] rates, since there are sharply differing rates among them with most infant deaths occurring in the first day, then the first week and next the first month of life, while the remaining 11 months see a definite decrease in the mortality rate. However, NFHS does not provide these breakups, so one has to turn to SRS [Sample Registration System, conducted by NSSO]. As such the two sets of data are not comparable.

Table 21.1: Current Child Mortality Rates :

Mortality	Karnataka			India	
per 1000 live births, as per SRS 2012	Total	Rural	Urban	India total	MDG 2015 Target
Infant Mortality Rate	32	36	25	42	28
Neonatal mortality rate	23	29	12	29	–
Early neonatal mortality rate	203	24	11	23	_
Perinatal mortality rate	33	40	20	28	–
Under -5 mortality rate	37	40	31	52	42
Low birth weight %, as per NFHS-3	18.7	–		22	–

Though Karnataka has a better infant mortality rate than most of the rest of India, it has yet to achieve the MDG- 4 goal for reduction of infant mortality by 2015. Karnataka is lagging behind the rest of the country in Perinatal mortality rate (table 21.1).

But mere survival is not enough; the quality of life, a child's health and growth, all these are important. Child mortality and morbidity rates and their reduction depend on a host of health and nutrition related factors, and in a detailed analysis, one would have to go into their several statuses and prospects.

According to the CD-SDG report: “India's Maternal Mortality Ratio has declined from 254 (2004-06) to 167 (2011-13) and then to 130 (2014-16) per 100,000 live births and institutional births have increased from 39 percent in 2005-05 to 79

percent in 2015-16". However there are large inequities and variations between states (for example, currently the MMR ranges from 300 in Assam to 61 In Kerala) and across rural-urban categories (for example, only 75 percent of women delivery in health facilities in rural areas as compared to 89 percent in urban areas). Further, social location (class, caste, religion, tribe) plays a role in determining access to services and outcomes. For instance, UNICEF also notes that there are gross disparities in mortality indicators with Scheduled Castes, Scheduled Tribes and minorities having a higher IMR and U5MR than other groups. One may surmise that such inequity is true of MMR too.

Disease Patterns

Diarrhoea episodes [in the 2 weeks previous to the survey] is 4.5 in Karnataka – a rather high figure [and the urban level (4.8) is more than the rural one (4.5)] but it has come down from 8.6 previously. Usage of ORS and being taken to a health facility are also higher than in the last survey.

ARI incidence [in the last 2 weeks] is 1%, down from 2 %, with the majority taken to hospital.

While the incidence of the two diseases is less in urban Karnataka than rural, the recommended treatment levels are higher nationally than in the state urban locations.

It must be noted that both these diseases have highly variable seasonal patterns, and as the NFHS survey was carried out between February to July 2015 in Karnataka, areas first covered within it might have lower diarrhoeal episodes, but higher ARI ones than areas covered later.

Nutrition Status of the Young Child

Children in the State have many nutritional deficiencies. A third to two-fifths of the under five year olds are underweight – 32% urban as against 29% nationally, while it was 26% before, which is a worrying deterioration; and 38% rural, making the average 35% as against 38% before, which is an insignificant improvement. Other aspects of malnutrition are still more worrying: a third of urban children and nearly two out of five rural children are stunted, meaning all aspects of their growth and development are compromised. The corresponding figures earlier were 34 and 48 % before, which implies that the urban level has remained stagnant.. Karnataka is again worse off for this indicator than the country [31 urban]. And when one considers that one in ten is severely wasted [or near starvation], up from just over half that level, one must be seriously concerned. Here again the difference between rural and urban areas is not much.

Further, the percent of wasting has actually risen from less than a fifth [itself bad] to over a quarter overall with the rural level being slightly higher than the urban one. Once again the national overall level is not as bad [a fifth]. And since one in ten is severely wasted [or near starvation], up from just over half that level, one must be seriously concerned. Here again the difference between rural and urban areas is not much; nationally it is much less [8%].

Yet again, anaemia among children under five, a key nutritional deficiency with a number of deleterious effects, is very high in

the state now at 61%; the level has improved only by about 10 % since the previous NFHS survey. There is a noticeable difference between the urban and rural levels, with the urban being 57% [just higher than the national urban level], but showing a tremendous drop from 82% since a decade ago].

This blighted picture of the nutritional status of the State's children, that shot into headline news and concerted actions by the High Court, followed by special committees and governmental action in 2011-12, shows that the situation has not really changed and the pro-active efforts taken up then not been sustained. It is noteworthy that women, both pregnant and those who are not pregnant are also highly anaemic. The percentage of anaemic women is now 45 in both cases, while it was 60 and 51 before. Even urban levels are 40% for pregnant women and higher at 43 for non-pregnant ones. Though these are better than the corresponding national ones, they have disastrous consequences; it is obvious that this poor status negatively affects not only the well-being of the woman, but also that of the foetus and the newborn, leading to inter-generational deficit of nutrition and its spinoffs.

Looking at a related statistic – BMI [Body Mass Index] , a fifth of adult women and a sixth of men have below normal levels, while over a fifth among both are obese. Urban levels are higher for obesity than rural and both lower than normal and obese are higher than the national levels. These indicators call for attention to both the quantum and nutritional content of adult food intakes. Higher obesity levels among urbanites may be due to more sedentary lives or junk foods or both or perhaps due to an inability of the poor to afford higher cost proteins and fill their bellies with cheaper starchy foods.

Per capita calorie intake has declined by 6% from 1993-94 to 2009-10 both in rural and urban areas of the country, and even more if the 1983 level is taken as the benchmark. Government schemes like the Public Distribution System [PDS] and the Mid-day Meal Scheme [MMS] for children in Anganwadi Centres [AWCs] and elementary schools are working sub-optimally and with many hurdles. The NFSA Act has not been properly implemented.

Thus, achievement of the SDG goal 2.2 - “By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age” - will be a herculean task for the State and its urban areas, given the above trends. Problems like low BMI of women especially, early marriage, poor maternal health and nutrition, low birth weight, poor breastfeeding and weaning practices continue to fuel various forms of malnutrition and contribute to higher child mortality.

Child Feeding

A review of child feeding practices starts on a positive note with breastfeeding having shot up from 36% in NFHS 3 to 56% in NFHS 4; the urban rate is 54% while the rural one is 58% and urban India is 43. But exclusive breastfeeding has come down from 59% to 54% largely due to low urban rate [47% as against 54% nationally] though the rural one is much higher at 58%. Continuation of breastfeeding the child of 6-

8 months has dropped drastically from 70% to just 46 since the previous survey; rural levels [43%] are much lower than urban ones [52%]. In this last round of NHS, there is information on whether the diet of the child between 6 and 23 months is adequate; those not any longer breastfed have higher satisfactory diets, but still woefully low at 14% [urban 16%], while those still being breastfed are only 6% [urban 8%]. National urban levels are respectively 17 and 10, thus a little higher].

MCH Services

While full immunisation coverage is less than 2/3 of the eligible age group in all areas, the state's urban children are worse off in stark comparison with its rural children [almost 2/3], who are better than the national averages [urban only one percentage point less] too. This may be partially due to the higher recourse to private health providers in the towns, who are required to report the number of each type of vaccination they perform to the State Health authorities, but do not always comply with this order. Or it be due to lack of full coverage of slum and low income areas.

Ante-natal check up [ANC] in the first trimester of pregnancy is marginally down from NFHS 3 but for 4 visits [up marginally] about 70 % in each locale. Full urban ANC coverage is above a third; up from a fourth in the previous round. While nationally the urban level is almost the same (69%), it is very low overall due to abysmally low rural levels; the State is much better at a third.

Iron-folic Acid consumption is less than half but this is also up from 28 % previously. Urban and rural levels are about the same; and all State levels are better than the national ones.

2/3 or half of all deliveries are in public hospitals. Ceaserean sections have gone up from a sixth of all deliveries to nearly a quarter; with urban levels nearing almost a third, while rural ones are 2/3 of that or a fifth of deliveries there [private hospitals have twice or more the public rate]

Post-natal care within 2 days of delivery is in 2/3 cases, up from 57% in previous round.

Child health check up within two days of birth was 21% in urban while it was 23% in rural areas! [NFHS-4]. On the other hand, less than 5% in rural areas of children born at home received it within 24 hours as against over 7% in urban areas.

Both urban [93%] and rural [82%] areas show very high levels of household use of iodised salt, making the overall 87% as against 66% in the previous round..

Child Marriage and Pregnancy

More than a fifth of Karnataka's women in the age group 20-24 were married before 18, the legal age for marriage. While this is less than the proportion in the country as a whole [over a quarter], it is just a few percentage points lower in its urban areas [17%]. All these are far better than the previous overall figure in NFHS 3 [41%]

Pregnancy or motherhood in the age group 15-19 years has come down 17% in NFHS 3 to 8 % in NFHS 4 with the urban level being 5 and the rural one nearly10. Apart from the deleterious effects of child marriage [and pregnancy] on the survival and health of the newborn and the adolescent girl, it is clearly inimical to her education, social

development and her very childhood.

Urban levels in the south as in the country as a whole are higher than rural ones – could be due to higher abortion rates, either to limit family size or sex selective abortions. Urban areas may also have higher rates of pregnancy of unmarried girls.

Unexpectedly, use of any family planning method has come down from 64 % in NFHS 3 to 52 in NFHS 4; it is also surprising that the urban rate of 48 is less than the rural one of 54. Almost all use a modern method, in fact, predominantly, female sterilisation. This trend does not augur well for child spacing and the health and nutrition statues of child and mother. Another worrying point is that the trend may suggest either illegal abortions or the sex- selective ones performed after ultrasound scanning, also an illegal practice.

Sex Ratios

The trends in sex ratio at birth in the State are worrying – it has come down from 922 in NFHS 3 to 910 in NFHS 4; urban [874] is much worse than rural level [934]. All these figures are lower than the corresponding ones for the general sex ratios though this is also worse now than before. While the lower urban ratio in the general sex can be partially explained in view of possible higher male migration, there no other explanation for the ratio on birth being so poor except sex determination, which could be in greater vogue in urban areas.

Literacy and Education

As per census data, both male and female literacy have improved since the previous survey but there is still some way to go especially for females. [In 2001, male literacy in the state was 76% and female was 57%; in 2011, male literacy rate rose to 83% and female literacy rate to 68)]. The gap between rural female literacy [64] and urban [82] is also of concern.

On the other hand, female school completion as a minimum is noticeable as 59% in urban areas and 35% in rural have achieved this, leading to an average of 46 as against 28 previously. Enrolment of children above six years of age is 81% in urban, 63 in rural and thus an average of 71 compared to 62 formerly. These gains too are less than expected.

The retention rate in elementary school is 85.38% and it is almost equal between boys and girls.

PTR for sanctioned teachers is 19.66 and for working teacher PTR is 23.18. (UDISE report 2016-17)

In elementary schools of the state (all types of management) a total of 2,83,922 [or 88 %] teachers are working against the sanctioned strength of 3,22,173.

Out of the total 3,64,342 classroom in elementary schools only 2,87,583 [79%] class rooms are in good condition.

According to ASER 2018, In rural Karnataka, standard IV children who can read standard II text are only 33% and only 29% can subtract numbers. As no similar surveys have been conducted in urban areas, we do not have comparable figures.

Drinking Water and Sanitation

Karnataka has lower coverage of safe drinking water than nationally though both are reported to be quite high even in rural areas. Unfortunately the actual quality of the water is neither tested regularly nor

published. Some sources may contain unacceptable levels of fluoride, iron or arsenic. It is also known that, sometimes, the drinking water availability varies with season. Piped or borewell water is not available 24x7 and in some urban low income areas, women have to queue up in the middle of the night at public taps. Tanker-supplied water is increasing in summer, posing problems of quality and cost

Urban area levels are far higher than rural ones of households using an improved sanitation facility, and Karnataka is better off in both areas than India. The situation may be rapidly changing due to schemes like Nirmal Bharath, Total Sanitation and Swach Bharat. The figures given are for numbers of household and community toilets; usage is much more difficult to ascertain and open defecation does continue. Other aspects of sanitation such as hygienic hand washing, insanitary spaces around habitations and fields, leading to problems arising from going barefoot and a cultural belief that children's excreta are not defiling, are mostly ignored and these contribute to water-borne diseases.

Protection

Child Labour

The CLPRA had till recently excluded under its purview agricultural and such other rural sectors. So Child Labour [CL] laws and programmes generally referred to the urban sector. Also, only the hazardous occupations, as defined in the Act, were covered for the 14-18 year olds. In 2016, amendments to the Act allowed children even in the age group of 6 to 14 to work in home-based work [such as artisanal and ancillary cottage industries] if they attended school – this is nothing but thinly disguised child labour! The nod to children in the entertainment industry is even more blatant.

Government reports are unclear as to how many child labourers have been rescued and rehabilitated as well as figures on how many children have been prevented from becoming child labourers. After 2013, the state budget for CL eradication has been at the same level of a few lakhs p.a.

Bridge Schools under the NCLP and SCLP programmes have not been successful. The compensation amounts deposited by convicted employers were for years not used to help the victims; but it is now reported that this has been rectified.

Recent [2019] estimates of out of school children put them at 70,000. This figure is the best proxy of CL in the State, probably urban, by and large.

Child Trafficking

According to the National Crime Records Bureau, while about 27 girls and women go missing or get kidnapped in Karnataka every day, Bangalore tops the list of the State's urban areas registering the maximum numbers of missing or kidnapping complaints. The numbers reported have increased in recent years. Girls aged between 9 and 14 years seem to more often trafficked than other groups.

Urban Child-related SDGs

The status and progress of Karnataka's children can be checked for several SDGs through the achievements of MDGS; the shortfalls in the goals regarding hunger eradication, maternal mortality, minimum levels of learning, and regular access to safe drinking water and environmental sanitation can be noted. This paper cannot attempt

such detailed analysis given lack of space and data, but looking at just the data discussed above, one can imagine the kind of scenarios that will pop up. Beyond these is the looming gap of the lack of trend data and data disaggregation. Karnataka may have achieved the MDGs with respect to a few indicators, and the urban picture may be quite rosy for some of them, but this may have happened in some urban centres and have failed in many others, so that the average hides a lot of shortfalls. Further, the disparity within an urban area, between the haves and the have-nots could be vast for many indicators, as anecdotal evidence as well as some studies indicates.

We need to remember moreover that if U5MR has to be reduced to 25 by 2030 in India, specific states [e.g. Kerala] and urban or rural areas that may have already come close to that desirable figure, need to reduce too [by an equivalent factor]. Perhaps such states/districts and urban centres may erroneously claim they have achieved even more already! The idea in the global MDG or SDG consensus has been that a country has to do better than the baseline at every level, and aim further in the same direction at every new deadline, till one approaches the ideal maximum attainable. The same applies to sub-national levels from our state to even GP levels. To monitor the trends and achievements or shortfalls, we need a robust ongoing monitoring system along with periodic reviews.

Still other factors affect child mortality and morbidity including various facets of malnutrition and its causes – these can just be mentioned here – breastfeeding and weaning practices, mother and child [MCH] programmes that include ante-natal and post-natal care, Iron-folic acid consumption, delivery care, de-worming, and parent counselling; institutional delivery, and whether this is in a public or private facility; and the safe drinking water, santation and hygiene status. The inference one can make when one notes that so many factors impinge on the SDG U5 mortality and nutrition goals is that such complex phenomena need concerted synergetic massive actions on all these fronts.

Are the State and Country geared up to this challenge?

Should not governments at the centre and state levels support such studies, evaluations and analyse?

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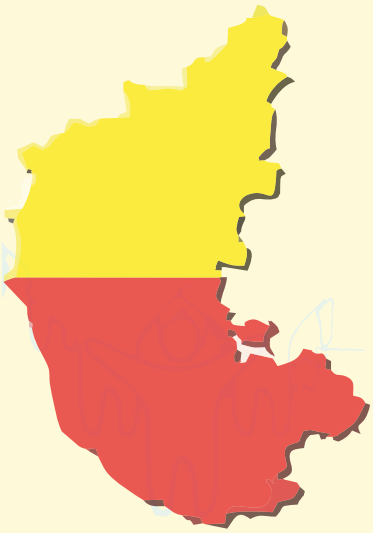

The situation of the children of and in Karnataka, as indeed those of/in the country and any state, needs periodic review and updating. However, such reviews are rare, especially at the State level. This book reviews some key aspects of children's rights, based mainly on secondary data and the experience of practitioners and academics. Even though some of the Articles were written five years back, they are still relevant, testifying to little or no progress in most aspects of the situation of State's children. Moreover, the data serve as measures of progress towards the MDGs and as baseline for the SDGs.

Karnataka Child Rights Observatory (KCRO)

KCRO is a network of several NGOs and individuals with the objective to lobby with the Government and the communities to develop pro child attitude and policies. KCRO is involved in the analysis of situation of children through statistical data, fact finding and organizing discussions on child rights issues at various levels of the society.www.kcro.in

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