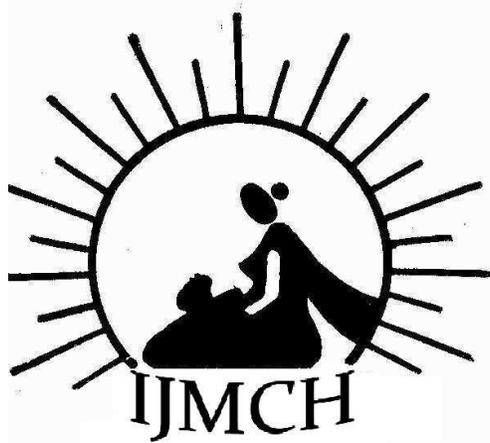


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From the Literature

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HEALTH**

From the Literature

THE NEXT REVOLUTION GIVING EVERY CHILD THE CHANCE TO SURVIVE *

*The current focus in the area of MCH is on reducing child and maternal mortality as enunciated in MDG # 4 & 5. There is a clarion call for a **second revolution in new born and child survival.***

“...WE ARE CALLED TO ACT BY OUR CONSCIENCE BUT ALSO BY OUR COMMON INTEREST, BECAUSE WHEN A CHILD DIES OF A PREVENTABLE DISEASE IN ACCRA THAT DIMINISHES US EVERYWHERE.”

Barack Obama, President of the United States of America, 11 July 2009.

“...OUR LONG-TERM CONCERN IS FOR THE FUTURE OF OUR CHILDREN. THEY NEED TO BE HEALTHY, WELL EDUCATED, WITH HOPE FOR THE FUTURE...WE WILL WAGE A WAR AGAINST MALNUTRITION OF CHILDREN, AGAINST MALARIA, TUBERCULOSIS, HIV/AIDS AND OTHER DISEASES.”

Manmohan Singh, Prime Minister of India, August 2006

“THE SURVIVAL OF CHILDREN IN LIBERIA IS A FUNDAMENTAL UNDERPINNING OF OUR DEVELOPMENT AGENDA BECAUSE IT SHAPES HOW WE PROGRESS AS A NATION...THERE NEEDS TO BE RENEWED MOMENTUM AROUND THE ISSUE OF CHILD SURVIVAL, AND LIBERIA IS LEADING THAT CLARION CALL.”

Ellen Johnson Sirleaf, President of Liberia, 200

6 The number of countries where more than half all child deaths occur – India, Nigeria, Democratic Republic of Congo, Ethiopia, Pakistan and China

57 The World Health Organization's assessment of the number of countries with 'critical shortages' of health workers – 36 of them in Africa

15 The number of times less likely an infant is to die from pneumonia if she or he is exclusively breastfed for the first six months, compared to an infant who is not

28% The proportion of children's deaths that are linked to poor sanitation and unsafe water

200,000–

400,000

The additional number of children who may die each year until 2015 because of the global financial crisis, according to the WHO.

FIGHTING INEQUITY IN INDIA*

In India nearly 2 million children under five die every year – more than in any other country. Its record on newborn and child mortality (72 per 1,000 live births) is worse than that of neighboring countries such as Bangladesh (61 per 1,000) and Sri Lanka (21 per 1,000). It accounts for one-fifth of newborn deaths, and is also home to one-third of the world's undernourished children. These figures persist, despite nearly a decade of high economic growth – which has not translated into improved healthcare and nutrition for the majority of children. However, there are huge differences between different states, and between different income groups, tribal groups and castes within India. For example, whereas the under-five mortality rate in Kerala is 16/1,000, and in Goa 20/1,000, in Uttar Pradesh it is 96/1,000, in Madhya Pradesh 94/1,000, and in Rajasthan 85/1,000. Across the whole country, the under-five mortality rate for the lowest wealth quintile is 92/1,000, compared with 33/1,000 for the highest wealth quintile. For many poor parents and their children, seeking medical help is a luxury, and health services are often too far away. Patriarchal norms, which place severe restrictions on women's mobility, prevent mothers being able to seek medical help. To achieve MDG 4, India will have to tackle poverty, inequality, exclusion and discrimination and take decisive steps to strengthen the rights of women. The federal government is already taking some important steps. Its ambitious National Rural Health Mission aims to bring infant mortality down to 30 per 1,000 births by 2012. It has increased the resources allocated to state governments for health. The Integrated Child Development Services – the country's nutrition supplement programme for children under five – has also been restructured to give greater priority to infants up to three years of age. The real challenge will be to ensure that high level policy commitments are translated into improved outcomes for the poorest and most marginalized children and their mothers.

*Second revolution in new born and child survival.**

Nearly 9 million children die every year before the age of five that is nearly one child every three seconds. Just fewer than 4 million of these children die within their first month, during the so-called newborn period. Nearly 3 million babies die within one week of birth, including up to 2 million who die on the first day of their lives. Nearly all – 97% – of these children die in low- or middle-income countries, and disproportionately from the poorest and most marginalized communities within those countries.⁴ In Afghanistan, one child in five will die before their fifth birthday.⁵ Across the whole of sub-Saharan Africa, the figure is one in seven. Thirty years ago, Jim Grant, then head of UNICEF, spearheaded a surge of global action to save millions of children's lives. Faced with the fact that many children were dying from conditions that could easily be prevented, he mounted a campaign to raise widespread awareness, money and political support for change. His efforts, and those of many others, became known as the 'child survival and development revolution'. Now, as we enter the second decade of a new century, we can count the successes of that revolution. Millions of children have survived who would otherwise not be here today, thanks to that extraordinary effort. Many of them have gone to school and

grown up healthy and ready to make their own contribution to their communities. There are doctors, teachers, nurses, and small businessmen and women who are changing the world around them – because a generation knew enough to care, and cared enough to act. Every child – no matter where or to whom they are born – has an equal right and deserves an equal chance to survive. And every one of us has a responsibility to act. It is time for the second revolution in newborn and child survival.

Why High levels of Child Mortality?*

High levels of child mortality can be explained at **three** levels.

1. There are a small number of diseases and conditions that **directly** cause more than 90% of deaths in under-fives. These are pneumonia, measles, diarrhea, malaria, HIV and AIDS, and neonatal conditions that occur during pregnancy and during or immediately after birth. The latter conditions are particularly significant in respect of newborn deaths. Severe infections, asphyxia and premature births cause 86% of newborn deaths. In nearly all cases, the diseases and conditions that are the direct causes of child death are preventable and treatable with proven interventions. But these interventions remain unavailable or inaccessible to many of the world's poorest children.

2. There are a series of **intermediate** factors that make some children more likely to fall prey to these diseases or medical conditions, and limit their chances of recovering from them. These factors include: the absence of essential healthcare or the inability of many mothers and their children to access it; high levels of maternal and child under nutrition and poor feeding practices; lack of access to clean water and safe sanitation; lack of maternal education; and limited access to contraception.

3. The deaths of children are not random events beyond our control. To a considerable extent, they are the outcome of policy and political choices taken by governments. They are also influenced by cultural, economic, environmental, political and social factors that governments, international institutions, the private sector and civil society could help to shape or mitigate. These are the **underlying** causes of newborn and child mortality. Of these factors, poverty, inequality and discrimination are particularly important. Women and girls face pervasive discrimination in many countries – their rights and opportunities denied. This is why a commitment to equity and justice – reducing disparities, realizing rights and empowering the poorest and most marginalized women – is absolutely critical for reducing child mortality rates. Poor governance, violent conflict and worsening environmental trends like climate change are additional underlying factors that impact on the survival prospects of children. Eight of the ten countries with the worst rates of child mortality have recently experienced conflict, violence or political instability, and climate change is already increasing the frequency of disasters that kill poor children. Children's chances of survival are also influenced by global economic conditions. The World Bank estimates that child deaths could be 200,000 to 400,000 per year higher between 2009 and 2015 as a result of the financial and economic crisis.¹⁰ And new global health pandemics, like the H1N1 virus (swine flu), could spread further and faster, or mutate into a more virulent form, overwhelming already fragile health systems and increasing levels of newborn and child mortality.

THE FOOD PRICE CRISIS.*

High food prices are having a serious impact on the world's poorest people, including poor children. Food prices rose to peak levels between 2005 and 2008. While they have fallen globally, they are expected to remain on average 35–60% higher than in the past decade. In April 2009, the UN Food and Agriculture Organization surveyed domestic food prices in 58 developing countries. They found that high food prices were persisting, and in some cases had reached record levels. In 80% of the countries looked at, food prices were higher than a year earlier, and in about 40% of countries prices had actually increased from January 2009. A number of longer-term factors will also push food prices higher over the coming years, including climate change and its impact on agricultural yields, water scarcity, the rising cost of energy, competition for land, and growing demand for food as a result of world population growth. For example, the World Bank has estimated that by 2030, the worldwide demand for food will have increased by 50%.⁶⁶ What does this mean for children? Poor rural families in countries with high levels of malnutrition need to spend at least half and sometimes as much as 80% of their income on food, depending on the season. Very small fluctuations in food prices can therefore have a serious impact. Using World Bank figures, Save the Children estimates that in 2008 alone a minimum of 4.3 million (and potentially as many as 10.4 million) additional children could have become malnourished in developing countries as a result of global food price rises.

**The Save the Children campaign report October 2009.*

CHILD ABUSE**

Child abuse is a state of emotional, physical, economic and sexual maltreatment meted out to a person below the age of eighteen and is a globally prevalent phenomenon. However, in India, as in many other countries, there has been no understanding of the extent, magnitude and trends of the problem. The growing complexities of life and the dramatic changes brought about by socio economic transitions in India have played a major role in increasing the vulnerability of children to various and newer forms of abuse. Child abuse has serious physical and psycho-social consequences which adversely affect the health and overall well-being of a child. According to WHO: "Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power."

Child abuse is a violation of the basic human rights of a child and is an outcome of a set of inter-related familial, social, psychological and economic factors. The problem of child abuse and human rights violations is one of the most critical matters on the international human rights agenda. In the Indian context, acceptance of child rights as primary inviolable rights is fairly recent, as is the universal understanding of it.

Definition of child abuse

The term 'Child Abuse' may have different connotations in different cultural milieu and socio-economic situations. A universal definition of child abuse in the Indian context does not exist and has yet to be defined.

According to WHO

Physical Abuse: Physical abuse is the inflicting of physical injury upon a child. This may include burning, hitting, punching, shaking, kicking, beating or otherwise harming a child. The parent or caretaker may not have intended to hurt the child. It may, however, be the result of over-discipline or physical punishment that is inappropriate to the child's age.

Sexual Abuse: Sexual abuse is inappropriate sexual behaviour with a child. It includes fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism and sexual exploitation. To be considered 'child abuse', these acts have to be committed by a person responsible for the care of a child (for example a baby-sitter, a parent, or a daycare provider), or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

Emotional Abuse: Emotional abuse is also known as verbal abuse, mental abuse, and psychological maltreatment. It includes acts or the failures to act by parents or caretakers that have caused or could cause, serious behavioural, cognitive, emotional, or mental trauma. This can include parents/caretakers using extreme and/or bizarre forms of punishment, such as confinement in a closet or dark room or being tied to a chair for long periods of time or threatening or terrorizing a child. Less severe acts, but no less damaging, are belittling or rejecting treatment, using derogatory terms to describe the child, habitual tendency to blame the child or make him/her a scapegoat.

Neglect: It is the failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. Physical neglect can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or cold). It may include abandonment. Educational neglect includes failure to provide appropriate schooling or special educational needs, allowing excessive truancies. Psychological neglect includes the lack of any emotional support and love, never attending to the child, substance abuse including allowing the child to participate in drug and alcohol use.

Working definition of child abuse

- **Child abuse** refers to the intended, unintended and perceived maltreatment of the child, whether habitual or not, including any of the following:
 - **Psychological and physical abuse**, neglect, cruelty, sexual and emotional maltreatment.

Any act, deed or word which debases, degrades or demeans the intrinsic worth and dignity of a child as a human being. Unreasonable deprivation of his/her basic needs for survival such as food and shelter, or failure to give timely medical treatment to an injured child resulting in serious impairment of his/her growth and development or in his/her permanent incapacity or death.

- **Physical abuse** is inflicting physical injury upon a child. This may include hitting, shaking, kicking, beating, or otherwise harming a child physically.
- **Emotional abuse** (also known as verbal abuse, mental abuse, and psychological maltreatment) includes acts or the failure to act by parents, caretakers, peers and others that have caused or could cause serious behavioural, cognitive, emotional, or mental distress/trauma.
- **Sexual abuse** is inappropriate sexual behaviour with a child. It includes fondling a child's genitals, making the child fondle an adult's genitals, sexual assault (intercourse, incest, rape and sodomy), exhibitionism and pornography. To be considered child abuse, these acts have to be committed by a person responsible for the care of a child or related to the child (for example a baby-sitter, parent, neighbor, relatives, extended family member, peer, older child, friend, stranger, or a day-care provider).
- Child neglect is an act of omission or commission leading to the denial of a child's basic needs. Neglect can be physical, educational, emotional or psychological. Physical neglect entails denial of food, clothing, appropriate medical care or supervision. It may include abandonment. Educational neglect includes failure to provide appropriate schooling or special educational needs. Psychological neglect includes lack of emotional support and love.

CHILD ABUSE SCENARIO

Child abuse across the globe

The UN Secretary General's Study on Violence against Children³ has given the following overview of the situation of abuse and violence against children across the globe.

- WHO estimates that almost 53,000 child deaths in 2002 were due to child homicide.
- In the Global School-Based Student Health Survey carried out in a wide range of developing countries, between 20% and 65% of school going children reported having been verbally or physically bullied in school in the previous 30 days. Similar rates of bullying have been found in industrialized countries.
- An estimated 150 million girls and 73 million boys under 18 have experienced forced sexual intercourse or other forms of sexual violence involving physical contact.
- UNICEF estimates that in sub-Saharan Africa, Egypt and Sudan, 3 million girls and women are subjected to FGM every year.
- ILO estimates that 218 million children were involved in child labour in 2004, of which 126 million were engaged in hazardous work. Estimates from 2000 suggest that 5.7 million were in forced or bonded labour, 1.8 million in prostitution and pornography and 1.2 million were victims of trafficking.
- Only 2.4% of the world's children are legally protected from corporal punishment in all settings.

One of the major problems in understanding the scope of the subject of 'child abuse' is that it is extremely difficult to get responses from children on such a sensitive subject because of

their inability to fully understand the different dimensions of child abuse and to talk about their experiences. It is therefore difficult to gather data on abused children. Further, definitions of abuse are not yet consistent within countries, much less from country to country or region to region. Yet governments do estimate that the number of abused and neglected children is alarming, and unless governments get their act together and respond to the situation by way of both prevention and treatment, we will be doing a grave injustice to our children and would be denying them their basic rights.

Child abuse in Asia

While certain child abuse and neglect issues are common in almost all countries at the global level such as physical abuse, sexual abuse, emotional and psychological abuse, abandonment and, increasingly, problems of street children, there are also many issues which are prevalent only in certain regions of the world. For instance, in Asia where population density is high, the issues of child labour and child sexual exploitation are also high. Political instability and other internal disturbances, including conditions of insurgency in many countries in Asia are also creating major problems, with increasing number of child soldiers, refugee children, trafficked children and children on the streets.

Prevention of child abuse and neglect is still an uncharted field in Asia. The largest population of children in the world live in South Asia and majority of these children lack access to proper health care, nutrition and education. This reflects the socio-economic reality of the developing countries of the Asian region. The main factors that contribute to the magnitude of the problem of child abuse are poverty, illiteracy, caste system and landlessness, lack of economic opportunities, rural-urban migration, population growth, political instability and weak implementation of legal provisions.

Mostly, the approaches for prevention and methods of treatment of child abuse do not cover the entire gamut of abuse. Lack of reliable data on the incidence of child abuse and of knowledge of methods of prevention and treatment has been recognized and is being addressed by sovereign governments, national and international organizations e.g., UNICEF, Save the Children, Plan International, ISPCAN, etc.

Child abuse in India

Nineteen percent of the world's children live in India. According to the 2001 Census, some 440 million people in the country today are aged below eighteen years and constitute 42 percent of India's total population i.e., four out of every ten persons. This is an enormous number of children that the country has to take care of. While articulating its vision of progress, development and equity, India has expressed its recognition of the fact that when its children are educated, healthy, and happy and have access to opportunities, they are the country's greatest human resource.

The National Policy for Children, 1974, declared children to be a 'supreme national asset'. It pledged measures to secure and safeguard all their needs, declaring that this could be done by making wise use of available national resources. Unfortunately, ten successive Five Year Plans have not allocated adequate resources to meet the needs of children. An exercise on child budgeting carried out by the Ministry of Women and Child Development revealed that total expenditure on children in 2005-2006 in health, education, development and protection together amounted to a mere 3.86%, rising to 4.91% in 2006-07. However, the share of resources for child protection was abysmally low at 0.034% in 2005-06 and

remained the same in 2006-07. Available resources have also not been utilized effectively for achieving outcomes for children. As a result, the status and condition of children have remained far from secure.

Harmful traditional practices like child marriage, caste system, and discrimination against the girl child, child labour and Devadasi tradition impact negatively on children and increase their vulnerability to abuse and neglect. Lack of adequate nutrition, poor access to medical and educational facilities, migration from rural to urban areas leading to rise in urban poverty, children on the streets and child beggars, all result in break down of families. This increases the vulnerabilities of children and exposes them to situations of abuse and exploitation.

According to the report published in 2005 on 'Trafficking in Women and Children in India', 44,476 children were reported missing in India, out of which 11,008 children continued to remain untraced. India, being a major source and destination country for trafficked children from within India and adjoining countries has, by conservative estimates, three to five lakh girl children in commercial sex and organized prostitution.

CRITICAL CONCERNS**

- Every fifth child in the world lives in India
- Every third malnourished child in the world lives in India
- Every second Indian child is underweight
- Three out of four children in India are anemic
- Every second new born has reduced learning capacity due to iodine deficiency
- Decline in female/male ratio is maximum in 0-6 years: 927 females per 1000 males
- Birth registration is just 62% (RGI-2004)
- Retention rate at Primary level is 71.01% (Elementary Education in India Progress towards UEE NUEPA Flash Statistics DISE 2005-2006)
- Girls' enrolment in schools at primary level is 47.79% (Elementary Education in India Progress towards UEENUEPA Flash Statistics DISE 2005-2006)
- 1104 lakh child labour in the country (SRO 2000)
- IMR is as high as 58 per 1000 live births (SRS- 2005)
- MMR is equally high at 301 per 100,000 live births (SRS, 2001-03)
- Children born with low birth weight are 46% (NFHS-III)
- Children under 3 with anemia are 79% (NFHS-III)
- Immunization coverage is very low (polio -78.2%, measles-58.8%, DPT-55.3%, BCG-78%)(NFHS-III)

****Study on Child Abuse: INDIA 2007** Ministry of Women and Child Development Government of India.

STATUS OF INDIA'S CHILDREN***

Child Survival and Child Health

2.5 million children die in India every year, accounting for one in five deaths in the world, with girls being 50% more likely to die. One out of 16 children die before they attain one year of age, and one out of 11 die before they attain five years of age. India accounts for 35% of the developing world's low birth weight babies and 40% of child malnutrition in developing countries, one of the highest levels in the world. Although India's neo-natal mortality rate declined in the 1990s from 69 per 1000 live births in 1980 to 53 per 1000 live births in 1990, it remained static, dropping only four points from 48 to 44 per 1000 live births between 1995 and 2000.

The 2001 Census data and other studies illustrate the terrible impact of sex selection in India over the last few decades. The child sex ratio (0-6 years) declined from 945 girls to 1000 boys in 1991 to 927 in the 2001 Census.

Around 80% of the total 577 districts in the country registered a decline in the child sex ratio between 1991 and 2001. About 35% of the districts registered child sex ratios below the national average of 927 females per 1000 males. In the 1991 Census, there was only one district with a sex ratio below 850, but in the 2001 Census, there were 49 such districts.

India has the second highest national total of persons living with HIV/AIDS after the Republic of South Africa. According to National Aids Control Organization (NACO), there were an estimated 0.55 lakh HIV infected 0-14 year old children in India in 2003. UNAIDS, however, puts this figure at 0.16 million children.

According to the 2001 Census report, amongst all persons living with disabilities, 35.9% were children and young adults in the 0-19 age group. Three out of five children in the age group of 0-9 years have been reported to be visually impaired. Movement disability has the highest proportion (33.2%) in the age group of 10-19 years. This is largely true of mental disability also.

Child Development

The population of children aged 0-6 years is 16.4 crores as per the 2001 Census. According to a UNESCO report, however, of the total child population, 2.07 crores (6%) are infants below one year; 4.17 crores (12%) are toddlers in the age group 1-2 years; 7.73 crores (22.2%) are pre-schoolers in the age group 3-5 years. The report highlights that only 29% of pre-primary age children are enrolled in educational institutions in India. Services under the ICDS scheme covered only 3.41 crores children in the age group 0-6 years as in March 2004, which is around 22% of the total children in that age group. Supplementary nutrition too was being provided to 3.4 crores children, as against 16 crores children. Of these, 53% were reported to be under-nourished.

Child Protection

While on the one hand girls are being killed even before they are born, on the other hand children who are born and survive suffer from a number of violations. The world's highest number of working children is in India. To add to this, India has the world's largest number

of sexually abused children; with a child below 16 years raped every 155th minute, a child below 10 every 13th hour and one in every 10 children sexually abused at any point of time.

The National Crime Records Bureau (NCRB) reported 14,975 cases of various crimes against children in 2005.

Most subtle forms of violence against children such as child marriage, economic exploitation, practices like the 'Devadasi' tradition of dedicating young girls to gods and goddesses, genital mutilation in some parts of the country are often rationalized on grounds of culture and tradition. Physical and psychological punishments take place in the name of disciplining children and are culturally accepted. Forced evictions, displacement due to development projects, war and conflict, communal riots, natural disasters - all of these take their own toll on children. Children also stand worst affected by HIV/AIDS. Even those who have remained within the protective, net stand at the risk of falling out of it.

Child Participation

Children in most sections of Indian society are traditionally and conventionally not consulted about matters and decisions affecting their lives. In the family and household, the neighborhood and wider community, in school or in work place, and across the settings of social and cultural life, children's views are mostly not given much importance. If they do speak out, they are not normally heard. The imposition of restrictive norms is especially true for girl children. This limits children's access to information and to choice, and often to the possibility of seeking help outside their immediate circle.

*** Ministry of Women and Child Development (2007): Working Group Report on Women and Children for the Eleventh Five Year Plan (2007)

CHILD DOMESTIC WORKERS****

SITUATION OF CHILDREN IN INDIA

The children of India continue to be the most vulnerable section of the society and their growth and development remains a major concern. In India, the population of children below 18 is as high as 41 %. A large proportion of these children languish in the quagmire of apathy and alienation, suffering from the worst forms of deprivation and abject poverty and are victims of various forms of exploitation and abuse. According to the 2001 Census, India is estimated to have more than 400 million children below the age of 18 out of which 35 million children are in need of care and protection. Efforts to overcome the problem have led to the formulation of several legal provisions largely aimed at providing adequate protection to them.

ILO Convention on the prohibition and elimination of the worst forms of child labour has recognized children in domestic work as a new form of slavery and as a priority sector for removing children from work.

Though child domestic work is widespread, the basic characteristic that the child remains within the four walls of a house makes it invisible. It is therefore challenging to bring the issue from the confines of a home onto a public debate and government's agenda.

The Ministry of Labour, Government of India, only through a notification issued on July 10, 2006 has broad based the scope of the Child Labour (Prohibition & Regulation) Act, 1986, by including child domestic workers and children working in dhabas, up to 14 years of age within the purview of the Act.

Although this widens the scope of the Act, it poses serious challenges to all civil society organizations and the government machinery to reach out to children, especially in domestic work, since most of these children are invisible, working within the four walls of the employers' homes. These children are deprived of their right to education, health, play, security, protection, equal opportunity, participation and development. This further increases their vulnerability to exploitation and abuse.

With no official statistics available, it is difficult to estimate their actual numbers. Also, majority of child domestic workers fall in the age category of 15-18 years and in the absence of any law for them, it is difficult to wean them out from work.

In this scenario, the interventions on the issue of child domestic work should generate public opinion through awareness campaign and make the issue visible. It should also help in formulating meaningful policies and programs and ensure effective implementation of these programs with an inter sectoral approach and advocating for legislative reforms. In order to ensure children's participation in all the stages, it is crucial to carry out capacity building of children's groups on issues related to the rights of child and create opportunities for them so that the issue of child domestic workers is brought to the fore front.

CHILD DOMESTIC WORKERS

WHO ARE CHILD DOMESTIC WORKERS (CDWS)?

∅ CDWs are girls, sometimes boys, who come from villages to work and support their parents, pay back a loan, feed their siblings or are living with their families in the city and work in three to four homes.

∅ They either are live in (fulltime) or part time workers.

∅ Fulltime child domestic workers live in the house of the employers, away from their parents, brothers and sisters, away from home, to supplement the income of their family.

∅ They are invisible because each child is separately employed and works in the seclusion of a private home.

∅ Part time child domestic workers work generally at the cost of their education.

∅ Children in domestic work are difficult to reach as they are hidden and silenced behind closed doors.

∅ Their jobs are invisible as they are being undertaken within closed doors.

HOW IS CHILD DOMESTIC WORK DIFFERENT FROM OTHER FORMS OF CHILD

LABOUR?

∅ Domestic work is among the lowest in status, least regulated and poorest in terms of remuneration.

∅ They live in child domestics are under the exclusive control of the employers; They have little or no freedom or free time.

∅ Since it is possible for very young children to undertake light household tasks, the age of entry can be as young as six.

∅ Many child domestics do not handle their earnings; some are unpaid while the earnings of others are given to their parents.

∅ Their powerlessness within the household environment renders them vulnerable to verbal, physical or sexual abuse.

∅ The live in child domestic is cutoff from her own family, has little opportunity to make friends, and almost no social exchange with peers.

FACTORS THAT ENCOURAGE CHILD DOMESTIC WORK

There are several reasons why children become domestic workers:

∅ Children can be bonded, lent, given or sold into domestic work. Undoubtedly, the most prominent one is extreme poverty at home and the parents' inability to look after their children. Thus, many children work in order to supplement the family income. In most cases the parents or the guardian of the children decide this.

∅ Some cultures traditionally have a system of sending children from poor rural families to be "looked after" or be "adopted" by more wealthy urban families. It is assumed that they will be exposed to a better environment and will have better opportunities for her future. A

number of parents believe that a child domestic worker ensures basic social and economic security for herself.

∅ Few children work as domestic workers in the hope that their employer will help them to achieve a better future either through a better job or through marriage.

Push factors

∅ Deepening poverty, failure of government programs to make an impact on poverty reduction and the adverse impact on globalization has further impoverished the poor.

∅ Hope for a bright future.

∅ Family problems, ill treatment and loss of one parent or both parents.

∅ Natural calamities and poor rehabilitation of victims of natural disasters.

∅ Male unemployment and loss of family income that puts pressure on women to earn.

∅ Biased religious and cultural practices that go against women and girl children.

∅ Porous borders and weak law enforcement in border areas due to inefficient or corrupt policing.

Pull factors

∅ Demand for cheap labour in growing market economies.

∅ The preference for children in domestic work as they are powerless, docile and less likely to organize themselves against abuse.

∅ Women's unequal status and commoditization of women in a patriarchal society.

∅ Glamour of city life.

∅ Rising consumerism and lack of access to education.

∅ False image of security, and a stable, healthy environment in the home of the employer.

∅ Debt bondage.

∅ Inaccessibility to education.

∅ Trafficking related to migration where families migrate to the cities slums and pavements.

Children get into domestic work:

∅ Through the mother who is a domestic worker.

∅ Through family / neighbours.

∅ Other domestic workers from the region.

∅ Placement agencies.

IMPLICATIONS OF THE WORK OF CDWS

Ø Respect for identity, selfhood and freedom

The younger the child starts work as a domestic, the greater the risk to her sense of identity.

The labels 'servant', 'maid', 'girl' used to describe child domestic workers have proved to be significant in reinforcing their low self esteem.

Ø Physical well being:

Accusations of laziness or bad work are often behind violent incidents against domestic workers. Accidents are also a risk, especially when the child is exposed to hazardous work like cooking, ironing of clothes, boiling water, chopping vegetables, using chemicals for cleaning, changing gas cylinders, carrying heavy items, etc.

Ø Educational development:

Lack of schooling not only reduces skills, but limits personal development.

Ø Psychosocial and emotional development:

Confinement to the house, lack of interaction with peers, recreation nonexistent, no time to play and having to adopt varied roles and personalities within the household can psychologically and emotionally wreck the child.

Culture of Alienation:

Children are often separated from their families at a very young age. This separation may be for life as many children are too young at the time to remember their full name or where they came from. They are transferred into a set up and culture alien to them and very minimal (if any) adjustment assistance is provided to them. They are forced to grow into sudden adulthood and many cannot comprehend why they had to leave their parental home and carefree childhood only to be plummeted into a life of work and slavery. The alienation and isolation child domestic workers experience tends to be greater in the urban areas than in the rural areas. In urban areas, child domestic workers are completely cut off from their known surroundings and are frequently deprived of their access to even environmental resources such as space and open air.

Ø Sense of Deprivation:

As CDWs watch other children play, study, enjoy sweets and other food, and go on outings, in essence, enjoy their childhood, the sense of deprivation child domestic workers experience is heartbreaking. Their social interaction, if not completely prohibited, is limited. They have no coping mechanisms and often experience a sense of rejection. These conditions, especially when compounded by verbal, physical abuse and harassment, often result in personality disorders.

An important characteristic of child domestic workers is that they live and work in a family environment they do not belong to. At an impressionable age they have to adapt to many norms of societal behavior depending on the outlook and value system of each family. Child domestic workers may work in many houses but still have no home. This can also hamper their normal psychological development.

Ø Dependence Proneness

Rather than being taken in and treated as part of the family, majority of child domestic workers are viewed as a transferable resource that is only as useful as her/his productivity.

Employers, instead of seeing themselves as exploiters, regard themselves as benefactors, and this assumption, ingrained in the minds of many, is difficult to challenge. Unfortunately, the child domestic workers are under the care of adults whose primary concern is not the welfare of the child, but rather what contributions the child can make to the household.

This leads to a special case of dependency where all decision making power is in the hand of the employer. Complete dependency upon the employer means that the child is unable to take any decisions regarding her own welfare and that she is subjected to the whims of the employer. Not only are the child's choices limited, but the child's right to freedom of choice is taken away all together.

The child domestic worker is not able to insist on her/his rights or on decent treatment, as she/he has no support structure outside her/his place of work.

TRAFFICKING FOR CHILD DOMESTIC WORK

Trafficking of children, especially girls for forced labour is one of the fastest growing areas in inter country and intra country trafficking. Children and women are trafficked from rural, tribal areas – drought prone and disaster affected areas to the bigger cities of India from where they are often trafficked to foreign countries. The phenomenon of intra country trafficking is important in a huge, multicultural, multi linguistic country like India where there are cultural climatic and linguistic variations among regions. A girl trafficked from the Jharkhand tribal belt is as alien in Mumbai as a girl from Nepal.

Trafficking is closely linked to forced migration. Trafficking has been most often linked to prostitution but trafficking is also closely associated with forced labour, especially domestic work.

Children who do not have parents or relatives to look after them often find employment in an urban household through village contacts. These children are brought along by relatives or neighbors to bigger cities under the pretext that they are actually helping children to stand on their own. It becomes an “invisible” way of child trafficking. These children are trafficked to work as domestic labourers, which in some cases can be compared to slavery. However, this form of trafficking is not within the purview of law. Trafficking of children and women for forced labour is one of the fastest growing areas in inter country and intra country trafficking.

CHILD DOMESTIC WORK AND INTERNATIONAL STANDARDS

The UN Convention on the Rights of the Child (UNCRC) sets up standards concerning childhood. If a child enjoys all the rights as per the UNCRC, it enjoys a well protected childhood and one, which equips him or her for adulthood. A child placed in a so called “good” household, learning how to do domestic chores, is not being protected and prepared for adulthood, for she is being “protected” by the employer only in exchange for her work. And her entire “preparation for adulthood” is confined to domestic chores. Her other childhood needs are neglected and her other avenues for better life opportunities are closed.

Virtually all countries in the world have now ratified this human rights treaty agreeing

to abide by the standards it has set for the treatment of children. Therefore, along with the 1956 UN Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery, ILO's Forced Labour Convention No. 29 (1930) and Convention No. 138 on the Minimum Age for Admission to Employment (1973), the UN CRC provides international legitimization for action on behalf of child domestics.

The Rights in the UNCRC which child domestics do not or may not enjoy are as follows:

- ∅ The right of nondiscrimination, on grounds of ethnic or social origins, birth or other status(Article 2)
- ∅ The right to be cared for by his or her parents (Article 7)
- ∅ The right of a child separated from his or her parents to maintain regular contact with them (Article 9)
- ∅ The right to be brought up by parents or guardians whose basic concern is the best interests of the child (Article 18)
- ∅ The right to protection from physical or mental ill treatment ,neglect or exploitation (Article 19)
- ∅ The right to conditions of living necessary for the child's development (Article 27)
- ∅ The right to education (Article 28)
- ∅ The right to rest, leisure, play and recreation (Article 31)
- ∅ The right to protection from economic exploitation and from performing any work that interferes with his or her education or is harmful to his or her mental, spiritual or social development (Article 32)
- ∅ The right to be protected from all forms of sexual exploitation and sexual abuse (Article 34)
- ∅ The right not to be arbitrarily deprived of liberty (Article 37)

CDWs and ILO Convention 182

The ILO adopted a new Convention in 1999 in an attempt to outlaw the worst and the most damaging forms of child labour,

Ratifying States pledge immediate and effective action to prohibit and eliminate the worst forms of labour for anyone under the age of 18.

Child Domestic Work is not specified in Convention 182 as a "worst form" of child labour per se.

However, many children who are employed as domestic workers fall into one or the other category of the worst forms, either because of their extreme young age or because of the way in which they have been recruited or because of the treatment they are subjected to.

The 'worst form' categories are defined as follows:

- All forms of slave labour, including a situation where the child has been trafficked, sold or is forced to work to pay off family debt.
- The exploitation of children in commercial sex or pornography.

- The exploitation of a child for illicit purposes, specially production and trafficking of drugs.
- Work which, by its nature or the circumstances in which it is carried out, is likely to harm a child's health, safety or morals.

*****Evaluation of Project 'Comprehensive Intervention on Child Domestic Work' Save the Children Federation.*

Management of Children with Severe Acute Malnutrition (SAM) is a National Priority to Achieve Reduction in Under Five Mortality*****

Background

Severe acute malnutrition (SAM) or severe wasting is defined by very low weight-for-height (below -3 z-scores of the median WHO child growth standards), a mid-upper arm circumference < 115 mm, or by the presence of nutritional edema. SAM remains one of the major killers of children under five; it contributes to approximately 1 million child deaths every year. Globally, it is estimated that 26 million children under five years are severely acutely malnourished, most of whom live in South Asia and in sub-Saharan Africa. India alone is home to 8,105,000 children with SAM (31.2 % of the world's severely wasted children).

Most of the deaths caused by SAM can be averted. In recent years, there have been significant developments in the prevention and treatment of SAM. WHO and UNICEF recommend two major approaches to the treatment of SAM.

1. Facility/hospital-based approach for clinical management using the WHO protocol
2. Home/community-based approach, an integrated public health response to acute malnutrition without medical complications.

The summary below gives an overview of the scientific evidence presented in the accompanying compendium of research (Volumes I and II) on the contribution of SAM to child mortality; detection and management of SAM among children aged 6-60 months; and the management of SAM with other conditions (for example HIV/AIDS).

Child under nutrition and mortality

As stated above, SAM is a deadly condition. It kills children by increasing the case fatality of common childhood infections, and therefore it is an immediate or direct cause of child death.

Malnourished children who are ill die because they are malnourished. Mortality rates in SAM children are 9 times higher than those in well-nourished children. According to the Maternal and Child Under nutrition Study Group, 3.5 million child deaths, 35% of the disease burden in children younger than 5 years, and 11% of total global disability-adjusted life-years (DALY) are attributable to maternal and child under nutrition(1). It was estimated by the same group that stunting, severe wasting, and intrauterine growth restriction together were responsible for 2.2 million deaths and 21% of DALYs for children below five years of age.

A recent study in Senegal and Congo among children below 5 years found that severe wasting was one of the leading causes of death among under-fives, with a high incidence (about 2% per child semester), long duration of episodes, and high case fatality rates (6-12%) (2).

Severe wasting is not the only form of malnutrition that kills children. A re-analysis of six published population-based studies of anthropometry-mortality indicated that mild to moderate malnutrition was associated with increased mortality and that there was an epidemiologic synergism between malnutrition and morbidity.

It appears from the current evidence that malnutrition has a far more powerful impact on child mortality than generally appreciated, and strategies combining prevention and treatment of mild to moderate, and severe acute malnutrition will be more effective to address this challenge and reduce its negative impacts.

Case detection of SAM using clinical and anthropometric assessments

Several clinical and anthropometric methods are commonly used for case detection of severely malnourished children aged between 6 and 60 months. These methods include the measurement of weight-for-age, mid-upper arm circumference (MUAC), and bipedal pitting edema. The complexity and cost of measuring weight-for-height make it unsuitable for use by community-based volunteers. A 2006 review of these different clinical and anthropometric methods with regard to their ability to predict mortality risk and reflect nutritional status revealed that MUAC < 110 mm, with the addition of presence of bipedal edema, is the indicator best suited for screening and case detection of child malnutrition in the community(3).

WHO child growth standards and their implications

In 2006, the World Health Organization released new child growth standards. The introduction of these standards with the z-score criterion (weight-for-height < - 3 z-score) for identifying children for admission into SAM treatment programs has some important programmatic implications. Using < - 3 z-score implies the inclusion of children who are younger but have relatively higher weight-for-height on admission compared with the National Center for Health Statistics (NCHS) reference that uses weight-for-height <70% of the median criterion for SAM case detection. Using the WHO standards in developing country situations results in 2-4 times increase in the number of infants and children falling below - 3 SD compared to using the former NCHS reference. The introduction of the WHO child growth standards (and MUAC < 115 mm) to identify SAM children will increase the caseload for therapeutic feeding programmes, however at the same time, more children will be detected earlier and in a less severe state; thereby resulting in faster recovery and lower case fatality rates. Increasing numbers of children with SAM identified using the new WHO cut-offs has cost and human resource implications, especially in resource-poor settings.

WHO and UNICEF recommendations

WHO and UNICEF recommend the use of a cut-off for weight-for-height of below - 3 SD of the 2006 WHO child growth standards or a MUAC < 115 mm to identify infants and children (6-60 months) as having SAM (4). The prevalence of SAM based on weight-for-height below -3 SD or a MUAC < 115 mm are very similar. The presence of bilateral edema remains another independent indicator of SAM.

With the new WHO standards, it was also essential to redefine the discharge criteria for inpatient SAM children. It is recommended that the discharge criterion be based on percentage weight gain. For simplicity, it is possible to use 15% weight gain as discharge criterion for all infants and children admitted to therapeutic feeding programs.

The lower case fatality rates and slower weight gains of children selected by the WHO standards should be taken into account when monitoring the effectiveness of therapeutic feeding programs. To improve planning, it is vital that the same criteria are used for estimating case load as are being used for admission into programs.

Facility/hospital-based management of SAM

The treatment of SAM occupies a unique position between clinical medicine and public health.

Hospitals treating SAM are commonly challenged with extremely ill patients who need intensive medical and nursing care. Most of these medical care facilities are in the poorest parts of developing countries with severe capacity constraints, in particular, very few skilled staff.

Additionally, the children's caregivers come from economically disadvantaged families whose existence depends on daily labor. Admitting their children into a medical care facility puts great demands on their time and this should be taken into account to achieve an impact at a population level.

The case fatality rates for severe malnutrition treated in health facilities in resource-poor settings have remained high at 20-30% for marasmus and up to 50-60% for kwashiorkor(5). The high case fatality rates in children with SAM can be substantially reduced by methodically following standardized treatment protocols such as the WHO protocol for in-patient management.

The core of the accepted WHO management protocol is 10 steps in two phases – stabilization and rehabilitation. These 10 essential steps are listed below: 1. Treat/prevent hypoglycemia; 2. Treat/prevent hypothermia; 3. Treat/prevent dehydration; 4. Correct electrolyte imbalance; 5. Treat/prevent infection; 6. Correct micronutrient deficiencies; 7. Start cautious feeding with F-75; 8. Achieve catch-up growth by feeding F-100 after appetite returns; 9. Provide sensory stimulation and emotional support; and 10. Prepare for follow-up after recovery (6). This approach requires many trained staff and substantial in-patient bed capacity. Adequate training of health staff in the management of SAM is essential if the WHO guidelines were to be effective.

Experience over the past decade indicates that the survival of malnourished children improves substantially if the WHO guidelines are followed systematically. A halving of deaths, from 40% to 20% has been regularly reported when the guidelines are followed to a large extent(7) (e.g. special feeds day and night, antibiotics, electrolytes, avoiding intravenous fluids except in shock, and not giving diuretics for edema). Mortality can be reduced to below 10% when the guidelines are meticulously followed. This involves training of all incoming staff, careful supervision of junior staff, careful monitoring of intake to guide selection of oral or nasogastric feeding, careful monitoring during rehydration to prevent fluid overload, daily ward rounds to identify children with new episodes of diarrhea or illness, good hygiene to prevent nosocomial infections, attentiveness to danger signs, and diligence in performing all tasks. Specialized skills of experienced pediatricians are required

to reduce mortality below 5% as these residual deaths are usually among very seriously ill children.

Successful implementation of the WHO protocol in hospital settings has been reported in studies from Bangladesh and South Africa where quality of care improved with implementation of the WHO guidelines and case fatality rates reduced(8,9). However, it should be taken into account that these observations are from studies done in a few well-resourced hospital settings, with skilled and motivated health staff that is the major determinant of their success. In reality, access to suitable health facilities is often limited where it is needed most, and the skilled staff required is rarely available in resource-poor contexts. In another study to improve the hospital management of malnourished South African children, participatory research led to the formation of a hospital nutrition team, which identified shortcomings in the clinical management of severely malnourished children and took action to improve quality of care. These actions were associated with a reduction in case fatality rates.

Modifying WHO guidelines

The efficacy of protocols based on WHO's modified guidelines has been tested in India and Bangladesh on a small number of children(10,11). In both countries, it was found that following modified WHO guidelines is feasible, efficacious and cost effective in resource-limited settings.

Early discharge of patients is possible with no complications or mortality. However, critical reviews of the modifications of WHO's guidelines for the treatment of SAM indicate that while efficacious simplifications to these guidelines to suit local conditions and needs are welcome, they must be based on sufficient sample size.

This approach requires careful monitoring because nutrient adequacy is hard to achieve with mixtures of low-cost local foods combined with micronutrient supplements. Data suggest that it is not possible to attain the micronutrient content of milk-based therapeutic diets (F75 and F100) with local foods only. Nonetheless, these mixtures of family foods also make good complementary foods and have the potential to prevent malnutrition in the long term.

SAM and other infections

Infections such as HIV and tuberculosis increase the workloads of hospital units treating children with SAM. These infections raise the prevalence of SAM and increase the case fatality rates. Although experience in resource-poor sub-Saharan countries has shown that many HIV positive children can recover normal nutritional status when given standard treatment protocols for SAM; their recovery is slower than that of uninfected children.

HIV infection is also associated with high rates of complication and case fatality. A study on management of SAM in areas of high HIV prevalence was carried out using (i) an initial inpatient phase, based on WHO guidelines, and (ii) an outpatient recovery phase using RUTF. The inpatient mortality and cure rates improved compared to pre-study data but the overall mortality rate did not meet international standards. Home-based therapy with RUTF was associated with more rapid weight gain and a higher likelihood of reaching 100% weight-for-height.

Home/community-based management of SAM

Evidence suggests that large numbers of children with SAM with no medical complications (60 – 90% of children with SAM) can be treated in their communities without being admitted to a health facility or a therapeutic feeding center (12). Community-based management of SAM results in a substantial increase of program coverage and successful treatment of children leading to lower case fatality rates.

Community-based management of SAM is based on early detection and assessment of children with SAM in the community, and home-based care of those without complications. Those with complications, evidenced by loss of appetite, will still need facility-based treatment. This approach involving active case finding ensures that many children with SAM who usually remain undetected because their families do not seek care for them are reached.

The community-based component of the treatment of severe malnutrition should be closely linked with the facility-based component, so that children who are too ill to be treated at community level or who are not responding to treatment can be referred to the facility level, and those receiving facility-based treatment who have regained their appetite can be transferred for continued care in the community.

Experience in Ethiopia showed that in community-based therapeutic care (13), families became key participants in the rehabilitation of their children, and communities became strengthened through the mobilization of local networks and the improved knowledge base of local health networks. Recovery rates were comparable with international standards, and coverage far exceeded that of traditional center-based care.

In other experiences in twenty-one community-based therapeutic care programs implemented in Malawi, Ethiopia, and North and South Sudan between 2000 and 2005 where 23,511 cases of SAM were treated, coverage rates were 73% and recovery rates of 79.4% and mortality rates of 4.1% were achieved. Of the SAM children, 76% were treated solely as out-patients. The cost effectiveness analysis of these programs indicated that the cost varied from US\$12 to US\$132 per year of life gained.

In addition, thirty-three community-based rehabilitation programs delivered by day-care nutrition centers, residential nutrition centers, primary health clinics, and domiciliary care with or without food from 1980-2005 were reviewed for their effectiveness. Effectiveness was defined as mortality of less than 5% and an average weight gain of at least 5 g/kg/day. It was found that all four delivery systems can be effective with careful planning and resources. However, it is unlikely that a single delivery system would suit all situations worldwide. The choice of a system depends on local factors. High energy intakes (> 150 kcal/kg/day), high protein intakes (4-6 g/kg/day), and provision of micronutrients are essential for success (15).

A study in Malawi compared therapeutic feeding program coverage of severely malnourished children (16) achieved by a community-based therapeutic care (CTC) program and a therapeutic feeding center (TFC) program operating in neighboring districts. Results revealed that CTC gave substantially higher program coverage than a TFC program. Findings of a study from Niger suggest that satisfactory results for the treatment of severe malnutrition can be achieved using a combination of home and hospital-based strategies.

Ready-to-use therapeutic food (RUTF)

Children with SAM need safe, palatable foods with high energy content and adequate amounts of vitamins and minerals. RUTF spread is an edible lipid-based paste that is energy-dense, resists bacterial contamination, and requires no cooking. The most widely used RUTF is a high protein and high energy peanut-based paste approved by the World Health Organization. The spread is a mixture of milk powder, sugar, vegetable oil, peanut butter, vitamins and minerals. RUTF spread can be safely and easily produced in small or large quantities in most settings worldwide. Several countries in Africa such as Niger, Congo, Malawi and Ethiopia are manufacturing RUTF following appropriate technology transfer. Presently there is no indigenously available RUTF in India and it is time to manufacture it in partnership with industry and food technological institutes and pilot test on a programmatic scale.

The development of RUTF has allowed much of the management of SAM out of hospitals. In Malawi, a large-scale home-based therapy with RUTF yielded acceptable results with respect to recovery and case fatality of 6-60 month old children without requiring formally medically trained personnel (17). In addition, 1-5 year old children with edematous malnutrition and good appetite were successfully treated with home-based therapy with RUTF.

A controlled, comparative, clinical effectiveness trial in Southern Malawi compared the recovery rates (defined as reaching a weight-for-height z score > -2) among 10-60 month-old children with moderate and severe wasting, kwashiorkor or both receiving either home-based therapy with RUTF or standard in-patient therapy(18). It was found that home-based therapy with RUTF was associated with better outcomes for childhood malnutrition than standard therapy when compared on recovery rates, relapse, case fatality and prevalence of fever, cough and diarrhea.

During periods of food insecurity in developing nations, a recurrent challenge is to reach out to affected populations in rural areas where malnutrition is widespread but distance or geographic location makes health services inaccessible. These areas may also be without trained health personnel or a health care structure to treat malnutrition. In such situations, home-based therapy with RUTF is effective in treating malnutrition. For example in rural Malawi, home-based therapy and RUTF were used to successfully treat children with severe malnutrition by village health aides with nearly 94% of the children recovering from SAM. The results demonstrate that home-based therapy with RUTF administered by trained village health aides is an effective approach to treating malnutrition in areas lacking health services.

The efficacy of RUTF and F-100 in promoting weight gain in malnourished children was compared in 70 severely malnourished Senegalese children (6-36 months) who were randomly allocated to receive 3 meals of either F-100 (n=35) or RUTF (n=35) in addition to the local diet.

It was found that the energy intake and the rate of weight gain were significantly greater in those receiving RUTF than in those receiving F-100, whereas time to recovery was significantly shorter in the RUTF group.

In India the acceptability and energy intake of imported RUTF was compared with cereal legume based khichri among malnourished children 6-36 months (19). RUTF and *khichri*

were both well accepted. However, the energy intake from RUTF was higher due to its better energy density.

In Malawi, home-based treatment of 1-5 year olds with RUTF was successful in affecting complete catch-up growth (20). In this study, locally produced and imported RUTF were similar in efficacy in treatment of severe childhood malnutrition. Results of a study from Senegal indicate that home-based rehabilitation of severely malnourished children with locally made RUTF was successful in promoting catch-up growth. The locally produced RUTF was as well accepted as the imported version and led to similar weight gain.

Psychosocial stimulation of children with SAM

Under nutrition in early childhood is associated with poor mental and motor development.

Nutritional deficiencies and a lack of stimulation create a vicious cycle in which deprivation in one can result in further deprivation in other. For example, a malnourished infant may show reduced psychomotor activity such as crawling and engagement in creative play. As the child becomes more apathetic and less demanding, parents often provide less stimulation.

The combination of malnutrition and a lack of psychosocial stimulation are particularly harmful.

A cluster-randomized study in Bangladesh provided psychosocial stimulation for 12 months to undernourished children attending community nutrition centers. Children receiving stimulation had improved mental development and behavior and their mothers' knowledge regarding child care practices increased as compared with the control group children.

To conclude, severe acute malnutrition among children under five years remains a major scourge in the developing world, including a booming economy like India. Investing in prevention is critical but treatment is urgently needed for those who are already malnourished.

Until recently, treatment had been restricted to facility-based approaches, thus limiting its coverage and impact. New evidence suggests that large numbers of children with SAM can be treated in their communities without being admitted to a health facility or a therapeutic feeding center. The community-based approach involves early detection of SAM and provision of treatment to those without medical complications with ready-to-use therapeutic food or other locally produced nutrient dense foods at home. If the community-based approach is appropriately combined with facility-based approach for malnourished children with medical complications at large scale, it could prevent the deaths of thousands.

Children's lives can be saved by: (i) adopting and promoting national policies and programs that ensure that national protocols for the management of SAM have a strong community-based component (based, if necessary, on the provision of RUTF or locally produced nutrient dense food) that complements facility-based activities, achieve high coverage of interventions for identifying and treating children through effective community mobilization and active case finding, provide training and support for community health workers to identify children with SAM who need urgent treatment and/or referral, provide training for improved management of SAM at all levels; (ii) providing the resources needed for management of SAM, and (iii) integrating the management of SAM with other health activities such as preventive nutrition initiatives (promotion of breastfeeding and

appropriate complementary feeding, provision of relevant information, education and communication materials), and activities related to the integrated management of childhood illnesses at first-level health facilities and at the referral level, and initiating such activities where none exist.

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Management of Children with Severe Acute Malnutrition (SAM) –A National Priority*****

Globally, 26 million children under 5 years suffer from severe acute malnutrition (SAM) and of these over 8.1 million children are in India. The children suffering from SAM have low weight-for-height. They are too thin and indicate occurrence of acute under nutrition in them. The SAM amongst children is associated with a failure to receive adequate nutrition in recent past or due to seasonal variations in food supply or due to recent episodes of illness.

According to National Family Health Survey-III, conducted during 2005-2006 in India, 6.8% of children below 60 months of age, were suffering from SAM (acute variety of severe under-nutrition i.e. weight-for-height less than $-3SD$). With the current estimated total population of India as 1100 million, it is expected that there would be about 132 million “under five children” (about 12% of the total population in the country). Of these 132 million children, it is expected that 6.8% i.e. 8.97 million children, will be suffering from SAM.

Severe acute malnutrition (SAM) is recognized as a major killer of children under five years of age. Mortality rates in SAM children are nine times higher than those in well-nourished children.

Severe acute malnutrition kills children directly by significantly increasing the case fatality rate in those suffering from common childhood illnesses such as diarrhea and pneumonia. Deaths amongst SAM children are preventable provided timely and appropriate actions are taken. WHO and UNICEF recommend the following two major approaches to the treatment of SAM (also referred to as the integrated management of SAM) (i) Hospital-based approach for clinical management using the WHO protocol and (ii) Home based approach, an integrated public health response to acute malnutrition without medical complications, with the use of ready-to-use therapeutic food or medical nutrition therapy. The home based approach for management of SAM children has evolved from experiences of treatment of children in emergency situations where significant impact on reducing case-fatality rate was demonstrated by ensuring timely actions for management of SAM. Experiences show that with an integrated management of SAM, case fatality rates can be reduced to less than 5 percent.

With the emergence of home based management approach for SAM children, today there is scope and capacity to cost-effectively address the problem of SAM in developing countries, including India. In fact, it has been observed that between 60 and 90% of SAM cases, identified through active case finding in community are without medical complications, and there is adequate evidence that such SAM

children can be successfully managed at the home level.

As per the WHO / WFP / UNICEF, the community-based approach involves timely detection of SAM in the community (community health workers or volunteers can easily identify SAM children using simple colored plastic strips that are designed to measure mid-upper arm circumference (MUAC) and MUAC less than 115 mm indicates SAM) , provision of treatment for those without medical complications with Ready-To-Use Therapeutic Foods (RUTF) or other Nutrient- Dense Foods at home along with administration of basic oral medication to treat infection. Home based approach for children without medical complications, if properly complemented with hospital based approach could result in saving thousands of lives.

The medical nutrition therapy (MNT) has been used in many developing countries for home based approach is through RUTF (ready to use therapeutic food). RUTF are soft or crushable foods that can be consumed easily by children from the age of six months without adding water which implies bacteria cannot grow in them. Therefore such medical nutrition therapy can be used safely at home without refrigeration and even in areas where hygiene conditions are not optimal.

Home based management of SAM children through medical nutrition therapy has many more advantages since children have reduced exposure to hospital-acquired infections and receive continuity of care after discharge. It also benefits by increasing the time available to mothers to spend with family and reduces the risk of possible neglect of siblings. Additionally, mothers are able to look after other family responsibilities simultaneously and can receive training on better feeding and care practices in their own settings.

Around the world, data from Malawi, Sudan, Niger, Ethiopia, and Bangladesh have described the successful management of SAM children in the community, with high recovery rates and low case fatality rates. The data from Malawi has also reported a very low relapse rate for children even after 15 months of their discharge from medical nutrition therapy programmes. The efficacy and effectiveness of such programs when basic principles of treatment are followed are now well established.

Management of SAM Children in India –An Urgent Need

Investing in prevention of under nutrition in young children is critical but this needs to be coupled with earnest efforts to urgently treat those who are severely malnourished. This is challenging since SAM children are often within the families with limited access to nutritious food and higher exposure to repeated infections and live in unhygienic living conditions.

We need to change the ways by which we are addressing SAM in our children. It is time, we shift our mind set entirely from hospital or facility based management of SAM to the integrated model that combines a coordinated home based approach with the hospital approach as and when required. Therefore, a specific and

comprehensive national policy is required to address the problem of SAM.

Presently in India, we are caring for children with SAM in Nutrition Rehabilitation Centres (NRCs); but these NRCs are very few in number and hence majority of SAM children never get admitted and receive any kind of treatment. We in India have the means to do better and to reach out to larger numbers of SAM children. Therefore, at the national level, it is critical to identify the measures that need to be taken to ensure timely and quality care for children with SAM, including through the use of medical nutrition therapy.

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