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CHILD DEVELOPMENT IN INDIA: AN OVERVIEW OF CHILD HEALTH

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Abstract

India being home to the youngest population of the world needs to take utmost care of its future citizens for harnessing the benefits of demographic dividend. It specifically needs to invest in child health so that its future can be secured by physically and mentally fit citizens who are not a burden on the nation but act as a catalyst of change. Health and Education are two prime indicators of child development. Of these two, health comes first. As said healthy mind resides in healthy body. Only healthy child is able to grasp, understand and analyse the things he/she learns at school. Hence it is fundamental duty of state to ensure that its children are healthy and fully developed- physically, mentally, psychologically and emotionally. Given India's resource crunch and mass level ignorance, children who are already vulnerable, are left to deplorable conditions as far as health is concerned. India is home to highest malnourished children in the world. Children have to face numerous health issues like stunting, underweight, felling pray to deadly diseases and infections like Choleras, Diarrhoea, HIV etc. It is high time when India proclaiming its position as one of the upcoming superpower in the world, needs to have a deeper overview of its children's health and development. This paper aims at understanding the health scenario of Indian children, their various health issues, its causes, results and suggest some suitable remedies for the same so that country can have healthy and happy children.

Keywords: *Child, Development, Health, Nutrition, Diseases, Malnourishment*

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Introduction

Child is the future of any nation, so securing development and welfare of the children is equal to securing the future of nation. India has the largest child population of the world. In 2016 27% persons were below 14 years of age (NHP, 2018). Thus to reap the benefits of demographic dividend it is of utmost importance that India should have a pro-active, holistic and balanced approach to deal with the development, security and welfare of the children in an integrated manner. UN in 1989 in the Child Rights Convention (UNESCO, 1995) declares, "A child means every human being below the age of eighteen years unless under the law applicable to the child, maturity is attained earlier." According to Indian Government's National Policy for Children, 2013, "A child is any person below the age of eighteen years" (The National Policy for Children, 2013, p.7). Same way Rajasthan Government also recognizes that a child is someone who is less than 18 years of age. But as per India's census child is a person below the age of 14 years (Census, 2011). Right to Education Act also provides free and compulsory to the children from6-14 years of age (The Right of Children to Free and Compulsory Education Act, 2009). Abolition of Child Labour Act, 1986 also prohibits child labour for the children below the age of 14 years (Child Labour Prohibition and Regulation Act 1986, 2016). Since majority of data regarding various indicators considers that child a person up to the age of 14 years, this paper will also take into consideration the people below 14 years of age.

Throughout Indian history children were given special treatment. Kings and rulers from time to time carried out various welfare activities for children along with other weaker sections of the society like women and elderly people. Indian Constitution recognized the supreme importance of this national asset thus laid the policy of children's welfare and development. Article 21A, 24, 39, 45 and 51A (k) specifically deal with child development and welfare. Under the Directive Principles of State Policy India directs its policy for holistic development of the children.

Article 21 A: "State shall provide free and compulsory education to children between 6–14 years of age."

Article 24: "No child below the age of fourteen years shall be employed to work in any factory or mine or engaged in any other hazardous employment."

Article 39: "The State shall, in particular, direct its policy towards securing

(e) that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength;

(f) That children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment."

Article 45: "The State shall endeavour to provide, within a period of ten years from the commencement of this Constitution, for free and compulsory education for all children until they complete the age of fourteen years."

Article 51A: "It shall be the duty of every citizen of India-

(k) Who is a parent or guardian to provide opportunities for education to his child or, as the case may be, ward between the age of six and fourteen years." Under this policy of protection and promotion of children Indian Government started various programs of child development like The Immoral Trafficking (Prevention) Act (1956), Integrated Child Development Scheme (ICDS), 1974, "The Child Labour (Prohibition and Regulation), Act, 1986", "The Pre Conception and Pre-Natal Diagnostic Techniques Act, 1994."

To strengthen and structure the child development government set up a Department of Women and Child Development in Ministry of Human

Resource Development in 1985. In 2006 this department was given the status of separate ministry. Hence 2006 onwards Ministry of Women and Child Development has become the nodal ministry for child development in the country. Despite so many comprehensive programmes and policies on Child development, India stands very low on child development indicators. According to joint report by ASSOCHAM and EY (ASSOCHAM and EY, 2017) about 37 per cent of our under-five children are underweight, 39 per cent are stunted (low height-for-age), 21 per cent are wasted (low weight-for-height) and 8 per cent are severely and acutely malnourished.

According to UNICEF (UNICEF) 12 % Children aged 5-17 years are engaged in child labour, only 20% children under five years old with diarrhoea receive oral rehydration salts, 27% of under-five children with suspected pneumonia are not taken to health provider. As per WHO (United Nation Inter Agency Group for Child Mortality Estimation UNIGME , 2018) in 2017 Infant Mortality rate in India was IMR 32. It was 34 in 2016 and in 2016 Mother Mortality Rate MMR/100000 was 170 in India. According to NCRB (NCRB, 2017) in 2016 106958 cases of crime against children were reported in 2016 that was higher than 94172 cases reported in 2015. Of these cases reported in 2016 Cases of kidnapping were 52253 and reported cases of sexual assault were 12226. According to NSSO (NSSO, 2017) in 2016 Dropout rates for Primary (class I to V) is 4%, for Upper primary (VI TO VIII) it stands at 4% and for secondary classes (IX to X) it is as high as14%.

Objectives

These facts compel us to think what is wrong with our policies of child development, welfare and security? Therefore this research paper would attempt to analyse certain objectives such as:

1) To explore the bottlenecks, that even after having so many structural and policy interventions our children have not got what they deserve.

2) To analyse the measures need to be taken to make these policies more effective.
3) To assess the gap between policies and the results.
4) To make suggestions for effective policy making.

Research Methodology

To analyse the objectives researcher in this paper mainly focused on the secondary data analysis. Critical and systematic analyses of the existing literatures have been performed, official documents have been comprehensively analysed, and websites of the related ministries have been explored and extensive use of internet data have been used for this research paper.

Analysis

As far as child development is concerned we mean a healthy mind living in a healthy body availing all available opportunities to its best. As far as physical aspect of development and healthy body is concerned this paper will consider health and nutrition of children in India. The National Policy for Children, 2013 recognises children as “supremely important asset” and sees survival, health, nutrition, education, development as key priorities. Health is a prerequisite for human development. That is why out of 8 Millennium development goals (MDGs) 3 have been set for health. These are enhanced motherly wellbeing, child mortality, and fighting malaria dangerous HIV or AIDS, and other diseases. (C.Rokk, 2004) So health of children is prime concern for all the countries because healthy and fit children provide the much needed human potential for the growth and development of any country (Sadaruddin Biswas, March,2010). But in India situation of health and nutrition of children is very poor. One in every three malnourished children of world is in India. (R.E.Black, 2014). Malnutrition is a situation where the body is depressed of minimum daily nourishment and food. India stands second in having malnourished children. In Sub-Saharan Africa the average rate of malnourishment is 30 where as it is 37 percent in

India. After so many plans and programmes by the government, under the age of 3 years 47 percent of the children are malnourished. It is so alarming that 32 babies per 1000 born alive will not even live up to their first birthday (Anoop Paruchuri, 2012).

Proper nutrition is very important for the overall development of children. Spears (2011) in his study find that early life health and nutrition results in taller children, with better cognitive achievements. In their study of India David Pelletier and his colleagues conclude that undernourishment leads to higher child mortality (David Pelletier, 1994). Children's ability to gain knowledge, to grow and their capacity to defy infections and ailments are negatively affected by malnutrition. (UNICEF, 2007). Children's cognitive development is determined by nutritional status and household resources. (A. Bhargava, 2005). Malnourishment can lead to stunted growth (short for their age), wasted (thin for height), underweight (thin for respective age), overweight (heavy for their age). In 2015-16 under five years age children in India are stunted, 21% are wasted, 36% are underweight and 2% are overweight. (NFHS-4, 2017). On the other side a healthy and well-nourished child contributes in the development of society. Only healthy students can be regular in studies. Thus achieving proper education and enhanced mental ability is directly linked to nutrition. Better educated children can help in boosting the economy and creating a fair and just society. Proper nutrition is considered mandatory for universal education and gender parity. (World Bank, 2006). Nourishment starts at the birth itself. Breastfeeding is essential part of child health. Mother's milk has colostrums which gives required immunity to child and help in his growth. In India malnourishment starts in the very first hour of the birth as only 42% newly born babies are breastfed within initial 1 hour of birth that is highly recommended by the doctors. It is shocking that only 5% Indian children under 6 months age are exclusively breastfed (NFHS-4, 2017).

Diet intake is considered an important measure of nutritional status. (Singh, 2006) Dietary intake depends upon availability of grains and purchasing power of people. In the studies of Washburn it is found that access and

intakes of nutrition and calories depend upon household consumption levels (S.Hoddinatt, 2000). Malnutrition is directly linked to poverty and hunger. Evidence suggests nutritional status of children is affected by family income (Jensen, 2000) In India with widespread levels of poverty hunger and malnutrition is obvious result. According to World Bank 2009 76 per cent of Indian survive on less than $2 per day. As per Tendulkar methodology, for the year 2011-12 NITI Aayog estimates that 25.7% of rural population and 13.7% of city population is below the poverty line. (NHP, 2018). This negatively affects the food intake of children. Not only is the food intake of children but food intake of pregnant mothers also crucial for the health of children. Nutritional deprivation in mothers can lead to impaired fetal development. It has adverse effects on child after birth and his development (Baker, 1990). Infant mortality is also dependent upon income level of the household. In high-income and developed countries, old people compose the greater part of population who die every year. But in poor nations children aged under 5 years account for one in three deaths of the country (World Health Statistics, 2019).

Studies have shown two way relationships between nutrition and economic development. When economic development takes place it leads to improved nutrition. Also improved nutrition helps in achieving better economic growth (M.Chatterjee, 1999) . Even though our economy has been growing at good rate, per capita income is way less than world average. India's growth didn't benefit the poor. It was not pro-poor. Reductions in subsidies to poor people have negative impact on household wealth. This badly affected the nutritional intake of children (Rutstein, 2014). Despite being the second fastest growing economy of the world India's growth has also witnessed dismal human development improvements and increasing disparity (Himanshu, 2007).

India's major part of wealth is in the hands of few this increases inequality. The condition is further worsened by lesser government spending on per head for health and family welfare (Economic Research Foundation, 2006). This is one of the major factors why rate of malnutrition has not witnessed

any decline over the years. In 1992–93 (NFHS-4, 2017) it was 54%; in 1998–99 (NFHS-4, 2017), it was 46%, and in 2005–06 (NFHS-4, 2017) it was 46%. Proper nourishment doesn't only mean dietary intake but proper intake of carbohydrate, proteins, and essential vitamins in proper amount. Indian children not only face the issue of full meal but whatever they get is also not healthy. In NFHS-4, 2017 it was found that 58% children between age of 6-59 months have anemia. "Sixty percent of children age 6-59 months was given vitamin A supplements in the six months preceding the survey. Forty-four percent of children age 6-23 months consumed foods rich in vitamin A in the day or night before the interview and 18 percent consumed iron-rich foods." (NFHS-4, 2017,p. 291).

Poverty is not the only reason for India's poor performance on health indicators. If we talk in terms of poverty Bangladesh is poorer to India but IMR is high in India compared to Bangladesh. In 2011 IMR in India was 47 per 1000 live births, whereas it was 37 in Bangladesh. India's per capita income is twice as of Bangladesh. As per 2011's per capita income India has highest per capita income when compared to world's 16 poorest countries other than sub-Saharan Africa. But in terms of U5MR and IMR its rank is 10. India's coverage of children with the measles vaccine in is lower than 10 other countries in this list (Dreze J. and A.Sen, 2013). So along with avaliabilty of nutritional diet various other factors are also important for overall health development in India. Along with nutrition intake other factors like woman literacy, urbanization, right to use to safe water, health facilities and proper cleanliness also help in improved nutrition. (Bhargava, 1998). Malnutrition also results from mal absorption, which is usually linked with a disease. (Smith, 2010). Majority of under-5 child deaths result from ailments that are curable with simple and easily affordable interventions. The leading causes of neonatal deaths are diarrhoea, pneumonia and malaria. Most of neonatal deaths in 2017 took place due to shortage of quality health concern at birth, shortage of trained care assistance and cure, Preterm birth, complications related with intrapartum, infections and birth defects. (World Health Statistics, 2019). Lack of clean and safe drinking water and

persistence of infectious diseases also result in lower nutrient intake (Soares, 2015). Natural Disasters also affect the health development of children. When children are exposed to it at in utero (before birth) or face any natural disaster at their birth their growth is adversely affected. Because disasters lead to financial stress in the family so the reduced incomes lead to reduced intake of food and reduced health expenditure. This results into detrimental health impacts (Santosh Kumar, 2016).

Famine is also a major cause of Malnutrition in some parts of the world. (Nicholas A. Boon, 2006). World Health Statistics, 2019 underlines the 10 conditions which lead to reduced life expectancy in poor nations. These are diarrhoeal diseases, respiratory infections, HIV/AIDS, stroke, TB, heart disease, malaria, birth asphyxia and birth trauma, road injury and protein-energy malnutrition (World Health Statistics, 2019). Children in poor countries are at 100 times greater risk to die from contagious diseases than from the rich nations (World Health Statistics, 2019). Due to its geographical and ecological conditions India is home to various seasonal diseases like cough, fever and malaria (Desai SB, 2010).

Most of the sickness in the country is attributed to water borne diseases. Every year 1.5 million people are lost to waterborne diseases (K.Park, 2011). Every year 37 000 cases of measles are reported (N.S.Deodhar, 2001). Only 62% children of 12-23 months age had received basic vaccination in 2010-11. (NFHS-4, 2017). 5-6% children received no vaccination at all (NFHS-4, 2017). Still India has launched so many immunization programmes which have shown successful results like diseases such as polio, small pox and critical guinea worm have been eliminated. India has showed noteworthy advancement in providing immunization through Universal Immunization Programme (UIP). It provides deterrence against six vaccine escapable diseases (NHP, 2018). Leprosy has been nearly eradicated (NHP, 2018). Mission Indradhanush is mission mode project to fully immunize newly born children. It aims to immunise more than 90% of new-borns by 2020. It has covered 528 districts of the country (Mission Inderdhanush, 2018). Despite a number of

Diseases control programmes have been launched in India but majority of these programmes face the issues of funds. (L.S.Chauhan, 2011) Their proper implementation at local level is also a challenge (K.Park, 2011). In spite of remarkable progress India's immunisation programme has to pass through a long journey before achieving its targets (NHP, 2018).

Till 2014 India had been on the top of open defecation in the world. Half of the Indians were not using a toilet or latrine. (Shamika Ravi, 2016). Although things have improved a lot after Swach Bharat Abhiyaan but still it will take long time to see the results. In 2015-16 only 36 percent of Indian children's stools were disposed of safely. (NFHS-4, 2017). As per the Census of 2011, access to water through various sources has been limited to 87 per cent of rural households only. More worrisome is the fact that coverage of tap water was only about 30 per cent. (Census, 2011). 13,492 habitations have been reported to be affected from fluoride. 18,258 habitations were polluted by arsenic (NHP, 2018).

As far as other health indicators are concerned India's performance is not satisfactory on many of them. In 2010-11 under-five mortality rate was 50 deaths per 1,000 live births. Infant Mortality Rate was 41 deaths per 1,000 live births. The neonatal mortality rate was 30 deaths per 1,000 live births. (NFHS-4, 2017). No doubt India has shown progress in this direction. As The under-five mortality rate declined from 109 deaths per 1,000 live births in 1992-93 to 50 deaths per 1,000 live births in 2010-11. The infant mortality rate declined from 79 deaths per 1,000 live births to 41 deaths per 1,000 live births (NFHS-4, 2017) It is higher in rural areas where it is 56 deaths per 1,000 live births whereas in urban areas it is 34 deaths per 1,000 live births (NFHS-4, 2017) In 2015 Infant mortality rate (IMR) further declined and was recorded as 37 per 1000 live births. IMR of rural area was 41 per 1000 live births). For urban population it was 25 per 1000 live births (NHP, 2018) but still the conditions are alarming. Around 20 % Indian children die before their fifth birthday. Around Four-fifths (82%) of these deaths take place during infancy. (NFHS-4, 2017). IMR is still much higher than global average for the same period of 33.6 per 1,000 live births (World

Health Statistics 2015). In 2017 Under-five mortality rate was 39 per 1000 and Neo Natal mortality rate was 24 per 1000 live births (World Health Statistics, 2019).

Under five mortality depends upon so many factors. Mother's education has a positive impact on it. She can take care of the nutrition and hygiene of the new born. Hence reduces the chance of mortality. This is supported by the evidence of National Family Health Welfare survey. "The under-five mortality rate declines with an increase in mother's schooling." (NFHS-4, 2017). Poverty and economic growth also affect the mortality rate amongst under five children. in the lowest wealth quintile under-five mortality rate was 72 deaths per 1,000 live births. In the highest wealth quintile it was 23 deaths per 1,000 live births.

Antenatal care is very important part of child health and development. Health care services during pregnancy and at child birth have the potential to reduce the risks for mother and child both. Antenatal care screens out any complications during pregnancy. It leads to institutional delivery under skilled supervision. It reduces the risks of infections during delivery thus saves the life of mother and child. But in India only 79% women received antenatal care during 2011-11. (NFHS-4, 2017) .Its credit also goes to National Rural Health Mission (NRHM) who with the help of female Accredited Social Health Activists (ASHAs) is able to improve health care system even in the remotest part of the country. It is visible from that number of women who received ANC visits four or more times as recommended by doctors increased from37 percent in 2005-06 to 51 percent in 2015-16. (NFHS-4, 2017) Only36 % newly born babies had the facilities for postnatal check-up. (NFHS-4, 2017) This describes a sad state of affairs.

Institutional deliveries are a key factor in reducing neonatal mortality and maternal mortality. There is considerable improvement in Institutional deliveries. It got almost double from 39 percent in 2005-06 to we saw a remarkable growth. In 2015-16 it was recorded at 79 percent. (NFHS-4,

2017). It is affected by various factors like antenatal care, mother's education, economic growth etc. Antenatal care raises the chances of delivery at health institutions as mothers are more aware about its benefit. Educated mothers prefer institutional deliveries. Rate of institutional delivery in mothers who attended 12 or more year of schooling was 95% whereas only 62% of women who had no schooling had institutional deliveries. Same way rate of institutional deliveries was high for the women with high wealth quintile compared to lower one. 95 % of Mothers belonging to highest wealth quintile had institutional deliveries but for lower wealth quintile it as low (NFHS-4, 2017).

Mother's education level has a direct relation with child development and welfare. "Education enhances women's ability to access existing health care resources, including skilled attendants for childbirth, and directly leads to a reduction in her risk of dying during pregnancy and childbirth." (NHP,2018, p. XIII). Apart from all the above mentioned factors country's overall health system also has a bearing on child health and development. India's spending on health has been as low as to only 1.02% of its GDP (2015-16). The contribution of Centre in entire public expenses on health has been waning for some years. (NHP, 2018). Not only the expenditure but India also has a shortage of skilled manpower for health services. India has one of the lowest density of human resources in health. It has 7 physicians per 10 000 population and 17.1 nurses for 10 000 population. Global average for physicians is 13.9 and for nurses it is 28.6 respectively (World Health Statistics, 2015).At present, one allopathic doctor serves average population of 11,039 (NHP,2018).

Findings

1. On the basis of review of literature and its analysis it is found that in India undernourishment is major hurdle for holistic child development. Poverty, inaccessibility of balanced diet, ignorance towards the importance of micro nutrients in the diet, infections and other factors

lead to malnourishment. Hence government needs to take care of them while formulating any plan for child welfare and development.

2. It was found that there was widespread negligence about the importance of nutrition for child development. As discussed people at large are unaware about healthy yet simple practices which can prove a milestone in securing a healthy childhood. As discussed people don't acknowledge due importance of breastfeeding particularly at first hour of birth. It is only 42% children who are breastfed on first hour and number decrease to alarming low of 5% when we take into count the exclusive breastfed children under 6 months (NFHS-4,2017). This simple practice of breastfeeding can save children from various deadly infections and provide them much desired immunity. The need is to highlight such practices and make masses aware about them.
3. It was also found that foundation of child health was deeply related with mother's health and her awareness and education about healthy practices. Malnutrition in mothers adversely affects the child development in the embryo and in lactating stages. Chances are high that educated and aware mother will take care of institutional deliveries, antenatal care, proper nutrition, immunisation and hygiene of the child, ultimately benefitting child health and development.
4. Another interesting finding is that poor child health is not solely dependent on poverty or inaccessibility to nutritious diet. Even the poorer countries than India were performing better on health indicators. It depends upon the 'culture of health awareness', people's education about health and nutrition, hygiene practices of community and health infrastructure in the country. Hygiene practices reduces the chances of infectious diseases like. Cholera, Diarrhoea, Pneumonia and Malaria etc. Supply of clean drinking water can show significant improvement in health indicators.
5. Another notable finding is that proper and prompt disaster management can have positive impact on child health. If disasters like famine, floods are managed well and dealt with anticipatory mode it can help in reducing financial stress and economic vulnerability of the family.

Children can also be saved from Ill effects of in utero exposure to disasters and their separation from their families. Thus they can be given securing environment with their families which will not only save them from the trauma of separation but also provide nurturing environment for growth.

6. It was found that countries with best infrastructure in men and material like institutional deliveries, proper immunisation facilities and general health practices like having clean water supply, proper hygiene system, absence of open detection were in better position to deal with spread of any infectious disease. Hence it improved the chances for child welfare.
7. It was also found that rural children were at greater risk as far as nutrition, immunization, ante natal care is concerned. It is due to lack of proper infrastructure and education in the rural area and people.

Suggestions

From the above findings researcher proposes some suggestions to improve the scenario of child health, development and welfare. These are as follow:

1. India needs to build a 'Culture of Health Awareness' in which people are educated and made aware about basics of health and hygiene. Simple and healthy health practices need to be publicised. People should understand importance of health and nutrition. Task for creating health awareness should be taken in mission mode project. Starting from camps at village level in Anganwadi to primary and middle school and taking it at district level, it should be made regular feature of health programme of the country. Involvement of local bodes and panchayats must be ensured for the same. If needed, it should be specifically specified in the 11th and 12th schedule of the constitution to make it obligatory for local bodies to take care of it. Active participation of students' organisations like NSS and NCC must be mobilised for achieving the same. This culture of health awareness will not only provide the foundation stone but also act as a catalyst for securing child health and development.

2. Since it is found that hygiene and cleanliness play a prime role in the health and nutrition a 'Culture of Hygiene' should also be promoted on the same lines of 'Culture of Health'. People should be made aware about the importance of healthy, hygienic and clean environment and practices. Administration should serve nothing less than clean water supply, open defection free villages and public places, maintaining purity of air and infection free environment. Swach Bharat Abhiyan should be further strengthened covering clean water and air. Hygiene should be made a fix part of curriculum. The values of cleanliness should be deeply imbibed in the children from first day at school. Strict laws should be formulated and implemented in spirit to ensure cleanliness on large scale. When 'Culture of Health' will combine with 'Culture of Hygiene' we will be halfway towards the goal of healthy childhood in India.
3. Mothers' education and awareness needs to be focused. They should be trained in ante natal care. Anganwadi workers should be assigned it as main responsibility. They should regularly contact with pregnant and lactating mothers. Technology and IT can be used for it. Mobile number of expecting and lactating mothers need to be recorded with Anganwadi workers who should send them informative messages about health practices in regional language and also promote them to share their experience in the group.
4. Community mobilisation needs to be geared up for taking care of mother and child. Families who are taking utmost care of mother and child on the basis of regular consultation in Anganwadi centres and primary health centres, institutional deliveries, immunisation etc. should be acknowledged in Panchayat level meetings. Also like basic education some health practices should be made compulsory qualifications for elections like ante natal care of the women of house, institutional deliveries and immunisation card of children. At least this idea can be tried on pilot basis in some villages and worked upon accordingly.

5. Anticipatory Disaster management should be promoted. Children should be given utmost priority in any case of disaster. Administration should be sensitive enough to take care that children don't get separated from their families in the hours of disaster. Special acre of such children especially regarding nutrition and psychological counselling should be ensured by government. Special Child Helpline for disaster management should be developed. In cases of widespread disasters like famines and floods nutrition of pregnant and lactating mothers needs to be managed so as to reduce ill effects on the embryo and developing child.
6. Government needs to further strengthen poverty removal policies and programmes. While the same is achieved it should be ensured that women and children are provided adequate nutritious food at any platform like Anganwadi or mid-day meal scheme. Special packages directed at nutrition should be of prime concern for government's poverty reduction efforts. Special provisions regarding supply of micronutrients like iron, calcium and vitamins should be ensured.
7. Health infrastructure must be built up and strengthened particularly in rural areas. Tax exemptions can be channelized for building community and commercial support for the same. Special efforts should be directed to enhance rural people's education and awareness for health and wellbeing. Health workers serving in rural areas should be given added advantages to motivate them for offering their services in rural areas.

Conclusion

From the above facts it is clear that child health is a multi-varied subject. It doesn't depend upon one or two factors but interplay of several factors together. If we work upon the causes that lead to endanger the child health we can surely chalk out the way for healthy child development. No doubt India has moved forward in this direction. Initiatives such as Janani Suraksha Yojana, Janani Shishu Suraksha Karyakarm, Reproductive Health Care Services, Child and Adolescent Health Services and various

targeted Health programmes to restrain diseases like polio, TB, HIV, leprosy etc. have played crucial roles in humanizing India's health indicators. (NHP, 2018) Programmes like Janani Shishu Suraksha Karyakarm (JSSK) that was launched in 2011 ensures skilled assistance form antenatal care to neonatal care. It ensures the right of all pregnant women to have a delivery in public health institutions that also absolutely free. It provides them free consultations, free diagnostics, free drugs and free diet during stay in the health institutions. It also provides them free transport from their home to health institute and institute to home along with free provision of blood. (Manual on Health Statistics in India, 2015). In the Union Budget 2018-19, Government announced world's largest health scheme Ayushman Bharat Mission. It aims to expand health insurance net. It has a target to cover 10 crore poor and underprivileged rural families (NHP,2018).

Still we need to have widespread health drives, cleanliness and hygiene campaigns, augmentation in the number of hospitals and medical staff, enhanced immunization etc. (NHP,2018). We need to improve preventive and curative health care in order to save ourselves from premature deaths. Need of the hour is strengthened healthcare workforce and augmented prerequisite of health facilities, medicines, medical equipment, and vaccines. Along with improving the medical infrastructure we also need to rule out disclosure to risk indicators such as unsafe water and sanitation, violence, Inequality, contamination, hazardous roads, consumption of tobacco and alcohol. (World Health Statistics Overview, 2019). We need to have early intervention and timely health care services as aimed at by Rashtriya Bal Swasthya Karyakram (RBSK) that was launced in 2013 . It facilitates Child Health Screening. It helps in early detection of Deficiencies, Diseases, and Defects at birth and disability. (Manual on Health Statistics in India, 2015). This kind of proactive approach will help us in better managing the child health care. We also need to focus on reducing the disparity in rural and urban areas as far as access and quality of health care is concerned. (NHP,2018). We need to create awareness about quality

antenatal health services, postnatal health and welfare for mother and baby, trained assistance at birth, and care of small and ailing newborns. (World Health Statistics, 2019). For this we need innovative programmes like IT based programme Mother and Child Tracking System (MCTS). With its help service providers can track the record of pregnant mothers and their children for antenatal and postnatal care services and immunization. Thus it ensures continuity in the service and fills service delivery gaps. It will surely help in better antenatal and postnatal care thus reducing mother mortality rate, neonatal morality rate and infant mortality rate. (Manual on Health Statistics in India, 2015). Thus by focusing on these simple and small needs we can ensure a very healthy, safe and conducive environment for the children of India.

References

1. A. Bhargava, M. D. (2005). Modeling the effects of Nutritional Status and the educational infrastructure on the cognitive development of Tanzania School Children. American Journal of Human Biology , 280-292.
2. Anoop Paruchuri, V. P. (2012). Malnutrition in India:A Major Problem with Minor Attention. IJPI's Journal of Hospital and Clinical Pharmacy , 2, 9.
3. Article 21A,Constitution of India (2018). Ministry of Law and Justice, Government of India, New Delhi
4. Article 24, Constitution of India(2018). Ministry of Law and Justice, Government of India, New Delhi
5. Article 39 , Constitution of India(2018). Ministry of Law and Justice, Government of India, New Delhi
6. Article 45 , Constitution of India(2018). Ministry of Law and Justice, Government of India, New Delhi
7. Article 51 A (k) , Constitution of India(2018). Ministry of Law and Justice, Government of India, New Delhi
8. Baker, D. J. (1990). The fetal and infant origins of adult disease. British Medical Journal , 301 (6761), 1111.

9. Bhargava, S. O. (1998). Health and Nutrition in Emerging Asia. Asian Development Review , Vol.16(1),pp.31-71.
10. C.Rokk, R. C. (2004). The Nutrition MDG indicator-Interpreting Progress. World Bank Discussion Paper . Washington, DC: World Bank.
11. Child Labour (Prohibition and Regulation) Act,1986. (2016, July 30). Retrieved from https://labour.gov.in/sites/default/files/THE%20CHILD%20LABOUR%20%28PROHIBITION%20AND%20REGULATION%29%20AMENDMENT%20ACT%2C%202016_1.pdf
12. David Pelletier, E. F. (1994). A Methodology for Estimating the Contribution of Malnutrition to Child Motality in Developing Countries . Journal of Nutrition , 2106S-2122S.
13. Desai SB, D. A. (2010). Human Development in India: Challenges for a society in Transition. New Delhi : Oxford University Press.
14. GOI (2011). Census of India 2011: Provisional Population Totals. Registrar General and Census Commissioner of India, Ministry of Home Affairs, New Delhi, India.
15. Himanshu. (2007). Recent Trends in Poverty and Inequality: Some Preliminary Results. Economic and Political Weekly , XLII (6), 497-508.
16. Jensen, R. (2000). Agricultural volatility and investments in children. The American Economic Review,Papers and Proceedings , 90 (2), 399-405.
17. K. Park. (2011). Textbook of Preventive and Social Medicine. Jabalpur: Bhanot Publishers.
18. L.S.Chauhan. (2011). Public health in India: Issues and Challenges. Indian Journal of Public Health , 55 (2), 88-91.
19. M.Chatterjee, A. a. (1999). Wasting away: The crisis of malnutrition in India. Washington, D.C: World Bank.
20. Manual on Health Statistics in India. (2015) New Delhi, Government of India , Central Statistical Office: Ministry of Statistical and Programme Implementation.

21. Mission Inderdhanush. (2018, June 18). Retrieved April 20, 2020, from National Health Portal: https://www.nhp.gov.in/mission-indradhanush1_pg
22. N.S. Deodhar. (2001). Health Situation in India. New Delhi: Voluntary Health Association of India.
23. National Family Health Survey, 2015-16. (2017). New Delhi, India: Ministry of Health and Family Welfare
24. National Health Profile. (2018), New Delhi, Government of India : Central Bureau of Health Intelligence
25. Nicholas A. Boon, N. R. (2006). Principle & Practice of Medicine. USA: Elsevier.
26. R.E. Black, A. S. (2014). International Nutrition:Achieving Millennium Development Goals and Beyond. Santiago: Karger Medical and Scientific Publishers,.
27. Rutstein, S. C. (2014). Household wealth and child health in India. Population Studies , 68 (1), 15-41.
28. S. Hoddinatt, K. a. (2000). The impact of Economic Progress on Consumption: A Final Report. Washington DC: IFPRS.
29. Sadaruddin Biswas, K. B. (March,2010). Mid-upper Arm Circumference Based Undernutrition among Bengalee Children of CHapra, West Bengal, India. Iranian Journal of Pediatrics , 63-68.
30. Santosh Kumar, R. M. (2016). Draught and Early Child Health in Rural India. Population and Development Review , 42 (1), 53-68.
31. Shamika Ravi, R. A. (2016). Health and Morbidity in India. New Delhi: Brookings India.
32. Singh, K. G. (2006). An Analysis of food and nutrient intake of rural pre-school children in Punjab. Journal of Human Ecology 20(3) , 161-164.
33. Smith, J. S. (2010, December 10). Malnutrition: Causes and Consequences. Retrieved April 20, 2020, from NCBI: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4951875/
34. Soares, R. R. (2015). Water Scarcity and birt Outcomes in the Brazilian semiarid. Journal of Development Economics , 112, 72-91.

35. Spears, D. (2011). Height and Cognitive Development among Indian Children . Economic and Human Biology.
36. The National Policy for Children, 2013. (2013, April 26).Retrieved from https://wcd.nic.in/sites/default/files/npcenglish08072013_0.pdf
37. The Right of Children to Free and Compulsory EducationAct,2009. (2009, August,27). Retreived from https://mhrd.gov.in/sites/upload_files/mhrd/files/upload_document/rte.pdf
38. UNICEF. (2007). Children and the Millennium development goals: progress towards a. New York: United Nations Children's Fund.
39. World Bank. (2006). Repositioning Nutrition as central to development: A strategy for Long Term Action. Washington DC: The International Bank for Reconstruction and Development, World Bank.
40. World health statistics 2019: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.
41. World health statistics overview 2019: monitoring health for the SDGs, sustainable development goals. Geneva: World Health Organization; 2019 (WHO/DAD/2019.1). Licence: CC BY-NC-SA 3.0 IGO.