International Journal of Scientific Research and Engineering Development-– Volume 3 Issue 6, Nov-Dec 2020
Available at www.ijsred.com

RESEARCH ARTICLE OPEN ACCESS

Addressing Child Health Through Poverty Alleviation Programmes in India

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Abstract:

Poverty leads to limited or no access to services like good health and education and leaves an individual socially marginalized. The Government of India has launched many such programmes aiming at reducing poverty and achieving economic stability with sustainable development. This article highlights the various poverty alleviation programmes in India and how they have been an instrument of change for the Child health in the country. The poverty alleviation programs have a direct impact on the health of child by improving nutrition, physical and mental growth and decreasing morbidity and mortality in both child and mother. Therefore, an evidence-based policy making is needed withcommunity-based monitoring to increase transparency and accountability in decisions regarding their health, education and economic development.

Key Words: Child Health, Poverty alleviation, Public Distribution System, Mid-Day Meal, Janani Swasthya Yojana

I. INTRODUCTION

Poverty is a complex phenomenon. Mostly talked about in economic terms, is an amalgamation of the social and economic factors. The social dimension is often ignored when poverty is considered but it is social marginalization of the poor leading to inequality. Being poor implies to limited or no access to other services like good health, education and social status. Thus, poverty eradication has been one of the Millennium Development Goals and now also forms part of the Sustainable Development Goals. The poorest 40% of world population account for 5% of global income while the richest 20% account for 75% of world income as per UNDP (Kumari L, 2013). According to the estimates of Food and Agricultural Organization of United Nations, the number of hungry people worldwide is approximately 15% of the world population. In 2005, The World Bank estimated 41.6% of total Indian population living under International Poverty line of US $1.25 per day (PPP), (Sreedhar M, 2015). The Planning Commission in India estimated poverty in 2004-05 as 28.3% of rural and 25.7% of urban population BPL that is 27.5% of total population.

Since the time of planning in India, economic stability has been focused upon and many programmes to generate employment and sustainable development of the population have been implemented. The Poverty Alleviation Programs have been classified under programs for self-employment, wage employment, food security, social security and urban poverty alleviation programmes. The Prime Minister's Rozgar Yojana, Rural employment Generation Program and Swarna Jayanti Shahri Rozgar Yojana launched in 1993, 1995 and 1997 respectively, focused on generation of self-employment opportunities. National Social Assistance Program launched in 1995-96 included the components of National Family Benefit Scheme, National Old Age Pension Scheme (along with Annapurna Scheme for elderly) and National Maternity Benefit Scheme. While the Indira Awas Yojana launched in 2000 focused on construction of houses, the Pradhan Mantri Gramodaya Yojana (2000) envisages for selected basic services such as primary health, primary education, rural shelter, rural drinking

water, nutrition and rural electrification. Also, in year 2000, Antyodaya Anna Yojana was launched to provide highly subsidized food grains under Targeted Public Distribution System (TPDS). Valmiki Ambedkar Awas Yojana (2001) facilitated healthy and enabling urban environment through community toilets construction. The National Food for Work Programme was launched in 2004 to intensify the generation of supplementary wage employment and centrally sponsored scheme.

Through the Public Distribution System, the poor people are provided cheaper food grains through fair price shops so as to assure food security to them. Almost 3% of government budget was spent on this scheme. The Mid Day Meal Scheme was started to provide free meals to school children while in 1975 the Integrated Child Development Scheme with a focus on mother and child below 6 years of age was started. MGNREGA started in 2006-07 and extended to cover the whole country during the 11th Plan (Shreedar M, 2015). Another program called Urban Basic Services for Poor launched in 296 cities of India focused on the community participation for health, nutrition, water and sanitation components and also on immunization coverage and utilization of antenatal care in urban poor (Yesudian CAK, 2007).

Children form a vulnerable population and are directly or indirectly impacted by poverty. The poor children are denied the basic right to health and development as poverty results in loss of fair chance in life. The burden of ill health is greatest among the poor children, they are malnourished and poverty adversely affects their growth and psychological development. "Poverty multiplies the risk that children will die before their 5th birthday" (WHO/World Bank Report). In year 2000, malnutrition was responsible for 60% of all childhood deaths. Also, micronutrient deficiency is on the rise in these children leading to delayed motor development, impaired cognition, and poor school performance, later problems in reproductive health and even lower adult wages and productivity. Unsafe hand and water sanitation practices, use of biomass fuel at home, lack of antenatal care by woman and low weight, lack of breast feeding and nutritional supplementation to child, accompany poverty and lead to halted growth and development of the child (WHO/World Bank Report).

II. PROGRAMMES FOR POVERTY ALLEVIATION

Some of the programs for poverty alleviation have had a direct impact on the health of the children with targeted nutrition and maternal service provision. Programmes including the ICDS, Mid-day meal Scheme, Targeted Public Distribution System, Janani Swasthya Yojana (JSY), Indira Awas Yojana and RahstriyaSwasthyaBima Yojana are a few schemes which have directly benefitted the child health.

Integrated Child development Scheme is focused to provide the nutrition, immunization, ANC of pregnant women, referral services and growth-checkups. It aims at physical and psychosocial development of the child and reduction in morbidity and mortality. It covers 7.6 million pregnant women and lactating mothers and around 36 million children less than six years of age (Kapil U, 2002).

The Mid Day Meal (MDMS) is the world's largest school feeding Programme reaching out to about 12 crore children in over 12.65 lakh schools. Free supply of food grains @ 100 grams per child per school day at Primary and @ 150 grams per child per school day at Upper Primary is provided for government schools. It has increased school enrollment and improved nutritional status.

The JSY has reduced socioeconomic disparities in maternal care. Women are encouraged to avail free post and prenatal care in public facilities and are paid cash benefits ranging from Rs 600-1400, counselling of breast feeding and spacing of children. The ASHA get Rs 200 for registering the woman for institutional delivery (Ravi S and Singh R, 2016). The benefits are given to a woman over 19 years of age, not more than 2 children and there is difference between the low and high performing states (Gopalan SS and Varatharajan D, 2012). There has been decrease in maternal mortality and morbidity

and increase in institutional delivery by 42.6% after the scheme (Gupta SK, 2012).

The PDS distributes the wheat, rice and coarse grain to the poorest of the poor at lowest prices. Adopted in 1997, it aimed at increased affordability of food and a minimum support price to the producers. This was aimed at all age groups especially female as underweight females lead to low weight babies. The scheme adds to country's food security.

With the advent of these programs and special focus on mother and child health, the NFHS indicators, 2015-16 show improvement over 2005-06. Where IMR has reduced to 41 from 57 per 1000 live births the U-5 mortality reduced from 74 to 50. The coverage has marginally increased for 1st antenatal care utilization but remains low overall. There is a decline in MMR but still the home deliveries conducted by skilled professionals are less than 5 %. Child immunizations increased to around 60-90%.Children under 5 who are stunted (height-for-age) decreased from 48% to 38.4% and a decrease from 42.5% to 35.8% among children under 5 who are underweight (weight-for-age) while children under 5 who are wasted (weight-for-height) increased from 19.8 to 21%. (NFHS-4).

III. CONCLUSION AND RECOMMENDATIONS

There is still a wide gap in 100% coverage and huge mortality and morbidity burden. The lack of infrastructure and low pay to AWW, budget cuts (nearly 50%), low quality food in recent years along with shortage in maintenance of supply form some basic issues with sound functioning of the ICDS program (Gupta A, 2013). There is also food bias, leakage of supplementary and take-home food, poor targeting and actual implementation (Gragnolati M et al 2006). The MDMS faces issues of low budgetary allocation, poor quality, caste issues, and storage and leakage issues. Targeting the poorest of poor has been difficult for PDS, leakage of grains, fortnightly supply, high operational costs, and no benefits for migrants and other vulnerable groups form major hindrances for success of PDS (Yesudian CAK, 2007). Limited financial resources, low wages to ASHA, high opportunity cost of institutionalization to patients, lack of multi-sectoral coordination and insight, blocks the path for success of JSY (Ravi S and Singh R, 2016).

The poverty alleviation programs have a direct impact on the health of child by improving nutrition, physical and mental growth, high survival rates, low chance of diseases and decreased mortality in both child and mother. As per Offord DR (1999), "Three strategies or types of programs should be in place to improve the life quality of poor children: universal programs that are offered to all children; targeted programs that are only offered to certain children or groups of children; and clinical programs where children and their families can seek help".

The shortcomings of existing ones could be overcome by strengthening the decision-making bodies for ICDS and PDS and accountability to prevent leakage, fortification of food and private partnerships in scaling up the food system. Synergistic approach with intersectoral integration is needed. Increase in government budget and introduction of insurance schemes specific to children with low cost loans and grants is a must. Community participation and formation of self-help groups is important (WHO/World Bank Report). Conditional cash transfer based on immunization and nutritional status of child in high risk population and incapacitated households. Community involvement in the same will increase accountability and transparency (Robertson L, 2014). Evidence based policy making should be the prime focus based on the impact of contextual factors (Wagstaff A, 2004).

Conclusively, the programmes should address the issue in holistic manner catering all socio-economic determinants. Improving the health of children and focusing on holistic development is therefore crucial as children are the future of the world.

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