

2.22 Indira Bal Swasthya Yojana: Applying preventive healthcare measures to promote children’s health in Haryana

The Indira Bal Swasthya Yojana (IBSY) is a preventive health scheme launched by the National Rural Health Mission (NRHM), Haryana, which aims to screen all children accessing public health and education facilities like schools and anganwadis, for diseases, disabilities and deficiencies and refer them for free follow-up treatment if required. This makes Haryana the only state in the country to have a single preventive healthcare measure that so comprehensively covers the under-18 population. The IBSY screens lakhs of children each year, resulting in large-scale preventive treatment and the discovery of significant health risk patterns in society that are used for future policy formulation.

Rationale

Until this scheme was implemented, none of the Indian states had a single preventive healthcare measure that comprehensively covers the under-18 population. If detected early, diseases and illnesses can often be treated at a far lesser cost than in advanced stages. Prevention is better than cure is an axiom of medicine that has even more relevance when seen from the perspective of governance.

In keeping with this preventive approach toward healthcare, the Government of Haryana launched the IBSY scheme to screen the state’s children (up to 18 years of age) on three major indicators: disease, disability and deficiency. *Table 1* shows the main health conditions screened under IBSY. As can be seen, a wide range of health conditions are covered under the screening process. However, this list is not exhaustive, and if any

other ailments are detected, they too can be noted down by the functionary carrying out the screening.



Image 1: Beneficiaries of IBSY receive medical care at Karnal Civil Hospital

Table 1: Health conditions screened for under IBSY

Deficiencies	Childhood Diseases	Developmental Delay and Disability	
<ul style="list-style-type: none"> Anaemia Vitamin A deficiency (bitot spot) Vitamin D deficiency (rickets) Malnutrition (SAM) Goitre 	<ul style="list-style-type: none"> Skin conditions Otitis media Rheumatic heart disease Reactive airway disease Dental problems (caries) Convulsive disorders 	<ul style="list-style-type: none"> Vision impairment Refractive error Cataract Squint Ptosis Visual Disability Hearing impairment Hearing and speech disability 	<ul style="list-style-type: none"> Neuro-motor impairment Orthopaedic disability Motor delay Cognitive delay Mental retardation Language delay Behavior disorder (autism) Learning disorder Attention deficit hyperactivity disorder

Source: National Rural Health Mission, Haryana, and OneWorld Foundation India, 2014

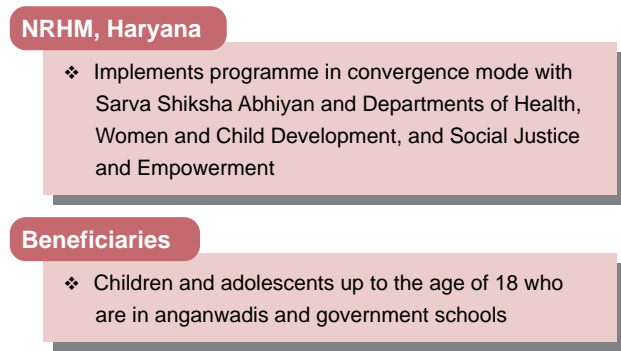
Objectives

IBSY aims to provide free preventive and curative healthcare to the under-18 population, with focus on disease, disability and deficiency. The scheme seeks to cover all the children in *anganwadis* (child-and mother-care centres) and government schools.

Key Stakeholders

The key stakeholders in the IBSY are NRHM Haryana and the beneficiaries are children and adolescents up to the age of 18 who are in *anganwadis* and government schools.

Figure 1: Key stakeholders in the IBSY initiative



Implementation Strategy

The IBSY was launched on January 26, 2010, with a formidable goal to screen an estimated population of 38 lakh under-18 children in the state. Plans were made to implement the scheme in a phased manner and in convergence mode. The first phase was to cover primary schools, the second phase was for *anganwadis*, and the third phase was for middle and senior schools, thereby covering the under-18 population.

However, the modalities of implementation changed in 2011, and the strategy was changed to cover all the students in a single school (Class 1 to 12) at one go and the children in *anganwadis* separately. In the case of schools, teachers have been selected as the functionaries to conduct the screening. This was done because each teacher has a class of 30–40 students and is well placed to carry out the screening. In the case of *anganwadis*, the *anganwadi* workers (AWW) are the functionaries selected to carry out the screening. Extensive capacity building has been done for both the teachers and the AWWs. The process has been kept as simple as possible, and the functionaries only have to tick against the relevant condition if a diagnosis is made. The registers, which are

used for data collection, have index pages to carry a summary highlighting the children who need referral.

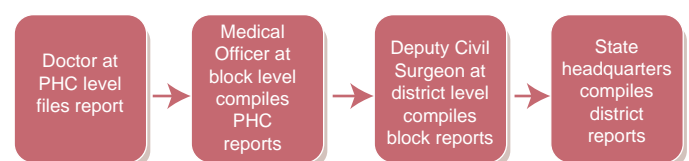
Anganwadis conduct screenings during two periods. First, when mothers come to the centre to avail services like rations and the second, during immunisation drives. This approach ensures almost universal screening.

After the screenings are done, health check-up camps, involving medical and paramedical staff, are organised. Parents are informed in advance about the date and time of the health camps and also about the ailments their children are suffering from. Owing to the shortage of doctors, dental surgeons have been made part of check-up teams. The children requiring further treatment are referred to the relevant health facility, such as the Primary Health Centre (PHC), Community Health Centre (CHC) or the district hospitals. Over the course of its implementation, IBSY has also developed convergence with other programmes such as Adolescent Reproductive and Sexual Health (ARSH) and Weekly Iron Folic Supplement (WIFS) for maximum utilisation of existing resources.

During the implementation of the scheme, the critical importance of community involvement in ensuring acceptance and sustainability of the scheme became evident. Simply motivating teachers proved insufficient, and demand from the community for the scheme had to be created. Therefore, an IEC campaign was undertaken to improve community awareness about the impact of the scheme on the health of their children. Community leaders such as Sarpanchs (village heads) were brought on board and made nodal functionaries for disseminating information on the scheme.

The data collection strategy also underwent a gradual change. The screening data was initially stored in three separate registers categorised on the basis of age — one for 0–6 year old children in *anganwadis*, another for 6–12 year olds in government primary schools and the third for 12–18 year olds in government secondary schools. However, a shortage of female doctors meant that questions on menstruation could not be asked of adolescent girls, leading to some questions being dropped. The registers were later simplified and all three were integrated into a single register, which now tracks the same data for the entire age bracket of 0–18 years.

Figure 2: Reporting system used in IBSY



Source: OneWorld Foundation India, 2014

A state monitor and three consultants are doing the monitoring for IBSY. Field inspections are conducted for IBSY and ARSH implementations, and teachers are made aware of their responsibilities, if necessary. *Figure 2* shows the reporting system utilised for tracking the scheme's progress across the state.

Resources Utilised

IBSY operates in a convergence mode, harnessing the existing infrastructure and human resources of various departments. In terms of financial expenditure, the cost of the scheme stood at Rs. 52 lakh in FY 2011–2012.

Impact

Wide coverage: The IBSY has covered a massive population of 38 lakh and made a huge impact through preventive disease screenings. *Table 2* provides details about the number of screenings conducted and cases detected.

Identification of adverse health conditions and pre-emptive treatment: From the data it is evident that a very large proportion of children (71%) are suffering from anaemia. Various other health conditions have also come to the fore and been pre-emptively dealt with. An exhaustive list of interventions is provided in *Table 3*.

Key Challenges

The greatest challenge faced by the scheme has been to convince parents to avail of the benefits and bring their children for follow up treatment. A majority of

the beneficiary parents are daily wage earners steeped in poverty, who stand to lose their day's income if they take their children for follow-up treatment. There is a tendency to downplay the effects of adverse health conditions till the child becomes dangerously ill. This

Table 2: Number of screenings conducted and cases detected in Haryana

Activity	FY 2010-11	FY 2011-12	FY 2012-13
Children screened	30,65,974	32,06,797	22,66,751
Children detected anaemic	11,11,736	6,05,975	1322081
Heart disease cases detected	112	200	214
Malignancy cases detected	40	13	16
Tuberculosis cases detected	965	630	206
Hernia and hydrocele cases detected	198	305	167
Juvenile diabetes cases detected	40	292	103
Epilepsy cases detected	948	749	1737
Skin disease cases detected	46,470	50,486	22480

Source: National Rural Health Mission, Haryana

Table 3: Interventions under the IBSY in Haryana

Activity	Total	Disability related activities	Total
Children treated at health facilities	5,92,185	Disability camps done	397
De-worming doses given	3,974,447	Children examined in disability camps	36,033
Dental cases treated	51,155	Disability cases detected	46,045
Disease cases treated	1,16,446	Disability certificates given	15,152
IFA tablets given	10,51,75,658	Children identified for aids and appliances	3,352
Spectacles given free of cost to children	10,480	Identified for corrective surgeries	1,038
Cleft lip/palate	20	Corrective surgeries done for children with disability	99
Heart surgeries done	12		

Source: National Rural Health Mission, Haryana

happens particularly in the case of disabled children. Even parents who do bring their children for treatment tend to drop out if repeated follow-ups or travel to a distant facility are required. Poverty and lack of awareness about the long term effects of neglecting healthcare appear to be the key impediments in bringing the children for follow up treatment. The IBSY is tackling this issue through Behaviour Change Communication (BCC) to build awareness among parents about why they must go for follow up treatment.

People speak...



“My son Hitanshu was born with a cleft lip and palate. I am a poor man who has neither the time nor the money to go to Chandigarh or Rohtak to get him operated. Through this initiative, my son was operated for free and all facilities were taken care of. For me this is no less than a blessing from God. I am very grateful for this initiative.”



“My daughter Deepshika had a severe case of bow legs. She has benefited from this initiative, something good has happened to her and that is more than enough for me.”



“My daughter Chintan had a heart problem. Within six months of detection she got operated upon for free. I make it a point to take her for the follow ups. We are very happy with the services provided. ”

Bringing the teachers on board was the other major challenge the scheme faced during the initial period. Teachers initially refused to support the IBSY as they saw it as the job of the Health Department. Securing the teachers' cooperation was essential as they play a key role in the scheme. A series of meetings were thus held between key NRHM officials and senior educational administrators, such as district and block education officers, and the teachers themselves. The efforts eventually fructified, and the teachers came on board. However, some teachers are not very proactive and do not screen children in advance, preferring to do it only when the health check-up team comes to the school. This gives the doctors also an excuse to skip the school and come back later, thereby delaying overall service delivery.

IBSY has also faced logistical and coordination challenges. Several issues concerning coordination and supply chain management came up during the initial stages of the implementation. For example, while holding disability camps in 2010, calipers that had to be supplied by the Sarva Shiksha Abhiyan reached about 8 months late; these became obsolete as the measurements of beneficiaries had changed by then. However, subsequent improvements in coordination have largely addressed these issues.

There has also been a change in the strategy of holding camps. The earlier approach was to hold block-level camps and transport doctors from the district to the block level. However, this resulted in long waiting times for beneficiaries and had a discouraging effect. The approach was then reversed, and beneficiaries were taken from the block to the district level, where the doctors were already stationed. This arrangement has proved to be much more effective.

Creating a functional MIS for monitoring and evaluation of the scheme remains a challenge. Tablet-based field monitoring was piloted, but connectivity issues have acted as an impediment to the successful functioning of this approach.

Overall, the scheme is seen to result in excessive pressure on higher-level (tertiary) healthcare facilities. Limited capacities and knowledge of doctors at lower levels (such as PHCs) result in more referrals to the higher-level units. This increases the workload on tertiary care units, reducing their ability to deal with priority cases.

Replicability and Sustainability

IBSY has received high-level political and administrative support, which provides a good foundation for sustainability. However, as the scheme involves convergence of several different government departments, the first and foremost requirement is that all the stakeholders must be convinced

about the value of the scheme and be brought on board. Their doubts and uncertainties should be addressed through patient and persistent dialogue so that there is sufficient motivation all the way to the field-level operatives.

A top-down approach would be disastrous and result in innumerable bottlenecks at every level. There must also be special emphasis on capacity building and incentives for teachers, who are the main field level operatives who motivate the parents to bring their children to health facilities for follow-up treatment.

On the demand side too, a lot more needs to be done to counter the structural limitations (for example, poverty) that hinder effective demand by beneficiaries. One good approach could be to introduce extensive and sustained IEC and BCC campaigns for the target beneficiaries.

Conclusion

A flagship scheme of the Government of Haryana, IBSY has had a major impact on disease prevention in the under-18 population. The scheme has been able to successfully converge and leverage the existing infrastructure and resources of various departments. Attention must, however, be paid to the hindrances encountered during implementation, primarily the issues related to motivation of field-level operatives and insufficient appreciation of the value of the scheme by all the stakeholders, including the beneficiary population. Greater dialogue and persuasion, capacity building, measures to improve motivation and effective awareness-generation campaigns are some other strategies to tackle these issues.

Fact Sheet

Theme	Health
Nodal Implementing Agency	National Rural Health Mission, Haryana
Geographical Coverage	All districts of Haryana State
Target Groups	Local population up to 18 years of age
Years of Implementation	2010 - Present



Staff of the Narayana Nethralaya Postgraduate Institute of Ophthalmology, Bengaluru where the KIDROP, aimed at preventing vision loss in premature infants of underserved areas in Karnataka has been initiated.