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FUNCTIONING OF GOVERNMENT AND NGO-RUN ANGANWADI CENTRES IN DELHI: A COMPARATIVE STUDY

Abhiman Chauhan[1], V. K. Tiwari[2], Sherin Raj[3], P. D. Kulkarni[4], K. S. Nair[5] and Ramesh Gandotra[6]

ABSTRACT

The introduction of public-private partnership in running the Anganwadi Centers (AWCs) in under-privileged areas is an innovative step by the Ministry of Women and Child Development, Government of India. However, success of such an initiative affected by several factors need to be studied for further strengthening the programme. The present study attempts to compare the functioning of government and privately-managed AWCs in the slum areas in Delhi. The study found that AWC run by the NGO had better qualified, trained, knowledgeable and pro-active workers with flexibility in approach; and their performance was also better as compared to their counterparts in the government-run AWC. The only constraint was lack of coordination from local government health functionary and absence of supervisory mechanism for the NGO-run AWC. The study also found that given a level playing field, the NGO run AWC may outperform the government-run AWC. The detailed cost benefit analysis and coverage of services has been major limitation of the study. The study recommends further expansion of NGO run AWCs in the country.

Key words: AWC, AWW, CDPO, ICDS, MUAC, Non-Formal Pre-School Education.

In pursuance of the national policy for the children, several schemes are implemented for the welfare of children, and one of them is Integrated Child Development Scheme (ICDS). ICD scheme was launched on 2nd October 1975[1]. Initially, the scheme was launched on experimental basis in 33 project (19 in rural, 10 in tribal and 4 in urban areas), which were spread over 22 States and the UT of Delhi. Encouraged by its success, the scheme has been expanded to 6120 projects in 2009 and 7025 in 2013[2].

The ICDS was evolved to make coordinated efforts for an integrated programme of delivery of a package of services. Package of services was meant for the early childhood pregnancy and lactating women which

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A STUDY ON THE CONTENT OF ANC SERVICES PROVIDED BY THE SUB-DISTRICT LEVEL HOSPITALS OR THEIR EQUIVALENTS AND THE PERIPHERAL HEALTH FACILITIES IN A SELECTED DISTRICT OF DELHI

Shalini Kelkar[1] and K. Kalaivani[2]

ABSTRACT

The aim of this study was to assess the content of the ante-natal services provided by the sub-district level hospitals or their equivalents and by the peripheral health facilities in Delhi; whether the content matched the norms; and what were the deficiencies or gaps in the operating system of these health facilities. The content of ante-natal care services provided to 247 new cases of pregnancy in the above-mentioned health facilities was observed. ANC records of 276 women delivered in the sub-district hospital (or its equivalent) during January 2012 to December 2012 were studied for the details of the content of ante-natal care provided to these cases w.r.t. history, examination, investigations advised and/or done and ante-natal management of these cases. All the health facilities had the written guidelines given by the Government of India for provision of ANC services. There was adequate trained manpower available for provision of ante-natal care services in all the health facilities and there was no deficiency of both consumables as well as equipment in all the health facilities. Lack of supervision was noticed in all the health facilities. Many of the services were not being effectively delivered e.g. weight not being measured, proper history not being taken, laboratory investigations not being done, etc. There was lack of utilization of the consumables and equipment available for provision of ante-natal care services. The sub-district hospital or its equivalent was overloaded with normal cases of pregnancy which should otherwise be managed by the peripheral health facilities. No per-abdominal examination was being performed at any of the dispensaries. In none of the health facilities, anaemia treatment was being done as per the guidelines. Proper referral mechanism was not functional- the health facilities referring the ante-natal cases to the sub-district hospital for management at the time of delivery or complication were not sending the ante-natal details of cases which could play a crucial role at the time of management.

Key words: Ante-natal care (ANC), Content, Referral mechanism, SDH (Sub-district hospital), PUHC (Primary Urban Health Centre), Maternity Homes.

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A STUDY OF ORGANIZATIONAL STRUCTURE AND FUNCTIONING OF CHACHA NEHRU SEHAT YOJNA (CNSY) IN GOVERNMENT SCHOOLS OF A SELECTED DISTRICT IN DELHI

Prakash Jha[1] and A. K. Sood[2]

ABSTRACT

Providing efficient school health services to all the government school children of the State of Delhi is a enormous challenge. The present article looks at the matter from the provider's end, highlights the structural, organizational features and functioning of Chacha Nehru Sehat Yojna in government schools of West-A district in Delhi and tries to come out with some suggestions for its improvement. The organizational structure in West-A district was according to CNSY guidelines but no separate post for district In-charge was sanctioned. The coverage of CNSY was also very poor and only 50% of government schools were covered during 2013-2014.There is a need for better coordination between health and education department and clearly defining their roles to implement this scheme in the district. There was no adequate mechanism of transport for referral of students or follow-up cases which needs urgent attention to improve the CNSY services. Proper documentation of CNSY health records and timely dissemination of reports to concerned stakeholders are also equally important and need improvement.

Key words: Chacha Nehru Sehat Yojna (CNSY), School Health Programme, National Rural Health Mission, Government Schools.

India's school age population, aged between 5 and 14 years, currently stands at 192 million[1] and is growing. To achieve the Millennium Development Goal (MDG) of universal primary education and health, this population is of utmost importance.

WHO's Global School Health Initiative, launched in 1995 guided by the Ottawa Charter for Health Promotion (1986) emphasized on health promotion and education activities at the local, national, regional and global levels to improve the health of students, school personnel, families and other members of the community through schools. Bhore Committee (1946) emphasized on health education and environment hygiene in schools[3].

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DESIRE TO TERMINATE FERTILITY IN MADHYA PRADESH

Jogindar Singh Chauhan[1]

ABSTRACT

This paper is an attempt to study the differentials in desire for no more children and determinants by the women's background characteristics and by using data from the National Family Health Survey-III, conducted during 2005-06 for Madhya Pradesh. Data from the Sample Registration System of different years are also used for this study. Both bivariate and multivariate analyses have been used in the present study. The various independent variables such as Place of Residence, Caste, Religion, Women Educational level, Work status of women, Wealth index, Age at first marriage, Experience infant death and Media Exposure are used in this study. Percent not desiring another child naturally increases with increasing number of living children. This is 34 per cent, 90 per cent, 97 per cent for those with one, two and third and above living children in urban areas, the pattern is similar in rural areas but the levels are lower 30 per cent, 83 per cent, and 93 percent respectively. With increasing level of education desire for no more children increases. By age at first marriage, desire for no more children increased with increasing age at marriage. The differentials are wide for women with one living child but narrower among those with two or more living children. The logistic regression analysis indicates that Caste, Religion, Women Educational level, Wealth index, Work status of women Age at first marriage, Experience of infant death and Media Exposure are major determining factors for not desiring another child in Madhya Pradesh.

Kew words: Differentials, Determinants, Desire fertility, Terminate fertility, Madhya Pradesh.

In recent decades, remarkable change has been observed in society, polity, and economy of India. India's economic development and society changed in many ways. Soon after independence, India experienced high population growth. To control population growth, India became the first nation to officially announce family planning programme in 1952. Despite this programme being in operation for more than half a century, India's population growth is continuing though the pace has slowed down in the last few decades. Fertility has been declining with varying times of onset and rate from one state to another beginning with the state of Kerala

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PROGRESS AND CONSTRAINTS OF REPRODUCTIVE HEALTH IN INDIA AT SUB-NATIONAL LEVEL: AN EXPLORATORY STUDY

Gargi Bhattacharya[1] and Sushil K. Haldar[2]

ABSTRACT

This study tries to evaluate the status of reproductive health (RH) comprising five selected parameters across 15 major states of India over five time points using the National Family Health Survey (NFHS) and District Level Household Facility Survey data. There exists wide range of inter-state variations of RH status. The trend of inequality of RH Index is found to be declining but parameter specific inequality is quite mixed. The determinants of RH parameters across states are examined in panel data regression incorporating both demand and supply side factors. Female literacy, female labour force participation rate and per capita social sector expenditure appear to be significant in most of the regressions of RH parameters; in some cases poverty and health infrastructural gap are revealed to be appeared significant. Achievements of Millennium Development Goals (MDGs) in respect of RH and 'Health for All' programme have been a distant dream in India.

Key words: Reproductive Health, Achievement Index, Health Infrastructure, Reproductive Health Inequality, Demographic Dividend.

The 2010 United Nations Summit on the Millennium Development Goals (MDGs) concluded with the adoption of a global action plan to achieve the eight anti-poverty goals by their 2015 target date and the announcement of major new commitments for women's and children's health and other initiatives against poverty, hunger and disease[1]. The outcome document of the three-day Summit sets out a concrete action agenda for achieving the Goals by 2015. The Global Strategy for Women's and Children's Health initiated by United Nations has the potential of saving the lives of more than 16 million women and children, preventing 33 million unwanted pregnancies, protecting 120 million children from pneumonia and 88 million children from stunting due to malnutrition, advancing the control

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UTILIZATION OF THE PHC AND SUB-CENTRE BY THE COMMUNITY IN A RURAL AREA NEAR BANGALORE, INDIA

Chandana Krishna[1] and N. R. Ramesh Masthi[2]

ABSTRACT

In public sector, the Primary Health Centre (PHC) is the cornerstone of rural health services while the Sub-Centre (SC) is the most peripheral and first point of contact between the primary health care system and the community. To find out the utilization of PHC and SC by the women in study area; and to describe the availability of infrastructure and services provided in the PHC and SC; this descriptive study was done over a period of 6 months during April-September 2014 in the rural field practice area of a medical college near Bangalore. The study subjects were resident mothers of the area and Junior Health Assistant Female (JHAF). 200 mothers were interviewed. The findings show that 85 (85%) had heard about PHC and 72 (72%) had heard about SC. Among them, 72 (84.7%) and 59 (81.9%) of the subjects had utilized the PHC and SC. Utilization of PHC was mainly for OPD (76.4%), MCH services (93.1%) and family planning (12.7%). Utilization of SC was mainly for OPD (57.6%) and MCH services (98.3%). 27% of the respondents had informed that the JHAF had visited their homes and majority of visits were made once a month. 95.8% and 44% were satisfied with the services provided by the PHC and SC. 67% 81.9% and 50 % of the PHC and SC had own building. Utilization of the PHC was high and sub-centre utilization was low.

Key words: PHC, Sub-centre, Mothers, JHAF, OPD, Health services.

The Bhore Committee in 1946 gave the concept of Primary Health Centre (PHC) as a basic health unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The health planners in India have visualized the PHC and its Sub-Centres (SCs) as the proper infrastructure to provide health services to the rural population. Primary Health Centre is the foundation of rural health services, a first port of call to a qualified doctor for the sick for curative, preventive and promotive health care[1]. The Primary Health Care Infrastructure has been developed as a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of

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