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REVIEW OF UNDER-FIVE CHILDREN'S HEALTH POLICIES AND PROGRAMMES IN INDIA WITH REFERENCE TO TRIBAL POPULATION

Prashant Kulkarni* and Anjali Kurane**

Abstract: The Sustainable Development Goal set by United Nations aims to reduce under-5 mortality to at least as low as 25 per 1,000 live births.Under-five children, not only constitute a large group but they are also vulnerable or high-risk group in India. UNICEF mentions that the largest proportion of child death reported,was in South Asia and India accounts for a quarter of them. Belongingness to tribal community adds burden to this vulnerability. The tribal children have 19 percent higher risk of dying in neonatal period and 45% higher risk in post-neonatal period as compared to other social classes. The government of India strive to put front the agenda of child survival and carved out special plan for vulnerable groups (MOHFW, 2014). The present paper attempts to provide context by understanding the development of the policies and programmes in India targeting under-five children's health with special focus on tribal population. It uses content analysis for existing policies, programmes and relevant studies conducted for under-five children. The results indicated historical development of policies formulated for children from 1974 when the first policy for children was formed. Since then various attempts made to improve health condition of under-five children. Recently, the focus of the health programmes has shifted from treating single illness condition to integrated management of diseases. The existing policies and programmes indicates shift from institute based to home based care. In spite of these attempts, there is a need to have in-built implementation research as a part of health system, which would provide insights to understand the efficacy of the programme.

Keywords: Under-five children, Tribal, Public Policy, National Health Programmes, India

INTRODUCTION

The number of under-five deaths worldwide has declined from 12.7 million in 1990 to 5.9 million in 2015("WHO | World Health Organization," n.d.). Pneumonia and diarrhoeal diseases are the leading causes of death reported among U5 children worldwide. The largest proportion of child death was reported in South Asia and India accounted for a quarter of them (UNICEF, 2007). In order to reduce the mortality and morbidity, WHO (World Health Organization) and UNICEF (United Nations Children's Fund) have developed Integrated

Management of Childhood Illnesses (IMCI) strategy. IMCI is a multi-phase integrated approach rather than focusing on single medical condition. The strategy focuses on wellbeing on the child and aims to reduce death, illness, disability and to promote growth and development among children of under-five age. The strategy works along with 3 components which are case management skills of healthcare staff, health system and family and community care practices ("WHO | Integrated

* Research Fellow, Department of Anthropology, Savitribai Phule Pune University, Pune, India, E-mail: prashant1505@gmail.com

** Professor, Department of Anthropology, Savitribai Phule Pune University, Pune, India. E-mail: anjali@unipune.ac.in

Management of Childhood Illness (IMCI)," n.d.). The iCCM (Integrated Community Case Management) plan suggests that correct treatment of childhood pneumonia, diarrhoea and malaria is one of the most powerful interventions to reduce mortality ("WHO | Integrated community case management of malaria," n.d.).

SITUATION IN INDIA

The under-five mortality reported to be 39.4 per thousand live births. ("India (IND) - Demographics, Health & Infant Mortality," n.d.).The leading causes of death reported were due to infectious, neonatal and nutritional conditions("WHO | India," n.d.). The government of India strive to put forth the agenda of child survival and development in order to overall development of the society(MOHFW, 2014). As per Census 2011, the share of children (0-6 years) accounts 13% of the total population in the Country. 81% of under-five child morality takes place within one year of the birth which accounts nearly 10.5 lakh infant deaths whereas 57% of under-five death takes place within first one month of life, which accounts 7.3 lakh neo-natal deaths every year in the Country("Child Health & Immunization - Governnment of India," n.d.).

As per WHO 2012 estimates, the causes of Child Mortality in the age group 0-5 years in India are: (a) Neonatal causes (53%), (b) Pneumonia (15%), (c) Diarrhoeal disease (12%), (d) Measles (3%), (e) Injuries (3%) and (f) Others (14%). The state wise scenario shows that Kerala (16) state has lowest mortality whereas Uttar Pradesh (96) has high proportion of under-five child death followed by Madhya Pradesh and Jharkhand. Maharashtra falls in-between with 47 deaths per 1000 children (Region, 1995). Mortality due to pneumonia accounts for approximately one-fourth of the total deaths or 22%, among under-five children in India (Mathew et al., 2011). Many of these deaths could be averted if parents recognized warning signs, undertook appropriate feeding practices or had access to skilled health workers and facility-based care (UNICEF, 2007).

Various studies focused on understanding social determinants of under-five children's health which were closely associated with health seeking behaviour, antenatal care, delivery practices and postnatal care of infants (Ghosh, 2012). A study conducted by UNICEF-PHFI suggests significant gap in utilization of existing services, provider practices as well as family practices in seeking care (Mathew et al., 2011). Few studies also stated need of developing new strategies for health education based on indigenous concerns, addressing socio-cultural barriers (Ghosh, 2012;Gilmore and McAuliffe, 2013).

Diarrhoea accounts for 14% of the total deaths in under-five children in India. ORS and zinc is the mainstay of management during an episode of childhood diarrhoea but have low coverage in India. An impact assessment study of workshop conducted for peripheral health workers to understand zinc and its role in managing diarrhoea indicates that lack of awareness and training were the two main reasons for not using zinc supplement during diarrhoea(Singh, Thakur, Chavan, Patil, & Chaturvedi, 2014).

ARI causes about 20% of all deaths in pre-school children worldwide, with 90% of these deaths being due to pneumonia (Ansari, Khan, Khalique, & Siddiqui, 2008). Risk factors for severe ARI include malnutrition, low birth weight, passive smoking,

non-breastfeeding, low socio-economic status, overcrowding, immunodeficiency and HIV infection, and consequently, most of the morbidity associated with ARI is found in the developing world. Children are especially at risk of getting ARI because of their constant contact with other kids who could be virus carriers. Children often do not wash their hands regularly, rub their eyes, and put their fingers in their mouths, resulting in the spread of viruses("Acute Respiratory Infection," n.d.).

SITUATION IN TRIBAL AREAS OF INDIA

The Millennium Development Goal (MDG)-4 targets minimizing under-five mortality to 39 per 1000 live births by 2015 in India. Child morbidity and mortality under-five years of age in the tribal area is one of the major challenges in reaching this goal (Sahu et al., 2015)(Swaminathan, 2014). Diarrheal diseases and acute respiratory infections are the leading cause of morbidity and deaths among under-five year tribal children. The literature suggests that the tribal children have 19 percent higher risk of dying in neonatal period and 45% higher risk in post-neonatal period as compared to other social classes (Sahu et al., 2015). A community based cross-sectional study was carried out in tribal areas of India where nutritional status of 14587 children between 0-5 year age was assessed. The results showed declined prevalence of under nutrition and stunting but wasting remained similar. The factors reported as causes were literacy status of mother, household wealth index and morbidities (Meshram et al., 2012). Melghat area in the State remains in the limelight for under-five child deaths and under-nutrition("Melghat," 2009)(Datta & Mail, 2013)*. ShibshekharDatta conducted a study in Melghat region to understand the determinants of child health. Improper childrearing practices, poor diet intake by pregnant women, early marriages, poor spacing of children, lack of health education and awareness, adequate income and purchasing power etc. were the determinants identified by the study influencing child health situation(Datta & Mail, 2013). Most of the studies on children in tribal areas focus on malnutrition but very few studies focus on the health system problems focusing on particular illnesses (Chirmulay & Nisal, 1993)(Das & Bose, 2015)(Debnath & Bhattacharjee, 2014)("Melghat," 2009).

Indian government has taken various measures to combat the problem of child mortality by implementing various policies and programmes. It becomes necessary to document the process of formation, implementation and status of outcome from these efforts. Hence, the study looks at historical development of child health policies and programmes.

The current paper focuses on documenting the process of development of these policies and programmes by content analysis of the relevant documents. The focus of the content analysis is on identifying the extent to which the general approach and the key areas of the policy document fit with the aim of wellbeing of children under five years.

METHODOLOGY

Design. Narrative review and synthesis.

Data sources. Key seminal texts and papers from policy documents, and studies, which looked at health care of under-five children. Search sources included internet

based primary policy documents, national health programmes, project implementation reports and other relevant documents covering the period from 1974 until2014.

REVIEW METHODS-

We conducted a review of India-specific, health policy, programmes and systems-relevant documents produced between 1974 and 2014. The year 1974 marked the beginning of formulation of national policy concerning the needs and rights of children. The review involved five steps, which that include identification of the research question; identification of relevant documents; screening and selection of the documents; collating, summarising and reporting results. We presented the review findings as numerical analyses of the volume and nature of documents and trends over time in the form of descriptive analysis.

TABLE 1: DOCUMENTS REVIEWED

S.N.	*Title*	*Type of document*	*Year of implementation*	*Source*
1.	National Policy for Children	Policy	22nd August, 1974	Childline India
2.	Universal Immunization Programme	Programme	1978	National Health Portal
3.	Promotion and adoption of International Year of the Child (IYC), 1979	Strategy	9th January 1979	Proclamation by United Nations
4.	National Nutrition Policy	Policy	1993	Department of Women and Child Development, Government of India
5.	National Health Policy	Policy	2002	Ministry of Health & Family Welfare
6.	Reproductive and Child Health (RCH) Programme	Programme	1997 & 2002	Ministry of Health & Family Welfare
7.	National Charter for Children	Strategy	23 July, 2003	Government of India
8.	National Plan of Action for Children	Action Plan	2005	Ministry of Health & Family Welfare
9.	National Policy for Children	Policy	2013	National Health Portal
10.	National Early Childhood Care & Education (ECCE)	Policy	2013	Women & Child Development
11.	Rashtriya Bal Swasthya Karyakram	Programme	2013	National Health Portal
12.	India Newborn Action Plan (INAP)	Policy	2014	National Health Portal

RESULTS AND DISCUSSION

Declaring its children as the nation's "supremely important asset" in the National Policy for Children, 1974, the Government of India reiterated its commitment to secure the rights of its children by ratifying related international conventions and treaties. The policy gives utmost priority to right to life, health and nutrition and gives importance to development, education, protection and participation. To address the issue of morbidity and mortality in under-five children, government of India has carved out various national health programmes.

Several significant steps have taken to implement the NPC 1974. These include implementation of the ICDS programme since 1975 to address the need for early childhood care; implementation of the immunization programme since 1978 as an essential intervention to protect children from life-threatening diseases that are avertable; and the adoption of the Child Labour (Prohibition and Regulation) Act since 1986. National action plans were revised in 1979, 1992 and 2005.

The Integrated Child Development Services (ICDS) programme launched in the year 1975 aiming to early childhood care and development. ICDS programme is flagship programme of government of India, which targets health of 0-6 years or pre-school children. The emphasis of ICDS is to improve the nutritional and health status of pre-school children, which included laying foundation of proper psychological development of the child, reduction in incidence of mortality, morbidity, and malnutrition and school dropout. In addition, the programme also enhances capability of mother to look after normal health nutritional needs of child through proper nutrition and health education("ICDS," n.d.)(Kishore, 2007). The RCH programme targeted on maternal health, child health, immunization, family planning, adolescent health and PC-PNDT. The main aim of the RCH programme was to reduce infant, child and maternal mortality rates by improving implementation and management of policy by using participatory approach as well as improving quality, coverage and effectiveness of services. In 2007 a Joint Review Mission (JRM), under the Ministry of Health and Family Welfare, reviewed the progress of RCH-II and found with a number of key concern areas. The JRM found that child health was being limited to immunization and other aspects werenot been considered. The other concerns reported were with regard to implementation of guidelines and requirement of additional training to the health staff. The National Population Policy (NPP) 2000, the National Health Policy 2002 and the Eleventh Five Year Plan (2007-12) and National Rural Health Mission (NRHM - 2005 – 2012) have set the standard specific goals for child health(*http://mohfw.nic.in/np2002.htm*, n.d.).

The National Plan of Action for Children, 2005 is by far the most comprehensive planning document concerning children. Its value is that it clearly outlines goals, objectives, and strategies to achieve the objectives outlined and recognises the needs of all children up to the age of eighteen. It has mentioned underserved population

and weaker section of the society as a priority. Further, Twelfth Five Year plan (2012-2017) and National Health Mission (NHM) laid down the Goal to Reduce Infant Mortality Rate (IMR) to 25 per 1000 live births by 2017("Child Health & Immunization - Government of India," n.d.). Thrust areas to work towards child health include targeting on neonatal health, nutrition, management of common childhood illnesses and immunization. The neonatal health includes newborn care, facility based sick newborn care and home based care whereas nutrition focuses on promotion of feeding practices, micronutrient supply and management of children with severe acute malnutrition ("Child Health & Immunization - Governnment of India," n.d.).

Government of India has launched Integrated Disease Surveillance Project (2004-09) with the objectives of establish a decentralized state based system of surveillance for communicable and non-communicable diseases and to improve efficiency of existing surveillance activities of disease control. Its major emphasis was on identifying and responding to disease outbreaks quickly("Integrated Disease Surveillance Programme (IDSP)," n.d.).

On 18thApril, 2013 the Union Cabinet approved the National Policy for Children to help in the implementation of programmes and schemes for children all over the country. It reflects a paradigm shift from a "need-based" to a "rights-based" approach.Further, India Newborn Action Plan in 2014 which targets to reduce death of newborn and preventable still births to single digit by 2035(MOHFW, 2014). The plan also envisages strengthening surveillance mechanism in order to reduce the child death proportion to single digit by year 2035. The research priorities in the plan includes scaling up simplified newborn recovery; Identifying barriers to exclusive breastfeeding; Operationalizing KMC (Kangaru Mother Care) at both the facility and community level; and simplified antibiotic regimen for management of neonatal sepsis. In an effort to address high neonatal death rates, along with stagnating IMR and under-five mortality, the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) program was started implementing in India, which was adopted from IMCI, which has been implemented worldwide with additional focus on neonatal children. The IMNCI program aims to improve child survival rates by extending the interventions/services in homes, communities, and the health care system. IMNCI will focus specifically on the management of acute respiratory infections (ARI), diarrhoea, measles, malaria and malnutrition, which are the main causes of childhood deaths in India(Mohan et al., 2011)India is unlikely to achieve the Millennium Development Goal on child survival. Integrated Management of Neonatal and Childhood Illness (IMNCI.

Facility Based Newborn Care (FBNC) is one of the keycomponents under the National Rural Health Mission toimprove the status of newborn health in the country. Home based and facility based newborn carecomponents ensures that every newborn receives essentialcare right from the time of birth and first 48 hours at

thehealth facility and then at home during the first 42 days of life. Newborn Care Corners (NBCCs) have established atdelivery points to provide essential newborn care, whileSpecial Newborn Care Units (SNCUs) and NewbornStabilization Units (NBSUs) provide care for sicknewborn.

Home based newborn care strategy is been implemented since 2011 for reduction of neonatal mortality in the first month of life in rural areas. ASHAs [Accredited Social Health Activist]were given a prime role in providing care under this strategy.

In order to combat the severe malnutrition problem among under-five children, Nutritional Rehabilitation Centreshave started at district level. These are facility-based units providing medical and nutritional care to SevereAcute Malnutrition (SAM) children under 5 years ofage who have medical complications. In addition, specialfocus is on improving the skills of mothers on childcare and feeding practices so that child continues to receiveadequate care at home.("Role of NRCs (Nutrition Rehabilitation centre) in preventing malnutrition related deaths among under 5 children in Odisha," 2015)incorrect feeding","URL":"https://iphindia.org/role-of-nrcs-nutrition-rehabilitation-centre-in-preventing-malnutrition-related-deaths-among-under-5-children-in-odisha/","title-short":"Role of NRCs (Nutrition Rehabilitation centre

Recently, RashtriyaBalSwasthyaKaryakram (RBSK) has been launched since February 2013 to provide Child Health Screening and Early Intervention Services through early detection and management of 4 D's i.e. Defects at births, Diseases, Deficiencies, Development Delays including disability. The programme covers 30 common health conditions for early detection, free treatment and management. ("Guidelines_RBSK | NHM," n.d.)

RNTCP, NACP and RCH have developed tribal action plan to reduce morbidity and mortality among tribal population. Tribal Action Plan developed by RCH-II promotes approaches by involving the community in the planning process and in the management and implementation of various programs; using Community Based Workers as social mobilizer, educator and provider of non-clinical services; involvement of local elected bodies including Tribal boards; and promotion of tribal system of medicine, and involvement of tribal healers.("VULUNERABLE COMMUNITIES MODIFIED," N.d.).

CONCLUSION

There are identified determinants, which are making influence on improvement of status of health of under-five children. On the other hand, various policies have been adapted to reduce proportion of child mortality. The focus is now been shifted from health system to home based care with care provided by community workers. It would help in early diagnosis as well as prompt treatment of minor illnesses and

early referrals. Additionally, the focus of the health programmes has shifted from treating single illness condition to integrated management of diseases. There is a need to assess burden, training need and quality of service delivery by health workers at grassroot level considering the large number of intervention strategies expected to implement by them. In context of tribal population despite several policies and program provisioning, the accessibility, availability, affordability and community childcare practices and strengthened implementationremain a challenge to the Indian health care system. In order to strengthen the health system and internal evaluation of the activities for their efficacy, the implementation research has to integrate as a part of policy and programme implementation.

Notes

1. 45,000 children die of malnutrition every year in Maharashtra | News Scan | Children [WWW Document], n.d. URL http://infochangeindia.org/children/news-scan/45000-children-die-of-malnutrition-every-year-in-maharashtra.html (accessed 10.3.15)

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