

THROUGH THE LIFE CYCLE OF CHILDREN

Factors That Facilitate/Impede Successful Primary School Completion

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Introduction:

In a recent qualitative research study funded by the World Bank, Educational Resource Unit, explored factors that contribute towards or impede successful primary school completion among children living in diverse poverty conditions¹. The issue was approached from select vantage points across five social domains - the child, family, community, institutions (pre-school and primary school), and other services (health care, sanitation, water, transport etc.). This domain analyses helped highlight the causality as well as social processes, implicated, wholly or partially, in children’s full participation in schooling (e.g. poverty, class, gender, birth order, ethnicity, lack of schools or transportation, poor health etc.).

We attempted to explore the critical intersection between sociological analyses of the identified domains and a lifecycle perspective on child development. The research focused on children in discrete age groups along the integrated child development continuum - conception to birth, 0-3 years, 3-6 years, and 6-11 years. The adoption of a life-cycle perspective helped us to highlight the cumulative impact of neglect of or support extended to a child along the continuum and the different needs of children of varied age groups. The dual yet integrated focus on physical development as well as psycho-social factors framing it enabled us to explore the continuous and cumulative nature of social and economic exclusion that poor children face from the moment of conception and its possible impact on their ability to complete primary education².

The study is based on detailed fieldwork conducted in both rural and urban areas between September-November 2002 in the three states of Andhra Pradesh, Karnataka, and Uttar Pradesh. It was primarily a qualitative enquiry that relied on detailed observation and formal and informal interviews to collect data. The study is exploratory and illustrative, focusing on children, their family, larger community, and the extant local education and health services within the context of the larger socio-economic situation in the selected states and the specific study area. Six villages and urban settlements each were selected for the study to reflect diversity in terms of location, demographic characteristics, remoteness / accessibility, caste and community composition and functioning of ICDS and primary education facilities.. Hence the study is not and does not purport to be an evaluation of existing programmes on the ground. Further, the sample is also skewed in favour of children living in diverse poverty situations – primarily focusing on the bottom quartile of the socio-economic ladder.

The essay is based on the findings of our field study. The initial section of the article briefly summarises what we actually observed in the field regarding health, education, and nutrition status of the child and the

(dis)enabling role played by the family, community, and local infrastructure and service delivery system. Section II identifies the social, economic, and political factors that exert considerable influence on the ability of a child to complete primary education, individually and in tandem with each other, and as they play out along the integrated child development continuum. The concluding Section III explores the possible implications of these findings for policy-making as well as implementation.

SECTION I

From Conception to Birth:

Children in this stage of development have been the focus of a number of health and family welfare programmes – ICDS programme since the mid-1970s, Maternal and Child Health (MCH) and Family Planning (FP) programme of the 1980s, Child Survival and Safe Motherhood (CSSM) programme in the 1990s, and more recently the Reproductive and Child Health (RCH) programme. Notwithstanding

- Across the three states, few women took any special nutrition during pregnancy; if anything *most women reported that they consciously ate less in order to ensure a smooth delivery*. Most believed that it was all right to eat less and have smaller babies as it is easier to deliver them. Many women interviewed said that they ‘fatten them (children) up’ after they are born.
- Nearly all deliveries across the three states took place at home assisted by the *Dai* (traditional birth attendant or TBA) or a relative/neighbour. Trained midwives were either not within their reach or families did not think it important to access one. Even though macro data indicates a higher incidence of institutional and trained midwife assisted deliveries in Karnataka and Andhra Pradesh, our research shows no significant difference across the states.³ It is likely that as we go down the socio-economic ladder, inter-state variations on key indicators of maternal and child health are minimal. Institutional delivery still remains uncommon.
- Most women continue to breast-feed their children till the next child is on its way, even up to 24 months. Special nutrition during lactation was clearly a novelty for most women. Since, most children began to eat food only when they were able to pick it up or take it from a person or another place, the activity could as well be called eating and not feeding.
- Most women in the surveyed households were thin, anaemic and ate once or at best twice a day. Given that the severe drought situation prevailing during fieldwork, especially Karnataka and AP, food was limited to rice/broken wheat with salt and some chillies. Children were fed the same food. Many women reported they were given iron/folic (IFA) tablets by the ANM. However, given the very low awareness about its benefits, consumption was irregular. Very few had taken pre-delivery tetanus toxoid injection, especially in Uttar Pradesh⁴.

Perhaps the most disturbing finding of the study relates to the low level of awareness about health including antenatal care, immunisation and nutrition during pregnancy. Despite the presence of the *aanganwadi worker* (AWW) and monthly visits by the ANM – nutrition and health education activities are practically non-existent, at least vis-à-vis the poorest women in the surveyed villages and urban slums. *While general awareness levels were certainly higher in urban slums, there was little difference in practice*. Focus group discussions usually revealed that the monthly visit of the ANM is limited to one specific area in the village and that she rarely visits distant settlements inhabited by SC or ST groups. Similarly in urban areas, recent migrants (especially those to the slums at the periphery) are often bypassed by service providers.

Unsurprisingly, the workload of women in the poor households was fairly high, more so in the case of those engaged in daily wage labour and there was no respite evident for pregnant women either. Many women also feared losing children due to several illnesses that could easily be prevented by vaccinations. Regarding birth control, very few women used IUD or Mala D (contraceptive pill) and the dominant

measure was female sterilisation. The health situation of women and children, as evident by all indicators, is very poor.

The initial phase of child development is without a doubt dependent on the overall well being of the mother. Given that mothers in our sample belong to poor families, the picture that emerges is rather dismal – of women having babies too soon, too often, and too many. While the average age of marriage in the different states as a whole are 19 (Uttar Pradesh), 20 (Karnataka) and 18 (Andhra Pradesh), the mean age of marriage in the profiled households is much lower at 13, 15 and 15 respectively. Clearly, very poor households in all the three states record a much lower age of marriage than the state average. The combination of low awareness and poverty of individual households contributes to both poor health of mothers and low birth weight of babies. We could not ascertain the birth-weight as most of the children in the surveyed households were born at home; however, the children appeared visibly small and malnourished. Our investigation confirm macro finding that one-third of all babies in India are born with low birth weight (as compared to Bangladesh where the proportion is 50% and sub-Sahara Africa where it is one-sixth. (Ramalingaswami et al, 1996). This has important implications for physical survival of children as well as their ability to grow and learn.

Table 1: Key reproductive health indicators in selected households UP, Karnataka & AP

	Uttar Pradesh	Karnataka	Andhra Pradesh
Number of mothers profiled	18	18	18
Average age of marriage	13.1	15.1	14.8
Average age of first conception	17.2	16.3	18.8
Average number of pregnancies per woman	6.2	5.4	4.3
Average number of successful deliveries per woman	5.9	5.3	4.1
Successful deliveries	89 out of 114 pregnancies	89 out of 92 pregnancies	65 out of 76 pregnancies
Abortions / miscarriages	3 out of 114 pregnancies	3 miscarriages reported	4 out of 76 pregnancies
% Children died under 5 years of live born	20.8%	10.9%	14.9%
Average number of children per woman	4.7	4.5	3.5
Deliveries at home / assisted by <i>dai</i> (TBA) or relatives	109 out of 110	83 out of 89	68 out of 76
Deliveries in hospital	1 only	6 out of 89	8 out of 76

Source: Household survey data

Exploring zero to three years:

Families surveyed in Uttar Pradesh reveals that out of the 85 children in the 18 households, 13 were below the age of three and most of the two-year-olds and below were still being breast-fed. They hardly ate any food – partaking in what was cooked in the house, mostly roti dipped in tea! As evident from Table 2 on nutritional status of 6 to 60 months, mortality rates (in the surveyed households) for the under-five age group were high in all the three states. Even though the sample studied is very small and statistically insignificant, we apprehend higher deprivation and vulnerability of population living in urban slums in all states. In the case of Andhra Pradesh, contrary to experiences in Karnataka and Uttar Pradesh, the situation in the centrally located slum was far worse than the periphery, especially with respect to

under five years mortality. Is it because of greater of environmental pollution, abject poverty and lack of coping mechanisms vis-à-vis pressures of modern life, despite better access to health facilities?

Table 2: Nutritional status of children – aged 6-60 months

State	Number of children	Level of malnutrition	Wt for age Under nutrition	Ht for age Stunting	Wt for Ht Wasting
Uttar Pradesh	22	Severe (-3SD)	7	3	1
		Moderate (-2SD)-*	10	6	6
Karnataka	18	Severe (-3SD)	4	9	0
		Moderate (-2SD)-*	11	13	3
Andhra Pradesh	23	Severe (-3SD)	1	2	0
		Moderate (-2SD)-*	3	3	0
Total for 3 states	63	Severe (-3SD)	12	14	1
		Moderate (-2SD)-*	24	22	9

Source: Household Survey Data

*Includes -3SD

** The above 'Z' Scores are obtained using NCHS standards through 'EPINFO' package of WHO of measured anthropometrical measurements of height and weight and reported approximate age in months in AP Schools.

Though there was no severe water shortage in the study area, hygiene was poor and most children were unclothed or unkempt with uncombed hair, unwashed face and unbathed bodies. Running noses, skin rashes and boils were a fairly common sight. Close to 64% of children in Uttar Pradesh and 83% children in Karnataka reported that they suffered from some ailment during the last three months. In Andhra Pradesh 37% children were suffering from some ailment during the field visit. The incidence of water borne diseases is still high - despite that finding that majority of the houses obtain drinking water from tubewells and protected water supply schemes, This could be due to lack of sanitation and poor personal hygiene as indicated by the lack of good practices for water dispensing, hand washing habits with soap at appropriate times both at the household and school level. Exposure to smoke is very high in all the observed habitations as firewood is the main fuel used and there is no separate cooking space. These factors may also be contributing to low birth weights.

Table 3: Immunisation status of children observed

	BCG and Polio	Only Polio	NA
Uttar Pradesh (36)	11	18	7
Karnataka (25)	12	12	1
Andhra Pradesh (57)	28	23	6

Source: Survey Data

A shocking finding in Uttar Pradesh was that out of 36 children (a total from the families surveyed) 11 were partially immunised, 18 received only polio drops (50%) and 7 received no immunisation! Regular child health and immunisation services were also non-existent. There was no discernable difference in the immunisation status of Muslim families profiled in Uttar Pradesh. The situation in Karnataka and Andhra Pradesh was somewhat better. While nearly all children had received polio drops and approximately 40% BCG shots, other vaccine preventable diseases (DPT, Measles) did not seem to be on the priority list of service providers (Table 3). During discussions and interviews it emerged that families do not resist immunisation services if they are provided within their hamlet, *but rarely go out of their way to get their*

children immunised. Awareness about the importance of vaccines in disease prevention is low, as is knowledge about the links between clean drinking water and proper sanitation and disease.

Ramrati of Village 2 of Uttar Pradesh uses powdered ‘Septran’ (Sulpha drug) tablets bought in the village shop to manage her one-year-old son’s fever⁵. In Karnataka the medicine shop in Village 2 stocks antibiotics and sulpha drugs – which the shopkeeper dispenses after ascertaining the symptoms. Small babies too are given powdered drugs dissolved in water⁶. The situation was similar in Andhra Pradesh.

The impact of malnutrition is evident in children underweight and small with unhealthy reddish brown hair and cracks at the edges of the mouth indicating vitamin deficiency. The situation seemed particularly alarming in the tribal village studied with around 59% of children observed suffering from some ailment.

Table 4: Status of children in surveyed households

	Uttar Pradesh	Karnataka	Andhra Pradesh
Children below 36 months	12	17	7
Children enrolled in AWC	1	3	None
Children 3 to 6 years	13	19	15
Enrolled AWC	5	13	10
Children 6 to 11 years	36	32	31
Enrolled in school	30	24	30
Dropouts	2	6	1
Never enrolled	4	2	-
Children in 11+ age group	24	14	5
Enrolled in primary school	4	1	2
Dropped out before completing primary	5	NA	NA
Completed primary and dropped out	4	2	-
Enrolled in upper primary	2	1	-
No information		-	3
Never enrolled / went to school	9	1	-

Notwithstanding, 4 out of 6 rural children and 2 out of the 3 urban children below 3 years in Uttar Pradesh (Muslim and Hindu families) attained age appropriate development milestones – they were seen crawling, walking, running, communicating their needs, laughing and playing. The sheer joy of being a child and running free is visible in their bright eyes and shrill voices. It is heartening that children are in constant interaction with older siblings and other neighbouring children and families. These experiences provide the children with a rich repertoire of communicative and social stimulation. While stimulation from parents who are terribly overworked may be limited, this seems to be more than compensated by siblings and other people in the extended family and community.

When poor and weak mothers give birth to children in the absence of family, community, and institutional support, an inter-generational process of poor health, nutrition and education is set in motion in which majority of Indian children are willy-nilly caught. These very handicaps have a long-term effect and become more evident in children further ahead on the child development continuum.

The pre-school period age 3 to 6:

This phase in the life of a child is critical for physical, emotional and intellectual development. Adequate nutrition, vital for children in this very important stage of development, is unfortunately deficient in poor households. While children are able to feed themselves, the inability of parents to provide a balanced diet, or even basic food at regular intervals, emerges as one of the important areas of concern in this age group.

This is also a period when the child becomes a little more independent, is able to eat by herself, ask for food and communicates her needs. At the same time she is more susceptible to infections as she wanders around.

Measurements taken in the course of the study (see Table 2 on Nutritional Status) showed that the majority of children observed in poor households seem to be moderately to severely malnourished. Though appropriate indicators for rural and urban poor have still to be worked out, the children look underweight for their age or height, their skin is coarse / rough, their hair discoloured and many of them (6 months to 4 years) are pot-bellied with extremely thin limbs. While children are very active and alert, playing and running around, it is apparent that greater attention needs to be paid to their overall nutritional status.

Most experts argue that a child can be positively prepared for schooling through supportive experiences in the home, neighbourhood and community. Our household observations however suggest that there is little structuring by adults/parents of children's activities whether it be play, language or health. However, when it comes to participation in household activity, care of younger children, economic participation, food processing and other productive activity, the parents' messages are unambiguous, assertive, directive and sometimes even autocratic. Socio-economic participation in household and productive activity seemed far ahead of age-expectations. Even young children are taking responsibility for a range of sibling care / household / farm / cattle care related work. (Neerja Sharma and Nandita Chaudhary, 2003)

The children observed have little to eat and that too few times a day. A limited number of children access ICDS services with the location of the AWC and the caste of the AWW determining access. Further, the quantity and regularity of distribution of supplements remains a major source of worry in Uttar Pradesh. While this does not seem to be a major issue in Karnataka and Andhra Pradesh, discussions with women revealed that only a fixed number of children are admitted; many of them were turned away because the centre could not accommodate more children. Fortunately in some areas, like the two villages visited in Karnataka, the government has responded by opening an additional ICDS centre in the village (one in the Golla community in Village 1 and one in the SC community in Village 2). Such was not the case in Uttar Pradesh.

Even in a relatively better performing state like Andhra Pradesh, children's access to AWC is far from satisfactory. For example, out of the 22 children in 0 to 6 year age group, there were 7 children below 36 months and 15 in the 3- 6 years age group. None of the children below 3 years of age group utilised the services of the Aanganwadi centres. In the 3 to 6 year age group, of the 15 children only 10 were enrolled in the Aanganwadi. This includes the one disabled boy in the urban centre household. Of the remaining 5 children who were not enrolled, 4 were in the tribal village. *It is worth stressing that enrolment does not automatically imply access to services. Some children are merely enrolled and not necessarily benefiting from the ICDS programme.*

The problem of irregular food supply was most acute in Uttar Pradesh. Our qualitative study confirms findings reported in larger surveys: 'According to the National Institute of Public Cooperation and Child Development (NIPCCD) report (1992), 27 per cent of AWC did not receive any nutrition supplement for over 90 days, i.e., the average disruption in their supply was for 63.7 days... *Similarly, the provision of double ration to severely malnourished children is often ineffective, because such children are often incapable of eating much at one go.* Again the morning hours appear to be the time when pregnant and lactating women are busy with domestic chores and hence attendance at AWCs for accessing these services, especially supplementary nutrition, tends to be poor'. (D B Gupta, et al, 2002)

The above analysis was confirmed during our investigations. Discussions with AWW revealed that there is no system for identifying the severely malnourished for providing double rations. While we saw

pregnant and lactating mothers coming to AWC in Karnataka and Andhra Pradesh, we did not come across even a single woman who came to the AWC in Uttar Pradesh. Most distressing was that in Uttar Pradesh the fortified '*dalia*' meant for the AWC was being sold in the local shops with people buying it both for their own consumption as also to feed their cattle!

While recording the food habits of children in the three states, we were alarmed to see that in Uttar Pradesh most often the children ate *roti* with salt, this in a region where a wide variety of green leafy vegetables are grown and locally available. Consumption of meat and fish was at best sporadic, with boys getting a very small piece and girls making do with the gravy. Andhra Pradesh and Karnataka also reported that the main diet was polished rice with some chutney or diluted '*saru*'. It needs to be stressed that state averages camouflage extreme inequalities that prevail between and within communities. Since the study has focused on children in diverse poverty situations, our findings may appear far more alarming than indicated by state or national averages.

The pre-school education component of the ICDS programme, although evident on paper was non-existent in reality. While we did find play material in most AWCs, *it was locked up in cupboards*. This seems to be a result of a fairly common belief that expensive (relatively speaking) and attractive things are too precious to be handled by children and need to be brought out for display only during inspections. The same was the case with library books in schools.

During our visits, children were usually sitting quietly in rows with a slate and chalk in their hands. In some villages we could not interact with the children because they dispersed soon after the meal. The attitude of the teacher and the helper also leaves much to be desired – they were indifferent if not shouting at and scolding the children. Only in Karnataka we observed some pre-school play activities. Clearly the ICDS programme, as operational in the villages, did not seem to play a significant role in enhancing the preparedness of children to go to school – unless of course sitting quietly in rows with slate and chalk can be considered preparation!

The mother's committees were introduced to strengthen IEC activities (education and awareness) and make the AWW accountable to the community. In all the villages/slums surveyed, these committees are dysfunctional, even though they exist on paper. We also found that villages with other women's groups (Mahila Samakhya groups, SHGs) are more aware of the ICDS programme and what it is supposed to deliver, though this awareness rarely translates into active collaboration.

The visibility of the ICDS programme is high, both in the villages and in urban slums. People are aware of the AWW and the helper. Focus Group Discussions invariably turn spirited, in most cases leading to vocal criticism about the helper (who is expected to escort children to the centre), other services (looking after the children), irregular supply of nutritional supplements (Uttar Pradesh) and timings of the centre. The ICDS programme, however, does not seem to enjoy the same importance as other schemes, more so in the eyes of government. The status of the AWW, as compared to the schoolteacher or the ANM is low. Consequently, even if the AWW is motivated and wants to be active, she has little space for demonstrating initiative. She also receives little support from her superiors.

Many AWWs (especially in UP) were not trained and essentially learnt on the job. They look upon the ICDS as a nutrition programme and their role as one who distributes food and maintains records. Interviews with AWWs in all the areas revealed that record keeping was seen as a key function.

The AWW does not make any conscious effort to enrol the most deprived strata. Though Karnataka and Andhra Pradesh have sanctioned additional centres in hamlets / settlements, this was not the case in Uttar Pradesh where one ICDS centre caters to the entire village, regardless of the number of children in the appropriate age group. As a result in Uttar Pradesh only 40 children per centre are enrolled and even this

is not done on the basis of who needs the services. *Caste is a serious issue with the teacher and the AWH helper (AWH)*. If both are from the forward caste, then children from Dalit families have little access. Parents in the sample households felt that they could make no demands on the teacher, as she is upper caste. Almost all the families we interacted with expect the AWH to come and fetch the kids, which does not happen. Therefore, if the AWC is at some distance and mothers are overworked, the children do not reach the ICDS centre.

As children reach the pre-school age, education and access to education becomes a defining variable in framing their life-chances along with health and nutrition. It is an exploratory phase on the child development continuum, where pre-school exposure and adequate nutrition (as an integral part of service delivery) become essential inputs to further the holistic development of children. Evidence from the ground indicates a rather contrary picture, marked by erratic provision of nutrition by the state and a rather weak and ineffective pre-school component. Politics of caste identity and status too emerges as an important factor in denying access to children and parents to the nutrition supplements and the effective functioning of the AWCs.

Going to school: age group 6-11

The good news on enrolment:

In the decade of the 1990s the issue of access to primary schools has received considerable attention in all the three states. Most children in the surveyed households are enrolled. Many of them are also attending school, with varying degrees of regularity.

- In Uttar Pradesh the 18 poorest households selected for the study had a total of 85 children, of whom 60 were in the 6+ age group. Of these 40 children were in primary school or had completed primary education, 13 never went to school and 7 had dropped out. An interesting pattern that emerged from the educational history of these families was that *of the 36 children in the 6-11 age group, 30 are in primary schools. This included all the children (including girls) in the 6-11 age group from Muslim households*. In the 11-14 age group there are 11 children – four are currently in primary school. Of the six who have completed primary schooling, which included one Muslim girl and two Muslim boys, only two (one boy and one girl – both non-Muslims) had moved to the upper primary level. Of the remaining 13 children who were in the 14+ age group, only one had completed primary schooling and another was still in primary school, 11 never went to school or dropped out. The families reported that the educational situation has significantly improved in the last five to seven years.
- In Karnataka, out of the 30 boys and 30 girls in the 18 households surveyed, 57 children (29 G and 28 B) were either enrolled in the AWC or primary school. One boy had dropped out in class 4 and 1 boy and 1 girl was not going to the AWC. Discussions with mothers and adolescent girls and boys revealed that campaigns like *Chinnara Angala* (to get children back to school), *Ba Marali Shalege* (Monday morning procession of children with songs, slogans asking children to come back) and *Pratibha Karanji* (encouraging creativity) have made a significant impact. Almost all the children in the village / urban settlements are in school. The state government also provides free uniforms, textbooks and school bags to all SC and ST children up to class 5 and the same is extended up to class 10 for children of *devdasis*.
- In Andhra Pradesh, out of the 58 children observed in the 18 households surveyed, 31 children were in the 6 to 11 years age group, of whom 30 were enrolled and attending schools. Only 2 out of the 5 children in the 11+ age group were in school. Enrolment in AWC was low. Out of the 22 children in

the 0-6 year age group, none of the 7 below 3 years were enrolled in the AWC, while 11 out of the 15 in the 3-6 years were enrolled in the AWC.

Enrolment is obviously not a big issue anymore: attendance, transition, completion and learning outcomes are emerging as bigger issues and it is these that are intimately related to our preferred proxy indicator of child development – namely completion of primary schooling. The cohort study, based on official school records in all the schools visited gives a fairly positive picture. For example in Karnataka 71% of the children who entered class 1 in 1998, from 6 sample schools, reached Class 5 in 2002. However, once we moved beyond the ‘official’ records, conversations with teachers revealed a different and a more complex picture. In all the three states the teachers are reluctant to admit that children drop out and hence many children are shown in the registers and some of them are marked as long-absentees. In some schools, they are also marked present, especially when distribution of dry rations is linked to attendance! Teachers often become defensive when asked about dropouts or long absentees.

Attendance and work burden of children:

Children from poor households are not very regular. They tend to absent themselves for a range of reasons. In Karnataka and UP, parents said it was difficult for them to ‘force’ their children to go to school, especially when nothing much happens there. Some parents said that they need their children at home for small chores – especially during the heavy / peak agricultural seasons, when a child is sick or when they have to migrate for work.

Many children above the age of 6 in the surveyed households and attending government schools reported that they work before as well as after school. *The burden of work was most severe for the first-born – especially if she is the eldest daughter. There was no appreciable difference between Muslim / Hindu and Tribal / non-Tribal families.* Apart from sibling care, children support their families with care of milch cows / goats, fetching fuel wood / fodder, water, running errands and looking after sick family members. As a result children either get late for school or miss it altogether. *The gender division of work and added responsibility of household work on older girls in the family was marked in all the three states.* In Andhra Pradesh and Uttar Pradesh we met boys who were in temporary bondage to pay off a loan taken by the parents. Engaging in full-time work during weekends and holidays is a fairly routine activity among children.

If such is the situation with respect to children and work, what implications does this have for primary schooling? The community is aware of the need for educating their children yet the children are burdened with work before and after school, during holidays and vacations – both household/domestic and sibling care related chores as well as work outside the home or in home-based occupations. This obviously directly impacts on the learning abilities of children – especially when they put in long hours every day. Most children in poor households do not get time to revise / read their books – especially girls who are higher up in the birth order. Given the nutritional status of most poor children, energy levels are low and impact upon children’s ability to concentrate in school. The impact of working and yet attending school needs to be examined with reference to its impact on learning outcomes.

Learning outcomes:

In Uttar Pradesh we observed that most children in classes III, IV and V were neither able to read fluently from their textbooks, nor could they solve simple addition or subtraction sums. For instance, 11 (out of 18) children were attending the GPS from the 18 households in the urban sample from UP. Five children attending classes II, III and IV showed poor learning levels. Three children from class II were unable to recognise alphabets or numerals. The two children in class III were also unable to read, write or count, though they knew certain lessons by rote. *‘Earlier class II pass could read postcards, now they cant even*

write their names’, complained a father during the FGD in urban Sitapur. ‘*What is the use of sending him to school?. I pulled him out after class 4 and he now helps me with my work.*’

The situation was not dramatically different in Karnataka or in Andhra Pradesh. Yes, a few more could read, but on further investigation we realised that children with literate parents (especially mother) or those who attend private tuition classes are the ones most able to read. Children who are first generation school goers barely manage to recognise alphabets and can, at best, read a few words. Group discussions in the community revealed that parents feel that the quality of teaching has declined, that the community the teachers do not really care if the children of the poor learn to read or not. Also teachers are not made accountable for learning outcomes of children, especially in the primary and middle schools where there is no board examinations. Other qualitative and quantitative research studies have also made similar observations. (PROBE, 1999, Vimala Ramachandran, 2002, Pratichi Education Report 2002, Jha and Jhingran 2002)

Is schooling really free for the poor?

There is today widespread agreement that access to education has improved significantly in the last decade and even very poor parents want to send their children to school. There is also growing evidence that private schools are mushrooming all over and that children are being sent to private schools if the parents can so afford. In some cases, parents decide to send their children to private schools, even when they cannot really afford it!

In Uttar Pradesh we found that the teachers collect ‘fees’ – official and unofficial. Community members and students reported that teachers in government schools often asked children to get Rs. 5 to 10 during national festivals for issuing of Transfer Certificates or for release of scholarship money. If payment for schooling is necessary, parents consciously opt for private schools. Perceived poor quality and poor learning outcomes in GPS often seem to be instrumental in the emergence of these private schools. In one study village in Uttar Pradesh we came across a private school that *did not expel children even if they did not pay the fees regularly – hence making it more attractive to parents.*

Private tuition classes profiled in Karnataka were priced at around Rupees 30 a month. Parents seem to believe that children learn fast and are able to cope with their studies if they are enrolled in tuition classes. One mother said: ‘*I send my child to a private tutor for 2 hours because it is better to have short time of concentrated learning than many hours of not learning at all!*’ Collection of unofficial fees, compelling children to buy guidebooks, private tuitions are gradually becoming more common. What is noteworthy is that such practices have become more widespread in the last decade, the period when community demand for perceivable good quality education has also grown.

Hunger in the classroom:

Discussions with children revealed that many of them do not eat anything in the morning, especially girls, who have little time, given their morning chores. In Andhra Pradesh several girls said they only drink water before coming to school and eat only during the lunch break! Given that most poor households have to gather fuel wood, families basically cook two meals a day – mid-morning and after sundown. Where children do eat before coming to school, the staple diet seemed to be *roti* and salt (Uttar Pradesh), and a piece of *jawar roti* or rice with chilly chutney (Andhra Pradesh). On most days, almost 10 to 15% of children (majority of them being girls) come to school without eating. When we explored further and asked why few children ate in the morning, some girls said they did not have time to eat! Lack of an adequate meal before attending to school, what has usually been referred to as short-term hunger, has an adverse impact on the child’s performance in school, her ability to concentrate as well as learn new concepts. In such a situation, the provision of a hot mid-day meal becomes all the more necessary.

Incentives – do they make a difference?

We heard conflicting statements. Some teachers, especially in Uttar Pradesh, argued that incentives like dry rations had little effect on retention or achievement levels and that students who enrolled for incentives were regular only on the days prior to distribution. They were of the opinion that scholarships should be handed over at the end of the academic session to ensure that children did not drop out mid term or attend classes at random intervals. The teachers did not think that rations for poor children ensured food security at home or prevented them from taking on extra work. The community and teachers were all praise for the mid-day meal programme in Karnataka and the mid-day meal programme in Andhra Pradesh that commenced 1 January 2003.

Incentives like textbooks, uniforms and scholarships though welcome but were also issues over which parents and teachers complain and argue. While we did not come across any case of delayed distribution of textbooks, the distribution of scholarships and uniforms leave much to be desired. In Uttar Pradesh free textbooks mean little because most children purchase 'guide books' – right from class 1. Parents insist that teachers forced them to buy these while the teachers aver that parents buy them on their own. The fact remains that most children had them in their school bags and copy the question and answers in their notebooks – some of the children could not even read what they had written!

Teachers' attitudes and development of self-esteem and confidence:

What value does education add to the lives of children? There is little disagreement over the role of education in enhancing the self-esteem and self-confidence of children. Yet, discrimination and/or differential treatment in school can and does affect the overall confidence levels and the self-esteem of children. Both children and parents are categorical that teachers treat poor children differentially, that they do not appreciate the predicament of children who have to work before and after school. Constant reinforcement of caste and community based negative stereotypes also have a long-term effect on children, whereby they internalise these perceptions and see themselves as being solely responsible for their own situation. Hence, it is not surprising to come across parents and children alike, who believe that their inability to be 'literate' or 'get an education' is more a function of their caste/community identity (for instance adivasis (STs) are backward and uncivilized etc.) as opposed to the larger political economy. Casual and sometimes sarcastic comments on the worthwhileness of education in the lives of children who will 'end up' doing what their parents do – agricultural wage labour, sweeper, cobbler etc. - dampens a child's self-esteem and aspirations.

Section II

Emerging issues:

As stated earlier, our sample is skewed in favour of the very poor; therefore, the observations need to be read contextually and may not be completely applicable to other socio-economic groups. However, this sample enables us to understand the situation with respect to the 10-15% of the poorest households in a village or a slum, and provides insights into the ways in which children from these households continue to be deprived or marginalized. The rest of the section elaborates on the emerging themes that characterise the interplay of the proximal and distal factors in determining educational outcomes of children living in diverse poverty situations, especially with specific reference to gender, caste, community and region.

Cumulative impact on child development

The research, by focusing on children in different age groups along the integrated child development continuum illustrates the continuous and cumulative nature of social and economic exclusion that children

face from the moment of conception. Health, nutrition, and education are no doubt the three main sectors that impact on a child's development. However, as we have seen, the nature of impact of these sectors is not discrete or merely additive; rather it is far more complicated, varying in its intensity as well as manifestation according to the sub-stage under consideration. Health and nutrition status of both mother and child is clearly significant in the early years. The continuous and cumulative nature of impact has also meant that, although the age groups are discrete in nature, the impact of non-attainment of appropriate developmental milestones, health and nutritional outcomes, or learning capacities implies that these necessarily accompany the child to the next stage leading to more failures than successes and in some cases intergenerational transfer of these handicaps and resulting in a downward spiral of poverty, ill health, malnutrition, and poor learning outcomes for children. Our research also indicates that, despite the potential, the current social policy is unable to effectively capture and tap the positive synergy of the different sectoral interventions. It is also unable to proactively harness the family and community in meeting its objectives of reaching the child, especially the poorest child, and creating a supportive environment for its development.

Intermeshing poverty and social status

Poverty impacts the overall health status of children. Lack of easy access to water affects the overall hygiene of children. Even when poor families have access to safe water, storing practices and usage affects quality of the water they drink. The level of poverty significantly impacting on food and nutrition security is closely related to availability of work⁷. During 'normal' times, most poor (below poverty line families) eat less nutritious food than households above the poverty line. Discussions on intra-household food distribution also revealed that adult men get precedence followed by boys, girls and finally women.

Economic explanations per se rarely explain persistent bottlenecks in attaining universal primary education. The reality is that economic factors are inextricably entwined with social variables in determining children's ability to both access and continue in schools, often making it difficult to distinguish between the two. The in-depth study of elementary education of the poorest and other deprived groups by Jha and Jhingran (2002) provides perhaps one of the more exhaustive databases in recent years on the issue as well as sheds light on competing factors that frame educational decision-making in poor households. They argue that enrolment and attendance is not only determined by economic situation but also by the social status of groups.

The same is reflected in our study, where caste and community of children influence educational participation and outcomes along with the economic status. While an improvement in economic situation certainly makes a difference, this alone does not explain lack of access or regularity of attendance in school and probably explains the why the SC, ST and other minority groups (Muslims in UP) in our sample emerge at the bottom of the educational ladder. The attitudes and prejudices of teachers and children regarding social and community identities of marginal groups in the school also play an important role in defining educational outcomes for the latter. As a result, schools that cater to a specific disadvantaged group often record better attendance / performance of these groups, provided the quality of schooling is satisfactory. In many areas of the country, the teacher-pupil ratio and overall infrastructure/ facilities in schools that exclusively cater to marginal groups are not comparable to the regular government schools that cater to mixed social groups. This phenomenon, known as hierarchies of access, has come to be accepted as a significant factor in explaining children's access to as well as the quality of schooling they receive – thereby influencing the ability of children to successfully complete primary schooling. (Ramachandran, 2002)

The interplay of gender with social and economic status adds another important dimension to the issue. Gender relations in the family, community and in the society exert significant influence on the ability of girl children to access services, nutrition, immunisation, healthcare (especially during bouts of illness) and

schooling. The good news, however, is that if girls do reach school and are able to cross the initial barrier, they are highly motivated and struggle against all odds to remain in school. Similarly, if regularity can be assured, girls perform as well, if not better, than boys in school.

Another significant factor that emerged during the course of this study as well as previous quantitative as well as qualitative studies (Ramachandran 2002, Jha and Jhingran 2002) is one of changing social norms with regard to schooling. Discussions in rural Karnataka and Andhra Pradesh revealed that sending children to school has become a norm in the community. This transformation in social norms and practices has occurred in the last eight to ten years. Government initiated campaigns (*Chinnara Angala, Ma Marali Shale, Chaduvula Pandaga*), intensive NGO led mobilisation against child labour (notably the contribution of M V Foundation in Andhra Pradesh) and sustained efforts to make school a joyful experience (*Nalikali* and *Kalinali* of Karnataka) have made a major difference. The governments of Karnataka and Andhra Pradesh have ensured that teachers reach the schools and tried to address cadre management concerns to rationalize teacher deployment. Conversely, lack of sustained mobilisation and corresponding governmental efforts in Uttar Pradesh to ensure functioning schools is perhaps responsible for the persistent apathy with respect to education, especially for the poor who rely on government schools.

Health, nutrition, and Education:

The relation between health and education is often perceived as a one-way street, with most discussions focusing on the role education can play in facilitating health awareness and improving the health status of individuals and communities. Usually left out of the debate is the critical and reciprocal nature of the link between health and education, specifically in relation to children, whereby poor health and nutrition can actually prove to be a barrier to attendance and educational attainment/achievement. The most obvious medical evidence indicates that childhood disability, chronic illness, and extreme malnutrition of children are a direct impediment to his/her participation in school. Further, the level of frequency, duration and severity of illness that affects a child also influences the regularity and attendance of an enrolled child. However, barring the polio drive, there is little energy in the health sector. What still remains fuzzy is the less than tangible link between endemic poverty, malnutrition, and educational attainment/achievements.

Further, inadequate nutrition manifested in short-term hunger syndrome, impacts on a child's ability to learn and retain new concepts⁸. Hence, common complaints by teachers that children lack the ability to concentrate are listless etc. take on a new urgency. Several studies, especially those on the Tamil Nadu mid-day meal programme, have stressed the benefits of a hot and sumptuous meal in school, particularly for children in poverty situations. As discussed earlier, dry rations seem to have little impact. No wonder the Supreme Court's judgement on serving cooked meals in school instead of distributing dry rations was welcomed by parents and children. The experience of Karnataka was quite impressive – not just in ensuring regularity in school, but in making a significant difference to children from the surveyed households.

Section III

The way forward:

The school system:

An important insight of this study is that a well functioning and attractive school, with basic facilities and motivated teachers, makes a major difference in the lives of poor children. *Access and quality have thus*

to be seen as being part of the same continuum – one without the other is meaningless. This is of particular importance in government schools that cater to the majority of poor children in rural and urban areas. The shift that we are seeking is that the school system has to gear itself to ensuring learning outcomes of children. If this is taken as a non-negotiable principle, then the school needs to function as an integrated whole where a range of inputs / activities converge in order to create a non-intimidating and a creative learning environment.

Equally, a well-run mid-day meal programme positively impacts on enrolment, retention as well as learning. While Karnataka and Andhra Pradesh have a good programme, Uttar Pradesh is yet to implement it.

The teacher is the fulcrum around which effective schooling system revolves. While this appears to be a cliché, the real task before us today is to break this down into doable steps, for instance making them accountable for measurable learning outcomes. Actual teaching time and teacher-pupil ratio remain important areas of concern. In the schools visited in UP the TPR in rural schools was high as 1:173 in one case and the actual teaching time was less than one hour per class / per day! In the tribal school visited in AP, only one of the three teachers was present on any given day.

Another context-specific strategy worth exploring, especially in tribal areas, where it has not been easy to ensure posting and regular attendance of teachers, is to locate a school in a cluster (Mandal in case of AP) that is easily accessible and transport children from the class 4 onwards to the school rather than a school in every habitation. This recommendation is being made in the light of evidence that the tribal and SC children who are studying in residential schools (Ashram Shala, Residential School for SCs) come across as better equipped academically. This might enable the government to pool its resources, human and financial, and ensure children from poor families and disadvantaged communities get good quality education. It would also facilitate good teacher-pupil ratios and also ensure regular teaching. In the same vein, residential condensed programmes for girls in the 11+ age group could be particularly valuable in educationally backward regions.

The ICDS programme:

A major finding relates to the ineffectiveness of the pre-school education component of the ICDS programme in all (except one) centres observed. This has also been highlighted in recent studies (NCAER, ICDS Field Study 1999).

Our discussions in the community raised the question of whether the ICDS programme should indeed be the nodal point for pre-school education. One proposal worth considering is de-linking the pre-school education component from ICDS and AWC, instead making it an integral part of primary schools. An important spin-off of this restructuring would be that children in the 3 to 5+ age group could benefit from the universal mid-day meal programme, thereby improving their nutritional status. This is of particular importance for children from poor families. For example, the Government of Assam took a policy decision to open a pre-school section (Ka-Maan) for under-6 children. Similarly, the Shishu Shiksha Kendra in Madhya Pradesh caters to the pre-school education needs of children in the 3 to 5 age group. There are several such initiatives from across the country underscoring the importance of pre-school education in preparing children for primary schooling. Balwadis of Pratham (Mumbai, Delhi etc.) and Uttarakhand Sewa Nidhi of UP are examples of successful innovations in the non-government sector.

This shift will enable the AWW to concentrate on nutrition and health of children in the 0 to 3+ age group, pregnant and lactating mothers, adolescent girls and more importantly in nutrition education of the community. This will also ensure that nutrition supplements and other health interventions reach the most needy. Since not all poor children have access to the ICDS centre (especially in UP where each village

has only one centre), the government could consider making it a universal programme for all children in the appropriate age group as also all pregnant and lactating mothers in the catchment area of the ICDS centre. It is important to emphasise that provision of dry rations to pregnant and lactating mothers' defeats the very purpose of supplementary nutrition. Given the precarious economic situation of the households studied, the supplement goes into the food kitty of the family.

Health and Nutrition:

Public education has received a setback in the last 30 years. It may be worthwhile re-visiting earlier nutrition education and preventive health programmes. One disturbing feature is that every new programme introduced tends to diminish the validity of earlier efforts. In all the three states it was rather disconcerting that simple messages (kitchen gardens, eating leafy vegetables, universal planting of common fruits like guava / berries, nutritional value of coarse grains etc.) that enable people to harvest whatever local resources they have to improve their nutritional status are no longer seen as being important.

More effective public education is needed to highlight the link between complete immunisation and disease prevention. Discussions in all the three states revealed big gaps in people's appreciation of immunisation. Unfortunately, as pointed out in the Mid Term Review of the Ninth Five Year Plan of the Government (Planning Commission, GOI, 2001) routine immunisation has suffered – this has serious implications for the health of children. 'It is a matter of concern that there has been a fall in routine immunization. It is obvious that the target of 100% coverage of all six Vaccine Preventable Diseases has not been achieved. Several states have reported substantial decline in routine immunization...Reported factors responsible for poor coverage range from vacancy at ANM level (40% in Bihar), poor mobility, poor access, problem in distribution and storage of vaccines, lack of supervision and monitoring, poor cold chain maintenance and ongoing campaign mode programmes disrupting routine activities...?' (Planning Commission, GOI, 2000-01).

Role of community groups and listening to voices of children:

There is today a multiplicity of village level groups and committees with competing goals and overlapping roles. To seriously address crucial factors that facilitate / impede the overall development and growth of children, it is vital to re-examine the roles / mandate of these committees and look for ways to empower specific groups of people to play a more positive interventionist role in ensuring that benefits accrue to those most in need. The enthusiasm with which these committees are constituted is rarely matched by resources / activities to educate and empower them. It is thus necessary to pay special attention to the process of constitution of committees and strengthen training / capacity building activities that are necessary to give them the teeth – to make the difference. This applies to all the committees established for primary education / child development at the village level.

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ENDNOTES:

¹ We are grateful to Dr. Venita Kaul of World Bank for giving us the permission to publish an abridged version of the synthesis report.

² Successful primary school completion requires not only completion of five years of schooling. It also implies the ability to read and write with comprehension, be an active learner as well as develop self-learning capacity, ability to articulate / communicate, and develop positive self-esteem and self-confidence.

³ Interestingly, the official statistics compiled by the Registrar General of India from the records of ANMs or other sources and those collected by the NFHS from responses of women are at variance as evident in Table 2. The households consistently report a much higher proportion of deliveries taking place at home.

⁴ NFHS-2 (1998-99) reveals that only 52.89 rural and 76.34 urban women were given iron folic acid tablets during pregnancy. If we are to look at Uttar Pradesh, only 32.91 per cent women received IFA tablets!

⁵ Nishi Mehrotra et al. 2003. Against All Odds: A study of children in poverty situations, in Vimala Ramachandran (ed) 2003.

⁶ Lakshmi Krishnamurty and Vani Periodi: Listening to children in Vimala Ramachandran (ed) 2003

⁷ Jha and Jhingran argue, 'The issue of acute food shortage faced by poor people in drought affected areas in the midst of gigantic 'surplus' food stocks rotting in godowns has been an area of debate and

discussion... What is important to point out in this respect is that the poor do not face food insecurity only during drought or drought-like situations. In many places, periodic food crises are an annual phenomenon, the intensity of the crisis and length of the period increases during years of bad or no crop... Nearly one third of these families usually face a food crisis for more than four months in a year, the rest go through this for about two-three months' (Jha and Jhingran, 2002).

⁸ A review of literature on the subject notes that the capacity for processing, structuring and classifying information, ability to ask and answer appropriate questions, short term memory, levels of alertness, attention and concentration are some of the capacities which are crucial for success in school. These are known to be adversely affected by nutritional and health deficits, which therefore limit the ability of the child to benefit from classroom instruction or later learning opportunities (Levinger, 1994; Del Rosso and Marek, 1996 cited in New Concept 2003). Malnutrition, even in its milder form, can dull motivation and curiosity, reduce the child's exploratory play and interaction with care givers and the environment, this restricting the child's psychosocial development. (Martorell (1997) cited in New Concept, 2003)