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# Snakes and Ladders

Factors Influencing Successful Primary School Completion for  
Children in Poverty Contexts

Vimala Ramachandran and ERU Research Team

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## Research Team

Coordinator:	Vimala Ramachandran
ERU Core Group:	Kameshwari Jandhyala, Nishi Mehrotra, Lakshmi Krishnamurty, Vani Periodi and Aarti Saihjee
<b>Experts:</b>	
Child Development:	Nandita Chaudhary and Neerja Sharma (Lady Irwin College, New Delhi)
Health and Nutrition:	A P Ranga Rao, Hyderabad
Research Methodology:	Leela Visaria, Gujarat Institute of Development research, Ahmedabad
<b>Field Investigators:</b>	
Andhra Pradesh:	Vijaya Usha Rani R, K Venkatamma, D Lakshmi, B Chukamma, S Vijaya Rekha and G Jayasri (Mahila Samakhya Resource Centre, Andhra Pradesh)
Karnataka:	Usha P A, Uday Kumar, Claramma and Pramod
Uttar Pradesh:	Niti Saxena and Shahira Naim (ERU Lucknow) Richa Singh, Surbala Vaish, Anupras Mishra and Vibha Bajpai (Mahila Samakhya, Uttar Pradesh)
Editors:	Sunanda Bhattacharjea and Harsh Sethi

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Vimala Ramachandran  
Educational Resource Unit  
Delhi, Hyderabad and Lucknow

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## GLOSSARY

Ab iska kahan fayada hota hai	These things don't work any longer
Afsar	Officer
Ajji/ Ayah	local term used for ICDS Helper (AWH)
Akshara Sankranthi	Adult literacy initiative
ANM	Auxiliary Nurse Midwife
Aqal	Common sense / knowledge
AWC	Anganwadi Centre – ICDS Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
ANM	Auxiliary Nurse Midwife
Ayyo	Expression of pain
Bagupadadaniki	To have a better life
Baila'	Bovine
Baniyan	Vest
Basti	Settlement
Basti	Settlement
Bathua	A green leafy weed that is edible and rich in iron
Bhima Shangha	Young people's groups
Bigha	1 bigha = .02 acres (measure of agriculture land)
Chaduvula pandaga	Education festival
CHC	Community Health Centre
Chitranna	Coloured rice
Christian mem	Christian lady
Chulha	Hearth
Chullah	Fire
CRC	Cluster Resource Centre
Daddi	Stupid
Dai	Traditional birth attendant
Dal	Lentils
Dalia	Porridge
Dalit	SC groups listed in IX Schedule of the Constitution of India
DH	District hospitals
Didi Namaste	Greetings for elder sister/person
DIET	District Institute of Education and Training
DOE	Department of Education
Doordarshan	Government television channel in India
DPEP	District Primary Education Project
Durries	Colourfully woven cotton or woollen floor mats
ECCE	Early Childhood Care and Education
ECE	Early Childhood Education
Frr..frr.	Fast (colloquial word)
Ganj	Market yard
Ganja	Green cannabis
Ganji	Gruel

Garibi hatao	Eradicate poverty
Ghee	Clarified butter
Gram sabha	Assembly of all the people
Gulli danda	Game played with a stick and a stone
Gutka	Betel nuts with powdered lime and other ingredients
Haat	Market
Haldi	Turmeric
Half-saree	Drape worn by adolescents
ICDS	Integrated child development scheme
Joginis/devdasis	The practice of pre pubescent girls dedicated to local deities
Khadia	Chalk
Kirana	Grocery
Koli	Hen
Kuccha	Unpaved
lehyam/ kashayam	The semi-solid and the liquid versions of ayurvedic remedies
Madarsa	Place where Muslim children are taught their holy book -???
Mahila sangham	Women's groups
Maidan	Open playing field
Mandal parishad	The elected Panchayat Raj structure above the Gram Panchayat
Mandals	Administrative unit of about 30 to 40 villages with around 5 to 8 gram panchayats under it
Matras	Vowel signs
Mehndi	Henna leaf ground to a paste for ornamenting the body
Mistris	Masons
Nalla	Open drain
NFHS	National Family Health Survey
NSS	National Sample Survey
Panjeeri	Granular nutrition supplement
Paratha	Shallow fried unleavened bread
Payasam	Sweet porridge made with rice, sugar and milk
PHC	Primary Health Centre
PHU	Primary Health Unit
Phulwari	Well maintained garden with flowers
Poochi	Worm
PROBE	Public Report on Basic Education (1999)
Pucca	Permanent
Purdah	Veiled
Raja	King
Rasam	Thin spicy soup
Rava	Semolina
RMP	Registered medical practitioner
Rotis	Unleavened bread
Sambhar	A lentil and vegetable preparation
Sarkar	Government officials
Sarpanch	Elected leader of the village
School Chalo Abhiyan'	School Enrolment Campaign
SDMC	School Development and Management Committee
Sulekh	Hand writing
Tali	A chain made of black beads - symbol of marriage



Taluka	Administrative unit – often used along with Block
Tandas	Cluster of tribal households usually located outside the main village
Tava na kariya hoye	The griddle does not blacken (nothing to cook!)
Tehsils	District subdivision
TLM	Total Literacy Mission
Tola	Locality
Uppittu shale	Feeding centre
Uppitu	Sprouted green gram
VEC	Village Education Committee
Velugu	Light
Vistharana Shale	Extension schools
Yajman	Landlord/employer

## SECTION ONE: BACKGROUND

The current study is a part of a multi-sectoral research project on Integrated Child Development in India supported by the World Bank in 2001-03. This study was commissioned in June 2002 with the objective of exploring the various factors that contribute towards or impede successful primary school completion, with special reference to children living in diverse poverty situations. An earlier commissioned study<sup>1</sup> provided the conceptual framework to review and understand child development along an age-continuum of 0-11 years as it relates to the final objective of successful completion of primary schooling. That study has been taken as the point of departure for the current research and the present objectives, as stated in the terms of reference, are:

- i. To explore significant factors influencing the situation around a child entering and successfully completing the primary education cycle, based on information regarding the status of children in the different sub groups of the identified development continuum and its relationship with the proximal and distal social environment as highlighted in the conceptual framework
- ii. To elicit feedback on existing programmes of the government designed for children – their provision and utilisation – especially relating to primary education, early childhood care (ECCE) and health.
- iii. To identify elements in each of the identified domains – the child, family, community, institutions, specifically the school, Integrated Child Development Services (ICDS) and other health related services - that impact on child health, nutrition and education and their inter-linkages, both positively and negatively.
- iv. Finally, implications for a holistic and integrated approach to social policy with reference to children.

The conceptual framework attempts to capture the process of child development along the age continuum of 0-11 years within the larger social environment context. It identifies five stages along the age continuum [conception-1 month, 1 month-3 years, 3-6 years, 6-8years, & 8-11years], and links corresponding environmental determinants to related development indicators and expected child development outcomes. The child's environment is visualised in terms of

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<sup>1</sup> 'Integrated Child Development – A Conceptual Framework' (New Concept Information Systems, New Delhi, April 2002).

concentric domains that span proximal factors like the immediate family and the extra-familial context of the larger community, social institutions like school, and extent of utilisation of services and provisions (distal factors) – especially those relating to health and childcare. In the final analysis, the framework adopts ‘successful primary school completion’ as a proxy indicator for child development<sup>2</sup>.

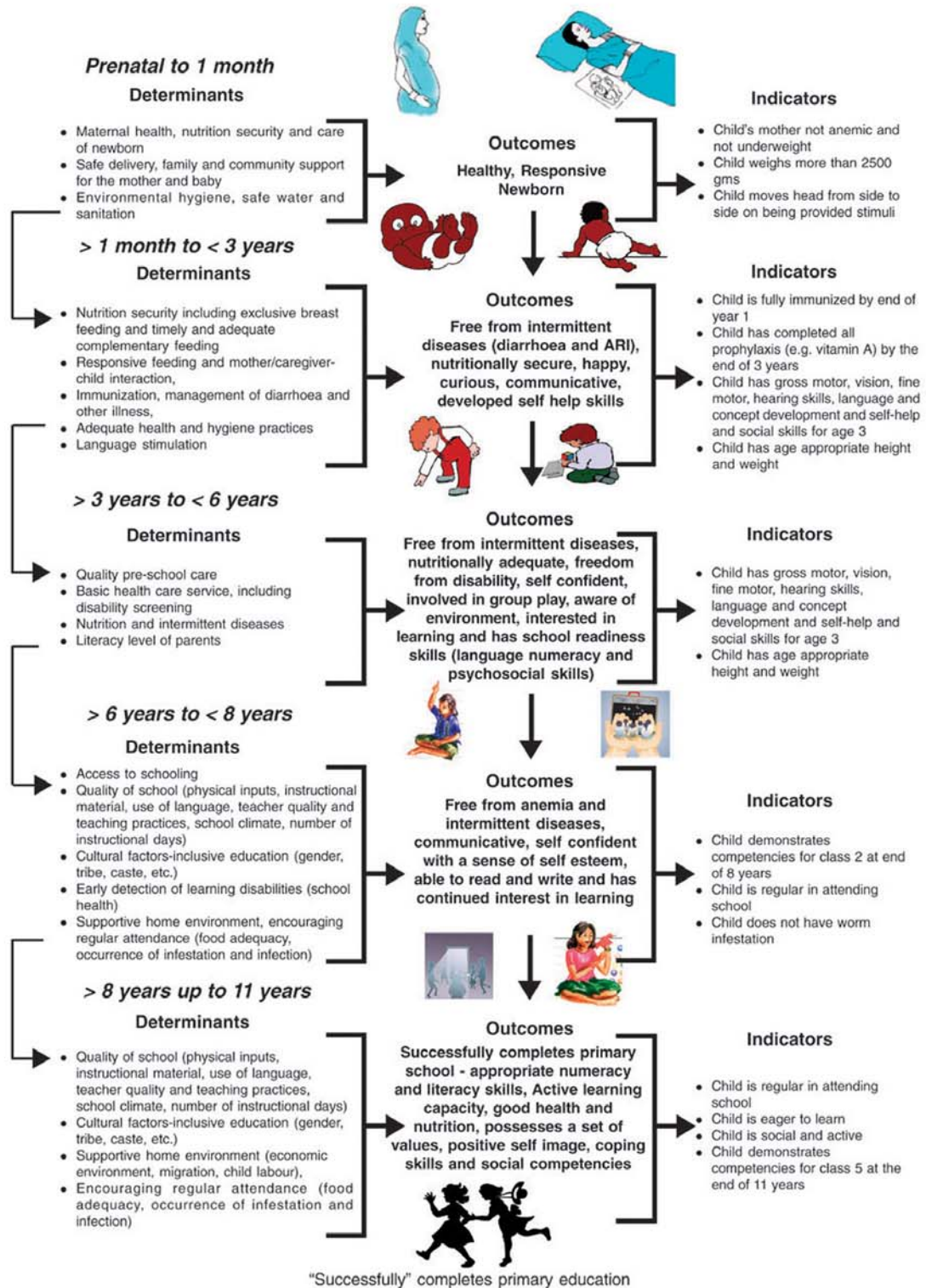
The framework identifies certain constant determining factors and developmental milestones across the stages, namely adequate nutrition and balanced diet, protection from illness and timely medical care, hygienic living conditions and clean drinking water, safe environment – free from violence, abuse, bondage, hazardous work, full-time work and trafficking - and above all, constant love, affection and mental and physical stimulation for all children. Other factors and milestones are more specific to the particular stages in defining child developmental outcomes. These vary from an emphasis on maternal health and nutrition during the pre-natal phase, a shift to quality care and immunisation during the early years of childhood, followed by institutionalised mental and physical stimulation during pre-school and primary school years that focus on holistic skills development. Finally, 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. The strength of the framework lies in its ability to integrate the physical and psychosocial development of children with the social, political, and economic dimensions of health, nutrition, and education, view child development as a continuous and a cumulative process, and finally put forth a holistic understanding of what is desirable and necessary for developing as well as evaluating a child-centred social policy.

Table 1: ICD Conceptual Framework  
Source: Conceptual Framework, new Concept, 2003  
(Following page)

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<sup>2</sup> A review of existing literature indicates that the vision or developmental task for the Indian child (by age 11) is that s/he should ‘successfully’ complete primary education. By ‘successful’, it is meant that the child should not only acquire appropriate numeracy and literacy skills but also an active learning capacity, good health and nutrition, a set of values, positive self image and motivation, coping skills and social competencies. (National Curriculum 1988; Primary Years 1998) (Page 6 CF, New Concept)

## ICD CONCEPTUAL FRAMEWORK



Taking its cue from the above framework (New Concept 2002), the study looks at children from conception to 11 years – tracking key milestones of children in diverse poverty situations in one district each in the states of Andhra Pradesh, Karnataka and Uttar Pradesh. It explores the synergy between health, education and nutritional inputs in the overall development of children in different poverty situations and reflects on whether the proximal and distal environment promotes holistic development of the child.

It is important to clarify that this study *is not and does not purport to be an evaluation of existing programmes on the ground although the discussion does include appraisal and evaluative comments about the services at the ground level*. Being essentially qualitative in nature, it is exploratory and illustrative, seeking to understand context specific factors at each stage of the development of children. *The sample is skewed in favour of children living in diverse poverty situations and, therefore, the findings of the study cannot be generalised to the larger universe of children in the 0-11 age group*. There is a wealth of quantitative and qualitative information generated by the government giving an overall picture of both early childhood care and nutrition on the one hand and primary schooling on the other which is often used by the government and donor partners for making overall assessments. This study – at best – can enable us to understand / analyse issues in-depth that are generated from these macro studies, with reference to children from the poorest households

At this stage, it would be valuable to recapture broad trends with respect to poverty and how it influences maternal and child health and school participation.

It is now universally accepted that poverty is not only about income, it also encompasses factors like health, education, nutrition and access to basic needs and services. Notwithstanding decades of poverty alleviation and income generation programmes and an average rate of economic growth of GDP of about 5 per cent per year, the country's performance on the poverty alleviation front has been disappointing, especially during the 1990s. The impact of rising food prices on the real consumption of the poor and of stagnant rural employment opportunities continues to be a matter of significant concern. A sharp decline in the off-take of the public distribution system (PDS) food grains by states where poverty is concentrated is the result of a combination of fiscal pressures on state budgets and the effect of policies resulting in higher prices for food grains. Besides this, the increasing debt ratio and interest payment in the 1990s in contrast to the 1980s, when the growth rates were at similar levels, worsened the scenario. The implications of these

trends on the nutritional levels of the poor and especially of women and children are deeply worrying. The overarching challenge faced by India is to improve the health, nutrition and education status of the poor, particularly women and girls.

Let us start with some basic mortality indicators. In the past decade the pace of improvement in key health status indicators appears to have slowed down. The rate of decline in infant mortality has been slow in the 1990s; in fact perinatal and neonatal mortality has not fallen and their share in the total infant mortality has increased. Reviewing the working of the 9<sup>th</sup> Five Year Plan, the Planning Commission has expressed concern at the decline in routine immunisation of children against the major vaccine-preventable diseases. This fact is also borne out by the data from the first and the second rounds of the National Family Health Survey (NFHS) conducted in 1992-93 and 1998-99. The NFHS also showed that maternal mortality has remained unchanged at an unacceptable high level.

**Table 2: Mortality indicators**

	UP	Karnataka	AP	India
MMR (Maternal mortality rate)	707	195	154	408
IMR (Infant mortality Rate)	86.7	51.5	65.8	73
CDR (Crude death rate)	10.2	7.9	10.7	9.7
NMR (Neonatal mortality rate)	53.6	37.1	43.8	47.7
Post Neonatal	33.1	14.4	22.1	25.3
Child Mortality	39.2	19.3	21	30.6
Under five mortality	122.5	69.8	85.5	101.4

Source: NFHS II (1998-99)

A comparison of data from the National Sample Surveys (NSS) in the late 1980s and mid-1990s, points to significant increases in the cost of both in-patient and outpatient healthcare in rural and urban areas. Analysis of the NSS data shows that untreated illness among the poor has clearly increased due to financial constraints (Gita Sen et al, 2002). Inequity as measured by figures of the household consumption expenditure group appears to have worsened, and the divide between rich and poor in terms of untreated illness and expenditure on health services, as well as their use of both public and private health care institutions, has grown. The rich are now the major users not only of private but also of public hospitals. Increased drug costs and rising fees for different health services in both the private and public sector seems to have played a major role in this<sup>3</sup>.

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<sup>3</sup> Fees for service are being increasingly used as part of decentralisation and in order to increase financial viability. However, globally, support for user fees has declined for three main reasons: (i) the net revenue earned is insignificant; (ii) effective targeting is difficult and its absence reduces demand for health services

The rising cost of healthcare can have a range of possible effects on the poor. These include cutbacks on other consumption like food, which directly impacts on nutrition and health status; growing untreated illness; and growing gender biases in health seeking behaviour<sup>4</sup>.

Collating available evidence from national sample surveys, D B Gupta notes, ‘Despite nationwide programmes (for e.g., the ICDS and RCH) for nutritional supplementation for pregnant women and children, available indicators present a depressing picture. NFHS-2 (1998-99) data shows 36.8 per cent of women with BMI (34) of 1805 kg/m<sup>2</sup> or less, indicative of chronic energy deficiency (CED). Anaemia in women varies from 41.9 per cent in high-income groups to 60.2 per cent in low-income families. 47 percent of under-3 children are underweight and 18 per cent are severely underweight. There has only been a marginal improvement since NFHS-1 (1992-93) (from 52% in NFHS-1 to 47% in NFHS-2)’. The situation of women and children in the last poverty quartile of the population is alarming – leading to an inter-generational spiral of poor nutrition and poor health.

**Table 3: Proportion of underweight mothers by social group & location, NFHS-2**

	SC	ST	OBC	General	Missing	Total
Per cent underweight mothers	45.44	42.09	35.47	30.39	46.45	35.68
	Rural			Urban		
	40.54			22.21		
Lowest quintile	47.23			38.72		
Highest quintile	28.37			8.57		

Source: L Bhandari: Empirical Analysis of Integrated Child Development, 2003

**Table 4: Sex ratios, 1991 and 2001**

State	All ages 1991	All ages 2001	Age (0-6) 1991	Age (0-6) 2001
All India	927	933	945	927
Andhra Pradesh	972	978	975	964
Karnataka	960	964	960	949
Uttar Pradesh	876	898	927	916

Source: Census of India 2001; Paper 1 of 2001 – Provisional Population Totals

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by the poor and women; (iii) separation of users into two categories of those who pay and those who don't leads to significant quality differentials, and also reduces the political support for free or subsidised services.

<sup>4</sup> Until the mid-1980s, public hospitals were still the dominant providers of in-patient care especially for the poor, even though patients were increasingly resorting to the private sector for outpatient services. Although this varied considerably across states, public hospitals provided an important alternative to the private sector and at significantly lower cost. By the mid-1990s, there is clear evidence that the private sector had become dominant in terms of both outpatient and in-patient services (Gita Sen et al, 2002).

At the societal level, gender bias persists in key areas in the form of society's preference for boys over girls, the continuation of the dowry system, early marriage and violence, including sexual violence against women in both private and public spaces and women's lack of decision-making powers. Only 52 per cent of women reported being involved in decisions even when it concerned their own healthcare. Barring Kerala, the juvenile sex ratio has worsened in every major state, even though there has been some improvement in the overall sex ratio. Perhaps the most striking evidence on women's low status is that 21 per cent (NFHS-2 1998-99) reported being victims of domestic violence from age 15 on. Illiterate and poorer women experienced higher than average rates of violence.

**Table 5: Literacy rates: All India and Major States, 2001**

State	Male rate	Female rate	Gap	Decadal increase, male rate	Decadal increase, female rate
All India	75.96	54.28	21.68	11.83	15.00
Andhra Pradesh	70.85	51.17	19.68	15.72	18.45
Karnataka	76.29	57.45	18.84	9.03	13.12
Uttar Pradesh	70.23	42.98	27.25	15.40	18.61

Source: Census of India, 2001; Paper 1 of 2001 – Provisional Population Totals, Series 1– India: Statement 35, pp.126

While most observers would agree that at least in the education sector - tremendous progress has been made in the decade of the 1990s, a 'hard core' of 5 to 15 per cent of children (depending on the region and social groups) continue to remain outside the ambit of primary schooling. Additionally, irregular attendance, high drop out rate and poor learning achievement appear endemic among certain specific sections / groups in society. Recent studies have also highlighted the phenomenon of children from different social and economic groups accessing different types of schools – regular government primary schools, alternative / Education Guarantee Scheme schools (EGS), private schools (Vimala Ramachandran 2002). Given the gradual increase in the number of private schools on the one hand and an exponential rise in the number of alternative / habitation specific schools on the other, children from different socio-economic groups are increasingly attending different kinds of schools. As the more powerful and the better-off shift their children to private or special schools, societal pressure on government schools to function well reduces considerably (Aggarwal 2000). Similarly, where children of relatively better-off communities in rural and urban areas rely on private tuitions, the importance of ensuring requisite teaching/learning in schools also goes down. This phenomenon, for example, has recently been highlighted as a major area of concern in West Bengal (The Pratichi Education Report 2002)



This emerging phenomenon of ‘hierarchies of access’ has important consequences for the process of teaching and learning in the classroom. As Aggarwal (2000) notes ‘... out of a total of 30 districts in which the ST population was more than 5 per cent, as many as 11 districts showed less than 10 per cent female ST literacy (1991 Census)... In the 66 districts where the share of SC population was more than 5 per cent, as many as 29 districts had female literacy varying between 10 and 25 per cent (1991 Census). *Thus most of the school-going children, especially the girls, in these districts will be first generation learners*’ (emphasis added). Schools with large numbers of first generation learners require more experienced teachers. Further, most children are not only first generation school goers but often live in difficult circumstances. The absence of a facilitating educational environment in the family, need to support parents with household/farm and non-farm work, lack of electricity, seasonal migration and many other factors act as impediments and place additional pressure on children. It is also fairly common to come across children who work before and after school. It is not possible to understand the predicament of this small and important segment of our society without delving into economic, social and cultural factors that frame their life.

Macro data / statistics can at best indicate the existence of this ‘hard to reach’ group of children. However, context or/and group specific factors that influence their access to schooling as stated above, along with basic health care, immunisation services and early childhood care seem more elusive. As a result most policies and programmes factor in broad parameters neglecting contextual factors that might make a significant difference to children in these special focus groups. It is this gap that qualitative studies seek to fill. Focused policy prescriptions based on in-depth detailed understanding are needed if we want to truly universalise education. This study is an effort to understand the subtle and complex nuances behind the statistics and as also the dynamic interplay among the variables that promote or impede primary school education, with reference to their relative strength and quality in different field contexts. The report tries to explore the cumulative impact of health, nutrition, stimulation and education at different stages of the life of children – from 0 to 11 years.

## Methodology:

The primarily qualitative study is based on detailed fieldwork conducted in both rural and urban areas between September-November 2002. Given the research mandate of our study, the focus

was on fleshing out factors that impede or facilitate successful completion of primary school education among children living in diverse poverty situations in the three states of Andhra Pradesh, Karnataka, and Uttar Pradesh. This necessitated a detailed focus 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. Box 1 provides an illustrative list of the research tools used to elicit and explore the data on which this study rests.

### **Box 1: Research Tools**

<p><b>A1:</b> Information collection through key informants for identification of households in diverse poverty situations (Rural) – with special care to capture ‘diverse’ poverty contexts. For urban area – a geographic location was selected for complete house listing.</p> <p><b>A 2:</b> House listing schedule (Rural) to capture basic socio-economic characteristics and children in appropriate age group.</p> <p><b>A 3:</b> House listing schedule (Urban) to capture basic socio-economic characteristics and children in appropriate age group.</p> <p><b>B 1:</b> Village profile schedule – to capture overall status of services, institutions (especially primary schools), access to basic services health, immunisation, water etc.</p> <p><b>B 2:</b> Urban settlement profile – to capture overall status of services, institutions (especially primary schools), access to basic services health, immunisation, water etc.</p> <p><b>B 3:</b> Household Schedule and interview schedule with mother or primary care provider in the household.</p> <p><b>B 4:</b> Health checklist to canvas with children in the selected household to capture age, height and weight, immunisation, external observation of skin, hair colour, legs, vision, ear/hearing etc.</p> <p><b>B 5:</b> Observation checklist – developmental milestones of children, breast feeding, supplementary nutrition, food habits, illness, disability etc.</p> <p><b>B 6:</b> Matrix for observation of 2 children from each household for detailed profile and adult-child interaction.</p> <p><b>C 1:</b> Interview schedule – Aanganwadi Worker (ICDS), Primary School Teacher (Government Primary School)</p> <p><b>C 2:</b> Interview Schedule – Healthcare Provider – Auxiliary Nurse and Midwife (ANM) and/or any other local health service provider.</p> <p><b>D 1:</b> Format for cohort analysis in Government Primary School (GPS) – tracing children who enrolled in academic year 1999-2000</p> <p><b>D 2:</b> Classroom observation checklist to capture school based activities, attitude and practices in the classroom, mid-day meal programme and teaching – learning environment.</p> <p><b>D 3:</b> Guidelines for group activities with children in the 6 + age group</p> <p><b>D 4:</b> Information collected from the private school in the village/urban area</p> <p><b>E 1:</b> List of questions explored in Focus Group Discussions with the following:</p> <ul style="list-style-type: none"> <li>- Women’s group</li> <li>- Mixed group – including members of Village Education Committee (VEC), Panchayat, School Development and Management Committee (SDMC)</li> <li>- Adolescent girls and boys</li> </ul>
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An initial step, following the sanction of the research project, involved the preparation of the research tools. The core research team debated and developed a matrix of research questions to be explored in the study across all the identified social domains. The research tools were initially pilot tested in one site each in Andhra Pradesh, Uttar Pradesh, and Karnataka and were subsequently revised after detailed interaction with researchers and field investigators in a three-

day workshop in Hyderabad in late August 2002. The revision was based on the feedback from the pilot testing as well as technical inputs from experts in child development, health & nutrition and qualitative research.

Care was taken that the selection of the research district/block, villages, urban localities, and households was done on a systematic basis to ensure non-biased representation as well as provide an effective backdrop to explore the research issues at hand. Districts in each of the research state were listed on the basis of female literacy rates, social composition [Scheduled Castes (SC), Scheduled Tribes (ST), and minority population], rural-urban demographics, poverty indicators, sex ratio, and presence of governmental and non-governmental programs in the area (for instance Mahila Samakhya, ICDS, etc.). Given the size of the 3 states and significant internal variations between different regions in the state, selecting one district for a detailed qualitative study was a daunting prospect, especially in the case of Uttar Pradesh. After several rounds of discussions with government officials and the World Bank team, it was decided to choose a district that is fairly representative of the state. The selected research districts include Sitapur in UP, Nizamabad in AP, and Bellary in Karnataka and all are average performers with reference to human development indicators. Since qualitative research demands intense and sustained interaction with the community – therefore, among the important criteria for selection was also the presence of Mahila Samakhya Programme (MSP) or an NGO in the area to facilitate initial rapport building with the community – especially women.

A listing of villages was generated on the basis of average population of 1500 and other criteria used for selecting the district - presence of pre-school and primary school facilities, social demographics, infrastructure, presence of MSP/NGO. The final selection of villages was done on the basis of lots. This was followed by the generation of a house-listing schedule. The households were categorized on the basis of number of children and their ages and a shortlist of households with at least one child below the age of five, but with minimum of two children, preferably one girl was created. Out of the short listed household a further categorisation was done by caste and occupation, female-headed households, bonded children, and adult disability in order to capture diverse poverty situations. On the basis of this process, 6 households in each village and 3 households each in the urban areas were randomly selected by drawing lots.

Selection of urban areas followed a slightly different trajectory. The initial step involved the identification and selection of a big town in the district, normally the district headquarters and

followed by a ward list, based on census enumeration maps or municipality maps. Yet another list was generated based on population size, poverty indices used by the municipality, existence of the slum for at least 5 years, presence of ICDS programme, GPS, and location in relation to the town centre or periphery. Selection of two urban areas was done with care taken to ensure that one was located in the periphery and the other in the centre. Urban households were identified on the basis of criteria used in rural areas, however care was taken to ensure that relevant urban characteristics were not ignored (e.g. housing conditions etc.) and the selected households were not contiguous in location.

Overall, the six villages and six urban settlements selected for the study reflected diversity in terms of location, demographic characteristics, remoteness / accessibility, caste and community composition and functioning of ICDS and primary education facilities (For detailed profile of study villages see respective state reports in Part II of this report). In order to maintain the confidentiality of our respondents we have taken care to use pseudonyms in our report and (apart from the research districts) extend the blanket of anonymity to the research villages and urban settlements.

## Profile of the study area:

**Table 6: Profile of the 3 states:**

Key indicators	Uttar Pradesh	Karnataka	Andhra Pradesh	All India
<b>Population</b>				
Population, 2001 (in million)	166.1	52.7	75.7	1027.0
% Intercensal decadal growth, 1991-2001	25.8	17.3	13.9	21.3
Sex ratio, (females per 1000 males)				
1991	876	960	972	927
2001	898	964	978	933
Juvenile sex ratio 1991	927	960	975	945
(Age group 0-6) 2001	916	949	964	927
<b>Fertility and Mortality Indicators</b>				
Crude birth rate, 2000	32.8	22.0	21.3	25.8
Total fertility rate, 1998	4.6	2.4	2.4	3.2
Crude death rate, 2000	10.3	7.8	8.2	8.5
Life expectancy at birth 1993-97				
Males	58.1	61.6	61.2	60.4
Females	56.9	64.9	63.5	61.8
Infant mortality rate, 2000 (Per 1000 live births)	83	57	65	68
Neo-natal mortality rate, 1998	52	42	46	45
Post neo-natal mortality rate, 1998	33	17	21	27
Child mortality rate, 1998 (Below 5 years)	30	17	18	22
% Of children under age 3 with weight for age <3 SD NHFS II 1998-99	22	17	10	18
Maternal mortality rate, 1997 (Per 100,000 live births)	707	195	154	408
% Of births <u>NOT</u> attended by trained personnel, 1998	50	25	30	46
NFHS II, 1998-99	77	41	35	57
% of children aged 12-23 months receiving all vaccinations NFHS II 1998-99	21	60	59	42
<b>Literacy</b>				
% Literate				
Males, 2001	70	76	71	76
Females, 2001	43	57	51	54
Male female gap in literacy rate, 2001	27	19	20	22
1991	30	23	22	25
% Of 6-10 years attending school NFHS II, 1998-99				
Boys	84	88	88	85
Girls	74	85	83	78
% Of 11-14 year old children attending school NFHS II, 1998-99				
Boys	81	75	71	80
Girls	62	68	55	67
% Of girls aged 15-19 married*	40	31	44	33
Singulate mean age at marriage of girls NFHS II, 1998-99	19	20	18	20

\*Inclusive of girls for whom *gauna* (formally cohabiting with husband) was not performed.

Table 6 above captures some of the key indicators of the population, in particular the demographic characteristics, access to health care and literacy in the three research states of Uttar Pradesh, Karnataka, and Andhra Pradesh. Wherever possible, data are presented separately for boys and girls. The 3 states represent an interesting range in terms of the composition of the population and their differential access to schemes of primary education, child health, nutrition and early childhood care and education (ECCE). As evident, the three states of Uttar Pradesh, Karnataka and Andhra Pradesh are relatively large with population exceeding 50 million according to 2001 Census. Population grew at a relatively modest rate of 14 and 17 percent between 1991 and 2001 in Andhra Pradesh and Karnataka, lower than the all India rate of 21 percent. However, Uttar Pradesh recorded a growth rate of nearly 26 percent, one of the highest in the country. Between 1991 and 2001, the overall sex ratio of population improved in all the three states as it did in the country as a whole. However, the sex ratio of children aged 0-6, deteriorated in the three states and stood lowest at 916 girls per 1000 boys in Uttar Pradesh.

**Table 7: Profile of the sample districts**

	<b>Sitapur Uttar Pradesh</b>	<b>Bellary Karnataka</b>	<b>Nizamabad Andhra Pradesh</b>
Population	3. 62 Million	2.01 Million	2.34 Million
Decadal growth rate	26.58	22.30	14.98
Sex ratio females for 1000 males	833 (1991 Census) 862 (2001 Census)	966 (1991 Census) 969 (2001 Census)	1017 (1991 Census) 1016 (2001 Census)
Juvenile sex ratio	926 (2001 Census)	949 (2001 Census)	966 (2001 Census)
Literacy (1991 Census)	43.10 (M) 16.90 (F)	59.11 (M) 32.24 (F)	47.33 (M) 32.24 (F)
Literacy (2001 Census)	61.02 (M) 35.08 (F)	69.59 (M) 46.14 (F)	66.27 (M) 40.57 (F)
SC population (1991)	35%	50	15%
ST population (1991)	NA	19	6%
Urban population (1991)	12%	31	18%
Educational programmes	DPEP	DPEP - II	DPEP II
% Single teacher schools (Primary) 2002	NA	13.4%	60.8%
Pupil-teacher ratio, 2002	NA	33.5	40.9
Female teachers, 2002	NA	36.4%	29.9%
ICDS	Yes, rural only	Yes, rural and urban	Yes, rural and urban

Uttar Pradesh also stands out also in terms of its high levels of fertility and mortality. With an average of 4.6 children per woman, Uttar Pradesh is a long way from attaining replacement level fertility of 2.1. For the other two states of Karnataka and Andhra Pradesh attainment of replacement level fertility is quite likely within the coming decade. What is worth noting is the sex differentials in life expectancy at birth. While at all India level as well as in Karnataka and Andhra Pradesh, female life expectancy is higher than that of males and the turn-around seems

stable, Uttar Pradesh continues to have lower female life expectancy than that of males raising important and recurring questions about the persistence of gender biases and disparities and how best to address them through policy interventions. Infant mortality ranging between 83 in Uttar Pradesh and 57 in Karnataka also suggests that there is scope for significant decline and points to a need for improvement in deliveries by trained personnel and universalisation of immunization. The National Family Health Survey of 1998-99 indicates a very dismal performance in Uttar Pradesh, where only 21 per cent of children aged 12-23 months had received all childhood vaccinations. There has also been a decline in the percentage of children weighing over 2500 grams – it declines from 60.4 (Rural) and 61.99 (Urban) in 1992-93 to 56.89 (Rural) and 61.03 (Urban).

**Table 8: Proportion of 1 year olds fully immunised, by Social Group**

Per cent	SC	ST	OBC	General	Missing	Total
NFHS-1 (1992-93)	28.26	26.00	39.69		-	36.92
NFHS-2 (1998-99)	41.93	28.28	45.72	49.74	47.05	37.70

Source: L Bhandari: Empirical Analysis of Integrated Child Development, 2003

On the literacy front, between 1991 and 2001, all regions of the country have showed tremendous progress. However, the gender gap continues to mar the overall performance. It is heartening that among the young aged 6-10 years in primary cycle of education, the gender gap is virtually non-existent in Karnataka, very low in Andhra Pradesh while there is a gap of 10 percentage points in Uttar Pradesh. Among the older children aged 11-14, who would be at secondary level, the gender gap in the case of both Uttar Pradesh and Andhra Pradesh is significant and comparable to the all-India situation. The persistence of gender gap also indicates the possibility that a similar situation is very likely to prevail among certain disadvantaged sections of society – the ST, SC, and some of the larger minority groups – who are usually located on the bottom rungs of the socio-economic ladder.

Our study, while not addressing the above issues directly, tries to understand the process by which girls as well as boys belonging to marginal social groups drop out of school or become irregular in their attendance. Our overwhelming impression is that parents both recognise the value of educating their children and are willing to invest whatever meagre resources they can afford in education. Despite this **acceptance of the value of education**, there are significant impediments to the **full realisation** of this aspiration – generating ambiguity about the relevance

of education. Nevertheless, families welcome discussions on schooling and education. This may partly be a result of increased awareness and mobilisation of educational activities initiated by the government in the decade of the 1990s.

As evident from Table 9, the villages selected are neither too remote nor very accessible, thus fairly representative of the study area. All six villages are served by functioning Government Primary School and Aanganwadi (ICDS) Centre, private schools and in some cases, private tuition classes. The urban settlements are quite diverse (Table 10). Location (middle of town / periphery), years of settlement and migration pattern influence the character of the settlement. Relatively new settlements on the city outskirts are the most deprived in terms of infrastructure, i.e., electrification, road, transport, access to safe drinking water / sanitation, health care and immunisation services. The living conditions – type of housing (plastic sheet shacks / metal or tin roofs), unhygienic surroundings, open drains and garbage from the city affects the health and overall well being of families in general and to children in particular. Involvement in collection and sorting of garbage, processing recyclable waste and in petty chores in and around the house take up a significant proportion of time of a child's life. Discussions with children in all the three states revealed that many of them work before and after school – especially the girls (See Tables 22 and 23: What children do before and after school). Thus, being enrolled in school does not necessarily imply that they are free from work. If one were to compare the overall living conditions of children in the different areas surveyed, the situation of children in urban slums stands out as the most dismal.

#### **Children in urban slums**





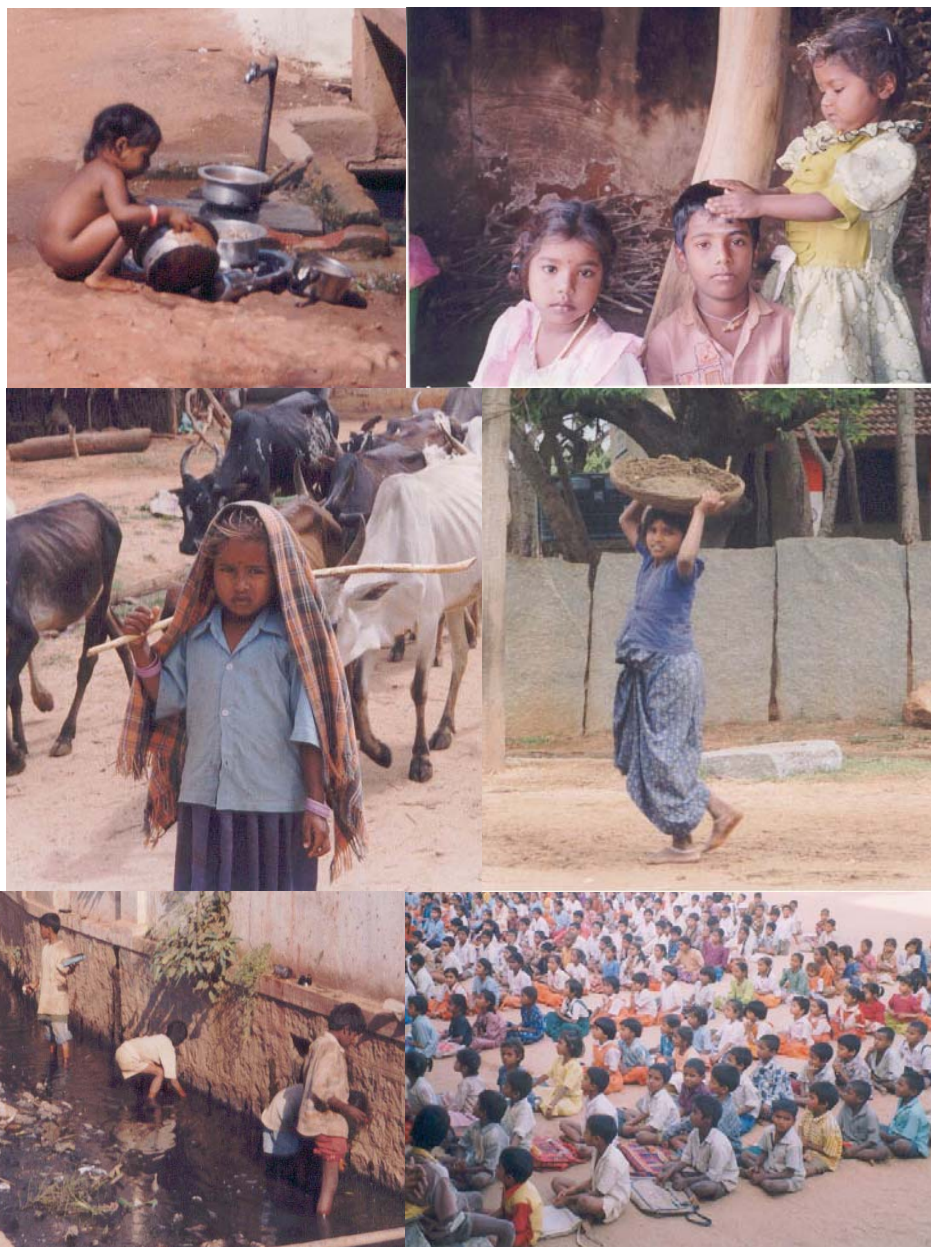
**Table 9: Profile of sample villages**

Village	Population	Caste / Community	Infrastructure	Occupation	Location	ICDS Centre	School	Health
Village 1 UP	2294	OBCs – dominant. SCs Few Muslims families	Pucca road, electrified but erratic, open wells for water, few personal toilets	Ag wage labour – mainstay of poor Few children work to repay loan	30 KM and 7 KM from main road	Yes	1 GPS 1 Pvt. School	PHC 3 km, ANM irregular, shop sells OTC medicines
Village 2 UP	1600	OBC – dominant SC poor Few Brahmins	Pucca road 2 km away, erratic electricity, hand pumps, few toilets	Wage labour, road construction, seasonal migration to city	20 KM from Block HQ 2 KM from Pucca Road	Yes	1 GPS 1 Pvt School	Trained CHW in village, ANM irregular, shop sells OTC medicines
Village 1 Karnataka	1704	ST (Dominant), SC, muslim and OBC	All weather road, electrified, bore wells / hand pump	Ag labour, construction work	11om Taluk HQ	2 AWV 1 Golla and 1 other	Beautiful and bright schools 1 GPS (Golla) 1 GPS (others)	ANM visits village, PHC 11 KM away
Village 2 Karnataka	5094	SC (dominant), ST and OBC	All weather road, electrified,	Ag labour, wage labour including construction	14 KM from Taluk HQ	2 AWC 1 SC and 1 other	Beautiful and brightly painted government schools 1 GPS (SC) 1 GPS (all) 1 Pvt. Sch	ANM visits village, PHC 14 KM 1 PHU and 1 Med Shop
Village 1 AP	1205	Tribal 100%	10 KM from Mandal HQ	Ag labour, road work and other wage labour	Pucca road up to village, good bus service	1 AWC	1 GPS 1 TW Res School	ANM visits 1 a month, Govt. hospital at Mandal
Village 2 AP	1115	SC, BC, ST and OC	4 KM from Mandal HQ	Ag labour Construction Wage work	Pucca road up to village	1 AWC and 1 ECE at Tribal hamlet	1 GPS 1 GUPS 1 Pvt Sch High School and degree at Mandal HQ	ANM visits 1 a month. RMP in village

**Table 10: Profile of sample urban settlements:**

Urban settlement	Population	Caste / Community	Location / Infrastructure	Occupation	ICDS Centre	School	Health
UP Urban 1	3510	OBC, Muslim and SC almost equal proportion	Periphery Brick road, electrified, hand pumps, public taps and public toilets, Open drains	Wage work in PAC, vending, petty business, domestic work. Children work as apprentice to tailors and mechanics	Not available	2 GPS and several recognised and un recognised private schools	RMP Petty shop sells OTC medicines 4 KM to District Hospital
UP Urban 2	9136 in the entire ward. 250 families selected	OBC, SC, Muslim and few FC	Centre of town Paved roads Electrified, Hand Pumps Mix of open and covered drains	Construction workers, masons, painters, Vendors, wage workers	Not available	2 GPS and several private schools	1 KM from District hospital RMP OTC medicines in shops
Karnataka Urban 1	1105 in selected Ward	Adikarnataka SC ST OBC	Periphery of town, kutcha approach road, municipal bus twice a day, Open drains Municipal lorry comes once in 3 moths to pick up garbage.	Dependent on wagon loading – near the railway station where coal and iron ore wagons are loaded	1 AWC (many families do not know of its existence) 1 pre-school (private)	1 Ambedkar School 1 GPS 2 Private HPS Mid-day meal served	No government or private hospital nearby, have to go into twwn Health assistant visits occasionally for immunisation.
Karnataka Urban 2	698 in selected Ward	SC, ST, Muslim and OBC – together	Centre of town All facilities – road, piped water supply (below ground level with taps in pits), electricity, public community toilets etc. Open sewer that runs through the settlement	Manganese and iron ore mines Occupational diversity – construction work, tailors, drivers, domestic labour	Pre school by SJSRY – not food  10.00 AM to 2.00 PM	1 Geetha Govt. Lower Primary School serves mid-day meal, 1 Govt. Urdu Lower Primary School – no mid-day meal Several private schools in the area.	Several private clinics around the area. People did not report using government health facilities
AP urban 1	1313	SC, BC and OC (incl Muslim)	Centre of town all facilities	Daily wage work Domestic work Petty trade	2 AWC	1 GUPS 1 Private School Many other nearby	Urban health post, district hospital etc
AP Urban 2	1192	SC, BC, OC, ST	Periphery – 6 KM from city centre	Daily wage, auto drivers Construction Beedi rolling	1 AWC		ANM and urban health post 1 KM away

## SECTION TWO: THROUGH THE LIFE CYCLE OF CHILDREN



## Why lifecycle approach?

As indicated in Section I, this study explores factors that contribute towards or impede successful primary school completion across the identified social domains - the child, family, community, institutions (pre-school and primary school), and other services (health care, sanitation, water, transport etc.). Recent researches on the issue have either been sociological explorations or policy analyses that primarily focus on the differential social, economic and political dynamics of 'supply' and 'demand' for education to explain children's access to primary education or lack thereof. Unfortunately, there are few socio-psychological studies examining similar concerns from the perspective of age-specific child development. Further, few attempts have been made, so far, to draw on both the frameworks simultaneously to generate deeper insights for policymaking purpose.

### **Box 2: Long-term effects of childhood malnutrition**

Although childhood malnutrition has been found to be associated with smaller head circumference and altered brain biochemistry, the functional significance of these changes needs to be understood. There is clear evidence that severe clinical under nutrition at specific periods during the developmental process does lead to a decrement in intellectual function and to alteration in behaviour in individuals. However, the evidence relating to mild or moderate under nutrition to impairment of mental function is inconclusive. The functional impairment in children affected by mild or moderate under nutrition may not be due to lack of food *per se*, as other socio-environmental factors may also be synergistically involved... Children are born with physical, social and psychological capacities that allow them to learn, communicate and develop. Research points out that the major proportion of development of intelligence in children occurs before age 3. The brain cells of a new infant proliferate exponentially and as synapses connect, the patterns of a lifetime are established. In a short period of 36 months, the child develops his/her abilities to think, speak, learn, reason and lay the foundation for values and social behaviour as an adult... Obviously, a healthy development and supportive social interaction at the second stage will encourage positive brain development and an increased learning potential. Also, in the early childhood years, the experiences and interactions with parents, family members and other adults influence the way a child's brain develops, with as much impact as factors such as adequate nutrition, good health and availability of clean and safe water. How the child develops during this period sets the stage for later success in school and the character of adolescence and adulthood. Indeed, the effects of occurrences during the prenatal period, the formative months, and the early years of the child's life can last a lifetime... Therefore, the probability of the child completing school successfully is not only dependent on the determinants that act between the years 8–11 but also on (1) what happened in each of the preceding stages, i.e., 6–8 years, 3–6 years, 1–3 years and between conception and 1 month after birth and (2) the synergy between health, nutrition and education.

Source: Conceptual Framework, New Concept, 2003

This study, in keeping with the conceptual framework, attempts to explore the critical intersection between sociological analyses of the identified domains and a lifecycle perspective on child development. The domain analyses helps 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.). However, it needs reiteration that these processes are neither universal nor are they equally important in determining educational outcomes for children of different age groups. For instance, pre/post natal care would assume a greater significance when focussing on infants and the AWC in case of a pre-schooler. Hence, the adoption of a life-cycle perspective helps recognise the differential needs of children of varied age groups even as we engage with the cumulative nature of child development on one hand and the politics of social exclusion and economic deprivation and its implications for schooling on the other.

**Table 11: Tools used to explore each stage from conception to age 11+**

	<b>Interviews</b>	<b>Observation</b>	<b>Measurement / Records</b>	<b>FGD* / Group activities</b>	<b>Records</b>
<b>Conception to birth</b>	Mother ANM AWW	Food / health practices Work during pregnancy	Immunisation ANC Weight	Women's group	ICDS ANM
<b>0 to 3 years</b>	Mother AWW	Feeding practices Childcare Stimulation Social and emotional interaction Activities	Immunisation Anthropometrical measurements	Women's group Children's group	ICDS ANM
<b>3 to 6 years</b>	Mother AWW	Feeding practices Child care Stimulation at home and in AWC Social and emotional interaction Activities	Immunisation Anthropometrical measurements School enrolment	Women's group Mother's group of AWC Children's group	ICDS
<b>6 to 11 years</b>	Mother School teacher	Food Play Activities before, in and after school Work children do Stimulation at home and in school Participation in the household	Enrolment record of school for performance / transition (cohort analysis) Observation and interview about activities	Women's group VEC / SDMC and Panchayat Group activities with children	Primary School

\*Focus group discussions

In this research, we have opted to use the age-specific child development schema as an organising principle since it is more amenable to the construction of a relatively stable framework of analysis, namely: conception to birth, 0-3yrs, 6-9, & 9-11. The domain analysis by its very nature is dynamic and the social processes at play are constantly in flux, defying encapsulation in rigid

categories. In this study we attempt to capture the various processes and their shifting significance across the age groups through the research tools elaborated in the matrix below:

## From Conception to Birth:

Children in this stage of development have been the focus of a large number of health and family welfare programmes of the government, for example the 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. Similarly the ICDS programme, operational since the mid-1970s, focuses on nutrition of mothers during pregnancy and lactation (see Table 13).

- Across the three states, a disturbing finding was that 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*. Few women were aware that pregnancy requires extra nutrition. Most believed that it was not an important matter and 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.<sup>5</sup> It is likely that as we go down the socio-economic ladder, inter-state variations on key indicators of maternal and child health is minimal and the ANM is rarely called upon at birthing. The community primarily relies on a local *Dai* or a relative to assist, while institutional delivery still remains uncommon or rare (See Table 13).
- Most women continue to breast-feed their children till the next child is on its way. Often in the case of the latest child, breastfeeding continues as long as mothers have milk, which often means almost 24 months. Special nutrition during lactation was clearly a novelty for most

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<sup>5</sup> 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.

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.

### Box 3: Conception to birth – reviewing evidence

Pre-natally malnourished babies enter the world with serious problems. They frequently catch respiratory illnesses, since poor nutrition suppresses development of the immune system (*Chandra 1991*). Anemia and chronic undernourishment (85% amongst pregnant women, 63% in pre-schoolchildren) are problems of considerable magnitude. There is an established link between maternal nutrition and LBW of children (25%–56% in urban slums and 35%–40% in rural communities) and the prevalence of iron deficiency amongst preschoolers (*Goel 1993*).

A healthy pregnancy increases the likelihood of full-term uncomplicated births, normal birth weight and healthy brain development (*Mc.Cain, Mustard et al 1999*). Pronounced and prolonged maternal malnutrition may lead to mental deficiency or some physical abnormality (rickets, epilepsy, or cerebral palsy) in the child.

Likewise, zinc supplements are recommended during pregnancy to combat the significant drop in zinc levels due to increased requirements of zinc coupled with foetal utilization (*Satyajeet et al, 1999*). Zinc is equally necessary for the growth of the child and for the expectant or nursing mother. Zinc is good for the health of the immune system; its deficiency may result in frequent infections, reduced appetite, skin disorders and horizontal white marks on the nails. The World Health Organization (WHO) recommends an intake of 15 mg of zinc per day. Further, positive correlation has been found between dietary copper intake and serum copper levels and also between serum copper levels and infant birth weight. (*Parvatham and Banumathi 1999*). Also, the roles of calcium, manganese, iodine and folic acid are established (*Vijayaraghavan 2000*).

There is a strong relationship between malnutrition and psychological factors. Certain mental features of children suffering from kwashiorkor have been found to resemble mental features of children suffering from maternal deprivation (*Jelliffe 1955*).

Source:: Conceptual Framework, New Concept)

**Table 12: Package of services offered by the ICDS programme**

Children 6-12 months and 1-3 years	Children 3-6 years	Women in 15-45 age group – pregnant and lactating	Adolescent girls 11-18 age group
<ul style="list-style-type: none"> <li>Health check-up</li> <li>Immunisation</li> <li>Growth promotion</li> <li>Supplementary feeding</li> <li>Referral services</li> <li>Vitamin and iron supplement</li> </ul>	<ul style="list-style-type: none"> <li>Health check-up</li> <li>Immunisation</li> <li>Growth promotion</li> <li>Supplementary feeding</li> <li>Referral services</li> <li>Early childhood care and pre-school</li> <li>Vitamin A and iron supplement</li> </ul>	<ul style="list-style-type: none"> <li>Health Check-up</li> <li>Immunisation</li> <li>Referral services</li> <li>Registration of ante / post natal care</li> <li>Vitamins and iron supplements</li> <li>Nutrition and health education</li> </ul>	<ul style="list-style-type: none"> <li>Health check-up</li> <li>Referral services</li> <li>Vitamin A and iron supplement</li> <li>Health and nutrition education</li> <li>Self-development, recreation, skill formation</li> </ul>

Source: DWCD, GOI 1999

- Most women in the surveyed households were thin, anaemic and ate once or at best twice a day. Given that the drought situation was rather severe in some of the areas, especially Karnataka and AP, food was limited to rice/wheat with salt and some chillies. Children too were fed the same food, with the mother's share being the least. Many women reported that they were given iron/folic (IFA) tablets by the locally appointed auxiliary nurse and midwife (ANM). However, given the very low awareness about the benefit of taking IFA tablets, most of them were irregular in consuming them. Further, very few had taken pre-delivery tetanus toxoid injection, especially in Uttar Pradesh<sup>6</sup>.
- 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 moves around, especially to distant settlements mostly 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. Respondents admitted that only census enumerators and others doing surveys (like our team) visit them!
- 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 (no records); however, the children looked small and obviously malnourished. Our investigations confirm the 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. 'Low birth weight indicates that the infant was malnourished in the womb and / or the mother was malnourished during her own infancy, childhood, adolescence and pregnancy...Girls and women in South Asia seem to be generally less well cared for by their

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<sup>6</sup> 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!



families... The incidence of low birth weight is one clear marker in this process. Another is the level of anaemia. About 40% of women in sub-Sahara Africa suffer from iron deficiency anaemia, as opposed to approximately 60% of women in South Asia, a proportion that rises to 75% in pregnancy (a staggering 83% in India)' (Ramalingaswami et al, 1996)

**Table 13: 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

While the age of marriage in the state as a whole is 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.

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 Mala D (contraceptive pill) and the dominant measure was female sterilisation.

Table 11 is clearly indicative of the overall reproductive health of mothers and their newborn children. Contextualising the findings of this study with larger representative sample surveys

(NFHS 1 and 2), it is apparent that the health situation of women and children, as evident by all indicators, is very poor. Nevertheless, despite the seemingly grim situation, women were energetic and bright, had dreams and aspirations for their children and most important, appeared undaunted by their life situation. This picture during the field visit in Karnataka captures the situation:

*‘This is a large family, parents and 8 children - four girls and four boys. When we visited the house, a two-year-old boy was standing outside half-naked, he had defecated but was not cleaned up. He had a running nose and flies were hovering over his face. Another child, a four-year-old handicapped girl (one of twins) had measles and fever – she looked pale and weak... We were very hesitant to go up to the mother and ask her if we could weigh her two-year-old, we could not muster enough courage to approach her. She called out, we went in. We found her clean, calm and not at all overwhelmed by her circumstances – she was grinding mehndi! She welcomed us and offered us some mehndi to us too! We are neither glorifying nor romanticizing the situation, we just could not comprehend this marvellous woman who seemed so calm and composed in the middle of the chaos all around her. We just could not comprehend it.’*

The very same grit and confidence came across when women said: ‘We want small babies and will fatten them up after they are born – why do you worry?’

## **Summing Up**

The initial phase of child development (conception to birth) is without any doubt completely dependent on the overall well being of the mother. Given that all 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. The picture is further complicated by the gender bias evident in the lack of family, community, and institutional support with regard to maternal health and nutrition information/ awareness and services, lack of material resources, and an increasing workload. This has important implications for physical survival of children as well as their ability to grow, learn, and function in society. Lack of awareness regarding maternal and child health often translates into pregnant women’s preference for low birth weight babies, because popular wisdom associates it with a smooth delivery. A large volume of embryonic growth occurs in this stage, which is most critical for brain development and for survival and care of the newborn.

#### Box 4: *Devdasi* woman of Karnataka

Kariyavva had just finished class IV when she was dedicated as *Devdasi* to *Yellamma*. She didn't know why. Generally there are a few reasons for such dedication. If a family has just one boy and one girl and if the parents are not sure of the survival of the boy child then the girl is dedicated. The expectation is that the girl would remain in the maternal home and take care of the parents. Kariyavva acquired a 'spouse' when she turned 17. She got pregnant 7 times and has 4 boys and 1 girl, two children (boys) died. While aware of the importance of immunisation for her children, she is unaware of the need for a tetanus injection during pregnancy and nor did she avail of any prenatal care.

When asked about being a *devdasi*, she said that it is better to be formally married, even though her partner is good-natured and lives with her like a typical husband. He meets all financial requirements and cares for the children. Kariyavva does not go out to work. Despite this seemingly normal and happy relationship she yearns for a formal relationship. *Devdasis* are considered inferior and she definitely does not want this life for her daughter. Yet, she is not sure how far her daughter should study. With regard to the sons, she said that they should study till they got some job.

While enrolling the children in the school, the father's name is not given. Though Rangappa is no less a father than any other, he doesn't have a legal status. They are listed as *devdasi's* children. Kariyavva said that they didn't even attempt to put Rangappa's name because they would be deprived of government facilities meant for *devdasi's*. Their children get some kind of scholarship. She said that they get around Rs.500 per annum.

Source: Karnataka Report

### Exploring zero to three years:

A rapid survey of the 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! Discussions with mothers revealed that they did not give the children any special weaning food. Given their work burden and that they had to light a wood stove to cook, it was clearly difficult to make separate food for children. As evident in the table below, weight for age and height for age is an area of concern especially for children in poor households.

**Table 14: 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.

As evident from Table 14 on nutritional status of 6 to 60 months, mortality rates 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, specially if one looks at the under five years mortality. *Is it because of greater of environmental pollution/ sheer poverty/ lack of coping mechanisms vis-à-vis pressures of modern life, despite better access to health facilities?*

#### **Box 5: The positive impact of enriched day-care**

The Infant Health Development Project cited by Mary. E. Young at the International conference on Early Childhood Care for Survival Growth and Development in India, 2000, was a longitudinal randomized state trial for the effectiveness of Early Childhood Development (ECD) and family support services for 1000 LBW premature babies till 3 years. Between 12–36 months, they were placed in enriched daycare centres; it was found that children of the poorest and least educated mothers gained the most. They sustained higher IQ and verbal scores; they also had fewer behavioral problems... Family-related determinants also play an important role in the child's health and nutrition. Malnutrition never occurs alone, it occurs in conjunction with low income, poor housing, family disorganization and the climate of apathy, ignorance and despair. Sub-culture influences within the home environment, the psychosocial climate, the role of the mothering person, intra-familial conditions are all responsible for the ill consequences of malnutrition (*Vazir et al, 1988*).

Source: Conceptual Framework, New Concept, 2003

Though there was no shortage of water in both rural and urban areas, yet 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.

**Table 15: Health related Practices in 3 States**

	<b>Uttar Pradesh</b>	<b>Karnataka</b>	<b>Andhra Pradesh</b>
<b>Drinking Water</b>			
Source of water	83%-Bore water 11%-Piped protected water	44%-Municipal 17%-Hand pump 39%-Water Tank	66%-Bore water 38%-Protected water 11%-open well water
<b>Sanitation</b>			
Water dispensing	All unsafe practices	All unsafe practices	All unsafe practices
Defecation	All in open public places	17% use Toilets (only in urban)	All in open public places
Hand washing habits-with soap	None	None	None
<b>Pollution</b>			
Exposure to Fire wood Smoke	100%	100%	100%
Exposure to allergens	NA	NA	Wild growth of Parthenium in rural and peripheral urban habitations
Density-Crowding in house	7.1	7.2	7.5
Alcohol consumption - Head of HH	11%	11%	11%

Source: Field survey data, 2002

Even though a majority of the houses obtain drinking water from tube-wells and protected water supply schemes, the incidence of water borne diseases is still high. This could be due to lack of sanitation and poor personal hygiene as indicated by the total lack of good practices for water dispensing, hand washing habits with soap at appropriate times both at the household and school level. There is a need for a massive campaign for personal hygiene and water storage and dispensing. 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 16: Vaccination Status (NFHS II)**

	Uttar Pradesh	Karnataka	Andhra Pradesh	India
BCG	57.5	84.8	90.2	71.6
Polio –0	4.7	26.4	5.3	13.1
DPT– 1	57.3	87	89.8	71.4
2	46.5	84.8	86.9	650
3	33.9	75.2	79.5	55.1
Polio – 1	66.5	91.9	93.8	83.6
2	60.3	89.0	90.9	78.2
3	42.3	78.3	81.6	62.8
Measles	34.6	67.3	64.7	50.7
All	21.2	60.0	58.7	42.0
None	29.5	7.7	4.5	14.4
% With Vaccination Card	20.4	41.2	41.3	33.7

**Table 17: Immunisation status of children observed**

	BCG and Polio	Only Polio	NA
<b>Uttar Pradesh (36)</b>	11	18	7
<b>Karnataka (25)</b>	12	12	1
<b>Andhra Pradesh (57)</b>	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 (Table 17 above).
- 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 17 above).
- 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.

#### **Box 6: Mid-term Review of Ninth Plan, Planning Commission, GOI**

- There are 1,34,094 Sub Centres, 1,27, 384 ANMs in position, 22,991 Primary Health Centres with 24,648 doctors, 2712 Community Health Centres with 3624 specialists... A vast infrastructure of primary health care has been created but it is still functioning sub-optimally. The factors responsible for this condition at the rural institutions are:
  - Inappropriate location, poor access and poor maintenance;
  - Gaps in critical manpower;
  - Mismatch between personnel and equipment; and
  - Lack of essential drugs / diagnostics and poor referral linkages.
- The prevailing high maternal and prenatal morbidity and mortality is a source of concern. It is noteworthy that there has not been any substantial decline in these indices in the last two decades.
- In the nineties the reduction in IMR has been slow. Over the last two decades the peri-natal and neo-natal mortality rates have not declined. These are matters of concern.
- 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... Coverage Evaluation Survey (HFHS, UNICEF 1998) indicate that only about 50% of infants get immunized against 6 VPD in the first year. There is a substantial difference between coverage reported by service agencies and observed coverage evaluation surveys... 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...
- Diarrhoea remains one of the major causes of death among children. The Oral Rehydration Therapy (ORT) initiated in 1986-87 has resulted in reduction of mortality in some states. However, even today access to and utilisation of ORT is poor in many states.
- Pneumonia is a leading cause of death of infants and young children, accounting for about 30% of under-five deaths.

Source: Mid Term Review of Ninth Five-Year Plan, GOI, 2001

- Ramrati (name changed) 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 fever. Most children in the 0-3 age group suffered from regular bouts of diarrhoea and fever, one girl child had night blindness and another girl Marasmus. 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 water. The situation was similar in Andhra Pradesh. Even as the popularity of injections and allopathic medicines has gone up, the poor simultaneously seem to have lost faith in traditional medicines. While elderly women still know about home remedies, *this knowledge is slowly disappearing*. For

instance in Village 1 of UP, several children had scabies and other skin infections. The area is full of *Neem* trees. Yet, mothers elect to put ointments (if they can afford it) on unwashed and dirty sores rather than bathe the child in water boiled with *Neem*. The traditional practice of treating skin infections with a paste made of *Neem* leaves was not popular – at least amongst the poor. However, the better-off families in the village and in urban areas have not only rediscovered the importance of home remedies, but consciously opt for them in case of ailments like jaundice or chicken pox for which allopathic cure is perceived to be deficient.

- In Andhra Pradesh the overall health picture of the children observed does not appear encouraging. 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 with around 59% of children observed suffering from some ailment.
- It is clear from the study that children between 6 to 18 months receive very little extra food. *The problem is not only with the non-availability of food, but equally that, mothers have little time (as lighting the fire for cooking is a cumbersome process) or energy to prepare separate food for the babies.* Though some forward caste groups reported using traditional weaning foods, most SC and ST families did not cook anything special for children. They are constantly on the breast, cry a lot and are given a few pieces of *roti* (Indian bread) or some rice to nibble on. Frequent illness – even if only cold and cough – affects the ability of the child to access food on his or her own, feed and absorb the food. Rarely is cooking oil or fat used in most of these households, even for children.
- Non-availability of safe water, poor sanitation and unhygienic surroundings also lead to frequent bouts of diarrhoea or other communicable diseases. Even where water availability was not a ‘problem’, collection and storing practices left much to be desired. Further, we noticed, that neither children nor their mothers washed their hands before eating or even after handling mud/urine etc. For example, during the fieldwork period in Uttar Pradesh, children in 8 households were suffering from skin ailments, 12 with diarrhoea and 9 with fever bouts. A downward spiral of frequent infections, poor growth and poor nutrition leads not only to stunted growth but, in some cases, higher than average child mortality.



### Box 7: Glimpse of healthcare facilities in a Tribal village, Andhra Pradesh

The ANM in the tribal village has been working in the area for over 5 years. A tribal herself, she enjoys a good rapport with the villagers. The village community too respects her and appears happy that she is fairly regular in her visits. The ANM, however, seemed indifferent to the health problems in the village despite widespread scabies and respiratory problems. These could be a result of the fact that the village is overrun by *parthenium* (a wild shrub that is known to trigger allergies). The ANM seemed quite unaware of the situation. While the government doctor, to whose private practice almost all the tribal households go (paying an initial consultation fee of Rs.50), reported that there were 5 HIV+ cases in the village, the ANM herself did not seem aware.

This doctor was our best informant on the health situation not only in the tribal village but in the entire Mandal. He said that skin diseases were rampant in the area due to very bad hygienic conditions and the lack of sufficient protected drinking water. He was quite worried about the spread of HIV in the area saying that since this is migratory population there is danger of higher risk. He was especially concerned about the risk faced by women and newborn children. He was emphatic that a sustained health education programme is required in this area. He was critical of the way the food for work programme was being implemented. In the case of the tribal village better sanitation and waste management would be more beneficial than laying a pucca road. Efforts are misplaced and designed to line the pockets of the rich and powerful. Generally he felt the government was neglecting remote and tribal areas. The system as he kept repeating was corrupt and dysfunctional. Ironically he did not see that he himself was corrupting the system by engaging in up private practice, which is against the rule. We met him in his private clinic at a time when he should have been in the hospital.

Source: Andhra Pradesh Report

- Existing programmes have not been sufficiently focused on improving overall awareness levels, instruction on supplementary nutrition for pregnant and lactating mothers. The IEC component of ICDS or three generations of maternal and child health programmes (MCH/FP, CSSM, RCH) seem to have made little impact on the overall awareness of the surveyed community towards nutrition and hygiene/sanitation. ANMs concentrate on family welfare activities, and in AP and Karnataka on antenatal care and immunisation. Even in the case of immunisation the focus, as mentioned above, is on polio prevention, which in any case is being delivered as part of a mass campaign.
- Nevertheless, 4 out of 6 rural children and 2 out of the 3 urban children below 3 years in Uttar Pradesh (Muslim and Hindu families) have 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.

**Table 18: Status of children in surveyed households**

	<b>Uttar Pradesh</b>	<b>Karnataka</b>	<b>Andhra Pradesh</b>
<b>Children below 36 months</b>	<b>12</b>	<b>17</b>	<b>7</b>
Children enrolled in AWC	1	3	None
<b>Children 3 to 6 years</b>	<b>13</b>	<b>19</b>	<b>15</b>
Enrolled AWC	5	13	10
<b>Children 6 to 11 years</b>	<b>36</b>	<b>32</b>	<b>31</b>
Enrolled in school	30	24	30
Dropouts	2	6	1
Never enrolled	4	2	-
<b>Children in 11+ age group</b>	<b>24</b>	<b>14</b>	<b>5</b>
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	-

- 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. Children learn from each other – both the good and the not so good habits. Love *per se* is not an issue.
- The sheer drudgery of somehow eking out a livelihood often leaves little time for anything else. As a result, in most cases, mothers reflect a very short time horizon, trying to somehow tide over the crisis at hand. Long term planning for children was not common – barring in fairly exceptional cases. Nevertheless, the affection and care for the children was discernible during the visits. Also, the situation seemed easier for the child when the mother was at home, even if it was only for the day of the observation. Both her presence and that of older kin at home, was positive for younger children.

### Summing Up:

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. Children below the age of 3

years, in our sample, suffer from endemic malnutrition, are only partially immunised, and are often dirty and unkempt given the lack of sanitation and hygiene among the poor. They suffer from poor health; often chronically suffering from ailments like cold, diarrhoea, skin allergies etc. Local health services that cater to the needs of the child, her mother, and the larger community – be it the ANM, AWH, or the local doctor – are a shadow of what they are ostensibly supposed to be on paper. Despite the state of affairs, what the children do not lack is love, affection, and mental stimulation by the mother, siblings, and other family members. Despite the handicaps – lack of resources, ill health, inadequate nutrition, lack of sanitation and potable water – majority of the children are showing visible signs of development – crawling, responding to stimuli etc. without necessarily conforming to weight/height ratios. Yet, as we very well know that these very handicaps have a long-term effect and become more evident in children further ahead on the child development continuum.

#### **Box 8: Quality of care**

Quality of care is largely an avoided topic, perhaps because it is seen as a private activity, and one that is difficult to quantify. Perhaps it has also been avoided out of a proper concern that emphasising care can too easily become an exercise in ‘blaming the victim’ – or in this case the victim’s parents. But these cannot be excuses for avoiding an issue, which so largely determines whether a child is malnourished or not.

Although greater involvement by fathers – in all countries and cultures – is one of the most fundamental priorities for improving the care and upbringing of children, it is in practice the mothers who are the principal providers of care. And the first thing to be said is that however much a mother may love her children, it is impossible for her to provide high quality child care if she herself is poor and oppressed, illiterate and uninformed, anaemic and unhealthy, has five or six other children, lives in a slum or shanty, has neither clean water nor safe sanitation, and if she is without the necessary support either from health services, or from her society, or from the father of her children.

We are therefore talking as much about care of the mother as care by the mother.

Source: V Ramalingaswami, Jonsson and Rhode, UNICEF 1996

### **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. Preparation to acquire a wide range of skills is influenced by the extent and quality of nutrition a child has access to her/his interactive experiences. This is also

a period when the child comes into her own, 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.

### **Box 9: Why early childhood care and school readiness is important?**

Effective early childhood and school readiness programs become priority issues in this stage, as it is the pre-schooling stage. Recent brain research confirmed that early childhood experience could shape an individual's development. The difficulty of reversing negative outcomes later in life makes early intervention attractive/ The interval of 0–3 years offers a unique opportunity to change the life course of children at risk (*Young, 1997*). Impacts of the Early Childhood Care and Education (ECCE) programme include improved nutrition and health, high level of intelligence, high school enrolment, low repetition, fewer drop-outs and better rates of attendance (*Myers 1995*). Indirectly, ECCE programs are also expected to contribute to girl's enrolment and continuation in primary schools, freeing the older girls from this chore of looking after the young ones in order to be able to attend school (*Kaul, Ramachandran and Upadhayay 1993*).

The focus in (Early Childhood Care and Development) (ECCD) is generally in the first six years of life and the sixth year is the cut-off point. Research in the areas of ECCD has consistently shown that a very large percentage of children, who are now coming into primary school, are first-generation learners (*Muralidharan and Kaul, 1983*)

A significant cause of the high rates of dropouts in the primary grades is the lack of preparedness in children to meet the demands of the primary curriculum. Exposure to (ECCE) certainly facilitates retention in the primary grades, not only in the initial stages, but also tends to have a sustained and cumulative impact right through primary grades (*Kaul, Ramachandran and Upadhayay 1993*).

Findings of a study conducted in 5 states (Delhi, Haryana, Madhya Pradesh, Karnataka and Assam), on the numeracy and reading readiness levels of entrants to Class I revealed that high-quality preschool education facilitates both adjustment and achievement at the primary level. Deprived of this benefit, a large percentage of children would continue to be at risk for failure at the primary school level. It has also been found that children who speak a particular dialect or have a mother tongue other than the language used as medium of instruction have preformed poorly in numeracy and reading readiness (*Upadhayay 1995*).

Reading readiness, numeracy readiness and social readiness are directly influenced by preschool experiences of the child. In a study conducted in one rural and one urban region in Chennai, taking 193 children aged 4 years and using the TECERS tool (adapted, tested), it was found that there is a strong 'relationship between quality of ECD and level of learning competencies'. Active learning (perceptual and motor skills) is the key to develop children's learning competencies. The teacher's role in providing quality education to young children, linkages between programme quality, teacher characteristics and children's learning are all very significant determinants of providing quality school readiness (*Swaminathan 2000*)

Source: Page 29, Conceptual Framework, New Concept, 2003

Measurements taken in the course of the study (see Table 12 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. Given the above, children's profile on standard indicators like health, play, education and literacy is poor.

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.

The children observed have little to eat and that too few times a day. The ICDS programme was introduced as a result of recognition of the impact of larger economic and livelihood issues on nutritional status of poor children. It is therefore ironical that only a fixed and limited number of children can access these services. The location of the AWC and the caste of the AWW determine access. Several children profiled did not access ICDS even though they were from very poor families. 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<sup>7</sup>. 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*

**Table 19: Profile of ICDS / Pre-School Visited**

	Enrolment	Attendance on day of visit	AWW / AWH	Premises	Hours	Food supply	Pre-school Education
<b>Andhra Pradesh</b>							
Rural 1			1 AWH	Att to GPS	Not regular	Regular	
Rural 2 A	12 B, 14 G	8 to 10	1 AWW	Rented	Flexi	Regular	No evidence
Rural 2 B	20 Total	8 to 10	1 AWW	Att to GPS	9 to 12	Irregular	No evidence
Urban 1 A	25 Total	5 to 6	AWH / AWH	Rented	Flexi	Regular	No evidence
Urban 1 B	23 Total	None DOV	AWW	Rented	Flexi	Regular	No evidence
Urban 2	12 B, 19 G		AWW / AWH	In AWW House	Flexi	Irregular	No evidence
<b>Karnataka</b>							
Rural 1 A	60 Total	30 DOV	AWW / AWH	Own	10 to 1.00	Regular	Sometimes
Rural 1 B (Golla)	56 Total	28 DOV	AWW / AWH	Own	10 to 1.00	Regular	Sometimes
Rural 2 A	54 Total	42 DOV	AWW / AWH	Own	9.30 to 1.00	Regular	Regular
Rural 2 (SC)	64 Total	40 DOV	AWW / AWH	Own	10 to 1.00	Regular	Regular
Urban 1	64 Total	50 DOV	AWW / AWH	Own	10 to 1.00	Regular	Sometimes
Urban 2 (SJSRY)	50 Total	35 DOV	Teacher	Community hall	10 to 2.00	No food	Teaching
<b>Uttar Pradesh</b>							
Rural 1	40 Total	8 to 10	AWW / AWH	In AWW House	2 to 3 hours	Irregular	No evidence
Rural 2	40 Total	25 DOV	AWW only	In GPS	2 to 3 hours	Irregular	No evidence

DOV: Day of Visit

<sup>7</sup> Non-utilisation of Anganwadi service among children less than 3 years may be on account of perceptions that they are too young to be left alone, availability of services for only ½ a day making alternate childcare arrangements necessary for the remaining half day, discrimination against children from lower-castes, dissatisfaction with food served at AWC, unhealthy environment at the AWC and better facilities for elder children at AWC. Outreach to children can therefore be improved if mothers are convinced that their children are being well looked after and that the supplement is appropriate.

See (Ranjan Jayesh and Krishnamachari K. A. V. R. (1997) 'Community based strategy for improved health care delivery in the agency areas: Case study of ITDA Rampachodavaram. Presented at the Seminar on Perspectives and Strategies for Sustainable Tribal Development Beyond 2000AD organised by Dept. of Anthropology, Andhra University, Visakhapatnam, India, April 29-30, 1997.)

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. This in turn affected the functioning of the AWC. In some cases the AWCs are closed for weeks altogether due to non-availability of nutrition supplements. In addition there are other factors like the poor attendance of children of working parents belonging to the poorest section as a result of which these children cannot avail of these services to the fullest extent. *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)

**Table 20: Percentage of moderately and severely malnourished children:**

State	Normal Children			Moderately malnourished (Grade I & II combined)			Severely malnourished (Grade III & IV combined)		
	6-12 months	13-36 months	37-72 months	6-12 months	13-36 months	37-72 months	6-12 months	13-36 months	37-72 months
Uttar Pradesh	99.6	98.3	93.5	0.4	1.6	6.3	0.0	0.1	0.2
Karnataka	82.4	79.4	79.9	14.6	19.2	19.3	3.0	1.4	0.8
Andhra Pradesh	77.1	80.3	77.7	17.7	17.8	21.0	5.2	1.9	1.3
All States	92.3	80.7	91.9	6.4	7.7	15.7	1.3	3.6	1.4

Source: NCAER, ICDS Field Survey 1999

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. The customary bias against eating

‘*Bathua*’ rich in iron was noted; the only ‘vegetable’ children ate was potato. 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*’.

Table 20 needs to be read / interpreted with care. As Gupta et al point out: ‘The above results suggest that the states that performed well, such as the southern states have a higher number of moderate malnourishment cases in the age groups 37-71 months. This may be because of certain severely malnourished children moving up the ladder due to the ICDS programme and due to early and accurate identification of malnourishment among children in these states. *Another reason for this finding might be the inadequate measure to assess malnourishment among children – one of the commonly used measure in AWCs has been through height and weight of children, which is a crude measure of malnourishment because it does not reflect the anthropometric variations existing across the country*’ (Gupta et al, 2002).

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. *Nevertheless, it is crucial to either target the ICDS nutrition component on those who need it most, or better convert it into a universal programme like the mid-day meal scheme.*

The pre-school education component of the ICDS programme, although evident on paper (see Box 6) was non-existent in reality. While we did find play material in most AWC, *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.



### **Box 10: The Aanganwadi worker of the ICDS programme**

The Anganwadi Worker (AWW) is the fulcrum around whom the entire programme revolves. Originally conceived of as a part-time worker and social animator, the AWW today is more than just a nutrition-assistant. She is expected to promote good nutrition practices, monitor the growth of children and communicate the same to the mothers and the community, advocate for a preventive approach to child care by propagating timely immunisation, growth monitoring, supplementary feeding etc. She is expected to have some basic knowledge about common ailments and diseases so that she can advise the mothers and also alert the Lady Health Visitor (LHV), Auxiliary Nurse Midwife (ANM) and / or the Medical Officer (MO). She is the link between women and the health care system of the government. In addition to the above she is expected to distribute supplementary nutrition, vitamins, iron and folic acid tablets, keep a stock of some basic over-the-counter drugs for distribution and also motivate mothers to limit family size. As an animator she is expected to motivate children for enrolment in school and as a pre-school education worker she is expected to initiate some educational activities for children in the 3-6 years age group. The 'more visible aspect of her role is in making the Anganwadi – literally a courtyard play centre – nurturing and joyful with play activities attracting and sustaining the participation of children and families. She strengthens the capacity of caregivers – the mothers, family and the community – for childcare, by building upon local knowledge and practices. This creates a nurturing physical and social environment for the child, not only at the Anganwadi Centre but also in the family and the community.'

Source: DWCD Annual Report, GOI 1995-96

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 witnessed some of 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 so. Possibly, the link of the ICDS with primary school as an important input in ECCE needs re-examination. This is not to question the validity of pre-school education and its contribution to primary schooling. Existing research tells us that the difference in the percentage of retention between children with ECE experience and those with direct entry into schools is within the 8.4 per cent–20.5 per cent range (Kaul, Ramachandran and Upadhyay 1993 quoted in the WB concept note). Rather, we need to consider new ways in which the pre-school component can be strengthened and delivered in an effective manner. For instance, where the ICDS centre was located within the primary school, as noted in Karnataka, the situation was more encouraging.

### Box 11: Glimpse of ICDS centres in Uttar Pradesh

- ❖ The AWCs in the two villages were equipped with play materials and equipment like weighing scales, growth monitoring charts and other gadgets. The equipment and toys were dusty and unused. **In Village 1**, the centre runs in house of the AWW who is from a forward caste. The children sit in an anteroom, barely 6 x 8 feet wide. We saw only 8-10 present during fieldwork days (10 days), even though 40 were enrolled. These children were from the adjacent houses. The children enrolled were representative of the mixed community in the village, though the adolescent girls and lactating mothers registered were upper caste. This caste factor has another dimension in **Village 2**. In the 6 months to 3 year age group all the 40 children enrolled were from the SC community. Overall 67 children (including 0-3 years) were enrolled here. There were approximately 25-30 children present during fieldwork days.
- ❖ The AWWs informed us that, though they had been running the centres for over two years, they had not received any training! They participate in the monthly meetings at the Block-level in the third week of every month for which they are paid no TA. They said that they also had to make their own arrangements for transporting the *dalia* to the village and stocking it. The AWWs submit their reports to the Supervisor. They did not have any supervisory visits to help guide them during the course of running the centre.
- ❖ The community perceives of the AWC as a waiting hall for *dalia* (nutrition) distribution. During discussions in Village 1 it emerged that the centre opened erratically and that too only for an hour or two instead of the stipulated four hours.
- ❖ Pre-school activities are non-existent. The community is not aware of the pre-school component of AWCs.
- ❖ Similarly, the community is not aware of the other services like – growth monitoring of children, immunisation, health check-up and other health related services.

Source: Uttar Pradesh Report

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 except during the polio immunisation campaigns when they are temporarily activated in some areas. 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. Clearly, even these groups have not contributed significantly to improving awareness about basic maternal and child health issues, in particular nutrition.

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. They did not think it necessary to co-ordinate with either the schoolteacher or the ANM in order to make the services more effective.

In the study villages, it was disturbing that 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 AW helper (AWH)*. If both are from the forward caste, then children from Dalit families have little access. Parents in the sample households for instance 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. However, children from Muslim families were all enrolled in the AWC and their attendance was not markedly different from that of other children in Village 1 of Uttar Pradesh. Probably, unlike caste, religious identity was a less serious concern in our sample.

### Box 12: Glimpses of the ICDS programme in Karnataka

- ❖ The centre is open for about 3 hours, typically it starts off with 5 or 6 children and the number goes up to 25 or 35 by noon.
- ❖ AWW are regular, unless they live outside the village.
- ❖ The helper is invariably from the village/slum and the usual practice is for her to go around collecting the children.
- ❖ The main activity is feeding. In Urban 1, it is known as '*uppitu shale*' (nutrition school).
- ❖ The major nutrition supplement consists of what is called energy food (fortified *rava* i.e. flour); *uppitu*; sprouted green gram; *chitranna* (coloured rice); *payasam* (rice, dal, jaggery), etc. The quantity served is adequate and the taste not at all bad
- ❖ Cleanliness is poor; the food is kept uncovered and exposed to flies.
- ❖ Pre-school education does not seem to happen consistently.
  - In Urban 2, alphabets and numbers are taught in the usual routine way.
  - Village 2 was an exception. The AWW there was introducing the concept of height, weight and measurement along with interesting conversation. Children were responding well. The pre-school curriculum is interesting but elaborate – there is a manual incorporating activities and methodology too. If used well, it provides a good base. But there aren't enough teaching-learning materials. (TLM). Play materials too are inadequate. Generally speaking, even the available material is not used properly. The community, on its side, expects the children to acquire competencies related to literacy.
- ❖ The growth charts are kept in the AWC, but not used for nutrition education of mothers.
- ❖ Children are not given food according to their level of malnutrition – the parents object if some children get more food.
- ❖ There were several *Stree Shakthi* Groups (SHG) in our study area, in both Village 1 and Village 2. Both the AWWs have organized 3 to 4 SHGs, which meet every week. The AWWs have good communication with women of these groups and discuss immunisation, breast-feeding and family planning. Some families maintained immunisation cards.
- ❖ Yet, caste related conflicts were evident – some women in village 1 complained that the AWW was misusing the food items.
- ❖ AWWs have their own problems too, in village 2 the AWWs have not been paid a part of their honorarium.

Source: Karnataka Report

## Monitoring and supervision of Aanganwadi Centres

Monitoring is based on a perusal of documentation and reports maintained by the AWC. In Andhra Pradesh and Karnataka while the CDPO appears to be regular in her visit to the AWC, her monitoring seems to be confined to ensuring that the data has been properly filled in the appropriate documents. The quality of record keeping in the two states was quite exceptional; however, close observation of the functioning of the centre revealed a not so perfect picture. This is a grey area and there was little feedback from the community on this issue.

In Uttar Pradesh the AWC centre is supposed to be visited by the block supervisor at least once a month to guide and help the AWW to improve her work, check on her records and meet the

women who are pregnant and those who are nursing babies to provide on the spot advice. In the two villages studied in UP, the AWWs did not report of any visits of the supervisor to their centres, even though both of them were untrained. They went for monthly meetings, in the third week of every month, to the Block office to submit their reports and show their registers. This was also an opportunity to receive guidance and collect funds. The focus of monitoring was mainly on the distribution of supplementary nutrition rather than on the educational activities, health measurements and monitoring of children and information/guidance to women at the AWC.

In neither state did the Panchayat play any role in monitoring the ICDS programme.

### **Summing Up:**

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. These detrimental practices persist in the absence of effective monitoring strategies as well lack of positive synergy with other grassroots social delivery apparatuses – be it state-sponsored or NGO initiatives.

## Going to school: age group 6 to 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.

**Table 21: Profile of GPS visited**

	Enrolment		Cohort reaching from class 1 to 5 in 4 years	Teacher-pupil ratio	No of classrooms	Mid-day meal	
	Boys	Girls					
Uttar Pradesh							
Village 1 SC/OBC	129	115	28 out of 53 (53%)	1:122	2 + veranda	Dry Rations	
Village 2 SC/OBC	191	154	38 out of 109 (35%)	1:173	2 + veranda	Dry Rations	
Urban 1 All	85	150	11 out of 78 (14%)	1:78	5	Dry Rations	
Urban 2 All	41	41	4 out of 37 (11%)	1:41	1+1 veranda	Dry Rations	
Karnataka							
Village 1 GLPS	129	147	19 out of 23	1:42	3 (incl staff room)	Mid-day cooked	meal
Village 1 GHPS	51	42	22 out of 33	1:37	6 (incl staff room)	Mid-day cooked	meal
Village 2 GLPS	624	643	15 out of 21	1:42	4 (incl kitchen)	Mid-day cooked	meal
Village 2 GHPS	169	158	57 out of 77	1:41	16 (incl AWC)	Mid-day cooked	meal
Urban 1	109	83	29 out of 47	1:63	2 rooms	Mid-day cooked	meal
Urban 2 GLPS	123	79	28 out of 38	1:40	4 rooms	Mid-day cooked	meal
Urban 2 GLPS Urdu	39	91	Not available	Not available	Not available	Mid-day cooked	meal
Andhra Pradesh							
Village 1 Tribal GPS Till class IV	57	44	4 out of 17 23.5%	1:33	3 rooms (including AWC)	Mid-day	meal begins Jan 2003
Village 2	71	60	*	1:32	3 rooms and 2 veranda	-do-	
Urban 1 GHPS	86	80	*	1:21	1 large hall partitioned	-do-	
Urban 2 GHPS	121	156	31 out of 67 46%	1:30	1 large hall partitioned	-do-	

\* Do not have data for all 5 years. Registers not available and teachers did not have any information as many of them have been posted in the schools only during the past 3 years.

- 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 were 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, carried out 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, casual 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.

### **Box 13: The primary education scenario in Bellary**

- It is encouraging to see the school. This is DPEP territory. The schools are painted in bright colours of the national flag. There are teachers bustling around and children are all over the place. Schools appear alive and active. There is more evidence of DPEP – walls covered with posters, writing, drawings, teaching-learning materials hanging from thread strung across the ceiling.
- So many children seem to want to go to school. In Village 1 there is a school in the Golla area, there are enough children from the community to fill the school. In Village 2, which has a ‘model’ school with buildings sprawled around a large courtyard, there is also another school in the S C residential area. Though we expected this school to compare badly with the model school, this was not the case. The buildings are good, the grounds are adequate and, above all the atmosphere in the school was in no way any less energetic than that in the model school.
- But walk along the streets during school hours, in any of these areas. The number of children one sees wandering around is shocking – there appear to be as many children out of school as in school!
- *It is with these two contradictory impressions in one’s mind, that one starts exploring the school-education-community-teacher-children conundrum.* Parents, teachers, students all advance their own interpretation. Parents blame the teachers; teachers assail the community; children are caught in-between.
- The community is aware of the woeful state of their children’s education. They grumble: ‘Look at this girl! She has been going to school for 4 years. Ask her whether she can read a line properly; whether she can write any letters.’
- There is a policy for not detaining children in classes up to 5, this does not mean that children from Class 5 end up being able to read and write. This is what makes the community disillusioned with schooling and therefore, if not downright adamant, certainly reluctant and hesitant to persuade their children to go to school.
- The midday meal is a recent phenomenon. In 7 of the most backward districts of Karnataka, of which Bellary is one, a midday meal is being provided. It is cooked on or near the school premises and served hot. Usually it is rice and *sambar*, *uppitu* once a week. The quality is good and children eat with relish. The teachers, the SDMC members, and even the general public say that the attendance has undoubtedly increased.

Source: Karnataka Report



The same issue was reiterated as we explored the school and its significance in the lives 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 (See Table 22). *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.

**Table 22: Understanding what children do before and after school**

Culled out from discussions and activities with children in school

Boys			What children do?	Girls		
*Rarely			● Sometimes	◆ Always	▲ Almost	Never
UP	Kar	AP		UP	Kar	AP
			Before going to school			
*	●	▲	Sweeping, cleaning the house	◆	◆	◆
*	*	▲	Washing utensils and clothes	◆	◆	◆
*	*	*	Lighting the fire, cooking	◆	◆	◆
●	◆	●	Fetching Water	◆	◆	◆
◆	◆	●	Eating Breakfast	●	◆	●
◆	◆	●	Getting ready for school	◆	◆	◆
			In the school			
◆	◆		Locking and unlocking the classrooms	▲	▲	
◆	◆		Cleaning the rooms	●	◆	
◆			Spreading the mats and putting them away	●		
◆			Taking out tables/chairs, putting them back	▲		
◆	◆		Ringling the bell	●	*	
◆	●	●	Getting water for teachers	◆	●	●
			After School			
●	●	●	Going straight home	◆	◆	◆
●	●	●	Wandering leisurely while returning home	▲	▲	*
●	●	●	Collecting fodder/ fuel wood	◆	●	◆
●	●	◆	Domestic labour (urban slums)	●	●	●
		◆	Working in fields (rural) or shops in urban areas during vacation			◆
▲	▲	●	Collecting cow dung	◆	◆	◆
●	●	●	Fetching water	◆	◆	◆
●	◆	▲	Feeding the cattle	●	◆	◆
◆	◆	◆	Grazing cattle and goats	*	◆	◆
◆	◆	◆	Doing odd jobs in the fields	*	◆	◆
◆	◆	◆	Running errands	●	*	*
●	●	●	Studies/ Tuition	*	●	*
▲	*	▲	Cooking	◆	◆	◆
*	●	*	Sibling care	◆	◆	◆
			Making beds	◆		
*	*	▲	Washing utensils	◆	◆	◆
●	●	◆	Leisure time spent playing, watching TV (urban area)	*	*	*
*	*	●	Free time used for weaving baskets / Beedi rolling	◆	●	●

### 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, let us take the example of the 11 (out of 18) children attending the GPS from the 18 households in the urban sample. 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.’*

#### **Box 14: The difference a committed teacher can make**

The Headmaster has made all the difference to the functioning of the school in the urban periphery slum. He restored our faith in the possibility of a government school functioning well. He was posted to the school only about a year ago. All the teachers live in the town 6 kilometres away. The HM has planned how the teachers could coordinate their travel, share an auto and come to the school on time. Further sharing the auto means that none of the teachers has to spend too much. He has allowed some of the women teachers to leave 15 minutes earlier but ensures that no time is wasted between classes. The HM keeps a close watch, crosschecking with the children to see what is happening in the class.

We were witness to a somewhat funny situation. On one of our visits, a child came to the HM saying the teacher had asked him to bring paper. The HM handed over a few blank sheets of paper. About 15 minutes later the teacher came bustling in and quite annoyed that he had wanted the daily newspaper. The HM ticked him off saying that the classroom was not the place for reading the paper. He further remarked that many complaints were coming that the teacher was not teaching. The HM threatened to withhold his increments if this continued. The children in their interactions confirmed that the HM had on several occasions pulled up this particular teacher.

The community feels that the HM has a positive impact on the school. Teachers are regular, classes are held and therefore many more children are present in school. This is borne out by the fact that the average attendance in this school is about 70%. The HM is confident that this would improve considerably once they are able to demonstrate that children are indeed learning.

For a long time this school had functioned as a single teacher school. It has the distinction of being the oldest primary school in the town. The impact of a full complement of teachers for the past two years on children’s learning levels has still to be seen. He is quite aware that many children are well below par in terms of learning. The HM feels that this impact too would be visible within a year. He has now ensured that teachers give homework and we saw some of the teachers actually checking the homework notebooks.

The HM has also been active in mobilising funds for school improvement from the Rotary Club. He raised 15,000 rupees towards repairing the asbestos roof in the main classroom hall in the school.

The final testimony to his commitment to the school was from a mother who now plans to withdraw her daughter from a private school where she pays Rs.50 per month and put her in the government school as she says the Headmaster has restored her confidence in the school.

Source: Andhra Pradesh Report

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 most 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, Pratiche 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* (see Box 15).

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 guide books, 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.

### **Box 15: Profile of an unusual private primary school in UP**

At first appearance it looked more like a cowshed with three low thatched sheds. Running in a compound fenced by a neat hedge, was the village private school. Sitting under the low roofed sheds class 3 students were revising their General Knowledge lesson when the team visited the school. It was a pleasant surprise talking to them. When asked, 'What is the language spoken in Karnataka?' 'Kannada' came the pat reply! This school is not just located physically opposite the village GPS but is a welcome contrast in many other aspects as well.

While it had none of the trappings of a regular school, the children could read, write, count, solve sums, draw and even recite a poem to welcome the team. Set up by members of a OBC sub-caste community 5 years back, the school however, doesn't cater to any specific caste group. It is open to all children from the village as well as neighbouring villages. The land belongs to one of the eminent members of the community. 'I have given it for the betterment of the village. After all our children run it and our very own children study', he told the team.

The school, run by a registered society, received 'temporary recognition' in 2001 up to primary level. Starting with 60 children from the village and nearby villages, some from even Hardoi, across the Gomti –the school today has 133 students studying from Nursery to class 8. While the maximum children were from the OBC community, a sizeable number (15%) of the children in the primary section were from the minority community- the poorest in the village. Another 13 % were from the SC community. There were more boys (72%) than girls (28%). One of the households observed in the village had sent their three daughters to the village GPS while the son came to this school as they could afford the Rs 30 fees for one child at least.

It is run by the educated village youth, who take teaching the children from the village as a challenge, while waiting for better job opportunities. The four teachers have varied qualifications – one is Class X pass, 2 are class XII pass and one is doing his graduation privately. They have no magic wand, no teachers training, no teaching aids, no TLMs. Still they are confident of their teaching inputs and encouraged the team to quiz any of their students. They follow the basic textbooks available in the open market and employ multi-grade/multi-level teaching. But the human input is clearly visible and is helped by the 1:33 TPR. 'It is the personal touch that makes all the difference', said one of the teachers, who lives in the village. 'I know every one in the village. I went from house to house to get these children here. When a child doesn't come to school I go to their homes to find out. The fee is running in arrears to the tune of Rs 10,000. But we know that they will pay up whenever they can. How can we throw the children out of school? They are our own children.' The teachers divide whatever fee money is received every month, ranging between Rs. 300 to 500 per month.

In the eyes of the community private schools are synonymous with 'quality education'. The value they place on these private schools was evident. It was repeatedly articulated that only the poorest study in the GPS. They move to private schools as soon as they are able to afford. '**Children there can read fr..fr..**' as one parent put it. This phenomenon is more pronounced in the urban areas. The urban private schools offer better physical amenities: classrooms, toilets, drinking water from taps, benches, tables and electricity. The children wore uniforms, paid school fees ranging from Rs

25-40 a month and bought books ranging from Rs 60-80 a set, along with notebooks and pencils. Student attendance was regular and achievement levels were visibly satisfactory.

Source: Field notes, Uttar Pradesh, 2002

### What about 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 either 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. They said that most of the parents enrolled their children just to obtain scholarships and dry rations. The scholarship money was utilised by the family to meet household needs, indicative of the dire economic conditions of the community. On the other hand 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 (before our fieldwork).

Corresponding 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 none of the 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 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!

### Box 16: Inside the classroom: Attitudes and practices

**Uttar Pradesh:** Caste discrimination was discernable in the attitude of teachers during interviews. The six FC teachers out of nine showed a definite upper caste bias in their expressions saying that as children from ‘*Good families*’ (i.e. upper castes) are not coming to GPS the standards had gone down, especially in urban GPS. The community on the other hand felt that FC teachers discriminate against children from lower castes (including poor Muslims) and misbehaved with the parents when they tried to monitor their child’s performance in school.

**Karnataka:** Humiliation of children who come late: ‘Oh you went to graze the sheep and collect fodder?’ Sarcastic remarks when a child asks for help: ‘So, you are going to become the D.M. (district magistrate), is it?’ – knowing well that the child comes from a very poor family with little means. Or the observations of a girl who was often scolded for being a ‘pure breed *daddi* (idiot)’: I can’t do anything properly at school and if what I do at home is stupid, then I am a useless person. Some of the children stop coming to school because of this, afraid of what the teacher will say.

**Andhra Pradesh:** The headmistress of the urban centre slum school (who has an M Phil degree in Telugu literature from the Hyderabad Central University) felt that she was being punished for ‘*papam*’ (sin) she had done in her previous life and hence had been posted to this slum. For the Headmaster who is never there in the tribal village, parents are not interested. They never come to the school. They are ‘vulgar, rough and tough and so dirty. They have no manners. Look at their crude language. How can we expect anything from their children!’

Source: State reports – Uttar Pradesh, Karnataka and Andhra Pradesh

### 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 (See Box 16).

### Ambiguity about the value of education:

Ambiguity about the value of education was reflected in almost all interactions. At one level people agree that education is important, that it is valuable in itself and enhances self-worth and dignity. Yet, when they see young men / boys who have dropped out midway, those whose lives have not changed despite formal education, they are perplexed whether education is really a stepping stone to a brighter future – meaningful employment, improved status etc. They see that education does improve self-worth and dignity, yet point out that many children who attended school for four to five years are not able to read or write fluently. They are torn by this contradiction. This ambiguity is reflected at all levels and in almost all discussions with families, adults, children etc. One manifestation of this ambiguity is the decision to send some children to school while holding back others at home, all within the same family.

### Summing Up:

As children in our research sample reach school-going age, the one thing they are assured of (despite poor nutrition, health, and sanitation) is that their name is going to be recorded in a school register as proof of formal enrolment. However, what is not assured is whether most children will be able to attend school uninterrupted – not merely because of ill health but also because they may need to work and the existing school does not motivate them or their parents to attend/send them to school. Attendance is erratic and chronic absenteeism often the norm – especially for older boys and girls. In other instances, both boys and girls also work before and after school, engaging in a wide range of chores – grazing, collection of fodder and fuel, domestic work, sibling care, and filling water. Our research indicates that this pattern of (non) attendance as well as physical energy expended on work does impact on the learning outcomes; however, it is unable to conclusively demonstrate the link. In the absence of monitoring systems that can and should hold teachers accountable for learning outcomes and the pervasiveness of caste and gender-based discrimination practices in school, the picture remains



fuzzy. Learning outcomes are integral to the validity of completion of primary schooling as a proxy indicator of holistic child development. Further, the ‘free’ aspect of primary schooling too requires constant interrogation as indirect costs continue to expand – be it in nature of voluntary contributions, purchasing guidebooks etc. Despite evidence of universal primary enrolment, a holistic approach to child development constantly needs to tackle the cumulative nature of social, political, and economic exclusion that frames the lives of poor children. One should not, thus, be surprised by the ambivalence expressed towards the value of education in poor households.

## Health and nutrition:

The irony is that a similar engagement (including ambiguity) is missing when discussing health and nutrition. There is a sense of resignation – not only in families but also among health (ANM) and nutrition (AWW) service providers. The medical expert associated with the study, Dr. Ranga Rao, explained that 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 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 is a direct impediment to his/her **enrolment** 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.

### Box 17: Synergy between health, nutrition and education

Recent surveys of research constitute strong evidence that the synergy among health, nutrition and education becomes important not only from the overall development perspective but also from the point of view of success in schooling (*Levinger 1992, Myers 1992, Pollitt 1990, Kaul 2000*). This synergy positively or negatively contributes to the development of the child at each stage, i.e., from year 0 (conception) to 11. It is commonly recognized that a good foundation, from the early years, is critical for the development of the child’s active learning capacity. The capacities for processing, structuring and classifying information, the ability to ask and answer appropriate questions, short-term memory and the levels of alertness, attention and concentration are all influenced by what happens to the child at each stage between 0–11 years and what s/he experiences from the point of view of health, nutrition, psychosocial support, etc. Better health and nutrition are positively associated with gains in schooling in many areas—enrolment at younger ages, lesser grade repetition, lesser absenteeism, higher-grade completion and better test scores. Most of these studies are based on socio-economic survey data that provides information

on the associations between health and nutrition on the one hand and education on the other (*Behrman 1996*). The research emphasizes the need for child development to be approached in an integrated manner.

Source: Conceptual Framework, New Concept, 2003

What still remains fuzzy is the less than tangible link between endemic poverty, malnutrition, and educational attainment/achievements. As reported in the preceding sections on the different stages of child development, children definitely do not receive adequate nutrition. Even if families have heard about balanced diet, safe water storing practices and importance of eating vegetables, they have not paid much heed to them. ICDS has had a demonstrable impact on the incidence of severe malnutrition in children, although moderate levels of malnutrition and morbidity continue to severely constrain better life chances for more than half of the child population.

We, researchers (as lay persons), observed children who were active and playful despite looking thin and malnourished. According to Dr. Ranga Rao (an public health expert associated with this study) children often use and exhaust the available energy for physical activity and this is often at the cost of growth and development of mental functions and faculties. The WB in a review of literature on the issue, further elaborates that: ‘For example, 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). Malnutrition, even in its milder form, can dull motivation and curiosity, reduce child’s exploratory play and interaction with caregivers and the environment, thus restricting the child’s psychosocial development. Conversely, there is evidence to suggest that children who receive psycho-social stimulation along with nutritional supplementation tend to benefit more in terms of gain in nutritional status as compared to those who receive nutritional intervention alone (Martorell, 1997)’ (Conceptual Framework, New Concept, 2003).

Further, inadequate nutrition manifested in short-term hunger syndrome, impacts on a child’s ability to learn and retain new concepts. Hence, common complaints by teachers that children lack the ability to concentrate, exhibit listlessness in the classrooms 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.

Further, our conversations with parents, especially mothers, revealed that what we may consider ill and malnourished seemed to be 'normal' in their perceptions. Subjective perceptions apart, it is quite likely that these women see only such children in their vicinity and hence conclude that such looks are 'normal'. Dr. Ranga Rao further elaborates and qualifies that, 'other common factors like poverty, illiteracy, and ignorance of parents, not only directly influence these levels in education, but also a child's health. Hence it would be difficult to quantify the influence of the isolated and individual health factors on successful completion of primary education'.

## Community involvement and participation:

The DPEP programme is a major votary of Village Education Committees (VECs), School Development and Management Committees, Parent Teacher Associations (PTA) and Mother Teacher Associations (MTA). However, we did not come across effective groups in the surveyed villages. In fact their absence was most marked in the urban areas, with the exception of Karnataka where an urban School Development and Monitoring Committee (SDMC) was playing an important role in the school. Community participation is one of the more misused and misunderstood words in the development literature. 'Community' by itself means very little – it is like saying 'India' or 'Uttar Pradesh'. Therefore, at the outset, it is important to define community participation in the specific context of primary education – referring to those parents whose children are enrolled in government schools or those who are participating from the margins.

In the specific context of government schools community participation should ideally involve people who have little or no access to basic education but have a greater stake in the school. This is easier said than done because these are the very people who are the most difficult to reach out to. The poorest are caught up in the daily battle for survival. From their perspective, education that does not lead to any tangible or intangible gain can be dismissed as being irrelevant. They do not readily participate in local societal forums and bodies – whether the Panchayat or the Village Education Committee or the Village Women's Health Committee. Even when made mandatory

members, they rarely speak out, even if they attend. Being at the bottom of the social ladder, their interaction with the rest of society is from a position of relative powerlessness. The most beleaguered position is that of women in poor communities who shoulder the burden of gender-based discrimination and face the added pressure of sexual abuse and oppression.

### Box 18: Tale of three VEC/SDMC

**Karnataka:** We came across an active SDMC in an urban area. This was in Urban 2. Members met regularly; others, besides the members, interested in the proceedings also attend meetings. We met with them in the school. There was energetic interaction between teachers and parents. There were some 20 to 25 women and one man present, all of them knew what happened in the previous meeting and what they planned to discuss today. What is their role? To support the school, help resolve problems, they said. Since the school doesn't have much space, they found another place nearby for cooking the midday meal. They managed to get two additional teachers for the school. They were able to remove the liquor shop from the vicinity of the school. They also monitor the teacher. The potential for the SDMC as an effective body was demonstrated. Good relationship between teachers and parents is indeed important. They feel empowered. Parents are usually illiterate and come from an uneducated background. What can they do for the school'', we asked them. 'Look, we are here,' they said, 'We are able to participate. It is we parents who care for our children. We have a direct stake in their education.' What if the SDMC is wound up? They strongly asserted that such a body was necessary: 'There is somebody who can 'ask' (question) the teachers. And teachers are not left to themselves.' The teachers became a bit defensive at this unwittingly forthright statement; they said they would do their duty even if there were no one to watch over them!

**Uttar Pradesh:** In village 1 the Village Education Committee (VEC) was 'technically' present. But the members had been handpicked and were not clear about their roles and responsibilities. They had neither a formal meeting nor any training. The Pradhan usually got their signatures individually whenever he required. In Village 2, while the Pradhan had taken the initiative to constitute the VEC but members were not clear about its role / functions.. Here he had not done anything about the garbage dump at the entrance of the school and the illegal occupation of the campus for a temple. The Pradhans as VEC chairpersons was basically involved in the construction activities of the schools and not the maintenance aspect. The urban schools did not have a PTA or any other committee.

**Andhra Pradesh:** The role of School Education Committees (SEC) seems to be limited. In the tribal village the committee consists of members whose children do not go to the school. This is in total violation of the School Committee rules. The community and the teachers feel helpless in this situation as all the members are related to the tribal leader. Consequently, here, the committee has not used the school improvement grant to get even blackboards! In the mixed village, the committee meets and includes a *Sangham* member. They have focused on infrastructure improvement and enrolment drives. In the urban areas the gap between the SECs and the school is wide. We could not meet the members in the urban periphery, which, as far as the headmaster was concerned reflected the indifference of the community towards the government school. He complained that the SEC did not support him in any way. In the urban centre slum it is an all woman SEC and they did not see any role for themselves in the running of the school. This was the peg on which the Headmistress hung the issues of poor functioning of the school. What was surprising was that the urban SECs seemed totally dysfunctional compared to the SEC in the

mixed village pointing to the need for more concerted work with the SECs to enable them to be more proactive.

Source: State Reports

Given the social and economic status, prevailing gender inequality, and that the overwhelming proportion of the poor are illiterate, mechanisms and processes instituted for community participation need to be appropriate. Systems that succeed in Karnataka or even Andhra Pradesh are not likely to be as effective in Uttar Pradesh. Similarly, mobilisation and training inputs for the poorest of the poor are likely to be more human resource intensive than for families with higher educational status. Equally, some areas have a history of popular participation in social reform movements or struggles, while others do not. Therefore, universal approaches are not likely to be as effective as those tailored for the specific needs / circumstances of a given area, community or school<sup>8</sup>.

We found little evidence of linkages between the ICDS centre, primary school and Panchayati Raj Institutions. Extant power relations rarely facilitate the involvement of the poor in village level committees. Effective women's groups, be it self-help groups or *Mahila Samooh*, need to be nurtured and supported. The presence and impact of the Mahila Samakhya programme in the villages surveyed was very uneven. While it was more visible and effective in Nizamabad in Andhra Pradesh, its impact on women's participation seemed more limited in Sitapur in Uttar Pradesh and Bellary in Karnataka. In Bellary, however, the children's committees formed by CWC had a greater impact in the villages surveyed.

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<sup>8</sup> The limitations of the School Education Committees to shoulder the burden of school improvement are evident in other areas as well. In a study done in Warangal district we found that the SEC see its role in infrastructure improvement and resource mobilisation. The focus of the SEC training had been on these issues. The linkages between the SEC, parents, the community, and the Panchayat are weak and there is no role that the SEC sees for itself in ensuring regularity and retention of children. See Jandhyala (2002) in Ramachandran 2002 (ed) *Hierarchies of Access*.

## SECTION THREE: EMERGING ISSUES

This study explores the situation of children in diverse poverty situations. 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. A consequence of this sampling characteristic is the minimal variation in income, education, literacy, occupation and caste, unlike what can be expected in a representative sample. 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. An unambiguous message from this study is that even the poorest of poor families acknowledge the importance of education in the lives of their children. All parents want their children to have a better life and are ready to make big and small sacrifices to ensure it. There are, however, differences in aspirations as dreams are often circumscribed by life situations. Given their daily struggle for survival, the poor often find themselves held hostage to time – especially when it comes to making plans either for themselves or their children. Education often emerges as a main casualty of this trade-off. 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 is clearly able to illustrate and explore 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 more significant in the early years as opposed to cognitive development in the later years, although one cannot treat them as being mutually exclusive. The family, community, state, service delivery mechanisms, and the presence of NGOs all play important mediating roles

and further fragment the experience at the grassroots. 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. Often 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 for a host of reasons. It is also unable to proactively harness the family and community in meeting its objectives of reaching the child and creating a supportive environment for its development.

### **Box 19: The development continuum**

Learning and development are essentially cumulative phenomena whereby what precedes influences the quality of what follows (*Kaul 1997*). Therefore, in effect, each substage becomes a readiness for the next, thus determining the potential for ensuring expected outcomes. Children's development is also multi-determined and varies as a function of the child's nutritional and bio-medical status, genetic inheritance and sociocultural context. One must look at it as a process integrating all critical variables—health, nutrition, education, social, emotional, and spiritual. Evidence from fields of nutrition, health, sociology, psychology and education continues to accumulate, indicating that the quality of life in the early years is crucial in the formation of intelligence, personality and social behaviour. The physical, social and psychological capacities that children are born with allow them to communicate, learn and develop. If these capacities are not recognized and nurtured, they will wither rather than flourish (*Evans, Myers and Ilfeld 2000*). Studies show that under-nutrition, specifically during pregnancy and early childhood, can have profound effects on cognition and developmental behaviour later in the continuum (*Vazir and Seth 1992*). Studies also reflect that most early failure in growth is irreversible (*Martorell, Khan and Schroeder 1994*). The quality of child care and parent-child interaction become significant factors as well. (*Kaul, Ramachandran and Upadhyay, 1993*).

What becomes even more critical is the importance of the *continuity of experiences* for children. The transition from each stage of development in the continuum to the next has to be smooth and successful (*Evans, Myers and Ilfeld 2000*). It is ideal that the child crosses each substage of development successfully in all aspects. In the event that s/he fails in one or more aspects of development as expected in terms of developmental milestones, health and nutritional outcomes, or learning capacities, the child carries this burden to the next stage, where this failure may lead to more failures or others may get added on.

Applied to the Indian context, this translates into a high-risk situation for children with high under-5 mortality rates, low female literacy rates, early marriage, food security issues, malnutrition and lack of adequate health services. In such an environment, the very survival of the child, even before its birth, is in question.

Source: Conceptual Framework, New Concept 2003

## Relevance of regional and rural-urban variations

While deciding the sample for this study, given our focus on the poor, we had consciously decided to not only capture the inter-state variations, but also to include rural and urban differences as well as Tribal and Muslim families in the sample. To this end, our research was carried out three states with very different development trajectories, in districts that were ranked similarly in relation to human development indicators, in rural and urban areas of the district, and finally, we profiled one tribal village in Andhra Pradesh and selected one village and one urban slum with significant Muslim population. There is no doubt that relatively better functioning of healthcare, immunisation, child nutrition and primary schooling programmes in the two southern states has made a difference in comparison to UP. However, despite the differences with respect to availability of resources and provision of social services between states/regions, the also indicates that at the micro-level there is little variation in the access to and utilisation of services by the poor households. Poverty continues to exert a strong influence on nutrition of children, on health seeking behaviour of households and most importantly on overall living standards. Physical and environmental hygiene is also affected, increasing susceptibility of the very young to preventable diseases. Incidence of indebtedness is high among the poor and unexpected health emergencies are often identified as a significant cause for incurring debt leading to further immiseration of the households.

## Poverty and educational opportunities:

The level of poverty significantly impacting on food and nutrition security is closely related to availability of work. 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). Non-availability of food is not a function of landlessness alone, availability of wage labour in agriculture or non-farm work affects access to cash for food. The notion of scarcity is also subjective and differs across economic groups. During ‘normal’ times, most poor (below poverty line families) eat less nutritious food than households above the



poverty line. The households surveyed in the study ate little *dal* or vegetables and ate meat / fish very infrequently. Discussions on intra-household food distribution also revealed that adult men get precedence followed by boys, girls and finally women. As discussed in section two above, girls said that they invariably get the gravy while their fathers and then brothers get the meat pieces.

The economic situation of the households affects children in several other ways. A large number of children from poor households work long hours. If enrolled, they either work before and after school or skip school resulting in irregular attendance. Our study, along with others (see table below) reveals that apart from household work and supporting the family on the farm, non-farm or home based work, placing young boys in short-term bondage to tide over extreme economic crisis is not uncommon. Collection of fuel wood, minor forest produce and other such chores are most often the responsibility of older children (most of them 8+). Taking care of other people's cattle is mostly left to young children. Understanding the world of poor children is extremely crucial, in particular the heavy burden of work of older girls in poor households. This is particularly important when mothers are burdened with household work and a range of farm and non-farm work in rural areas and work in the informal sector in urban areas. Children of domestic workers, especially girls, are overworked, even when they are attending school regularly.

**Table 23: Engagement of children in economic activities and mean hours of work**

Kind of work	% Of total (BPL) children engaged in work			Mean hours of work	
	Boys	Girls	Total	Boys	Girls
Wage work	20.2	5.9	13.2	8.58	7.84
Own work	8.5	14.2	11.1	5.80	6.14
Cattle grazing	12.3	8.6	10.6	7.64	7.56
Household chores/sibling care	6.1	47.8	25.5	5.1	5.8

Source: Jha and Jhingran, 2002 (Page 40)

Seasonal migration or short-term movement to construction sites and richer agricultural areas also indirectly effects schooling as it has a significant impact on the frequency and quality of food children eat. Children reported that mothers cook only twice a day and they either eat the previous night's leftovers or go hungry in the morning hours when their mother has to report for work. As we have stated earlier, the link between nutrition, school performance, and learning outcomes is definitely an area that needs to be explored further and in greater detail.

Overall, there are other both tangible and intangible effects of poverty on the lives of children.

- On 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.
- On the ability of a child to be regular in school and / or continue and complete primary education. Seasonal migration / work during peak seasons / sibling care / survival chores, all have a bearing on this.
- Intensity of poverty (acute poverty) influences parental choice of how many children go to school and up to what level (beyond primary). The same household may send a few to school and retain some at home. (It is here that alternatives for communities to enable such children to catch up and continue school become important.)
- The recognition of the value of education by poor families and decision to remove children from full time work and send them to school has not in any significant way reduced the work burden of children. Children continue to work before and after school and during peak seasons. A new pattern is also emerging - more children report that they work during holidays and weekends. This situation is more acute in urban areas where many children work as domestic labour. We may need to re-examine the issue of child work from a different perspective, one that recognises the reality on the ground. In particular, the impact this kind of work has on learning outcomes needs to be explored. We cannot afford to take an uncomplicated position of work or schooling since the situation on the ground is far more complex and makes it critical to distinguish between child labour and child work.
- Girl children, especially those who are higher in birth order seem to be the biggest losers. They are burdened with the drudgery of household chores and often lose out on completion of primary schooling.

## Intermeshing poverty and social status

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 (see Table 24).

**Table 24: Patterns of enrolment and attendance: Socio Economic Groups<sup>9</sup>**

Social group	APL		UPBL		UBPL		Total	
	% Enrolled	% Regularly attending	% Enrolled	% Regularly attending	% Enrolled	% Regularly attending	% Enrolled	% Regularly attending
UCH	94.7	86.0	77.9	92.3	66.7	100.0	83.2	90.75
OBC	87.2	68.3	66.1	64.2	63.6	60.0	70.5	64.52
SC	91.5	80.0	72.3	65.8	54.4	48.1	67.3	61.86
ST	82.5	89.1	61.8	70.7	48.6	62.5	59.8	71.30
Muslim	49.1	40.0	55.7	28.7	46.2	27.0	50.8	30.23
Total	80.9	75.6	66.3	-	52.6	53.6	64.5	42.00

Source: Jha and Jhingran, 2002 (Page 57)

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)

However, inter-group dynamics between the already marginalized groups reveal no clear indication that caste and community identity is paramount in circumscribing the life chances of

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<sup>9</sup> APL: Above Poverty Line, UBPL: Upper Below Poverty Line, LBPL: Lower below Poverty Line; UCH: Upper Caste Hindu, OBC: Other Backward Castes, SC: Scheduled Caste, ST: Scheduled Tribe

tribal children or Muslim children per se. While issues of access of the tribal hamlet was influenced by remoteness we did not come across any significant factor that set Muslim families apart from the rest of the poor households. The economic status of Muslims, who were landless, was not significantly different from the non-Muslim poor households. It is also important to note that there was also not much difference in immunisation and health status of children, school enrolment and regularity of attendance.

However, attention needs to be paid to the overall importance of education in the region and its role in determining the larger social educational norms of a community. For example in rural Karnataka and Andhra Pradesh, the norm is to send children to school and families that do not conform to this social norm feel uncomfortable. Although this attitude is yet to be firmly entrenched in Uttar Pradesh, our study reveals that this is clearly emerging in urban areas. (See Box 15).

#### **Box 20: Recognizing change: community and education in UP**

Small school bags hang neatly in a row on a kutch wall. This is not a classroom but the one-room house of a Muslim family in an urban slum in Sitapur district. The primary earner, father, is a rickshaw puller who obviously believes in the value of education and ensures that all his six children (2 boys and 4 girls) go to school – a local private school.

This is not an isolated instance. Contrary to stereotypical assertions regarding the lack of demand for education in the Muslim community, our survey of Muslim households in UP revealed that this is not the case and children were actively participating in mainstream education. 3 Muslim households (2 rural & 1 urban) observed had a total of 14 children – 7 boys and 7 girls. Of these 2 boys and 1 girl had completed primary education and were not studying further. 6 children (2 boys & 4 girls) were attending the GPS and 1 boy was in a private school. 2 girls were enrolled in the AWC.

In the UP sample of 18 households, there were only 2 girls who had completed primary schooling. One of them is the eldest daughter of a Muslim household in village 1. She is unable to continue with her studies, since her disabled father does not have the resources to send her to the upper primary school that is located outside her own village. In the Muslim households surveyed, 57% of the fathers had some education – either religious or formal in nature, and 46% had studied up to Class V or more. 21% of the mothers surveyed were educated either in formal schools, at home, or in a madarsa.

Source: Uttar Pradesh Report

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.

**Table 25: Snakes and ladders**  
**Factors that facilitate (ladders) / impede (snakes) successful primary school completion**

<b>LADDERS</b>	<b>Mild</b>	<b>Strong</b>	<b>Very strong</b>	<b>Exceptionally strong</b>
A bright and welcoming school				++++
School within reachable distance (boys)		++		
School within reachable distance (girls)			+++	
Having teachers who are affectionate, kind and empathetic				++++
A mother who values education for the child				++++
Good relationship between mother and father		++		
Having an adult in the family who values education			+++	
A mother who is concerned about welfare of the child			+++	
Strict monitoring by parents / family members			+++	
Being a boy		++		
Having other adults in the family who can care for siblings and supervise the home				++++
Having fewer siblings, but not being the eldest			+++	
Being in good health		++		
Being the youngest child			+++	
Role models / success stories where education has resulted tangible benefits in terms of social status and / or livelihood / upward mobility (girls).				++++
Role models / success stories where education has resulted tangible benefits in terms of social status and / or livelihood / upward mobility (boys).			+++	
<b>SNAKES</b>	<b>Mild</b>	<b>Strong</b>	<b>Very strong</b>	<b>Exceptionally strong</b>
<b>GIRLS AND BOYS</b>				
Having a parent with disability		++		
Having a mother who goes to work for long hours			+++	
Large family and many siblings to care for			+++	
Birth order – being eldest				++++
Having an uncaring mother			+++	
Having an uncaring father	+			
Alcoholism in the family (father / mother)			+++	
Domestic violence		++		
A school that is too close (frequently run home)	+			
Being in a lower caste / disadvantaged community		++		
Being sick or disabled			+++	
Taking care of cattle / other livestock		++		

Death, disability and illness in the family			+++	
Work during peak agricultural cycles (regularity)			+++	
Where education <u>has not</u> led to tangible benefits in terms of social status/livelihood / upward mobility of local youth (negative role models).			+++	
Drought / other disasters			+++	
Hunger (Every morning)		++		
Hunger (Persisting)			+++	
Teachers get children to do personal chores		++		
Teacher beat children and other harsh punishment		++		
<b>GIRLS</b>				
Being a girl		++		
Being the oldest child				++++
Sibling with disability				++++
School that is far away		++		
Burden of work (at home / outside)			+++	
Social practices: early marriage			+++	
Social practices: dowry (more education leads to greater demand for dowry)		++		
Teacher addiction (safety of girls threatened)				++++
<b>BOYS</b>				
Having no sisters		++		
Sibling with disability	+			
School that is far away	+			
Burden of work (at home / outside)			+++	
Indebtedness leading to short-term bondage				++++
Gambling in the neighbourhood				++++
Teacher addiction: boys susceptible to bad habits			+++	
	<b>Mild</b>	<b>Strong</b>	<b>Very strong</b>	<b>Exceptionally strong</b>

A considerable amount of work has been done in India on the impact of gender relations on educational access. The important issue, however, is the ability of the delivery system – healthcare, child development and education – to recognise gender as an important variable and gear the service delivery system to address it in a systematic manner. A disturbing finding is that despite several years of advocacy by social activists, researchers and the international development community, the criteria used for monitoring impact are yet to be disaggregated by social group/gender, greatly diminishing our ability to provide a textured analysis. The table, through the metaphorical lens of the children's board game of snakes and ladders, explores the specific attitudinal and social circumstances and their gendered implications in promoting or impeding primary school completion. Birth order, gender, and poverty seem to emerge as the determining variables and have qualitatively different implications for boys and girls; and

contrary to current received wisdom, having a school in close proximity seems to exercise the least pressure in influencing educational outcomes.

### **Box 21: A ray of hope in an otherwise hopeless situation**

Not far from Sitapur, actually adjoining it, in Barabanki district 40 km from Lucknow, we had the occasion to randomly visit a GPS in Baddupur village. The school caters mostly to 257 disadvantaged SC children located in a catchment of about eight villages within a three KM radius. The school was established about 11 years ago, under DPEP in this most backward block. This school tough competition from 15 private schools in same village that serve the better off Kurmi (OBC) farmers' children.

The headmaster, the assistant teacher and the lady para teacher run an active school where learning was taking place in a disciplined environment, without traces of corporal punishment. The children had arranged their slippers neatly in a row and were seated in their respective classrooms in mixed groups – classes I and II together, III and IV together and V separately on the veranda.

The rooms had visible TLMs and could do with more. The head teacher regretted that they had not received the teacher grant this year even though they were actually using it. Even the school improvement grant had not been released. However, these were no deterrents to activity-based learning taking place in the classrooms and outside. The blackboard in the classrooms was creatively used by children, for writing and doodling, while the copies had been neatly piled on the teachers' tables for corrections.

The teachers were aware and empathetic to the children with disabilities and those from poor families who had to work with their parents. The head teacher said he was lax with those who had to work in the fields during harvest time by permitting them to come late and go early, provided they did their written work. When the dry ration (wheat) was deposited in the school, by the PDS distributor, it was distributed by the children in the presence of their parents. Parents of 75% of the children visited the school to ask about the performance of their wards as the school was close to the market. In fact, parent teacher meetings were organised every other month, especially on market day when they could make it. Though the school had a formally constituted VEC of five members, they rendered far more support on an informal basis for school activities and needs. The Pradhan of the village visited the school almost on a daily basis. Here the school has no other formal or informal community groups to either monitor or support it.

The head teacher reported that academic supervision/support was rendered by the Cluster Resource Coordinator on a fortnightly basis. This was evident from learning achievements, which were clearly visible in interactions with children and random testing and questioning. So we can say that good teachers do make good schools – in the government school system. The community (parents), school and the VEC are not isolated entities. They can actually be the pillars of a child's development continuum if well co-ordinated efforts are made.

Source: Uttar Pradesh Report

## Social attitudes and practices:

Observers have repeatedly pointed out that there is a gap in the community and what are considered objective perceptions of health / nutrition and well-being (put forth by experts / policy makers / service providers). The latter seems unable to look at issue of nutrition and child development from the viewpoint of the mothers and the community. Our field experiences reveal that appropriate nutrition for the community is framed in the alternative discourse of cold and hot food, energy giving and ‘strong’ foods as opposed to mainstream understanding in terms of vitamins, micronutrients, iron etc. *The indigenous concepts for well-being also differ and this may (see table below) possibly explain the persistent gap in communication between the experts / system and the community.*

**Table 26: Exploring alternative perspectives**

EXPERTS / POLICY MAKERS	PARENTS AND COMMUNITY
From conception to birth	
<ul style="list-style-type: none"> <li>- Healthy mother essential for healthy child.</li> <li>- Pregnant women should eat well and gain weight.</li> <li>- Keep count of month of pregnancy.</li> <li>- Antenatal care important, at least three or four check-ups, measure blood pressure, check for anaemia and / other danger signs.</li> <li>- Anti tetanus injection and IFA tablets.</li> </ul>	<p>Eat normally, not too much. Small child for easy delivery. No extra eating when pregnant – so that child stays small. Do not go to a doctor unless there is a ‘problem’ – pregnancy a part of life, it is not an ‘illness’. Not really aware of exact weeks of pregnancy, have rough idea. Not serious about anti tetanus injection, not sure why it is necessary. Iron pills given by AHW thrown away or eaten irregularly.</p>
From birth to 18 months	
<ul style="list-style-type: none"> <li>- Mother to eat well and balanced diet, to produce sufficient milk for child. Breast-feeding up to one year. Demand feeding. (Child knows best when it needs a feed) Weaning food / solids from 3 months on. If supplementary milk is unavoidable – emphasis on keeping bottle clean (sterilise)</li> </ul>	<p>Mother to eat well but only ‘hot’ foods and foods for healing the wound’. Breast-feeding till next child is on the way, feed up to 2 years. Demand feeding and comfort feeding and to keep the child quiet, even when the mother has little milk. No concept of special weaning food among the very poor; child eats whatever is cooked for others. Biscuits are a great favourite. Supplementary feeding irregular, mostly with spoon or glass. If bottle used, it is just washed</p>
Early childhood care, immunisation and illness	
<ul style="list-style-type: none"> <li>- Immunizations absolutely essential:</li> <li>- Triple antigen (DPT)</li> <li>- Polio – at least three doses</li> <li>- Measles.</li> <li>- Vitamin A.</li> <li>- Approach to illness is preventive.</li> <li>- Proper nutrition and safe water important.</li> </ul>	<p>No much motivation for immunizations, all 3 doses not given. Polio drops given if available at doorstep and because of sustained campaign. Little knowledge of triple antigen and measles vaccines. Not serious about Vitamin A. Educated parents more serious about immunizations. Approach to illness is curative. Cold, cough, skin irritations, moderate fever not considered serious.</p>



	It is too common to be taken as an abnormal state of health. Nutrition not directly connected with health - the special diet (not necessarily nutritious.) after an illness, is important. 'Filling the stomach' is of primary importance. 'Hot and cold' are key concepts, not nutrition or balanced diet.
Growth-	
<ul style="list-style-type: none"> <li>- Height and weight for age an important indicator of health.</li> <li>- Also age specific milestones for assessing physical and mental development. Immunizations and proper nutrition are for achieving these ends. If milestones are inordinately delayed, a doctor should be contacted.</li> </ul>	Height and weight have little meaning - unless very noticeably different from other children. Children not tracked accurately after 2 or 3 years. As a result, the height/weight/age charts don't mean much, not even to the AWWs. There is a different awareness of milestones (not the result of awareness-building efforts). But the time-period when milestones should take place is understood more liberally. No action is taken if a milestone is not reached. 'If it is to happen it will' is the attitude.
Environmental hygiene	
<ul style="list-style-type: none"> <li>- Good health is also dependent on cleanliness - of the self and of the surroundings.</li> <li>- Bathe every day, wash hands before eating.</li> <li>- Keep surrounding free of household waste, urine, defecation, cow dung, etc.</li> </ul>	Poor personal hygiene and unclean surroundings not necessarily connected with illness. It is linked with socio-economic status. Daily bath for upper castes only. The need to imitate upper castes is there, but you can be made to feel that you think you are aspiring beyond your station.
<b>The irony is that children are made aware of their own untidiness / unwashed state - <u>not in relation to health but in relation to social status / community identity, especially when commented upon by the teacher</u></b>	

There is a clear need to bridge the gap in concepts as well as language. Discussion with service providers (ANM, AWW and even some school teachers) revealed that though their belief systems are not very different from the community, they often convey messages that they themselves are not convinced about. They are expected to repeat these messages even when they are not getting through. In some cases, if the messages do get through, they do so in a negative manner – viz. children are made aware at their own untidiness, not in relation to health but in relation to social status, especially when commented upon by a teacher who is of a higher economic status.

Further, if we assess the children against existing standards of height and weight, most children profiled would fall in the moderately to severely malnourished category. Yet this was not our feeling we got when we interacted with the children or the parents or even the teachers. Children were active, running around and having a good time. There did not appear any significant association (save the severely malnourished and sick children who were listless) between

malnourishment and the cognitive development / ability of children. Children who were thin and short were doing as well in school despite putting in several hours of work at home. Do we then need to revise our notion of appropriate age to height, height to weight measurements? Are the Indian standards drawn from the more well to do population? *Obviously this study is not in a position to make any conclusive statement on this issue.*

A key issue here is that policy-makers and programme managers are still unwilling to take on board the existing social practices and tailor IEC and behaviour change communication strategies to ground realities. We all accept that a number of traditional practices are not conducive to the overall well-being of children. Yet, we cannot afford to ignore them since understanding why people believe what they do and taking that as a point of departure is perhaps the first step in initiating meaningful communication.

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 to ensure functioning schools is perhaps responsible for the persistent apathy with respect to education, especially for the poor who rely on government schools.

## Role of services and institutions:

Another dimension relates to the impact of services and institutions on the ability of children to access and successfully complete primary schooling. An important *message filtering through the study is that notwithstanding social, economic and cultural factors that impact on the lives of children, the presence of a functioning school can help surmount most barriers. Similarly,*

*reliable and regular immunisation, maternal and child care facilities and, above all, nutritional support and pre-school education through the ICDS programme can make the initial difference in accessing primary schooling.* Despite no dramatic difference in the social and economic status of the poorest strata in all the three states, the difference on the ground is palpable. Relatively better functioning of healthcare, immunisation, child nutrition and primary schooling programmes in the two southern states has made a big difference. The obverse however holds true for Uttar Pradesh.

Variations between Uttar Pradesh on the one hand and Karnataka and Andhra Pradesh on the other on the functionality of health care services are stark. Notwithstanding differences, consumption of IFA tablets was low in all the three states. There are several reasons for this, namely: lack of understanding among women of the importance of IFA, the focus on distribution rather than on enabling consumption (explaining side effects, timing of consumption, the need to eat before consuming, and creating an association to ensure regular consumption). Equally, the current form in which IFA is given needs revision. Field observations suggest that IFA in the form of a tonic maybe better accepted than as a tablet, as there is a close perceived association between a tablet and ill health. The composition also needs to be examined at a technical level. Current IFA is Ferrous sulphate with unpleasant side effects; passably Ferrous Fumarate formulations may be better. Tetanus immunisation of pregnant women is also very low. However, with increase in immunisation services provided in childhood and also targeting the adolescent girls for tetanus immunisation, this problem can be overcome in the future.

The ANMs, where regular, tend to focus on the following in order of priority – immunisation, family welfare, care of pregnant women and distribution of ORT etc. However, the felt demand and need of the poor seems to be for curative services, which is mostly met by the village practitioners or private sector. AP is the exception, where 66% of households surveyed utilised the government facilities (see Table 27). This higher percentage usage may be because of the recent commencement of urban health posts in urban slums in AP. However, the village practitioners and the private sector in neither state deliver family welfare services and their participation in immunisation and care of pregnant women is very limited – a glaring lacunae. The high reliance of the poor on village practitioners for curative services could be utilised for immunisation and care of pregnant women after appropriate training and with the ANM playing a pivotal role in forging the linkages.

Similarly, it is observed that there is no fixed day, time, or place for delivery of services in habitations by ANMs. There is no co-ordination between the AWC, ANM, the village practitioners and other elected representatives, functionaries or groups in service delivery. Fixed day services in coordination and complemented by services of other functionaries and the ANM could significantly improve access, coverage and quality of service delivered.

The practice of giving dry rations instead of cooked food to pregnant women and lactating mothers in AP and UP may not help the women, as this is likely to be used for the entire household, particularly in very poor households where overall food availability is low. The overall health situation of the community and in particular of the children is influenced by availability (or its lack) to basic healthcare facilities. Interestingly, most mothers report the use of allopathic medicines for all illnesses that affects their children and rarely herbal medicines and home remedies. For instance, simple home remedies for scabies seem to have been forgotten or are seen as being ineffective. In the tribal village of Andhra Pradesh, for instance, several children had mild to severe scabies. In one of the households the 3-year-old girl had severe scabies on her scalp. When we told the mother that she could apply *Neem* and turmeric paste and this would not only provide immediate relief but also cure the child, her reaction did not convince us that she might actually do something about it. However, on our final visit to the village 20 days later, she proudly produced both her children before us. Both the girl and her brother were free of scabies and the child was smiling. *This seems to suggest the need for a concerted effort to retrieve, revive, and revalidate herbal medicines in the eyes of the people, an intervention that would place medicine back in the hands of the poor themselves.*<sup>10</sup>

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<sup>10</sup> Our research indicates, that traditional health practices of households and communities and alternative modes of indigenous medicines are fading away among the poor. Although our research mandate precluded the exploration of the ‘why’ underlying this emerging trend, one can put forth a host of reasons based on secondary research as well as our experiences in the field. Earlier studies have indicated that the destruction of forest cover has led to the extinction of certain herbs and hence traditional herbal remedies. Further, deforestation has further made the task of collecting herbs and making medicines a tedious process. Often this has meant adulterated traditional medicines leading to reduced faith in them. However, one of the major blows has come from the pervasiveness of allopathic medicines and its association with modernity, education, and also status – irrespective of its efficacy in treating certain local ailments. Some also say that traditional cures, often demand certain dietary restrictions etc. which allopathic medicines do not.

**Table 27: Utilisation of health related services in 3 states**

	<b>Uttar Pradesh</b>	<b>Karnataka</b>	<b>Andhra Pradesh</b>
<b>Pregnancy and Delivery Care</b>			
Number of mothers observed/interviewed	18	18	18
Iron supplementation in last pregnancy	5.5%	27%	94%
Tetanus immunisation- in last pregnancy	11%	22%	94%
Supplementary nutrition	Where available not used. None in urban areas	Available in 75%- not specific to these families	Available in all habitations, no specific information for these mothers
%Delivery at home	99%	93.2%	78.4%
%Delivery assisted by un trained	99%	93%	88%
Children observed	22	18	27
<b>Immunisation</b>			
BCG	0	50%	30%
Polio	64%	94%	89%
DPT	14%	NA	NA
Measles	0	0	19%
<b>Nutrition</b>			
Supplement	Where available not used, none in urban areas	Available in 75%- not specific to these families	Available in all habitations-No specific information for these mothers
Vitamin A	None	None	None
Curative services			
Obtained from Govt	5.5%	22%	66%

Access to modern medical care is no longer seen as a problem given the improved transportation system, at least in Karnataka and Andhra Pradesh. Here people approach private medical practitioners or go to the government doctor in his / her house (paying a fee). The charges include consultation and medicine. Discussions revealed that not all government PHCs / District Hospitals provide free medicines, and if people have to purchase the medicine themselves, they find it more convenient and cost effective to approach a private practitioner. The harsh reality is that since medical care is expensive people often decide to wait till the situation turns grave. No wonder, more often than not the burden of non-treatment is disproportionately borne by women and girls.

Unlike maternal nutrition, a more direct link can be forged between other programmes (e.g. ICDS) and the ability of children to enter and successfully complete primary schooling. The table below provides a comprehensive survey of the differing impact of provision and utilisation of social services for children and their impact on educational – outcomes of children in the 0-11 age group that have emerged from our study.

In the case of the ICDS programme there is a clear disjunction between the stated concerns and praxis of the AWW. The teachers claim that they too want to ensure a functioning centre and that efforts should be made to ensure that children from poor families come. In the urban areas of Karnataka and Andhra Pradesh, most of the children are from SC / beggar / daily wage families. However, reaching out to these children still remains a big concern. For instance, 4-year-old Geeta who lives in the urban slum of AP is left out on the streets as everyone in her household goes to work. For Geeta, a functioning AWC would have made all the difference in that she would be in a safe and perhaps stimulating environment instead of being left to her own devices. Her parents do not seem to have the wherewithal to ask any questions or demand a better service. They just cannot interact with the AWW with any degree of confidence. One cannot escape the conclusion that the AWCs we saw in all the three states were some distance from ensuring nutritional support or pre school education. In sharp contrast to primary schools, the community too was unaware of the significance of the AWC for pre-school children and its implications for primary schooling.

**Table 28: Summarising the institutional factors  
Factors influencing successful primary school completion**

<b>Mild +, Strong ++, Very Strong +++ and Extremely Strong ++++</b>				
	<b>Boys</b>		<b>Girls</b>	
	<b>Positive</b>	<b>Negative</b>	<b>Positive</b>	<b>Negative</b>
<b>Child health and immunisation</b>				
Sustained education / awareness about immunisation	+++		+++	
Sustained education about situation of girl children			++++	
Regular availability of immunisation services	+++		+++	
Motivated ANM / health worker	+++		+++	
Easy accessibility of health facilities	+++		+++	
Non-availability of healthcare facilities within reach		++		+++
<b>Nutrition and pre-school education</b>				
Location of AWC – forward caste area		++		++
Location of AWC closer to disadvantaged groups	+++		+++	
ICDS centre functional – opens every day	++++		++++	
ICDS centre irregular		+++		+++
Regularity of Aanganwadi worker	++++		++++	

Aanganwadi worker irregular		+++		+++
Aanganwadi Helper fetches children from home	++		+++	
Conscious policy to enrol children from poor households	++		+++	
Enrolment of 40 children on first comes first served basis – no targeted focus on most deprived children.		++		+++
High caste AWW		+++		+++
Availability of play material	+++		+++	
Nutrition education of mothers leading to higher awareness	+++		++++	
Health education of mothers (ORT, immunisation etc)	+++		+++	
Functioning mother's committee	+++		++++	
Distribution of nutrition for pregnant and lactating mothers	++++		++++	
<b>Primary School</b>				
Bright and welcoming school	+++		+++	
Building and compound wall	++		++	
Teacher pupil ratio between 1:20 and 1:40	+++		+++	
Teacher-pupil ration very high, above 1:40 and in many areas 1:65.		+++		+++
Teacher regular	+++		+++	
Teacher irregular / take turns to come		++		+++
Actual teaching time very low – less than 45 minutes a day and less than 20 minutes per period.		++++		++++
Actual teaching time satisfactory – more than 1 hour 20 minutes a day and at least 35 minutes per period.	++++		++++	
Female teacher who is regular	++		++++	
Distribution of textbooks	+++		+++	
Village Education Committee active	++		++	
Active SDMC / PTA / School Education Committees	++++		++++	
Mid-day meal – hot food	++++		++++	
Mid-day meal – dry rations	+		+	
Punishment – mild		+		+
Punishment – harsh		++++		++++
Teacher attitude towards poor dismissive		++		++
Teacher exhibits prejudices (caste / gender)		+++		++++
Joyful learning methods used	++		++	
Children learning to read and write	++++		++++	
Learning outcomes poor – children in class 4 and 5 not able to read or write.		+++		+++
Learning songs, rhymes and poems	+++		+++	
No-detention policy	+		+	
Extra-curricular activities	+++		+++	
Enrolment campaigns	++		+++	
Back-to school campaigns	++		+++	
	Boys		Girls	
	Positive	Negative	Positive	Negative

Extant literature underscores that early childhood education programmes were initiated to provide cognitive stimulation for children. They were also expected to prepare children for schooling. It is now widely acknowledged that good pre-school education does indeed prepare the child through socialisation and stimulation. If this component has failed to take off, as illustrated by our study, serious re-thinking is necessary. The programme may have to be restructured in a manner that the overall administrative culture of the area is incorporated as an important variable in ensuring effectiveness [see Box 17]. A universal model in such a diverse country is not only ineffective, but also reflects poor planning. What works in Karnataka or Maharashtra may not succeed in Uttar Pradesh or Rajasthan. At times lack of administrative will or the simple fact that welfare of children is not a political priority makes all the difference in the way a programme such as this is administered. Similarly, given the social and economic differences, targeting the programme to the poorest of the poor would necessitate context specific planning and priority setting. Equally, it may be worth exploring how the AWC could be brought into public focus in the way the mid-day meal programme has. Cannot the government piggyback a universal nutritional support to all children in the 0 –6 years to the mid-day meal programme?

The centrality of the government school in the lives of poor children is undeniable. Across all the 3 states, between 70 to 80% of children from poor households are enrolled in government schools. The growing numbers of private schools do not cater to the poorest of the poor. For example in the three urban periphery samples over 90% of children are enrolled in GPS. This is why the overall functioning of the government school, in particular quality of teaching, becomes so critical for the poor. As discussed in the introductory section of this report, most poor children are first generation school goers. What is even more important to note is that if poor parents are able to exercise choice, they prefer to send their boys to private schools and their girls to government schools - a subtle but definite trend that government schools are emerging as the preferred choice for girls (especially in the urban areas).

Hardly any of the school-going children we interacted with could read and write, although not due to lack of motivation on the part of the child. Pankaj of UP, a nine-year-old and 7<sup>th</sup> born in his family, missed school for a month as he was taken for a family visit. Upon his return, he was severely punished by the teacher for being absent. Pankaj stopped attending school and his name was struck off the rolls. After a few days, he made another attempt to join school, but the teacher said it was 'too late'. This was the month of September and not even half way through the term. Pankaj has persisted and now sits un-enrolled in Class 1. He wants to be in school. What certainly



impedes retention in school is the teachers' harsh treatment of and negative attitudes towards the children and their families, and not just poor infrastructure. What continued to surprise us was that despite all odds children wanted to be in school. *In Karnataka, the best school, the one most liked by the children, runs in a temporary building! A teacher who is liked attracts children to school and becomes the single most important factor.*

### **Box 22: Do current strategies need reconsideration?**

There are around 44 boys and girls in the tribal village who are studying in the residential schools, or staying in the tribal welfare hostels and studying in government schools in several mandals of the district. Of these 13 boys go to the Gurukul residential school run by the tribal welfare department. Admission to this school is through an entrance exam. Everyone recognises that this is a premier school, with quality teaching borne out by the high levels of achievement of boys who study here. During our discussions, the boys of this school raised some fundamental questions.

- What is the point of having a school in each habitation when they do not run properly and all teachers do not come?
- Is this not a colossal waste of public money?
- And yet another generation being cheated of learning guarantee?
- Why are policy makers / administrators so impervious to the ground realities?

The suggestion was that the entire structure needs overhauling. In the tribal village their solution to the problem was that there be more residential schools so that all tribal children actually have an opportunity to study.

These views were echoed and strongly endorsed by some senior bureaucrats and friends we talked to during the course of the study. In addition to the residential school options, the regular school structure could be and perhaps needs to be modified

- The suggestions were that up to class III maybe have a village/habitation level school,
- After that provide one good cluster school at Mandal HQ level or any convenient location. These schools should not only be well equipped with playgrounds, laboratories, teachers and an appealing school environment, but should have separate classrooms for each grade.
- Given the excellent roads / transportation in Andhra transportation children could be ferried to this cluster school, even if it means travelling 5 to 10 km a day.
- Such restructuring would not only enable closer monitoring of the school and teachers but also concentrate resources to develop the schools and thereby may have positive impact on children's education.

In the case of Andhra Pradesh, some such restructuring could possibly be considered since in any case the concept of bridge courses and residential bridge courses for working children, older children and school drop outs, hostels and residential schools have been widely accepted and accessed by the community at large. This of course goes against current views that schooling, if it is to be effective, is best provided as close to the child's home as possible more so in the case of girls. In any case this issue of quality education and children's learning that is emerging as a key concern of parents and the community needs to be met head on, otherwise there is every risk of another generation falling between the cracks.

Source: Field notes, Andhra Pradesh 2002

Cohort studies of children who are currently in class 5 reveal that a significant number of enrolled children do reach class 5. However, merely the fact that children make it to class 5 has little meaning unless we are also in a position to assess the learning outcomes of children. The no-detention policy ensures children move from one class to the next, regardless of what or how much they learn. Attendance seems to be the only criteria. Parents are not happy about this ‘automatic promotion’ and this may actually be a stumbling block in the way of ensuring teacher accountability with respect to learning. Completion of the primary cycle does not automatically imply achievement of primary level of learning! If we are, therefore, to define successful primary school completion as including learning outcomes, then the existing evaluation system does not lend itself to assessing how many actually complete the primary cycle with satisfactory learning outcomes.

This brings the issue of quality of education centre stage. As discussed in Section Two above, while the question of enrolment has been addressed in all the three states, indifferent learning outcomes of children remain troubling. What use is education if children emerge barely literate! Making teachers accountable for the learning outcomes of children needs more attention. The choice is not between teacher autonomy or child learning – the way the questions are being posed itself makes it impossible for us to reach a resolution. The teacher centres / CRC need to be given the task of monitoring learning outcomes instead of functioning as supervisors and data gatherers.

The community is an active participant in the debate and is aware about quality issues. But it does not have sufficient knowledge about what children should learn and what competency they should acquire at different levels of the schooling continuum. It is also in no position to monitor teacher competency. Therefore, it maybe premature to talk about community participation in quality improvement –at least in the three states surveyed. It is not equipped to ask the right questions. The situation may change when education level of adults / parents increase in the next generation. For the moment, *we have to fall back on the teacher and the system itself to do an assessment and ensure quality.*

Another Hobson’s choice relates to innovations (at various levels) versus upscaling and teacher’s autonomy versus child learning. We need mechanisms to ensure both work and not force a choice between two equally important concerns. The choice is also not between enhancing access and social segregation on the one hand and quality of education on the other – it is important to plan

for both. Enhancing access without ensuring quality defeats the very purpose of educational access.

### **Summing up:**

This study explores the situation of children in diverse poverty situations. An unambiguous message from this study is that even the poorest of poor families acknowledge the importance of education in the lives of their children despite the cumulative nature of social and economic exclusion that circumscribes their experiences of education. The research, by focusing on children in different age groups along the integrated child development continuum is clearly able to illustrate and explore the latter. Health, nutrition, and education are no doubt the three main sectors that impact on a child's development, while poverty continues to exert a strong influence on nutrition of children, on health seeking behaviour of households, and framing access to/experience of education.

The economic situation of the households affects children in several other ways. A large number of children from poor households work long hours – if enrolled before and after school, or at times seasonally and resulting in chronic absenteeism. Hence, we cannot afford to take an uncomplicated position of work or schooling since the situation on the ground is far more complex and makes it critical to distinguish between child labour and child work. Similarly, caste and community of children influence educational participation and outcomes along with the economic status. 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. Gender relations in the family, community and in the society too exert significant influence on the ability of girl children to access services, nutrition, immunisation, healthcare (especially during bouts of illness) and schooling.

Services/institutions relating to health, nutrition, and education also impact on the ability of children to access and successfully complete primary schooling. Reliable and regular immunisation, maternal and child care facilities and, above all, nutritional support and pre-school education through the ICDS programme can make the initial difference in accessing primary schooling. Hence, notwithstanding social, economic and cultural factors, the presence of a functioning government school can help surmount most barriers. Across all the 3 states, between 70 to 80% of children from poor households are enrolled in government schools. The growing numbers of private schools do not cater to the poorest of the poor. Most poor children are also

first generation learners and hardly any of the school-going children we interacted with could read and write, although not due to lack of motivation on the part of the child. Enhancing access without ensuring quality thus defeats the very purpose of educational access. What certainly impedes retention in school is the teachers' harsh treatment of and negative attitudes towards the children and their families, and not just poor infrastructure.

## SECTION FOUR: POLICY IMPLICATIONS

At the outset it is important to reiterate that this qualitative study was undertaken with the objective of fleshing out the multiple factors that influence the ability of children, in particular those in diverse poverty situations, to successfully complete primary education,. As discussed in Section I, the study focuses on children from conception to 11 years – tracking key milestones in one district each in the states of Andhra Pradesh, Karnataka and Uttar Pradesh. It explores the synergy between health, education and nutritional inputs in the overall development of these children and reflects on whether the proximal and distal environment promotes holistic development of the child. Being essentially qualitative in nature, it is exploratory and illustrative, seeking to understand context specific factors at each stage of their development. The recommendations discussed herein, therefore, need to be read in this context.

### Institutions:

#### The school system:

Let us start with schools and learning. 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. 80 per cent of the children in the surveyed villages / slums are attending government schools. What thus do we need to ensure in order to gear the school system to the meet the needs of these children?

- 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 realise this objective.
  - o Creating a learning environment is perhaps the key to enable this shift. For many years now this is often translated into unrelated inputs by way of infrastructure, teaching learning material, teacher training, regular supply of textbooks, content of process of education inside the classroom and community participation. While

each of these inputs is no doubt valuable, the problem seems to be that these inputs are not organically interconnected.

- While integrated strategies have been tried out in some areas across the country (model clusters, joyful learning approaches), the challenge before us today is to make effective practices a central part of the entire schooling system.
  - It is worth noting that the focus, at least in DPEP and SSA, has shifted to retention. Though an improvement from the earlier focus on enrolment, this is insufficient. Moving from retention to ensuring learning outcomes necessitates a qualitative leap in the way primary and upper primary education is managed.
  - Teaching time remains a problem area. Interactions with children revealed that the time spent in classroom transaction, especially given high teacher-student ratio / rotation of teachers teaching in the school, reduces the actual time devoted to teaching. A large proportion of the time of children is spent copying down from the board, or self-studying, while the teacher is busy with another group.
- The teacher is the fulcrum around whom 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 teachers accountable to measurable learning outcomes. This implies that we need to agree on how learning will be assessed on a continuous basis. This is of particular importance in the context of the no-detention policy being followed at the primary level in most parts of the country and the upper primary level in some areas. Pushing children from one grade to the next without ensuring learning not only defeats the very purpose of schooling, but, as voiced by people, is actually cheating the poorest. There is growing evidence to show that those who can so afford are already taking recourse to private tuitions or private schools.
  - Effective advocacy for ensuring learning outcomes and making teachers accountable for it implies not only dealing with the general public, but more importantly with teacher unions. It is important to revisit the recurring recommendation (made since the 1960s) that primary school teachers be hired for a specific village school by the Panchayat and their service be made non-transferable.

- While in-service teacher training has received considerable attention in DPEP and other EFA projects across the country, a holistic approach to teacher education is necessary. Effective intervention at the pre-service training stage is called for. Teacher training is not only about imparting skills, but also about enabling the teachers to understand and appreciate the learning needs of first generation school-goers and children from disadvantaged communities. Teacher attitudes leave much to be desired, stereotypical attitudes towards poor children and the 'use' of education in their lives needs serious attention. This calls for a systematic review of teacher education curriculum.
- The teacher-pupil ratio, both on paper and on the ground in some areas continue to remain an important area of concern. In the schools visited in UP the TPR in rural schools was high as 1:173 in one case! In the tribal school visited in AP, only one of the three teachers was present on any given day. Even where teachers have been deployed, the practice of rotation followed in many areas effectively negates favourable teacher-pupil ratios. This situation begs a more effective monitoring mechanism.
  - The Village Education Committees / School Development and Management Committees are mandated to monitor teacher regularity. However, interactions with the committees in all the three states indicated that members feel powerless. While there are exceptions, the general point about the real power of these committees needs to be taken on board.
  - We are yet to fully realise the potential of Teacher Centres / Cluster Resource Centres in ensuring regularity of teaching as well as providing continuous academic support to teachers<sup>11</sup>.
  - Responsibility for routine enrolment drives and identification of out-of-school children needs to be shifted to Panchayat Raj Institutions and other village level structures like PTA, MTA, VEC and SDMC.
- 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 transporting children from the

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<sup>11</sup> It is indeed interesting that none of the teachers interviewed talked about the supportive role / monitoring role of Teacher Centres (AP) and Cluster Resource Centres (Karnataka and Uttar Pradesh). At best they talked about specific training programmes they had attended under the aegis of DPEP.

class 4 onwards to the school rather than insisting on having a school in every habitation just to ensure that the distance to the school meets specified norms. 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.

- Forward linkages emerged as an important factor in influencing motivation to complete the primary cycle. Low accessibility of upper primary and middle school, especially for girls, emerged as an important stumbling block. Equally, the link between education and employment / self-employment capabilities emerged as an important area of concern.
- There is need for more systematic health, hygiene and nutrition education. Children provide an important window in bringing about change in individual households and the community, and the teacher can play a very important role in communicating the importance of balanced nutrition and personal and environmental hygiene. The VEC /SDMC, PTA and MTA can be drawn into the ambit of health and nutrition education.

### 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). **How can the system respond to this situation?**
  - o Our discussions in the community raised the question of whether the ICDS programme should indeed be the nodal point for ECCE as well. 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. 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.
  - Another 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.
- Since not all poor children have access to the ICDS centre (especially in UP where each village has only one centre), the government should 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.
- Educating the women / adolescent about the importance of iron supplements and how it impacts on the overall health and well-being of women in the reproductive age group needs serious attention. How and when the tablet should be taken (definitely not on an empty stomach) needs to be driven home. One of the suggestions made was with respect to changing the form and composition of iron supplements in order to minimise side effects and increase acceptability.
- The monitoring of ICDS centres and workers needs an urgent review. It may be worthwhile considering the involvement of the Panchayats or educating and empowering the women's committee to play a more effective monitoring role to ensure that programme meets its stated objectives / goals.
- In particular, that women's groups like *Mahila Samakhya*, *Swashakti* or self-help groups are educated and empowered to play a proactive role in ensuring effectiveness of the ICDS programme. It is a matter of concern that these groups, though aware of the problems and the mandate of the ICDS programme, are not playing any significant role in the villages surveyed.

## 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 basic public health and nutrition messages have been lost in the din of family planning and now HIV and AIDS control. While not challenging the importance or validity of the new focus, 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 need strengthening.
- Equally important is to ensure potable water in the house and in the school. It is surprising that though water is routinely boiled for bathing, this is not true of drinking water. Finally, greater attention needs to be paid to sanitation and building toilets, at least in areas with assured water, as is reported for sanitation programme of the government in West Bengal (World Bank supported).
- Learning from the successful polio campaign in many parts of the country, the media could be encouraged to promote better and accessible nutritional practices. Existing women's programmes and other environment education programmes are not paying much attention to nutrition and health of children.
- 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.

Education, nutrition and welfare schemes of the government need an extraordinary amount of individual attention. Given the size of the problem, and the complexity of issues involved – there is no other alternative. In addition to decentralization of authority and responsibility for spending money, programmes need to have much smaller 'beneficiary' groups than at present. Where there is one aanganwadi, we probably need four. Of course, these four aanganwadi, or four primary schools, will be plagued with the same problems of non-attendance of AWW/AWH and the like, but that is a matter of administration. There is no lack of people who are ready to work – but it is important that they get out of the typical *sarkari naukri* (government service) mentality. Where the parent is unable to provide the necessary support for education or is incapable of doing so, the primary school teacher has to assume some surrogate responsibilities. Similarly, the aanganwadi worker needs to have greater empathy and reach out to children who are in dire need of proper nutrition and pre-school education. They have to transform themselves into 'professional caregivers', working with and giving attention to fewer numbers of children. This is especially true for children in diverse poverty situations. All this does not only mean more resources, but a lot more care and attention. Can we not involve mothers in the nutrition component of ICDS programme

and the mid-day meal? May be this is asking too much of a system that is so enormous and impersonal. But there are no shortcuts – children need care, love and above all individualised attention.

Children are not passive but active participants in the process of their development and education. Throughout our research it was the interactions and activities with children that gave us an in-depth understanding of the functioning of the school, teacher attitudes/practices, physical and verbal abuse in the classroom, household nutrition/food practices and the negative impact they have on children's self-esteem/dignity. Similarly our understanding of the world of work with respect to both school-going children and those who are out of it provided valuable insights. Therefore, listening to children and giving them a voice/a forum is of great importance.

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