REVIEW OF RESEARCH

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ASSESSING UNDER LYING IMPACT OF MATERNAL & CHILD HEALTH SERVICES IN ICDS & PHCS THROUGH SOCIAL ACCOUNTABILITY APPROACHES

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ABSTRACT

We have made less progress to Reduce Infant mortality rate & improving maternal health than any other goals. As a result, millions of preventable mother and child deaths occur every year.The detailed deliberations were held on public provisioning and budgets for several themes including agriculture, food security, public health, education, fiscal decentralization, dalits, Adivasi's and nomadic tribes, women, children etc., under five thematic sessions and group discussions. The initiative drafted a people's health charter of demands for consideration for the increase the budget allocations and proper implementations at all levels. While many such demands were drafted which are the unfinished promises of the Union & State Governments, few demands also highlight broader economic, health policy and governance issues.

This research study focuses on the two government institutions that play a major role for the cause Child Development as well provided health & nutrition services in India. They are the Integrated Child Development Scheme and the Public Health Centre. The catalyst used i.e. Citizen Voice & Action score-card that delves into the strengths and weaknesses of the ICDS and the PHCs through Citizen Voice & Action (CV & A)assessment Score Cards validation processes of 7 States (Jharkhand, Chhattisgarh, Odisha, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh) and Analysis Report.

KEYWORDS: *ICDS, PHC, CHC, NHM, CVA, Maternal Child Health & Nutrition.*

INTRODUCTION

The National Rural Health Mission (NRHM) was launched to provide accessible, affordable and accountable quality health services to women and the poor and vulnerable sections of society even those living in the remotest corners of the state. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water and sanitation, nutrition, education and social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. From previously narrowly defined schemes, NRHM was shifting its focus to a functional health system at all levels, from the village to the district.

NRHM strives to provide universal access to health care which is accountable and at the same time responds to the needs of the people, especially those who are marginalized and live in rural areas. It aims to make necessary architectural corrections to basic health care systems, reduce regional imbalances, pool resources, integrate organizational structures, optimize human resources, decentralize management of district health programs and integrate many vertical health programs. It aims to facilitate community participation, partnership and ownership of health and health care

delivery. The NRHM framework for implementation has provisioned communitisation of facilities, adequate and flexible financing with community accountability, monitoring progress against Indian Public Health Standards, innovations in human resources, engagement and building of capacity at all levels for effective and efficient decentralized management of health systems.

It also provides an opportunity at each level from the village to the sub centre, the PHC, the CHC, the Sub Divisional Hospital and the District Hospital to create a Community Institution under the umbrella of the Panchayati Raj Institutions / Local Government System with Provision of untied funds to meet the institution and village specific needs for health care.

Similarly the Women and Child Development Department was created as a separate Department during 1994-95. Since inception, it has been working for the overall development of children and women through a host of specially designed schemes and programmes, along with some welfare schemes for the Senior Citizens and Persons with Disability. There has not much change, progress and development to the programmes being undertaken by the department. Department has launch of some new scheme like MAMATA, BhimabhoiSamarthyaAbhiyan and Decentralized Feeding Programme of ICDS. The focus of activities continued to be on welfare and entitlements of children, women, and persons with differently able. From the initiation the department of W& CD has tried to address the women and child nutrition and health issues in the grass root level. Series of program has been implemented through this department but due to callous attitude of official and without community involvement the benefit of the program has not reached to the people of state.

The Role of ICDS:

ICDS is a centrally sponsored flagship scheme for holistic development of children and was introduced in 1975. It is implemented through the concerned States/UTs with the funding by the Government in the ratio of 50:50 for supplementary nutrition (90:10 in NER) and 90:10 for other operational components between the Centre and the States.ICDS today is the world's largest community based outreach program for early child development, reaching out to over 9.65 crore beneficiaries of which 7.82 crore is children under 6 and 1.83 crore is lactating mothers. ICDS has been universalized largely post 2005-06 and finally in 2008-09 through 7076 approved projects and 14 lakh AWC's across the country.ICDS acts as a critical link between children and women and with the primary health care and elementary education systems. It also provides a protective environment for young children-including care and protection of the young and adolescent girl child.

Why ICDS Restructuring:

The expansion of the scheme did not commensurate with the resources both human and financial as a result of which number of gaps/shortcomings crept, which were essential to be rectified. There was a need to address these gaps/shortcomings through restructuring and strengthening of the scheme.

These related to enhancing nutritional impact, reaching the child under three years in the family and community, changing caring and feeding behaviours in the family, reaching the most deprived community groups, responding flexibly to local needs for child care, responding to community demand for early learning, increasing ownership of Panchayati Raj Institutions and achieving an optimal balance between universalization and quality.

A major challenge was in implementation gaps that arises out of inadequate resource investment, inadequate funding, lack of convergence, lack of accountability of those managing and implementing the programme, especially, at the level of anganwadi centres and supervisory level, lack of community ownership and the general perception about ICDS being a "Feeding" program and not an Early childhood development program.

The Role of NHM..:

The National Health Mission (NHM) encompasses its two Sub-Missions, **The National Rural Health Mission (NRHM)** and **The National Urban Health Mission (NUHM)**. The main programmatic

components include Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

Six financing components under NHM:(i) NRHM-RCH Flexipool,(ii) NUHM Flexipool,(iii) Flexible pool for Communicable disease,(iv) Flexible pool for Non-communicable disease including Injury and Trauma,(v) Infrastructure Maintenance and(vi) Family Welfare Central Sector component.

Within the broad national parameters and priorities, states would have the flexibility to plan and implement state specific action plans. The state PIP would spell out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes.

The State PIPs would be an aggregate of the district/city health action plans, and include activities to be carried out at the state level. The state PIP will also include all the individual district/city plans. This has several advantages: one, it will strengthen local planning at the district/city level, two, it would ensure approval of adequate resources for high priority district action plans, and three, enable communication of approvals to the districts at the same time as to the state.

Some of the key issues are given below

Health facilities viz, Sub-centre, Primary Health Centre, Community Health Centre and District Headquarters Hospital, have improved drastically in terms of infrastructure, personnel and drugs. However, the response from the public viz, GKS members and patients indicate that the service provided needs further streamlining in terms of patient care, drug availability and positioning of personnel in the facility.

There is no doubt that NRHM has contributed a lot in improving the health status of the people and has been successful in many fields especially in arresting infant and maternal deaths in the state. However, on scrutinizing the resources utilized vis a vis the impact gained, it was seen that a huge difference still exists between them.

Institution building at community level like GKS, RKS, Mother Committee and Janch Committee needs to be further strengthened to yield the best results possible.

The village health plan is still a distant dream. The community's involvement in the planning process is still a dream.

PRI involvement in the health care delivery system is still not up to the desired level which further questions its efficacy and effectiveness.

Inter sectoral convergence both at program and planning level needs to be further strengthened.

The Study Methodology:

Social Accountability in the context India, is a distant dream for a majority of the common people to access quality and equitable services from the available institutions and power holders. India is a country famous for its diversity with regard to the caste, religion, class, region, religion and race. As a result only a few stronger are able to access to their rightful entitlements and ensure accountability from the service providers. These disparities have caused enlarging social & economic gap between the rich and poor / powerful & powerless wider. Such situation attributed to the following reasons such as: Exploitative pubic delivery Social System; Lack of demand driven approach and poor access to services; Poor awareness on rights and civil entitlements; Poor quality of delivery of services; Poor monitoring and lack of political will of existing local institutions (CBOs and Govt.)

The community is not able to properly access their rightful entitlements from the service providers. Thus the CVA process will trigger a sense of social accountability to create demand and availability of services. CVA will promote behavioural change to be a good citizen who practise social accountability, demands entitlements and participate on government programming to ensure transparency and integrity. CHN is working for promoting social accountability through CV&A activities in building alliance and networks with people, mobilize CBOs and work with local government.

The study area covers the sample from 7 states, (Jharkhand, Chhattisgarh, Odisha, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh). The assessment was conducted in 113nos. of Anganwadi centres and 23nos. of CHC/PHC/SHC's of 7 states, 31 districts and 59 Blocks. 27 CHN partners' conducted the CVA validation exercises.

The purpose of the research study:

- To assess the status quo of 'Child Development' in India.
- To understand the latent factors slowing down development.
- To bring about lasting impact.
- To make the shift from the almost to the absolute.

Child Health Now (CHN), who have been involved with health related issue Nationwide from the very beginning and dream of seeing India as a healthy and salubrious country.It has been working with the women and children of Odisha for the past three years to address the MDG 4 & 5. The CHN Core Group has addressed gaps in the system and multiple layers of exclusion faced by women and children across the state in accessing health services and exercising their right to health.

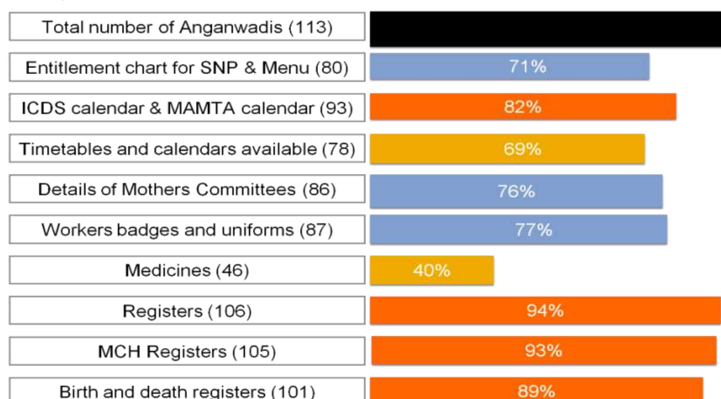
The researcher used both the primary and secondary method of data collection. The primary source of the study for data collection done through score card, observation and the focus group discussions methods.Referred the secondary data sources to get the knowledge in more detail about the problem, existing situation and earlier studies has been taken from various materials, books, journals, articles from newspaper, seminars, workshop documents, magazines and the records of women empowerment from different developmental agencies.

The data obtained from the field will be carefully computed, systematically classified and represented in the tabular form under the different headings and sub-headings. In the final analysis, a critical analysis of the collected data will be made for further verification and re-interpretation of variables found crucial to the study areas.

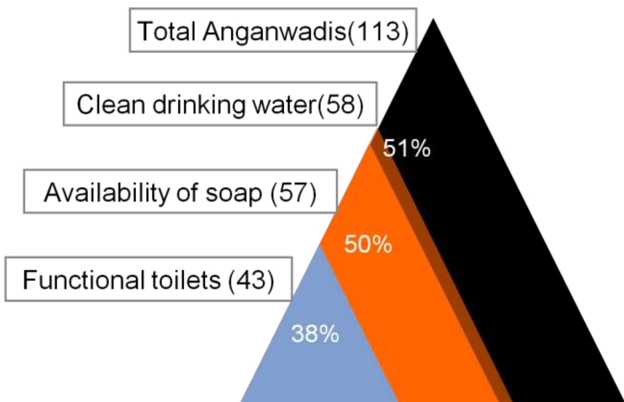
The major Findings of the study:

Analytical Assessment of the ICDS:Anganwadis and staff: Total Number of Anganwadis (113), Anganwadis with Trained staff (105) and Anganwadis with local staff (89).

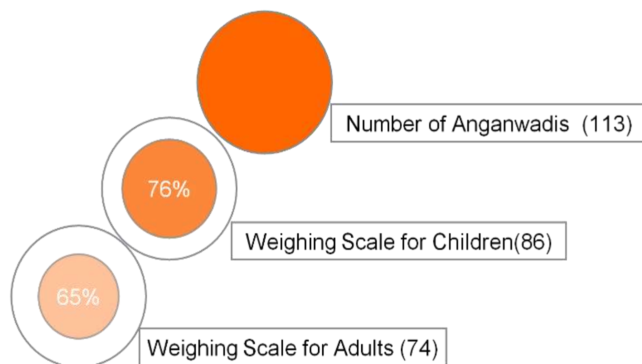
Infrastructure At Anganwadis: 113 Anganwadis, 71 Govt/Rented buildings (63%), 85 with Pucca buildings (75%) and 44 with Separate Kitchens (39%).



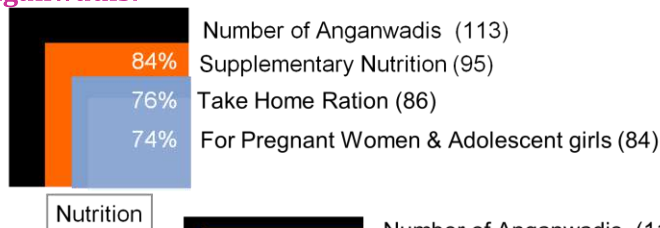
Resources at Anganwadis: Sanitation & Hygiene at Anganwadis:

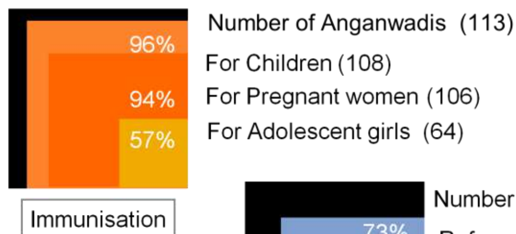


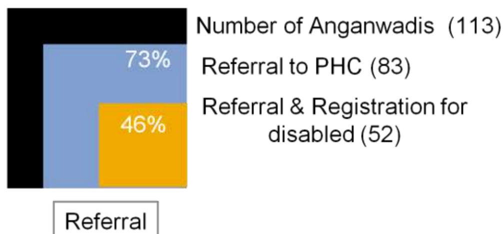
Weighing Scales AtAnganwadis:

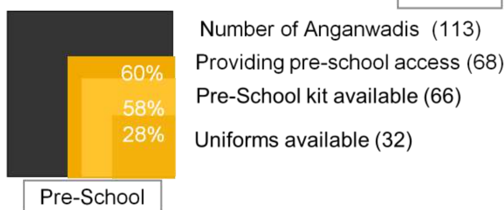


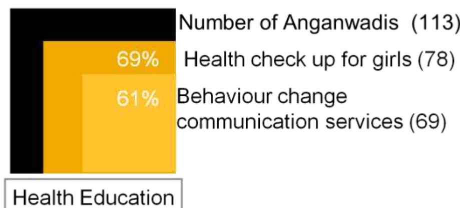
Services AtAnganwadis:



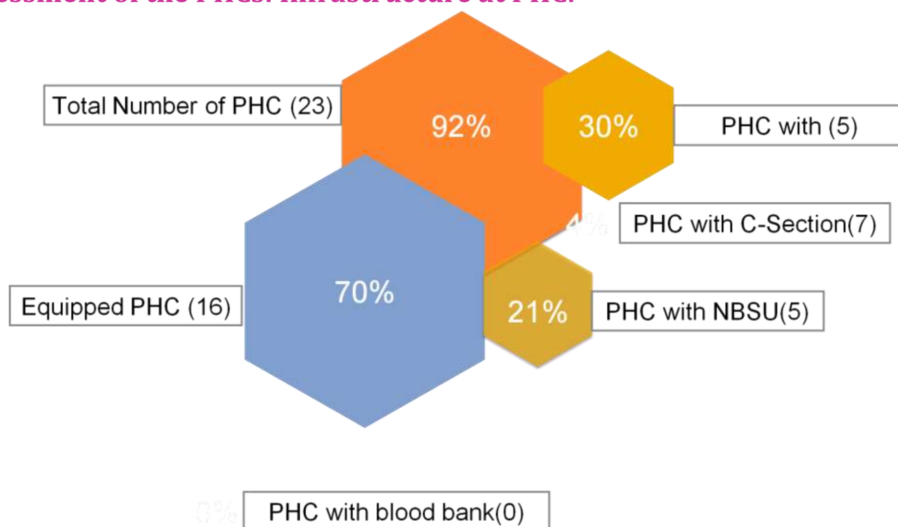






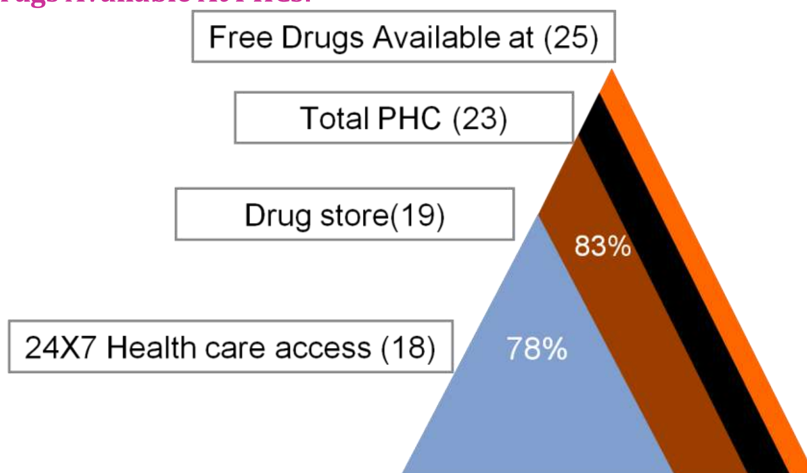


Analytical Assessment of the PHCs: Infrastructure at PHC:

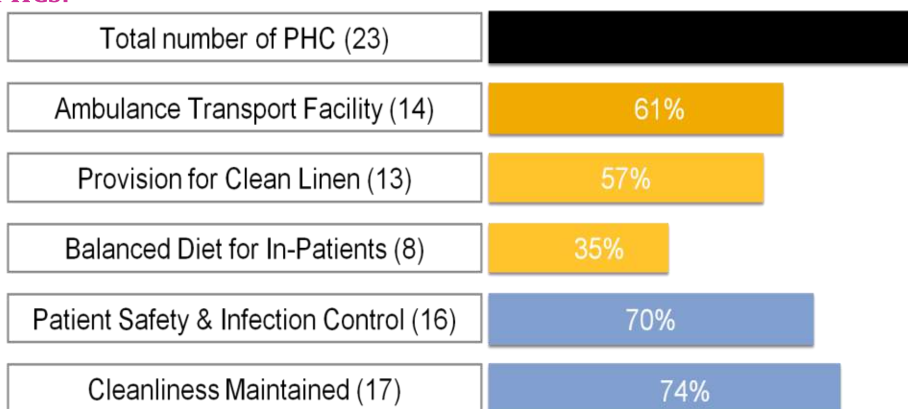


Human Resource at PHC: 23 nos. of staff as per prescribed norms (100%) and 2 specialists (9%).

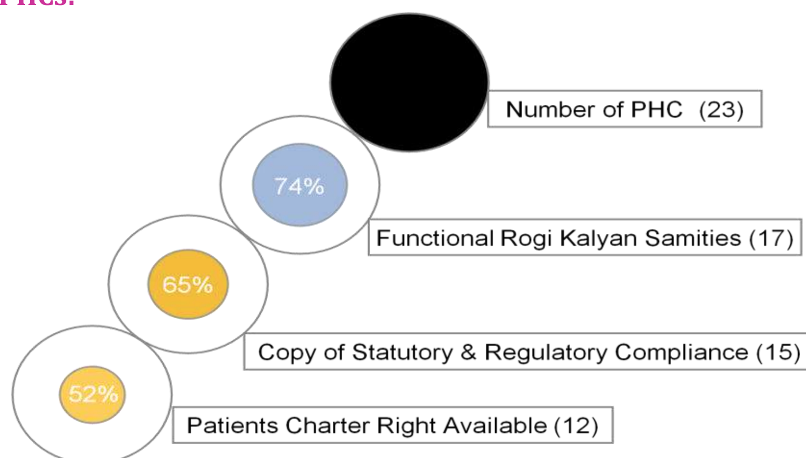
Pharmaceutical Drugs Available At PHCs:



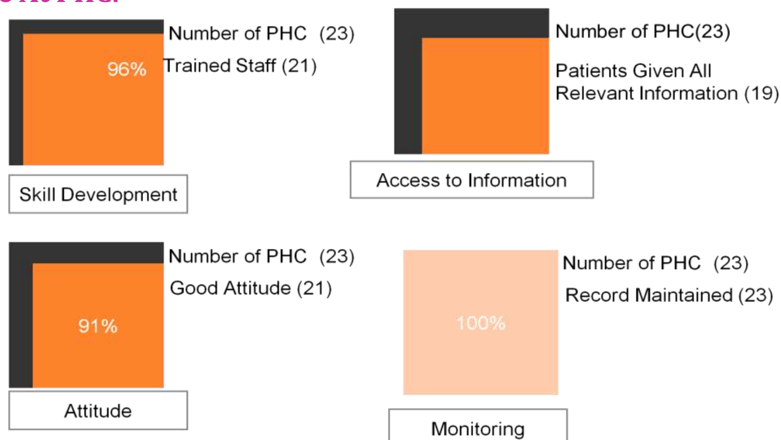
Resources At PHCs:



Accountability At PHCs:

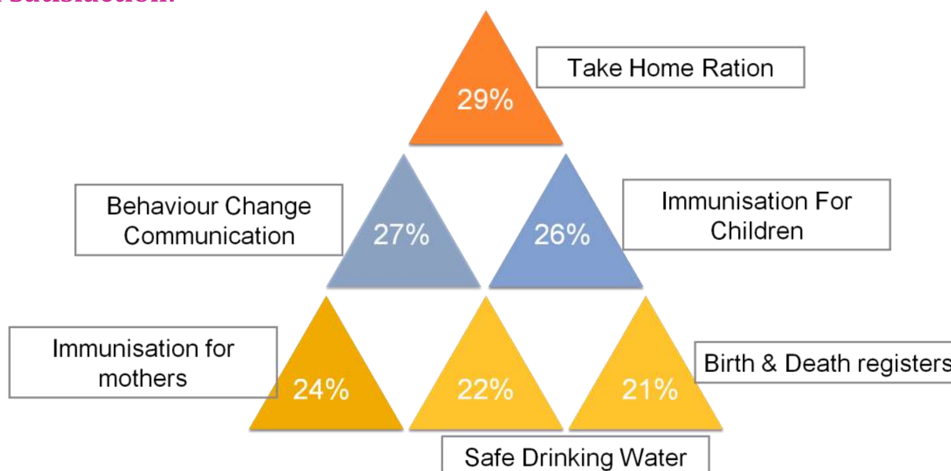


Quality Assurance At PHC:



The Citizen Voice & Action tool allows the characters to hear directly from their audience. The hierarchy of satisfaction and dissatisfaction is calculated from the audiences reaction to the services. It recognises the top six services that correspond to the 'very happy' scale and the bottom six services that correspond to the 'very unhappy' rating. The resolution of this conflict lies in filling up these gaps fastest.

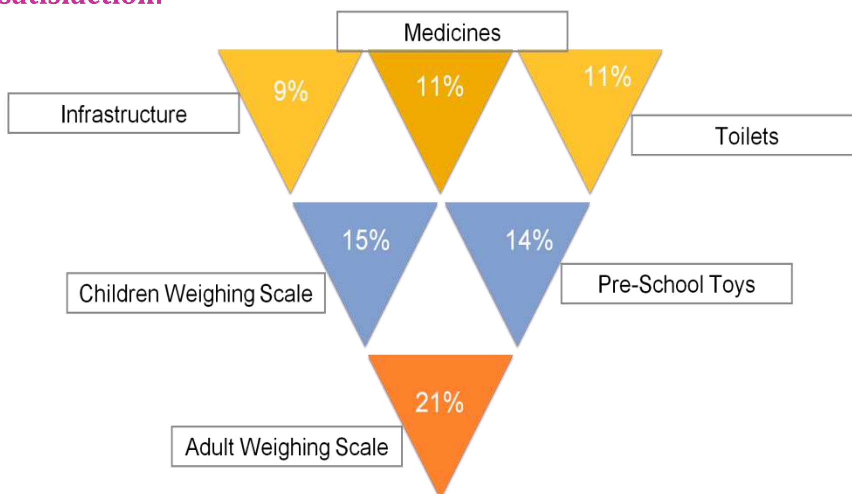
Hierarchy of Satisfaction:



Latent Observations On Anganwadis :

The Hierarchy of Satisfaction recognises the top scoring aspects of the Anganwadi: the Take Home Ration, the Behaviour Change Communication, immunisation services for children and mothers and finally the provision of safe drinking water.It is to the credit of the Anganwadis to note that five out of six top scores are the services provided. This implies that there is a need to improve the facilities and resources at the Anganwadis.It is also vital to note that the first ranker has scored only a 29%!

Hierarchy of dissatisfaction:

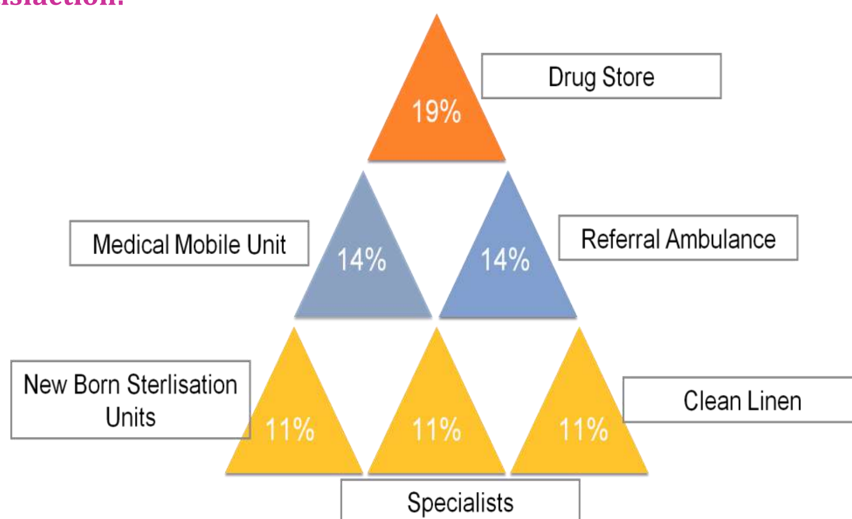


Latent Observations onAnganwadis:

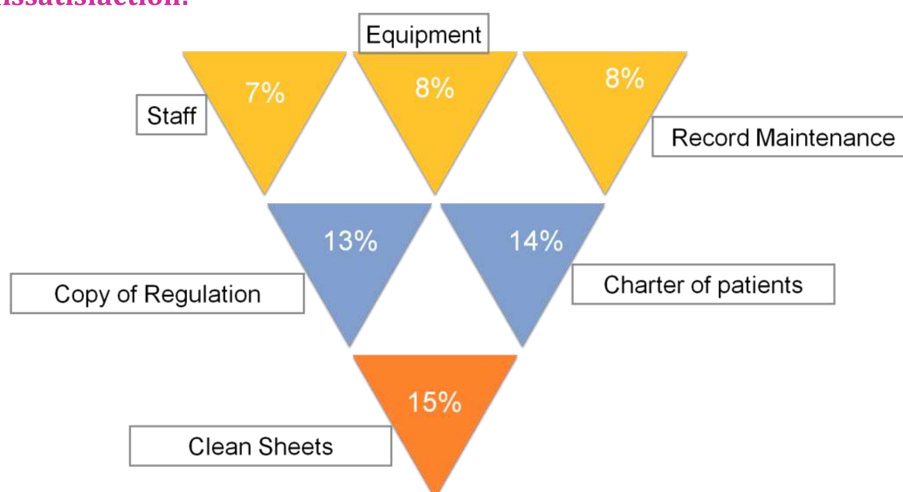
The Hierarchy of Satisfaction recognises the top scoring aspects of the Anganwadi: the adult and children's weighing scales prove to be the biggest disappointment, followed by the pre-school toys, toilets, medicine and infrastructure.

Each of these low performers correspond to the facilities, and resources essential for the smooth functioning of the Anganwadis. This gap proves to be the first step towards improving the services.

Hierarchy of Satisfaction:



Hierarchy of dissatisfaction:



Latent Observations onPHC:

In the case of the PHC it is vital to compare and contrast the top scorers and the low performers because of the glaring overlaps. The Hierarchy of Satisfaction recognises the top scoring aspects of the Anganwadi: the drug store, the MMU, the NBSU, the transportation ambulance, the specialists and the clean sheets. While the hierarchy of dissatisfaction points out that clean sheets is disappointing. Also, while the Medical Mobile units and the New Born Sterilisation Units are appreciated the basic equipment at PHCs seem unfit. Further, while specialists with a 9% track record show up on the hierarchy of satisfaction, staff with a 100% track record show up on the hierarchy of dissatisfaction.

Suggestions / Recommendation for improvement of Maternal Child Health & Nutrition in ICDS and PHCs:

The first and foremost step is to demand for more public investment in health care and oppose this slashing of the health budget. The reasons provided by the state for cutting down the health budget should also be firmly rejected and the true reason- that it is meant to help private sector growth should be exposed.

There is urgent need to reform and strengthen the delivery of ICDS.The focus of ICDS on children under 3, pregnant and breastfeeding mothers is relatively weak and there is therefore a need to take a hard look at the ICDS to improve the programme.Immediate intensive interventions on Safe drinking water & nutrition cell centre at Anganwadi centres. To achieve good health indicators, Integrated Child Development Services be universalised to reach the last child in the state and to improve the pregnant and lactating mother's health status.

- The Women and Child Development Dept in State Govt. should constitute a high-level committee to enquire into large number of children suffering from malnutrition and take action against the officials like Anganwadi Workers, supervisors and CDPO, identifying all the malnourished children and taken immediate measure to send hospital or NRC.
- There should be orientation training programme for Mothers' Committee and Janch Committee from time to time to make them sensitized about their role and responsibilities in respect of management of the centre. NGOs should be assigned to conduct the training programme.
- The dilapidated building of AWCs should be declared as dilapidated by Govt. and new building needs to be sanctioned. The new building which is under construction for years together should be completed immediately.
- Draw up clear road maps of where we are in the path to universal health care- and what specific investments and programmes are needed to reach there. These are best done in the form of district health plans with clear costing of what it takes to provide additional services and what institutional changes are needed for a pro-people, pro-poor health care. This could go along with clear

constructive suggestions of what changes in policy and strategy are needed to strengthen NRHM as a vehicle of financing the strengthening of public health service delivery in the states and the achievement of health outcomes.

- Government (Central government and states combined) should increase public expenditures on health from the current level of 1.2% of GDP to at least 2.5% by the end of the 12th plan, and to at least 3% of GDP.Ensure availability of free essential medicines by increasing public spending on drug procurement.
- The Union & State Government should take the necessary steps towards improving the processes of district & block level planning, flow of funds, community participation, capacity building of existing and new concerned staff, and availability of adequate program staff in order to improve the proper implementation of programs/schemes.

CONCLUDING NOTE:

In order to realize this vision of a better future, we will continue to collaborate with our many allies, partners and government officials, but we will hold ourselves accountable for reaching our goals. As this is a living document, we will revisit this charter and make course corrections as needs change. And we will ask the community to join us in these efforts. We hope our vision for healthy & safe community for women, children and families. And we hope that if you do, you will raise your voice with ours and speak for the children.

A healthy community is one in which children and their parents have access to affordable primary health care, including preventive health services/facilities. In a health community, everyone is invested and involved, and neighbors work together to achieve the maternal and child health care facilities at all levels.More importantly, community participation and involvement in terms of GKS, RKS, Community Monitoring, and village health plan need to be further rightly envisaged. The advocacy effort needs to be more systematic not only for service recipients but also for service providers.The resource allocation in terms of % age of GDP needs to be increased to reduce the out of pocket expenses. Special strategies need to be developed to address the issue of health equity among the marginalized/vulnerable groups.The inter and intra district variation in terms of process indicators, utilization of funds, improvements in health care delivery, health indices and in community participation needs to be checked.

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