Frame work for

C R Y's

Health Policy Development

EMERGING FROM CASE STUDY OF ITS GRASSROOT INVOLVEMENTS and IN THE LARGER CONTEXT OF THE CHILD IN INDIA

By

MANI KALLIATH MBBS, MPH

Frame work for

C R Y's

Health Policy Development :

EMERGING FROM CASE STUDY OF ITS GRASSROOT INVOLVEMENTS AND LARGER CONTEXT OF THE CHILD IN INDIA

By
MANI KALLIATH MBBS, MPH

August 2002

Published by

Year of Publishing

CONTENTS

ANNEXURES

ACKNOWLEDGEMENTS

This report is the result of the idea conceived by Ms. Shefali Sunderlal, the earlier Director Development Support CRY and made possible by the Trustees of CRY sanctioning this Study. This task was ably pursued and supported by Ms. Ila Hukku, the present Director, Development Support.

The author of this report is Dr. Mani Kalliath, Public Health Specialist, and the findings, interpretations and conclusions expressed have been made by the author. The author was supported by Dr.David Antony, Public Health Specialist, in carrying out part of the field study and by Mr. Shaju Joseph, Social Scientist, who not only provided editorial support, but also developed the note on 'Civil Society Responses'.

The Program Support Unit (PSU) of the CRY team facilitated the field study. The author is grateful to Mr. Subhasis, Mr. Atin, Mr. Vasu and Mr.John as well as the regional team members, Mr.Singh, Mr.Manav, Ms.Sangamitra, Ms.Soha, Mr.Sotto and also the team of the partner programs studied. The author acknowledges the enthusiastic support received from the PSU team, during the planning meeting, the field visits and during the review meeting in May 2002 which brought out specific suggestions.

Dr. CM Francis, Medical Educationist and Public Health Specialist, guided the study at the conception stage, and gave valuable support through specific feedback and suggestions to the first draft. Dr. Abhay Bang, 'SEARCH' Gadchiroli, gave valuable feedback and suggestions to the first draft.

The author acknowledges numerous resource persons especially, Dr. Rajnikant Arole of Jamkhed and Dr. Vandana Prasad of FORCES, for their written feedback to questionaire on 'child health priorities', Dr. Suneeta Prajwala, Ms. Gayathri Ramachandran IAS (former Secretary,DWCD, AP), Dr. Vijayaraghavan Associate Director NIN, Prof. Babu Mathew, National Law School, Ms.Sudha Murali UNICEF for the time made available on this subject.

Ms. Lakshmi, Documentation Officer CRY was very resourceful in getting relevant documents and Mr. Satish provided able assistance in typing, making the layout and cover page.

Last but not the least the author wishes to thank his wife Ms.Cecily, who through her support and encouragement made it possible to complete this report through the long process involved.

I. INTRODUCTION

CRY network is going to be in existence for almost 25 years, working on developmental issues of children.

Over this period, the scenario of issues affecting children and their quality of life has undergone vast changes, mostly for the worse. During this two and a half decades the understanding of development has also undergone paradigm changes. Social sector perspectives have moved from charity orientation to development orientation and from there further to empowerment orientation.

Starting with small beginning and intense passion in its child focussed partnerships, the CRY family has expanded into a large network and as a resource support organisation. The CRY has moved into "Third Generation" NGO resource group by Korten's nomenclature whose primary role is "to address societal concerns in a substantive way" (Shaping Policy : Do NGOs Matter ?, Aseez Mehdi Khan, PRIA, 1997). During these two and a half decades, some of this shift of priority and role may have taken place proactively, by design. More likely much of the change may have been reactive, in response to the needs and pressures from the grass roots partnership.

It appears to the outside observer, a watershed in the maturing of CRY into a third generation NGO network /resource support organisation started about 5 years ago. During these five years, CRY has consciously moved from relief and development oriented approach to a 'rights' oriented (empowerment oriented approach). This has resulted in CRY investing for and being a prime mover for the campaign for universal education rights of the child. This process has built in (internalised) new collective learning in the areas of rights oriented perspective, strategies, skills and tools.

CRY's focus and emphasis over these years have been primarily on education sector. Though health interventions have been part of CRY involvement, these have happened because of needs raised by partners.

The health sector interventions seem to be sporadic and adhoc and it is not clear how effective they have been. Nor have there been much internal documentation reflecting on evolution of policy and strategies in the health sector. It makes the observer conclude health sector intervention did not result from conscious and planned steps.

Now with the organization better established in its perspective and strategies regarding a rights oriented approach in the education sector, it is time to do the same in the health sector.

Purpose of this assignment

The purpose can be summarised as the following:

To prepare the CRY organization and partnership network to develop long term systematic involvement in child health issues.

Towards this purpose the assignment would help to develop a long term perspective and understanding of strategies at different level of the network and open the way for appreciating the capacities, systems and resources required.

It would also help in identifying immediate activities to be carried out

Terms of Reference (TOR)

The objective of the Study

To develop recommendations for CRY's future health sector thrusts from a child rights point of view, both for grass root involvement through CRY partners and for Policy Advocacy efforts at the national and state levels

To suggest Child Health issues to be addressed

The strategic paper on health issues would have to address the following categories of issues:

❖ Generic issues, many of which have also been identified by health activists as "child health campaign" issues :

- Poverty, food, under-nutrition and malnutrition
- Mother health and effect on child health
- Lack of basic systems for care (of the child)
- Stresses on family caring system
- Issues in weaning and supplementary feeding
- Promotion of micro-nutrients versus lack of food
- Malnutrition in older children
- Access to quality primary health care.
- Withdrawal of state from basic services (including health)
- Inadequacies in comprehensive policies and schemes for the child
- Health issues of an inappropriate schooling system
- Inadequate budgetary allocation for child health

❖ Special issues affecting specific sections of children:

- Violence against children (including sexual abuse)
- Deprivation of the girl child.
- Street children and child labor
- Female foeticide
- Children affected by AIDS
- Children with disabilities

To analyse primary and secondary data to identify issues specific to children of age :

- 0 to 2 years
- 2 to 6 years
- 6 to 14 years

Study Process

- Analysis of relevant government policy and program review documents to arrive at likely child health impact :
  - In the context of child rights milestones
  - Controversial issues and gaps
  - Steps towards correction
- Scanning of child health related documents that are likely to influence governmental policies in the future.
- Studying the experiences and priorities of voluntary sector
- Interacting and observing experiences of 2 or 3 experts, promoting child health from a "Rights angle" to identify key program and policy interventions
- Field visit of five CRY partners from the three regions of Mumbai, Chennai and Calcutta and interacting with concerned program support team, to identify priorities for CRY's interventions.

Expected outcome

A referenced document that suggests directions and modifications in reference to government policies and program affecting child health in India.

Guidance for developing CRY's health sector policies, approaches and interventions, both for micro level policy advocacy and for direction action through micro level partnership.

Significance of the Document

This document can become a blue print for CRY's planning process in the health sector. It brings together current data on child health issues both from micro level observations of issues confronting CRY partners and from macro level data available from secondary sources. It analyses strengths and limitations of public health policies and programs for child health combining the insights of health activists and researcher's own perceptions gained over two decades involvement. It puts together an overview of civil society responses regarding child health and the opportunities inherent in that. It summarises key concerns and issues of child health keeping the larger perspective of determinants. It suggests strategies within a "Rights oriented Approach" of participatory decentralised interventions, wherein it also tries to locate CRY's own possible roles. This document also spells out specific recommendations that CRY could take up keeping in mind CRY organisation and networks perceived strengths and limitations.

II. METHODOLOGY

The TOR identified the following types of information to be collected.

- Analysis of primary and secondary data specific to age categories of children
- Field data from CRY partners.
- Experiences of 2 – 3 experts on child health rights.
- Experiences of CRY program support team
- Generic and special issues affecting children health.
- Policy and program review documents
- Experiences of voluntary sector.

Micro level study

A PSU meeting with the consultant was held to plan the study which decided to study 2 different regions of CRY Network namely North and East. One NGO from Karnataka was also included totalling six projects. In addition it was decided to interact with resource groups and eminent persons involved in public health to gather perspectives on key issues for child health. Based on their feedback the key issues to be focussed in the study were identified. Many of these issues were incorporated into the micro-study questionnaire.

Study teams decided to use a case study method using 3 levels of interactions with each project.

1. Studying available written information on the programe.
2. Directly interacting with the key staff members of the organization
3. Focus group discussion with sample groups from the community of intervention.

The concerned regional offices sent the internal monitoring report by CRY of each organization being studied. It was informed to the study team that the NGOs own reports were not available.

Tools

Two types of questionnaire were developed for data gathering from the field. A questionnaire having questions pertaining to nine different areas were sent, 2 weeks prior to the visit to the NGO partners in order for them to be prepared with relevant data. (This step was to prove to be ineffective subsequently as the questionnaire in English was poorly understood and responded to by the NGO partners). A more detailed format with nine sub areas for information gathering was developed after the first NGO visit to be used as a guide by the investigators, while interacting with the different levels of functionaries and intervention community. The information emerging was entered into the formats during or immediately after the focus group discussion (these formats are appended under Annexure IV).

Justification

The study team adopted these tools for the following reasons.

1. Baseline data regarding health status of the area or project output indicators were not available (not being collected)

2. During the short visit to each project (less than two days) focus group discussions with different stake- holders was thought to be most appropriate method of gathering qualitative information which would provide a deeper understanding of the ground situation.

The sampling of the focus group was decided by the project holder based on the criteria suggested that is to include different categories of stake holders – women's group, prople's organization, Panchayat members etc. In each location a member of the regional PSU of CRY and a key functionary of the NGO accompanied the researchers.

CRY PSU team based on the variations in partnership involvement and type of issues taken up for intervention determined the location of projects visited.

The data collected was collated and interpreted by the study team based on the qualitative impressions gained. (This was necessitated, as the data recording method by the two members of the team were not identical).

The presentation of the field study data is made in three different manner:
A "case study" of each institution is included in the annexure, the SWOT analysis is presented in a tabular form "Partner Performance" and a summary of the findings is included as "Observations from the Micro Situation".

Two model programs were visited to identify best practices at programmatic and policy levels ie 'SEARCH Gadchiroli' and 'ICDS program of MediCiti Hospital'. A description of the relevant program is attached in Annexure, drawing conclusions for child health.

The study team interacted at depth with the members of the regional PSU team including CRY Fellows, to identify perspectives, capacities and issues identified by them. The outcome lead to recommendations made under 'CRY organization related'.

The macro literature study

Several sources of literature was referred to develop the macro-perspective. These included national policy documents related to health, national program documents from government and UNICEF, national health survey outcomes, critiques of policy and programs by national networks or resource bodies. Also accessed were web-sites and published information from national level NGOs, networking forums and political parties concerning public health and child health. Digesting this vast literature also lead to defining the chapterisation of the study and identifying key recommendation to CRY. Accordingly the chapterisation and recommendations have been modified in the final report.

III. A CRITIQUE OF INTERNAL CONTEXT

Context / Premises / Background of the Recommendations To CRY

The recommendations, which we make to the CRY, that constitute the main theme of this document emanate from the critique of the situation - child survival and development. The critique is dealt with at two levels, viz. internal and external.

The organization of CRY and the performance of its partners constitute the internal context. The problem of child survival and development and responses of various groups or sectors (like government, civil society, NGOs, political parties, private sector and so on) in the form of policies, legislation and programmes comprise the external context. A critique of developments at these two levels, brings to light certain key issues in the area of child survival and development, from which emerge our recommendations.

CRY organisation, policies and programmes

(This is extracted from the internal document "CRY,a View of the Organization")

CRY is a young network working on the issues of the child. Started in 1979 with a shared capital of Rs. 50 and working from a kitchen table, it has grown into a national network of 300 ground level partnership and impacting on about 9 lakh children. Their objective is to be a facilitator through the partnerships at the ground level and their macro level initiatives, to positively influence the lives of children in the country. CRY raises its resources primarily from around one lakh individual donors. The other sources of include sale of products, about 100 corporate donors and resources raised from outside the country. Hence CRY has the added opportunity of influencing public opinion on behalf of the deprived child through its donor-related network.

CRY's program include development support, communications, youth wing resource generation (which activities constitute the face of CRY to the world) as well as human resource development, finance and information technology. Development support is the key program impacting on the life situation of the child and is carried out through 6 levels of partnerships. These are the following: fellowship program for individuals, support to implementing organisations, support to resource organisation, partnerships with nodal agencies, alliances and with the government. CRY supports resource organization that has expertise to enhance the quality of small initiatives. This is done through development of innovative models, teaching methods, materials and training programs. Similarly CRY is involved with nodal agencies which can offer both financial and non-financial inputs to smaller initiatives in the same geographical region.

Alliances are promoted on an issue-based angle both between CRY partners and other NGOs. In several states such state level alliances exists. At the national level CRY is part of alliances such as 'Campaign Against Child Labour', 'National Alliance for the Fundanemental Rights to Education, ECPAT etc. Over the next 3 years CRY aims to enable a convergence of these issue- based alliances, towards the formation of a

national child right alliances. CRY is also partnering government through experimental projects, which are meant to be developed as 'models' for replication.

These different levels of partnerships help in magnifying the outcomes, as well as making effective outcomes in relation to the situation of the child.

CRY's Focus Areas in Development

CRY undertook a comprehensive programme evaluation in 1995-96, which covered all partners and took over a year to complete. Three key decisions that emerged from this process were the holistic focus on child rights, role expansion to organization building (in the realm of non-financial support) and a proactive role in influencing the national agenda for children.

This evaluation also validated CRY's belief in the importance of education in a child's life. It also pointed out the gaps in understanding of health-related issues and the need to intervene in the area of preventive and promotive health. Given the gaps in understanding, it was decided to further research the issues of health before identifying a relevant and effective approach. However, in the area of education CRY's experience and perspective enabled it to formulate a coherent intervention strategy for immediate implementation. Five years later in the year 2000, CRY find that the focus on education has yielded enormous learning and has put CRY in a position to influence related agendas at the micro levels.

In the absence of a national CRY policy on health, regions have worked with their partners based on their own skills and perspectives and regional expertise. However, CRY moved away from supporting nutrition programs for children to supporting community health initiatives focussed on mother and child health. Traditional systems of medicine have also been supported through some projects. CRY pro-actively supported initiatives on the issue of child labor and disability in different parts of the country by building strong linkages between these issues and education focus. CRY also supported a few initiatives working with issues such as child sexual abuse, institutionalization of children and adoption, in order to understand these issues further.

Concerted efforts have been made in the past four years to move from a child relief perspective to child rights perspective. The importance of the child's right to participation has also been understood by CRY and explored in its own work and that of its partners

STRENGTHS OF CRY

As an institution

CRY is an independent Indian organisation working for Indian children. CRY's agenda is not determined by political will or donor ideology.

Strong belief in the power of collective action which has been demonstrated in 2 different ways. In 21 years, CRY has reached out to over 1,00,000 individuals and organisations that have pledged their support to children. On the other hand, CRY has supported over

300 child development initiatives and has disbursed Rs.43.40 crores to reach out to over 9,00,000 children.

A strong, committed Board of Trustees: CRY's Board of Trustees are professionally qualified people, with a varied experience. The role of the trustees extends from ensuring adherence to policy, to questioning and supporting actions taken. The Board of Trustees sanctions each and every one of the initiatives supported by CRY.

People: Over the years, CRY has managed to attract and retain professionally qualified people who are committed to working for children.

Clear articulation of mission statement: While there always has been internal clarity of the vision of CRY, largely due to the conviction of the founder, the articulation of the mission statement has enabled external clarity and the ability to take a leap forward.

Accountability and transparency are the tenets on which CRY stands. This is reflected in the fact that CRY is the first non-governmental organisation to publish its annual results.

Philosophy of partnership: This is a philosophy that CRY believes in and is implemented in all its relationships from project holders, donors and well wishers. Programme planning, monitoring and evaluation is done on a participatory basis. There is no "donor-donee" relationship with any of the institutions CRY is working with, be it through raising resources or disbursing them.

Action oriented ideology -"What I can do, I must do" a simple statement made by the founder is a driving force within the organisation.

Ability to evolve as a learning organization: The commitment and perseverance of the individuals who joined hands with the founder have guided the evolution of CRY as an organization. CRY has always responded to the needs of the external environment and internal infrastructural limitations by proactively restructuring the way it works.

As a development support organisation

Support to small, struggling organizations with a focus on vulnerable children and women: CRY has recognized the value added to the development sector through the innovations of new, small organizations working in the field and their need for sustainability and guidance.

A strong Development Support Team consisting of professionally qualified people to provide extensive support to the initiatives selected.

A proactive approach of working in partnership for monitoring and evaluating the supported initiatives.

A thorough process for selection and appraisal of initiatives to be supported.

Development of a financial risk management module, assisted by a team of chartered accountants.

In-depth assessment of non-financial needs of partners with respect to training needs, capacity building, information and material requirements.

As a resource raiser

Unique application of fund raising as a strategy to sensitize, motivate and create opportunities for people to take responsibility for the situation of deprived children in India.

Provision of a simple, affordable way to involve ordinary people who feel they are not in a position to make a sizeable difference to the situation faced by children.

Providing an opportunity to each and every person to participate in this movement for child rights within the context of their own lives.

Use of "products for a cause" as an effective strategy for raising resources and creating awareness.

Creating opportunities for artists, photographers, designers, and printers to contribute professional services.

Recognised the importance of events as opportunities to reinforce credibility, enhance image, increase awareness levels, create media excitement and raise resources. Events are another illustration of our belief in the power of collective action.

As a networking organisation:

As a result of its belief in the power of collective action, CRY has recognized the value of networking amongst organizations as a platform to learn and share from a variety of experiences.

CRY has promoted the setting up of partner alliances on a geographical basis with the objective of putting forth issues and organizing collective action for change.

CRY is a part of the Campaign against Child Labour, ECPAT, Donor Agency Network, and the National Alliance for the Fundamental Right to Education.

CRY has recognized the importance of formation of networks and strategic alliances to influence policy to make an impact at the national level on issues affecting the child.

CRY – THE BUSINESS MODEL				
WHO	**WHAT**	**HOW**	**THROUGH**	**CRY'S ROLE**
CHILD	RIGHTS TO ➢ SURVIVAL ➢ DEVELOPMENT ➢ PROTECTION ➢ PARTICIPATION	➢ DIRECT ACTION WITH CHILDREN ➢ COMMUNITY MOBILISATION ➢ POLICY IMPLEMENTATION	➢ FELLOWS ➢ PROJECTS ➢ RESOURCE ORGANIZATIONS ➢ NODAL AGENCIES	FINANCIAL SUPPORT ➢ CAPACITY BUILDING ➢ ORGANISATION BUILDING ➢ PROGRAM DEVELOPMENT ➢ TRAINING PERSPECTIVE BUILDING ➢ CHILD RIGHTS ➢ ACCOUNTABILITY MODEL BUILDING DEVELOPMENT SECTOR STANDARDS
STATE	➢ POLICY FORMULATION / IMPLEMENTATION ➢ LEGAL REFORM	➢ PARTNERSHIPS WITH GOVERNMENT ➢ ADVOCACY	➢ ALLIANCES ➢ THINK TANKS ➢ MEDIA	➢ FINANCIAL SUPPORT ➢ DOCUMENTATION RESEARCH ➢ PUBLICATION ➢ NETWORKING
PUBLIC ➢ IN INDIA ➢ OVERSEAS	➢ AWARENESS ➢ SENSITISATION ➢ ACTION	➢ FINANCIAL & MATERIAL SUPPORT ➢ VOLUNTEERISM ➢ ADVOCACY	➢ INDIVIDUALS ➢ ORGANIZATIONS ➢ PRIVILEGED YOUTH ➢ MEDIA	➢ INFORMATION ➢ MOTIVATION ➢ ACCESS ➢ LINKAGES

CRY: Critical Review of Micro Level Situation and Partner Performance

An over view of the micro level reality in which CRY partnership with other NGOs operates is given first. The details of the same situation are given as annexure under the title 'Perceptions from Micro Situation'. A summary statement of the findings of a SWOT analysis of partner agencies of CRY follows this brief description in the following pages.

AN OVERVIEW OF MICRO LEVEL CRY PARTNERSHIP

SL. No.	Areas Examined	Prevailing Situation	Initiatives Launched	Remarks
1.	Major health problems	Malnutrition in all age groups, Malaria, ARI, Measles, Whooping cough, TB, Arthritis and Pneumonia	Promoted herbal medicines, village clinics and moving through vaids and RMPs	The approach is not comprehensive and the thrust is on curative care
2.	*Health Care:*			
	Natal, ante and post natal	*TBAs and elderly ladies are the care-takers; the coverage of TBAs below 50% and trained TBAs are less than 50%; PHC not catering to this need;*	*In some places TBAs were trained and engaged ; a cadre of village health workers created; awareness building made*	*The communities do not have any idea of neonatal problems and death; this vital area is not seriously dealt with*
	Care of the under-two	*No facility exists; pulse polio was the only intervention; indigenous practitioners and RMPs only resort*	*Village clinics; feeble efforts to activate PHCs; village health workers*	*No data on the issue; Not very seriously and systematically dealt with*
	Care of the 3-6 year old	*No facility except near 25% coverage of ICDS; these are not fully functional too; elder female sibling or elderly women are care-takers*	*There a few crèches and centres;*	
	Care of the 6-14 year old	*No facility at all.*	*Adolescents girls group started in one program.*	
	Disability Programme	*No facility existing in the public health sector*	*A specialized programme*	*CBR activity is done only in specialized programmes. It*

SL. No.	Areas Examined	Prevailing Situation	Initiatives Launched	Remarks
			(disability) initiated community based rehabilitation (CBR).	*is not yet integrated by other NGOs.*
3.	Nutrition	A very serious problem of all age groups; ICDS and PHC coverage very poor	Awareness building; in one place kitchen garden promoted	This problem has not been tackled effectively
4.	Safe water	The coverage is below 40 %; still protected water is not guaranteed;	Initiated efforts for more coverage; in some places awareness on water protection effected	No long-term and sustainable measures adopted.
5.	Sanitation	Very poor sanitation; very few toilets; no arrangement for disposal of wastes	Very little efforts in this direction	Community mobilisation towards this end was not attempted at
6.	Housing	Not much information collected on this	Nothing has seriously been done	Community sanitation and improving inhabitability of dwelling places could be addressed by community mobilisation
7.	Children under stress	Child labour and differentially abled, are the common issues identified.	Two partners having special focus on these issues initiated a few set of activities	Not seriously integrated into the operations.

Sources: 1.Focus group discussions
2.Studies of five partner agencies

A summary of the findings of SWOT analysis of five partner agencies of the CRY.

(For the detailed report of the review of these agencies, see the Annexure 1)

SL. No.	Partner Agency	Strength	Weakness	Opportunities	Threat	Remarks
1.	CWS	1.Programmes have gone beyond service delivery and have managed to organise the community for peoples action for basic rights;	1.Training for the various functionaries and community leaders not need based;	1.The forum of VOP which can develop a health perspective towards leveraging public health infrastructure responding to peoples health priorities;	1.Leadership belong to the local feudal elite structure;	Perspective building, capacity building and building up collaboration and linkages are the major areas of thrust for this organisation.
		2.Working with structures of governments;	2.Non-existent Government interface;	2.Interventions with RMPs through the people's movement (VOP) for rational services;	2.They may not side with issues of the poor. Hence, there is a threat of sabotaging the process;	
		3.Promotion of herbal medicine as a relevant effective and potentially sustainable intervention;	3.Weak vision and low commitment of the project leadership;	3.The excellent and rational Ayurvedic doctor as local resource.	3.The spread of RMPs who are irrational in treatment and pricing of their services ;	
		4.A collective democratically functioning core team of dedicated individuals with wider perspective;	4.The capacity of health team in perspective and in public health areas is weak.	*4. Chances for critical collaboration in health sector programmes particularly towards ensuring accountability of the local functionaries.*	4.Denegrating the rich herbal traditions and cause the eroding of their status;	

SL. No.	Partner Agency	Strength	Weakness	Opportunities	Threat	Remarks
		5.Credibility with government bureaucracy; 6.A TBA as the central person in the health care team	5.The central person in the health care team is weak in perspective, knowledge and networking skills.			
2.	GSS	1.Promotion of herbal medicines as a local appropriate and potentially sustainable response to the health needs of the people; 2.Experience of peoples mobilisation and asserting and demanding basic needs and public accountability; 3.Creditability of project holder and team with	1.Negligible interventions in health sector (only around 5% of total budget); 2.Low level of capacity and poor vision of the leadership; 3.No secondline leadership;	1.The people's organisation into which health dimension can be built into ; 2.The involvement of morcha into the self government system would make it possible for leveraging of better implementation of government primary health care programmes; 3.The school clinics		The perspective and capacity building, lobbying and linkage with government, proper utilisation of school clinics and consolidation of people's organisation are the requirement.

SL. No.	Partner Agency	Strength	Weakness	Opportunities	Threat	Remarks
		the people; 4. A team of enthusiastic dedicated person; 5. The organization has a good reach in around 200 villages.	4.The tendency of the project to institutionalisation			
3.	MONF	1.A team of purely professional staff. Personnel with the right attitude, motivation and enthusiasm. 2.A successful and a replicable project ;	1.A few part time temporary and project based associates and staff with too many commitments and hence stretched out in terms of time allotment.	1.The result of this action research also should be made available to the other partners; 2.MON Foundation can be a resource support organisation for Child Mental Health.		This can be developed as a model and a resource support one
4.	PKK	1.The experience and expertise arising from 26 years in the field; 2.Committed and	1.Focus totally on disability; 2.No structured	1.Evolving organisation; 2.The excellent rapport	Interpersonal relationship problems in the adolescent and teenage groups of disabled children	

SL. No.	Partner Agency	Strength	Weakness	Opportunities	Threat	Remarks
		motivated project holder and the core members of the Staff; 3.Skilled and technically trained manpower ; 4. Technical support in terms of latest equipment such as computerised audiology aids;	development and delegation in terms of second line leadership; 3.Absence of good systematic database of available resources both governmental and otherwise	of the organization at least with concerned Ministry of the GOI		
5.	SSDC	1. Simple curative healthcare is being made accessible in remote villages; 2.Most of the promotive and preventive health care is done indirectly at the level of the village communities;	1.Undue emphasis on curative care; 2.The belief of villager that safe deliveries are those done in institutions or Hospitals;	1.Village level health cadres; 2.Community structures and collectives;		

SL. No.	Partner Agency	Strength	Weakness	Opportunities	Threat	Remarks
		3.Self-reliant and sustainable interventions; 4.Committed and are active project holders: 5.Vision and mission to empower the people are shared by all the staff at various levels 6.Very good response from the target communities ;	3.Poor concept of antenatal care; 4.No two-way second contact care or referral services ; 5.Poor linkages with government; Poor communication skills; 6.Low level of linkages with government	3.Willingness of community to contribute		
6	APD	This specialized community based health program with disability focus has addressed the preventive promotive curative and rehabilitative aspects of disability well.	The strategic planning efforts of ADD Rural need to improve. There appears to be come unclarity on evolving directions of the program i.e. whether to develop further in community based disability work or into an integrated health and development	The APD team works in close collaborations with the ICDS centre and the sub centre ANMs in the area of pregnancy care and promoting immu-nizations. Though they are not directly providing these services to the community, however the facilitation of the	Changing occupational patterns of the area is exposing working adolescent girls to occupational health hazards associated with sericulture.	

SL. No.	Partner Agency	Strength	Weakness	Opportunities	Threat	Remarks
			program.	village based government cadre has produced good results.		
		They have had good results especially in the direct involvement areas of disability work as per the outcomes already brought out. This can be enhanced further with a dimension on mental disability.	Some of the present priorities of the program need to be reevaluated, such as the appropriateness of adopting certain villages and validity of continuance of nutrition supple-mentation activities.	Orienting the local level functionaries of the government system on disability issues is generating results. The primary teachers given orientation are screening the students for disabilities.	Government promoting women's sangha's in an adhoc manner through anganwadi workers could bring about division among women's organizations between beneficiaries and those deemed benefits.	
		Good rapport has been built up with the community especially as an outcome of the direct involvement. This has enabled them to mobilize the community to take up some responsibility in the children's health and education. This needs to be strengthened further.	No work is being done in the area of mental disability. This group is ideally placed to take up this dimension, given the necessary supports.	Similarity interacting and motivating the health professionals at the district level, is resulting in better functioning of the orthopaedic referral system at the district level.		

SL. No.	Partner Agency	Strength	Weakness	Opportunities	Threat	Remarks
		The government interface has been strengthened. Both the support given by the program, to community level government program and the dialogue entered into with government functionaries have contributed to this.	Program lacks good quality education material for health education of the community groups.	The early efforts at larger networking and mobilising people's groups on children's issues, will promote opportunities in building people's confidence.		
		The organization inherited a positive image of strong values, from the swamiji who donated the property. This image has been maintained.	There is no intervention with the community based health providers such as dais, herbalists and RMPs. This sector has important contributions to make in sustainability of the program.			
		There is a positive staff culture of openness transparency and accountability to each other. Accordingly the plans are made and	The program's ability in mobilizing grass root communities and empowering them for political action is a weak area. This is			

SL. No.	Partner Agency	Strength	Weakness	Opportunities	Threat	Remarks
		reviewed by the group themselves.	also reflected in related activities such as mobilizing panchayat bodies, and issue based networking at a wider level in support of local health needs.			
		The organization has invested in staff capacity building so much so that some of the staff is becoming local resource persons.	There is need for a competent core team in health. Such a core team need to have a minimum required training in health, atleast three months training in community health program manage-ment in a good field based facility.			

IV A CRITIQUE OF EXTERNAL CONTEXT

We shall present a critical evaluation of the problem situation related to child survival and development, namely indicates of child health care, child health and physical environment, child under dress, problems affecting child welfare. We will also examine policies, legislation, programmes of government agencies, responses of civil society organisations, positions of leading political parties and interventions of private sector.

CHILD HEALTH PROBLEM SITUATION

The child health related situation in the country though snowing minimal improvement over the years shows that the various programs have hardly made a dent on the problem situation or the underlying causes. We will examine at some detail the priority indicators related to child health : namely physical health indicators (infant and child mortality, maternal mortality, malnutrition communicable diseases), child health supportive physical environment (Water, sanitation and housing), child under stress and risk (working children, sexual abuse and child prostitution, disabled child, juvenile delinquency, children infected/affected by HIV, female foeticide) and problems affecting child welfare (deteriorating child care systems, deterioration of women's livelihood security and community level food security). I believe these indicators capture the health aspects of the 'child survival and protection needs'.

CHILD HEALTH CARE INDICATORS[1]

Infant Mortality

Infant mortality rate at national level has declined from 110 per 1,000 live births in 1981 to 71 per 1,000 live births in 1997. However, wide disparities persist. IMR varies from 12 in Kerala to 96 in Orissa (a level higher than *that of* Bangladesh or Nepal). Mortality rates among socio-economic classes show wide variation. Children of literate rural mothers have much lower IMR i.e. 64 vs. 89 for illiterate mothers (NFHS, 1998). The IMR and the child mortality amongst Scheduled Castes and Scheduled Tribes are 22% and 45% respectively higher than the national average at the same point of time. The IMR is 83-84 and child mortality 39-46 for the SCs and STs against the national figures of 76-61 IMR and 29-22 child mortality. The IMR for children of families with high standard of living is 43 whereas for those from low standard of living is twice high as 89.

The rate of decline of infant and child mortality has also slowed in recent years. Infant mortality overall has remained close to its present level of 71 per 1,000 live births since 1993. There has been no decline in urban IMR during the same period.

[1] The following topics infant mortality, maternal mortality, malnutrition, access to safe water sanitation and housing have been extrated from 'A Programme for Children and Women in India, Plan of Operations 1999 – 2002, GOI with UNICEF'. The author has contributed in the above topics only the paraphrasing and emphasis whenever it appear.

Moreover, age-specific child mortality (between the ages of 1- 4) at 24 per 1000 live births has been declining at a slower rate since 1981 – three points per year between 1981 and 1986, two points between 1986 and 1991, and 1.5 points between 1991 and 1993. This slowing of momentum on child survival is a cause of growing concern at a time when other conditions are becoming increasingly favourable particularly with the spread of literacy and improved communications.

Deaths in infancy are not spread out evenly throughout the first year. In 1992, 66% of infant deaths were neonatal deaths. This concentration of deaths in the first month of life underscores the importance of the peri – and neonatal period for urgent policy attention. Whereas mortality differentials between boys and girls in the first year of life are small at the national level, with greater desegregation of data, *it has been found that* girls continue to face higher risks of mortality. Mortality among girls is 20% higher than *that* among boys throughout childhood. One of the largest such differentials in developing countries, this reflects the unequal treatment that girls receive, especially in caring practices and health – seeking behaviour.

Much of this mortality is attributable to underlying malnutrition. *The fact that* nearly one third of babies born are low birth weight itself is a reflection of poor condition of women's nutrition. Some 80% of women are anaemic and as many as 58% reduce, rather than increase, their food intake during pregnancy.

Another reason for infant mortality is the incidence of vaccine – preventable diseases. The national EPI programme has helped to reduce the deaths caused by illness from vaccine – preventable diseases. Immunisation coverage, however, remains low in many districts, with as many as 30% of children not receiving any vaccinations at all. Deaths from measles, pertussis and diphtheria are now as much as 80% less than pre – immunisation levels. There has been success in bringing down the incidence of neonatal tetanus which has fallen from 20 to 10 per thousand live births in the last 5 – 8 years. However, there is still a large disparity between states in reported TT coverage. Multi-indicator cluster surveys indicate that only 43% of pregnant women had received full TT immunisation in Rajasthan, while 92% had received such immunisation in Tamil Nadu.

Infections of the lower respiratory system continue to account for 15 – 28% of infant deaths, with twenty per cent of children suffering from acute respiratory infections receiving no treatment at all.

Deaths due to diarrhoea have been declining, although only 43% of mothers in India (in 1993) knew about ORS, and only 26% reported having ever used it. These figures point at the difficulties the primary health care system has faced in responding to illnesses that cannot be predicted, and to the need for care to be available at all times. It is here that preventive activities but repeatedly fall short of responding to the needs of urgent 'unscheduled' care. As a consequence, families often turn to an unregulated private sector for curative care.

The key issues of serious concern emerging from the foregoing analysis are: overall slowing of momentum in child survival, the predominance of neonatal death in infant mortality, social background and sex still remaining as strongest variables for infant mortality, and malnutrition, low coverage of immunisation and infections that can either be easily preventable or be controlled without much difficulty are the causes for infant mortality

Maternal Mortality

The maternal mortality rate estimated to be between 437 – 570 per 100,000 live births remains unacceptably high. Close to 125,000 women die from pregnancy or pregnancy-related causes every year. A study of NFHS (GOI 95) revealed that about 42.4 percent women in rural areas did not get any antenatal care, with wide state-wise variations. Among these 15% were provided care at home by the health worker and only 48% received two tetanus injections and folic acid. Only 16 per cent had institutional deliveries. Of those who delivered at home (84%) only 40% were assisted by dais (both trained and untrained). Community studies in tribal areas show that almost half of the women dying of maternal case die at home and another 10 – 15% die on the way to hospital

Many of these deaths occur in young women. It may be noted that most of these deaths are preventable, through appropriate service provision.

However if the causes of death of women are analysed one finds that child birth and pregnancy related deaths accounted only for 2.9% of total deaths of females (Modal Registration Scheme quoted in, 'A Public Health Perspective, Imrana Quadeer, Anubhav Feb 99') The main cause even in child bearing group (15 – 44 age group) are the communicable diseases which has more than double the proportion of deaths from maternity causes. Other priority causes include anemia and malnutrition.

Hence public health program for women/ mothers need to prioritize the main causes of mortality rather than exclusively focus on reproductive health alone. It needs to be recognized that general illnesses of mothers also contribute to maternal mortality. Hence the main program addressing women's health, the reproductive and child health program (RCH) need to be looked at critically.

The examination and analysis of data on maternal mortality brings to light the following issues. The precise levels of maternal mortality are not known which itself is a comment on the low political priority given to women's health. The fact that most of the maternal mortality cases are preventable points at a prevailing major service gap for women in management of obstetric emergency. The major program focussing on women's health, the RCH, has a selective focus and doesn't cover all the priority causes of women's mortality and morbidity.

Malnutrition

Fifty three per cent of under-five children in India are malnourished and this accounts for the one-third of the world's children who suffer from malnutrition. The

rate of decline in malnutrition remains strikingly low, at no more than one per cent per year.

Over 50 per cent of young children, adolescent girls and women in the reproductive age group suffer from nutritional anaemia. Only 10 per cent of children can be classified as normal. Nearly, 90 per cent of children had low weight for age and 45-50 per cent is classified into moderate and severe category. There is a wide difference between high income and low income categories with only 10-15 per cent of high income category children showing moderate malnutrition (NNMB, 1984; NIN, ICMR, Hyderabad). 88 per cent of pregnant women were anaemic.

Vitamin A deficiency among pre school children is estimated at 1.1 per cent (NNMB, 1994). The NIN estimates that 56 per cent of pre-school children and 50 per cent of expected mothers suffer from iron deficiency. It is estimated that iodine deficiency accounted for 90000 still birth and neonatal death annually. Nutritional blindness affects over seven million children in India annually. Some amount of progress has recently been achieved in salt iodination (86 per cent) throughout the country. Still considerable number of newborns and school children remains vulnerable to iodine deficiency disorders (IDD). However, progress in tackling anaemia and vitamin A deficiency has been far from being satisfactory.

Sub-clinical Vitamin A deficiency in pregnant women and children increases morbidity and mortality. Iodine deficiency disorders (IDD) in expectant mothers can result in mental retardation in their infants while iron deficiency in infancy and early childhood period delays psychomotor development and impairs cognitive development.

Nutritional status especially of the youngest child during the first three years of life, has significant implications for physical and cognitive development just as the psycho – social stimulation and the child-parent interaction has. Neglect of children in this age group has serious implications in terms of overall development, readiness for schooling and learning capacity.

Such high levels of malnutrition persist despite the major investment of human and financial resources by the State in child development programmes. The Integrated Child Development Services (ICDS) programme, launched in 1975, has become in the largest effort in history to improve nutrition and child development and now operates in over 400,000 of the country's 600,000 villages. However, the expansion and continued strengthening of infrastructure support to ICDS Aganwadi Centres (AWCs) to meet the goals for children represents a continuing challenge, especially in unreached areas.

The "invisibility" of malnutrition has much to do with its neglect. *Low birth weight is the best single indicator of the risk malnutrition.* Therefore, the only means of assessing *the* degree of malnutrition is by measuring weight against child's age. Yet growth monitoring is neither widespread nor focused on the very young child. Low

birth weight is also emerging as a major cause of chronic illnesses later in life, as well as a factor in mental retardation. Close to 33 percent of all infants born in India are of low birth weight – a level that has hardly fallen in the last two decades.

Low birth weight reflects an inter-generational transmission of malnutrition. Girls are married young, thus enduring early pregnancies and childbirth before they attain physical and mental maturity. While differences in nutritional status between boys and girls are not visible in macro – level data, the care – seeking and care-providing behaviour of families continue to discriminate against the girl child. A first daughter is often given care comparable to a son, but second or third girl children are particularly vulnerable to malnutrition and higher child mortality.

Malnutrition is not necessarily an outcome of low incomes. It could be an outcome of infections, and illnesses as well as inadequate or inappropriate feeding and caring practices. Caring practices include not only care of children, but care of women as well. Care of women and girls is as important as care provided by women. Girls and women in India find themselves in a particularly disadvantageous position in the extended family, with excessive demands on their time and energies to meet household needs. They are also vulnerable to violence and abuse and poor care within the family. Promoting gender equality, particularly shared parenting and care responsibilities are crucial for preventing malnutrition

Environmental stress and geographical remoteness present special difficulties in realising nutrition rights for children and women. Nutritional security is severely compromised at certain times of the year because of adverse weather conditions and poor land productivity. These have an even more profound effect on people belonging to the Scheduled Castes and Scheduled Tribes due to their inadequate household resources and lack of access to social services. Concerted efforts are required to address the nutritional needs of these under-served communities.

The spread of HIV/AIDS in India poses a special threat to the nutritional wellbeing of the child.

Insufficient attention has been paid to the child's growth during the critical period between 4 and 24 months when malnutrition sets in and peaks. This period is critical for mental development. Recent data reveals, for instance, that only one-third of children are given complementary foods between the ages of 6-9 months, when breastfeeding needs to be supplemented with regular consumption of semi-solid or mushy foods. Low level of awareness among families and service providers about proper feeding practices directly contributes to the problem.

Better education for girls, improving the knowledge of mothers and adolescent girls, and better care of girls and women, especially during pregnancy, are vital conditions for improving the health and nutritional status of both women and children. ***These pre-birth and socio-cultural factors have not so far been well addressed within child development and nutrition programming in India.***

The right of all women to be informed and counselled on appropriate infant and young child feeding practices needs to be recognised. This is even more crucial for the most marginalised and disadvantaged groups. Similarly, the choice of feeding practices by an HIV positive women should be an informed one

The review of nutritional situation in our country reveals quite a lot of information pertinent to policies and programme. Even now the rate of malnutrition among children in India is very high. Still the growth monitoring is not properly done. Low weight at birth, the best single indicator of malnutrition reflects both economic and socio-cultural factors of malnutrition. Low weight at birth in general is inter-generational transmission of malnutrition. Factors like social segregation; remoteness and so on act as additional factors in the case of SCs and STs. In the case of the other sections of the poor, feeding and caring practices and neglect of or inadequate care during the early years of childhood are important factors. Mothers affected by HIA/AIDS constitute another factor for low nutrition. It is unfortunate to observe that our policies and programmes do not address these socio-cultural factors of nutrition.

Communicable Diseases

Overview of Communicable Diseases (CD)

Our country is witnessing an upsurge in communicable diseases causing millions to be sick and lakhs to be dying annually. Communicable diseases are caused by microorganisms, which can spread from one infected individual to another through varied mechanisms. The major communicable diseases (according to their severity and extent in chidren) are: Malaria, Tuberculosis, HIV/AIDS, Leprosy, Diarrhoeal diseases, Upper Respiratory Illnesses, Filaria, Viral Encephalitis and Kala Azar, to name but a few.

Diarrhoeal diseases or faeco-oral diseases is an important category of 'food, water and soil borne dieases'. The important ones in this category are, amoebiasis, giardiasis, gastro-enteritis, bacillary dysentry, cholera, typhoid hepatitis Aand E, and poliomyelitis. Fifty percent of infant deaths are attributed to diarrhoeal diseases. An estimated 1.5million under-five deaths occur in India every year, due to water related diseases (Report of the Task Force on Health and Family Welfare Karnataka, 2001).

Acute Respiratory infection in children are responsible for 25 to 35% of deaths among children below five years of age (Report of Independent Commission of Health in India, Control of Communicable Diseases 1997).

Though Tuberculosis primarily is a decease of adults, TB in children is a serious problem. Good estimates are not available due to the difficulty in diagnosing pediatric age group Tuberculosis. About 3 lakh children become orphans due to TB annually.

Malaria causes serious medical complications and death for mothers in pregnancy (upto 10% of pregnant women). It can blight the development of the child before and after birth and also cause deaths (spontaneous abortions upto 60% pregnancies). In highly endemic areas frequent infection helps communities to buildup natural immunity to malaria, though at an enormous cost in sickness and loss of life in early childhood.

Women loose some of their acquired immunity to Malaria during pregnancy especially during first pregnancy, exposing them to life threatening anaemia and miscarriage. It also results in delivery of under-wieght babies the "small baby syndrome" (Risks in motherhood, David Payne, World Health, May – June 1998).

Japanese Encephyalitis is a viral disease causing brain fever, transmitted by mosquitoes. It is highly prevalent in southern and eastern parts of the country. Reported JE cases in India have been around 4000 in epidemic years. It affects mostly children between 2 to 15 years. It is major concern because of the high mortality rate of 20 to 40% (Manual on JE, IIHFW, Hyderabad 2001).

There has been an increase of old communicable diseases as well as emergence of new ones in epidemic proportions. We find in India some communicable disease occur across the country, whereas some others though prevalent in large numbers, are restricted to specific regions.

Communicable diseases can be grouped according to their mechanism of spread, (as the interventions are also aimed at tackling the mechanisms). They are classified in order of spread as :

- Persons to person transmission eg. Tuberculosis, AIDS, Leprosy
- Food, water and soil borne eg. Diarrhoea, Hepatitis A, Hook Worm Infestations
- Insect or vector borne eg. Malaria, Dengue, Japanese (Viral) Encephalitis
- Animal borne eg. Rabies

The Role of Public Health Sector In CD Control: Weakness of public health efforts

Historically India's public health system has not fared well in controlling communicable diseases. This is partly to be explained by the reality that the role of the health system in combating public health problems (such as communicable diseases) is limited. Interventions of other sectors aimed at the root causes of diseases such as provision of: safe water, environmental sanitation, security of food and nutrition and healthy life styles are equally important, if not of prime importance. Public health strategies adopted, are believed to have been short sighted and blighted with many faults such as: being centralised (with no space for decentralised planning), techno-bureaucrat driven (with no community participation), technology oriented (overlooking the socio-environmental dynamics).

Compounding the problem further, it is believed by many public health experts that there has been a breakdown in the public health system in the recent decade. The quality and motivation of public health professionals, the functioning of public health institutions and laboratories, the effectiveness of the surveillance system, as well as the relevance and effectiveness of the public health policies and programmes, have all believed to have deteriorated.

Lessons from major C D Control Programs

We will look deeper into three nationally priority diseases namely Tuberculosis, Malaria and HIV/AIDS, to learn urgent lessons.

(a) Tuberculosis

It is believed that the tuberculosis epidemic in the country is over 3 centuries old. Present situation (given below) has not appreciably improved from what it was at the time of independence.

Active disease	15 million (about 20 out of 1000 persons)
Infectious stage (sputum positive)	3.5 million (one fourth of all cases)
New patients per year	2.3 million
Annual Deaths	0.5 million (number one killer amongst infectious diseases)

Tuberculosis was recognised as a national priority from the time of independence. Based on a path breaking research done in the country, the National Tuberculosis Programme (NTP) was initiated in 1962. The study found that TB patients were bothered by their disease and sought help early from care givers (but usually turned away by care giving with only cough medicines). The programme was integrated into the Primary Health Services so as to be accessible to the dispersed population. The basic unit of the programme is the District TB Programme (DTP), which functions through the Peripheral Health Institutions (PHIs) which are primarily the PHCs and some NGO/Private institutions. The case identification, treatment and follow up are to be done at the PHIs and DTPs provide capacity building, coordination and monitoring. The multi drug regime of treatment based on daily dosage schedule (given free of charge) has been revised over the years.

In 1997 with World Bank loan of 440 million dollars, the Revised National TB Control Programme (RNTCP) was started, which would cover 1/3 all districts. Incorporated into the policy guidelines are specific roles for NGOs and other Civil Society groups (5 types of TB control activity NGOs could take up).

Critique of the policy and programme for TB control ('Whatever Happened to Health for All by 2000 AD', The National Coordination Committee of Jan Swasthya Sabha, May 2000)

The NTP or DTP though based on sound research, for its effectiveness is dependent on the public health system (mostly primary health care system). However the PHC system has failed in the country and along with that the TB programme has also failed.

- The public health sector is only the first contact for chest symptomatic patients in less than 50% cases (recent data shows less than 30%) hence the number of cases diagnosed was low.
- The treatment completion (case holding) of those started on treatment has been poor in the long course treatment (about 30%) and even in the short course chemotherapy (SCC) regime only about 60%.
- The programme has been beset with problems resulting from lack of political and bureaucratic will – exemplified by the lack of regular and assured supply of drugs and other diagnostics.

The basis for the new RNTCP policy and programmes are being contested for the following reasons:

- There is not enough evidence to show the effectiveness of the treatment regime introduced (intermittent regime).
- The Directly Observed Treatment Strategy (DOTS) in practice (at the level of the peripheral health care workers) may result in many patients being left out of treatment, if the staff feels they will not be regular. The principle of DOTS is questioned, as impractical to implement.
- The high cost of the drug regime, puts question on the sustainability of the programme, in situations where external loans are not available for the same.

The key lessons we learn from the failures are:

- Public sector must ensure minimum resources - infrastructure, human power and drugs.
- Need for promoting community pressure and partnership for TB Control (through locally elected representatives) so that public health sector will be responsive and accessible.
- Involving the private health sector into the control programme in a systematic manner.
- Need for asserting people's right to conditions that promote health (as TB is directly related to poverty).

(b) Malaria

The National Malaria Eradication programme was initiated in 1957 as a vertical programme on a war footing. In every block malaria workers were appointed for both

spraying DDT and to detect outbreaks early, supervised by a hierarchy of officials. The programme was based on the strategy of vector control through spraying DDT and chloroquine treatment for those affected with malaria.

By early 60s there was drastic reduction of malaria cases and deaths. However by early 70s the epidemic started rising again when a 'Modified Plan of Operation' was put into action. Other modification of strategy has been introduced in the 90s such as 'High Risk Areas Plan'. This time round there was no appreciable improvement in the problem and besides more malaria is being caused by Plasmodium Falciparum. Falciparum infection is more severe and resistant to drugs. Now malaria control is felt to be unattainable and the name changed to 'National Anti Malaria Program.

The present estimate of Malaria is about 20 - 30 million cases per year (based on other sources of information) whereas government data shows ten times lower figures!

Critique of the Programme (Whatever Happened to health for All by 2000 AD)

As a vertical programme, it has three basic limitations, which was bound to cause failure in the long run.

- Programme is technology centric (relying on DDT and drugs) but not recognizing the social and environmental factors contributing to the problem.
- Programme is fragmented - using only limited options, whereas a wide variety of options based on local needs, needs to be utilized.
- Programme is administration driven with no community participation. Most of the measures required for success need community involvement (such as ensuring personal protection, clearing breeding sites etc)

Learning

The key lessons we learn from the failures are:

- Need for implementing localized plans based on local needs and hence making funds available for the same.
- Need for institutionalized arrangements for participation of community (such as panchayat's role)
- Importance of adequate surveillance mechanism (with input from the community, private health sector, and state health sector) at the district level.
- Required resources must be made available through state health department (for personal protection, environmental management, pesticide spraying, and drug treatment) as well as through ensuring required public health infrastructure.

(c) HIV/AIDS

Overview of the problem ('Strategic Plan of AP State AIDS Control Program', APSACS,2001)

In India HIV/AIDS epidemic is now a decade and a half old. Within this short period it has emerged as one of the most serious public health problem in the country. It is estimated that 3.7 million Indians are HIV positive. Though presently this figure is less than 1% of adult population, it is expected to reach 5% of the population by 2005 (40 million).

The available surveillance data clearly indicates that HIV is prevalent in almost all parts of the country. In the recent years it has spread from urban to rural areas and from individual practicing risk behavior to the general population. Studies indicate that more and more women attending antenatal clinics are testing HIV positive thereby increasing the risk of prenatal transmission.

About 75 per cent of the infections occur from the sexual route (both heterosexual and homosexual) about 8 per cent through blood transfusion, another 8% through injecting drug use. About 89% of the reported cases are occurring in sexually active and economically productive age group of 18 – 40 years. One in every 4 cases reported is a woman.

Root causes of the problem

- Rural poverty and urban migration, with resultant stressed life situations, breakdown of traditional values and support structures.
- Cultural taboo on sexuality, resulting in ignorance and unhealthy sexual attitudes and practices.
- Sex-worker profession being illegal (not monitored and supported in health parameters), leading to spread of Sexually Transmitted Diseases (STDs) and HIV infections to the clients.
- Prevalence of significant levels of STDs and Reproductive Tract Infections (RTIs) and insufficient resources for management of these problems in the health system.

Draft National AIDS Control Policy ('Draft National AIDS Control Policy', NACO 2001)

The general features of the policy are:

- Prevention of further spread of the disease by awareness generation among people at large and specially among high risk behavior groups and making available to them tools for protecting themselves.
- Efforts towards control of STDs and RTIs.
- To enable individuals and families affected by HIV/AIDS to manage the problems with their family and community support.

- Improving services for the care of People Living With AIDS (PLWA) both in hospitals and at home.
- Strengthening and capacity building of the health care system, for surveillance, diagnosis, management, blood safety, attitudinal change etc.

The policy is being implemented through state level agencies set up for the purpose, which in turn operate through the District Leprosy Control setup. There is emphasis on partnership with NGOS in several areas of implementation namely:

- Consultation at the policy making level
- In awareness generation, provisioning of counseling facilities, intervention projects among high-risk behavior groups.
- Provision of medical facilities, home based care and hospice (terminal) care.
- Capacity building of NGOs to take up newer responsibilities.

Critique

The program is in its infancy stage and as such it is too early to make a learned critique. However one can anticipate that, the weaknesses of the public health system (already discussed), will affect the AIDS Control Programmme's effectiveness.

There is an undue reliance on technology (condoms) as a preventive measure, though the cultural and environmental setting of the problem is very clear. Government programs would find addressing them difficult.

As yet HIV/AIDS care is not integrated into the public health system, besides there exist, fear and bias even among health functionaries, which make them refuse care to the affected.

As yet the private health sector including the Indian Systems of Medicine (ISM) are not integrated into the overall plan. This will lead to failure in containment of transmission as well as exploitations by unscrupulous elements.

Though policy documents refer to involvement of the community the past record of government initiatives suggests, it is unlikely to succeed. However community based strategies, support structures and awareness campaign is a crucial element (as a root cause is embedded in the socio-cultural environment).

CHILD HEALTH SUPPORTIVE PHYSICAL ENVIRONMENT (Sanitation, Hygiene and Water Supply)

Denied access to required quantity and quality water, grossly inadequate sanitation facilities and poor personal hygiene practices are major contributors to ill health especially of children.

In the 80s decade the policy attention on safe water, promised the possibility of universal access to protected water. However the outcomes have belied that hope.

Unhygienic practices and contaminated water cause diarrhoea and ill health that account for nearly 400,000 child deaths annually. The lack of sanitation is a significant contributory factor in malnutrition, which impairs the growth of more than 58 million children. Over 70% of the health problems faced by children in primary schools are caused by inadequate hygiene.

Access to safe water

India has made significant progress during the last three decades in provisioning of rural water supply. The government has adopted a coverage norm of one safe source supplying 40 litres per capita per day, for a population of 250 within a distance of 1,600 metre in the plains or 100 metre elevation in the hills. The Rajiv Gandhi Water Mission took up provision of safe drinking water to 100 per cent habitations in the 80s with support from UNICEF. It relied mostly on borewells for extracting ground water, to be supplied through hand pumps or overhead tanks. Though almost complete coverage was claimed, on a disaggregated analysis it was seen that a third of hamlets were not covered. After launching new schemes further to address the sections not reached by the earlier ones, more coverage has been claimed.

As per the official estimate, In 1996 about 86 per cent – 85 % urban and 86 % rural – of the population had access to safe drinking water.

The 14% of the population that remains without access to safe water represent in numerical terms a substantial population, many of whom reside in tribal or remote geographical areas. Statistical coverage does not always guarantee effective access to all social groups, especially those living in India's many hamlets, often composed of Scheduled Castes and Scheduled Tribes.

Access to water sources by itself does not assure protected water. An NCAE country wide sample study puts unprotected water usage at 52%. Of the protected water sources 17% is piped water, 18% is from hand pumps and 13% from sources such as open wells.

The challenges currently faced by our country in the case of drinking water can be summarised as given below:

- Problems of water quality are becoming increasingly acute. Borewells, long promoted as safe sources of water, are found to be faecally polluted as a result of poor well construction and insanitary well surroundings. At least 10% of the

population has higher levels of fluoride, arsenic, iron or salinity in their sources of drinking water.

- The limitations of centralized, sectoral and technology oriented approach has had its limitations. Sustainability of the very technologies used to rapidly and cost effectively provide access to safe water to millions of households is under threat from falling water tables, caused by over-exploitation of groundwater for irrigation and industry. The fresh water situation is increasingly threatened by indiscriminate pollution of surface as well as ground water.
- Even the available water sources are not accessible equally. Various socio-political factors intervene in accessibility to water sources. The public water supplies that as per official estimates provide water are often irregular or out of order for long periods. (A recent Government study revealed for instance, that 23% of hand-pumps, 14% of mini – piped schemes and 44% of larger piped water supply schemes were not functioning due to breakdown and poor maintenance.) These could be related to poor community ownership of and maintenance water source, and poor community monitoring of quality. Coupled with these are problems of transparency in governance.
- Under the influence of new economic policy, government is inclined to privatise the service of supply of drinking water. There is much apprehension on the cost increase for the poor that it will entail.

The poor access to drinking water by a household directly affects the child's right to survival and development. The failure to assure safe water and clean environment affects the fulfillment of other rights also. For instance, the absence of separate, safe and clean toilets deters parents from sending their daughters to school and denies many girls the right to basic education (give data and source). Non availability of potable water nearer to the dwelling places imposes a heavy burden of drudgery on women and young girls as they are forced to walk long distances to obtain safe water for household use. This perceived duty of girls within the family to fetch water, and perform other household chores also contributes to the denial of education for girls.

Sanitation

In 1996, about 26% of households had access to proper sanitation – up from 23% in 1991 The national rates for access to sanitation increased in the year 1999 to 29% (urban 70% and rural 25%). This is a deplorably low figure. More over the access to sanitation facilities is uneven. The urban figure, however, disguises the fact that millions of families in the poorest urban settlements, many of which are unauthorized, face insanitary conditions that are life threatening to children. Communities belonging to scheduled castes and scheduled tribes stand out as the most disadvantaged groups in terms of enjoying equal access to environmental sanitation also as we found in the case of safe drinking water.

Another overlooked area in the case of sanitation is the facilities for disposal of solid and liquid wastes. This needs special attention and emphasis by the government by allocating adequate funds.

The continued neglect of the environment in urban slums poses one of the greatest threats to progress on reducing infant and child mortality and improving nutritional status of children living in such disadvantaged areas. Almost a third of households in urban slums do not have access to any kind of toilet. Drainage and garbage disposal systems are often overwhelmed or absent. Public latrines poorly designed and maintained, become themselves major centres of infection and often deter use by women and children.

On the other hand we find that the demand for latrine facilities is high from certain sections (especially from educated women given the decreasing scrub cover). This is inspite of the government experiences of poor utilization of funds.

One could identify a lot of reasons for poor achievement or underperformance in this sector

- Though planners have given consistent emphasis to sanitation in plan documents, the budgeting for this item has been low.
- There is a narrow focus on the choice of technology. Wide variety of technology options based on local situations and local resources need to be made available, which could lead to sustainable usage. Successful experience of Sulabh Souchalaya is an example.
- There is a general lack of demand for toilets, and indifference on the part of families and communities for a safe environment for their children and for themselves.

Community needs to be active participants in raising demands for services (based on felt needs) and in planning and paying for services (according to their capability) as opposed to being passive recipients. High prevalence of non utilization or under utilization especially of sanitation facilities when socio-cultural factors have not been considered in the plan, is observed

- Quality of service and its monitoring is another gap. Built in mechanisms for monitoring the safety and usability of sanitary facilities, changing in conditions of water availability is required.

Housing

There is immense shortage of housing needs estimated at a shortfall of 23 million. The outlay for housing has progressively decreased from 2.5% in the II plan to 1.47% in the VIII plan. The plan outlay centrally is routed through the Indira Awas Yojana (IAY) and at the state levels through the minimum needs programme. Trend is of increasing investment of private sector in housing, which tends to increase the prices.

Given the large investments required a more feasible approach to the problems to provide land rights and facilities like credit and support for upgrading. The poor themselves will build their houses. This is equally true in the urban areas where the

poor have through prolonged struggles managed to win legal rights to plots, however environmentally degraded they were and created them into suitable housing.

'However the new economic policies tend to aggravate the problem through accelerated unemployment, rising prices and cut back on state subsidised basic services and facilities. Policy trends are supporting the market forces such as repealing of the urban land ceiling act, and large-scale demolitions of slums for procuring valuable lands for business interests. The vision of social housing has been lost and housing is no longer considered an instrument for bringing about redistributive justice' Jai Sen, Convenor, NCHR.

A child's right to secure environment begins with assured access to safe water and clean surroundings both vital for healthy growth of the child. The assurance of such a right depends critically upon public provisioning by the state, the behavioural patterns of parents in the family and outside the home, and upon the level of information communities have on are the benefits of hygiene and environmental sanitation. Social discrimination and exclusion can deny the right to use public water sources and sanitation facilities by communities like SCs and STs even if all the above conditions are fulfilled.

Several factors thus constrain fulfillment of the child's right to safe drinking water and a clean environment. Some of them are with in the control of the household and the community, others beyond the control. A major factor however has been attitudinal and behavioural change that has been slow to come about. A child's most immediate environment is the family and the home, where hygiene practices, such as hand washing, toilet use and the safe handling of drinking water are critical. Behavioural changes become fundamental to alter such practices. Outside the home, the child's environment widens to include the community, where safe water sources, waste management and drainage are crucial. Public provisioning has been underperforming in these areas. The issues include adequacy in financial outlays, access and quality of services, the relevance of technology choices, community participation and sustainable usage. Beyond the habitation, the management of land, forest and water has a direct bearing on the living conditions of the communities depending on these resources. Very little public action has been mobilized for preventing environmental deterioration and its impact on water table replenishment and sustainability.

THE CHILD UNDER STRESS AND RISK

In the situation of growing economic disparities, break down of family support systems and changing values especially of consumerism In a patriarchal class and caste ridden society, the child is under stresses and risks to physical and mental health.

Working children and bonded child labour.

The country has a large number of children forced into adult roles of earning a livelihood. According to the 43rd round of the National Sample Survey (1987), the number of working children was estimated to be 17 million. The present figure is estimated to be around 20 million. The International Labour Organization (ILO) figures for year 2000 is given below:

Child Labour in India		
State	**Number**	**Percent**
Andhra Pradesh (Girls outnumber boys 51.5 to 48.5)	1.66 (92% rural)	14.7
Uttar Pradesh	1.41	12.5
Madhya Pradesh	1.35	12.0
Maharashtra	1.06	9.5
Karnataka	0.97	8.7
Bihar	0.94	8.3

(International Labor Organisation –AP Project on Child Labor)

This is a result of the increasing poverty, break down of family caring systems and other manifestations of the economic policy changes. Being in forced child labor invariably damages their growth and development and violates their basic rights. The children are scarred for life, by hampered growth, occupational diseases and having remained unschooled while their peers move ahead. These are handicaps that rob them of their full potential.

Legal Provisions, Policies and Programmes

The constitution contains provisions for protection of children from work that is beyond their capacity, or involves long hours of work interfering with their education, recreation, rest and overall physical and mental development. Protection is also available under various industrial acts labour laws enacted from time to time.

The Supreme Court in its land mark judgement delivered on 10 December 1996 in M C Mehta Case (M C Mehta Vs State of Tamil Nadu and others 1996 (B) SCC 756) gave a major fillip and encouragement to the efforts of various agencies working on child labor.

The Supreme Court directed among other things, to conduct a detailed survey of child labor in the entire country. According to the judgement, on completion of the survey an amount of Rs. 20,000 per child should be collected from those who have employed child labour in hazardous occupations and processes, to be used as corpus for a Child Labour Rehabilitation cum Welfare Fund to be set up at the district level. States should also ensure alternative employment to one able bodied adult member of the family of the child who was withdrawn from the work or alternatively contribute Rs. 5,000 per child to the said fund. The child would be ensured education in the formal school, and the employer should be prosecuted for violating the provisions of the child labour act.

If the identified children were working in a non-hazardous job, the child should be imparted education at the cost of the employer and the Government should ensure that the child does not work for more than 4 to 6 hours.

Features of Government Policy on Child Labour (2000)

- Universal Elementary Education by 2005 as the main tools.
- Time bound Programmes to end child labour.
- Shift of child labour subject to Education Department from WD & CW and labour departments.
- Provision of Schools, teachers etc., for child labourers by the government through DPEP.
- DPEP emerging as a main player to end child labour.

Most of the efforts towards the elimination of child labor thus far has been focussed only on the rehabilitation of the child by attempting to get the child into an educational or vocational stream using a variety of rather good and innovative strategies. However there has been little effort to look at and focus on the families of the children and provide to the families all such inputs which could bring about a strong commitment in the parents against child labour and towards the continuation of their child's education. This would also mean bringing about an improvement in the economic situation of the families.

A fall in incomes and simultaneous increase in family expenditures can at times make it difficult for parents or families of children to sustain rehabilitation efforts. But so far, most of efforts for rehabilitation of children have focused only on the child, attempting to get the child into an educational or vocational stream. Such as integrated girl child rehabilitation program of Women's Cooperative Finance Corporation, "Back to School Program" of Social Welfare Department or Non Formal Education scheme of ministry of Human Resource Development. There has been little effort to look at the families of the children whose incomes decrease when the child stops working and expenditures increase when the children are enrolled into schools. There has been no effort to provide additional assistance to improve the economic situation of such families (Which could be one amongst the primary causes of child labour) so that they are able to cope with the drop in incomes when the children stop working and join schools.

A comprehensive approach should also converge health inputs, both in the area of awareness generation and also in terms of curative care and health promotional aspects, for the families at risk, who are likely to send children into forced labor. Simultaneously health of children in hazardous occupations needs to be closely monitored and attended to using the legal instruments available.

Child Prostitution

Though reliable estimates are not available micro level studies show that about 15% of all women in sex trade are children. The most comprehensive study by Govt. of

India suggests atleast 28000 children are in prostitution in the 6 metropolises alone. India Today in 1990 quoted a figure of 500000 minors in prostitution ("Child Prostitution: The Ultimate Abuse" report of National Consultation on Child Prostitution 1995 UNICEF, New Delhi).

The contributing circumstances are utter rural poverty, illiteracy, dysfunctional families and the affected children themselves being illiterate. About 20% of child prostitutes are thought to come from the traditional systems of temple prostitution "Jogini or Devadasi". This system is also contributed to by the impoverishment of the lower caste groups (schedule castes). Exploiting these circumstances are networks of traffickers operating from the impoverished areas with direct linkage to the brothels in the metros. They dupe the family and the child through various inducements. Another factor that has suddenly increased this exploitation is the recent increase in 'sex tourism' and India becoming increasingly a center for global sex tourism.

Children in sex trade are exposed to various dangers. These dangers include physical and emotional violence, greater danger of being infected with STDs and HIV infection due to the immature development of their genital systems and the deep emotional trauma which leaves a permanent scar in their psyche. Some thinkers assert that it is the ultimate denial of the rights of the child, transforming his/her entire life; (DR John Rhode, UNICEF Representative)

Policy and Provisions

The solution to this problem of tragic proportions is difficult and complicated, requiring collaborative efforts from wide sections of the society and government the existing response of the state is very weak and inadequate.

The National Policy for Children, 1974 states that "Children shall be protected against neglect, cruelty and exploitation". The National Decadal Plan of Action for the Girl Child (1991 – 2000 AD) recognises the rights of the girl child to protection from exploitation, assault and physical abuse.

The Supreme Court of India in a "Public Interest Litigation" in 1990 on the subject of child prostitution had directed that the central and state governments should set up Advisory Committees to suggest measures to be taken in eradicating child prostitution.

However existing law related to the offense are riddled with loopholes. The law-enforces (police) are insensitive to the sociological and human problem, and often end up abetting the offenders and penalizing the victims.

The rescue work of children so trapped is dangerous for NGOS alone to handle as underworld Mafia's are involved. In addition a comprehensive mechanism for rescue does not exist as of now. Rehabilitation of the vulnerable or rescued children requires sensitive approach, both due to the social stigma and the psychological

scarring. The children's institutions such as the remand homes are least suitable for this.

Targeting of the vulnerable families for preventive work is a Herculean task, given the wide- spread rural poverty and illiteracy. Compounding all these inadequacies in the response, is the negative impact of globalization. Globalisation is increasing rural poverty and feminisation of poverty as well as increasing the market demand for child prostitution through global sex tourism. The legal statutes alone are not adequate to tackle this menace.

The Disabled Child

It is estimated that 10 per cent of the population worldwide is disabled. The extrapolation that 35 million Indian children are disabled is considered conservative by many. Most Indian children are disabled because of poverty and its correlates. Protein malnutrition, Iodine deficiency and Vitamin A deficiency are the major causes of mental retardation and blindness. Based on the type of disability, it is estimated that of the orthopaedically handicapped, locomotion disability is the most prevalent in the 0 – 14 age group with at least 2.4% incidence. The most significant causes are poliomyelitis, cerebral palsy, paralysis, arthritis and amputations. 5 – 7% children suffer from signs of Vitamin A deficiency with an estimated 60,000 children becoming blind each year; an estimated 6.6 million children are mentally retarded and 2.2 million afflicted with cretinism resulting from iodine deficiency. Developmental delays and mental handicaps are the most under reported of all disabilities. The National Sample Survey of 1991 estimated that in the 0 – 14 age group, the incidence of hearing handicap is 1.4%. Of the 4 million leprosy affected persons one fifth are estimated to be children and about 15 to 20% cases are with deformities. The available statistics on the incidence of various disabilities are limited and believed to understate the scale of the problem due to tendencies of families failing to recognise or acknowledge disabilities especially communication and mental disabilities. Lack of early detection and treatment leads, in most cases, to major and stressful secondary handicaps of physical function, intellectual handicap and social and emotional behavioural problems. The vast majority of disabled children lead lives singularly lacking in stimulation; they know no difference between childhood maturity and old age.

Health services for the Disabled

This situation is further exacerbated by the lack of basic services.
Very little care is available at the three levels of prevention (Primary, Secondary, Tertiary) in the field of disability.

In the chapters concerned with nutrition we see that Vitamin A deficiency, Iodine deficiency and protein malnutrition among children have not seen effective interventions (primary prevention). On the contrary the situation could deteriorate given the compromised food and nutrition security of the household. These are important contributory factors of disability. (Polio-eradication program however has

been one of the successful programs, we are proudly moving into the eradication stage).

A similar bleak situation is seen regarding early treatment of causative diseases, early detection of disabilities and appropriate medical rehabilitation (secondary and tertiary prevention). Skilled personals are not available at a countrywide level in the public health system. Even the PHC doctors are not adequately trained and skilled in rehabilitation aspects. The few services that exist are mostly in cities and accessed mainly by the middle and upper classes. Rehabilitation strategies focus largely on literacy and academic goals. The few assistive devices produced are suited to the aspirations of financially well off urban Indians. An estimated 98 percent of rural and 95 per cent of urban disabled children have no access to services.

The recent deaths from five of 29 inmates of a hostel for mentally ill at Erwadi, Ramanathapuram, has brought to attention the pitiable lack of resources for the mentally ill. It is stated that 80% of the districts in the country don't even have a trained psychiatrist, let alone mental hospitals! ('Shocking Neglect of Rights of Disabled Persons', Javed Abidi PUCL Bulletin Dec 2001)

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995, is a comprehensive legislation. It came to be passed with the concerted and sustained advocacy efforts of groups working on disability issues. The act defines disability to mean the following seven areas:

1. Blindness
2. Low vision
3. Leprosy
4. Learning impairment
5. Loco motor disabilities
6. Mental retardation
7. Mental illness

The Act has established the responsibility of society to make adjustment for disabled people. It has opened many doors to disabled children and adults. However the implementation of the Act so far has been very tardy. Critics attribute it to the following reasons:

- Though a mechanism has been put into place through the Act, implementation blocks, are systems pervasive.
- Lack of political will, financial support and excessive beaurocracy.
- Lack of awareness among government departments about the act.
- No monitoring mechanisms for the implementation of the Act
- Lack of awareness among the disabled people about the act.
- Lack of strong Advocacy groups to pressurize policy makers and implementers.

Juvenile Delinquents

Over the years, the process of social development in India not only led to changes in the family structure and values, but has also resulted in an increase in social problems like destitution and juvenile delinquency.

The government of India has introduced various pieces of legislation and programmes to minimise these social problems. A well-planned juvenile system comprising of Juvenile Welfare Boards, Juvenile Courts, Observation Homes, Juvenile Homes, Special Homes and After-care Organisations is in operation.

With a view to provide a uniform pattern of justice to juveniles throughout the country, Juvenile Justice Act 1986 came into force in 1987. The Act has brought a change in the upper age limit of juveniles (from the earlier age limit of 21 years for both males and females) to 16 years for males and 18 years for females. The Act provides for the care, protection, treatment, development and rehabilitation of neglected and delinquent juveniles and lays down a uniform legal framework to ensure that no child under any circumstances is lodged in jail or kept in police lock-up. The Act provides for a different approach in the processing of the neglected juveniles vis-à-vis the delinquents. While neglected children are produced before Juvenile Welfare Board, the delinquents are dealt with by the Juvenile Courts.

HIV Infected and Affected Children

At 1% of HIV prevalance among pregnant women in India it is estimated that there are annually 1.3 lakh HIV positive pregnancies and about 33% of the children born will be HIV positive (Dr Deepti Dingaonkar, paper presented at National NGO Meet on HIV/AIDS, May 2002, thane) Besides the positive children, a large number of children become affected as HIV orphans.

The basic needs of children who have been orphaned by AIDS are the same as needs of all children. A unique aspect of HIV/AIDS is the stigma and fear and isolation that accompany it and the possibility of rejection and prejudice. Infected and affected HIV orphans become dependent on the wider community to care for them. Other family members surviving such as grand parents are hardly in a position to care for them as majority are from poor socio economic background.

Hence issues of caring, schooling and psycho social support of these children become important societal concerns given the lack of programs and resources made available for abandoned children.

Medical management issues are complicated though effective and relatively economic preventive measures are now available (such as Nevarapine and AZT prophylaxis, planned ceasarian delivery and cessation of breast feeding). Considering the low resource set up in the country the above mentioned interventions are unlikely to be implemented universally.

This is inspite of the fact that AIDS control program is picking up well in the country, given the considerable international attention on this issue. Government efforts all never the world has not borne good results, without the catalyst role played by civil society groups.

Female Foeticide

Female foeticide and infanticide is one growing issue linked to the patriarchal value of male preference but exacerbated both by the new technologies introduced, as well as by the pressures built up to reduce the number of children. According to non-governmental organizations, over 2 million female feticides are reported every year. It is just the tip of the iceberg (Dr. V.C.Patel, IMA,Reuters New Delhi, November 12, 1999).

1991 census counted 927 females to every 1000 males in the Indian population. It showed conclusively a declining sex-ratio trend starting from the beginning of the century. Today in a population of one billion, males out number females by an estimated 48 million or there is a case of between 32 – 48 million missing females. There is a danger that as coercive measures to impose a two-child norm continue such as reduced maternity benefits, debarring from elective offices etc, the female feticide will worsen

Many Indian communities are known to practice female infanticide. In recent decades misuse of prenatal diagnostic techniques to determine sex of foetus even in the first trimester has become common. This followed by sex selective abortion.

Given the patriarchal value systems of the Indian society, there is a deep-rooted 'son preference' in the society. The female has a lower status and is discriminated against in most sections of the society.

Under pressure from 'rights activists' groups, the central government brought out the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act 1994. The Act, which required individual ratification by state assemblies, bans the use of pre-natal diagnostic technologies for sex determination and provides for a three-year imprisonment and a fine of Rs. 10000 for offenders. However it has been difficult to implement. An estimate puts the number of ultra sound clinics in India at 20,000 and the number of registered ones at a mere one percent (Sabu George, quoted in 'Demographic Danger Signals', Frontline Feb 4, 2000.)

There are loop-holes in the Act such as it does not provide for action on the basis of complaint by a third party i.e. other than the doctor who undertakes the procedure and the pregnant woman. The Indian Medical Association (IMA) has acknowledged that doctors are responsible in some measure for continuing practice of female feticide.

During the 'Decade of the Girl Child' (1990 – 2000) central and state governments introduced various schemes aimed at enhancing the status of the girl child. These

include the 'Cradle Baby Scheme' of Tamil Nadu, "Apni Beti, Apna Dhan' scheme of Haryana, under which small benefit is made available to the mother and to the girl on reaching 18 years, 'Girl Child Protection Scheme' for income poor families, involving monitory benefits to the family. However they have had little impact.

Since 1998 a campaign against this practice has been initiated by civil society groups "Campaign Against Sex Selective Abortion" (CASSA). CASSA is pressuring appropriate authority to implement PNDA focusing on the aspect medical ethics by medical profession.

OTHER PROBLEMS AFFECTING CHILD WELFARE

Deterioration childcare systems

Child care that is best accomplished in the home environment is increasingly affected as women spend more time away from home. On an average most women spend 7 hours working outside the house and 4 hours working inside the house making a workload of 11 – 12 hours daily. Most of them start working one month after the child is born. This leaves them little time to attend the young children who require much attention. The statutory maternity leave and such benefits are available only to the 7% of women in the organized sector. Even in their cases, the leave does not cover the 4 – 6 months of recommended breast feeding period. The remaining percentage of women in the unorganized sector are able to spend only little time in child care and hence child care is left to older siblings especially girl children and in conditions with no adult supervision - which could be both unhealthy and dangerous. This also affects the development in terms of schooling of children who become caretakers.

Study shows that only 30% of women exclusively breast feed in the period 0 – 3 months, when breast milk is the most protective and nutritious food; weaning food is introduced late 9 – 12 months by 60% of women ('Women in the informal sector', Indu Pathak and Pushpa Patnaik, NIUA 91).

Deterioration of women's livelihood security

As a direct outcome of the process of liberalisation, privatization and globalization the livelihood security and food security of the society especially the women and children are adversely affected. There is an increasing trend of casualisation of women's jobs accomplished by inappropriate and inferior working conditions including lack of maternity benefits and childcare (Jayanti Bhosh, Macro Economic rends and female employment in gender and employment Pg 348) There is a significant decline of female wage earners in the rural labour market from 42% in 74 – 75 to 30% in 93 – 94 ('Womens Workers in Agriculture', Jeemol Unni, in Gender and Employment in India, 1999, Delhi)

The increasing urbanisation and urban poverty trends, is resulting in a large segment of urban poor women in below poverty line wages and having to work over time.

Women are increasingly employed in conditions of cheap labour as domestic workers, construction labourers etc. There is a lack of appropriate legislation and social benefits for the unorganized sector – and this sector is increasing. As brought out in a later chapter this phenomenon drastically affects women's ability to care for the young children. The time available for care taking is cut into as well as the additional but critical resources that women bring into the family budget is reduced.

The state's response in this larger scenario has been totally inadequate. The state in fact has been cutting down poverty alleviation and employment schemes.

Food Security

The food security of women and children in low-income groups is badly affected. The daily deficiency of food of pregnant women in low-income groups is 500 calories, requiring additionally one fifth more quantity of food. This is reflected in the high incidence of low birth weight babies – 52% among severely undernourished women and 42% among moderately undernourished and 37% among mildly undernourished. ('Empowering Women', Rajammai P Das, in Proceedings of the Nutrition Society of India, 1995.)

The food security of the poor is affected in several ways. Agricultural production at the national level has shown a downward trend, the average growth registered being 3.4 in 80 – 81 and 1.4 in 90 – 91. The pulses and coarse cereals which are the food of the poor have come down by - 1.3 and – 0.7 respectively (J P Singh and Alok Darsh, Agriculture in Altemate Economic Survey 91 – 98) as the cash crop cultivation increases. At the same time another trend is the reduction of subsidy to the farm sector resulting in 75% increase in prices for the public distribution system (PDS). The coverage of PDS has come down from 15.3 % in 51 to 9.1 % in 1995.

Cultural factors especially relating to rearing foods and weaning practices also contribute to malnutrition. The market has a major influence in misinforming the poor mother leading to her introducing costlier but inadequate breast milk substitute or weaning food substitutes. Within the patriarchal system of the society, the girl children get most neglected i.e. get least amount of food and caring. Starting from infancy... this gender-biased discrimination continues during adolescence where they become further prone to anaemia due to menstruation and inadequate awareness of nutrition requirements. Early marriages and early motherhood continues the chronic malnutrition and poor health.

Recently much research has been done on the role of micronutrients' deficiencies in the health of children. This has led to high pressure marketing of micronutrients by large drug companies confusing and misinforming the poor, into buying costly tonics. The fact remains that if children ate sufficient food there would be no question of deficiencies.

SUMMARY NOTE

The foregoing discussion brought to light the following key issues in the area of child survival and development. Slowing of momentum of child survival reflected in slowing of decline in IMR, sexual discrimination in childcare leading to increased mortality rate of girl children, poor coverage of immunisation resulting in infant and maternal mortality, epidemic of HIV/AIDS, serious nutritional deficiency status, breakdown of child care systems, poor sanitation and housing, inadequate access to protected water and existence of a considerable number of children under various stresses.

The policies of programmes of CRY should address to these key issues. While decision on policies and programmes are being finalised, an understanding of the national level official policies, official programmes and responses of various civil society groups to the above problem situation is important on two grounds. The first, the magnitude of the problem is so huge that the efforts of the CRY alone are not sufficient to deal with the situation. The second, in the globalised environment, new paradigm of partnership of different stakeholders is emerging as a new strategy. Therefore, the policies and programmes of CRY must be able to provide space for these considerations. Hence, a review of policies and programmes of governments in the area of child survival and development, responses of NGOs, political parties, civil society bodies and other stakeholders of child development are made. The recommendations we make to CRY take into account these responses too.

NATIONAL POLICY ENVIRONMENT AFFECTING CHILD HEALTH

India's commitment to universal health care started from the time of independence. The Bhore committee report, which was independent India's charter on health begins with the opening statement 'No Citizen should be denied an adequate quality of health care, merely because of his or her inability to pay for it.

The Alma Ata Declaration

India as a signatory to Alma Ata Declaration committed herself to health for all by 2000.Alma Ata declaration recognised that health is a fundamental human right and that the attainment of the highest possible level of health requires the action of many other social and economic sectors in addition to the health sector.

The agenda stated among other things a complex set of strategies to improve people's livelihood and their quality of life and affirmed the state's responsibility in people's health. The priorities of 'Health for All by 2000' was captured in the National health Policy that was passed in 1983

The National Health Policy - 1983

Some of the significant features of this policy were:

- Large-scale transfer of knowledge and skills, to village based volunteers
- Sanitary cum epidemiological stations, dispersed through out the country.
- Emphasis on Primary Health Care (PHC)
- Community Participation

- Services to be available Free of cost
- Secondary and tertiary care provision in support
- Promote Privatization in health sector
- Medical education
- It, under emphasized Indian Systems of Medicine.

The policy had by and large been well thought through. It recognized that the majority of Indians the need was for a well-dispersed and accessible primary health care. The secondary and tertiary care structures were to function in support of primary health care. Given the preponderance of poverty related diseases and that they can be prevented by appropriate measures, the thrust of health policy 83 is logical and scientific. Though chromic diseases and disease of affluence were also becoming widely prevalent, the emphasis was on dealing with these also at the primary health care level.

In retrospect 'Health for All' was not given a chance to succeed, as it was made a vertical programme and a selective one at that without people's participation. But more importantly the World Bank that became increasingly influential in determining India's health policies had other agendas.

The World Bank's Influence on Health Policy

Increasing influence of World Bank on Country's health policy became evident from the early 90's, as the Bank's investments in health sector grew. The bank has funded through loans several health sector projects both at the central and state levels into which are built in bank" policy directions.

The Bank, document 'Investing in Health' 1993, calls for focussing on a small set of public interventions that would be judged by the technocrats to be cost effective in improving health indices for the minimum expense. In other areas private sector is to be encouraged in the provision of services. The World Banks idea of health care as a 'safety net' further interprets state supported intervention limited to a very select role. These are Family Planning, Women and ChildCare, Nutrition, TB and Sexually Transmitted Diseases. Within these areas the focus was further narrowed during implementation. In other areas of health sector bank policy holds that private sector will respond to the needs. This has translated into tertiary and secondary care facilities increasingly being privatized even primary health care is being contracted out (where suitable parties are found). Another policy component is for the public sector to levy 'user charges' for their services that the consumer is likely to value, namely curative care. Recently responding to lobbying by affected groups, user-charges in health sector is being removed by the bank.

Concomitantly other international trade related policies are also having their influence on Health Sector Policies. The WTO provisions of TRIPS (Trade Related Intellectual Property Rights) are going to have a negative impact on the self reliant pharmaceutical sector, which had contributed to lower drug prices in India. The

progressive patent law passed by parliament 1970 will get changed under TRIPS resulting in domination by Multinational Drug Companies.

In the present policy scenario the outcome of bank influence is that the state withdraws from its institutional responsibility of ensuring health, and move into 'regulatory roles' in health. The assumption that 'for- profit private sector' will meet the needs of the people in areas vacated by the state is ill founded. The poor are not able to pay even a minimum amount of the exorbitant charge of private sector, and hence will not be able to access their services. The worst affected in such a situation are the women and the children of the marginalized communities. The prioritization of state services purely on the basis of cost-effectiveness, results in local needs of people in health not being meet. This is already a problem of centralized health planning which becomes further accentuated.

National Health Policy 2002

Significant features are:

- Increased expenditure in health to 6% of GDP and 33% of it from public health investments. Present central government outlay to state health financing to increase from 15% to 25% over the next eight years.
- Increased emphasis to primary health care with a funding ratio 55% - 35 – 10 (Primary- secondary – Tertiary). Funds to be utilized for upgradation of facilities and increasing the number of facilities (to meet existing gaps). Essential drugs to the primary health care infra structure to be supplied directly from central funds. Charging of 'user fees' in secondary and tertiary establishment based on user's capacity to pay.
- Increasing the manpower in public health and the reach of health manpower in under served areas – capacitating licentiates in Allopathy, Practitioners of Indian systems and paramedical workers of Allopathy, to practice clinical work in specified under- served areas.
- Increasing the number of specialists in family medicine and public health.
- Medical grants commission to oversee even geographic spread of government medical colleges.
- Emphasis on control of prioritized communicable diseases – TB, Malaria, Blindness Control and HIV/AIDS.
- Specified roles and specific budgeting for involvement of NGOs in disease control.
- Decentralization of implementation through autonomous state level and district level committee in which health department will have monitoring role primarily.
- Emphasis on a national disease surveillance network on priority diseases through local, district and state level mechanism, strengthened with information technology

Health activists, who have welcomed some of the provisions of this new policy, are critical of the general thrust and orientation of the document, which they feel, has

been too much influenced by the World Bank policies and of the Industrial lobby (feedback from the constituents of People's Health Movement).

- The Policy document does not come out as advancement on the past experiences of health sector. It demonstrates a patchwork character and has significant omissions.
- Policy document in its analysis does not analyse the failure of the Health For ALL (HFA) commitment and build upon it. Hence a mere renewed commitment in a policy document to primary health care is unlikely to translate into results.
- Some of the basic factors that resulted in the failure are outlined below. They include lack of decentralization and investing control in the local bodies, lack of strengthening local level planning based on local needs, problems in convergence of health related public interventions. Policy is significantly silent on these aspects. Similarly the excessive influence of drug companies and techno- beurocrats on policy process- another factor for failure is not scrutinized.
- The charging of user fees in the public facilities at the secondary and tertiary level care without foolproof systems for identifying the poorest, experience has shown excludes the poorest.
- Policy support for the continuing withdrawal of the state from health provision responsibilities by 'leaving implementation to autonomous committees' has ominous implication for the weaker sections as the autonomous committee need not be accountable bodies in the same sense as the state is.
- Two important areas standing out by its absence are mention on issues of child health and issues of nutrition.
- There is evidence of ill conceived commercialization in health sector, with the policy encouraging through fiscal incentives earning 'foreign exchange' from service seekers from overseas.

National Population Policy 2000

The immediate objectives of the NPP 2000 is to address the unmet needs of contraception, health care infrastructure and health personnel and to provide integrated service delivery for basic reproductive and child health care. The medium term objective is to bring the Total Fertility Rate (TFR) to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long term objective is to achieve stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.

In pursuance of these objectives, several national socio- demographic goals to be achieved in each case by 2010 are formulated. In order to achieve these goals twelve (12) strategic themes have been identified, which include:

- Decentralized planning and program implementation.
- Convergence of service delivery at the village level.
- Empowering women for improved health and nutrition
- Child health and survival
- Meet the unmet needs for family welfare services

- Attention to Under served population

The National Population Policy and the new Reproductive and Child Health (RCH) programme reflect certain shortsighted visions. Though the policy has moved away from a target driven approach and recognizes importance of addressing all the issues concerning reproductive health, there are several problems in the policy directions. The entire approach is still contraceptive centred, and fails to recognize the relationship of population to poverty and under development. It equates reproductive health to maternal care and fertility control, wh[illegible] inadequately addressing determinants like sexuality, cultural values, infertility services and reproductive tract infections. They seek to introduce hazardous injectible contraceptives. Assumes that privatization of certain services will provide a better outreach and make it more consumer friendly. Though targets are removed a number of disincentives are introduced for two-child norm, which will discriminate against the poor.

The Convention on the Right of the Child (and evolving policy environment for the child)

The Government of India (GOI) had identified the need for a special policy for the betterment of the children as early as in 1974. The National Policy for children was initiated by the GOI in the year 1974. This policy had spelt out the various areas including health of the child, which needs to be worked upon.

It was in 1992, that the GOI ratified the Convention on the Rights of the Child (CRC). In the same year the GOI formulated the National Plan of Action for children in the context of cooperation. The health highlights of this Plan as put in the clause 2.7 had four main priorities, the reduction of the Infant Mortality Rate, the Underfive Mortality Rate and the Maternal Mortality Rate as well as bringing down the number of Low Birth Weight children.

The Convention on the Right of the Child (1992) and the National Plan of Action for Children, are progressive documents. However given the proven gap between policy and implementation in the country, concerted advocacy will be required to make gains.

NATIONAL PROGRAMME SITUATION

The Public Health Services

Access to and utilisation of quality health services is one of the most important determinants of child health. During the last 45 years a number of government health institutions have been established in the rural areas.

Although the country's primary health care system has expanded considerably, access to such services is still limited on account of many social and geographical barriers.

The organi. .tion and functions of country's public health services are detailed below (The Independent Commission on Health in India, Health For the Millions, Nov – Dec 1997):

Sub-centre level: As per current norms, one sub-centre (SC) has to be provided for a general population of 5,000 persons, and for a population of 3,000 persons in tribal and difficult areas. The standard staff in SC is one male and one female health worker, and one female attendant.

Primary Health Centre : As per current norms, one primary health centre (PHC) has to be provided for every 30,000 population, in general, and 20,000 population in tribal and difficult areas. Six SCs fall within this population base. Apart from rendering services, the other important functions of the PHC are supportive and supervisory in nature. It has to cater to all the SCs and villages within its jurisdiction. The PHCs were established to serve as a focal point, through which integrated curative, preventive and promotive health care could be delivered to the entire population of a defined geographical area.

A Community Health Centre (CHC): one for about a population of 1,00,000 persons. It was expected to provide public health expertise, epidemiological services, training, monitoring and evaluation, continuing education and to be the first level referral for specialist medical treatment – including diagnosis, special investigations, consultation, special treatment and surgery.

The CHC was to be headed by a Public Health Officer. Other specialists were to be a general physician, general surgeon, obstetrician and gynecologist and pediatrician. Many taluk or tehsil hospitals and even PHCs have just been redesignated.

Presently in most states, the Chief Medical Officer (CMO) is at the top leadership position, however, most of them only look after the hospitals and are interested in clinical work. Public health is responsibility of a Dy. CMO, most of who are not formally trained, either in public health or in management. Various national health programmes like malaria eradication, tuberculosis control, leprosy eradication and family welfare programmes, are managed by respective programme officers, without any co-ordination or communication.

HEALTH INFRASTRUCTURE AND MANPOWER – COVERAGE AND GAPS				
	Population Covered	**No. existing & in position**	**No. needed of 100% coverage (for 2002 population)**	**% vacant or uncovered**
Sub Center	5000	136818	23190	14.91%
PHC	30000	22991	4212	16.25%
CHC	100000	2712	3776	58.28%

ANM	5000	133567	27501	5.12%
MPWM	5000	72869	64860	16.39%
LHV	30000	19364	4224	13.76%
Doctor	30000	24648	1531	-15.11%
Source : Bulletin of Rural Health Statistics in India : June 1998, Rural Health Division. DGHS, MOHFW, GOI.				

Applying current norms it is estimated that the shortfall in the number of SCs/PHCs/CHCs is of the order of 16 percent. However this shortage is as high as 58% when disaggregated to CHCs only. This shortfall is not a national average as several states have adequate or excess requirements.

Public Health Investments and the quality of services

Public Health Investment as a percentage of GDP declined from 1.3 per cent in 1990 to 0.9 per cent in 1999. Central budgetary allocation for health has remained at 1.3 percent of the budget, whereas the state allocation have declined from 7% to 5.5%. The current annual per capita expenditure is only Rs. 160.

Given this low priority for health the reach and quality of public health services have been poor. It is estimated that less than 20 percent of the population seeks OPD services and less than 45 percent awails of the facilities for in-door treatment in public hospitals.

The access and quality of services in the public health system continue to remain poor. Public Health Critiques point out that due to the following policy and programmatic gaps the system is allowed to fail.

- There is inadequate funding for the infrastructure, inadequate staffing and very little essential supplies. As mentioned earlier the state funding has been declining in real terms.
- The costs of drugs have been rising as a result of the deregulation of drugs brought about by the new drug policy.
- The centralized system has a fragmented approach to planning. The criteria for program planning is determined by cost effectiveness and hence several needed services of the community are dropped out.
- The priority and emphasis in monitoring remains on a few programs, namely family planning, immunization and TB. Hence most of the national preventive programs remain on paper as the capacity for implementing is not built up and their progress not monitored.
- A referral system is not built up inspite of policy priority for 'community health center' for one lakh population. Con- committantly and indirectly private sector provisioning of secondary care is encouraged which cannot be accessed by the poor.

Strongly Emerging Private sector

Several recent studies have pointed out that 70 – 90% of all curative health care in India is delivered by the private sector. People who go to the private health practitioners, however, often do so because they have no other option. It is perhaps true that the private practitioners offer services that are more easily available at regular hours, more personalized treatment, a better supply of medicines, and offer continuity. But this does not mean that the quality of care is assured. The price paid for health through the private sector can be very high, often putting a poor family into debt and threatening an already precarious income flow. The private health care has shown to be on many occasions, irrational and unscientific too.

The poorest 10% of the population still depend on the government health facilities, however inadequate they may be. (study of sevapuri, Independent commission on health in India, P 304). The real issue is that the government primary health care centre and the sub-centre offer little by way of good quality or regular care to the community. Unless the sub-centres begin to function well, there is little that can be done to prevent the poor from being exploited by private practitioners.

Child care

Integrated Child Development Services (ICDS)

The ICDS programme was initiated in 1975 with the following objectives:

- To improve the health and nutrition status of children 0 – 6 years by providing supplementary food and by coordinating with the state health departments to ensure delivery of required health inputs;
- To provide conditions necessary for pre-school children's psychological and social development through early stimulation and education;
- To provide pregnant and lactating women with food supplements;
- To enhance the mother's ability to provide proper child care through health and nutrition education;
- To achieve effective coordination of policy and implementation among the various departments to promote child development.

In practice most beneficiaries of supplementary feeding are not selected through nutritional screening. Over the last two decades the ICDS coverage has progressively increased. As of 1996, there are 4,200 ICDS blocks with 5,92,571 anganwadis in the country; the number of beneficiaries rose from 5.7 million children and 1.2 million mothers in 1985 to 18.5 million children and 3.7 million mothers in 1996.

Nutrition Foundation of India (NFI) and National Institute of Public Cooperation and Child Development (NIPCCD) had conducted evaluation of ICDS. The following reasons for lack of improvement in nutritional status in ICDS areas were identified:

- Inadequate coverage of children below three years of age who are at greatest risk of malnutrition;

- Irregularity of food deliveries to anganwadis and hence irregular feeding and inadequate rations;
- Poor nutrition education for mothers and communities) to improve feeding practices at home;
- Inadequate training of workers in nutrition, growth monitoring and communication;
- Poor supervision
- Poor co-ordination and linkage with health workers.
- Lack of community ownership and participation.

Crèche Services:

In 1975, the Department of Women and Child Development started the scheme of Crèche / Day Care Centres for children of working and ailing mothers. The scheme was to provide daycare services for children (upto 5 years of age) of mainly casual, migrant, agricultural and construction labourers, whose total monthly income does not exceed Rs. 1,800 per month. The children of these women who are sick or incapacitated due to sickness or suffering from communicable diseases are also covered under the scheme. The services include supplementary nutrition, health check-up, immunisation etc. The Central Social Welfare Board and two other national level voluntary organisations implement the programme. During the year 1995 – 96, 12,470 crèche units provided services to about 30,00,000 children.

Government estimates that 12 lakh crèches are required to cover all needy children. But only 14,000 crèches are run by the government. A study of crèche services in India done by NIPPCD highlights a number of issues.

- only 70% of children enrolled were under one year age
- the average space provided per child was 3 – 6 square feet
- almost all centres had a dearth of play material,
- 73% of the centres did not have toilet facilities for the children
- the childcare worker was grossly underpaid.

With most women being working mothers, universal day care facilities and social security for caring for children is a minimum social obligation.

In pursuance of the commitment at the Cairo Population and Development Conference, the Family Welfare Program has been changed to RCH. The RCH program articulation includes 'Target free approach in Family Planning', integrating at the community level components of the programs- Family Welfare, Child Survival and Safe Motherhood, and Prevention and Management of Reproductive Tract and Sexually Transmitted Diseases. The activities are to be client centered, demand driven and provide services with quality assurance. Male participation is to be promoted. The spectrum of services have been enlarged and to be available from adolescent age through reproductive period.

In its aims and objectives RCH has several problems. These include concentrating on individual rather than community health, a contraceptive focused approach rather than a holistic approach, assume that privatisation of services will make it consumer friendly, and that problems are related to efficiency rather than need for greater public investments and does not promote appropriate values in respect to sexuality.

Programme Of Cooperation: UNICEF – GOI: 1999 – 2002:

The GOI in close collaboration with the UNICEF has formulated a Programme for Children and Women in India between 1 January 1999 and 31 December 2002. This programme is to be seen in the context of the CRC, the World Summit for Children, the World Declaration on the survival, Protection and Development of Children in the 1990s and the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW).

The areas of intervention were identified as the improvement of Child's environs (Sanitation, Hygiene & Water Supply); Reproductive and Child Health; Primary Education; Childhood Development & Nutrition; & Child Protection: Advocacy & Information for CRC.

Four important area of strategy was identified as the Country wide ones: -

1. Strengthening Partnerships, Cooperation & Alliances.
2. Promoting Decentralized Community Management or local governance.
3. Enhancing Women's capabilities.
4. Ensuring convergence of basic social services. Convergent Community Action for Capacity Building.

- To contribute to the fulfillment of the rights of the least-served children in deprived rural communities by ensuring adoption of appropriate community processes.
- To strengthen the capacity of government to respond to community plans and achieve convergence of services for the child.
- To promote sustained action through better awareness and capacity of all 500,000 women representatives of panchayaths.
- To develop and implement monitoring systems, which can be employed by the community to track the situation of children and women and generate, appropriate action in at least one-third of all villages.

To measure progress of this Programme, three complex goals were chosen as they depict the overall programme effectiveness. These three are:

1. Reduction in the incidence of Low Birth Weight (LBW) children.
2. Reduction in the Maternal Mortality Rate (MMR).
3. Elimination of Child Labour.

Health Goals

The following health goals were chosen in the Programme of cooperation:

- Reduction of the IMR to < 50/1000Live Births.

- Reduction of MMR from 437 to 300/ 100,000LBs.
- Other supportive goals to further the above two.

Nutrition

- Reduction of the 1990 levels in Severe and Moderate malnutrition among Underfive children by atleast 50% by 2002.

Water and Sanitation

- Universal access of Safe Drinking Water by 2002.
- Improvement in access to sanitation from the present level of 30% to at least 50% by the year 2002.

Critical Areas for NGO Intervention

- The programme strategy has envisaged an Intersectoral Facilitatory Team of functionaries (IFT). There is to be a nominee or representative of local voluntary organisations in the IFT.
- Through the CCA strategy also, voluntary agencies are to be involved at different levels.
- At the levels of blocks, districts, States and the center, the CCA support and steering groups will be formed with a range of functionaries. In all these support or steering groups, NGO representatives are present.
- The Programme for Cooperation has recognized the role of voluntary organizations in helping to raise the status of women and in participatory development through a wide spectrum of successful projects for social change.

The CCA strategy seeks the active involvement of the voluntary sector at different levels in partnerships with the GOI & UNICEF.

CIVIL SOCIETY RESPONSES

NGO Sector Child Concerns

Campaign Against Child Labour (CACL)

The Campaign for Child Labour (CACL) is a network of 5400 organisations and individuals sensitised towards the issue of child rights and child labour. Organisations that are active in child rights and human rights, research bodies, women's groups, trade unions, academic institutions, media agencies, corporate houses, student volunteers and eminent citizens constitute the campaign. The CACL has today been spread over in 12 states, viz. Maharashtra, Andhra Pradesh, Tamil Nadu, Karnataka, Gujarat, Bihar, Orissa, Goa, Uttar Pradesh, Rajasthan, West Bengal and Madhya Pradesh. It has State Secretariats in Andhra Pradesh Gujarat, Bihar, Karnataka, Kerala, Orissa, Maharashtra and Tamil Nadu. The *state co-ordination groups* initiate processes of CACL, seeking to strengthen state/district/taluk and grassroots networking. The *Executive Committee* of the CACL is comprised of the state convenors and nominated experts. The Central Secretariat administers co-ordination

and networking at the national level. Besides it has a National Coordination Committee and an Advisory Committee to provide directions and guidance in its operations.

The CACL defines child labor as "a phenomenon which includes children below 14 years, prematurely leading adult lives, working with or without wages, under conditions damaging to their physical, mental, social, emotional and spiritual development, denying them their basic rights to education, health and development". (Campaign Against Child Labour)

The Campaign is against all manifestations of child labor, in any occupation or processes in all sectors of work including the formal, informal, organized, unorganized, with or without wages, within or outside the family. Therefore, it holds that all forms of employment of children are hazardous ones.

The objectives of the Campaign are the following

- Create awareness on the eradication of child labour;
- Make education up to the age of 14 years a Fundamental Right and ensure free, compulsory and quality education till the age of 14 years.
- Highlight violations provisions of child labour laws and provide justice through fact finding and litigation;
- Lobby for the review of policies and legislation on child rights, child labour and education;
- Put forth successful strategies and alternatives for rehabilitation of working children;
- Facilitate field research to feed into the programme strategy of the CACL
- Popularise the UN Convention and the various Conventions of the ILO pertaining to child labour.

The major campaigns undertaken by the CACL in the recent past are given below.

- Litigation (both PIL an Judicial) on various acts governing child labour
- National Convention of child labourers.
- First alternate country report on child labour submitted to the UNCRC
- Postcard Campaign to make Education a Fundamental Right.
- Critical analysis of the rehabilitation scheme and mainstreaming in NCLP
- Petition of cases of child rights violation to the NHRC and obtain justice
- The first state level Commission on Child Labour instituted in Bihar
- 83rd Amendment Bill.

National Alliance For Right To Education (NAFRE)

The NAFRE came into existence in 1998 with the common goal of realizing education as a Fundamental Right of every child. Aga Khan Foundation, Bodh, CRY, MV Foundation, National Foundation of India, National Law School University of India, PRATHAM, Save Alliance, UNICEF and Vikramshila joined hands for this

common cause, and are united on a broad understanding that it must be realized with a sense of urgency. The NAFRE today is a national coalition of 2,400 education-centric grass root voluntary organizations and thousands of individuals from all sections of society working together to make education a reality for every Indian child. The Alliance has now its presence in 14 States in India. The 14 states are: Andhra Pradesh, Delhi, Gujarat, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharastra, Orissa, Rajasthan, Tamilnadu, Uttaranchal, Uttar Pradesh and West Bengal.

The NAFRE works with the following objectives. Act as a platform to strengthen micro level initiatives towards universalising education. Act as a critical link that transfers the learnings from the grassroots to the macro level to facilitate assessment / strengthening / reforming of various policies on education. Work with all levels of the Legislature, Bureaucracy, Media, and Corporates in pursuit of bringing NAFRE's holistic dimension to education. Monitor and promote the status of education while simultaneously catalysing replicable models.

NAFRE is concerned about the 63 million children who are still out of school. It feels that there has been a lack of political commitment in making Universal Elementary Education (UEE) a reality and that the entire approach to UEE should be from a humane perspective.

Currently, the NAFRE is working towards incorporating certain positive changes in the 83rd Constitutional Amendment Bill, a bill that aims to make education a fundamental right for every child in India. Quality education to all and decentralisation of education are the two other important concerns for the NAFRE.

Therefore, the NAFRE works for, along with Universalisation of Education, the systemic changes in education system that is relevant to each and every individual and community in every corner of the country. It implies the need for developing a system of education for the masses based on equity, excellence and relevance within the framework of affordability and the question of balancing the indigenous knowledge base of a marginalised community in a globalised economy.

The NAFRE has adopted four strategic measures to achieve its objectives. These strategic measures are:

Coalescing the national groundswell demand for UEE

Displaying the national ground swell demand

Developing national opinion towards UEE and

Showcasing workable models on ground that energize the government system

The Disability India Network

There are many *Non Government Organizations working in the sphere of providing facilities and services for persons with disabilities*, yet there is no comprehensive data available for the ready reference of professionals and parents seeking access to this information. The Disability India Network provides countrywide support and services to disabled children, their parents and organisations. It creates a Register of Services that could be made available to all - Nationally and Internationally - via the Internet. Thus, organizations would have the benefit of being accessible to those who require their services within the country, and additionally, have the advantage of being visible to the world outside. Organisations already on the web, with their web sites, will have the supplementary convenience of a link, enhancing their site visibility.

More than 400 organisations have so far become part of the growing database and each one of them has been given a free page to list their contact details and specialties. Pediatricians and other child specialists will be standing by to assist parents with their queries, Access Centres are proposed to be opened in various parts of the country to help parents access the site and retrieve relevant information without having to go from pillar to post.

Campaign Against Female Foeticide

Female feticide is one extreme manifestation of violence against women. Female fetuses are selectively aborted after pre natal sex determination, thus avoiding the birth of girls. In India where female infanticide has existed for centuries, now female feticide has joined the fray and is increasing each day. The campaign against female feticide is minimum two-decade-old. An earlier and successful case is the Forum Against Sex Determination and Sex Pre-selection (FASDP) in Maharashtra. The result of its campaign has been the Maharashtra Regulation of Use of Prenatal Diagnostic Techniques Act, 1988.

The enactment of legislation by the government of India in 1994 is the result of a national level campaign. The enactment of this legislation became instrumental for the National Human Rights Commission (NHRC) to intervene in the situation and to direct the Medical Council of India to take action against medical practitioners found abusing prenatal diagnostic techniques.

The Indian Medical Association (IMA), The UNICEF, the National Commission for Women, the People's Union for Civil Liberty (PUCL) the People's Health Assembly (PHA) and the Department of Women and Child Development jointly and separately started the campaign against female feticide. The given below are the positions taken by these organisation in this

The Indian Medical Association (IMA) decided in 1999 to join government and non-governmental organizations in their fight against female feticide and sex-determination tests. "The IMA has declared that no medical professionals would involve themselves in this heinous crime directly or indirectly," said IMA honorary

general secretary Dr Perm Aggarwal. He added the association had informed its members that doctors testing fetuses for gender faced possible expulsion from the medical profession. In 1994, Indian law ruled that informing parents of the sex of their unborn child was illegal, but Aggarwal says the practice is nonetheless widespread. In this context, the IMA decided to fight against this practice.

The PHA has suggested the following measures as campaign against female Feticide. The structures necessary for the implementation of the 1994 law have to be created at the district level. Volunteers have to be actively mobilized to monitor the registration and the functioning of the sex-determination clinics in different districts. Effective alliances with ethical Doctors have to be made from the local levels. Test cases have to be filed against the violators. And also important is that we have to preserve with the media to highlight obstacles in the implementation of the Act. The consciousness of our society has to be raised against this crime. Simultaneously we have to get involved in actions to ensure that the public at large becomes supportive of this campaign. Lobbying with political parties to put this issue on their agenda is imperative.

NGO Resource Groups Involving In Child Health Programmes

A brief description of the activities of a few major national NGOs has been presented below.

CARE-India

Cooperative for Assistance and Relief Everywhere (CARE)– India is the Indian chapter of CARE, an international relief and development organization. CARE began operations more than 50 years ago to help survivors of World War II. It was established by 22 charities to send CARE Packages of food, clothing, medicine and other relief supplies to people in Europe and Asia after the war. Now CARE exists to affirm the dignity and worth of individuals and families in some of the poorest communities of the world, in over 69 countries.

An "India where vulnerable people realise their aspirations for a better life in a better community" is the vision of CARE . Therefore, CARE works for the enhancement of the capabilities of vulnerable people, especially women and children, to enable them to control their lives better. CARE has identified its role as a "catalyst and innovator in relief and development, valued by all, striving for excellence".

CARE commenced its activities in India in1950 and currently it has its operations in eleven states in the country - Andhra Pradesh, Chhatisgarh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Maharastra, Orissa, Rajasthan, Uttar Pradesh and West Bengal. Over seven million individuals in nearly 100,000 villages in these states are covered by the operations of CARE now. It undertakes the task of sustainable development. It has multi-sector approach and addresses significant problems in the areas of nutrition and health, population, small economic activity development, girl's primary education, urban development, agriculture and natural resources and tribal empowerment. Besides, it provides emergency relief, often food, medical supplies

and so on. The immediate goal for CARE in such conditions is to save lives. The Central and State Governments, non-governmental organisations (NGOs) and community-based organisations (CBOs) are the project participants of CARE.

The main focus of the operations of CARE in India over the years has primarily been food. Until a decade and half ago, the primary thrust of the activities of CARE was provision of food to vulnerable groups, especially children in the age group of 6 to 11 years.

Christian Children's Fund (CCF)

The CCF is an UK based body working for the welfare of the children. The CCF was formed more than 60 years ago to help the children devastated by war. Later it extended its operations to other parts of the globe. Currently, the CCF is supporting more than 2.5 million children in over 30 countries.

The CCF believes that all children have the right to experience life with as much joy and hope as humanly possible.

The objective of the CCF is to further the good of the children who are in need, their families and communities. It proposes to create an environment of hope and respect for needy children of all cultures and beliefs in which they have opportunities to achieve their full potential, and provides practical tools for positive change to children, families and communities

The major thrust areas of operations for the CCF are safe water, nutritious food, medical care and an education for children.

Save the Children Fund (SCF)

Save the Children Fund (SCF) is an UK based body working to create a better world for children. It works in 70 countries helping children in the most impoverished communities of the world. The SCF is a part of the International Save the Children Alliance, which aims to be a truly international movement for children.

The SCF believes that all children have a right to a happy, healthy and secure start in life. Its vision mission statement reflects this belief. "In a world which continues to deny children their basic human rights, we champion the right of all children to a happy, healthy and secure childhood" (Save the Children's Vision, Mission, Values Statement, 1997)

The SCF is committed to narrowing the gap between real life situation of children and the ideal situation hoped for them. It supports practical projects that involve children and their families in improving their day-to-day lives. Emergency relief and preventive work to help children, their families and communities to be self-sufficient are also taken up alongside long-term development. Another important activity is the lobbying for changes that will benefit all children, including future generations.

The SCF has had a firm commitment to making children's rights a reality. All of Save the Children's work is now centred on its commitment to making a reality of children's rights.

Plan International India

Plan International is an international humanitarian, child-focused development organisation working with families and their communities to meet the needs of children around the world. Non-political, and with no religious affiliations, Plan International aims to build a better world for children, now and in the future.

Plan envisages a world where all children realise their full potential. It endeavours to crate societies that respect rights and dignity of people. It proposes to achieve the above by enabling deprived children, their families and their communities to meet their basic needs and to increase their ability to participate in and benefit from their societies; fostering relationships to increase understanding and unity among people of different cultures; and promoting the rights and interests of the children.

Plan works in five domains or critical and interrelated areas that produce long-lasting impact on a child's life. These domains are growing up healthy, learning, habitat, livelihood and building up relationships.

Plan works 45 developing countries throughout the world. The operations of Plan commenced in India in 1979. It operates in India through 14 NGO partners and 29 programme units in 13 states.

It influences opinions and issues at every level, from local community policy to the agendas of governments and international coalitions. And it affects the daily lives of countless ordinary people, from the children helped to the sponsors who give their support.

World Vision of India

World Vision is an international Christian relief and development organisation. It serves the poorest of the poor, without discriminating against caste, religion, region or gender. The focus of the operations of World Vision is on children because World Vision believes that they are the hope of the future. According to World Vision, the best way to ensure the total well being of children is to work through their families and communities. . World Vision seeks to help communities become more self-reliant. This means helping people to be able to take care of themselves and their families. Thus by helping families nurture their children, communities are helped to build their future. World Vision extends support in the form of child sponsorship and it reaches out to children through families and by involving communities. The assistance provided by regular sponsorship payments saves lives and improves the quality of life for many children

World Vision provides hostel facilities, food, education, and health care to children with special needs. The target group includes children affected by polio, children

whose hearing is impaired, mentally challenged children and tribal children. Besides, the issues of street children, child labour, children of commercial sex workers or those likely to be drawn into the profession, children with special needs, AIDS victims and children in especially difficult circumstances are addressed.

When disasters strike, World Vision responds immediately to provide relief and rehabilitation and remains in the area till the survivors are back on their feet.

World Vision strives to change a culture of poverty and despair to one of hope and opportunity, by building a nation that does not tolerate poverty.

World Vision began its work in India, at Calcutta in 1962. It was registered under the Tamil Nadu Societies Act in March 1976 as World Vision of India, with its National Office in Chennai (Tamil Nadu). The activities of World Vision India cover 1.5-lakh children through 28 projects in 24 states and almost 100 districts. It has 105 Area Development Programmes (ADPs) and 13 Community Development Projects. It works through the community to ensure a development process that will be sustained and continued even after World Vision withdraws from the area.

Private Sector And Child Health

The Indian Academy of Pediatrics

The Indian Academy of Pediatrics was formed 1963 by amalgamating the Association of Pediatricians in India and the Indian Pediatric Society. Today, the IAP has around 14,000 members with 140 branches that work for the furtherance of the objectives of the IAP and work independently as per IAP's constitution. The IAP has 13 subspecialty chapters and 4 working groups. Besides, various issue based sub-committees appointed by the Executive Board function from time to time.

The Indian Academy of Pediatrics is committed to the improvement of the health and well being of all children. The Academy dedicates its efforts and resources for this purpose. The members of the Academy are committed to achieve the optimum growth, development and health in the physical, emotional, mental, social and spiritual realms of all children irrespective of diversities of their backgrounds. The following are the major areas of activities of the IAP

Advocacy for children: Serve as advocates for the legitimate causes of children, their growth, development, health, emotional nurture, opportunities, rights, equity and justice. Serve as competent and responsible source of information relevant to the health and well being of children, to other organizations, the public and the governments.

Professional education and improvement: Provide and promote ethical and professional standards among the members and provide and promote education and training for the improvement of the knowledge, attitude and skills of members in pediatrics in its widest sense.

Research: Provide leadership, guidance and support for research in its broadest sense, relevant to the health and well being of children.

Support for pediatricians: Provide a forum for promoting the role and opportunities of pediatricians as the best equipped professionals for the care of sick children and to maintain the health and well being of all children. Remain as the spokesmedium of appropriate training of medical and related supportive professionals involved in the care of children in different settings.

Membership service: Provide services benefits and recognition to assist and support the members for meeting the needs and challenges inherent in pursuing our mission.

Education of parents and the public: Design and conduct programs and efforts for the education of parents, the public and policy makers on their role in the promotion of health and well being of children at home, in school and in other situations.

Political Agenda

This section examines the positions taken by the major national parties on health in general and child health in particular. The different positions of the national parties are examined separately

The Bharatheeya Janatha Party (BJP)

The position of the BJP on various issues are well articulated in its Election Manifest (1998) and the common agenda of the National Democratic Alliance (NDA) the ruling coalition led by the BJP

The agenda for governance put forth by the NDA commits itself to "efforts to ensure that potable drinking water is available to all villages"(Item 15, Agenda of Governance) and to pay due attention to the "age old and traditional methods of water utilisation, in both rural and urban areas"(Bid). A similar commitment has been made by the NDA in the case of education. This is very significant in the case of children. The agenda says," We are committed to a total eradication of illiteracy. We will implement the constitutional provision of making primary education free and compulsory up to 5th standard"(Item 16 of the Agenda). The most remarkable item in the agenda is the one dealing with children. " We will present a National Charter for Children. Our aim is to ensure that no child remains illiterate, hungry, or lacks medical care. We will take measures to eliminate child labour"(Bid item)

The Charter for Children developed by the BJP reflects these commitments. The Charter upholds the belief that every child is born and has the right to be happy and that all children have the right to food, shelter and clothes; they have the right to education. The Charter has been formulated in the context of the UNCRC. The manifesto makes it very clear that the BJP is committed to implement the UNCRC in both letter and spirit. Then the BJP pledges to protect Children's rights (I) to the highest attainable standard of health care; (ii) to be registered immediately after birth;

(iii) to protection from all forms of sexual exploitation and sexual abuse; (iv) right to play; (v) right to education; and (vi) right to shelter.

The manifesto then discusses the question of child labour. It commits itself to total abolition of child labour and proposes to amend the present Child Labour (Prohibition and Regulation) Act to remove the distinction between hazardous and non-hazardous processes. It identified the following as effective measures to abolish child labour. Regular and persistent inspections by labour departments at the Centre and in the States; special annual campaigns to detect child employment; identity cards which will be mandatory for all young workers; welfare benefits, especially social assistance to poor families, aimed at ensuring a minimum income and thus removing the need to rely on their children's labour; and free and compulsory primary education.

The Communist Party of India (Marxist) (CPIM)

The CPI (M) endeavours to achieve People's Democracy as a step towards the goal of a socialist society. The immediate target in this regard is to replace "the present bourgeois-landlord State by a State of people's democracy". (The programme of the CPIM adopted at the Seventh Party Congress of the Communist Party of India held at Calcutta, October 31 to November 7, 1964 and updated by the Special Conference of the Communist Party of India (Marxist) held at Thiruvananthapuram, October 20-23, 2000) The programme of the CPIM then moves on to spell out the tasks of a People's Democratic government, that is the government the CPI (M) proposes to install immediately, if voted to power as a strategic measure.

The CPI (M) document spells out 35 tasks or programmes as the document terms it, for a People's Democratic government under the leadership of the party. Only two among these pertain to children and health. They are: (i) "Public educational system shall be developed to provide comprehensive and scientific education at all levels. Free and compulsory education up to the secondary stage and the secular character of education shall be guaranteed. Higher education and vocational education will be modernised and updated. Development of science and technology will be promoted through a whole range of R&D institutions. A comprehensive sports policy to foster sports activities shall be adopted"(item 6.3.xvi of Peoples' Democracy and its Programme) and (ii) a wide network of health, medical and maternity services shall be established free of cost; nurseries and crèches for children; rest-homes and recreation centres for working people and old-age pension shall be guaranteed. The People's Democratic Government will promote a non-coercive population policy to create awareness for family planning among both men and women (item 6.3.xvii of Peoples' Democracy and its Programme).

The Communist Party of India (CPI)

The Communist Party of India (CPI) has made references to education and health in its draft programme. The draft party document speaks about education thus. "Urgent steps for **universal elementary education as also scientific and technological education**, secular in content and form without which it is foolish to think of a

modern, developed India competing with other developed countries"(Struggle for An alternative path, Draft political resolution for the 18th Congress of the CPI. Emphasis found in the original text). It assures " a comprehensive **health** and **education programme**; mobilizing tens of thousands of health workers and teachers for the job; measures to ensure potable drinking water facilities in every locality" in the area of health. (Struggle for An alternative path, Draft political resolution for the 18th Congress of the CPI. Emphasis found in the original text).

The Communist Party of India (Marxist Leninist)- CPI (ML)

The CPIML Liberation has made certain commitments in the areas of education and health. It pledges to strive for "effecting a modem democratic cultural transformation of the whole society, **ensuring universal education and basic health-care for the people,** abolition of a sorts of social, economic and sexual exploitation of women and ensuring their equal status and rights in all affairs of life, eradication of caste oppression, protection of the rights of dalits and adivasis and helping all weaker sections of the society to catch up in the race of social progress".

V PRELUDE TO RECOMMENDATIONS TO CRY

Perceptions from Micro Situation

The perception from ground situation supports the perspectives obtained nationally, though a regional variation is quite marked. The trends obtained from focus group discussion among the field staff and community group in the Kumaon sub region of the Eastern UP can be cited as example. The summary of the same is given below. The situation presented below is the worst one because the UP was the state with least infrastructure and facilities among the three states studied.

Health Care

Antenatal, Natal And Postnatal Care.

There is hardly any care provided through the PHC systems. The only care available is through traditional dais of whom 60% were untrained and through elder women within the family. But their knowledge on neonatal care is not adequate. As a result, there continues to be neonatal mortality from tetanus and other neonatal infections in the region.

Under Two Health Care

The only service available from the PHC systems at the village level was for polio mass campaign (pulse polio). People had to fend for themselves otherwise and significantly curative care was being provided by local vaids and indigenous practitioners.

Three To Six And Six To Fourteen Health Care.

On an average below 25% of the villages had ICDS centres. These centres were running at below par efficiency even in the area of nutrition supplementation, which is the only service provided in these centres. There was no school health programme existing for the elder children. The primary schools were rarely functional, there were no mid day meal programme or school health check-up organised from the health services. For the same reason there were no government programmes for the handicapped children or adolescent girls or for that matter for any of the children at risk.

Health Supportive Interventions

Malnutrition was stated as one of the four major health problems, others being Acute Respiratory Infections (ARI), Malaria and Diarrhoea of younger children of the area. However, as mentioned above, nutritional interventions are of limited consequence. The people perceived the changing food patterns (due to unavailability of traditional coarser grains) as deteriorating the health situation. The PDS, which is expected to provide minimum, required quantity of food grains to the poor is not properly functioning. In one situation where information on the functioning of PDS was available, it took protracted struggle with the active support of the NGO facilitator to

obtain ration cards for majority of BPL families. One can assume that a large number of BPL families are excluded from the PDS systems.

WATER .As also evident from national situation there is some improvement in the access of villages to borewell water. On an average 50% of the villages had round the year access to bore-well water. However, contamination of the water was an issue as there was no system for monitoring water quality.

SANITATION. Latrines and disposal mechanisms for liquid and solid wastes are practically non existent. Though there was a special scheme for public toilets for Ambedkar villages, it was not functional.

Situation in Other States.

The micro level situation was better in all respects in West Bengal. The care of the underfives and immunisation cover, as well as accessible curative care services (at least in terms of private health care) were better. More number of NGOs in general are functioning in the eastern region and so the general awareness level of the people are also higher. People's groups, in particular Self-Help Groups of women are slowly being empowered there. In Karnataka the public infrastructure was generally present, however services rendered to the community were inadequate.

Critical Issues of Child Health

In the previous chapter, dealing with the external environment we had a fairly detailed discussion on the situation of child health under various sub headings. We have also seen from a critical angle the state policies, legislations and programs and their relevance to child health. This picture is built up from secondary published data. However, when presented in compartmentalized fashion, secondary data does not easily help in constructing a larger picture. The larger picture emerges as one compares this data, against the impressions gained from the local level field study of CRY partners. The picture is further strengthened by the varied experiences of public health in the country brought into this analysis.

First Level Critical Issues

The larger picture has several levels or layers. At the surface or 'tip of the iceberg' are the commonly recorded and noticeable child health related indicators (symptoms). These relate to areas such as mortality, morbidity, and nutritional status. In recent decades newer risks have been identified - children at risk to various threatening social forces such as children in prostitution, children in forced labor, street children etc. These together constitute the first level critical issues.

The indicators of child health show that the situation is quite poor. Official statistics lull one to think that considerable and steady progress is being made. But a dispassionate analysis would prove that it is quite the opposite. The infant mortality rate in 1997 as per the official estimates was 71 per 1000 live births. Two thirds of these deaths happen during the first one-month and 70% of all deaths are due to

malnutrition and infection. The decline in these rates has slowed down in recent years. We don't have to look far to find the immediate reasons. The most important reason for this situation is malnutrition. In spite of 50 years of self-rule, more than 50% of the children do not get enough to eat. Similarly, more than half the women in childbearing age do not get enough to eat and essential nutrients are not available to them. Hence one third of these women bear babies who are underweight at birth and who have a greater risk to survival and development. Thereby the burden of deprivation is transmitted across the generation.

Another important immediate cause of mortality is infections. The important infections are lower respiratory tract infections, diarrheas and neonatal period septicemia. Infections and malnutrition form a vicious cycle as malnutrition leads to lowered immunity against diseases, and the repeated infections setting in results in further malnutrition. 70 percent of infant deaths in the country are due to these twin causes of malnutrition and infections.

The physical environment in the family also contributes to mortality and morbidity of children. This would mean access to safe water and sanitation, adoption of hygienic practices and availability of adequate housing. Again, one finds that 50 years of self-rule has not changed this situation much. Though official figures seem to suggest that as a result of the intense focus on provision of water in the earlier decade, more than 80% of habitations have access to safe water, the fact is that it is not so. Two under-emphasized aspects, namely that at least a quarter of the facilities (bore-wells) is not functional and up to 50% of the supposedly safe sources is not safe by virtue of being contaminated indicate differently. The facilities available regarding sanitation is so little (less than 25% rural coverage) that it does not give any protection. It is no wonder that a major cause of morbidity and mortality is diarrhea.

A possible bulwark against morbidity and mortality is a well functioning health system with curative, preventive, promotive and rehabilitative elements. Though a countrywide primary health care system accessible to all had been envisaged even before the country gained independence, and even though most of the infrastructure and part of the personnel envisaged have been in place, the service delivery has been sadly negligible. Immunization coverage is low in many districts, with 30% children not receiving any vaccination. Moreover, 20% of children with acute respiratory infections do not receive any treatment, and two thirds of children in the critical period of 6 – 9 months do no receive complementary feeding for want of health education. The infant mortality and neonatal mortality are positively influenced by the availability of quality health care provisions close to the community. Therefore, the persistently high levels of these indicators point to lack of such facilities. The same factor is a key reason for the high level of maternal mortality rate (437 – 570 per 100,000 live births).

Going beyond the statistics, we need to differentiate which social groups are most affected. The data confirms what we already know from common sense. The NFHS 98 shows that child of illiterate rural mothers, children of SC / ST women and children

of low standard of living families have higher mortality sometimes almost twice as high. IMR is 43 for high standard of living families and 89 for low standard of living families. A gender bias is also seen as expected, with mortality rates among girls being 20% higher than that among boys.

Maternal mortality rate is estimated at a high level of 437 – 570 per 100,000 live births. It is linked to inadequacy of health care services and poor health of the mothers, which in its turn is related to poor nutritional status of women reflected in the situation that over 50% of reproductive age group women are anemic and a large percentage are malnourished. It is the poor, the dalit and the tribal women who are malnourished and who have less access to health care (60 – 65% of tribal maternal deaths take place without any health care interventions).

Apart from malnutrition the level of chronic morbidity among child bearing age women is also high, 50 – 80% of women have reproductory tract infections and about 25% have sexually transmitted diseases and in high prevalent districts above 4% ante-natal mothers are HIV positive.

The modern medical system and its practitioners (allopathic practitioners) are reductionists in their approach. Hence health status measurement indicators are all focussing on physical health. However as our understanding of the dimensions of health expands and as the society confronts the disease producing factors, it is found that these indicators are insufficient. Social scientists are in search of identifying more sensitive indicators.

In assessing child health issues we are confronted with the need to understand sickness of society as a whole that manifests in the extreme cruelty on the most vulnerable sections of it. The phenomena of street children, children in forced labour, children in prostitution, female feticides and other forms of child abandonment, confront us with an extreme sickness of the society. These children are not only deprived of their basic amenities for growth and development, but their basic right to life is affected or they are forced to life long torture and misery. The state on its part in effect does not provide any protections or services to these children.

The estimated 20 million children in forced labor, are forced to work in physically dangerous situation in agriculture or hazardous industry. In addition they are deprived of just wages, just working and living conditions, basic right to education, health care and right to recreation. These children don't have the hope of catching up with their peers or of a semblance of ordinary life.

The children forced into prostitution estimated at 500,000 are bound in brothels in Indian cities. They are perpetually violently abused. Their physically immature reproductive system is easily prey to sexually transmitted diseases and HIV infection. The psychological scarring from the abuses stunts emotional growth for life.

The number of street children in the metropolitan cities is estimated to be 5 lakh. They face violence abuse and exploitation while they live and work on the streets and are without the protection of the families. These children are prone to substance abuse, STDs and HIV/AIDS. Thus the first level of issues in child health can rightly be described as indicators as they point not only at child health but also at a sick society. This understanding of the child health situation takes us to the issues critical to child health operating at the next level.

Second Level Critical Issues

Next we move to observe another level of phenomena at the local community level and find out the connections between the community level phenomenon and the first level symptoms observed. The phenomena at the community level include unsafe physical environment (water, hygiene, sanitation), break down of the caring systems at the family and community levels, food and income insecurity at the family and community levels and child exploitative forces operating at the community level.

There are a large number of families that are at risk. These are the families of the land less labour or marginal landholder belonging mostly to dalits, tribes and other depressed castes. Being casual labourers or single parent families, they are unable to earn enough to feed the family. The mothers are forced to work outside the house and then spend 11 –12 hours a day in their twin roles as wage earners and family carers. They have little time or energy to provide the caring needed for small children (let alone bigger children). As result of these factors, the family caring systems for the young child is in danger of breaking down.

Only one third of mothers breast-feed for more than one month and only 1/3 initiate appropriate top feeds during the weaning phase. The toddlers are left to the care of their elder girl siblings (as even elder adults have to go for work) as there are no provisions for crèches.

The family food security is compromised. The sources of food for the poor family used to be the following- what they grow for themselves, the cheaper locally available food items, subsidised food from the PDS and other poverty scheme and food available in the open market. With the changes in agricultural policies and practices and the control exercised by middlemen, small farmers are not cultivating food (instead they cultivate cash crops) and have to buy them in the market. Increasingly small farmers are also loosing their land. The PDS and poverty schemes are in shambles as discussed earlier. The result of these factors is that if they do not have cash reserves and the family is in danger of starvation.

The local middleman who provides loans (seeds, fertilizers, and pesticides) exercises much control, as he fixes the post harvest prices of the grains. Recently crop failure from adulteration of these items lead to mass suicides of farmers in AP.

Added to this is the fact that they can look to little support from the community, as they are from the bottom rung of the community. Their access to whatever social

support structures that exist is curtailed. They are easily duped or induced by the small money offered by the exploitative organized forces around them – child traffickers and child labor industries.

These factors that operate at higher level also contribute to child health. Therefore, these factors constitute the second level of issues critical to child health.

Third Level Critical Issues

We need to ask several questions on the issues operating at the first and the second levels. Why isn't the welfare state providing them the minimum supports and protection? Why is it that community level support structures (such as crèches for very small children of working parents, health care and education, access to simple credit etc) all of which can be made available with minimum budgeting are not being provided? The answers to these questions will lead us to different process happening to maintain this situation. These result from the various national policies governing the different sectors of the society. We find the following characteristics in such national policies. Continued centralization of power and dismantling of social support structures and re-treating of the state from its existing welfare commitments. Beaurocratized health systems showing apathy to people's needs and preventing people's initiatives. Civil society initiatives getting fragmented and co-opted by the dominant interests i.e. the market forces, which have now expanded into social sectors. These are some of the results of such policies. The primary influence in policymaking today, it appears, is the industry or market forces.

The local governance system (panchayat raj) is by design kept dis-empowered.. As per the act, Panchayat Raj has responsibility over thirty odd developmental areas. The PR is eminently capable of providing local need based services and facilities if only they are empowered (with finance and required technical and decision making powers). Kerala's People Plan Process has demonstrated that local planning produces local and sustainable solutions to what appears to be complex problems.

Another process taking place is the dismantling of the existing social support structures. Policy changes in the health sector are resulting in denying access to servises to the poor. We see this in the form of debarring those who cannot pay (user fees) from the public health services, or reducing the content of public health programs to only 'cost effective' ones, or transferring secondary and tertiary care structures to private sector (effectively barring the poor). Simultaneously, policies are allowing profit oriented drug industry to dictate the pricing of essential drugs (making them unaffordable). The state is similarly withdrawing from other social sectors also.

Coupled with the state withdrawal there is a cooption of the state beaurocracy taking place. Increasingly, the guideline for the decision making is not emerging from the ground realities of people's needs, but from the lobbies of industrial captains. The latest health policy is typical case. The process of formulation of this policy demonstrated that, the feedback from the health networks, public health professionals and people's coalition for health had little impact on the policy draft.

However, several questionable and commercially oriented recommendations of an industry core group on health (appointed by the Prime Minister), have been incorporated. The induction of higher technology and costly consumables into the public health programs is another pointer of this cooption, where the real gainer is the manufacturing industry and the looser is the already cash starved public health program. This is leading to market invasion of public health sphere, which traditionally had not attracted market forces due to the low profit margins.

Yet another phenomenon taking place is the cooption of and thereby fragmentation of civil society responses. The NGO community is a prominent section of the civil society and who have been closer to the people and their needs. We are witnessing an increasing crop of NGOs (who are connected to or floated by politicians and beaurocrats), who have easier access to state funds and whose agendas are determined by the agendas of the funders. They in reality function as sub contractors for the state funders. Thus the cooption of civil society actors has fragmented and made less effective the advocacy role of civil society, with regard to the marginalized groups.

The net results of these processes are the critical issues we examined earlier and found to be operating at the primary and the secondary levels.

Fourth Level Critical Issues – The unfair Globalisation

Beyond these national level forces, we find the international forces quite active in influencing the national policies and quite entrenched. This is the fourth level of issues and they exert considerable influence on national policies. The World Bank, WTO and trade related treaties, the UN agencies operating under varied levels of co-option (by the international market forces) are the major forces operating at international level.

These bodies are primarily the voices of the richer nations and the multinational corporations with the under-developed nations having little voice. The World Bank's influence on policy making in every sector has become entrenched and the state governments are also directly entering into agreements for loan with the Bank and its 'conditionalities'. The conditionalities for obtaining loans include – reducing states role in development sectors, to primarily regulatory role, reducing state investments in social sectors, reducing subsidies for the poor, and allowing greater role for private sector through friendly regulations and financial instruments and opening the sectors for international competition. Another con-commitant result is that even as the loan becomes debt for the state, the money gets spent without public consent or audit (on hardware benefiting mostly the elite). They are not scrutinised by the financial accountability structures in the same manner as state or central budgets.

The WTO and trade related treaties, compel the national laws to be modified, which in effect expose the small producers of goods and services to unfair international competition. With the result the small, marginal farmer/producer sector is endangered. So also the small health care providers. Simultaneously the UN related

bodies, which are meant to be a democratic forum, have been co-opted to become appendages (to varying extent) of the financial institutions. Hence their agendas reflect the multinational industries agendas.

Two events currently being initiated by the WHO point to this direction. The WHO has endorsed the Global Alliance for Improved Nutrition (GAIN) (involving giving assistance to multinationals selling "fortified foods" in developing countries, in lobbying for favourable tariffs and tax rates and speedier review of new products for them). Similarly WHO's involvement in the Global Fund for AIDS, TB, Malaria is an example of selective, piece meal approach (with charity funds from industry) to world wide health crisis, when the solution require a comprehensive people based approach.

This analysis of critical issues has brought out the intimate interconnection of the surface level symptoms with the deeper maladies and processes affecting at different levels. Solutions to these problems are not easy and should be explored for from all the levels. When we see through this larger frame the ramifications of the 'tip of the ice berg' phenomena becomes clearer. In this study all these levels of phenomena have not been studied in equal depth. In pointing the direction for interventions this larger framework is adopted by the study team.

Pointing at need for intervention.

The foregoing analysis of the problem points at the need for multi-dimensional intervention addressing the issues at different levels. An examination of the possible spectrum of interventions is required before we focus our attention to the recommendations specific to CRY and its partners (brought out in the next Chapter). In the following sections the author has taken the liberty of reflecting on the measures/strategies required, both general and specific to health sector.

A general rights oriented approach to health

'Right to health' approach in health interventions, would be premised on the fact that it is constitutional duty of the government to provide the wherewithal for the health of the child. Hence government has the responsibility to provide the enabling dimensions (namely the environment, infrastructure, services and resources for tackling all the determinants that impact upon the health) of the child. At the same time, if the child (within the context of the family and community) remains passive recipient of the governments programs, health is not obtained. Health, as per WHO definition (and other working definitions), is a creative process in which the individual the family and the community are active participants. Hence the community (child) has not only the right to health promoting environment but also has the responsibility for creating health, through actions by themselves, families and the communities.

Hence any facilitator need to be active at both these dimensions. The following are general strategies:

- Critical understanding of the linkages between the macro policy issues and the local level problems is to be developed
- Skills to influence the overt and covert decision making processes and the stamina to engage in long term public processes for influencing people-oriented policies are to be built up.
- Build on people's strengths in health – whether of local traditions or skills, local resources, social capital, experiences of livelihood struggles or ability to find out innovative solutions. This requires the support of the larger health system. The people's primary role in health creation needs to be recognised and valued by the higher levels of the health system. Then the limitations resulting from marginalisation will be minimised.
- Initiate "People's Plan Process" where people's (child's) articulated needs are the priority and they themselves become the actors for meeting these needs and not an external agency (however competent or resourceful in health). This process requires a good deal of preparation and ground work to ensure perfect democratic practices and total transparency.
- Only when the survival needs are met can the groups move to the next levels of action. Hence temporarily relief activities or gaps in services will need to be met, in order to move the group towards greater actions for their health. Proper perspective to understand and interpret such measures in the framework of right oriented approach has to be built up among all the actors involved in this process. Each step of planning and implementing by the community (children) could be an empowering process, building the knowledge, skills and confidence leading to bigger steps in health creation.
- Arrangements at different levels to keep vigilance on the operations of the larger health systems are needed. This has to be initiated from the community level upwards. Through this process, the community need to monitor deviations from health or from expected health services.
- Solidarity structures reaching up to apex levels need to be developed to magnify the power and reach of community controlled decision-making processes, for child health and to make it operative at higher levels.
- Networking and coalition building and advocacy need to be initiated at the macro level. However networking can happen constructively only between equals. Sustaining networking and coalition building requires ability to respect and accommodate other views, which are not contrary to the core values of the group. Hence issue based networking with specific roles of each group requires to be identified. Sharing of resources across organisational boundaries is another binding force.
- Dynamics pertaining to greater control of marginalised groups over appropriate health technology and people oriented health systems need to be brought out by people based 'action research'. This will counter the myths being created continuously by the dominant vested interests through manipulated research..
- Government policies and decisions relating to child health needs to be challenged and influenced. Confront the medical profession and industry (two dominant actors presently in health and who currently have vested interest of keeping people dis-empowered) to re-orientate their thinking and policies.

Specific Strategies

1. Reproductory and child health Services- a theoretical construct

Women in the reproductory age group and young children need several types of health care interventions namely, antenatal and delivery care, post natal care, neo natal, infant and care of disabled children and child care, control of communicable diseases, care of reproductory tract infections and STDs, contraception measures etc. Though many of these interventions are to be provided through the public health system, in practice very little is available at the level of the rural village.

Most villages have a traditional birth attendant (Dai), who may or may not have been trained by the public health system. In addition many villages have a traditional healer (often male). It is also possible to find in every village (or in a close by village) young literate women with aptitude and interest to take up health worker roles. They constitute a voluntary stream of health care providers based at villages and operating in villages. It is an important investment for the NGO to build the capacity of such a team, to deliver the first contact health care that they are capable of, in all the need areas identified above. Such personnel identified, trained and formed into a team become the most important part of the village level health corps.

Similarly there is a group of official health workers constituting the formal stream of health workers operating in villages. Workers and helpers of Anganwadi Centres of the ICDS and Multi Purpose Health Workers and Helpers attached to Health Sub-Centres constitute this stream at the lowest rung. The workers attached to PHCs also belong to this stream even though they operate at a higher level. Currently we may observe quite a few problems with this formal stream. Such problems can be remedied by the intervention of a committed NGO who could motivate them for more effective service delivery. Subsequently, this stream can be brought together with the non-formal stream to build up the Village Health Workers Corps.

The next step should be to make this corps accountable to the village community so that it may be able to deliver crucial health care. However a suitable democratic mechanisms for their selection, role definition, remuneration, monitoring as well as capacity building needs to be developed. The village health committee could be such a mechanism. It is necessary to enhance the power and reach of the health committees. In the present situation, genuine decentralisation of governance is not being allowed to develop in most states. It becomes necessary hence to have a representative federation of peoples organisation, that has federated the village, the panchayat, the mandal levels and above committees, into a democratic apex structure An apex body of people's organisations has the potential power to exert influence at higher levels of the health structure.

Such a mechanism will be able to increase the efficiency and effectiveness of the existing resources by attempting at the following.

- Increasing the working hours in Anganwadi Centres to full day instead of the present 6 hours.
- Admitting pre-schoolers into the facility.

- Improving the quality of the nutritional supplement and quality of service provided.
- Making it a base for women's health activities also at the village level.
- Capacity building of the staff and supportive monitoring by the community.
- Enhancing the mobility and reach of the sub centre and PHC teams, so as to regularly reach services to the village.
- Enhancing the professional and technical competency of the teams
- Making the team accountable to the local governance structures and mechanisms.
- As per local needs enhancing the resources (medicines and supplies) available with the team.

In this 'theoretical construct' that we have presented, a functioning partnership is expected between the two streams of village health workers, namely official and voluntary. We must be aware that there are blocks to this partnership developing. The health beaurocracy even at the peripheral rung and even if they are from the village itself, are not voluntarily going to cooperate with the civil society structures. They are accustomed to 'reporting upwards and ordering downwards'. Hence until such time that 'co-operation related targets' are officially part of their performance areas, innovative strategies will have to be found to foster such co-operation. Some experiences of People's Plan Process of Kerala, shows that if the beurocracy experiences support and improvements in their 'key performance areas', as a result of this partnership they are more open for it. Hence an external facilitator has a creative role to play to facilitate mutually beneficial co-operation. At the same time continued assertion of people's power and the right over the public services, need to be kept up.

It becomes necessary to have a larger force mobilized, through issue-based networking, campaigning and advocacy. It may be possible to promote policy and program changes in certain areas at the level of the district structures. However for some of the crucial changes and responses needed, sustained state and national level advocacy campaigns become necessary.

1. Nutrition and child care

With widespread malnutrition among mothers, infants and children and adolescent girls, addressing the nutritional issues is an urgent and priority problem. There are several levels of needs of the mother and child in the area of nutrition. They include nutrition supplementation in pregnancy, early initiation and maintenance of breast-feeding, weaning and supplementary feeding, nutritional support for the toddlers and pre-schoolers (anganwadi population), school nutrition programs and nutritional supplementation and education for adolescent girls, and enhanced PDS quota to "below poverty line" families. In addition agricultural policy issues related to family and community level food security needs to be addressed.

The basis for these interventions are premised on the facts that:

- India is presently producing all the food items needed for its population

- The nutritional problems have remained intractable, their root causes being the iniquitous socio-economic political situation and lack of political will to solve them.
- A vast infrastructure for nutrition security and a national nutrition policy has come into being based on decades of experience of confronting the nutritional problems of its vulnerable groups.

The nutrition related infrastructure has the objective of providing urgent and temporary relief interventions to meet the survival needs of vulnerable sections, while the larger national effort towards food and nutrition security of the population bears results.The wide spread nutrition relief programs, are underperforming and not responding to the urgent needs of the vulnerable groups. (These include the ICDS, School Nutrition, PDS, and Food for Work).

Strategic responses are required at different levels[2].

- Efforts towards making the ICDS effective in accomplishing its objectives

Enhancing the resource allocation to bridge the existing gaps in infrastructure coverage and supplies -Only 50% anganwadi;s are housed in their own centres -coverage only in 70% development blocks and -only 1 in 5 children in the 0 – 6 year age group are enrolled - disruption of food distribution on the average was 64 days per angwanwadi per year (NIPCID Evaluation) Sustained advocacy by coalitions of civil society groups would be essential to achieve this.

Targetting of the most vulnerable segments namely below 3 years old, pregnant and lactating women and adolescent girls. For this to happen the centre must become accessible to the poorest women both through its working timing and community outreach. At present the overworked AWW with feeding duties for the pre-schoolers is not able to do this. Hence additional cost effective supports need to be worked out.

Enhancing the affectiveness of the program in relation to under emphasised objectives. This requires better surveillance and supportive supervision, enhanced capacity building especially for nutrition and increased community interaction.

Improving the convergence of services especially between the departments of Health, Education (primary) and Panchayat Raj. More system level efforts are needed as opposed to the present efforts at convergence around immunization. This would require the priority for child nutrition and health is enhanced in these departments, with adequate capacities built in and concomitantly systems developed for joint effort with WACD (being the pivotal department).

Enhancing community involvement and ownership. At the policy level decentralization and devolution need to brought in so that program can be owned and managed by

[2] The following four sub-heads have incorporated ideas from 'Wasting Away, Antony Measham and Meera Chatterjee, The World Bank, 1999'.

decentralized structures especially the panchayat. This may require intermediate structures at the district level that can facilitate it given the low capacity of panchayats at the present juncture. Bottom up planning responding to local needs and resources through the initiative of mother groups would be part of this process. (The detailed recommendations of FORCES on ICDS is appended as Annexure -)

- Promoting family and community level nutrition security

Programmatic approach to family level nutrition insecurity is through the TPDS and Food for Work Programs. The following deficiencies in TPDS need to get addressed.

- The really poor are pushed out by the better off families and appropriate mechanisms for preferential access for the poor need to be built-up over a period of years.
- Monthly allocation of food needs to be enhanced. Estimates based on calorie gap argue that another 30 KG of food grains per month is required in addition to the present 10 kgs. The subsidy for the poorest need to be maintained so as to be affordable for them.
- Make the mechanisms workable through devolving the ownership to communities eg panchayat managed fair price shops, cooperative shops, group managed PDS etc.
- Rapid response during food calamities, to reach the vulnerable and in adequate quantities.

- Promoting community level (and higher level) nutrition security

Family level nutrition security through centralized programs (even when they are devolved to an extent) are unlikely to be the answer in the longer term. This is because factors affecting the 'vulnerability' of the family and the child at the community and macro level need to addressed, keeping in mind the analysis of the problem in the earlier section. We need to develop models based on successful experiences. A hypothetical model suggested by Dr Vandana Shiva is included for further reflections.

Elements of a People-and Food Security-centered Food Procurement and Distribution System

Genuine surpluses exported at

Fair price through state agencies

↑

Centre procures from various states to maintain buffer stock to ensure national food security, and to provide foodgrain for nutrition and food related schemes at the national level and for those that are directly u nder the centre.

↑

Surpluses sold to Rashtriya Annakosh

State procures from the Gram Sabhas within it, to ensure regional food security and to provide foodgrain for nutrition and food related schemes at the regional and district levels.

↑

Surpluses sold to Kshetriya Annakosh

Gram Sabha procures locally to ensure food security for the village, and to provide foodgrains for nutrition and food related schemes and programmes such as PDS, ICDS, Food-for-Work programmes.

↑

Surpluses sold to Gram Annakosh

Women-led household level food security based on improving women's capacity to grow and retain food.

This includes promotion of sustainable, low external input agriculture.

- Strengthening the nutrition related institutions and capacities (which are primarily in the public sector) the steps include :

- Quality and effective nutrition monitoring through strengthening National Nutrition Monitoring Beauro (NNMB) and bring out quality surveillance through ICDS
- Strengthening research and training by enhancing the priority of national and state level institutions for public nutrition and specific monitoring of their outcomes in the national programs.
- Strengthening nutrition capacity at all levels of the related national programs, such as AWW, ANM, Nutrition supervisory team, medical college departments etc.
- Promoting inter-sectoral co-operation between departments of WACD, Health, Primary Education and Panchayat Raj. This may require developing task forces, joint protocols, joint training , refined output indicators, high level annual monitoring and such measures. An important recommendation[3] in view of resource crunch for mid day meal program is to refocus on pre-schoolers in national mid day meal program and the ICDS to have emphasis on below 3 year olds and vulnerable mothers and adolescent girls.

- Political commitment to nutrition of the vulnerable segments needs strenghtening. Enlightened policy and programs though existing in paper are not getting implemented (such as National Nutrition Policy 1993 and Plan of Action and National Nutrition Council referred to in earlier chapters). Possible actions include:

- high profile, advocacy oriented public seminars, with specific action plans, -the involvement of Human Rights Commission and other Statutory Bodies, in the follow up etc.

[3] IBID

- Pressure through judiciary to meet constitutional responsibilities. (Interim order of Supreme Court 28 November 2001 in PUCL Petition on the "Right to Food ", Converts the benefits of eight nutrition related schemes into legal entitlements, directs all state government to begin cooked mid day meals for all children in government and government assisted schools, directs state and central governments to adopt specific measures to ensure public awareness and transparency of these programs)
- It also requires wide spread campaigns to bring the agenda to the centre stage of public debate.

2. Safe physical environment

Safe physical environment for the child is contributed by availability of protected water and sanitation facilities. Water and sanitation infrastructure requires high investments from government or large international agencies. We have observed from preceding chapters that policy for universal coverage exists and that programs of the concerned departments have been under performing. In spite of the decade of water in the 80s and of the claims of 87% coverage by the government our ground level observation was that 50% of villages had one source of safe water (corroborated by other studies quoted earlier in the critical issues).

- The interventions require partnership between government, civil society facilitators and community groups. There is need to inculcate ideas of hygiene at the personal family and community levels. This has been an area resistant to change and mass awareness campaigns are needed.
- Women (mothers) are the primary agents most concerned with the physical environment for the child. Their active role in decision making especially related to appropriate water and sanitation technology is required. Active participation of women in planning, implementing and maintaining these resources is required, (through panchayat committees, anganwadi mothers groups and mahila mandals) Involvement of women is required through the above forums for regular water quality monitoring and in promoting implementation bythe concerned governmental departments
- Promoting of goals of the 9th plan, for 100% coverage of habitation for water and extension of rural sanitation to 50% habitation. 100% safe water and sanitation coverage for schools, anganwadi, sub centers and promoting them as models for hygiene education

3. The child under stress and risk

A whole series of phenomena are, manifesting in recent decades where the child is pushed into extremely dangerous or risky situations. This has its roots in the economic insecurity of a large number of families belonging to landless labour and marginal farmer groups. The new economic policies resulting from 'globalisation' has made a further onslaught on these families with increasing indebtedness, casualisation of labour, feminisation of poverty urban migration and wreaking the family caring systems. With very little support structures existing at the community level or from the state, the family is forced to pressurise the child to be an income earner or to fend for him/ herself. Occasionally as an outcome of the broken family the child is abandoned or exposed to

abuses also. The exploitative forces existing at the local level such as the child trafficking mafia, child labour industry moves in and ensnares the child through duping or offering inducements to the family.

There is an urgency for developing programs for protecting or rehabilitating children in forced labour, street children, children forced into prostitution, HIV/AIDS affected or infected children, as well as for educating adolescent children in life skills. There is also an urgent need to enhance the community's caring structures to support deteriorating family caring systems. In the absence of well established model programs a variety of programs need to be tried out. The following areas of intervention are listed, which includes components that need to be acted upon by the government, civil society facilitators, as well as by community.

- Lobby for the present umbrella act covering children rights "Juvenile Justice Act 1985" to be more comprehensive (Universal Child Rights code) and for adequate mechanism for their implementation.
- Campaigning against male preference in society and eradication of female feticide and infanticide and punishing of guilty medical professional abetting the crime (pre natal a diagnostics act implementation) Promote innovative programs that enhances the status of girl child eg Kishora Shakti Yojana and adolescent girls life skill education.
- Abolition of child labour through universal free and compulsory elementary education, support to families of children in forced labour and deterrent punishment for employers of children. Ensure effective implementation of child labour act 1986 and national child labour policy 1987 and National Program for Elimination of Child Labour.
- Support campaigns against trafficking of children, ensure implementation of Devadasi Act and National Plan of Action (for integrating women and child victims of sexual exploitation) Promote programs for vulnerable children such as children of sex workers.
- Promote demands and right of street children through alliances between government, nodal networks and local NGOs for running services that respond to their needs. The needs identified have been for basic shelter protection from police and criminal harassment and sexual molestation, appropriately tailored health care, education, vocation support and recreation facilities.
- Promote implementation of "People with disabilities Act 1995" and campaign for recognising the rights and contributions of the disabled children. Promote programs in the areas of disabled friendly environment in public places and facilities integrated schools, community based rehabilitation, enhanced medical and surgical facilities at the district level for disabilities, locally adapted and manufactured prosthesis supporting self-help groups and vocational rehabilitation etc.
- Promote awareness regarding HIV/AIDS and against discrimination of the affected both by public institutions and civil society organisations. Promote community based programs for the care of affected / infected children and to support the families.

VI RECOMMENDATIONS TO CRY

The last section of the previous chapter presented a wide spectrum of intervention areas. The recommendations to CRY are developed in that wider context. While making recommendations to CRY we have besides, looked into CRY organisation.

CRY is well located to make strategic contributions to health of the children in the country. Cry's capacity as a National Resource Support Organisation (funding agency), its location as a key partner network of organisations active in child issues, its intimate connections to national campaigns on child issues and the connections CRY has with the private sector, give it an advantageous location to facilitate and intervene. However in the past Cry's interventions in health have been adhoc and unplanned. Hence the strategic planning process, CRY is entering into is timely and opportune.

The recommendations given here for CRY are at a preliminary stage and may undergo some additions and refinement as the other aspects of this study gets completed. The recommendations are organised starting with the micro level i.e. the partner NGO and moving to higher levels.

Partner NGOs

The budget allocation on health sector is said to be 8 to 10% of total CRY disbursements. In the 6 partner's studies, average allocation for health was 6% (if the specialised projects were separated). This is too low and we would recommend scaling it up to 20 - 25%. In the existing allocation to health, it is anticipated that a large chunk would be going to less cost-effective relief programme (Nutrition supplementation and curative services are termed in this report as relief programmes).

Within the health sector programmes we would suggest highest priority be for empowerment programmes and least priority for relief programmes. We do realise that both relief programmes and service delivery programmes are important especially to gain acceptance with the community at an early stage of work. However, the direction of programmes should move towards empowerment and advocacy, within the same issues and the relief programmes could be phased out. Some CRY regions are already using a grid to map out and prioritise the different types of health activities. This could be a suitable aid to guide the partner activities in the empowerment direction. Partner NGOs are likely to make a case for relief programmes such as nutrition supplementation in communities with severe nutritional deficiencies. In case the local situation and needs so demands to temporary relief input, it should be in the context of an overall empowerment oriented strategy in which the community also accepts the short term nature of such interventions and with adequate community contributions and participation right from the start. There will be a need for perspective building of the partner team and community leadership, on the political nature of health and the governmental responsibilities in people's health.

The newer interventions could be arrived at through criteria such as community's priority, local competency, severity of the issue etc. Another criteria for the newer interventions in health could be that it is a complimentary programme that could be built into existing programmes in other sectors especially education. This would require innovative programmes and would have the benefit of sectoral integration (e.g.: child-to-child activities in health or school adolescent health or school mental health could enhance the pre-primary / NFC education). As people are generally unaware of the determinants of health, initial tendency noticed is to suggest curative services. Hence a process of awareness building and analysis becomes necessary to arrive at programmes that would be community empowering and aimed at the root causes.

A deficiency we notice in the CRY partners is the lacunae of competent personnel who could anchor an effective health programme. We notice the health core team consists of dais or herbalists or doctor or social worker whose perspectives are either narrow technically confined or lacking sufficient knowledge of the health sector. It is our view that doctors will have only a limited technical role in empowerment oriented health interventions.

Hence there will need to be a systematic effort to train committed senior level staff in health sector concerns. A 3 months field based training programme with follow-up could be the minimum requirement. (Longer programmes along the same lines would have more advantages) We understand there are several resource agencies offering such capacity building programmes some of which are already linked to CRY e.g. CINI-CHETANA resource centre. Hence a systematic preparatory effort in the area of capacity building is important and for developing customised programmes, a team of persons with competencies is needed to facilitate training of the core health team of NGO.

Programmes to strengthen local providers Traditional Birth Attendants either trained or untrained and indigenous practitioners known by various names and to systematise their linkages with the community and health care system is a key area that CRY partners should take up. Such an intervention aims at making community level health care sustainable. The major successes of NGO models in health care in the last two decades have been due to the pivotal role played by strengthened local providers in improving the health of the communities e.g. Neonatal health promotion through trained local providers as demonstrated by Search-Gad-chiroli. Innovative training methodologies and materials are available from such experiences.

NGO interventions often induct these providers into their staff and thereby promoting their accountability to the NGO organisation alone. However it is our belief that while strengthening these providers, their linkage and role with the community structures and the larger health care system also need to be strengthened.

The functionaries of the government systems the ICDS worker and the sub centre ANM and male worker are important community level resources, whose services are often ineffective (even when they are present physically). Important interventions could be to

develop two-way linkages and accountability mechanisms with community structures as well as capacity building of these functionaries. Given the policy direction in the RCH programmes for greater community involvement and monitoring there is better scope for a critical 3 way partnership Community – NGO – Government systems.

Health Surveillance

There need to be systems for gathering and analysing both baseline and ongoing information, which would bring local problems to visibility and for action. The following areas have been suggested for collecting information. Mother and child care including safe delivery, neonatal care, early childhood illnesses, and epidemic diseases. A simplified community based health surveillance system could be established.

A priority effort needs to be on awareness generation and perspective building on health. Health has been mystified and irrational beliefs on many practices such as infections are quite prevalent. 'Doctor, Drug, and Hospitals' have been promoted and hence people see these as the solutions to health problems. Whereas the real determinants of health or disease are the environment (socio, politico economic as well), the individual habits and life style, the genetic potential of the individual and also the effectiveness of the health care systems. Hence the role played by the health care system both the Indian systems and allopathic systems is only a limited one (though an important one).

A perspective on health as a responsibility (of individuals and communities) and as a right to be demanded and obtained, need to be promoted which could lead to concrete community actions. This perspective could be complimented with a set of messages for promoting personal health and community's health. The various people's media could be utilised as well as mass media.

Community mobilisation and facilitating larger networking among the community units as well as at the NGO level is already an accepted strategic intervention among CRY partners. Building in a health dimension into this mobilisation would enhance the ability to intervene effectively in health issues. As examples the 'parent teachers committee' could develop an understanding on school health and their responsibility in promoting it, or larger network of NGOs could exert pressure on the PHC systems to be more effective.

District or Taluk level.

Facilitating an efficient two way referral system

The community level care providers can handle majority of health contingencies that come up generally provided they are competent and supported. However a small percentage of problems which includes emergencies (including obstetric) and complicated diseases will require referral to higher level. Presently these referral

channels are not existing nor a system for two-way referral, that is the patient is sent back to first contact care for follow-up with instructions after the emergency is dealt with. Though as per norms for a population of a lakh all secondary level referral facilities ought to be present, the reality experience is that if it exists, it is an exception. Hence the secondary level referral centre is often a taluk or district level hospital. It could also be voluntary sector agency or a private sector hospital but without effective referral systems and controls worked out.

A programme of lobbying and advocacy, strategised through people's network, for provision of minimum primary and secondary level health care, would be an important intervention. Though it may require prolonged peoples action, it is an important measure because it affirms the governmental responsibility for people's health.

As expressed earlier an important objective of the micro level intervention is to foster people's movement that advocates and pressurises for their basic needs. In some zones CRY partners are in the process of facilitating peoples movements focussing on basic survival issues. A health dimension needs to be built into the agenda of the movement through a process of clarifying the connections between health and livelihood issues. The connections may be already obvious or may require 'action research to bring out the ill health-underdevelopment – alienation from resource connection. A people's campaign built on critical information can be very effectiveness.

Strengthening Panchayat Raj Institutions for Child Health

Decentralisation of governance in most states appear to be still as populist idea, in that Panchayat Raj Institutions are not delegated finances and powers. Given the opportunities existing from the legislative framework, protracted peoples pressure from the bottom could wrest greater devolution of powers. Panchayat Raj elected representatives need to be educated for health roles and responsibilities and towards interventions for health supportive facilities (e.g. water, sanitation nutrition as well as accountability of public health functionaries).

A system of 'health watch' could be the initial step towards community monitoring of health services from village to district level.

Direct role for CRY at Regional and Sub Regional levels

Focus on regional health priorities

Facilitating the partner programmes to focus on the regional and local priorities would be an important intervention. When there are several partners in the same sub-region, common priorities being built into the partner programmes would enhance the outcomes of their interventions. For example malnutrition among children is a priority issue in many pockets of the country. Co-ordinated work at several levels among partners of the area, community groups and through direct advocacy by CRY at the higher levels have greater chance of generating responses, that can address the problem. Isolated works done by one partner NGO are unlikely to bring about lasting charges.

Action Research

Apart from certain national and regional priority issues in child health already discussed, sub regional and district (local) levels there would be priorities, which are ignored (as the health system plans vertically). Identifying unaddressed child health priorities from particular sub region and bringing it into policy level visibility through action research would be an important role for CRY. CRY need to develop the competencies for this function.

Capacity Building

CRY's professional resources for health regionally are very limited presently – resources need to be built-up for capacity building of partners for health. Competent resource personnel with pro-poor perspectives would be available at the district level or sub regionally. They need to be identified and arrangements worked out with them for ongoing capacity building of partners. Competency for direct lobbying and advocacy in child health (including for action research) need to be developed regionally. Possibly a cadre of 'CRY Fellows' with health professional background could be thought of, who would assist regional teams for partner capacity building.

Direct Intervention

Some direct CRY interventions for child health regionally could be in the following areas. Strengthening ICDS functioning at the district levels, children at risk and promoting alternate systems of medicine (ASM) especially herbal medicines for child health in regions where the traditions is fast loosing ground.

ICDS programme is the single integrated program meant solely for the health of the child and available countrywide to a large measure. However, as brought out in the earlier chapter, there are several weaknesses to the programme. Providing critical and cost effective inputs to strengthen the program would be worthwhile. A particular input worth exploring is capacity building and follow up of anganwadi workers at state or sub-state levels, as this is an important lacuna.

The tradition of herbal medicine is culturally acceptable low cost and effective for most common ailments, while at the same time having little side effects. However the tradition is fast disappearing under the onslaught of allopathic medicine. As a result of WTO induced policies, self-reliance at the family and community level on herbal medicines could be an important coping strategy.

There is a need to develop a mechanisms for integrating and monitoring of programmes for health needs of children at risk namely – children with disabilities, children in difficult circumstances adolescent girls. At present these areas are getting little effective attention. Basing on experience gained by specialist partners, CRY could think of interventions in this area.

CRY at National Level

Getting a health sector policy strategy and plans in place (this exercise being part of that)

As core values of CRY includes democratic functioning and transparency, the policy development process would require extensive consultation. Consultations would be required not only at the national and regional levels of CRY organisation, but also at the levels of partnership and people's organisations facilitated by CRY partners. It may be profitable to also dialogue with NGO networks interested in child issues. A mandate originating from such grassroots consultations will be focussed, with partner ownership and likely to have the planned impact. It is strength of CRY network that such process is already in practice in the organisational culture.

Upgrading organisational systems and procedures related to health.

Developing partnership criteria for health sector (as spelt out in the earlier recommendations) and developing assessment criteria for monitoring and impact evaluation at different levels is important systems improvements required.

Health Sector budget needs to be increased (suggested figure 20 – 25% of total budget) to make effective CRY network's health interventions. We have already discussed the type of interventions, which are to have an empowering, and advocacy focus. There is an increase in health sector financing resources from multilateral (World Bank) and bilateral international agencies, with policy directions for involving private sector and NGOs. Policy guidelines will need to be evolved in the context of critical collaboration that is called for with such agencies and government. CRY's expertise in resource raising will be an asset for the new initiatives.

Monitoring and impact assessment need special attention. A particular lacuna experienced is the lack of baseline data at the community level and partnership level, which would need to be attended to. The study team has taken the liberty of suggesting targets for impact, keeping in mind dovetailing with programme intent of government health ministry and related departments. However we recognise the targets need to be arrived at in consultation with CRY partnership and commu y based organisations.

It is necessary to upgrade the perspectives and understanding of PSU teams nationally.

A suitable training module and resource team needs to be identified. The module to contain an alternate perspective on health and an understanding of the policy environment. In addition knowledge of the health systems and National Programmes pertaining to the child health and an understanding on health advocacy and teaching of skills to monitor and evaluate health programs should be the minimum core of the module. A two – phased programme of totally three weeks with on site exposures would be needed. Ongoing inputs and discussions on issues arising from ground experience and discussions on issues arising from ground experience should form part of the annual meets of the PSU teams.

The study team found capacity building for playing an effective role in health sector programs a felt need of the PSU team members.

Several broad priorities affecting the children in the country have been identified in the discussions in the earlier chapters. CRYs health policy and medium term plan at the national level would need to reckon with these. Though these issues are countrywide multifactorial and have been resistant to effective solutions CRY would need to take on the challenge. CRY need to define what role in a larger canvas it can play given its limitations, of size, resources, personnel etc. The author puts forward the following suggestions for further reflection and deliberations.

Nutrition

The following categories from the poor, require special attention for improving child nutrition, namely children 6 – 36 months, pre- schoolers (3 – 6 years), pregnant and lactating mothers and adolescent girls. Two broad strategies are currently operational though their efficiency and effectiveness are low.

1. Direct nutrition interventions of government of which the key programs are ICDS, NMMP and TPDS.
2. Empowerment efforts towards family and community nutrition / food security.

District or Sub District level effective and efficient models are required. Public programs due to their inherent weaknesses of centralization, sectoralization beaurocratization and inability in community facilitation can not make these programs successful. The present policy environment being positive about public –private (NGO) partnership, there is the opportunity and the challenge to develop successful partnership programs. As shown in the case studies of Medi-Citi ICDS and T N Science Forum's Child health and Nutrition Initiative (Annexure 2), there is scope for successful innovative partnership at the district and sub district level.

In principle such a model could include the following strategies:

- Role in implementing at district or sub district levels the ICDS program, however with a flexible agenda.
- Ownership by people, CBOs, People's movements etc and developing of suitable district level mechanisms for facilitating it.
- Convergence of services of Health, WACD, Education (Primary) and Panchayat Raj Departments, through suitable MOU and Task Forces.
- Enhancing the structure and competence of the ground level and supervisory functionaries (including additional personnel for addressing the target group 6 – 36 month olds and adolescents and mothers)
- Adequate surveillance, documentation and publicity.

Complimenting such a district nutrition program, efforts at community mobilization, empowerment, towards family and community level food security need to be taken up. These could have the dimensions of enhancing women's capacity to grow and retain food (sustainable, low external input agriculture), community grain banks, through local procurement of food grains, use of locally procured grains for food related programs.

Such a program could be facilitated through CRY associates / and like-minded NGOs at the mandal level. At the program level (district or sub district) it would be a direct involvement of CRY, leveraging required personnel, contacts and minimum additional resources. It may become necessary for CRY to co-partner it with other resource agencies, depending on the financial implications for effective outcomes.

Health of the child at risk.

We have analyzed the situation of children in extreme risk such as street children, children under trafficking, children in forced labor, HIV affected / infected children etc. We have seen that by and large these children have been excluded from public programs, and even where some initiative do exists it is narrow, sectoral, institutionalized and not likely to meet the comprehensive needs of these exploited and deprived children.

An alternative model at a district or sub district level is needed, which is community based, integrated (survival, protection, growth and participation needs are included) and bringing about convergence of the government departmental services. The strategies would be similar as for nutrition, however being new areas, intensive process would be required in identifying the nature and extent of issues and appropriately specific responses. Promoting the health of these children would require creative responses, as they will not be in a position to access regular health resources. Some of the ideas to be explored are peer counselors, peer health guides, health surveillance built upon children and their contacts.

Simultaneously CRY would need to espouse the cause of these children at the policy and program level for greater policy attention. Hence each of these efforts need the support of an active, national level, advocacy resource.

Healthy physical environment

Safe water and sanitation are two key ingredients of the child's safe physical environment. The mothers at the community level would need to have control over these resources if they are to be available for the children. We have already read the analysis that though safe water and sanitation are priorities of public programs, a large percentage of the poor are not having access to these facilities.

CRY could undertake to facilitate implementation of locally suited plans for water and sanitation for the most marginalised groups at a regional or district level. Through action research, and advocacy peoples needs could be brought forcefully to the decisions makers.

Women's group capacities and skills for building these facilities need to be enhanced, as well as for planning, maintenance and monitoring of quality public services. One medium term target could be to ensure all ICDS centers and primary schools in the area, have the above facilities. Women's groups are empowered to maintain and monitor them as well as adopt personal hygienic practices.

Health care

It is opportune time to develop district health action models, which demonstrate active involvement and roles of the various stakeholders. The primary stakeholders are women's groups, CBOs, Panchayat Raj Institutions and other federated people's organizations in a district. Other stakeholders include NGOs, retired health professional of the area with a social motivation, community level health personnel, private sector in health and the public sector in health and the mass media.

Both the demand and supply aspects of health care and health promotion need to be developed. Demand side includes a 'peoples health watch' starting from village level and federated at the district or higher level. Basic health care skills and information related to public programs need to be transferred to the community. Mechanisms for convergence and effective functioning of the various health related services, need to be developed – best expressed as participatory district level plan. The various stakeholders could enter into a formal MOU regarding the implementation of such a plan.

The country's public health system has failed to deliver the goods. The system as we have noted is rigid, under-funded, centralized and not based on people's needs. As stated earlier there are opportunities in this system for partnership. One such possible program is the "Border District Cluster Program" of UNICEF. CRY could work towards developing in the medium term a district health action model program.

These four areas are presented for direct Involvement for CRY at the national level (through a region or sub region) as it would require considerable energy and resources (though most of the resources should be leveraged from public and other sources). Simultaneous with such a focussed action, there needs to be policy advocacy at the state and national level to expand rapidly the coverage of such initiatives. Hence an effective national and state level 'Advocacy Resource Group' is necessary.

VII IMPACT INDICATORS

I. PARTNER / COMMUNITY LEADERSHIP LEVEL

HEALTH CARE	PRESENT	IN 5 YEARS
No of pregnant women covered by awareness camps		100%
No of pregnant women who have had 3 comprehensive Antenatal Checkups (in checkup, supplementation and immunization)		100%
No of safe deliveries conducted by trained attendants		100%
No of neonates attended by trained personnel		100%
No of babies exclusively breast fed for first 3 months		50%
No of infants weaned at 6 months		
No of infants fully immunized for the six killer diseases.		100%
No of under 6 year olds monitored for nutrition		100%
No of moderate and severe malnourished children		< 10%
No of preschoolers receiving early childhood education		90%
No of homes with herbal / home remedy knowledge and access to remedies		100%
No of major childhood illnesses attended at community level by trained personnel		90%
No of two-way referral facilitated for complications		90%
No of school children covered by school health		100%
No of adolescents covered by comprehensive adolescent health programme		90%
No of children with disability served and provided supports		90%
No of children at risk covered by a comprehensive health programme (dropouts, working children, abandoned children etc)		
No of villages / hamlets having access to complete PHC / Sub Centre programmes		90%

HEALTH CARE	PRESENT	IN 5 YEARS
No of villages / hamlets with trained local health personnel (Dais and indigenous practitioners, anganwadi)		100%
No of villages / hamlets with access to childcare programmes (ICDS, Pre School Camps, Creches)		90%
No of schools (Govt and Private) with comprehensive school health programme		90%
No of schools / villages with special programmes for children at risk		90%
No of schools / villages with disability programs		90%
HEALTH SUPPORTIVE FACILITY		
No of villages / hamlets with round the year access to safe water (as per government norms)		100%
No of villages / hamlets with maintenance facilities in place regarding safe water		100%
No of villages / hamlets with functional community toilet facilities		100%
No of villages hamlets with maintenance facilities in place for community toilets		100%
No of villages / hamlets with sanitation facilities (waste water and slids)		75%
COMMUNITY MOBILISATION		
No of villages / hamletswith 'health committes (inclusive of panchayat representatives) formed and trained		100%
No of health committees monitoring community based public health service in health watch and serveillance of health		75%
No of school committees formed and trained for comprehensive roles (including health)		100%
No of school committees promoting schoo! health		75%
Health perspective incorporated into wider peoples network / movements facilitated by the NGO		100%
Health Advocacy events taken up by such health cells of peoples networks		1 Campaign Annually

HEALTH CARE	PRESENT	IN 5 YEARS
NETWORKING		
NGO forums of the area activated on health issues (inclusive of disabilites, health of children at risks)		100%
Active participation in communicable disease control societies of the district (new structure deing promoted by .... For civil society participative)		100% of operation societies

II. CRY PARTNERS

HEALTH CARE	PRESENT	IN 5 YEARS
No of partners helped to initiate integrated health programme		100%
No of partners with competent health core team		100%
No of partners facilitated in local need based rights based planning and monitoring for health (inclusive of disabilities, children at risk)		100%
No of partners supported with ongoing capacity building resources for health		100%
No of partners supported through district / sub regional level 'health watch' mechanisms		100%
No of partners supported through district / sub regional public health task force (Proposed mechanism of government NGO / Civil Society Committee for overseeing public health implementation		50%

III. CRY REGIONAL

HEALTH CARE	PRESENT	IN 5 YEARS
No of partners supported through 'Action Research' on new and emerging concern		
No of partners supported through 'resources' for new and emerging concerns		50%
CRY Regional teams with competent team and resources in health		

IV. CRY NATIONAL

HEALTH CARE	PRESENT	IN 5 YEARS
Health policy and strategy and plan in place and in practice.		
Competent team with background and experience to anchor health plan		
20 – 25% budget allocation for health activities		
CRY active in National Task Force on Child Nutrition		
CRY active involved in national forum for child health rights, implementation and monitoring		
CRY supported resources developed for research and advocacy on new and emerging child health concerns		

VIII CONCLUSIONS

CRY started this study endeavor, from the organizational need for a systematic evidence based and empowerment oriented involvement in health issues of the child. At this juncture of organizational evolution CRY felt prepared for new challenges and a more comprehensive role in taking forward the rights of the child.

The study looked at in detail the micro-situation of child health through the experiences of CRY partners and the community groups linked to them. It brought in the macro perspective affecting child health from an analysis of child health status, public policies and programs impinging on child health and the priorities and concerns of civil society actors in this area. This analysis made use of the clarity in perspectives emerging from the decades of experiences of voluntary sector health activists.

At the macro-level the health situation of the child is shockingly grim and should have spurred all the actors to find immediate solutions. Diseases and death among younger children remain persistently high even though all the technological solutions (involving low cost investments) for preventing them are known to us. More than half the children of all ages are starving (malnourished), some more acutely than others in spite of half a century of developmental efforts and surplus food rotting in the bulging go-downs of the government. The basic protection offered by safe physical environment of safe water, sanitation and housing is not available to more than three fourths of the children. Even water provisioning claimed to have been reached to majority of habitations (as per existing norms) in reality is ot accessible to considerable sections of the remote, marginalized lower sections of the society as the technology often is not functional Most shocking is that in recent decades the tender age of children have been abandoned to the depredations of a section of society obsessed with profit, control and selfish gratification. Statistics alone cannot bring to the reader the agony and misery of 20 million child laborers, 20000 – 5 lakhs child prostitutes, at least half a lakh (annually) AIDS orphans and other abandoned children.

As the bloom of childhood is prematurely snuffed out in the lakhs of child laborers, street children, children in prostitution children with disabilities and the AIDS orphans and other abandoned children, the state looks the other way chanting the mantra for all problems – privatization. The international elite club of industrial captains and their national counterparts in their relentless pursuit of 'profit over people' in the priced open markets of the country carelessly trod on the corpses of the millions of defenseless children and mothers. These realities expressed figuratively above do not detract from the truth being brought out by researchers through solid facts. Our own micro study convinces us of the magnitude of problems.

What is to be done. CRY should not 'reinvent the wheel' nor should it be only 'advocates' keeping their hands away from the nitty- gritty of people's struggles for a better quality life. CRY's strategies should build on the experiences of voluntary sector activists (that CRY is already a part of). Within an overall long-term strategy, different types, levels and geographically located strategies and activities need to be entered into. Even where CRY rightly is investing in partner's temporary relief oriented efforts for the child, the larger

perspective of influencing government at the micro and macro level and the linkages to be fostered at the micro, meso and macro levels should not be lost sight of. How much of the national resources are spent for child health and community's health will be making the difference ultimately.

Individual issues are also important as they are urgent and they lead to consolidation of affected community's energies for the larger livelihood struggles through solidarity groups.

In health sector CRY needs to consciously build resources and capabilities within itself so that it can be an able facilitator through its partners and linkages. Specific steps are needed at each level through inducting key health personnel, specific skilled training, systems for measuring health improvements, identifying support resources in health, undertaking research on specific geographic health issues etc. At the same time health knowledge, skills and perspectives need to be demystified so that CRY organization itself understands health through the interplay of health determinants and hence clarifies the same with the partnership network and beyond. This is necessary to confront the exploitative, monopolistic, disease creating (iatrogenic) health system and its masters the health industry.

Thus health sector involvement is specialized and yet generic in that what improves lives of children, their families their communities and the society improves the health.

This study would provide CRY the blue print required for engaging in long term health involvement.

REFERENCES

- 'Shaping Policy : Do NGOs Matter', Aseez Mehdi Khan, PRIA, 1997.
- CRY, a View of the Organisation, (Internal Document 1), 2000
- 'A program for children and women in India', plan of operations 1999 – 2002, GOI with UNICEF.
- Imrana Quadeer, Economic and Political Weekly, Oct 10, 1998
- India , National Family Health Survey-2, MOHFW, 1998-99
- 'A Public Health Perspective' Imrana Quadeer, Anubhav, Feb '99.
- Report of NNMB, NIN, ICMR, Hyderabad,1984.
- Report of Task Force on Health and Family Welfare, Karnataka 2001.
- 'Control of communicable diseases', Report of Independent Commission of Health in India, VHAI, 1997
- 'Risks in motherhood', David Payne, World Health, May – June 1998
- Manual on JE, IIHFW, Hyderabad 2001
- 'Whatever Happened to Health for All by 2000 AD', The National Coordination Committee of Jan Swasthya Sabha, May 2000.
- 'Strategic Plan of AP State AIDS Control Program', APSACS, 2001.
- 'Draft National AIDS Control Policy', NACO 2001.
- International Labor Organization – A. P. Project on Child Labor 2000
- 'Child Prostition, the Ultimate Abuse', Report of National Consultation on Child Prostitution, UNICEF, New Delhi, 1995
- 'Shocking Neglect of Rights of Disable Persons', Javed Abidi, PUCL Bulletin, Dec 2001.
- Paper presented at National NGO meet on HIV/AIDS, Dr Deepti Dingaonkar, Thane, May 2002.
- 'Demographic – Danger Signals', Sabu George, Frontline, Feb 2000.
- 'Children Vs The State', Background Paper for the Third National Consultation of FORCES, September 1997.
- 'Women in the informal sector', Indu Pathak and Pushpa Patnaik, NIUA,91
- 'Macro Economic Trends and Female Employment', Jayati Ghosh in, Gender and Employment in India, Delhi, 1999
- 'Women Workers in Agriculture' Jeemol Unni, in Gender and employment in India, Delhi, 1999
- 'Empowering Women', Rajamma P Das, in Proceedings of the Nutrition Society of India, 1995
- 'Agriculture' in Alternate Economic Survey, JP Singh and Alok Darsh, Year 1991 – 98
- 'Economic Reforms and the Child', Archana Prasad, Background Paper for MFC National Meet, FORCES Secretariat, 2000.
- 'National Health Policy', MOHFW , GOI, New Delhi, 2002
- 'National Population Policy 2000: Re-examining Critical Issues', Mohan Rao and Devaki Jain, EPW, April 2001.
- Investing in Health, The World Bank, 1993

- The Report of the Independent Commission on health in India, Health for the Million, Nov – Dec 1997.
- Bulletin of Rural Health Statistics in India, Rural Health Division, DGHS, MOHFW, GOI, June 1998
- Save the Children, Mission, Vision, Values Statement, 1997.
- Vision statement of CARE, India
- Election Manifesto, Bharateeya Janatha Party, 1998
- The Agenda for Governance, National Democratic Alliance, 1998
- The Program of the Communist Party of India (Marxist), (updated by the special conference) Thiruvananthapuram, 2000.
- 'Struggle for an Alternative Path', Draft Political Resolution of the 18th Congress of the CPI.
- 'Wasting Away', Antony Measham and Meera Chatterjee, The World Bank, 1999.
- 'Starvation Deaths, Overflowing Godowns', Vandana Shiva, Background Paper for MFC National Meet, September 2001.
- 'SEARCH', Anubhav Series, VHAI New Delhi, 1998.
- 'Maternity and Child Care Code: A Concept Paper, Maharashtra FORCES, in Report of National Seminar on Campaign for Maternity Child Care and Development, New Delhi, Jan 1999.

1. Children Welfare Society (CWS)

BACKGROUND

CWS was started in 1993 by the local zamindar who was interested in intervening in the severe problem of child bonded labour in the area. In collaboration with CRY 5 non-formal education centres were started as well as strategies to free the children from bonded labour in the carpet industryOver the years the program spread to 28 villages which were freed from child labour in carpet industry. However child labor in agricultural sector continues.

OBJECTIVES

- Working towards creating child labour free villages in the targeted block.
- Women's empowerment to assume greater responsibility in the development of family and community.
- Work towards empowerment of tribals by way of issue – based organisaton.

SPECIFIC OBJECTIVES

- To continue running 21 NFE centres and work for reactivation of Government Schools.
- To provide basic health facilities to children.
- To eliminate child labor from sectors other than carpet also.
- To mobilise the community to struggle for their rights.

DIRECT COMMUNITY ACTION

Health Care

Main Health Problems

The main health problems affecting the children were as follows

SL. No.	Age-group	Health Problems
1.	0 – 2 years	Pneumonia and URI, Malnutrition, Dysentery and fever
2.	2 – 6 years	Whooping cough, Measles, Malnutrition and Diarrhoea
3.	6 – 14 years	Malaria, Typhoid, Rheumatic fever, Malnutrition.

Source: Focus group discussion

Safe Delivery Care

Delivery care is managed by village dais. CWS conducted three day training of local dais from all programme villages by the health worker (who herself is a dai, with only four days training on the subject). However, this is a valuable input towards safe delivery care as no government training of dais has taken place.

The quality of care needs to be assessed, as there were tangential community feedback about delivery-related death and neo-natal tetanus.

Neo-natal Health Care

The only health care available is through older women in the family and the neighborhood. The only intervention project has made for this age group was pulse polio immunisation that had very good coverage.

Tangential information suggests that care for neo-natal health problems is deficient in the cultural knowledge base and fatalities are happening as a result.

Under Two Care and Health Care

Given the reality that both women and men are daily labourers in a large number of families regular care of the under two year olds is compromised. Women carry the children to the work place or they are left with the care of an elderly relative at home. If there is an elder daughter of around eight years or more considerable responsibility for mothering falls on her, with the resultant implications for her own development.

Health care is provided by local vaids in the first instance. Other trained health care is not available at the village level or sub-center level (most sub-centers are not functional).

Project intervention has been in enhancing the skills of vaids. The quality of the training given to vaids and herbalists need to be assessed.

Three to Six Care and Health Care

There is a little institutional arrangement for the care of pre-schoolers as only three Anganwadies (ICDS Centre) is present in the twenty villages of the project area. Feedback on these institutions showed that they are not functioning well.

Health care as for under two group is through the local vaids.

Project intervention has been through the PPS / NFE schools that admit children of this age the schoolteachers have been trained to use herbal

medicine. Complicated cases are referred to the doctor of the programme. No other interventions are made.

Six to Fourteen years Health Care

Vaids and PPS / NFE schoolteachers provide medicines for common ailments. In five model schools (for school health) children are promoting herbal medicine at home. Herbal nurseries are being promoted in several villages.

At the main centre, a large herbal garden has been developed, as well as several medicinal formulations.

A survey of handicapped children revealed seventeen of them. Presently they are being facilitated solely in the area of schooling.

Sports club and certain recreational activities are promoted for recreational needs in a few villages.

A qualified ayurvedic doctor holds a clinic once a week in main centre in addition to the resident full time vaid. The doctor is available to visit project villages in case of specific need, need makes periodic visits to the centres.

Health Supportive Activities

Kitchen garden has been promoted in all the villages through facilitating nurseries and has been a successful initiative. Tangential information points to a positive influence on the diet of the people.

Health education is happening through NFE schools and health camps held annually and through annual health mela. Schools have taken up herbal medicine promotion, and presently in five villages through children it is reaching the community.

Safe water

Ten out of 24 villages *(41 per cent in contrast to…. per cent at national and ….per cent at state levels)* have borewell supply of water round the year, where as the remaining villages do not have adequate borewells or the water yield does not last for through out the year. Hence, they are at risk of waterborne epidemics as was shown by the disastrous cholera epidemic of the previous year. Additionally there is no system in place to monitor the potability of water from the borewells (the bores have been constructed only upto 50 feet depth resulting from the corrupt practices of the contractor). Contamination of the borewell water is suspected from anecdotal experiences.

The program has not made any intervention as yet in this area.

Sanitation

No latrine facility exists in the villages, though Ambedkar villages were to be provided with public toilets. No sanitation facility exists for both liquid or solid waste.

Programme has not made any intervention in this area.

Village Based Health Cadres

The programme is promoting revival of the village-based vaids and giving some training to traditional dais. In addition all NFE teachers are trained to handle kit of herbal medicine for the school children. The NFE teachers being also activists of the peoples organisation, (***they)*** monitor (***for)*** epidemics and are the first to bring health emergencies to the attention of authorities.

Community Mobalisation

Effective community mobalisation exists in the programme villages. These groups have intervened in the following health issues.

They have promoted complete coverage of pulse polio campaign, a programme that Government department took strong initiative in.

Two other campaigns have been promoted by them for Tetanus immunisation and Safe deliveries. Local dais were identified and got trained by the programme for safer delivery practices

In the three ICDS villages community groups through panchayat leaders are monitoring the Anganwadies. In one village punitive action was taken against the Aganwadi worker for negligence.

During the cholera epidemic of the previous year political pressure was put on government structure to come to the villages and take measures.

Several pradhans and higher level functionaries were elected to the panchayat on the platform of the people's organisation (VOP). There are expectations on them to perform on behalf of the people's needs. Their capacity for functioning in their roles is being built-up through training offered by the programme.

Government Interface

Government resources in the project area are poorly functioning. It is understood that there are one community health centre, three primary health centres and corresponding number of sub centres are required as per government norms in this area. The community health centre practically functions at a low level of competency, without the required specialists, investigation facility, transport facilities etc. Hence no surgeries are obstetric emergency interventions are carried out here (there is only one specialist, a physician). Minor surgeries and periodic tubectomy camps are held apart

from the outpatient clinic. The national program including TB Control Programme are very poorly implemented. The medical staff did not appear to be serious about the community extension programmes that are to be implemented as per norms. It was gathered that the Primary Health Centres were operating far below the staffing norms and the sub centres were practically not existing.

It was learned that only in 3 of the 24 programme villages ANM visits took place at least quarterly, and in another village occasionally. In the remaining villages no visits are taking place.

The programme has collaborated on the single activity of pulse polio campaign. During the cholera epidemic of the previous year the District Health Authorities were successfully mobilised by the programme to respond to the emergency. Otherwise no interface with health structure has been established.

Larger Networking

The federation of people's organisations (VOP) has been successfully built-up. It was understood that they are in the process of working out federation procedure, structure and functioning along democratic and transparent lines. They have forcefully intervened in the issues of land alienation T through the action of the peoples organisation a number of acres of common land were re-claimed by the poor in the villages. They have also successfully intervened in raising minimum daily wages for agricultural workers from) Rs. 10 to Rs. 25/- They have also intervened succefully in child labour issues when the linkage to the primary issue of land alienation became clear.

The federation was involved in the campaigns for Pulse Polio and for Safe Delivery. There are some doubts whether these health issues have been interpreted from a rights based perspective or only as service delivery issues. No other direct health intervention has been taken up.

Partner Competence Building

The health core team has undergone the following training :-
Seven-day training programme on communicable diseases;
Five-day training programme on AIDS prevention;
Five-days training programme on Herbal Medicine;
Three-days training programme undergone by the health workers on the dai training.
All these trainings were advertised programmes from various resource centres in UP and not tailor made based on felt need of the staff.
CRY's direct Capacity Building has come through the quarterly visits where perspective building and process orientation inputs are given. However there has not been any perspective building on health issues.

Vaid samelan has been an appropriate training based on local resources through the exchange of the information by the vaids facilitated by the programme. This has been a specific, tailor made, and based on local resources programme, whose output has been good.

Strengths And Opportunities

Programme

- The programmes taken up (primarily in education sector) have gone beyond service delivery and have managed to organise the community for peoples action for basic rights (the peoples movement that evolved is vibrant and democratic and sustainable). This also points to the successful process of awareness generation and strategy building. The program has achieved that.
- Working with structures of governments – the people's movement facilitated by the programme has successfully involved in the local governance structure and have got several members elected into it. These members accept their responsibilities for mediating with the higher levels of the government towards community needs.
- Herbal medicine promotion is a relevant effective potentially sustainable intervention. This programme could be developed for greater coverage and diversify with an economic component for growing herbal plants for income generation.
- The panchayat elected representatives of the progrmme affiliates, potentially can mediate effective functioning of government programmes at village level. Given the disempowere state of panchayatraj in UP there is need to develop long term strategies to intervene effectively.
- The forum of VOP need to develop a health perspective towards leveraging public health infrastructure to be responding to peoples health priorities.

Organisation

CWS has built-up a collective democratically functioning core team of dedicated individuals. They have developed a larger perspective on sectoral issues and their linkage to primary concerns of the people such as access to resources and livelihood issues.

The organisation has also developed credibility with government bureaucracy due to the facilitatory role played in the health campaigns. Opportunity exists for critical collaboration in health sector programmes particularly towards ensuring accountability of the local functionaries.

Limitations And Threats

Programme

- Need based trainings for the various functionaries and community leaders have to be developed and appropriate resource persons identified who can implement them.
- Government interface, which is practically non-existant, as of now needs to be developed with clear and tactful strategies.
- Private sector in the programme area presently consists of vaids, ozas and RMPs. The spread of RMPs who are both rational in treatment and pricing of their services and are denegrating the rich herbal traditions and cause the eroding of their status. Programme could consider interventions with RMPs through the people's movement (VOP) for rational services.

Organisation

- The project leadership is weak in vision and commitment, as they are belonging to the local feudal elite structure, ability to side with issues of the poor is suspect. Hence, there is a threat of sabotaging the process.
- The capacity of health team in perspective and in public health areas is weak. The part time doctor from Ayurvedic background is an excellent, rational, local clinical resource. His potential is being tapped only for clinical work presently. It should be explored whether with additional perspective building he could be moulded into a trainer – within the programme and for other programmes of the region.
- The central person in the health care team, who herself if a dai, needs to get intencive training – in perspective, knowledge and networking skills. It is felt that suitable person to anchor the health programme is needed, who has the required background, experience and perspective.

Future Health Priorities

- Malaria which has become a large problem since the last decade will continue to grow as no intervention are in place, and as it requires a larger responses of several governmental departments as well as of the community.
- Pollution of water and soil will develop as a problem due to indiscriminate usage of fertilizers, insecticides and other chemicals in agricultural practices.
- Health problems of carpet industry workers are presently chronic respiratory, dimming of vision and muscular wasting and joint problems. This may decrease as the program has made interventions on child labor.

Role played by CRY

- CRY has played an indirect role in capacity building of the health team.
- Has supported the curative health programme component – for equipments, medicines, school check up and salary.

2. GRAM SWARAJ SAMITHI

Background

Gram Swaraj Samiti, Duddhi was formed in 1995 as an extention programme of Gandhi Mission which in turn was set up for realizing the Gandhian dream of village self sufficiency.

As a part of Gandhi Missions Gram Swaraj Samiti contributed in the following programmes :

A number of issues like child labor illiteracy, unemployment, migration, exploitation from local money lenders etc. were addressed through village peers, progressive people and other like minded NGOs.

Land development programmes were undertaken for the Southern Villages of Duddhi, resulting in the restoration of land under section 4 of Indian Forest Act to about 70 – 80% of the forest dwelling tribals.

In 1995, after the demise of Prem Bhai, GSS started working as a separate organisation but carried forward the same concept and activities till 1997.

Objectives

- To work on child labour eradication.
- To create total literacy among children and help them jjoin to mainstream school.
- To organise marginal farmers and landless labourers to fight against land alienation.
- To avail health facilities to the children.
- To work on alternative agriculture methods.
- To start IGP on large scale by introducing cotton, cultivation and tusser silk production to improve economic status of the villages.
- To work for women empowerment by promoting and skill development in them.

Specific Objective

To start health education program and work for promotion of traditional health practices.

Major illnesses

The following are the major illness reported to be prevalent in the area of operation of the organisation.

SL.No.	Agegroup	Health Problems
1.	0 – 2 years	Malnutrition, ARI

2.	2 – 6 years	Malnutrition, Diarrhoea, Malaria, Whopping Cough and measles
3.	6 – 14 years	Malaria, malnutrition, TB and arthritis.

Source: Focus group discussions

HEALTH CARE

Safe Delivery, Delivery care is done by village based dais. Only in four out of 10 villages trained dais are functioning.

Programme has no organised intervention in this area. At a personal contact level complicated pregnancies are guided to next level of expertise, which is at the district head quarters.

Immunisation, It is reported the pulse polio coverage is almost hundred percent. Other immunisations are not carried out.

Programme is involved through its staff and the activists of Bhoomi Haqdari Morcha in facilitating pulse polio campaign in the programme villages as well as fourty villages were the movement is active (2500 Children).

Neonatal Health Care, No facility exists in this region for neonatal care other then elder women of the family. Neonatal deaths are high in this region.

There is no program intervention in this area.

Under two care and health care, There is a lack of facilities for care taking of children of working parents. As is happening in the sub region either mother takes child to the working situation (however un-suitable) or an older woman in the family looks after the children (if available). Elder sister takes over this responsibility if she is around eight years resulting in her own development being effected.

Health care facility is at the first instance by herbalists and ozas (faith healers) who also use herbal medicine and subsequently by RMPs. Herbal skills and availability are on the wane, the RMPs on other hand are increasing in numbers and influence while providing irrational and expensive services.

The programme intervention is to revive the herbal practice. Occasionally interaction with RMPs towards rationalising their pricing has been done which has been un-successful. As with complicated pregnancies referral is not systamatised but on personal contact basis.

Two to six health care, No systematic health care exists other than what was described under two year olds. There are Anganwadies existing in 2 out of the 10 villages. However they are not functioning properly.

Programme intervention is through the pre-primary schools run in 10 villages. Monthly ones an ayurvedic doctor's clinic is held which also caters to other sick people in the community. In the current year, *the frequency of* clinic (***is)***

has been reduced to quarterly once. (It is our opinion that such clinics have only minimal value. Health education and health monitoring components are weak in this activity. Monthly clinics without village based supportive services are only minimally useful. This clinic activity needs to be re-organised.)

Six to fourteen year olds, No specific health care programme exists for this age group other than what is mentioned already.

The programme intervention is through PPS and night schools for working children. However, health interventions are not present or minimally present. Annually programme organises Bala Mela that has some health education component as well recreation component.

Others, There are no facilities for early and interventions for the disabled children.

Programme identified 38 children, 23 boys and 15 girls with disabilities through a survey and they are assisted for education. There are no health interventions as of now.

HEALTH SUPPORTIVE ACTIVITIES

Safe Water, Year round protected water is not available in most villages. In summer some of the existing bore wells dry up, in the rainy season open wells get contaminated producing water borne epidemics.

There is no program intervention in this area.

Sanitation, Sanitation amenities are very minimal or non-existent in the villages.

There is no program intervention for sanitation.

Village based Health Cadre, Swasthya Saheli (Voluntary Activists of the Morcha) meetings are held monthly in all the ten villages where health inputs are imparted by the health core team member. The quality and the outcomes of these meetings need to be assessed. Some of the sahelis are also herbalists.

As mentioned earlier there are only 4 trained dai's in the ten villages.

Quarterly once the morcha meetings are held in every village, during which also some health inputs are said to be given. The quality and outcome of these inputs need to be assessed.

Herbal Promotion,

Vaid Samelan is held one-to-two times annually for three days each where vaids exchange their knowledge. On an average 50 vaids attend these workshops. These are documented and made into educational material and used for health education meetings. A central herbal garden with around 35 plant varieties is being developed. It is proposed to promote herbal gardens in several villages. A full time vaid is part of the health core team.

Expansion of herbal promotion could be an important health intervention by the partners, which is presently not supported by CRY.

CAPCITY BUILDING

Community leaders, In the health sector there is no systematic training to community leaders being organised by the programme other than referred to already.

Project Team, The vaid member of the health core team had a five day training in herbal medicine. There was one day interaction with a team from UPVHAI and the project core team focusing on the perspectives in the health.

No systematic proactive and need based capacity building of the project core team or health core team is being done in the health area. However in response to initiatives from agencies such as UPVHA, the program has participated in a tribal health survey (part of larger socio – economic survey).

COMMUNITY MOBILISATION AND LARGER NETWORKING

Womens groups and peoples groups are existing in the programme villages and in the surrounding areas as a result of large scale mobilisation promoted by the parent Gandhian Organisation over the last two decades. In these groups, health issues such as herbal medicine, protected water, sanitation are discussed. The core group of the morcha meets regularly (Sakriya Sadassu) wherein also health awareness inputs are given.

The Bhoomi Haqdari Morcha has made significant gains around the basic issues of land alienation, forest conservation by people as well as social issues such as alcoholism. Peoples committees with specific responsibilities for forest conservation are functioning in the area. Women succeeded stopping in local alcohol brewing and developed social pressure against alcoholism. They have also successfully promoted education of girls.

The morcha contested in the recent panchayat election and several of its members are now panchayat leaders. They require capacity building on their roles and in particular on their responsibilities in health. Programme will need to intervene in these areas.

GOVERNMENT INTERFACE

Government facilities in health are functioning far below their capacity. The community health centre at Dudhi is functioning at far below norms with a specialist care available only in pediatrics. (A dialogue attempted with the government setup was resisted by the officials, who refused to provide any information).

Programme collaborated in the pulse polio activity resulting in a excellent coverage. In no other activity interface with government health machinery has developed.

However in the education sector interventions by the programme and the morcha has had successes – such as re-starting eight government primary schools, positioning

para teachers in three governm[illegible]t primary schools. Hence potential for interface in the health sector also exists.

STRENGTHS AND OPPORTUNITIES

Programme

Promoting the rejuvenation of herbal medicines is a local appropriate and potentially sustainable response to the health needs of the people. This needs to be complimented with a quality and a rational emergency health care (possibly through a well worked out referral system).

There is strong experience of peoples mobilisation and asserting and demanding basic needs and for public accountability through the bhoomi haqdari morcha. Building in a health dimension into the morchas agenda would make health intervention very effective.

The involvement of morcha into the self government system would makes it possible for leveraging of better implementation of government primary health care programmes.

Organization

Project holder and team have creditability with the people. The team consists of enthusiastic dedicated person. The organization has a good reach both through the pre-primary school (PPS) staff and the activists of the morcha in around 200 villages.

WEAKNESS

Programme

- Health sector interventions are negligable and budget-wise add upto only around 5% of total budget. This needs to be strengthened immediately.
- A major budgeted health intervention are the school clinics. The scope and strategy of intervention needs to be overhauled to include effective health educaton, on going support from village based cadres and sharply focussed preventive and promotive activities.
- Health support activities needs to be built-up in the areas pointed out already.
- The perspective and capacity building of community leaders and groups need to be enhanced in health sector.
- Core team requires intensive perspective and capacity building regarding health issues

Organization

- There is a perceived lack in need based and innovative responses of the programme. This could point to some diffeciancy in leadership and management system.

- Building second line leadership is a urgent need. Apart from induction of competent persons into the health core team, simultaneously enhancing the culture of delegation, accountability etc would be important.
- The tendancy of the project to institutionalise (as seen by the building up of a structure) could be a disadvantage in distracting from the movement process – which is where organisations energy should be focussed.

CRY's CONTRIBUTION

- CRY's direct involvement has been in regular monitoring interactions and inputs into micro planning this has improved the managerial functioning of the programme.
- CRY is also facilitating strengthening of core team, though it is a slow process.
- Apart from CRY other resource support for strengthening has come from – UPVHAI which is facilitating study on assessment of tribal resources and needs – resource exchange between CRY partner orgganisations especially in the area of herbal promotion

FUTURE PRIORITIES (These priorities are common for both GSS and CWS since they are operating in the same geographical area).

- Health outcomes resulting from issues of land and forest alienation, non-implementation of minimum wages and resulting poverty will continue to dominate. Hence, malnutrition is likely to continue to be a major problem with children. Consolidating the assertive resistance and demanding for rights need to be continued focus. In this context land improvement and exploring of income generating new crops would be a complimentary future initiative.
- The increase in malaria in all ages especially in pregnant women and young children (for whom it is a dangerous condition) requires attention. The underlying causes for this increasing phenomenon could be studied for pointing out effective solutions.
- Due to the unregulated flow of polluting effluence from the large industries located in the sub region (Hindalco, Kanodia Chemicals, Cement factories etc) diseases due to pollution are likely to increase in all age groups especially among children. As of now no mechanism from monitoring and intervening are in place.

3. MON FOUNDATIO[illegible] AN EVALUATION REPORT

INTRODUCTION:

Mental Health issues loom large over the world today. 2001 has been declared as the Year of Mental Health by the World Health Organisation (WHO) It is being realized more and more that about 50% or more of all diseases presenting could have a psychological overlay. The stressors and strains of the modern day and age keep increasing.

In India today, the following factors prevail:

- There is an increase in the breakdown of the traditional family system.
- A shift from the joint families to nuclear families.
- Number of working women is increasing.
- An ever-increasing competition in education and careers await today's children.
- The society at large is becoming increasingly consumeristic.

These factors are contributing a lot to the increase of mental ill health, which is surfacing as the increasing numbers of suicides, for instance. But these are only the tip of the iceberg. A much larger extent of today's children and youth are suffering from mental problems, whether they come out with it or not.

In this backdrop, there are only a limited number of Psychiatrists in India (about 3000) and an abysmally low number of mental health facilities available.

10 – 20% of all children under 15 years have some sort of mental health problems as per global statistics. The statistics gathered by MONF prove that 23% of school children have mental problems needing intervention.

The MON Foundation began about 8 years ago as an NGO. It was to address issues of mental health that a group of committed Psychiatrists and Psychologists came together to form this NGO to conduct appropriate research, training and building awareness about mental health illness and related areas in Eastern India. It is headed by the Principal Investigator Dr.Satyajit Ash who is a qualified and committed Psychiatrist.

They began the Mental Health Project for school children with the assistance of CRY three years ago.

DIRECT ACTION WITH CHILDREN:

The project aims at action towards children with psychological problems in a two-fold manner:

1. Intervention with the teachers, parents and others.
2. Direct intervention with identified 'problem' children.

They selected 4 schools, which are predominantly catering to low socio-economic standard children. The target population within these schools are the children studying from classes VI to X.

Teachers were involved in three aspects of mental heath:
@ Firstly, sensitizing them about mental child health issues.
@ Then, Orientation and Counselling training to enable them to identify and intervene in the mental health problems of students.
@ At the third level, Life Skill Education classes for the teachers to equip them and enable them to share this in turn with their students. These classes include enhancement of skills such as Communication, Anger Control, Decision making, Problem – Solving, and Stress Management.

Intervention with Children: MON Foundation initiated a survey of around 800 children in the 4 target schools and found that 23.8 % of children have mental health problems needing intervention of some sort. These 4 schools were selected after interacting with about 6 or more school authorities. They are all Government aided private schools whose managements evinced an interest in mental health issues. Initially even to broach the subject of mental health was difficult due to the widespread stigma attached to mental ill health. This survey was done at two levels: the Rutter's Child Behaviour Questionnaire was administered by teachers first and this was followed by the Developmental Psychopathology Checklist, which was given by the Clinical Psychologists of MONF.

Children with identified psychological problems are given counselling and other necessary therapy by the MONF. At least one success story could be seen at first hand when a problem child was counselled along with his parents and is now back in school regularly and is showing better scholastic record and attendance than before.

HEALTH SUPPORTIVE ACTIVITY:

MONF also provided physical health checkup and referral services for some of these selected target school children. The objective was to generate awareness about the mutual relationship between physical and mental health. So far about 398 students have been screened. The common ailments found are anemia, gastro-intestinal problems, dental problems, skin problems, eye ailments, ENT problems and chest problems. This additional service has enhanced the mental health project of MONF.

COMMUNITY MOBILISATION & INVOLVEMENT:

This is being done by the involvement of two important segments:

The teachers and the parents core groups. These core groups are formed with the really committed teachers. For instance about 4 teachers of 20 in a given school are members of a particular core group.

Sensitizing programmes in the community made parents aware of mental health concepts and it's impact on children. These were done only in the limited field of the parents of the children of the selected schools, which is the target population of the MONF. The parents of the problem children were involved in the Parents core groups, which works in tandem with MONF. Lack of time and adequate trained staff ahs made it difficult for the organization to

further follow-up these efforts, something, which is very essential for the sake of sustainability.

GOVERNMENT INTERFACE:

The Department of Science & Technology of the government is helping MONF to reach out to more number of schools. The DST has specifically funded some of their sensitisation efforts and has recommended by letter these sensitization programmes to other schools in the area. The Foundation has been persisting in advocacy efforts at different levels of the Secondary Education Department also. MONF had organised sensitisation and awareness seminars for functionaries upto the level of the Secretary to the Government. So far no clear outcome is visible from all these efforts except for the usual lip service paid.

LARGER NETWORKING EFFORTS:

Through CRY, MONF is providing resource support to other CRY partners to enable them to have a mental health focus in their work.
Other networking efforts have not been made. This is because the area of work is unique and there are hardly any other NGOs working in this particular focus area on this issue. MONF has conducted Sensitization and training seminars and programs for some ngos having a child focus, especially for those within Kolkata. They also developed a working relationship with these ngos and continue to interact with them. These ngos include some CRY partners. This is limited to the CRY partners in the city limits of Kolkata. This could be enlarged to include CRY partners and other NGOs of the entire Eastern Region and also the nation, in a phased manner. MONF can be utilised as a National Resource support group on Mental Health Issues. They can prepare and present a module on Mental health issues for the Capacity building programmes of the Cry DSU members at the regional and National levels.

PARTNER/STAFF COMPETENCIES/SKILLS:

Dr.Satyajit Ash, the Principal Investigator is a professional Psychiatrist with a good amount of commitment and motivation. The Research Associates also are competent and are motivated to work for the Action Research project.One of the Clinical Psychologists had additional training in Conflict Resolution at the Henry Martyn Institute, Hyderabad.

OVERALL STRENGTHS/ WEAKNESSES OF THE PROJECT:

STRENGTHS:

- The organisation has purely professional staff.
- Most of the personnel in the project have the right attitude and motivation for the project. They are largely enthusiastic about the mental health issues they are dealing with.
- The core teachers are motivated personally and are very active. One of them, a lady was asked why she was devoting her time and energy in the Core group. She became emotionally charged as she replied," When I was a child, I suffered greatly because no

one ever listened to me at home or at school. I don't want my students to suffer the same fate. That is my motivation."

- This project is successful and can be a replicable model.

WEAKNESSES:

The few associates and staff are part time and temporary and project based. They have other commitments too and they seem to be rather stretched out in terms of time allotment.

In this context, MONF is doing a pioneering work in this area. This is a model, which needs replication in other areas.

The issues and concerns which have come out as a result of this action research also should be disseminated to the other partners and all agencies working for Health and Development.

OPPORTUNITIES/ ROAD AHEAD:

MON Foundation can be a resource support organisation for CRY in the specific focus area of Child Mental Health.

Involvement of more and more professionals and fine-tuning the organisation to enable it to cater to more NGOs and partners is very much necessary in the near future.

Documentation of the life stories and impact of the project needs to be done more, perhaps with the help of a development-oriented journalist.

THE ROLE OF CRY:

There has been financial support from CRY for the Mental Health Project. Since the Foundation is a professional one, capacity building efforts have not been done from CRY. On the other hand, other CRY partners in Kolkata and West Bengal have been exposed to MON in order to sensitize them to Mental Health issues of children. This is a step in the right direction. CRY needs to go one step ahead and involve MONF in larger Capacity Building efforts for all the CRY partners in the country, for instance.

CRY can help MONF in dissemination of the right information on Mental Health issues to the society at large. The CRY Youth wing for instance can take this information to the privileged youth of India today.

The CRY Development support Unit team also needs to have the Life Skill Education classes if they have to understand fully the role played by MONF.

CRY can ensure that the Mental health focus on children is given a place in the course content of the overall child health capacity building programme which it can organise for all the DSU team members at the National level.

FUTURE SCENARIO:

MONF needs CRY's support in the following areas:

1. Advocacy and lobbying for correct Government policies to increase allocation of funds and inputs to the Mental health issues.
2. Dissemination and sensitization on Mental Health issues of children for other ngos including CRY partners from all regions.
3. Building up Public Awareness by means of intensive use of media: including print and audiovisual media by means of portraying human-interest stories.
   CRY could contribute financial aid and journalistic support, as well as help in marketing the news stories in the national and international media.

CRY has a definite role to play in the future vis a vis the Child Mental Health issues. Children of today and tomorrow have a right to better mental health.

(EVALUATION BASED ON A VISIT TO THE MON FOUNDATION ON 7th MARCH 2001 BY Dr.M.ANTHONY DAVID ALONG WITH Mr.MANAV AND Mr.SOTTO OF DSU, CRY CALCUTTA)

4. AN EVALUATION REPORT ON THE PRATIBANDHI KALYAN KENDRA: PKK, BANDEL, HOOGHLY DISTRICT, W.B.

INTRODUCTION:

In 1974, a group of youth near Bandel got together to start a school for the deaf. They were not technically qualified at that time but were motivated by their commitment to society and a strong belief that something had to be done for the disabled. Through the past 26 odd years, the organisation PKK has grown and evolved in response to the changing needs of the differently abled. Today it is a professionally and technically managed institution, which directly provides service to nearly 300 hearing and mentally handicapped children. It also now supports five community-based organisations in rural areas around Bandel. PKK also is reaching out now to Bhubhaneshwar where it is involved in a major community level project.

OBJECTIVES:

These are for the RRRC component of the PKK :

- To strengthen the capacity and activities of the clinic in order to raise its qualitative and quantitative aspects for early identification of childhood disability.
- Standardization of the module of services for hearing handicapped, mentally handicapped & multiple handicapped children developed during the first year of the project.
- To conduct training programmes for those whose involvement will directly contribute to change the quality of lives of disabled children.
- To undertake various programmes and activities as workshops, seminars, visits etc to sensitise the community and integrate various services available for the disabled children.

DIRECT ACTION WITH CHILDREN:

The activities of PKK are seven fold with almost all of them directly affecting the lives of children who are differently abled:

- RRRC: The Regional Resource and Research Center: It has audiology, mental assessment, counselling and other clinical services available mainly to children around Banned.
- School for the Deaf: This was the initial effort of this organization. It has two types of services for the children. The formal school caters to children and the aim is to get them integrated into the mainstream schools. The other service is to the preschool children with some hearing or mental handicap.
- Cooperatives:There are two separate cooperatives which are run and managed by rehabilitated hearing and mentally handicapped youngsters. The tailoring unit is run by girls while the Printing Unit helps the boys with handicaps.
- Parents organisation of the deaf.
- PARTNERS: Parent's organisation of the mentally handicapped. This is actively campaigning for the rights of the mentally challenged children.

- ADVOCACY and lobbying for implementation of the PWD act, etc.CERM Unit looking after community Education and Resource mobilisation.
- Community Based Organisations: These are grass root level ngos with a specific disability focus which are linked and promoted by PKK.These offer Community based services especially to the hearing and mentally handicapped children, at their doorstep, as it were. In one of the CBOs, the MUP, a survey was done two years ago to reveal the numbers of disabled children in their area of work: 44 villages: The survey showed that a total of 256 children were disabled; 52 of them mentally disabled; 128 Physically disabled; 20 visually disabled and 56 hearing disabled. The children who were identified are given intensive therapy esp. in the area of hearing disability. This is done at three levels:
    1. The Community Based Rehabilitation workers visit the homes of the disabled children to teach them and their carers, simple skills which can enable them to join the mainstream. One mentally disabled child we saw at her home was able to study at a normal government school due to these efforts.
    2. At the headquarters of the MUP in Mohammedpur, classes are held for children and their parents/carers on a weekly basis where rehabilitative skills are taught.
    3. In case of severe mental or hearing handicap, such children are sent to the PKK clinic or RRRC at Bandel for further assessment or follow-up.

On the whole the experience at PKK as seen in and through the CBOs was that the village children have a better chance of integrating in the community. They are better accepted by their peers and others in the village community. So the outcome of the CBOs intervention through CBR was on the whole encouraging.

PKK provides support to about 1800 children through various approaches as detailed above.

COMMUNITY MOBILISATION AND RESPONSIBILITY:

PKK works almost exclusively with a disability focus. That too specifically for the hearing and mentally handicapped. With this focus however,there are attempts at mobilising communities such as Parents of the deaf and mentally handicapped, cooperatives for the differently abled youth, etc. Through the CBOs, PKK is working at the village level for the assessment and service of the handicapped. There are four existing Cobs around Banned area. One of these, Mohammedpur Udnyaan Parishad(MUP) is an ngo with a multifaceted approach and activities. PKK has prime-moved that community disability prevention and rehabilitation be a part of their umbrella of activities. So PKK provides the technical wherewithal for the CBR part of the MUP. The other CBOs are largely working with CBR as their mainstay.
The Bhubhaneshwar project which the PKK is now taking up in a large way is different. Here PKK plans to implement the program directly and with a planned and systematic involvement of the community at various levels.

GOVERNMENT *INTERPHASE*

Largely PKK has worked very well with the government, especially in tune with the needs of the differently abled.

A large component of PKK's funding is from the GOI Ministry of Social Justice & Empowerment. This is for the infrastructure and recurring costs of the organization.

Training and exposure to the government officials at various levels such as AWWs, Supervisors, CDPOs, School Teachers and the like is being done by PKK, in its special focus areas.

The objective of this exercise is to expose them to the disability perspective and to help them give the service they should, to the differently-abled children. Most of them were enlightened on this issue due to this intervention by PKK. Some of them like a School teacher shared experiences like how she could help a physically disabled child by making sure that his class was always in the ground floor, year after year. What is possible if only we want to do something for these disabled children, was discussed in many of these interactive sessions. Most of the learning was an experiential sharing which helps the functionaries to come out of their self-built walls and grow out!

LARGER NETWORKING EFFORTS:

PKK has block and district as well as State level networking of NGOs and others involved in caring for the disabled. The objectives of these exercises were to share information and expertise and to lobby for advocacy at governmental levels. The outcome is yet to be materialised as it takes time and much more effort.

So far they have not tried networking with NGOs with a general or comprehensive focus. Recently they had some experience in working together with other NGOs during last years flood relief efforts. This was successful to some extent in that it widened the horizons of PKK to go beyond of their disability focus. PKK needs to continue to network at two levels:

- At the District or regional/block level with all other NGOs to develop a comprehensive development plan of the area.
- At State and country level of various other NGOs working with disability focus.

COMPETENCIES / SKILLS OF PARTNER/STAFF:

The project holder Mr.Subrata Bannerjee is a committed and sincere person who is the founder of PKK and a special educator himself. The organisation has staff who feel that PKK is not just an employer but a home away from home.

The core staff members and staff who are technical are all well trained. Most are graduates with specialized skills and technical training such as Audiologists, Clinical Psychologists, etc. Out of the ten odd technical full time staff they have, about 7 are technically qualified. The

others are multi talented and zealous and committed to their work and so are being utilized at different tasks.

Motivation and commitment levels in the staff members are generally very high due to the good work culture prevailing at PKK.

STRENGTHS AND WEAKNESSES OF THE PROGRAMMES & ORGANIZATION:

STRENGTHS:

The strengths of the programmes and the organisation are:

- The experience and expertise arising from 26 years in the field.
- The project holder and the core members of the staff show commitment and motivation to help the handicapped. Their involvement in PKK is not merely a "job" between 9 to 5. They are fully involved in caring for the handicapped children. As one of the core members of staff put it, "PKK is not just our employer, it is our home away from home". The fact that these staff continue to work happily in Bandel which is two hours away from Kolkata, and also the fact that at least one of them had left Kolkata to work in PKK, go to prove these facts.
- Technical support in terms of latest equipment such as computerised audiology aids.
- Skilled and technically trained manpower.
- Wholesome and committed work-culture which prevails in the organisation.
- Wholistic outlook of the holder and core staff vis a vis the focus group of children, i.e.the differently-abled.

WEAKNESSES:

- The focus of the organisation being totally on disability can be a weakness, as a wholistic development focus is not seen. The total development of the community at large in the target areas is not achieved due to the narrow focus.
- Long-term evaluation needs to be done in terms of changing direction if necessary. PKK has been an "evolving" organisation and as it is poised to go into a direct implementation role, it is time for reflection and redefinition of the vision and mission of the organization.
- Development and delegation in terms of second line leadership needs to be done in a more structured way. The present project holder seems to e more or less indispensable for various aspects of the functioning of PKK. But what happens after him? The sustainability of the organisation needs to be ensured by consciously building up second line leadership.
- There seems to be some interpersonal relationship problems in the adolescent and teenage groups of disabled children of PKK. Specifically focussed training or awareness workshops could be held for these teenagers on issues of Adolescent health & interpersonal relationships, communication, etc.
- The implementation of the PWD act. Networking and lobbying at various government levels needs to be more focussed. The excellent rapport the organization enjoys at least with the GOI Ministry concerned should be encashed as it were in this area.
- A good systematic database of available resources both governmental and otherwise is lacking in the context of the RRRC.

OPPORTUNITIES, ROAD AHEAD:

- While continuing with the disability focus, PKK can network with other ngos and go for comprehensive development of the area, or block.
- A proper database of disability focus can be developed not only at the regional level, but also at the national level with adequate help.
- The direct implementation role on which PKK is just setting out at Bhubhaneshwar should be properly documented and the benchmarks to be clearly set out. Proper documentation can mark it out to be a model and replicable experiment.
- The value based work culture prevalent at PKK with the excellent interpersonal relationships within the staff and with the children and parents could be documented and replicated in other partners.

ROLE OF CRY:

The RRRC has been made possible by the financial contribution of CRY.

The turning of the organisation towards community based services from a purely institutional approach is due perhaps largely inputs from CRY. Thus we can say that CRY's input has helped PKK decide its priorities properly.

CRY has not directly done much capacity building in PKK understandably because PKK is a specialized and focussed Partner, which can be a Resource Support Organization.

RECOMMENDATIONS TO CRY:

In future CRY can develop a legal cell which can, amongst other things help PKK to further advocate for PWD act and also lobby for other Disability friendly legislation if found necessary.

In the larger canvas, CRY needs to also focus on Child Health Rights and set up a legal cell to look into all issues of Child Health/Development related legislation. This legal cell can help PKK advocate for the PWD and other such differently-abled friendly acts and their implementation.

CRY can help PKK in documenting the community based project at Bhubhaneshwar and also the value based work culture of the organisation.

Further development of links with PKK can be done with a view to project it in future as a Resource support organisation especially in the field of Hearing Handicapped.

(EVALUATION BASED ON A VISIT TO THE PKK ORGANISATION, BANDEL ON 5 & 6 MARCH 2001 BY Dr.M.ANTHONY DAVID ALONG WITH Mr.MANAV & Ms.SOHA OF CRY DSU, CALCUTTA)

5. SUNDARBAN SOCIAL DEVELOPMENT CENTER: INTEGRATED WOMEN & CHILD DEVELOPMENT PROJECT (SSDC): AN EVALUATIVE REPORT

INTRODUCTION:

A group of educated youth hailing from remote areas of the Sundarban region within the South 24 Parganas District of West Bengal came together in 1986 to start on their own, the Sundarban Social Development Center,SSDC. The SSDC began its activities in 3 villages and now has grown to about 50 villages. The Integrated Women and Child Development Project in specific is targeting 8 villages and 45 hamlets in the South 24 Parganas district of West Bengal.

OBJECTIVES:

- Structural poverty alleviation of the community people especially the most backward segment with active involvement and participation of the local community.
- To organize education and training in different aspects of socio-economic development and sustainable empowerment for the local people through advocacy, mass education and pressing the vocational training in different pursuits as per felt needs of the people.
- To ameliorate the varied social odds and problems which generally crop up in the ways of life of the poor especially women and children.
- To uplift the health status and sanitation for people, especially for women and children.

The unique feature of this organisation is that, though they are a grass root level organisation, they want to be more of a facilitatory organization and not an implementing one. Rather than relief and charity, they are promoting empowerment and making the people stand on their own. One concrete way by which they are promoting this is by making all their services have a user fee.

DIRECT ACTION WITH CHILDREN:

EDUCATION :SSDC runs about 13 Pre-Primary Centers for children in the age group of 2 to 7 years in the target villages. Each PPC has about 50 children.

HEALTH : Preventive health care delivery is done indirectly in collaboration with the existing governmental health infrastructure. (Local PHC).
Nutrition education is being given to the PPC students and their mothers and other children too when they come to the Centers. As a planned strategic move, they do not do any direct nutritional supplementation at the PPCs. Two observations as an outcome of this indirect nutritional intervention seems to bear out the fact that this is bearing fruit:

- The attendance in the PPCs is improving in both dimensions. i.e: More number of children of the village are able to come, nearly 95% in a village, for instance. Secondly, the children who are coming are more regular, pointing out that they are healthier.

- The general physical appearance of the children in the PPCs as was observed showed that a majority of them, i.e. nearly 90% of them are not undernourished.

ADOLESCENT HEALTH TRAINING:

About 312 students of the IX class of schools within the target area are being trained in Adolescent health. The outcome observed was that these children, especially the girls had a working knowledge of adolescent health issues such as their own sexuality, reproductive cycles and major problems, and good habits in maintaining sexual health.

Another important outcome is that these girls have come out of their shyness or inhibition to discuss sexual health with others.

CURATIVE CARE:

Weekly clinics are being held in 5 villages, in the PPC buildings. Most of the 50 odd children of the PPC as well as other village children from 0 – 2 years and adults are seen by the doctor of the SSDC. This doctor has had an abridged MBBS course and seems to be competent. He has been working for SSDC for over three years now.

Apart from these village visits, the doctor is also available at the SSDC headquarters, Polerhat village, every day for a few hours and is made use of by all the villagers close by in case of need.

Since one of the objectives of SSDC is to uplift the health status, and since they have observed that the existing governmental health infrastructure is either inaccessible or unavailable to the people, they have made this provision. The outcome of this intervention is that affordable curative health care delivery services are available and accessible to the villagers. That the people value these services is evidenced by the fact that they pay for them. The ideal intervention here would be to motivate the collective people's groups of the villages, i.e. Mahila Mandals, VECs etc, to demand and get the governmental health care delivery services. But as a beginning SSDC has made the necessary services, i.e. Primary Health Care, available to the people. A good first step. This can be seen as an entry point for SSDC. The fact that these services are paid for by the people and are not delivered as charity or for free shows that the organisation is acting in consonance with their avowed objectives.

Deworming Camps: Two special deworming camps were held in the last year covering nearly 1500 children. The problem of thread, pin and hookworms seem to be endemic in this area and these special camps addressed this. The camps were also used to educate the people on good sanitation habits and the prevention of worms. Since there has been a perceptible decrease in the incidence of worms in the SSDC health care facility, the desired outcome seems to be achieved.

Referral Services: The ideal two-way referral services with a linkup with the locally available specialists at the secondary and tertiary healthcare levels is absent. This is being done only at a personal level. One real problem here is that a proper all weather road is not linking these villages to the nearest town. This causes a real problem in cases of complicated

deliveries. As most women here seem to consider institutional deliveries as desirable the lack of proper transport facilities is a major problem as felt by the villagers.

COMMUNITY MOBILISATION:

In this field the partner agency seems to have achieved most of what they planned to achieve. As their objective states, ".... Active involvement and participation of the local community..." A high level of ownership and pride in the achievements is seen at the village levels. In line with the philosophy of community participation and ownership, the SSDC has made it very clear that the Village Education Committee owns the PPC buildings and management, in effect.

The development of the villages concerned is being done in a systematic fashion by the mahila mandals and self help groups. In fact, they are mobilising funds for the development activities of the village and using the same for activities such as repairing the access roads. They are also planning to build a Crèche for their 0 –3 year old children in the near future and have identified a plot of ground close of the present PPC for the same.

As far as health goes, The children pay a certain amount per month as the consultation charges of the SSDC doctor. In fact this is done like a Health Insurance scheme. The parents of girl children pay Rs1/- per month and those of boys pay Rs.2.50 per month pe child. Simple and essential drugs are dispensed at cost price and other drugs are prescribed where necessary.

As regards sustainability of this curative care service, the villagers of one target village responded positively when queried about the withdrawal of these services. "We will ourselves pay and get this doctor to run our village clinic", they asserted.

Training of Village level health workers has been done to a certain extent. Each village has 3 to 5 of these trained women. These village cadres are specifically trained in home nursing and seem to be able to tackle minor ailments effectively, in consultation and collaboration with the SSDC health workers. These are about two or three in each village and they have been trained in simple home nursing. They function at these levels:

- Catering to the simple health care needs of the village at the first contact level. A simple primary drug kit is available with them and they dispense these drugs as and when necessary at their own villages.
- They also work on the clinic days by helping the doctor and collect and bring cases for his services.
- When necessary these women also take the villagers to the Polerhat clinic (SSDC headquarters) in case of emergencies.
- These village based cadre women are paid by the Project through the Village level Education and other such committees.

Promotion of Herbal and other locally appropriate and available alternative systems of medicine is just beginning in this area. The people are still having better respect for Allopathy and they also have a certain distrust of herbal medicines. The Alternate systems of medicine need to be stressed more and more due to the upcoming trends of globalization, liberalization and privatization.

Formation of Mahila Mandals, Village Education Committees has been done very well. All the five villages have functioning structures and two have youth clubs also. The heartening feature is that these committees are taking up the management of the PPCs as well as other development activities for the village.

WATER/ SANITATION:

These villages had earlier depended fully upon small ponds and lakes for all their water needs. But now all these villages have acquired borewells and are using these for their drinking water needs. Some of the more affluent villagers in all these villages have also got sanitary latrines constructed and the others are following suit. As the problem of worms is on the downward trend, it goes to prove the point that the people are using better sanitation.

CASE STUDY:

In the village of Madhya Nilambarpur, stands a Borewell hand pump. The area around it was well kept and a large notice was nailed to a tree nearby. On enquiring we were told that the notice gives instructions about the correct usage of the well. The water of the well has to be used only for drinking and has to be collected carefully and not wasted. No one should spit or wash their faces, etc in the precincts of the hand pump. It was mentioned that all the households of the village who use the borewell pay a small amount monthly for the upkeep and maintenance of the well. Every year the Birthday of the well is celebrated as a community celebration and the well is serviced, cleaned painted and decorated. A case of good traditions being encouraged!

GOVERNMENT INTERPHASE:

There is some amount of issue and need-based interface and coordination with the health infrastructure of the government. As far as Immunization and Family Planning goals are concerned, the ANMs and other health functionaries of the government take the help of the health workers and volunteers of SSDC for their own target fulfillment. So only in the area of National Immunisation Days, (Pulse Polio Immunisation), and chasing Sterilisation targets, is there any service available to the villages.

The PHC, Subcenter level functioning is very poor as they are not located in accessible places. As described earlier, the health functionaries of these structures merely chase their targets in the villages rather than deliver any service.

As far as the ICDS structures are concerned, in about 3 of these villages there are no Anganwadies because of the low population. The nearest Anganwadies are not easily

accessible. The services there are also not fully available. In spite of the excellent community mobilisation efforts, no steps have been taken so far as to collectively demand and get the health services from the PHCs and Sub-centres. This can and should be a priority area for SSDC.

NETWORKING EFFORTS:

In terms of Education, there was an excellent effort spearheaded by SSDC in the district level as they recently(December 2000) organised a Cycle Rally involving about 70 different NGOs working in the district of South 24 Parganas. Over 450 participants cycled and they submitted a memorandum to the block and district level officials, demanding education for all. The outcome of this effort was that the issue was brought to the forefront of the media and the public. This was because the main function was held on a Highway for over two hours, stalling all the traffic. The Block and District officers have agreed to consider the demands and initiate necessary action.

Similar networking with other NGOs on health issues is necessary.

PARTNER/STAFF COMPETENCIES SKILLS:

There are two active project holders who are basically graduates and sons of the soil. They have an open and committed attitude and have had formal and informal trainings and exposure in the field of social development. They seem to have together developed the philosophy of SSDC aided well by appropriate and well-timed inputs by the member of the Development Support team of the CRY Calcutta.

These core leaders have good leadership skills and team work abilities. As far as communication is concerned, they have enough and more skills for their work in the area. But they need to develop their understanding and speaking skills in English. They also need to further their skills in Community Health and ASM (Alternate Systems of Medicine) By attending some trainings or going for exposure to certain innovative and pioneering programs such as the Comprehensive Rural Health Program in Jamkhed or the Rural Unit for Health and Social Affairs(RUHSA) (***near***)CMC Vellore.

The other team members and health workers who are high school graduates in formal education have had adequate training. The Health workers of SSDC, for instance have had about 40 days training in Community Health as well as 15 days triphasic training in Reproductive and Child Health at the CINI Chetana Resource Centre, Calcutta.

The community leaders VEC and Panchayath leaders are having capacity building on issues such as Roles and responsibilities of peoples representatives, budget allocations, Panchayati Raj acts, etc. Appropriate health issues need to be built into these trainings.

The Adolescent girls and boys groups are having specially focussed health awareness training which is a good experiment worth replicating elsewhere.

OVERALL STRENGTHS AND WEAKNESSES OF HEALTH PROGRAMMES:

STRENGTHS:

- ACCESSIBILTY: Simple curative healthcare is being made accessible at these remote villages. As already discussed inefficient and inaccessible governmental health care delivery mechanism makes it necessary for alternative approaches as this. But the fact they value and pay for these services, and own them up enough to think of managing by themselves, goes to prove that these are sustainable ventures.
- SELF-RELIANCE: The villagers are made to pay at various levels for health care. The parents of the girl students pay Rs.1/- per month and those of boys pay Rs.2.50 per month in the PPCs as a form of health insurance. This covers only the consultation charges of the doctor and they pay more for the drugs. All services they get through the SSDC are paid for in one way or other. So the concepts of free and charity are not seen here at all. This augurs well for the sustainability of such interventions in the long run.
- PROMOTION & PREVENTION: Most of the promotive and preventive health care is done indirectly at the level of the village communities. For instance, though a borewell is sunk in the village, the management of the maintenance of this well is taken up at the community level. This makes sure that the village environs are kept clean and thus promote health. The active groups such as the VECs and the Mahila Mandals contribute to this.
- SUSTAINABILTY: The development of village level cadres for health is a venture to help in the sustainability of health care services of at least the basic nature to be available in the future when SSDC withdraws from these villages. The village level health functionaries are already delivering first contact care to a limited extent. If they can be further trained and used they may upgrade skills and continue as change agents in the health field: available and accessible by all, at the village level.

WEAKNESSES:

- There seems to be an undue emphasis on Curative health care at the expense of preventive and promotive health care.
- Safe deliveries, for instance the villagers believe are those done in institutions or Hospitals. Most deliveries (90%) are conducted at the nearest town hospitals. In case of complicated deliveries, the transport of the pregnant women is a difficult problem. One or two cases where the delivery took place on the road are quoted. In villages which have precarious road connectivity trained dais conducting safe deliveries at home should be the norm for a majority of the deliveries. This of course needs to be backed up by an efficient screening of high-risk cases and necessary linkages with the two-way referral systems.
- The concept of good antenatal care and detection of high-risk cases by screening and referral of the same is not being followed.
- The second contact care or referral services are not to-way and need to be built up as a system. For instance, the specialist doctors available at the nearest town should be contacted and a two-way referral services initiated where, when children are referred to them for specific problems, they will be sent back with instructions to the SSDC doctor or health workers.

- Adequate linkages need to be developed with the governmental health functionaries. Where government services are available or should be available, SSDC should use their community structures and collectives to make the Government accountable and render those services. For instance where the subcentres are not functioning properly, the Mahila Mandals should agitate or represent to the BMOH or other district or higher officials to ensure that they will function better.

ORGANISATIONAL STRENGTHS AND WEAKNESSES:

STRENGTHS:

- The project holders are committed and are actively involved in the programmes.
- All the staff at various levels share the same vision and mission to empower the people.
- The target communities are responding well especially given the fact that SSDC is working for only about 3 years in these villages.

WEAKNESSES:

- Exposure and communication skills are needed for the project holders. At present they are not able to communicate except in Bengali. Lack of communication in either English or Hindi could be a block to learning and broadbasing their future activities.
- The interface with the government needs to be made better. The problem of inaccessible or unavailable government facilities such as subcentres and anganwadis needs to be addressed by campaigns, etc.Staff strengths are to be built up on these lines.

ISSUES, CONCERNS & GAPS:

The needs in general seems to those of a larger canvas:

- Accessible all weather roads is a general felt need in these areas
- The government Health and ICDS machinery are to be made fully functional in the area.
- The unavailability of any institutionalized shelter facility for children in the age group 0 – 3 years seems to be the community's felt need at least in one village where they are planning to address this by setting up a crèche for such children.

OPPORTUNITIES, ROAD AHEAD:

SSDC is a well-entrenched grass root level organisation with a philosophy, vision and mission of facilitating communities to ensure adequate empowerment of community groups like women. They should work for replication of such successful models both at the micro level in other villages of the block/district after they withdraw from their present service villages, and also at the macro level by becoming a resource support group to expose other such partners or ngos in India.

CRY ROLE:

Apart from financially supporting the Integrated Child and Women Development Project of the SSDC, CRY has given inputs as :

- Training SSDC health workers both in Community Health and in Reproductive and Child Health.

- Regular monitoring and evaluation and guidance given to the project holders by the Development support team members.

FOLLOWUP BY CRY:

- The overall accessibility problem for the area in terms of better all-purpose roads needs to be addressed. This can be addressed by CRY playing a purely facilitatory role. SSDC functionaries are to be motivated to make the village level community structures like the VECs and SHGs to lobby at block and district levels for all weather roads. Given the strengths of SSDC it will be possible to do this.
- Further Capacity Building efforts in the direction of Alternate Systems of Medicine should be provided for the Core health workers of SSDC.

CONCLUSION:

SSDC is a successful model of a grass root level organization with a right development perspective. The most important strengths of this organization are the facilitatory focus and the sustainability status. Replication of such a model in health and integrated development projects is necessary.

##########

{EVALUATION REPORT BASED ON A VISIT TO THE SSDC PROJECT ON 2nd & 3rd MARCH 2001 BY Dr.M.ANTHONY DAVID ALONG WITH Mr MANAV AND Ms SANGHAMITRA OF THE DSU, CRY, CALCUTTA}

6. A P D (The Association of People with Disability)

A. Organisation

The Association of People with Disability (APD – formerly called as APH) was started by a group of differently abled persons and well wishers in 1959 to improve the quality of life of differently abled persons. The basic philosophy and aim of the organization is to help disabled persons join mainstream society and to help them become contributing and participating members. Ever since, the organization has been involved in educating, training and rehabilitating the differently abled persons in Bangalore so as to cover about a 1000 people at given time. All activities have been designed to satisfy the needs of all age groups irrespective of community, caste, creed or color.

The organization with the help of UNICEF conducted a program to train youth in CBR. As a part of the field work the organization visited Srinivasapura taluk and found that the taluk has one of the highest percentage of disabled persons, that too belonging to SC and ST community – 1985. Initially UNICEF supported the organization to initiate a program to screen and refer disabled to Bangalore and other places for treatment or to get assistive aids. CRY support to the program started in the year 1994.

From 1998 the organization took a leap to take up total community development activities by involving local youth, women and teachers. The organization initiated an orthotic unit in Kamthampalli. Worked with primarily schools to take up children with disability to study along with normal children. The organization initiated training of Anganwadi teachers as a part of capacity building exercises to them. Now it is a very well established program.

B. 1. Objective of the Organisation

- Empowering the differently abled persons to be active contributors in the society.
- Creating public awareness about the needs and abilities of differently abled and providing opportunities in the existing environment.
- Promoting community based rehabilitation.
- Developing a resource base for individuals and organizations by settling up pilot projects.
- Networking with Government and NGO's (National and International) to keep abreast of current trends.

B.2. Specific objectives of the Program

- Providing education to disabled children who are school dropouts at 8th to 10th level.
- Provide functional literary to disabled adults.
- Conduct a model Anganwadi in Kamthampalli
- Train Government Anganwaadi teacher.
- Immunization campaign in the taluk as a disability prevention program.
- Assessing and developing orthotic aids in the campsite – Kamathampalli.
- Organizing youth to take up a meaningful role in Health and education issues.
- Supporting government schools to develop infrastructure.

Activities

APD rural program is basically a community based disability program, that has expanded into certain development initiatives building on their core strength in disability related work.

In this context they have taken up pre primary schools, community mobilization and interface with government and making initiatives around larger networking.

1. **Direct actions with the community**.
   Pre-primary school – pre primary schools are run in 3 villages out of which one school also has a nutrition supplementation program. The impact assessment of four years of running the school showed that out of 130 children who underwent pre-primary education only 6 children have dropped out of school. The organization is in touch with the six children who are now attending NFE classes.

Immunization Campaign

In the fifteen focus villages campaign against vaccine preventable diseases is carried out complementing the government health center's effort. The percentage of children completely immunized against the six killer diseases is reported to be over 82%.

Adolescent Group

An adolescent girls group has been organized in which health issues are discussed. It provides an opportunity for adolescent girls to openly discuss themes, which are otherwise considered taboo – such as sexuality, marriage, gender issues. A gynaec screening and treatment camp was organized which also included a seminar for local GPs on Gynaec problems. This is a need based and innovative intervention. However it is being done low key (impressions gained). A forum for gender related

health issues need to be incorporated into the agenda of especially women sanghas and panchayath committees.

Disability Related – This being a specialized program on disability, several levels of interventions related to disability are being carried out. Regular awareness and training programs for persons with disability, their families and community members are being carried out. Presently the program is reaching out to 353 disabled children spread out 97 villages. Parents groups are trained to look after basic needs of children with disabilities. Through child-to-child activities awareness about disability and early identification and prevention of disabilities has reached larger number of families.

12 Camps were conducted in the year for screening and treatment of disabled persons. 49 new cases were detected and follow-up care was given to 211 cases.

24 ANMs of the health department under- went training on early detection of disability and about caring for pregnant mothers. They in turn contacted 71 pregnant and nursing mothers and gave need based health education.

Out of 17 disabled students who were coached in the special condensed course 4 students completed their SSLC and 13 got through in parts.

A leadership workshop was conducted for 58 disabled youth, which helped them in building self-confidence. They took the lead in organizing World Disability Day in the taluk and conducted a public rally to draw the attention of Government and public to the issues of the disabled.

Parents of disabled children were given an exposure visit to meet disabled people carrying on normal life. This program motivated the parents to invest in their disabled children. This is a successful effort to change the prevailing belief of seeing disabled children as a liability and hence not to invest in their development.

No work is being done in the area of mental disability. This group is ideally placed to take up this dimension, given the necessary supports.

2. **Community Mobilisation**

Several community groups have been organized. In five villages sanghas were organized and has successfully started savings and credit. These sanghas formed in poor villages have saved about Rs. 18,000. These sanghas are being oriented to take responsibility for their children's health and education.

Work with panchayat leaders: No significant mobilization or education of panchayat leaders related to priority child health issues of the community is happening it appears. This would be an important intervention even though the panchayat is not an empowered body at the movement.

3. Government interface

The APD team works in close collaborations with the ICDS centre and the sub centre ANMs in the area of pregnancy care and promoting immunizations. Though they are not directly providing these services to the community, however the facilitation of the village based government cadre has produced good results. It is reported that
Pregnancy care is 90%
Children protected against six killer diseases is 82%
Pregnant women protected against tetanus is 92%
Apart from that the program initiated the following interventions.

Anganwadi teachers training.

8 Programs were organized to train anganwadi workers especially regarding pre school education and which helped them to develop syllabus for the classes. On an average 18 Anganwadi workers attended the courses. Follow-up was done with all the training. As a result the Aganwadi workers are able to provide better care to the children, especially in providing a stimulating learning environment and not merely nutrition supplementation.

A workshop was held for the primary school teachers to develop awareness on child health and disabilities. As a result the schoolteachers are able to, screen for disabilities among the students and support the health worker in school health sessions.

ANM workshop.

A workshop for 24 ANMs was conducted on topics relating to disability, care of pregnant nursing mothers and immunization. The group found the training useful and has requested for future workshops.

Seminars were conducted with the government doctors as well as private doctors to increase the awareness on disability issues. This has resulted in better functioning of secondary level orthopedic referral facilities in the taluka. Some correctional surgeries are now being performed at taluk hospitals, free charge. Activation of the government orthopedic facilities in the area is significant achievement even though it still needs to get systematized.

4. Larger networking efforts

The group is involved in the taluk level NGO Network meeting. This appears to be at the early stage of getting to know each other and no agendas for common actions has been developed. No direct outcomes have come about yet.

People in the area were mobilized to participate in the "right to education campaign" and the public meeting at Bangalore on World Disability Day. This exposure to public articulation of issues is building peoples confidence in influencing public policies.

Linkage has been developed with a private school in the area for supporting education of disabled children in their school. The school is collaborating in disability education and making the school environment friendly for disabled children.

The larger networking effort is in a rudimentary stage. The staff of the program requires exposure and training for mass mobilization and advocacy. In the long term advocacy confined to the NGO networks alone will not be sustainable and effective.

5. Partner staff competence building

The staff in disability work has received the basic competency training from APD. This training is about a year's duration and is community based. Hence the training has developed the skills in the staff for their present tasks of community based disability work. Besides some staff being disabled persons themselves; are committed to the work.

The social workers and teachers have their basic academic training (Graduate). They have received task oriented in service training of one week to one-month duration, which has been very beneficial for skilling, them for their tasks. It is to be noted that these in service training were innovative and appropriate for building their skills.

There is supportive supervision through the weekly planning and reviewing meetings and through periodic visits from APD trainers to the field situation.

The staff team has the minimum competencies for their present roles and some of them are already functioning as resource persons. However if the program wishes to develop into an integrated health and development initiative apart from the core thrust on disability, competent core team on health would be required. At present the core team does not have a socio political perspective on health and managerial skills for a broader health program.

6. Overall strengths and weakness of the health program

(The program is evaluated against the overall opportunities for intervention visualized by the evaluation team, not only against the plans they had formulated)

Program Strength

This specialized community based health program with disability focus has addressed the preventive promotive curative and rehabilitative aspects of disability

well. They have had good results especially in the direct involvement areas of disability work as per the outcomes already brought out. This can be enhanced further with a dimension on mental disability.

Though some outcomes are seen in the other health areas, they are not the same order of effectiveness.

Good rapport has been built up with the community especially as an outcome of the direct involvement. This has enabled them to mobilize the community to take up some responsibility in the children's health and education. This needs to be strengthened further.

The government interface has been strengthened. Both the support given by the program, to community level government program and the dialogue entered into with government functionaries have contributed to this.

Program Limitations

The evaluation team thinks the strategic planning efforts of ADD Rural need to improve. There appears to be come unclarity on evolving directions of the program i.e. whether to develop further in community based disability work or into an integrated health and development program. This area needs to be addressed based on community's priorities and their ability to own them on the one hand, and on the other hand taking into consideration the core competencies and guiding principals of the organization.

For the same reason, some of the present priorities of the program need to be reevaluated, such as the appropriateness of adopting certain villages and validity of continuance of nutrition supplementation activities.

Program lacks good quality education material for health education of the community groups.

There is no intervention with the community based health providers such as dais, herbalists and RMPs. This sector has important contributions to make in sustainability of the program.

The program's ability in mobilizing grass root communities and empowering them for political action is a weak area. This is also reflected in related activities such as mobilizing panchayat bodies, and issue based networking at a wider level in support of local health needs.

A possible intervention in this context could be developing local mechanisms for 'health watch'.

The organization- strength

The organization inherited a positive image of strong values, from the swamiji who donated the property. This image has been maintained.

There is a positive staff culture of openness transparency and accountability to each other. Accordingly the plans are made and reviewed by the group themselves.

The organization has invested in staff capacity building so much so that some of the staff is becoming local resource persons.

The Organization- Weakness

There is need for a competent core team in health. Such a core team need to have a minimum required training in health, atleast three months training in community health program management in a good field based facility.

CRY's Role

Presently the role played by CRY relates to program monitoring activities, input to staff on planning and management, especially financial management and support to the capacity building programs for the staff indirectly. CRY has also facilitated the group for larger networking – NGOs in disability work, education network (NAFR)

Other Roles CRY Could Play

Facilitating strategic planning of the NGO and the required capacity building of the core team.

Action Research on priority health issues of children in the area and bring them to visibility e.g. it has been noticed that the working girl children in sericulture related industry have significant health problems.

Publicizing the successes and leanings of the community based disability work, and promoting this component among other CRY partners.

Promoting priority child health issues into the agenda of state level coalition for health (Jan Swasthya Abhiyan.)

Interventions into the government health system at the state and regional levels especially in the area of making ICDS structure more effective.

1 **SEARCH, Gadchiroli** (Based on field visit to SEARCH and the documents of SEARCH especially 'SEARCH', Anubhav Series, VHAI New Delhi, 1998)

The pioneers of SEARCH, Gadchiroli are the doctor couple trained in Public Health Research, Abhay and Rani Bang.

Early in their community involvement they recognized the effectiveness of community based research in policy changes for improving the lives of people. They settled in one of the most backward and remote districts of Maharashtra for their life's work.

Community Based Rural Health Care

SEARCH started its health work directly in a programme area of 58 villages of Gadchiroli district covering a population of nearly 50,000. The main emphasis of this work is to make community based health care possible through a band of trained community health workers who are able to take care of the majority of the health needs. The villagers nominate health workers who are called the arogyadoots (messangers of health), and all Traditional Birth Attendants (TBAs or dais) in the village are involved. They are trained by SEARCH on a continuing basis.

In addition to treating common illnesses, conducting deliveries and providing health education, these workers are unique for they have also been trained to diagnose and treat gynecological diseases in women, pneumonia in children, and care of neonates. A number of them have also been trained and worked as investigators for collecting data for the studies undertaken by SEARCH. When necessary they refer cases to the SEARCH hospital at Shodhgram.

The non programme area (the control area for field research) has 47 villages with a population of 45,000. Outside its direct programme area, SEARCH assists people when they approach the organization for some assistance of advice.

The Team

The SEARCH team consists of 5 doctors, including Rani and Abhay, three nurses, lab technicians, a deaddiction team, a keertankar who gives religious cultural discourses in the villages, a team working with youth, 6 field supervisors, women social workers, computer programmer, statistician, office and support staff. The community based workers are 120 dais and 80 arogyadoots – 35 women and 45 men. The gatekeeper, driver, registration clerk, deaddiction workers – many of the workers at Shodhgram are ex-addicts. The gatekeeper spins on a charka and keeps himself productively occupied.

Participatory Approach

Through their experience with the community SEARCH team recognised that only when the people were involved in research problem identification and finding appropriate solutions to

the problem, they owned it as theirs. The usual research and recommendations method alienated people from their own health problems.

Control of pneumonia in children and primary neonatal care in villages were two outcomes from 'action research' initiated by SEARCH team. SEARCH team focuses on problem areas of people where government attention is not given in terms of policies and program.

In two years (189-90) nearly 2000 cases of pneumonia in children were treated by the trained Arogyadoots and dais with resultant case fatality less than one per cent. The childhood mortality due to pneumonia in the intervention area of 58 villages declined by 75% the infant mortalitty rate by 33% and child mortality by 30%.

SEARCH has made two bold departures in programme to control acute respiratory infections in children (ARI). One to entrust TBAs and village level health workers the responsibility to manage pneumonia in children, thereby achieving almost 100% coverage of pneumonia attacks in children in their action area. Second, even the neonates with pneumonia are managed in the villages because parents are almost never willing or able to shift the baby to hospital.

Since the government ARI control programme has not incorporated such steps, its affectivity remains low..

Primary neonatal care in villages

Mortality in newborn babies within one month of birth constitutes nearly two thirds of the infant mortality rate in developing countries.

A study was started in 1995 in 39 villages to observe and record the type of diseases home cared newborn babies in rural areas suffered from. Thirty six femal arogyadoots from these villages were trained to visit families, examine newborn and record the findings. The study revealed that 95% newborns were home delivered 56% suffered from one or more major illness (prematurity, birth weight less than 2 kg, pneumonia, sepsis, birth asphyxia, hypothermia or breast feeding problems) and 52 infants out of every thousand died. Only 2% were treated by a doctor and barely 0.4% were hospitalised. It was thus obvious that newborns needed to be cared at the village level.

In 1996 a primary neonatal care system was evolved in 39 villages and now trained arogyadoots visit homes, examine newborns and manage the sick ones. The neonatal mortality in these 39 villages had decreased by 56% and Infant Mortality rate had come down from 74 to 44% lower than national figure of 74/1000 live births.

The two programmes – pneumonia management and primary neonatal care developed by SEARCH have the potential to reduce child mortality by 50%.

The Tribal friendly hospital

SEARCH started a hospital treating 15000 patients annually. This hospital which looks like a tribal village has been planned taking the socio-cultural characteristics of tribals. The waiting area, the outpatients section, is modeled after the 'ghotul' the discussion hall of the tribal village.

Here tribal educators in the local language carry out health education. The in-patient buildings are small hutments where patients and relatives can stay, as the relative is a caretaker for the patient. The medical team has taken the effort to document the tribal health practices (including herbs used) as well as the local terminology used to communicate symptoms and problems. The socio-culturally friendly atmosphere has contributed to the acceptability and success of the hospital.

Significance of SEARCH work

SEARCH's work with children have demonstrated that complex tasks involved in the medical care of infants and neonates can be handled by the semiliterate or illiterate health workers present in the community. Taking up from the learnings already demonstrated a decade back by Jamkhed project, SEARCH has demonstrated the same village health cadre based approach will work for neonatal care. In the process they have demonstrated bringing down infant mortality and especially the most resistant component, the neo natal mortality, through cost effective strategies.

Another contribution with regard to child health is through demonstrating the gross under reporting of infant and child mortality by the government sources. It has focussed policy maker's attention on the need for better, care strategies. This has resulted in SEARCH being asked to train government functionaries for childcare in Maharashtra.

SEARCH has demonstrated as Jamkhed had done earlier that participatory and democratic training methodologies could develop highly skilled local personnel, regardless of their educational background.

SEARCH has made several other contributions in the areas of women's health, sexual health, adolescent sexuality and alcoholism as a social and health issue. For the purpose of brevity in this case study, these areas are not being expanded.

The action-research outcomes of SEARCH have not remained localized to Gadchiroli. Through active networking, capacity building and policy advocacy, the influence of SEARCH in child health policy is strongly felt at Maharashtra level as well as at national and international levels.

Learning for CRY

SEARCH is a resource support organization for child health issues and resourceful partner for CRY. Though the SEARCH model at the ground level focuses only on health sector,

where as CRY has a multi sectoral approach in their interventions, the successful strategy for child health care need to be taken forward. SEARCH is also good resource for CRY for capacity building in 'direct health care' for CRY partners and on 'right based approach to health' for CRY team.

2 MediCiti, Medchal – ICDS Program

Special Nutrition Program 'SNP' (based on field visit and limited documents made available by the program)

The SNP was started in ICDS – Project in Medchal during May 1999 had the following aims:

Improving the nutritional status of the pregnant and lactating mothers and children from the age group of 6 months to 6 years, reduce the IMR, MMR, Infant Mortality Rate, improve the immunization coverage community participation and the pre-school attendance in the Anganwadi Centers.

The SNP was started initially in 3 centers, increased to 10 and then 15 and gradually to 157 centres.

In the beginning packed food with shelf life was served twice a week like groundnut- jaggery laddu, ragi porridge, biscuits, egg, chudwa etc.were distributed. Subsequently low cost locally available and acceptable food is being distributed. The accepted items are sweet pongal, wheat upma, idly, khichidi. These items are consumed with great relish and totally accepted by the community.

The 'mothers committees' having been given 3 days orientation training on ICDS activities and motivated to participate, by the ICDS functionaries. These mothers committees are regularly participating in all the activities at Anganwadi centers.

Pregnant Women

The Anganwdi workers conduct survey of pregnant women in the village. They register their names and motivate them to take precautions such as: TT Injections, IFA tablets, regular ANM checkup, balanced nutritious meal and also facilitate through institutional delivery, safe delivery.

Lactating mothers:

Their services to lactating mothers include:

Encouragement of colostrum feeding, regular weighing, education on breast feeding, immunization, introduction of complementary feeding, ORS, hygienic handling of the child and reference to the doctors. They also advice on family planning measures to eligible couples and encourage timely FP operation .

Children : 0 – 3 Toddlers

Advice to mothers to feed infants, hygienically and nutritionally to ensure optimum physical and mental health and on timely immunization.

3 – 6 years preschoolers

In all the 157 Anganwadi Centers the 'preschool' is regularly functioning for the overall development of the child before they move to the primary school. The World Bank has supplied the centers with outdoor and indoor play materials and preschool kit, which is helping in their development. These activities are helping the children to develop physically, mentally, emotionally and socially.

This has also helped in improving the attendance, social participation of children and mothers in all the 157 centers. In addition there are 53 ECE (Early Child Education) programs running under DPEP within these centers.

Adolescent Girls

Survey of adolescent girls in the entire project areas was done and mebandazole (for de worming) and IFA (for prevention and treatment of anemia) are being given to all of them.

MediCiti Involvement

MediCiti is assisting immunization and free health check, through their village health clinics and CHVs and they are monitoring health in the project area. They are providing transport for institutional deliveries (through a simple phone call). They are given 50% concession for treatment in the Medi-City hospital including surgeries by providing 'health card scheme' at Rs. 50/- per head, per year.

Strengths and weakness of the program

The program was unable to provide data on the outcome and impact of the project so far. However based on observations the following analysis is being made.

This is a good example of an effective collaborative Government –NGO program covering a fairly large area (157villages). The community actively participated in the construction of the centers, for which funds came from the World Bank. The centers have adequate equipment for indoor and outdoor activity for the children, which is quite different from anganwadi centers elsewhere. The center attracts and retains children. The 'mothers group', i.e. parents of the enrolled children are involving in the running of the center by helping out voluntarily by turn. These helps to maintain cleanliness ensure adequate food distribution and enrolling of the eligible.

The program took the initiative of negotiating with the department of WDCD, to provide cooked local diet. This superior to pre –cooked food transported from elsewhere, both in nutrition content and in acceptability.

The program also has initiated convergence of services of health, ICDS and primary school education, through its center. This initiative is worth duplicating, even though not easy to bring about in practice.
The program also provides ongoing capacity building inputs to the lower level functionaries of the ICDS program an aspect not emphasized from the department.

There are a few limitations to the program as well. To start with it is not a replicable model, as the NGO involved has brought in considerable financial and other resources into the partnership (being a tertiary hospital). Without the financial backing of the institution the partnership may not have sustained, as there was a prolonged period of twelve months when the government funds had not been released to the project.

There is no community ownership of the program, even though the mother's group is actively involving. The roots of this issue are linked to the poor decentralization being implemented by the state, as well as effectiveness of community organization carried out by the agency. It is an institutional approach to nutrition as opposed to community empowerment approach and unlikely to be sustainable. For the same reason one does not expect much changes in the family level or community level nutritional behaviors.

3. **Community Initiatives to Improve Child Health and Nutrition in Tamil Nadu, India: Strategies and Preliminary Results on Nutritional Impact – India**

Background

This programme was started in May 1999, and is being implemented in roughly 500 villages in 10 blocks in Tamil Nadu. Supported by UNICEF, the programme is executed by the NGO Tamil Nadu Science Forum. The programme has three main aims:

- Improve the use of primary health care services;
- Improve children's health and nutritional status; and
- Organise and empower women around their health needs.

The programme organised village health committees (VHCs), which each selected a local health activist. These voluntary health activists were trained together, and more intensively in the field, in talking to mothers about nutrition and diseases, and to pregnant women about nutrition, delivery, breast-feeding and other health matters. The VHCs also met to read and discuss health books, and helped the health activist to promote nutrition and health education.

The main strategies used to address child health are:

At the family level:

- identify children at risk by weighing each child
- constantly follow up each child at risk and assist families to prevent malnutrition or reverse it by appropriate health education and better use of existing health services

At the community level:

- strengthen primary health care and Tamil Nadu Integrated Nutrition Programme (TINP) services through advocacy
- make child malnutrition the most important index of health for local planning, and sensitise panchayat members as to its significance.

The activists were given intensive training in child health and nutrition to:

Analyze the combination of factors that led to particular cases of malnutrition; identify those factors that can be addressed in their individual and social context; discuss with the family about the child's risk factors and the importance of addressing those factors; and reinforce the initial message by repeated visits at the family level as well as through cultural programs and village-level meetings.

Programme principles:

The interaction between the health activist and the mother is central to the programme, and is based on principles derived from experience:

1. Respect . The mother and pregnant woman are seen as intelligent people coping with difficult conditions, and not as ignorant people who won't listen to sensible advice.

2. Understanding. The focus is therefore on understanding why a mother does not follow advice, rather than blaming her for not doing so. She already has a world-view, formed

by her own experiences and what she has learned from her community. That world-view guides her health practices for herself and her child. The advice she is given by the programme often differs from her own information; to succeed, one must integrate this advice with her world-view, by discussing in detail why it makes sense and how it can be adopted within the limits of her resources.

3. Skilled and patient negotiation. This kind of dialogue is difficult, time-consuming and requires considerable skill and confidence on the par of the person giving the advice. Training the activist in dialogue takes time; she must learn not only to advise, but to counter arguments and elaborate ways in which advice can be adopted in a resource-poor setting. The activist needs support from a group of trainers who visit her regularly, provide her work with legitimacy and constantly encourage and provide her with further training.

4. Peer discussion and reinforcement. One-to-one sessions between the activist and mother are complemented by group meetings called by the activist to discuss specific issues (e.g. feeding the colostrum). In such a meeting, a mother will invariably say they have fed the baby with colostrum and the baby is healthy; this can be used as "proof of concept" to convince others. This kind of negotiation with a larger group also requires skill, and often the block-level trainers help the activist to conduct such discussions.

5. Preliminary results on child malnutrition

As part of programme activities, children aged under five were weighed at the beginning of the programme, and again roughly 1.5 years later (in October-December 2000). Of 7,133 children weighed during both periods, the percentage of children with a "normal" weight increased from 34.5% to 45.8%. The percentage of "grade 1" children increased by 1.3 percentage points, while the percentage of children in grades 2-4 decreased by 12.6 points.

If one compares each child's status at the two times of measurement, one finds that 34.9% of children improved their category, while 13.5% deteriorated; the remainder stayed in the same category. That is, there was a net categorical improvement among 21.4% of the children.

These results understate the programme's impact, in that the nutritional status of a cohort of under-fives is not static in the absence of positive interventions in their favour. Rather, one expects their nutritional status to worsen. In areas of the State where the programme is not being implemented, one finds that the overall nutritional status of a cohort of children aged under five deteriorates over a 1.5 year time period; indeed this pattern is commonly found throughout India.

Organisational insights

Explanations for these positive results can be found in the actions of the health activist: the programme's design and operations place great emphasis on motivating her and making her effective:

- When measuring the activist's work, she is not blamed for children who are malnourished or in poor health. The emphasis is rather on measuring her work, i.e. talking to mothers and pregnant women. If children have worsened, the reasons are sought in her training or in programme design. Investigation sometimes reveals that there are underlying factors beyond her control, such as diarrhoea epidemics.

- The activist is always praised in front of the mothers. To boost her respect in the village and her self-confidence, village meetings are organised in which she is honoured and called to talk to the village community. These measures gain her respect locally and motivate her to work harder.

- An egalitarian and intensive relationship between the trainers and the activists is important. The motivation of these trainers, and their willingness to meet with mothers, often over a period of days, are crucial to providing the activist with a good example as well as the skills she needs.

- The activists' voluntary status is important to their motivation. The activists and the village understand that the work is done for the sake of improving children's nutrition.

- To ensure that the focus of the activist is on actually meeting mothers and pregnant women, administrative tasks such as report writing and maintaining records are kept to a minimum. The trainer is responsible for monitoring the programme, and is primarily responsible for administrative tasks; the activist is asked to maintain only one page from which all relevant data are gathered.

While the preliminary results will need to be independently verified, they suggest that this programme might provide a viable model to reduce child malnutrition. More time will be required to determine how long it takes to raise a community's capacity sufficiently to address malnutrition without ongoing support from an NGO; and to determine the cost of this model.

There are three further considerations relating to sustainability and replicability. First, the model requires supportive primary health care and nutritional services, which have traditionally been provided by the State. These services need to be reinforced. Second, this model is predicated upon intensive outreach counselling and personal relations. While resource constraints play a role in malnutrition, much of child malnutrition can be explained by behaviours. Poor feeding practices are common, and the in-home management of illness can be much improved. These problems can only be addressed through a dialogue that intensively and repeatedly seeks to ensure that the right behaviour has been understood and is being practised. There does not appear to be a shortcut or substitute for this approach. Third, the community's involvement is important: it provides support to the activist and examples of positive behaviour for others.

1. GAPS IN EXISTING LAWS, PROGRAMMES & SCHEMES AND IDENTIFIED REQUIREMENTS (Maternity and Child Care Code, a concept paper, Maharashtra FORCES)

The required and prevailing laws, programs and schemes may be grouped and considered according to the table of ECD needs. The gaps between need and present provision are summarized below.

Period	Required Interventions	Present Status
Ante-natal	Right to choice (Universal access to FP, including MTP)	Not fully available
	Protection of female foetus (Ban on selective abortion)	Pre-diagnostic Sex Determination Tests Act, 1994
	Right to nutrition (Maternal nutrition and universal access to health services)	Cash support through Maternal protection schemes in some States and nutritional support in some states. Access to health care inadequate.
	Education for childcare	Not available
Childbirth	Safe childbirth (Universal access to safe facilities)	Not fully achieved
0 – 2 Years	Right to nutrition (Access to mother's milk exclusively for four months from child birth)	Infant foods and breast milk substitutes Act (1992)
	Comprehensive, Maternity Protection Act, Fund or scheme for all, especially to those working in the unorganized sector. Employer contribution may be required in the case of organized sector.	Maternity Benefit Act and Employees State Insurance Act (1948) provide for only three months and is available only to women in the organised sector.
	Age appropriate framework for stimulation towards holistic development.	Limited maternity entitlement in cash in some states and nutritional support in some states.

Period	Required Interventions	Present Status
	Right to care and protection (Uniform adoption law and maternity entitlement for adoptive mothers)	Stress on holistic development by the ICDS scheme, however inadequate.
	Minimum standards of childcare in crèche / Day care centre and institutional care homes.	Hindu adoption and Maintenance Act (1956), Guardians and Wards Act (1890) and Hindu Minority and Guardianship Act (1956). No entitlements for adoptive mothers.
	Lack of childcare services for agricultural workers and for regulations of founding homes, orphanages and children's Homes Comprehensive Child Care Act Fund and scheme providing access to day-care for young children at locations, timings and of nature and quality appropriate and convenient to mothers, especially for those in unorganized sector with new and flexible ways of acquiring financial contributions from employers / contractors of women in the unorganised sector.	Several Acts (6) providing crèches for children below six mostly available only to women in the organized sector. No provision for women in Govt. or public sector service, or for those working in tertiary sector or, under the Shops and Establishment Act.
3 – 5 Years	Right to care and protection and a Comprehensive, age – appropriate Child Care Act, Fund or Scheme, as above, applicable to children up to the age of six.	The ICDS and the Acts mentioned above all provide for children up the age of six. The lacunae are similar.

Period	Required Interventions	Present Status
	Supplementary care and support, Right to education and holistic development. A compulsory Child Development and Education Act to provide free and universal development education, appropriate to age.	Proposed Compulsory Education Bill restricted children aged 6 – 14.
	Policy related to prevention and early detection of disability.	Persons with Disability Act (1993) not implemented.
	Regulation of all early childhood education which would ensure minimum standards in early childhood education.	No such comprehensive laws of rules. Some ad hoc rules passed in some States (Maharashtra and Delhi), some under consideration. Some court rulings with respect to admission tests.
Special Needs	Rights of homeless, refugees ethnic groups, single parents, migrants, itinerants, nomads, riot-hit, pavement dwellers and those in illegal settlements to all the services and provisions. Special facilities in response to needs of each group.	No special entitlement at present to ensure that such children are not deprived of their rights.

2. FORCES' Recommendations on ICDS

1. Upgrade facilities and infrastructure

   There is a need to upgrade the physical infrastructural facilities of AWC. Adequate indoor and outdoor space and separate storage space should be made available. Taps & hand-pumps should be installed within the premises of all A WCs & toilet facilities should also be provided.

2. Issue guidelines for locating Aanganwadis and setting their timings to correspond to needs of target group.

Proper. planning should be done to locate A WCs more appropriately so that beneficiaries could avail the services under ICDS more easily.

3. Redesign outreach to under-threes and pregnant and lactating women and make provision of Daycare arrangements cum Aanganwadis.

Efforts to increase the outreach of ICDS to pregnant and nursing women and to children below the age of 3 years must be well planned. It must be kept in mind that women are engaged in home-based works, household tasks, and as workers in unorganized sector. ICDS with its wide outreach and high investment does not Provide day .cafe for the hard pressed working mother, nor does it relieve older girls to attend school. Therefore the question of timings of A WCs is crucial for the improvement in outreach. The proposition of converting anganwadies into crèches/day care centres for facilitating the comprehensive coverage of younger children- needs to be emphasized.

4. Revise nutrition programme, distribution system and type of food supplied.

The nutritional Programme of ICDS has several drawbacks: poor quality food, inadequate quantities given at irregular intervals. Such nutritional support is not conducive improvement in nutritional status and needs serious rethinking. Surely it is time to insist that the nutrition component of the ICDS and mid day meal come from local sources, utilizing culturally acceptable foods and be protected from any technological manipulations that the world does not know about as yet. Caution needs to be exercised in giving genetically modified foods.

5. Increase emphasis on neglected components of ICDS package, particularly education.

The emphasis on the immunization and nutritional aspect of ICDS needs to be re examined and equal emphasis should be put on all components of ICDS' package of services.

6. Initiate Convergence of Services at both planning and field levels.

The real target must be all-round improvement in the health/nutritional status o1- mothers and children. It calls for convergence of other supportive services, which include safe drinking water, environmental sanitation, women's empowerment Programme, day-care services, non- torm.11 education and adult literacy. Only when Such convergence is done at the policy level and with meticulous planning then convergence of other services with the ICDS scheme will complement and help in the realization or the dream of child development in India

7. Revamp Status, remuneration .and conditions of work of the Aanganwadi Workers

The AWW is a tremendous resource and we need to prioritize her job responsibilities. Provision should be made to regularize their services like any other para-professional worker.

We can remind the Govt. that it has already committed itself in the New Education Policy of 1986 (chapter on ECCE) to bring child-care workers at par with primary school teachers in the long run, though it has not yet spelt out how long it will take and in what steps this will be achieved. A W\\"s salary must at once be raised and they must get at least minimum wages if not at par with primary school teachers & that should only be a starting point.

8. Revise Training and Evaluation to include critical missing components

Training needs of the ICDS, should be implemented and that will require greater commitment on the part of the government and financial inputs too. The aim of ICDS training is to develop all the functionaries of ICDS into agents of social change. It is strongly recommended that in addition to NIPCCD there must be a variety of models of training at different levels and stages and a diversity of patterns specifying only the approach and a minimum irreducible set of goals.

9. Build in flexibility in management and design of ICDS and include ground principle. of partnership between Government, NGOs and People groups

In addition to NGOs the state needs to encourage Gram-Panchayats, Mahila-Mandals, Business Houses. Trade Unions. Educational Institutions, Parents Groups etc., to make arrangement for childcare services. By opening its doors and getting away from fixed schematic patterns, and by encouraging a variety of models and managerial inputs in the management of crèches and Anganwadi centres, the state will be able to address the issue of child development more comprehensively.

10. Increase overall allocation for Maternity and Early Childhood Care and develop strategies for alternate source of funding

The great -future of ICDS lies in its development from a state financed and implemented intervention into a community-planned) community-administered and community- underwritten Programme but backed by the resources from the state. Trust and flexibility are the two essential factors tl1at contribute to the sustainability of partnership so the partnership should be based on principles of equality and rnutu:\1 appreciation of each other's role. The government may-decide how much funding can be given per child per day or year) and the local body, community structure or NGO could work out a

flexible programme suited to local conditions and needs. Accountability will be both financial and programmatic, to government and to the community and can be ensured by appropriate procedures. Responsibility and even authority if need be, should be fairly shared. The involvement of both partners in formulation of policies. and implementation should be done in a democratic manner and participatory methods should be encouraged in programme planning, implementation, monitoring and evaluation. Funding Resource allocated for ICDS need to be substantially increased. A completely fresh approach to the issue of resources for ICDS scheme will have to be adopted. The question of increased resources for childcare will have to be faced if ICDS goals and objectives are to be accomplished. A minimum annual amount calculated as a fixed share of, the GNP , for childcare services, will have to be allocated keeping in mind tha~ the children below the age of 6 years constitute 18% of the population. Our estimates show that a daycare provision with hearth and development inputs (including the salary of the childcare worker), requires Rs. 151- per day per child at current prices and current inflation levels.

A National Children's Fund need to be setup which can receive :

- public contributions through tax exempt donations,
- imposing a cess for child care, # industry based contributions,
- permitting fees and charges at local levels that are at present not allowed to agencies receiving grants from government schemes,
- #Contribution by communities to daycare arrangements in material, financial and management terms.(Communities can contribute in these ways but this must not be equated with total self reliance)
- # convergence of funds from all development programmes. All existing schemes will have to be scrutinized to find out what can be released for childcare.

11. Universalize ICDS and coincide it with removal of identified shortcomings.

Any attempt of universalization of ICDS will require a serious step to eradicate the shortcomings within the Programme and ensuring more effective and efficient implementation of the existing services to maximize the outreach and impact of ICDS. Only when the convergence of other services with ICDS is done at the policy level and with meticulous planning can the convergence of other services with the ICDS scheme develop at the program level.

RESEARCHER TABULATION FORMAT

Instructions

1. Please encircle the correct response
2. Be specific wherever possible
3. Where necessary, please elaborate

Organization : ..... Chief Functionary : .....
Place : ..... Date : .....

1. Target Community

a. Are you working with an identified target group, in Villages / Slums based on previous study / survey ?

i. Target Population

Population..... Household .....

Children ..... Special Focus Group .....

ii. Target : Villages..... Hamlets ..... Slums .....

b. How often does your team meet the target group

Daily ☐ Weekly ☐ Monthly ☐

c. What are the priority diseases affecting children

Age Group	Diseases	Evidence	Remarks
0 – 2 Years			
3 – 6 Years			
7 – 14 Years			

2. Health Care

a. What are the **health related activities** you are doing ? What are the problems and successes ?

Activity	Success	Evidence	Problems	Remarks
i. MCH (Mother and Child Health) Sex selective abortion prevented No. of Safe Deliveries Neo – Natal care U – 2 Care Crèches Anganwadis Other Programmes 3 – 6 Care Anganwadis Other Programmes				

Activity	Success	Evidence	Problems	Remarks
ii. Nutritional Supplementation Anganwadi Kitchen Garden Public Distribution System Others				
iii. Curative Care and referrals (Frequency Code : D – Daily, W – Weekly, M – Monthly, O – Occasionally) Camp Clinic School checkup VHW Care Traditional Practitioner Care Referral Fund Transport Linkage				
iv. Health Education School Child – to – child Mother's Group Community Groups Community Leaders Other groups				
v. Special Programmes Differently abled Others				

b. Health Supportive Activities

Activity	Success	Evidence	Problems	Remarks
i. Safe Water Chlorination Borewells Piped water				
ii. Sanitation Latrines Soap Pits Compost Pits Clean Surroundings				
iii. Village Health Workers				

Health Workers Volunteers Dais Traditional Practitioners RMPs				
iv. Health Watch Health information Monitoring Govt. Services				
v. Others				

3. Trainings

Group	Subject	Duration	Resource Person	Outcome	Remarks
a. Community Child Leaders VHWs Dais T. P.s RMPs Local Leaders Govt. ANMs Others					
b. Project Team Health Staff Core Team Leader Others		—			

4. Health Resources

Resource	Activities	Outcome	Evidence	Problems / Remarks
a. Government Sub centre P H C I C D S Centre Others				
b. Private MBBS Doctor RMP				

T P Others				

5. Community Involvement / Community Structures / Networking

Resource	Activities	Outcome	Evidence	Problems / Remarks
Children's groups				
Parent's groups				
People's groups				
Panchayat Committees				
Campaign Coalition				

6. Budget

Head	*Amount*	*Local Contribution*	*CRY Contribution*	*Remarks*
Programme				
Trainings				
Salaries				
Administration				

7. Future health priorities

Priorities	Reasons	Possible interventions	Support Required				Remarks
			Local	Govt.	Corpo rate	CRY	

8. Health Forecast

Areas	Short Term (5 Years)	Medium Term (10 Years)	Remarks

9. Partner / Community Profile

Areas	Proj. Holder	Core Team	Health Team	Comm. Leaders	Comm. Groups	Children Groups
a. Basic Qualification						
b. Attitude c. Knowledge d. Skills • Communication • Leadership • Team Work • Health Care • Team work • Others e. Systems & Structures • Delegation • Transparency • Accountability • Others						