Child Right's
&
Health

Charter
of
Demands

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Charter of Demands
Children's Health

The Indian child's share in Budget 2007 has been cut by 1.23%, with the Finance Minister Mr. P. Chidambaram reducing the resource allocation for children. Budget has once again neglected its focus on health and protection. In fact, allocation for child health has fallen for the second consecutive year from 0.55% in 2006-07 to 0.48%.

This only proves Government's immediate stand on the issue. We present our memorandum on the same for proper and immediate action in the best interest of children.

Integrated Child Development Services Scheme:

The universalization of Integrated Child Development Services Scheme (ICDS) is urgently required to protect the rights of children under six. Universalization means that the full range of ICDS services should reach every child under six, every pregnant or lactating mother, and every adolescent girl. It also required a radical improvement in the quality of these services. Thus our demand is not universalization but “universalization with quality”.

- To implement immediately the Supreme Court's order on initiating ICDS for every 40 children. In case of lesser children staying in adivasis padas or slums 40 should not be considered as the limit.
- To follow up on the announcement made last year by Shri Harashwardhan Patil – on initiating 1013 ICDS in
- In the process of universalizing ICDS, priority should be given to marginalized communities. In particular, SC/ST hamlets should get priority in the creation of new Anganwadi Centres(AWCs).

- The population norms for placement of AWCs should be revised. The revised norms should ensure that every child under-six is within convenient reach of an AWC.
- The physical infrastructure of AWCs should be racially upgraded. In particular, all AWCs should have their own pacca building, attractively designed and with adequate space. All of them should have basis facilities including storage arrangements, drinking water, cooking utensils,toys child-friendly toilets, etc. AWCs should also receive untied grants for improving the services in response to local requirements.
- Training programmes for AWWs also need radical improvement. They should include special training on child care for children under three, nutrition counseling, and pre-school education.
- Each AWC should have two Anganwadi Workers (AWWs) and one Anganwadi Helper (AWH) at the very least. One Anganwadi Worker should be in charge of looking after children below the age of three – the most vulnerable and neglected age group.
- The concerns and difficulties of Anganwadi Workers, particularly regarding excessive work burden, inadequate and delayed remuneration, and poor working conditions, need to be addressed. Their status as regular skilled salaried workers needs to be established as part of the process of institutionalizing ICDS itself. Anganwadi Helpers must receive the statutory minimum wage at least.
- For children in the age group of 3-6 years, supplementary nutrition should be provided in the form of a cooked, nutritious meal at the AWCs, using locally procured food. For children below the age of three, nutritious take-home rations (THR) based on locally procure food may be provided. Supplementary nutrition should always be combined with extensive nutrition counseling and home-based

interventions for both growth and development, particularly for children under 3. Parents have a right to monitor and suggest about the menu as well as about the quality of the food.

- Wherever required, day care services should be provided. The requisite resources, infrastructure, staff,space, training, etc., should be available for this purpose. The timings of Anganwadi Centres should be sensitive to the needs of working mothers.
- The process of “community participation” in ICDS needs to be defined and planned, and should involve all sections of the population.
- Special provisions should be made for differently-abled children. Also, surveys of children under six conducted by AWWs should include a survey of children with special needs.
- Special provisions should also be made for other marginalized groups of children, such as street children and children of migrant families.
- ICDS also needs to respond to disaster situations (floods, earthquakes, conflict, etc.) by opening emergency centres in the areas as soon as possible.
- There should be no privatization of any ICDS services. Moves towards privatization, such as the intorudction of user fess in ICDS or privatization in the name of community participation, should be resisted. The ICDS should be funded entirely from government funds raised without recourse to loans or grants from agencies such as the World Bank.
- All ICDS-related information should in the public domain. The provisions of the Right to Information Act, including pro-active disclosure of essential information, should be implemented in letter and spirit in the context of ICDS. All AWCs should be sign-posted and the details of ICDS entitlements and services should be

painted on the walls.

- Proper evaluation and monitoring of ICDS program, including regular growth monitoring of the children.
- End deliberate under-reporting of malnutrition in ICDS.
- Grade I of malnutrition to be considered significant as first step of deterioration of health
- Provisions made in the Eleventh Five Year Plan – Union Budget is not enough to meet the Supreme Court's directives of universalization of ICDS. There is an increase of Rs.673.46 crores in the allocation promised by the Finance Minister. There was already a short fall of 8.2 lakh Anganwadi centres at the beginning of 2007-08. (www.haqcrc.org)- Budget analysis done by HAQ.

Mid-day Meals

- Budget allocations for mid-day meals should be raised.
- Proper infrastructure for mid-day meals should be mandatory, including cooking sheds, storage space, drinking water, ventilation, utensils, etc.
- Responsibility for the management of mid-day meals should not be assigned to teachers, to avoid disruption of classroom activities.
- There should be no privatization of mid-day meals in any form.
- Serious action should be taken in the event of any form of social discrimination in mid-day meals against Dalit children or Dalit cooks.
- Priority should be given to disadvantaged communities (especially Dalits and Adivasis) in the appointment of cooks and helpers. All cooks and helpers should be paid not less than the statutory minimum wage.
- Mid-day meals should be extended to school vacations and out-

of school children (including street children, migrant children and drop-outs).

- Community participation in the monitoring of mid-day meals should be strengthened,particularly to prevent corruption and ensure quality.
- Quality should be maintained while preparing meals. Proper fund allocations should be made to maintain the quality. Corporators should also be made responsible by involving them in this scheme.
- Proper monitoring and supervision mechanisms must be adopted.

School Health Programmes:

- Regular check-ups for children should be done on mandatory basis.
- In case of any big sickness, schools should be made responsible for referral cases of children. Normally the school pressurizes parents to follow up the cases. Parents in turn are reluctant to do the same because of work pressures and forced holidays which becomes too expensive for them.
- Availability of medicines should be taken up on priority by schools. They should not leave it to the parents to do the needful.
- Vitamin A supplies need to be ensured and maintained.
- The School health scheme needs to be made compulsory for all private and public schools and should include annual general health checks, vision and dental checks,immunization and deworming, iron supplementation and adolescent health counseling.
- Regular eye-check ups should be held. Due to refractory

problems many of the children suffer from blindness.

- School should maintain Health Records of children.
- Health education should be part of the school syllabus.

HIV/AIDS

- there is need to control HIV/AIDS infection, stigma, discrimination and denial of services to children infected and affected with HIV/AIDS as soon as possible.
- MDAC/ NACO needs to review its programme from children's perspective and utilize the fund in a better manner instead of going for “low cost care and support programme”.
- AER should be made available in all government hospitals.

Health Care Services:

- ➔ Strengthen and support community health worker programme for community level care provision – by a volunteer selected and supported in every habitation.
- ➔ To implement immediately the 5 paise cess declared for Rag picker workers and their children.
- ➔ Standard treatment protocols for both paramedical and medical staff for management of the sick child.
- ➔ Staffing gaps in pediatricians, ANMs and AWWs to be filled with priority and urgency.
- ➔ Inclusion of children health specific services in general health services – eg. giving child health specific training to ASHA, ANM responsibilities,PHCs.
- ➔ Pediatric formulations of entire formulary to be made available.
- ➔ Special focus on the severely malnourished and on the sick malnourished child.
- ➔ Vitamin A supplies need to be ensured and maintained.

- Immunization drives such as pulse polio must be organized carefully to ensure that routine immunization is not being neglected. DPT, measles and T.B. while pregnant women should e immunized against tetanus. This is a joint responsibility of ICDS and the Health Department.
- Making available smaller dose forms (e.g. five dose vials) for BCG to ensure coverage even in small groups of children.
- Measles coverage must be achieved to 100% on a priority basis.
- Medicines of T.B.,Cholera, Jaundice,etc should be mandatorily made available to all those in need.
- Services for early detection and management of disability and developmental disorders, institutional support services at least at state level, Child Development Centres at district level.
- Strengthen the provision of appropriate child care in the health sub-center and 24 hour quality care for the sick child in the primary health centre with emergency transport connectivity with higher centers.
- Make provision for effective secondary care-hospitalized institutional care for the sick child at one lakh population level.
- Establish Pediatric and Neonatal emergency care units at the district hospital.
- Availability of Pediatric formulation at all levels.
- Ensuring no denial of treatment by the hospitals to malnourished child of IIIrd or IVth grade.
- Any child labour found or rescued should be given immediate required care and treatment with proper rehabilitation until repatriation.

Special Services for Children in special need:

- After care facilities for the homeless children including reservation

of beds in hospitals, provision of free medicines and expensive medical tests.

- Health care services for children in special needs eg- children in institutions, labor situations, abuse, etc.
- Health rights for the street children in urban areas- free medicines, tests, food, etc.
- All required processes to be arranged for getting IQ test done.
- Admissions for patients without support system should be prioritized. Every individual being is precious and therefore should be taken seriously.
- MRI tests should be done free of cost for the needy.
- All medical and institutional care should be provided to children suffering with HIV+/AIDS

Grievance Cell:

Grievance Cell should be re initiated and monitored so that anybody and everybody is able to have access to the same.

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