DEVELOPMENT OF CHILDREN, ADOLSCENT GIRLS AND YOUNG WOMEN IN INDIA: POLICY AND PROGRAM PRIORITIES

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Abstract

Adolescence has been described as the transition period in which young people undergoes enormous physical and psychological changes. It is a period of emotional changes, wherein their thinking becomes abstract. They are pressurized by fascinated peer, media and social influences both in terms of positive as well as negative. At the same time, the young mothers have a varied nature of needs and concerns. Accordingly, the challenges also vary depending upon one's skills, attitude and behaviour by acquiring education and bringing up by social environment. Though the needs and concern of adolescents and young mothers have remained quite the same, they have acquired other dimensions with new problems and challenges h. The present paper focuses on the development of children, adolescent girls s and young women and various policy and program taken up for their development.

Key Words: Development of Adolescent girls, Young women and Policy Programs

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Introduction:

The National Youth Policy 2012aims to target and focus youth in the country within the age-bracket of 16 to 30 years. All young people within this age-group are unlikely to be a homogeneous group, sharing common concerns and needs and having different roles and responsibilities. It is, therefore, necessary to divide this broad age-bracket into three sub-groups. The first sub-group of 13-18 years should cover adolescents whose needs and areas of concern are substantially different from youth under the following age-groups.The second group of 19-25 years includes those youth who are in the process of completing their education and getting into a career.The third group of 26-30 years comprises of young women and men most of who have completed their education, including professional, and are, more and less, settled in their job and in their personal life.

According to the 2001 Census, India's youth population (age-group of 15 – 35 years) was 355 million. This translated into approximately 390 million people as per the current definition of youth (age group of 13-35 years) in the National Youth Policy, 2003. Further, adolescents (age group of 10-19 years), for the first time in the country, have been recognized as a distinct sub-group. According to the initial figures of the 2011 census, the youth population in the country including adolescents is around 550 million. This phenomenal rise in the youth population has made India the youngest nation with a demographic dividend appearing to be a reality. It is indeed vital to utilise this demographic dividend and channelize the youth and their creative energies for nation-building.

The Social factors of poverty, illiteracy, ill-health and gender bias and failures of the poverty alleviation programme and lack of specific l measures for achieving health and nutritional security foradolescentgirlsandyoungwomen before they become mothers are the major contributors to Low Birth Weight (LBW) babies and the malnutrition among women reflected in Body Mass Index (BMI) below 18. These are more prevalent in South Asia viz. Nepal, Bangladesh, Bhutan and India as compared to that in Southeast Asian countries . The table no.1.1 below depicts the malnutrition status among children in Asian countries.

Table-1.1: Malnutrition Status among Children in Selected Asian Countries

Sl. No.	Country	Percentage Prevalence of Underweight among Children <5 years
1.	Bangladesh	48.0 (2004)
2.	Bhutan	18.7 (2000)
3.	DPR Korea	20.0 (2002)
4.	India	45.9 (2005)
5.	Indonesia	28.1 (2003)
6.	Maldives	45(2000)
7.	Mayanmar	36 (2000)
8.	Nepal	47.1 (2000)
9.	Sri Lanka	33 (2000)
10.	Thailand	9.0 (2003)

Sources : *Nutrition Profile for WHO – SEAR Countries*

Table- 1.2: Malnutrition Status among Adult females in Selected Asian Countries

Sl. No.	Country	Percentage Prevalence of BMI< 18 among women
1.	Bangladesh	-
2.	Bhutan	-
3.	DPR Korea	-
4.	India	33.0 (2005)
5.	Indonesia	-
6.	Maldives	-
7.	Myanmar	24 (2003)
8.	Nepal	26.7 (2001)
9.	Sri Lanka	-
10.	Thailand	6.6 (2003)

Sources: Nutrition Profile for WHO – SEAR Countries

Policy and Programs:

The Government of India has taken up various policy measures for the development of children, adolescent girls and young women. The following are the some of the major policy and programs.

National Nutrition Mission:

The Prime Minister had announced in his Independence Day address in 2001 that a National Nutrition Mission would be launched to provide free food grains to under-nourished, pregnant and lactating women and adolescent girls belonging to below-poverty-line. As the first intervention, the Government launched a pilot project in 2009, in 51 nutritionally deficient districts (out of 626 districts) in the country with the release of special additional central assistance of Rs. 1033.3 million to the states. The Mission has central supervisory structures and headed by the Prime Minister, which includes concerned union ministers, chief ministers by rotation, academicians, technical experts and NGOs.The Mission has an Executive Committee, which is headed by the Minister of State in charge of women and child development. It has two ministers in charge of nutrition / women and child development / health from nutritionally backward states, two ministers from states with good performance in nutrition related program, secretaries of union ministries concerned and experts. The states are represented by rotation also in Executive Committee. The Mission puts in place effective mechanism for coordinating the efforts of different ministries, after reviewing the goals set out in the National Nutrition Policy 1993, the National Plan of Action on Nutrition 1995 and the existing strategies being adopted by various ministries. The Executive Committee is responsible for identifying nutritionally backward regions and groups, monitoring and evolving mechanisms for coordination and conduct of evaluation studies.The objectives of the National Nutrition Mission are to review and revise the goals set out in the National Nutrition Policy, 1993 and the National Plan of Action on Nutrition, 1995 keeping in view the present nutrition profile of the country; reviewing strategies adopted by the various Ministries concerned with nutrition and revise them for achieving the goals set out by the Mission; to put in place effective mechanism for coordinating the efforts of different Ministries concerned with implementation of nutrition program to sub serve the nutrition goals; to review the systems of data collection and monitoring of the nutrition status across different regions, groups and particularly the vulnerable population of the country; to

review research & development and dissemination in the field of nutrition, especially regarding low-cost balanced diet, safe drinking water & sanitation, women & child development and health & family welfare; to address special problems of nutrition during natural calamities and any other nutrition related issues arising from time to time.

The functions of the Executive Committee are to identify nutritionally backward regions and groups in the country requiring special focus on implementation of nutrition program; close monitoring of implementation of the nutrition program with particular attention to resource constraints. Institutional bottlenecks or any other matter affecting service delivery; evolve mechanisms for coordination of the entire nutrition related program both at the policy and implementation levels; conduct of evaluation and impact studies of the program and identify mid-course corrections in strategies and implementation issues; any other function vested on it by the Mission.

The composition of NNM consists of Prime Minister; Deputy Chairman, Planning Commission; Ministers for Human Resource Development; Finance; Health & Family Welfare; Consumer Affairs, Food & Public Distribution; Science & Technology; Agriculture; Social Justice & Empowerment; Tribal Affairs; Minister of State for Human Resource Development (in-charge of Department of Women & Child Development) and Secretary, Department of Women & Child Development with Chief Ministers of nutritionally backward States by rotation for a period of two years (Uttar Pradesh, Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh and Rajasthan) and .Chief Ministers of States which have good performance in nutrition related programmes by rotation for a period of two years (Tamil Nadu, Punjab and Kerala0 . The experts are Dr. C. Gopalan, Dr. B.S. NarasingaRao, Dr. M.S. Swaminathan, Prof. Tara Gopal Das, Dr. Shanti Ghosh, Dr. H.P. Sachdeva, Dr. K. Ramachandran, President, Indian Council for Child Welfare and National Coordinator, Breastfeeding Promotion Network of India also the members of the NNM.

The composition of executive committee consists of Minister of State for Human Resource Development (in-charge of Department of Women & Child Development); Secretary, Social Justice & Empowerment; Secretary, Tribal Affairs; Finance Secretary; Secretary Health; Secretary, Family Welfare; Secretary, Food & Public Distribution Advisor (Health, Family Welfare & Nutrition), Planning Commission and Secretary, Department of Women & Child Development with two Ministers in-charge of Nutrition / Women & Child Development / Health

from these nutritionally backward States by rotation for a period of two years(Uttar Pradesh and Rajasthan) and two Ministers in-charge of Nutrition / Women & Child Development / Health from these states, which have good performance in nutrition, related program by rotation for a period of two years(Tamil Nadu and Punjab). The experts/people actively working in nutrition related sector (Dr. V. Raman Kutty, Dr. Mohan Ram Mamidi, Mr. AlokMukhopadhyay, Ms. SumitaGhose, Dr. H. Sudarshan and Dr. PrasantaMahapatra) is also members of the executive committee.

Nutritional Program for Adolescent Girls, 2002

A Pilot Project – "Nutritional Program for Adolescent Girls"(NPAG) was launched by the Planning Commission initially for a period of two years i.e. 2002-03 and 2003-04 in 51 identified districts i.e. in two of the backward districts in each of the major States and most populous district (excluding the capital district) in remaining smaller States/UTs in the country. This scheme was restarted in 2005-06. The Ministry of Women and Child Development administers the scheme at the central level and State/UT Governments implement the scheme at the State level.

As per the revised guidelines of the program, adolescent girls (age group 11-19 years) as identified by prescribed weight are covered irrespective of financial status of the family to which they belong. Free food grains at 6kg per beneficiary per month are provided to the adolescent girls (weight < 35 kg.), initially for a period of three months. Those beneficiaries, who cross the cut off point for weight, would not receive food grains any further. Those who in spite of receiving food grains for three consequent months do not show improvement in nutritional status is investigated by Anganwadi Workers and, if necessary referred to doctor for investigation and treatment, but continue to receive free food grains for the next three months.

Integrated Child Development Scheme (ICDS), 1975

Launched on 2nd October 1975, today, ICDS Scheme is one of the world's largest programs for early childhood development with India's response to the challenge of providing pre-school education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, on the other.

a) Priority the Integrated Child Development Services (ICDS) Scheme was launched in 1975 with the following objectives:

i. to improve the nutritional and health status of children in the age-group 0-6 years;

ii. to lay the foundation for proper psychological, physical and social development of the child;

iii. to reduce the incidence of mortality, morbidity, malnutrition and school dropout;

iv. to achieve effective co-ordination of policy and implementation amongst the various departments to promote child development; and

v. to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

b) Scope: The above objectives are sought to be achieved through a package of services comprising:

i. Supplementary nutrition,

ii. Immunization,

iii. Health check-up,

iv. Referral services,

v. Pre-school non-formal education and

vi. Nutrition & health education.

Three of the six services namely Immunization, Health Check-up and Referral Services delivered through Public Health Infrastructure under the Ministry of Health & Family Welfare.

c) Nutrition including Supplementary Nutrition:

This includes supplementary feeding and growth monitoring; and prophylaxis against vitamin A deficiency and control of nutritional anemia. All families in the community are surveyed, to identify children below the age of six and pregnant & nursing mothers. They avail of supplementary feeding support for 300 days in a year. By providing supplementary feeding, the Anganwadi Centers **[1**)attempts to bridge the caloric gap between the national recommended and average intake of children and women in low income and disadvantaged communities. Growth Monitoring and nutrition surveillance are two important activities that are undertaken. Children below the age of three years of age are weighed once a month and children 3-6 years of age are weighed quarterly. Weight-for-age growth cards are maintained for all children below six years. This helps to detect growth faltering and helps in assessing nutritional status. Besides, severely malnourished children are given special supplementary feeding and referred to medical services.

i) Immunization: Immunization of pregnant women and infants protects children from six vaccine preventable diseases-poliomyelitis, diphtheria, pertussis, tetanus, tuberculosis and measles. These are major preventable causes of child mortality, disability, morbidity and related

malnutrition. Immunization of pregnant women against tetanus also reduces maternal and neonatal mortality.

ii) Health Check-ups: This includes health care of children less than six years of age, antenatal care of expectant mothers and postnatal care of nursing mothers. The various health services provided for children by anganwadi workers and Primary Health Centre (PHC) staff, include regular health check-ups, recording of weight, immunization, management of malnutrition, treatment of diarrhea, de-worming and distribution of simple medicines etc.

iii) Referral Services: During health check-ups and growth monitoring, sick or malnourished children, in need of prompt medical attention, are referred to the Primary Health Center or its sub-center. The anganwadi worker has also been oriented to detect disabilities in young children. She enlists all such cases in a special register and refers them to the medical officer of the Primary Health Center/ Sub-center.

iv) Non-formal Pre-School Education (PSE)

The Non-formal Pre-school Education (PSE) component of the ICDS may well be considered the backbone of the ICDS program, since all its services essentially converge at the Anganwadi – a village courtyard. Anganwadi Centre (AWC) is the main platform for delivering of these services. These AWCs have been set up in every village in the country.

v) **Nutrition and Health Education:** Nutrition, Health and Education (NHE) are a key element of the work of the Anganwadi worker. This forms part of Behavior Change Communication (BCC) strategy. This has the long term goal of capacity-building of women – especially in the age group of 15-45 years – so that they can look after their own health, nutrition and development needs as well as that of their children and families.

vi) Type of Supplementary Nutrition:

Children in the age group 0 – 6 months: For Children in this age group, States/ UTs may ensure continuation of current guidelines of early initiation (within one hour of birth) and exclusive breast-feeding for children for the first 6 months of life.

Children in the age group 6 months to 3 years: For children in this age group, the existing pattern of Take Home Ration (THR) under the ICDS Scheme will continue. However, in addition to the current mixed practice of giving either dry or raw ration (wheat and rice) which is often consumed by the entire family and not the child alone, THR should be given in the form that is palatable to the child instead of the entire family.

Children in the age group 3 to 6 years: For the children in this age group, State/ UTs have been requested to make arrangements to serve Hot Cooked Meal in AWCs and mini-AWCs under the ICDS Scheme. Since the child of this age group is not capable of consuming a meal of 500 calories in one sitting, the States/ UTs are advised to consider serving more than one meal to the children who come to AWCs. Since the process of cooking and serving hot cooked meal takes time, and in most of the cases, the food is served around noon, States/ UTs may provide 500 calories over more than one meal. States/ UTs may arrange to provide a morning snack in the form of milk/ banana/ egg/ seasonal fruits/ micronutrient fortified food etc.

Registration of beneficiaries: Since BPL is nolonger a criterion under ICDS; States have to ensure registration of all eligible beneficiaries

d) Funding Pattern: ICDS is a Centrally-sponsored Scheme implemented through the State Governments/UT Administrations. Prior to 2005-06, the Government of India was providing 100% financial assistance for inputs other than supplementary nutrition, which the States were to provide out of their own resources. Since many States were not providing adequately for supplementary nutrition in view of resource constraints, it was decided in 2005-06 to support to States up to 50% of the financial norms or to support 50% of expenditure incurred by them on supplementary nutrition, whichever is less. From the financial year 2009-10, Government of India has modified the funding pattern of ICDS between Centre and States. The sharing pattern of supplementary nutrition in respect of North-eastern States between Centre and States has been changed from 50:50 to 90:10 ratios. So far as other States and UTs, the existing sharing pattern of 50:50 continues. However, for all other components of ICDS, the ratio has been modified to 90:10(100% Central Assistance earlier).

e) International Partners:

Government of India partners with the following international agencies to supplement interventions under the ICDS:

i. United Nations International Children' Emergency Fund (UNICEF)
ii. Cooperative for American Relief Everywhere (CARE)
iii. World Food Program (WFP)

UNICEF supports the ICDS by providing technical support for the development of training plans, organizing of regional workshops and dissemination of best practices of ICDS. It also assists in service delivery and accreditation system where the capacity of ICDS functionary is strengthened. Impact assessment in selected States on early childhood nutrition and development, micronutrient and anemia control through Vitamin. UNICEF also conducts 'A' supplementations and deworming interventions for children in the age group of 9-59 months from time to time.

CARE is primarily implementing some non-food projects in areas of maternal and child health, girl primary education, micro-credit etc. Integrated Nutrition and Health Project (INHP)-III, which is a phase out program of INHP series, would come to an end on 31.12.2009.

WFP has been extending assistance to enhance the effectiveness and outreach of the ICDS Scheme in selected districts (Tikamgarh&Chhattarpur in Madhya Pradesh, Koraput, Malkangir&Nabrangpur in Orissa, Banswara in Rajasthan and Dantewada in Chhattisgarh), notably, by assisting the State Governments to start and expand production of low cost micronutrient fortified food known as 'India mix'. Under this the concerned State Government are required to contribute to the cost of India mix by matching the WFP wheat contribution at a 1:1 cost sharing ratio.

f) Special Focus on North East:

Keeping in view the special needs of North Eastern States, the Central Government sanctioned construction of 4800 Anganwadi Centers (child care centers) at a cost of Rs.600 million (USD 12864231) in 2001-02, 7600 Anganwadi Centers (AWC) at a cost of Rs.950million (USD 20369572) in 2002-03 and 7600 AWCs at a cost of Rs.950 million (USD 20369572) in 2004-05. In the wake of expansion of ICDS Scheme in 2005-06, it was provided in the Scheme itself that GOI will support construction of AWCs in NE States. The cost of construction was also revised from Rs.125000 (US$ 2680) per centre to Rs.175000 (US$ 3752) per center. In 2006-07, 50% of funds have been released to all the NE States except the State of Manipur as per the information available in the Guidelines of ICDS.

g) BudgetaryAllocation**:**

Alongside gradual expansion of the Scheme, there has also been a significant increase in the budgetary allocation for ICDS Scheme from Rs.103917.5 million (US$ 2312062007 in 10th Five Year Plan to Rs.444000 million (US$ 9878705124) in XI Plan Period.

Challenges:

The ICDS has existed for over three and half decades. It was intended to address the problem of children and maternal nutrition, but has had limited impact.The ICDS program has not made a significant dent in child malnutrition. Child malnutrition is mostly the result of high levels of exposure to infection and inappropriate infant and young child feeding and caring practices, and has its origins almost entirely during the first two to three years of life. This is mostly due to the priority that the program has placed on food supplementation, targeting mostly children after the age of three when malnutrition has already set in. Community workers are overburdened, because they are expected to provide pre-school education to four to six year olds as well as nutrition services to all children under six. Because of the emphasis on food supplementation and pre-school education, most children under three years are not targeted. The day to day functioning of the AWC is a critical factor of the effectiveness of the ICDS program.Participation of beneficiary women and adolescent girls in AWC activities was reported to be low. These two segments of population form the foundation for any child care program and their involvement is imperative for successful implementation of the ICDS Services Child malnutrition has barely declined, anemia among women and children has risen and a third of all adult women were undernourished at the end of 1990s and also in 2005-06 .The National Nutrition Monitoring Bureau (NNMB) report of 2006 reveals that the consumption of protective foods such as pulses, Green Leafy Vegetables (GLV), milk and fruits was grossly inadequate. Consequently, the intake of micronutrients such as iron, Vitamin A, riboflavin and folic acid were far below the recommended levels in all age groups. Low dietary intake and poor iron and folic acid intake are major factors responsible for high prevalence of anemia in India. Iodine Deficiency Disorder (IDD) is the outcome of iodine deficiency, the cause for increased prenatal mortality and mental retardation. Micronutrient malnutrition continues unabated in the country and exact mapping of micronutrient deficiencies has not been done for the country. Existing programs do not address the problem in a holistic manner. The nutrient supplementation programs does not cover the entire high risk group. The key constraint on the ICDS effectiveness is that its actual implementation deviates from the original design with an increased emphasis on the provision of supplementary feeding and preschool education to children four to six years old. As a result, most children under three years do not get micronutrient supplements, and most of their parents are not reached with counseling on better feeding and child care practices using

family budget. Awareness generation on consequences of micronutrient malnutrition, its prevention and management is not being addressed adequately.

Achievements:

A five-pronged strategy has been adopted during the 11th Plan (2007-2012) to accelerate the program to overcome micronutrient deficiency in the country. These relate to i) dietary diversification that requires the implementation of programs to improve the availability and consumption of and access to different types of micronutrient rich foods such as animal products, fruits and vegetables; ii) nutrition supplement to children between nine months to five years, providing iron and folic acid supplement to children from six months to two years and adolescent girls of 10-19 years, administering iron tablets to all pregnant and lactating women and by emphasizing breastfeeding of infants up to six months under the National Rural Health Mission (NRHM) implementation plan; iii) Horticultural Intervention to include increasing the nutrient rich crops and promotion of home gardening at household level; iv) public health measures to streamline procedures of procurement and supply, building institutional capacity for monitoring and mapping micronutrient deficiencies; v) Food fortification involves the addition of one or more essential nutrients to food for purpose of preventing deficiency in the population or specific population groups. There has been significant progress in the implementation of ICDS Scheme during X Plan both and during XI Plan (up to 2008-09), in terms of increase in number of operational projects and AnganwadiCentres (AWCs) and coverage of beneficiaries as indicated in table no.16. As per the information available from Ministry of Women and child Development, Government of India the total number of operational ICDS projects in the country 6120, operational Anganwadi Centers 1044269, supplementary nutrition beneficiaries 87.34 million and pre-school education beneficiaries 34.06 million till 31st March 2009.

Table No.1.3 Achievements of ICDS Scheme

Year ending	No. of operational projects	No. of operational AWCs	No. of Supplementary nutrition beneficiaries	No. of pre-school education beneficiaries
31.03.2002	4608	545714	37.51 million	16.65 million
31.03.2003	4903	600391	38.78 million	18.80 million

31.03.2004	5267	649307	41.51 million	20.44 million
31.03.2005	5422	706872	48.44 million	21.84 million
31.03.2006	5659	748229	56.22 million	24.49 million
31.03.2007	5829	844743	70.54 million	30.08 million
31.03.2008	6070	1013337	84.32 million	33.91 million
31.03.2009	6120	1044269	87.34 million	34.06 million

Source: Ministry of Women and Child Development, Govt. of India

CONCLUSION

To ensure food security to weaker sections of the society, Government has been implementing a number of program/schemes such as Targeted Public Distribution System (TPDS) focused on Below Poverty Line (BPL) families, Other Welfare Schemes such. as Mid-Day Meal Scheme for School Children, Integrated Child Development Services Scheme (ICDS) for pre-school children and mothers, Annapurna Scheme for indigent citizens who are not eligible for National Old-age Pension/benefits under other schemes of Government, Village Grain Banks Scheme (VGB) etc. However, to ensure food security to all citizens to the country based on rights approach, there is need for providing a statutory basis to food security. In order to provide food security to all citizens of the country especially the BPL households, the Government of India has proposed to enact a National Food Security Act in 2010.

The ICDS has to be universalized. The current scheme focuses on 0-3 year children. But malnutrition sets in uterus and is more likely to intensify during 0-3 year period. The under nourished pregnant women deliver undernourished children. Emphasis should be given to improve mothers feeding and caring behavior with emphasis on infant and young child feeding and maternal nutrition during pregnancy and lactation. The scheme accordingly needs to be restructured in a Mission Mode like that of National Rural Health Mission with a mission structure at the Center and similar structure at the State Level. The feeding component that is preparation of meals is to be entrusted to Self –help Groups (SHGs) or Mother's Groups as per

decision of the village committee. As Community workers are overburdened with day to day activities to provide pre-school education to four to six year olds, the preparation of meals under feeding component can be better served by the SHGs or Mothers Group from the same locality.

1. **AnganwadiCentre:**Anganwadi means a courtyard that is a child care and play centre located in a village/ slum. It provides services to children, pregnant women and lactating mothers under ICDS program.

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