

**One Year of NRHM - A Review
Survey & Consultation Report**

by

Centre for Health and Social Justice, New
Delhi

With support from

Population Foundation of India, New Delhi

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Thank you all.

Abhijit Das
Director
Centre for Health and Social Justice

Preface

The health status of the poor and socially excluded population over large parts of India is very poor, to say the least. Where maternal health indicators are concerned the situation in some states is akin to sub-Saharan Africa. Despite 58 years of independence and a economy which has been booming for over a decade, age-old communicable diseases like tuberculosis and malaria are making a come back along with new ones avian flu and chikunguniya. However this sad state of affairs is not all-pervasive because existing cheek and jowl with such an abysmal situation are gleaming chrome and glass corporate hospitals which promise the cheapest high-technology medical care in the world. And medical tourism is seen as a high-growth industry. Clearly something is wrong in the state of health care delivery in India.

The reasons for the poor health status of millions of Indians are not hard to find. Very low public investment in health, and increasing privatization is one reason for the high out of pocket expenses for health care. Health care is also one of the most important reasons behind indebtedness. The public health system is fragmented into vertical health programmes, and there has long standing call for integration of the health and family welfare departments.

The National Rural Health Mission (NRHM), not only makes significant promises but also acknowledges most of the reasons given above. The NRHM was also formulated after a large number of consultations and many of the recommendations made on by civil society experts and representatives were accepted and incorporated into the many programme documents. Civil society participation has been given a prominent place in the scheme of the NRHM in the name of communitisation and community monitoring has been included as one of the operational monitoring mechanisms that the Mission will adopt.

The NRHM is now over a year old and even though it is in its preparatory phase and even the Framework for Implementation has not been adopted, it is time to take stock of the changes that have taken place, especially at the ground level. This Citizen's Report focuses on the performance of the NRHM on 8 of the 18 high focus states, which are also known as the EAG states in Ministry of Health and Family Welfare jargon. These states, comprising of Rajasthan, Madhya Pradesh, UP, Uttaranchal, Bihar, Jharkhand, Chhattisgarh and Orissa are ones in which the health and overall development is lacking the most. It is in these states that the success or failure of NRHM is going to be decided.

This report comprises of two sections. The first section comprises of the proceedings of the Stakeholders' and Civil Society Consultation on One Year of the NRHM. The second section includes statewise reports of people's experiences of one year of NRHM in the eight states mentioned above.

We hope that this report not only identifies some of the crucial bottlenecks but also serves as a guide for policy makers, international organizations, experts and members of the civil society as they engage in the design and delivery of the next six years of the Mission. The civil society, particularly those for whom the NRHM is meant and those who work with such communities are eager that the NRHM succeed, because it will mean an overall improvement in the lives of millions of Indians.

Executive Summary

Context

The National Rural Health Mission (2005 - 2012), formulated by the Government to improve availability and access to quality health care by those residing in rural areas in particular, as well as the poor, women and children, has completed one year of its implementation in April 2006. The flagship programme of the NRHM is the Reproductive and Child Health Two (RCH 2) programme that promises to address crucial issues like maternal mortality, family planning and child mortality through sustained interventions. However, these programs may not succeed without a creative and vigilant engagement of the civil society so that the policy directions and programme inputs actually lead to more efficient, effective and quality service delivery to the people in the community.

The Centre for Health and Social Justice, a civil society organization devoted to promoting evidence-based praxis and change in health-related policies and programmes, has taken a lead to strengthen this process of creative engagement of civil society with public health policies and programmes. On January 23 and 24, 2006 it organized a consultation in Delhi of civil society health experts, providers and community based programme implementers, on monitoring Public Health Policies and Programmes. This meeting laid down a broad framework of the issues and strategies that could be adopted for creative vigilance of the recently announced National Rural Health Mission and within it of the Reproductive and Child Health 2 programme. Following this consultation, a series of State and Regional level Consultations and workshops were organized from March to June in the eight EAG states where the health status of communities is the poorest. In these consultations over 125 civil society organizations were introduced to the different aspects of NRHM, RCH2 and the possibilities of Community Monitoring and Social Audits that exist within the programme. These organizations have in turn oriented more community based organizations and community leaders. The civil society organizations resolved to conduct a survey to monitor key elements of NRHM in their states and share their findings at the national consultation, in the form of *Citizen's Report on One Year of NRHM*.

A day long **Civil Society Consultation** was organized by the Centre for Health and Social Justice and Healthwatch UP Bihar on July 25, 2006 in Delhi to share and discuss the progress of RCH 2 and NRHM in eight EAG states and plan future action.

This consultation was followed by a two-day **Stakeholders Consultation on One Year of NRHM** on July 26 and 27, 2006 in which various stakeholders jointly reviewed the progress of the NRHM mechanism in fulfilling the reproductive health needs and rights of women. This consultation was organized by CHSJ in collaboration with the Advisory Group on Community Action of the National Rural Health Mission, a standing committee within the mission.

Objectives

The objective of these two successive consultations was to share and build a consensus over the *Citizens' Report on One Year of NRHM* and facilitate a process within the small group of civil society organizations to identify problems in the implementation of NRHM and strategies to resolve them. It also aimed to fine-tune these strategies in the larger Stakeholders Consultation with inputs from different stakeholders and come up with an effective future plan.

Structure of the consultations

The **Civil Society Consultation** began with sharing the progress and process of NRHM - RCH 2 in eight EAG states. This was based on the evidence collected during the survey by civil society groups in their respective states and included the key health issues, reproductive health status and an update on the important elements of NRHM since its inception in each state. Thematic Group Discussions were organized in the latter half of the day to facilitate the process of identifying the problems in implementation of NRHM and recommendations to overcome them. To advance the process of advocacy, a discussion on the future plan of action was undertaken at the end of the day.

The **Stakeholders Consultation** was structured into different sessions in which there were presentations and responses from various stakeholders. Each session was addressed by a public health expert and presented experiences from the field collated from civil society work, responses from international organizations involved in providing technical support and financial assistance, as well as from representatives of the Government of India. Recommendations to the government and civil society for more effective implementation of the NRHM were proposed at the end of the consultation.

Participants

The Civil Society Consultation was attended by 39 persons who represented different civil society organizations and networks that are actively working in eight EAG states. Gujarat was also represented. All the civil society organizations present here-were part of state level consultations held earlier. They were also part of the investigation process which has led to the preparation of *Citizen's Report on One Year of NRHM*.

The Stakeholders' Consultation was attended by 103 persons including public health experts and representatives of various civil society organizations, networks, Government of India, international organizations and donor agencies.

Recommendations

Based on thematic group discussions, the key recommendations* made in the Civil Society Consultation broadly related to:

- ASHA Selection and Training
- Decentralized planning, Monitoring and involvement of PRIs
- Maternal health related interventions
- Informed Choice in Family Planning

Recommendations* made in the Stakeholders Consultation can be broadly categorized as those:

- For the Government
- For Civil Society

^Detailed report of these consultations and recommendations is in the next section.

Stakeholders Consultation on One Year of NRHM

July 26, 2006, New Delhi

All the stakeholders present at the Consultation appreciated the progress made over one year through the NRHM at the National, State, District and Village levels. The deliberations also noted that after the Bhore Committee the NRHM is probably the first comprehensive and holistic approach to reforming the health system delivery in the country towards socially just and desirable health outcomes.

The following recommendations were made at the Consultation for more effective implementation of the NRHM:

Recommendations for the Government

1. There should be greater awareness generation about NRHM at the state and district levels. The NRHM's vision, goals and philosophy should percolate to the lowest level. This vision should be transferred to the district training teams. At present, the NRHM is being seen as a package of new schemes.
2. The speed of implementation should not compromise the quality of implementation (for example, selection and training of ASH As, standardisation of training, community planning and monitoring and VHC selection) Presently, at the District Level and below there is a hurry to achieve 'targets' in all these issues
3. There is need for greater involvement of Panchayat members. At present their participation is token at best, nor has it been systematically implemented. There should to be a clear plan of action, including capacity building plans on how panchayats should be involved
4. There is lack of clarity about the role and functions of the Rogi Kalyan Samiti at the grassroots level. While the Samitis have been formed, there is no clarity about their functioning
5. Mechanisms for ongoing and concurrent review of the NRHM are not yet visible on the ground. These reviews should not only assess NRHM process implementation but also incorporate the determinants of health
6. Civil society engagement has not yet taken place at the state level. There should be special steps taken to institutionalize civil society participation in NRHM activities, including monitoring at the state and district levels
7. Community based monitoring has not yet taken place and needs to be implemented as soon as possible. Mechanisms for introducing social audits and Jan Sunwai should be drawn up and implemented with care as soon as possible
8. District level planning has started in several places without village level planning processes being put in place first. This may set a counterproductive precedent. Village level planning should be introduced as soon as possible

9. MNGOs should be selected in consultation with civil society at the state level. The involvement of MNGOs as principal NGO partners in planning and particularly monitoring processes, should be reviewed as it can lead to conflict of interest
10. ASHA selection and training implementation is uneven across the states. In many places, the parameters for selection and training are not being followed. ASHA training needs to be evaluated as soon as possible and a more robust training methodology involving NGOs and women's groups' as trainers should be introduced
11. Declaration that the ASHA will not be a bare foot doctor is a cause of concern. She has to provide some curative services, that is, first line of treatment of essential medicines
12. AYUSH mainstreaming should not be seen only as a process of appointing an AYUSH practitioner and providing AYUSH drugs through the dispensary. There has to be ground level preparation for mainstreaming AYUSH, which must include the incorporation of local healing traditions and locally available herbs. Moreover, this process must be planned from the village level upwards
13. There is a need to integrate issues relating to the implementation of PCPNDT Act, for example, awareness generation on declining sex ratio, into NRHM's Block and District level planning, along with budget allocation for it
14. Adolescent health issues, including maternal health, contraception and sexuality education, should be included within the decentralised NRHM planning. Adolescents and young people should be included in all planning and monitoring fora/mechanism
15. Public-private partnership/ processes should not encourage the privatisation of health services. Financing should be from public funds so that universal access to services is ensured
16. Initiatives on launching Private-Public Processes must be formulated and implemented with care and within properly designed regulatory and monitoring mechanism, so that accountability and quality are ensured. Regulatory and monitoring mechanisms should be formulated immediately
17. There is a need to collate the best-practices in implementation of NRHM and make them available as examples
18. A mechanism needs to be established through which NRHM related information can be shared from the National level down to the villages, and information on implementation can be shared from the village and district level upwards to the state and centre

Recommendations for Civil Society

1. Civil society should systematically monitor implementation
2. Civil society groups should participate in joint social audits, mentoring groups, provide support in village health planning and in capacity building of Village Health Committees and PRIs
3. Civil Society should participate in Rogi Kalyan Samitis and share information on its roles and responsibilities
4. Civil society groups should share promising practices among themselves and with the government
5. The civil society should see to it that issues relating to the implementation of PCPNDT Act are included into Block and District level planning under the NRHM, and that there is budget allocation for it
6. Civil Society Groups should push for inclusion of adolescent health issues, including maternal health, contraception and sexuality education, within the decentralised NRHM planning.
7. Adolescent and young people should be included in all planning and monitoring fora and mechanisms, even in civil society groups

8. The input of civil society in the mission mechanism should not be incidental. A bridge mechanism should be developed comprising civil society, advisory groups and the government. There must be a mechanism for convergence on the issue among different civil society networks
9. Watchdog activities are already going on but mechanisms need to be developed to institutionalise them so that the feedback to GOI and State Governments can be regular. There should be policy-level monitoring as well. Watchdog activities can be moderated also through e-forums
10. Information from GOI must percolate to the grassroots, and feedback from the grassroots must reach districts/state/GOI authorities. The role of watchdog could include collection of evidence in the form of data, stories and case studies
11. There should be engagement with politicians and political parties instead of with bureaucrats only
12. The centre of gravity of the NRHM is the state and not the central government. Therefore, watchdog activities and efforts to influence the authorities should be targeted at the state governments
13. Some common events should be organised at the state level. At the national level, a joint event can be staged perhaps once a year
14. This consultation was conducted mostly in English, because of which some participants could make limited contribution as they were not fluent with the language. In future, such consultations should be conducted in Hindi or the local language
15. There should be an annual report on the state-wise health of NRHM, something like a shadow report. Additionally, there should be a central level report too
16. Civil society organisations should take responsibility according to their interests and capacities. Also, this should take place at different levels

Detailed Report of Stakeholders Consultation on One Year of NRHM

Day 1 - July 26, 2006

The consultation began with a welcome note by Dr Abhijit Das, Director, Centre for Health and Social Justice. He then gave a brief background for holding such a consultation, explaining that the preparation for it had begun much earlier. The preparatory process had begun with a two-day consultation of civil society health experts, providers and community based programme implementers in January 2006, titled 'Monitoring Public Health Policies and Programmes'. At that consultation, a broad framework was laid down on the issues and strategies that could be adopted for creative vigilance of NRHM and within it of the Reproductive and Child Health 2 (RCH 2) programme. This consultation was followed by a series of state level consultations from March to June in the eight EAG states where the health status of communities is the poorest. Over 125 civil society organisations were introduced to the different aspects of NRHM & RCH 2 and the possibilities of community monitoring and social audits that exist within the programme. These organisations have in turn oriented more community based organisations and community leaders. Dr Das also pointed out that participants from the different states had met the previous day, on July 25, to consolidate their findings and finalise presentations for this consultation.

A brief round of introduction of participants followed (See Annexure for Participants List). They consisted of an array of stakeholders - civil society representatives, public health experts, government representatives (bureaucrats), a Member of Parliament, donors and international organisations (WHO, UNFPA, UNIFEM, World Bank). The states represented included Rajasthan, Uttaranchal, Bihar, Jharkhand, Orissa, Chhattisgarh, Uttar Pradesh, Himachal Pradesh, Maharashtra, Gujarat and Delhi.

Then followed the first session of the consultation.

Session 1: Reviewing NRHM - Key Achievements and Roadblocks

Chair: Mr. A. R. Nanda (Executive Director, Population Foundation of India)

Co-chair: Mr. Sandeep Dixit (Member of Parliament, East Delhi)

The Chair introduced the speakers for the first session. He was happy to note that the Department of Health and the Department of Family Welfare merged at the central government level after 30 years. This was possibly because of the NRHM and stewardship of the Health Minister Dr Ambumani Ramadoss, as well as the leadership of Mr. P. K. Hota, Secretary, MOHFW, GOI. He was also happy to note that several states had followed suit, merging these Departments.

Presentation : Overview Presentation of NRHM Progress.

Speaker : Mr Amarjeet Sinha, Joint Secretary, MoHFW, GOI

Mr. Sinha began with emphasising that the NRHM was just one year old and still in the learning phase. He stressed that meeting people's health needs in rural areas was the primary focus of the Mission. Its mandate is to make the public health system functional at all levels. He presented the goals of the mission, namely (a) reduction in IMR and MMR (b) universal access to public health services (c) prevention and control of communicable and non communicable diseases (d) access to integrated comprehensive primary health care (e) population stabilisation, gender and demographic balance (f) revitalisation of local health traditions and mainstreaming of AYUSH (g) promotion of a healthy lifestyle.

The expected outcomes of the Mission by 2012 are to reduce IMR to 30 per live births, reduce MMR to 100/100,000 and TFR to 2.1. The Mission is also expected to engage 2,50,000 Accredited Social Health Activists (ASHA) in 10 states, upgrade CHCs to IPHS and increase utilisation of FRUs from 20 % to 75 %, reduce mortality due to malaria, dengue, kala azar, filaria and TB.

The Mission has also envisaged a number of outcomes at the community level. These include availability of trained community level worker (ASHA) at the village level, with a drug kit for generic ailments. He said that this could be a newly formed cadre or comprise the Sahayogini in Rajasthan or the Mitanin in Chhattisgarh. The Mission was committed to providing quality health care at the grassroots. He said that ASHA should be seen as a community worker who helps in linking the community with the public health system and not as a bare foot doctor. She has to be located within the Anganwadi and mobilise the community for the monthly health day.

Mr Sinha's presentation outlined the deployment of increased personnel at the PHC level based on feedback received from Andhra Pradesh. There was a request for more nurses and ANMs at PHCs. The Mission is already in the process of providing more nurses and two lakhs ANMs. The ANMs will be local women from the villages, even if it means reserving seats at nursing institutions. Each PHC will have a minimum of three nurses and one LHV. It will function round the clock, 24 hours and seven 7 days a week.

He also said that every PHC has to be accountable to the community. For this, a checklist prepared by the Jan Swasthya Abhiyan (JSA) has been used. Any vibrant community group that provides leadership can work with the government and utilise the untied funds. For example, in Tamil Nadu private practitioners came together and made use of this fund as the government is unable to retain specialist doctors due to inadequate compensation packages. Likewise, funds have been used innovatively at sub centres too, each of which have been sanctioned Rs 10,000. In West Bengal, this money has been used for making even small improvements, such as purchasing curtains to ensure privacy.

At the CHC level, the untied fund amounts to Rs 10 lakh each. This money is meant to ensure that they become functional. It can therefore be used for repair work or human resources or whatever it takes to get the CHC up

and running. Recently, the government released Rs 10 lakh for each district plan. However, it has categorically asked the districts not to engage consultants to chalk out the plan. Instead, the authorities should seek the services of civil society organisations.

He said the government is also keen on developing village health registers. Civil society organisations could aid in this. For instance, if they conduct a household survey in the course of their work, the village facility component could be added in it so that all data relevant to the village could be compiled for future reference. This could become a public document which could be used to make the government more accountable.

However, Mr Sinha requested civil society not to always stay outside the system and monitor it. He emphasised the Mission's commitment to inter-sectoral convergence. Here, Dr. Abhay Shukla, National Convenor of JSA, suggested that implementation and monitoring should be done by separate organisations. The presentation then outlined the five main approaches of NRHM, namely, communitizing, flexible financing, monitoring progress against standards, improving management through capacity building and innovation in human resource management. Mr. Sinha concluded his presentation by highlighting factor that make NRHM different from other government programmes -

- (i) It trusts communities and is about forging partnerships
- (ii) It is about innovation and autonomy
- (iii) Community organisations and PRI have a role
- (iv) Habitation level health workers in referral chains
- (v) Service delivery and outcome focus
- (vi) Pragmatic approach to providing service guarantees - moving towards a rights based approach
- (vii) Recognition of the need for management skills
- (viii) Public health through convergent action
- (ix) Giving authority to those with motivation

Presentation: Financing Challenges in the Context of NRHM

Speaker: Mr Ravi Duggal, Independent Consultant (Formerly, Coordinator CEHAT)

The presentation first focussed on healthcare financing in India. The largest source of financing healthcare in India is out-of-pocket expenses or self financing, comprising approximately 85 % of the amount spent on it. The rich are the biggest users of public health facilities. For those who are poorer, the ratio of their income that finances health expenditures is 2-4 times more than the average.

Additionally, while this burden is largely self-financed by households, a very large proportion of it does not come from current incomes. Much of the spending, especially for hospitalisation, comes from debt and sale of assets. There is inequity in health spending because of lack of access to services. A redistribution of the government's health budget (for example, increase in the budget to PHCs), could address some issues such as those relating to lack of access to healthcare. The lack of availability of doctors in rural areas may be addressed by mandating medical graduates to give three years of supervised community service before they begin private practice. Also, hospitals that have been given tax rebates (such as land at discounted rates) in return for a certain percentage of free treatment for the poor, should be strictly monitored to ensure that they comply. In addition, the Employees State Insurance Scheme should be converted into a national universal insurance.

The presentation then shifted focus to financing issues in the context of NRHM. It pointed to the fact that restructuring of healthcare delivery mechanisms was required. This would include organising, regulation and accreditation;

autonomy in decision making; PRI and civil society oversight and audit. It also spoke of restructuring of financing mechanisms, that would mean financial flows and autonomy in use of funds. Enhanced resource allocation was also required (for example, social insurance and additional taxes).

Mr. Duggal then delineated some financial issues with regards to NRHM - (a) source of enhanced revenues not clear (b) capacity of states to raise additional resources (c) fund flows still shrouded in a lot of distrust (d) poor capacity at unit/programme level in financial management (e) designing of payment mechanisms (f) dovetailing with restructuring and regulation of health systems. The presentation ended with an outline for an alternate model that should have universal access as the starting point and a comprehensive integration of the entire health system. The model should have public-private provision possibilities (Mr. Duggal deliberately avoided using public-private partnerships as the term was fraught with negative connotations of the private sector pulling strings and having a much larger share of the pie). All this could take place within 2% of the GDP.

Presentation : Taking Stock : One Year of NRHM

Speaker : Dr. Abhijit Das Director, Centre for Health and Social Justice (On behalf of Civil Society)

Dr Das noted that the NRHM implementation was evident at the grass roots level. Progress included selection of ASHA in several states; the seven-day first phase training of ASHA training had concluded in several states; development of innovative criteria for selection of ASHA had taken place in Chhattisgarh, Jharkhand and Rajasthan; the roll out of JSY had begun; there was the introduction of innovative schemes for maternal health in Madhya Pradesh and Jharkhand; disbursement of untied funds to sub centres had taken place; identification of CHCs for IPHS upgradation had started; and district planning had been initiated in some places. However, there were some causes for concern as well, and he listed out the ground realities of NRHM.

He said it has been observed that there is uneven implementation of NRHM across states.

- At the grassroots level, people know about ASHA but not about her roles. Even Gram Pradhans, AWWs, ANMs and MOs are unaware of her role. The quality of training to ASHA leaves a lot to be desired
- Fund disbursement has taken place but expenditures have not occurred
- Involvement of PRI has been minimal
- Planning and monitoring mechanisms are not in place. Neither are standards, charters and regulations in place

Dr. Das then went on to question some assumptions in the NRHM. It was assumed that there would be an automatic understanding of NRHM once it was launched. However, there is a lack of conceptual clarity in the states. For instance, different components are seen as new schemes (for example, ASHA, JSY, IPHS). There is an assumption that the presence of ASHA, notional PRI involvement, formation of RKS etc. would automatically result in community ownership. Time will tell whether this really happens. Further, letting district plans take shape before village plans are made and contracting out district plans to consulting agencies may end up setting precedents for the future.

Regarding flexi-pool funds, he questioned whether there were adequate guidelines and local capacity for financial planning. On the maternal health front, he questioned whether the JSY and call for institutional delivery make for sound policy in EAG states. Another assumption that he challenged was whether public-private partnerships and risk pooling automatically reduce corruption and reduce health related indebtedness. He also questioned if hasty implementation, as was seen at the grassroots level, will benefit the cause of sustainability.

Other concerns with regards to NRHM were how ownership could be strengthened both at the community and state levels. Also, the population control mindset prevails in many states. There was no clarity on the role of AYUSH as an alternate system of medicine and lifestyle. Provisions were made for PPP without clear regulations

and monitoring parameters. There have also been concerns about whether there are adequate resources (money and personnel - ANMs, doctors, specialists) to meet the Mission's deadlines. Lastly, one major concern was • regarding the last "A" in ASHA - would she finally emerge as an Assistant for the ANM or AWW, or as an Activist? It was hoped that it would be the latter.

Discussions

After the presentations, the floor was opened for questions and discussion. Questions/comments that emerged were as follows -

- How has the involvement of NGOs been envisaged in practical terms
- Can a budget provision be made for informing the Gram Sabha about the NRHM
- Why can information on health (availability of medicines etc.) not be given out to people at the community level? PRIs could play a role in this
- Is it possible to get more disaggregated information about the NRHM budget
- How can states be enthused with the same kind of zeal for NRHM as shown by the Centre
- NRHM cannot work without political will
- Can we also get an idea as to how health determinants are being met by NRHM instead of discussing only the administrative aspects
- Involvement of PRI has been very limited
- In Madhya Pradesh, community and civil society participation in planning has been very low - they have not been involved
- Do away with user fees, in which the poor pay and the rich benefit
- How are drugs being procured and who is procuring them
- In Orissa, the World Bank supported health project failed, so can the NRHM deliver
- Where will additional ANMs, nurses and doctors come from
- Have practical details been worked out, such as how will ASHA take women/girls to the PHC and who will pay for transport

Mr. Duggal addressed the questions/concerns on financing. He said that CEHAT has worked out a budget at the micro scale and a similar process could be carried out for those interested. Also, disaggregated data will be available if there is restructuring and unit expenses are tracked. He too agreed with the view that user fees should be removed. Research shows that the OPD is the largest revenue collector, followed by diagnostics. The revenue generated from inpatient department is very low.

The session concluded with closing remarks from Mr Sandeep Dixit. He requested civil society organisations to engage with politicians and the political system to achieve large-scale changes. The political system is very powerful - it can either boost an issue or distort it. He mentioned it was unfortunate that issues such as maternal or infant health which are crucial development issues, remain peripheral to the political agenda. It was not as if health was not a political issue, because in the recent past the doctors strike, the termination of services of the Director of AIIMS and demands for AIIMS-like institutions in different states had been of immense political significance in the national capital as well as in state capitals. It was a challenge for civil society to engage with

politicians and political parties and create an interest among them on these crucial issues. He cited the example of the National Rural Employment Guarantee Act and the huge financial commitment made to it because of political championship of the issue at the highest level. Further, there has been no involvement from the state governments to ensure that the NRHM succeeds. It is not an issue for the, at least politically. If state governments are to take note of NRHM, it must be made into an issue of political compulsion for them.

Session 2: Community Participation and Civil Society Oversight

Chair: Dr. H. Sudarshan, (Karuna Trust, Bangalore)

Co-chair: Dr. Thelma Narayan, (Community Health Cell, Bangalore)

Presentation : Community Perspectives on ASHA

Speaker: Ms SashiprabhaBidhani, NAWO, Orissa (On behalf of civil society)

Ms Bindhani started by saying that the community is confused when it sees ASHA and wonders whether she is (a) a community based functionary (b) a health activist (c) someone who will mobilise the community, increase utilisation of health services and increase accountability. At the same time the community is apprehensive about several things. There is no clarity on roles and responsibilities of ASHA at the grassroots level. Even concerned persons like AWWs, ANMs, PRI members, VHC members, staff at PHC or CHC do not have a clear idea. The ASHA too seems largely unaware of what she has to do and to whom she has to report. The selection criteria is becoming another problematic area. The prescribed norm is eighth standard pass but in many places, especially tribal and hilly areas, most women/girls do not reach that level of education. In some places, where the norm is being followed, there are different kinds of problems - those responsible for selection further the interests of their family, friends and kin. In both cases, women/girls with the strongest social motivation are being left out. There are examples of excellent results of Community Health Workers with responsibilities similar to the ASHA who have no education.

The training of ASHAs also leaves a lot to be desired. The general impression is that it is being rushed as the government is under pressure to show results. There have been complaints from some areas that civil society organisations were not consulted in the selection and training process of ASHA. Where NGOs are being involved, it is regarding logistics management rather than provide the training. AWWs, ANMs and PRI members are not aware about the ASHA honorarium package. In some areas, the honorarium has been given from the Sub Centre untied fund. Additionally, ASHA is being pressurised by AWWs and ANMs to work as their assistants. Finally, a lot of expectations have been heaped on ASHA - identifying cases for subsidies and compensations (to be made by the ANM), reporting to the health system, functioning as an activist and facilitating people's access to health service.

Ms Bindhani made several recommendations for improving the ASHA scheme. The minimum age for selection should be 20 years. The educational qualification could remain eighth standard but it should be flexible depending on the local conditions. Other attributes like leadership quality, attitude towards social causes, willingness to work on health issues and gender sensitivity should also feature as important criteria for selection. She could be a daughter or daughter-in-law, and single women could also be given preference.

The selection should be carried out in an open meeting (Gram Sabha) in the presence of civil society, SHG, PHC/CHC. Other recommendations included explaining in detail to ASHA her role and responsibilities and the compensation package before appointing her. The review of the present incentive package can be carried out taking into consideration her workload, not limiting it to some RCH2 activities. With regard to ASHA's roles and responsibilities, it was suggested that her geographical mobility be limited to revenue village or a maximum of 1000 population; in case of hilly terrain or areas where access is poor, coverage should be limited to hamlets. It was also suggested that an open discussion be held with ANM/A WW and the community prior to her appointment.

This discussion should include the list of her expected roles relating to registration of pregnancy, ANC, PNC, immunisation, institutional delivery, escort, drug kit etc.

The community perspectives on ASHA 's capacity building and training were as follows -

- Organisations having expertise in women's health and gender issues should conduct trainings
- District resource group (ZSS, local NGO, women's organisations) should comprise local experts
- Block training team (local NGO trainer, doctor from PHC/CHC and/or ICDS etc.) should be part of developing curriculum for training of ASHA
- Adequate budgetary allocation should be made for training and training compensation, developing and sustaining a cadre of trainers, remuneration for additional tasks, awareness building of community, regular replenishment of the drug kit and so on

The presentation ended with recommendation for follow up of ASHA - it can be done through feedback from the VHC (after strengthening it); feedback from registered clients; at monthly meetings with SHG, panchayat civil society and from the PHC. The feedback should include both technical aspects as well as social aspects.

Presentation: ASHA - Issues in Selection and Training

Speaker: Dr. Shyam Ashtekar, Yashvantrao Chavan Maharashtra Open University (YCMOU), Nasik

Dr. Ashtekar's presentation primarily focused on training as he had been involved in the development of the curriculum. He stressed that the post selection management of the programme may be far more important than the selection process itself, because many bright candidates had been selected. The presentation outlined the initial ASHA academic plan, which consisted of 23 days -

- Five training events and corresponding books,
- 20 themes, with 3-4-5 small lessons each;
- Progressing from simple to complex tasks;
- Allowing for simple and multiple tasks being done together rather than being "focused" using a rings approach)

The ASHA training is only in its first year and there are many more years to come, so there is plenty of scope for improvement. The technical content of the ASHA programme needs to be continuously upgraded and refined. The needs can vary from within and between ASHA groups. The option must be open for level two programmes. The rings approach makes it possible.

Calling for a Knowledge Management Approach rather than training, he said that the person who trains is important. Often, it is just the PHC/CHC staff who are unwilling trainers and have little time to devote. Also, they have little pedagogic orientation. On the other hand, the recipients (ASHAs) have no background or understanding of health issues. Further, the teaching style and the learning environment are also important. Dr. Ashtekar emphasised that only a little learning and internalisation is possible in the absence of assignments and workbooks. The ASHA programme has bypassed this. Another important consideration is to keep an ear to the ground about how the ASHA learning programme is faring. For this, a feedback and evaluation systems need to be in place, as also quality checks on training.

The presentation went on to highlight an initiative regarding ASHA by the YC Maharashtra Open University that will be piloted in 2000 localities (Arogyamitras). YCMOU will provide academic support through assignments as hands-on-learning events, workbook methods, e-book and IT aids for self learning. In conclusion, Dr. Ashtekar laid stress on learning from phase 1 for phases 2 and 3. A national resource network is required for ASHA resources, not a centre in some place. It is imperative that technology be utilised for this purpose.

Presentation : Decentralised Planning, Monitoring and Involvement of PRI **Speaker:**

Ms Sneha Mishra, Aaina and NAWO, Orissa (on behalf of civil society)

The NRHM document has provisions for the involvement of PRIs at all levels, such as representation of Zilla Parishad at the state level committee/mission (at least 30% on a rotation basis every year), District Health Mission (DHM) to be accountable to Zilla Parishad (ZP), training of PRIs, meeting by the Sarpanch with AWW, ANM and ASHA at the Gram Panchayat level, quarterly review at PHC, CHC and block level; convening of village health plan meetings and preparation of a plan along with Village Health and Sanitation Committee (VHSC), displaying of information and data at the panchayat office/AW center and so on. Despite so many provisions, the strategy for the involvement of PRI and the mechanism of involving them in the monitoring process is not clearly defined. While the Mission document states that the District Health Mission is to work under the leadership of the Zilla Parishad and be accountable to it, it has been observed that DHM supersedes the ZP. No clear guidelines have been issued about frequency of appraisal and stock taking meetings. The selection of ASHA is supposed to be done by the gram panchayat and she will be accountable to it. However, this has not been so in most places.

*Ms Mishra made the following recommendations for increasing **PRI** involvement in the NRHM:*

- To overcome foul play in selection, it was recommended that the selection committee should comprise at least 10 persons and that 50% of committee members be women. It was also recommended that PRI members and civil society be part of the committee. Selection should be in an open gram sabha meeting and before selection, all committee members should be apprised of the roles and responsibilities of ASHA.
- It was suggested that VHSC should have at least 50% women representation. State specific guidelines for VHSC formation needs to be developed as well as its role in monitoring. Untied funds should be given to VHSC and utilised as per guidelines (e.g., ANM and Sarpanch to be joint signatories). VHSC should be the deciding authority for the utilisation of untied funds. Monitoring of untied funds can be problematic in some places as there are more panchayats under one ANM. In such situations the question was which of the panchayats would be the joint signatory along with ANM.
- The Rogi Kalyan Samiti (RKS) should be a part of the block level planning, monitoring and review teams. However, RKS has not been constituted in many areas. Even where they exist, they are not functional due to lack of clarity about their role.
- The role of civil society organisations should be ensured - they should have a role in selection of ASHA; training of ASHA, PRIs and others (those having experience in health and women's issues should be given preference as trainers) should be members of district and block resource, advisory and monitoring bodies; be a part of external evaluation and social audit teams.

Some other suggestions from the presentation were - (a) to release funds after training of PRIs and ASHA (b) to release funds after submission of village health plans (c) to involve other health and supervisory bodies for monitoring (d) formation of mentoring groups for PRI involvement at state and district levels too.

Presentation: Community Monitoring under NRHM.

Speaker: Dr. Abhay Shukla, SATHI-CEHAT and National Convenor of Jan Swasthya Abhiyan (People's Health Movement in India)

Dr Shukla began with why community monitoring should be at the core of NRHM. He asserted that it should be so because the ultimate judges of health system improvements should be the beneficiaries themselves. Also, community monitoring and planning is a key step towards communitisation, one of the five approaches of NRHM. There are provisions of various levels of monitoring committees in the Mission. The composition of these monitoring committees should be as follows - 1/3rd PRI representatives, 1/3rd health officials, 1/3rd CBO/NGO representatives.

The Chairperson will be from the Panchayat, Executive Chairperson will be a health official and the Convenor will be selected from CBO/NGO. However, community monitoring is not expected to be a smooth process and one should be prepared for this. It will be a rough ride because it involves a decisive change in balance of power, from bureaucrats and health officials to the people. Nevertheless, efforts must be made to actively engage bureaucrats and health officials in this process of change. Also, it is important that genuine voices from the grassroots be represented in this process and not of "pet" or "cooperative" NGOs (e.g., MNGOs) as they often toe the line drawn by the government. Moreover, the skills required to mobilise communities at a large scale and to implement a project are different, therefore CBOs/NGOs best suited to mobilise and monitor should be involved. The other challenge is to motivate communities themselves to play the role of watch dog as for far too long they have been apathetic due to low expectations from the public health system.

Monitoring must be accompanied by rapid and effective remedial action, otherwise people will lose faith in the process. One prerequisite for effective community monitoring is some level of community organisation. Hence involving existing community based organisations, including people's movements, is essential. One way to effectively and rapidly develop community monitoring is by making it a movement. This can be done by allowing genuine community representatives and organisations to self-select and emerge; help people assertively dialogue with health officials; activate and enthuse communities regarding their health rights; and comparatively grow to scale. Dr. Shukla gave examples of Kerala's decentralised planning (1996 - 2001) and Nagaland's communitisation of social service that have proved very successful. Fostering a movement requires a different approach. Building of some critical mass is essential. This process needs to be facilitated at the state level by a mentoring group. Also, service guarantees mentioned in the NRHM documents should be converted into rights based entitlements. There should be capacity building of PRI members and transfer of increased amounts of funds to lower level committees.

Dr. Shukla then went on to outline some ongoing efforts by JSA. There have been regular efforts at monitoring and providing inputs for planning in Maharashtra. However, there is a lack of supportive framework. In Gujarat, joint monitoring and planning committees are being put in place based on model proposed by JSA Gujarat. There has been independent monitoring of NRHM (under People's Rural Health Watch) in the 10 states initiated since mid-2005. He also mentioned that JSA will be organizing a National Health Assembly in February 2007, preceded by nationwide process including district and state assemblies.

Discussions

Questions and comments that surfaced after the presentations were as follows -

- Why is there no integrated planning for NRHM, NREG and SSA? Why do we have separate operating guidelines for different schemes when they have to be implemented by same functionaries at the grassroots? It is very confusing
- There should be no parallel committees - all should be part of PRI
- One should start from what women want. They may not necessarily want health as a priority
- Jharkhand does not have PRI, so have some alternatives been thought of?
- CBO/NGO for campaign work and planning & monitoring should be different.

Ms. Sneha Misha agreed to convergence and integrated planning instead of having separate guidelines. Dr. Shukla was of the opinion that organisations that are in touch with people should be used and they need not necessarily be different.

The session was summed up by Dr. Thelma Narayan, She said that in the first session, the government was very seductive in presenting the NRHM but this session has brought us back to reality. The gaps have emerged. All those working for health as a right should be involved in NRHM to make these rights a reality.

Session 3: Ensuring Informed Choice in Family Planning and Contraception

Chair: Ms. Shailaja Chandra, Executive Director, Janasankhya Sthirata Kosh, Government of India

Co-chair: Dr. Venkatesh, UNFPA

Ms Chandra introduced herself and the newly formed organization - Jansankhya Sthirata Kosh (Populatisation Stabilisation Fund). The Fund has been recently set up by the government to expedite the process of population stabilization using innovative strategies and harnessing non-traditional resources. Resources are available with the government to start activities but they should be able to work through a multiplier effect. The fund has been given the responsibility to bring all good replicable examples (especially non-health sector examples) to further the goals of population stabilization in its widest sense, for example, resolving transportation issues relating to maternal mortality.

Presentation : Addressing population momentum, dual protection, and quality of care issues

Speaker : Ms. Renu Khanna, SAHAJ, Vadodara

Ms Khanna said that for many years the focus of health programmes was on women and on family planning programmes. With the advent of the NRHM, it no longer remains so and all health issues will be addressed under one umbrella. This is good because women will not be targeted but there was a flip side to this that also needed to be considered. There is a possibility that contraceptives services will no longer receive the importance that they should. There is a great unmet need of contraceptives, and as yet a beginning had not been made where temporary methods are concerned. She stressed that while there is a need to increase age at marriage and at the same time an increased supply of contraceptives are necessary to raise the age of first childbirth, spacing between children and also provide contraceptive for unmarried adolescents and adults having consensual non-coercive sex. She emphasized that contraceptives should be client-controlled and not provider-controlled and the emphasis should be taken away from female sterilisation. She drew attention to the occasional unavailability of contraceptives that affect the overall use and effectiveness of temporary methods and said that there should be no stock-outs of contraceptives.

She also said that the issue of 'demand for sterilisation' that is being attributed to women needs to be examined carefully. Is it really their demand or the result of pressure (of any kind) being exerted on them? Is the demand for female sterilisation inevitable when there are no other viable alternatives available? She asked what was happening to female condoms, and said that no one seemed to have any answer to this question. She also wanted to know what was happening to emergency contraception (EC). EC was supposed to be available over the counter, and at all PHCs but was this the reality? A third issue that needed consideration was the contraceptive needs of young people. Mainstreaming of adolescent friendly reproductive and sexual health services was essential. The government needed to wake up to the reality that young people also have reproductive and sexual health needs and that contraceptives are required outside of marriage too. Information on EC should be made available to young people too as many unsafe abortions take place, especially in remote areas.

Ms. Khanna also pointed out that condoms are increasingly being promoted only as a prevention strategy for HIV/AIDS. Condoms are being increasingly associated with high-risk behaviour, which while increasing dual protection may have an adverse impact on its overall usage. The issues of MTP or abortion being used as a family planning method also needs to be understood and addressed, because some disturbing figures have come out from Tamil Nadu and Maharashtra. She emphasized that efforts need to be made to increase male responsibility in sexual relationships and contraceptive usage, without which contraception will continue to remain the responsibility of women. It was unfortunate that the population control mindset (and promotion of 2 child norm) still exists, especially in some of the states. Ms. Khanna concluded by emphasizing that contraceptive services continued to remain a key component of holistic primary health care and that it was imperative to implement guidelines/checklists for quality of care, have good and effective IEC campaigns, increase efforts for male responsibility and also devote special efforts to include urban poor as their health indicators were often worse than rural counterparts.

Presentation : Community Experiences of Informed Choice in Family Planning

Speaker : Ramakant Rai. Healthwatch UP Bihar (on behalf of Civil Society)

Mr Rai started his presentation with the contention that informed choice should apply for the whole gamut of reproductive health services and not only family planning. He said that the presentation was based on the experiences from Uttar Pradesh, Bihar, Jharkhand and Rajasthan. While the NPP 2000 affirms its commitment to voluntary and informed choice and consent and continuation of target free approach, these states (and perhaps others as well) still have a hangover of population control mindset and two-child norm and incentives and disincentives are in place for promoting family planning. Unfortunately in the states mentioned earlier the focus is still on female sterilisation. In Jharkhand, sterilisation accounts for 88% of use of modern methods and in UP, it is 99.5%. Failure rates of sterilisation in UP is perhaps the highest in India, at 5 %. So is the case in Bihar and Jharkhand. Sterilisations are mostly done in "camps", and in Jharkhand these are also organised by corporate bodies on request from CHCs/PHCs. These camps ignore quality of care norms using the excuse that large numbers have to be catered to. Post-operative complications that arise after such camps are not attended to as there is no mechanism to address them. In most CHCs/PHCs, guidelines issued by the government are not available and neither are the surgeons aware of them. Women are made to sign or put their thumb impression on consent forms without its contents being explained. Also, forms are in a language that women do not understand.

Mr Rai now shared information about the recent Supreme Court directives to all states and UTs regarding sterilization operations. These include empanelment of post graduate doctors with at least five years training in Obstetrics & Gynaecology, formation of Quality Assurance Committees, maintaining records of all cases, punitive actions in case of negligence, free insurance coverage from states, compensation to survivors in case of death, disability or failure. However these directives are being flouted with impunity. Pre and post operative counselling and follow up services are still not in place.

Where other contraceptive methods are concerned, ANMs do not have the requisite skills for IUD insertion and information on contraindications of OCPs is not provided to women. It was recommended that individuals and couples be informed of all available contraceptives (temporary and permanent) and then given the opportunity to make the choice. He strongly urged that all forms of incentives & disincentives be removed as well as the two-child norm. Reproductive health programmes needed to focus on all aspects of reproductive health and on nutrition instead of sterilization. He agreed with Ms Khanna that contraceptives should be available to all irrespective of marital status or age and youth friendly services should be promoted. He drew attention to the fact that for certain tribes there were restrictions for providing contraceptive services and these should be removed and also exemplary maternal and child health services should be provided to ensure child survival. He also urged that traditional and indigenous methods of contraception should be mainstreamed. Training for quality RH services is essential and should be an ongoing process for all level of providers. Side by side the community also needs to be educated about its rights and the provisions of the NRHM so that informed choice and quality of care can become a reality.

Discussions

Some of the concerns raised during the discussions are as follows -

- MTP is being used as a family planning method in Jharkhand. Women know of side effects of contraceptives but not of repeated MTP. Most MTPs take place in private facilities where they do not give any information
- One to one counselling for MTP is very important
- In some areas, for providing condoms to single/widowed women and young people, the practice is to register them under other eligible couples (married) as health officials do not want to get into trouble
- MTP for young unmarried girls is a big problem as it is socially taboo

- It has been seen that women getting sterilised at a young age suffer from PID later as the condom is not used by the male partner (since the woman is already sterilised).
- Primitive tribes are legally not allowed to be sterilised for fear of extinction. They do not use any spacing methods too. IMR is high among them, so anyway they are dying

In summing up the session, Dr Venkatesh pointed out that in NFHS 2 it had emerged that the demand for other contraceptives was the same as sterilisation, yet the focus in many states continued to be sterilisation. And even though sterilization has been the method of choice for successive governments, the issue of quality of care in sterilisation continues to be a matter of grave concern. As far as male responsibility is concerned, the mindset of service providers is to take the path of least resistance. Therefore, women are targeted. However a change has been noted in Madhya Pradesh where there are now 7 to 8 % Non-scalpel Vasectomy users every year.

Session 4: New Experiments and Challenges

Chair: Dr. Leila Varky, Independent Public Health Expert and White Ribbon Alliance, India

Co-chair: Dr. G V Ramana, World Bank

Presentation : Reaching out to Adolescents Through the NRHM.

Speaker: Ms. Indu Capoor, CHETNA, and India Alliance for Young People

Ms Capoor started with the contention that adolescents have to be seen as a diverse group. Their diversity can be seen with respect to geographical location, school going and non school going, married and unmarried, sex and gender based differences, differences in socio economic status, employed and unemployed, religious and cultural differences, belonging to rural, urban and tribal areas and so on. In terms of RH concerns, 50% women in the age group 20 - 24 years are married by 18 years and about 24% by 15 years. However only 10% of the married adolescents in the age group 15-19 years use any method of contraception. Additionally 13 % of all deaths in women below 24 years, are related to pregnancy and childbirth. Ms. Capoor gave the example of a girl who was married at 16. She wanted to delay pregnancy but was too shy to speak to her husband about it. She went to a nearby clinic with her sister-in-law but on seeing the crowd, she came away. Soon she became pregnant. Thereafter she went to a local healer and got herself aborted. It was very painful and she bled profusely. Since then she remains unwell. She is also ridden with guilt and thinks that she has been punished by God for having done something wrong (having had an abortion). What is a case of septicemia is being seen as 'just' punishment.

Adolescents have been addressed in several existing policies and programmes. However, this has been largely fragmented. Young people have separate needs but they are either clubbed with adults or with children. They are also diverse but policies and programmes treat them as a homogenous group. Further, policies and programmes do not address young people with special needs. The presentation then highlighted some of CHETNA's efforts to reach out to young people. They include networking, state level consultations & dialogue on young people's issues, capacity building of young people and organisations addressing their concerns, documenting field experiences, developing BCC material.

Ms Capoor's recommendations included the following

- Providing adolescents access to information and services on health (including SRH), contraceptives, abortion services,
- The option for marriage by choice along with increasing age at marriage and legal support if necessary
- Information, services and support for increasing age at first pregnancy;
- Formal education including life skills; vocational guidance, vocational training institutes;

- Freedom from violence and fear of violence at home & workplace, elimination of gender based violence, legal information and support

Ms Kapoor concluded by saying that comprehensive and integrated policies and programmes are the need of the hour, and there is a need to involve young people in planning, implementation, evaluation and follow-up processes.

Presentation : Addressing Declining Sex Ratio Within NRHM

Speaker : Ms. Ena Singh, UNFPA.

Ms. Singh focused on three aspects in her presentation - What has been done? What has to be done? How can it be done within NRHM? She said that the answer to the first question was simple and that very little has been done about declining sex ratio, given the magnitude of the problem. What needs to be done is rigorous implementation of the PCPNDT Act, advocacy to force action and community action for behaviour change. For implementation of the Act, capacity building on the Act should be done as not many people know about its provisions. Also, there needs to be will and intention. Further, there needs to be widespread dissemination of information on status of cases in courts. While engaging in advocacy, it must be borne in mind that many of the perpetrators are educated, well to do and influential. Therefore, different strategies must be adopted. For behaviour change one to one counselling, mass mobilisation and social audits can all be used to bring about changes. NRHM is the main vehicle for delivering and monitoring health services both in the private and public sector and so is an appropriate mechanism to work on this issue as well.

Ms Singh suggested that those involved with NRHM could look out for the following -

- Has the issue of declining sex ratio been included in any of the plans made at different levels
- Has any expenditure been put aside for it
- Is it being monitored and are plans reviewed regularly
- Has the issue been integrated into training programmes and IEC (e.g., presence of one daughter in the family is indicative of impending sex selective abortion, so it can be incorporated in training/IEC on ANC)
- Where institutional delivery is high, delivery can be registered, monitored and correlated with records on ultrasound
- One also needs to explore the possibility of using NRHM mechanisms to mobilise people on the issue.

In conclusion, Ms. Singh said that analysis of Form F can be done as part of regular monitoring processes (Form F is mandated to be filled by ultrasound clinics). In Hyderabad, such an analysis caused an improvement in ratio at birth.

Presentation : Reaching the Unreached - Revisiting the MNGO Scheme.

Speaker : Dr. Sanjit Nayak, Population Foundation of India

Dr Nayak who is responsible for coordinating the Regional Resource Centre under the MNGO scheme in two states said that this scheme was introduced in the 9th Five Year Plan (1997 - 2002), under RCH 1. It was to nurture small NGOs through capacity building and awareness generation. The scheme was earlier directly managed by GOI. There has been a paradigm shift under RCH 2. From awareness generation, the focus has shifted to community mobilisation (through field NGOs) and service delivery (through service NGOs). A Technical Advisory Group has been formed for capacity building. An Apex Resource Cell has been set up at the national level and Regional Resource Centres at the state level to provide support to NGOs under the scheme. Some of the challenges faced were that it is a stand-alone scheme, and there is decentralisation without adequate support mechanisms. The role of NGOs in district implementation plan is not in consonance with state programme implementation plans. The MNGOs are also responsible for ensuring quantitative changes at community level with limited resources. There is high expectation all around but there is also absence of adequate monitoring systems.

Dr Nayak also drew the attention of the group to the dual role expected out of MNGOs in the NRHM - implementation as well as monitoring. Too many parallel structures are there for capacity building. While opportunities exist for MNGOs to voice community needs at every forum and to act as pressure groups towards strengthening community action and public health system, these activities could also be counter productive to their service provider role in complementing and supplementing government service delivery and to improve out reach of services to new areas.

Presentation : Public-Private Partnerships: New Experiments and Challenges

Speaker : Mr. J. P. Misra, European Commission Technical Assistance.

Mr Mishra started his presentation by mentioning that the underlying objectives of such public - private partnerships is to be seen in the context of health as a right and that the poor should have access to improved quality of care without having to pay exorbitant amounts for it. The state should ensure that essential services are provided to the poor, whatever the public-private mix of financing and provisions are. Also, resources should be used as effectively, efficiently and equitably as possible. Mr. Misra highlighted some recent initiatives in some states. In West Bengal, for example, out sourcing of ancillary ambulance services for emergency transport in rural areas has proved very successful. The process of policy development was gradual - first a pilot project was run, changes were incorporated based on feedback received and then the policy was formulated. Now there is a 5-year agreement between district health service and a non profit private service provider (PSP). The role and responsibilities of PSP are to operate and maintain the vehicle, ensure that vehicle "downtime" is not more than 1 day a month. In exchange for the endorsement the PSP is allowed to collect charges as per the charges fixed by GoWB and park the vehicle at the assigned health facility. The District Health Society's role and responsibilities include handing over the furnished vehicle with insurance and road tax pre-paid for 5 years, ensuring telephones at the assigned facility. After a rapid assessment, some of the lessons learnt were - (a) train driver/attendant in providing first aid (b) clarify payment structure when collecting user charges if two patients are transported. Some other questions that had come up during the assessment were who signs if patient is picked up and taken to private hospital within district, whether or not ambulance should be allowed to be taken to hospital of patients' choice and so on. The West Bengal PPP Policy Document (2006) has a wide range of proposals under consideration/implementation. In Bihar, health services that have been out sourced are ambulance services, diet, laundry, cleaning of premises, installation, running & maintenance of generators, x-ray/pathology etc. However Bihar has gone in for large-scale implementation without a trial phase and there may be many unanticipated problems.

In Gujarat, the Chiranjivi Scheme is an example of service out sourcing. The objective of the scheme is to promote institutional delivery for BPL in five districts with high maternal mortality. The approach is "bundled" financial incentive (for every 100 deliveries) to prevent "unnecessary" C-sections. Initial impact has been positive - many PSPs have enrolled in the 5 districts, 31 % BPL women accessed the service and there has been no case of maternal mortality, however there have been 19 infant deaths. Interestingly there have been 87.3% normal deliveries, 7.3 % assisted deliveries and 5.4% C-sections. The Indian Institute of Management, Ahmedabad has taken it up as a case study. There are some system issues that still need sorting out, especially those related to standards, accreditation and regulation. For example, in health sector, a public provider (CMO) is the implementing authority for implementing standards/protocols set out in PCPNDT Act. This creates conflict of interest. The biggest challenges are successful implementation of PCPNDT Act and other acts as well as design and implementation of demand side financing mechanisms (voucher scheme, micro health insurance) on a sustainable basis that requires creation of independent oversight agencies.

Discussions

Some of the questions and concerns that participants posed to the presenters are as follows •

There is no political will to implement the PCPNDT Act

- Declining sex ratio is a social issue. Yet there has been no meeting of the committee
- There should be emphasis on treatment of girl child that is born and that of mother. Is there discrimination in that too
- MNGO is an implementing agency, so how will it cater to voices that are different
- What is PPP? We should say no to it and reverse the process.
- PPP - why not build the capacity of government in the first place instead of out sourcing to private entities
- PPP - how much self-regulation happens? Where is the conflict of interest in case of CMO
- Livelihood issues too of young people need to be addressed
- We need to rock the boat and change the perspectives of service providers/system (vis-a-vis young people's SRH needs). This should be included in capacity building.

Dr. Sanjit Nayak agreed that there is over reporting and under performance. But this has been taken note of and is being addressed. Ms. Ena Singh agreed that there is no political will. Voices need to be raised and full-fledged advocacy should be taken up. Mr. J. P. Misra pointed out that self-regulation should be an overall mechanism. The CMO is in charge of public hospitals as well as responsible for quality checks. This causes conflict of interest. He was of the opinion that something like the RKS cannot be outsourced. It should be an empowering mechanism/platform. He said that PPP is to improve efficiency.

Day 2 - July 27, 2006

The second day began with reflections on the previous day's proceedings. Participants felt that there were no government representatives during discussions to address their concerns. It was therefore decided that a list of concerns/recommendations (key issues at grassroots) that emerged from the previous day's deliberations be compiled and presented to Ms. S. Jalaja, Additional Secretary, MOHFW, and Mission Director NRHM, who was to chair the first session of the day (session 5) later.

(These recommendations have been merged with those that emerged in the last session.)

Session 5: Securing Maternal Health and Safety

Chair: Ms. S. Jalaja

Co-chair: Dr. Ardi Kaptiningsih, WHO, SEARO

Discussant: Dr Win Win Soe, UNICEF, India

Before calling on the participants to make their presentations, Ms. Jalaja announced that the framework of implementation was scheduled be tabled before the Cabinet for approval that very day. So it was an important day for NRHM. (The framework of implementation has since been passed by the Cabinet).

Presentation : NRHM - An Opportunity for Improving Maternal Health Services in India.

Speaker : Dr. M. Prakasamma, Academy for Nursing Studies, Hyderabad

Dr Prakasamma began her presentation by mentioning that over the years there has been no change in the causes and magnitude of maternal mortality. The causes continue to be the same - (a) haemorrhage (b) hypertensive disorders (c) sepsis (d) abortion (e) obstructed labour (f) others. Even the magnitude remains the same, as high as five per 1000 live births. The current focus is on institutional deliveries and skilled birth attendance (SBA). However while tackling maternal mortality, ANC and PNC should not be excluded, otherwise the results will

remain the same in 10 years time. She then questioned some assumptions around delivery. The assumption seemed to be that childbirth is an individual event divorced from family processes. The assumption is also that every pregnancy is a risk and that institutions are geared to tackle complications and related morbidity. Institutional delivery is taken as a positive indicator and home delivery is seen as a negative indicator. Unfortunately sub centres are not seen as institutions and PHCs/CHCs are not ready for working 24X7. The truth however is that child birth can occur anytime and SCs are geographically closer to people. Further, can FRUs handle all the institutional deliveries if they came to them? She stated that there has been a shift in levels of skills for maternal health care - from TBA to SB A. However, the rationale for this shift is inadequately explained. It needs to be examined whether it is the TBA and her skills or the support that is lacking that lead to high MMR.

The speaker stated that by definition an SBA could be an ANM, GNM (nurse-midwife), professional midwifery practitioner, general doctor or an obstetrician. However the ANM of today is neither a nurse nor a midwife - she is a multipurpose health worker. But if she is going to take on the role of SBA, where is she going to conduct the deliveries? The ANMs working in the public health system are not used to provide the total range of maternal and child health services. Also, there is no support to facilitate and monitor attendance at deliveries. Training of ANMs as SBAs has not started. GOI guidelines are yet to be converted to training modules. Further why train ANMs in life saving skills if they are going to promote institutional delivery and if they are not empowered to conduct deliveries? the truth today in rural India is that not even a quarter of the childbirths are attended by ANMs and several self styled practitioners with no training or skill are attending to women in labour, thereby increasing MMR and IMR. The ANM at least has some training, so she should be used more efficiently. General doctors are not skilled enough to function as SBAs (medical education does not equip them). Also, their availability round the clock is doubtful. Using obstetricians as SBAs means irrational skill use and higher costs.

Today it is being accepted that PHCs are not adequately equipped for normal delivery, and the move is towards specialist services, however it is being forgotten that the higher the center, greater is the distance and fewer their numbers. Increasingly normal deliveries are being pushed to the realm of specialists, along with higher costs and privatisation (e.g. Chiranjivi Scheme in Gujarat). Dr. Prakasamma recommendations for improving maternal health and safety using the NRHM mechanism included the following-

- Skills and service analysis should be done at all levels from the home to the tertiary hospital
- Training of all level of providers to be given priority with intensive tutoring to ensure skill building
- Enabling environment for all levels of providers
- Rigorous monitoring at every level through professional and community based mechanisms
- Linkage building for efficient referral- ASHA to SBA to institution
- Protect ASHAs' role as activist, change agent, facilitator.

She ended by asserting that NRHM is an opportunity - it indicates a desire to change. However the direction of change needs to be examined carefully if necessary and given a different direction.

Presentation : New Initiatives in RCH 2.

Speaker : Mr. Sanjeev Gupta, , Deputy Director RCH 2, MOHFW, Gol

Mr. Gupta first gave an introduction to RCH 2. He then went on to explain at length the corrections done from RCH 1. The presentation then delineated the guiding principles for new initiative for maternal safety under RCH 2. They are (a) equity - focus on the poor, underserved and vulnerable sections (b) evidence based - only Interventions that have proved successful to be included (c) continuum care - complementary mix of community and facility based interventions (d) health systems approach - core focus will be on strengthening of health systems (e) integrated services - a comprehensive package of RCH, new born and child health. The objectives of the new initiative are improved access to skilled care and emergency obstetric care, improved coverage and quality of

antenatal care, and increased coverage of postpartum care. To enhance availability of facilities for institutional deliveries and EmOC, several provisions have been put in place although many of them are yet to become operational. Provisions include

- Operationalisation of all CHCs and at least 50 % of PHCs for providing round the clock, 24*7 delivery services
- Operationalisation of emergency obstetric and child care services at the 2000 FRUs
- Ensuring access to blood bank at all district hospitals and a blood storage facility at the FRUs
- Training of Medical Officers in anesthetic skills for EmOC, training of MBBS doctors in conducting caesarian sections
- Providing emergency obstetric care to BPL families at recognised private facilities
- Redeployment of specialist from dispensaries and PHCs to FRUs and CHCs, involving general surgeons in providing EmOC
- Providing ambulances at PHCs/CHCs/ FRUs.

Presentation : Maternal Health in NRHM: Community Experiences

Speaker : Ms. Smita Bajpai, Chetna, Ahmedabad (on behalf of Civil Society)

Ms Bajpai began by quickly recounting the steps included in NRHM for improving maternal health including the Janani Suraksha Yojna and emphasis on institutional delivery through mobilization by the ASHA. The presentation then pointed out some operational issues with regards to each of the components

- How does one ensure that women will go public health centres when they do not know of their entitlements there, are abused by the public health system and have to travel long distances to avail life saving services
- Families make culturally appropriate decisions about health, pregnancy and childbirth and these are domains the domains of the household. How will an impersonal institutional delivery process help
- How does one ensure availability and accessibility of the SBA 24x7 within 2 hours of reach? Also, who will be the SBA in India? Where will she reside
- What will happen to dais? Will the SBA reduce maternal mortality on her own? How will JSY reduce maternal mortality? What is the evidence for success
- Who will be in control of the delivery process- the woman or the providers
- How to prevent marginalisation of poor women that are bound to take place because of the linkage of JSY with the two child norm and age parameters
- How to ensure smooth coordination between AWW/ANM /ASHA? How to deal with power struggle between women/ ASHA/ Dai/ AWW and ANM? What if a woman delivers on the way? Who will get the incentive money, and how much
- How to build the ASHA's self confidence and make her gender sensitive? How to build capacities of ASHA trainers
- Why is the burden of JSY on ASHA? What if ASHA turns out to be a worker and not an activist

Ms. Bajpai then drew the participants' attention to key problematic areas. Maternal health is viewed very clinically. Inequities and diversities are not addressed. There is lack of evidence based planning (e.g., more than 60% maternal deaths occur in post natal period, yet focus is on institutional deliveries to reduce maternal mortality. Dais assist more than 50% of births, yet dais have been scrapped from the system). Male responsibility is not addressed. There is lack of linkages between nutrition and maternal health and well being. Due recognition has not been given to indigenous knowledge on maternal health and healing and AYUSH.

Mrs. Bajpai recommended that maternal health be rooted in the community.

- Women have the right to safe motherhood, whether in an institution or at home. Women should be informed about their rights. Social audits should be done at gram sabha level for maternal deaths too. Also, VHC should be empowered to monitor maternal health plans. Facilities should be made accountable to the community.
- Dais should be preferred in the selection of ASHA, where ever possible. In places where incidence of home delivery is high, dai training must be continued. If a woman prefers home delivery, a trained dai should be available, with a referral system in place. Dais should be birth companion in institutions.
- For strengthening of public health systems, complete and continuous essential and basic emergency obstetric care should be provided at sub center level (24x7), display of services provided be made mandatory at all health facilities. There be birth preparedness and complication readiness at all levels
- Quality of services have to be improved. Services should be women friendly, community friendly, and there should be gender sensitive providers and facilities. Companions should be allowed in labour room and best practices like squatting, no episiotomy, movement etc. should be adopted.
- To enhance poor women's access to JSY, it was suggested that a pilot project first be implemented; all women be included irrespective of age and number of children. There should be no compulsion to accept terminal methods, BPL proof should not be made mandatory and the cash should be paid to the woman through the VHC in the last trimester.
- There should be linking of nutrition with maternal health. All women, adolescents and children should be able to access ICDS (locally available foods, rich in energy that are not easily available at home should be distributed). Adequate resources should be allocated for IEC and access to nutrition should be improved (promotion of kitchen garden, herbal garden for nutritious foods). There should be minimal usage of drugs such as micro nutrients/fortification/tonics. AYUSH should be mainstreamed.

Summing Up

The Co-chair, Dr Ardi Kaptiningsih of WHO SEARO summed up the session by giving the gist of each presentation and then invited Dr Win Win Soe of UNICEF to give her comments. Dr Win Win said that during her field trip to UP she found that sub centres functioning out of government owned buildings functioned well but not so when operating out of rented spaces. She also suggested that medical schools should provide training on delivery to all medical students instead of them having to undergo that training later.

Ms Jalaja Chair of the session and Mission Director NRHM gave the concluding remarks. She began by quoting Karl Marx who had said that many ideas have been conceptualised but very few have been implemented. NRHM is one good idea and right now the efforts are on to implement it. For reducing maternal mortality, institutional mechanisms were being set up in the last one year. There has been a policy intervention - training on anesthetics is to be given to all doctors. Training of ANMs as SBA at district level will take place soon. However, dais have not been forgotten - their training will continue. There was a request from Bihar if TBAs could be recruited as ASHAs. They have been discouraged as ASHAs require some level of education. PPP need not be viewed with suspicion. It can be a productive partnership also, for example, FOGSI is to train in Obstetrics and Gynaecology and Karuna Trust is to run some PHCs/CHCs.

She said that seventy to eighty percent of funds under NRHM will be utilised below district level. States will have to take the lead in this. Issues have been demarcated at the national but states will have to prioritise them according to their own needs. AWW, ANM and ASHA will work in tandem. This will happen because the ASHA will be placed at Anganwadi and convergence will happen on the monthly health day. NRHM is also making efforts to increase human resources. If the Cabinet approves, each PHC will now have two ANMs, one of whom will be a local resident and 3 nurses. A request has been made to state governments for imparting multi skills to doctors in

medical colleges. There is an excellent example from Tamil Nadu where AYUSH has been integrated into sub centres and PHCs. Also, HIV/AIDS has been integrated into RCH. There are other excellent examples - in Bihar, 800 ambulances have been commissioned and in Chattisgarh, Mitatin intervention has brought down IMR by 17 %. She also said that according to a recent amendment in rules sub centre deliveries will be deemed as institutional deliveries under JSY. ASH A will be trained in home based care to bring down neo natal deaths. Also, there is going to be integration of PCPNDT Act in NRHM. To overcome staff shortage, appointment of doctors and nurses on contractual basis (for the time being) has taken place till such time this system gets regularised. Ms. Jalaja emphasized that the government believes in community participation and monitoring and rights based approach.

Session 6: Recommendations

The last session comprised of a plenary discussion on recommendations for the government as well as the civil society. Detailed recommendations have been provided at the beginning of this report.

In order to understand the influence and potential of civil society organizations in the design and monitoring of the NRHM and the following matrix was made.

<i>Mission Mechanisms</i>	<i>Mission mandated bodies</i>	<i>Civil Society</i>
Mission steering group, ASHA mentoring group, Advisory Group on Community Action, Task group on PPP, Task group on mainstreaming AYUSH, Task group on Medical education, Task group on IPHS	State Health Society, District Health Society, Rogi Kalyan Samiti, Village Health and Sanitation Committee	AIDAN, Health Watch, Health Watch UP-Bihar, Indian Women's Health Movement, Jan Swasthya Abhiyan, Mahila Samakhya (not represented in the group), MASVAW, Medico Friends Circle, MNGOs, National Alliance for Young People, National Alliance of Women's Organisation, Wada Na Todo Abhiyan, White Ribbon Alliance, India Women's Health and Rights Partnership (WHRAP)

It was found that civil society participation had been included at the national level in the ASHA mentoring group and the Advisory Group on Community Action, and in the Task Groups but the task groups were being wound up because most of them had finished their assigned tasks. Also there were hardly any opportunities to prepare a consensus and coherent action plan that could be placed before the government and usually individual opinions were solicited and considered. However where states were concerned the influence was limited because many mission mechanisms had not been put in place. In Orissa and Jharkhand, there was a Mission Steering Group. One of the participants is a member of the steering group in Orissa. In Rajasthan, an ASHA Mentoring Group has been set up and there are five civil society in it. Where mission mandated planning and monitoring bodies were concerned there was hardly any participation of civil society bodies and networks beyond the MNGOs and the problem with MNGO participation had been discussed during the consultation. There was a discussion on whether civil society groups should become members of various committees just to keep the notion of civil society participation alive, or whether they should participate as activists.

The group felt that in addition to providing recommendations to the Government it was necessary to have recommendations for the civil society as well. It was essential that the civil society groups and networks shared information among themselves. This would be the only way in which effective and coherent civil society participation could be ensured for successful implementation of NRHM in the interests of health equity.

The Consultation ended with Ms Jayeeta Chowdhury of the Centre for Health and Social Justice proposing the vote of thanks.

Taking Stock: Civil Society Consultation on NRHM & RCH 2

July 25, 2006, New Delhi

Session 1

Welcome and background to the consultation

The consultation began with a welcome note by Jayeeta Chowdhury and Abhijit Das from the Centre for Health and Social Justice. Jayeeta gave a brief description of the preparatory process that had taken place earlier in the year. The objective was to prepare a base for advocacy for proper implementation of the National Rural Health Mission (NRHM) and within it, of the Reproductive and Child Health 2 (RCH 2) programme. More specifically, it was to identify spaces for creative vigilance of these programmes by civil society groups in the eight EAG states (Bihar, Jharkhand, Uttaranchal, Uttar Pradesh, Madhya Pradesh, Rajasthan, Chhattisgarh and Orissa).

Towards this end, a multi stakeholders' consultation took place in January 2006 where a broad framework of strategies for creative vigilance of NRHM and RCH 2 were identified and planned. Following this consultation, a series of state and regional level consultations and workshops took place in the eight EAG states from March to June 2006. The civil society organisations that took part in these consultations in turn oriented more community based organisations and community leaders.

It was emphasised that this process was followed so as to see how civil society could play a creative and effective role in monitoring NRHM and RCH 2. An investigative study on key components like JSY, ASHA and Unfunded was also conducted in these states to understand the progress of NRHM. The study showed that the problems and issues in all the states were similar. The study led to the compilation of a citizen's report on one year of NRHM. This document will be used as an advocacy tool.

The challenge in front of civil society was to plan for the future. This consultation was a platform for the participants to make an action plan and decide on a time frame within which this plan would be implemented. As representatives of civil society groups, participants had to take a decision on precisely what they would do in the next phase of advocacy and how they would monitor the Mission's progress keeping in mind their respective strengths. Participants also discussed problems that they faced in the last six months.

The recommendations of the consultation were shared at a larger consultation held on July 26 and 27, 2006. The larger consultation was attended by different stakeholders (See section 1 of report).

Abhijit stressed that this consultation was not meant to facilitate a new networking process. Rather, it was part of a process to strengthen the work of all networks working on health issues.

Introduction of networks

As most participants were from some health network or the other, they were requested to acquaint others with the work of their network.

Indira Chakravarthi from **Jan Swasthya Abhiyan (JSA)** introduced her network that began in 2000. It emerged out of the fact that while the slogan 'Health for all' was coined in 1978, the promise remained unfulfilled. JSA therefore started a right to health campaign. The network has organized various public hearings where members of the National Human Rights Commission have also been present. These public hearings have brought to light gross violations of right to health care. JSA members are also part of various task groups where they raise significant questions at different fora. People's Rural Health Watch was started by JSA in January 2006 to monitor the impact of government initiatives on health. JSA has formulated different survey formats based on key components of NRHM. It has also begun documenting the impact of NRHM. A critique and analysis of the programme is in progress.

Another participant, Dr. Alpana Jana from Chhattisgarh gave a brief description of **Shaheed Hospital**, established in 1982. Doctors used to deny medical services to labourers as they were considered dirty. This resulted in labourers and people from weaker sections collecting funds and opening a hospital for themselves. What began as a 15-bed hospital has now expanded to a 100-bed facility. Medical services here are provided at a very low cost. The Shaheed Hospital is an excellent example of community owned service. Labourers take pride in saying that it is their own hospital. The hospital also trains nurses from villages. Despite its achievement, the hospital has the perennial problem of paucity of doctors.

Sneha Mishra from Orissa introduced participants to the **National Alliance for Women (NAWO)**. NAWO has its head office in Delhi. The Orissa chapter has been active since 1995. It is working on violence against women, empowerment, poverty and health. Advocacy against the two child norm and land rights has also been taken up. Additionally, it has been working on women centered health training programmes. NAWO has also been helping UNICEF with the school curriculum in southern Orissa.

Dr. Maya Prasad, a **NAWO** member from Jharkhand, provided further information on this Alliance which has chapters in several states. It functions in 12 critical areas in accordance with the Beijing Conference of 1995 - political participation of women, violence against women, health, poverty, education, gender resource training, research, gender budgeting and preparing gender trainers. Dr Prasad added that the **Jagran Samiti and Samadhan's (JSS)** focus was health and it was keen to take up ASHA training. She told participants that NAWO was in a bad shape in Jharkhand and that her organization was trying to rejuvenate it.

Voluntary Health Association (VHA), Bihar/Jharkhand participated in the regional consultation held in Lucknow. VHA is a part of Health Watch UP Bihar.

Susheela from U.P described the **Women's Health & Rights Advocacy Partnerships (WHRAP)** as a South Asian network advocating in particular two sexual and reproductive health rights, viz, maternal and adolescent sexual health. The network started in 2003. Besides India, it has NGO partners in Bangladesh, Nepal and Pakistan. Its Indian partners are CHETNA in Gujarat and SAHAYOG in U.P. Working at different levels; it focuses on evidence-based advocacy. WHRAP is presently gathering case studies on maternal health. It is also involved in developing community leadership.

Bharat Gyan Vigyan Samiti (BGVS) is spread across 23 states in India. It used to work on education when it first began but its work now centers around women's reproductive health issues. In Orissa, BGVS is a part of JSA. The BGVS presented 20 cases of health-care denial before the NHRC. While the JSA works for 'Health for all', the NRHM concentrates on RH components only. But even though ASHA is a key component of NRHM, the government is only concerned with achieving quantitative targets as a result of which the ASHAs do not know much about NRHM or their roles and responsibilities. BGVS plans to launch a movement to monitor the implementation of NRHM.

Ravi from U.P. gave a brief description of **Men's Action for Stopping Violence Against Women (MASVAW)**, a network started by men to involve other men in the journey towards gender justice. Maternal death is one of the

issues on which it works. It raises awareness and works towards dispelling myths and superstitions, addressing patriarchal notions, as well as ignorance and neglect by private doctors. MASVAW initiated a 16-day campaign against maternal death in 18 districts of the state. It conducted action research in six villages of two districts of U.P. to understand maternal death and how men could promote women's reproductive health.

Sadhna Pathak from YSSS which is a part of JSA Madhya Pradesh, informed that she is also associated with **White Ribbon Alliance (WRA)**. The White Ribbon Alliance for Safe Motherhood was formed with a view to increase awareness on the need for safe pregnancy and childbirth. The alliance recognises and builds on the work of the Safe Motherhood Initiative (SMI) launched in 1987 at an international conference held in Kenya. The goals of WRA are to build awareness, build alliance and act as a catalyst for action.

Ramakant Rai from U.P. described **Health Watch U.P. Bihar (HWUPB)**. It is a national network formed during ICPD to advocate for women's health issues. Health Watch is active in the four states of U.P., Bihar, Uttaranchal and Jharkhand. It keeps a watchful eye on health and population policies and their effect on vulnerable groups. Since 1996, it has been working against coercive family planning policies. It has also worked to bring to an end the two-child norm. It considers population as an asset. Government sterilisation camps, which have been organised on a very large scale in the states where Health Watch works, are blatant examples of violation of rights on a large scale that the network has raised. HWUPB conducted a study on this issue in 11 districts and filed a PIL in 2003. This resulted in the Supreme Court issuing guidelines on family planning. HWUPB has also helped the Uttaranchal Government in drafting its population policy. The network has been working to ensure state responsibility towards public health.

Lalu Ram Gameti introduced PRAY AS in Bikaner, Rajasthan that was working with Rural Health Watch.

Sudipta Mukhopadhyay introduced the **Population Foundation of India (PFI)**. PFI works to strengthen non government organisations, community based organisations, self help groups, Panchayati Raj Institutions and the organised sector. Its works on population, health and social development issues with the goal of empowering the community as a whole. Its focus areas of interventions are:

- RCH issues - direct support/alliance building
- Advocacy against sex selective abortion
- HIV/AIDS - it works in, six, high prevalence states in the area of treatment and awareness
- Encouraging participation of young people - involving young people on health issues, holding workshops for consensus building and working towards influencing policy

After the introductions, Abhijit Das raised the issue that mere mention of high MMR in policy documents by the Government was not sufficient. Civil society needs to monitor the MMR for the next six years as the high maternal mortality rate in India is a matter of shame. This problem should also be tackled in the eight EAG state and not only in states like Maharashtra and Tamil Nadu. India's success in tackling high MMR depends upon its success with the issue in these eight states where the situation is looked at with complete despair. The challenge in front of all civil society groups is to ensure that the government fulfills its responsibility in these states.

In the end, Abhijit introduced the Center for Health and Social Justice (CHSJ), one of the organisers of the consultation. CHS J is an endeavor to bring health experts, indefatigable companions, their viewpoints and 10-20 years of experience of working on health issues to the same platform. It is not a network but has been formed to function as a support centre. It works to ensure that through exchange of information, skills and capacity building, all existing health networks are strengthened and advocacy efforts are successful. CHSJ is eager to extend its support to all networks.

Session 2

This session comprised groups making amendments to their respective citizen's report on completion of one year of NRHM (state wise). The report was compiled by CHSJ, on the basis of survey reports collected from different states, with the exception of Bihar. The second activity undertaken in this session was working out recommendations in thematic groups for the larger consultation that was to follow in the next two days. This was attended by government officials, members of the advisory group and mentoring group, experts and donors (see section 1 of report).

The participants broke up into state-wise groups. Each group shared the draft citizen's report among itself, deliberating upon the changes that were required. These were later shared with all, each helping all the participants to understand the overall status of implementation of NRHM in the eight EAG states. The proposed amendments were incorporated into a state-wise Report on One Year of NRHM (See Citizen's report).

The participants were then asked to divide into the following four thematic groups:

- a. Maternal health related interventions
- b. ASH A Selection and Training
- c. Informed Choice in Family Planning
- d. Decentralized planning, Monitoring and involvement of PRIs

Depending on their interest, participants chose one of the four groups to deliberate upon key issues and recommendations. These thematic groups later made presentations to the larger group, which were incorporated into the presentations finalized for the Stake holder's Consultation (For the recommendations on each of these thematic areas, please see the detailed report of Stakeholders Consultation).

Future planning

Towards the end of the discussions, Abhijit Das invited Ramakant Rai of U.P. to facilitate a discussion on future planning in order to take the-advocacy efforts forward. Rai pointed out that several new features were incorporated in the Mission document. The document talks of transparency in the system. However, the ground reality is exactly the opposite. On being asked about IPHS, a CMO replied that it was being formulated and that he could give more information on it later. Civil society groups must ensure that there is transparency in the NRHM system. Rai invited participants to forward their concerns and offer suggestions for future planning. Important issues emerging from the discussion were:

- A lot has been said for working collectively but how to work as a single forum?
- Can we make pressure groups? Another meeting is needed to plan in detail.
- Role of the media was not discussed. The media can play a role in updating people on the Mission's progress.
- Future planning should be done at the district level.
- NRHM gives an opportunity to reflect on broader issues and not only about women and child health.
- A campaign can be started to sensitise service providers at PHC level and PRI members. If PRI members could be given the authority to issue BPL certificates then women who do not hold BPL cards may also take advantage of JSY scheme.
- The 8 EAG states should work collectively with Health Watch and should engage in advocacy.

- A participant from M. P. informed that his organization had been working on Right to Information Act and had met with some success. He suggested that it should be used while advocating for proper implementation of NRHM.
- Steps should be taken to ensure the completion of ASHA training by the end of 2006.
- Compliance with timeline, as mentioned in the Mission document, must be monitored.

The Consultation ended with Ms Jayeeta Chowdhury of the Centre for Health and Social Justice proposing the vote of thanks.

One Year of NRHM in Bihar

Bihar at a glance

Demographic Profile

According to Census 2001, Bihar has a population of 82.8 million. It has a population growth rate of 28.4 %. The overall sex ratio is 921 and the child sex ratio (0-6 years) is 938. The state has a female literacy rate of 35 % and an overall literacy rate of only 49%, which is lower than the national average of 65.38 %.

Health status

According to NFHS 2, Bihar has a birth rate of 32.1 % and death rate of 10.2 %. There is a lack of work culture in its government service providers. The evaluation and monitoring components of health programmes implemented by the government are weak. The health infrastructure is very poor. RCH Facility Survey results (phase 1) show that only 15% PHCs have labour room facility. EMOC drugs were available at only 0.8% facilities and ORS packets were available in only 19% of the PHCs. Of 24 FRUs surveyed, only 17% had labour rooms and only 33 % had specialist obstetric-gynaecology facility. There was an acute shortage of health personnel in the state. Lack of coordination among existing health functionaries further worsened the situation.

The National Disease Control Programme has not shown any success in Bihar. The state has the highest number of Kala Azar cases (a whopping 21,797 cases) and the highest number of deaths from the disease. The prevalence of other vector-borne diseases like malaria and of filarial and communicable diseases like tuberculosis is quite high. The occurrence of water-borne diseases is also high as only 30% of households get safe drinking water.

Reproductive and child health status

According to NFHS 2, Bihar has a Maternal Mortality Rate of 452 per 1, 00,000 live births (SRS- 1998). The percentage of women getting adequate antenatal and postnatal care is abysmally low. Only 15.1 % of pregnant women get an antenatal check-up in the first trimester. Only 36% get their antenatal check-up from a health professional. 57.8% women get two or more tetanus toxoid injections during pregnancy. 44.2% women report at least one reproductive health problem. 65.8% women are assisted by traditional birth attendants at the time of delivery. The women do not get enough nourishment. 63.4% of women suffer from anaemia. The health system provides no respite as only 24.1 % women get IFA tablets or syrup during pregnancy. Social factors also contribute to highMMR. Bihar has the highest percentage (51.5%) of girls marrying before 18 years.

Women bear the burden of population control. There is a vast difference between the figures of female and male sterilisation. Female sterilisation is 19.2% whereas male sterilisation is a mere 1.0%. Condom use is only 0.7%.

The state has an Infant Mortality Rate (2002) of 72.9%. Only 11% of infants are fully vaccinated. 81.3% of children (6-35 months) suffer from anaemia. Further, 53.7% of children are chronically undernourished (stunted) and 54.4% are underweight.

Implementation of NRHM in Bihar

The implementation of NRHM is quite sluggish in Bihar. A document published by the Ministry of Health and Family Welfare shows that not even a single BPL woman benefited from the JSY scheme till June 2006. State and district action plans and an action plan for mainstreaming of AYUSH were yet to be made. None of the CHCs were upgraded to FRUs. Human resource planning for IPHS was yet to be done. However, Bihar had the highest number of ASHAs selected till June 2006, a total of 39,312.

Bihar: A Grassroots Review

To understand the status of NRHM implementation in the state, a survey was conducted in 17 districts of Bihar - Banka, Sitamarhi, Madhepura, Patna, Saran, Shekhpura, West Champaran, Gaya, Nalanda, Purnia, Buxar, Gopalganj, Vaishali, Suapaul, Bhojpur, Jehanabad and Navada. A total of 14 district authorities, 43 PRI members, 34 Anganwadi Workers (AWWs), 16 ANMs and 13 ASHAs were covered. Additionally, 32 women who had family planning operations in the past three months and 39 women who delivered in the past three months were interviewed.

The key findings of the study are:

General provisions

- Half of the AWWs had not heard about NRHM. Of those who had heard about it, almost half did not know its main features.
- Two third of PRIs and ANMs had heard about NRHM. However, only half knew its salient features or had limited knowledge about it (some were under the impression that NRHM was for promoting immunisation programmes or was for pregnant women).
- District Health Missions/Societies were constituted in almost all the districts.
- The District Action Plan was yet to be prepared in one third of the districts. Where plans had been made, the basis of planning was district PIP and in very few cases State PIP.
- In two districts, Rogi Kalyan Samitis (RKS) had not been formed. Where RKS had been formed, district authorities were not able to share the details.
- Some progress had been made in the upgradation of PHCs. All district authorities, except two, reported upgradation of PHCs in their districts.

ASHA scheme

- A third of the district authorities said no training had been given to ASHA as yet.
- In one third of the districts, selection of ASHAs had not been completed.
- Over half of the district authorities responded that ASHAs were selected by CMO or village head and Health Officer or ANM and village head. They had no idea that she was supposed to be selected in the village meeting.
- One fourth of the PRI members had no idea of her roles and responsibilities.
- Most of the ANMs & AWWs also had very limited idea of her work. They were under the impression that ASHA was meant to assist them in immunisation and listing of pregnant women.
- Even ASHAs themselves had very limited knowledge about their work.

Janani Suraksha Yojna

- None of the women got any money from the government under JSY (10 out of 39 women interviewed were from BPL families).
- 13 out of 16 ANMs said that they did not receive any money to disburse under JSY scheme. An ANM said that she had not heard about the scheme. Another ANM said that the objective of JSY was to promote female sterilisation.
- Most of the ASHAs did not know the main features of JSY.
- District authorities accepted that no money had been disbursed under the scheme. None of them had any record of women who had benefited from the scheme.
- Half of the women responded that their deliveries took place at home with the help of a midwife. Women had spent money ranging from Rs 100 to Rs 5,000 on delivery.
- Half of those who had undergone a child-birth in the last three months had received either no checkup or had received incomplete checkup during pregnancy.
- One fourth of these women said that ANMs did not visit them during their pregnancy.

Untied Fund

- Four out of 14 District Authorities said they had not received money to disburse as Untied Fund. Most of them said they had no report to show for what purpose this fund was being used.
- Half of the PRI members had not heard about Untied Funds.
- Out of those who had heard about it said that they have yet to receive the money.
- Most of the ANMs said they had not received any money.

Target-free family planning with quality services

- Almost half of the District Authorities accepted that there were targets for sterilisation and most knew the exact numbers.
- In most of the districts, Quality Assurance Committees had been formed.
- Half of the women who had undergone sterilisation said they did not get any certificate after operation.
- None of these women know about Family Planning Insurance Scheme and nobody had told them about it either.
- One third of these women said that ANMs never visited them after the operation.
- The women had spent amounts ranging from Rs 800 to Rs 8000 on sterilisation.
- Ten out of 32 women said that terms and conditions were not explained to them before getting their signature on forms.
- Two women developed complications after sterilisation.
- A few women said no test was conducted on them before the operation.
- Although most of the District Authorities and ANMs had heard about the Supreme Court guidelines, none of them knew the salient features.

Village Health committee (VHC)

- One fourth of ANMs said there was no VHC in their village. Of those who had a VHC, half of them said they had never attended VHC meetings. A few said they did not know what VHC meant.
- One fourth of the PRI members had not heard about VHCs. Half of the PRI members said there was no VHC in their village. Half of those who had a VHC in their village had never attended any of its meetings.
- Only one ASHA said that she had attended the last meeting of a VHC. The others had either not heard about it or responded that there was no VHC in their village.

Conclusion

Village health functionaries were not very familiar with NRHM. VHCs had not yet been formed in many villages and village functionaries had no idea what a VHC meant. Women were not getting benefits under JSY. ANMs had still not got any money to distribute under JSY. Information about the Family Planning Insurance Scheme was not being shared with women who underwent sterilisation and no compensation was provided to women in case of complications or failures. Target driven sterilisations were still being undertaken by District Authorities. Most of the PRIs and ANMs had not heard about untied fund and its usage. The ASHA component had not received due attention in Bihar. Selection and training had yet to take place in many districts. Also, village health functionaries had very little knowledge about ASHA's work.

Shape of Things to Come A Review of the Mitanin programme in Chhattisgarh

Compiled by Illina Sen

Chhattisgarh at a glance

Chhattisgarh was carved out from the eastern part of erstwhile Madhya Pradesh. It came into existence on November 1, 2000. Following statehood, Chhattisgarh initiated several measures to improve the status of its people and move towards universal access to health care. The key factors constraining efforts to improve the health of its people and health service indicators in the state are the physical inability to ensure outreach coupled with the poor economic status of the rural majority.

Demographic Profile

Chhattisgarh is a land of cultural diversity. Over 43 % of its population belongs to disadvantaged groups, that is, Scheduled Tribes (ST) and Scheduled Castes (SC).

Population Total (2001 Census) 20,833,803

Male 10,474,218

Female 10,359,585

Decadal Growth Rate 1991-2001: 18.27

Sex Ratio (0-6 age group): In 2001, the ratio dropped to 975, nine points lower than 984 in 1991. Compared to other states, though Chhattisgarh shows a better gender equity situation, it is a matter of concern that the sex ratio in the 0 to 6 age group is declining. The Literacy Rate also establishes the gender disparity, with only 51.9% females being literate as compared to 77.4% literacy among males.

(Source: Registrar General of India, 2001)

Health Indicators

Chhattisgarh has a Birth Rate of 25.2 and a Death Rate of 8.5, with the Life Expectancy at Birth in the state being 61.4 years (1991). Chhattisgarh shows an Infant Mortality Rate of 70, which is higher than India's IMR of 63. Its Maternal Mortality Ratio is also higher than the national average of 406.

(Source: Mortality and Fertility Data based on Sample Registration Survey Bulletin 2005, National Family Health Survey-II, 1998-99).

Recent significant achievements in health services in Chhattisgarh have been the near eradication of polio and yaws and a considerable reduction in leprosy. However, diarrhoeal disease, malaria and tuberculosis are still

major public health problems. Malaria is endemic in Chhattisgarh with an Annual Parasitic Index (API) of 10.21 in 2002 and an annual incidence of over about 100,000 cases reported in the public system alone.

Public Health Services

The Doctor Population Ratio in the year 2006 is 1:3,100. The state has 132 CHCs and 712 PHCs. The number of Specialists provided by the public health service is abysmally low at 210

(Source: Bulletin on Rural Health Statistics in India, 2005)

The data showing the percentage of population in the state having access to basic amenities like electricity, safe drinking water and toilets is disheartening. Only 7.6 % of the population has access to all three. A whopping 36.1 % of population has no access to any of these.

(Source: [http://chhattisgarh.nic.in/development/development, htm](http://chhattisgarh.nic.in/development/development.htm))

The health of women and child remains neglected. Only 21.8% of children receive all vaccinations, as compared to the national average of 42.0. As many as 87.7 % children (age 6-35 months) are anaemic and 18.5 % children are acutely undernourished (wasted) while 60.8 % children are underweight. The status of women's health is also discouraging, with 68.7 % women suffering from anaemia. Low socio economic conditions coupled with poor health services further worsens their situation. The percentage of girls marrying below 18 years is 31.1 *. Only 41.7% of pregnant women get ANC* while the percentage of Institutional Delivery is approximately half the national average of 40.5*

(Key RCH Indicators NFHS - II (1998-99)/DLHS (2002-2004))*

The state shows a fertility Rate of 2.79 (Source: Registrar General of India, 2001)

The RCH and NFHS survey shows that Couple protection rate is 46.6* .The state has not been able to provide access to family planning choices to its population. Current contraceptive use is only 45.0 %, with 13.5% population living with unmet needs for Family Planning.

*(Source: National Family Health Survey - 77, 1998-99, * District Level Household Survey, Reproductive Child health, 2002-2003)*

The State initiated the Mitandin (community health volunteer) Programme, the nation's largest community volunteer health programme, in November 2001. It was meant for improving health awareness and utilization of health services and to enhance the community's capacity to plan for and cater to its own basic health needs. Presently, there are over 60,000 trained Mitandins who provide voluntary health service in all the state's hamlets. Sector wise health development plans have been drawn up under the sector investment programme, the RCH-II programme and the state partnership plan with the European Union.

The Mitandin of Chhattisgarh is said to be a precursor of the ASHA, the original on which the ASHA has been modelled. Since the Mitandin programme is now a few years old, reviewing its implementation will help to see what lessons there are for the implementation of the ASHA programme. While the Mitandin and ASHA appear similar in perception, there are crucial differences between the two concepts. These can be summed up through a short review of the Mitandin programme:

The concept of the Mitandin evolved from a series of discussions among community health practitioners from within and outside the state. The participant comprised an informal network that later formalized into the State

Advisory Committee (SAC) to the government of Chhattisgarh on Health Sector Reforms. Fifteen pilot blocks were selected for implementation of the programme by NGOs who had significant experience in social mobilization and/or community health worker training. These decisions were made during the deliberations of the original State Advisory Committee that debated on the scope and nature of structural reforms in health care in Chhattisgarh. At that time, the implementers in the pilot blocks were entrusted with the responsibility of experimenting with innovative approaches from which learning inputs could be fed into an expanding programme at a later stage.

The highlights of the programme are:

Mobilization phase: In this phase the main objectives were introducing the idea of the Mitantin to the village communities and arriving jointly with the community at the concept of the Mitantin as a village based change agent of health. The primary responsibility of the Mitantin was to articulate the village communities' Right to Health Care. This was a period of intense environment building in the villages with the help of a cultural programme designed comprising a Pandwani, songs and a short play.

Selection phase: The selection of the Mitantin was through a detailed community process. The Preraks who acted as facilitators for the process only emphasized the role that Mitantins were expected to play. The parameters of this role were derived from the ongoing discourse on the Mitantin programme and the intensive deliberations of the State Advisory Committee. These were:

- a. All the workers were to be women. They would be known as 'Mitantin'. The use of this term, which denotes a culturally hallowed relationship, generated considerable opposition; what was finally agreed upon was a compromise
- b. All the women would be selected from within the communities that they would be serving through a process of consensus
- c. The communities in question would be self-defined hamlets rather than villages. In other words, any group of families could define themselves as a community and select a health worker among themselves. This provision was specifically designed to tie in with the concept of "Gram Sabha" in the PESA.
- d. Educational attainment would not be a constraint on selection.
- e. None of the Mitantin would receive any Government salary or allowance in lieu of their services. This provision generated prolonged debate, but was agreed to on the grounds that the Mitantin should be a community representative rather than a government functionary. However, this provision did not preclude the payment of compensatory allowances during training or the provision of community based subventions at a later stage of the programme.
- f. The Mitantin would perform certain technical functions by way of first contact care within the community, for which she would be specifically trained. However, her main function would be to articulate the demand for health care from within the community in the form of the right to health care. In particular, she was to actualize for the community the programme slogan on Right to Health, viz - "*Swasthya Hamar Adhikar Howe* " (Health is our Right).

In keeping with the above principles, the Mitantin was selected by consensus from the para or village women. In demarcating the para (hamlet), issues of distance, homogeneity and acceptability of the selected Mitantin were kept in mind. The idea that the Mitantin was not an individual *karyakarta* (worker) but rather a part of the village women's community, was expressed repeatedly. This led to the Mahila Swasthya Samitis (MSS) being conceived.

Training and Deployment phase: Once the Mitantin was selected, the process of formation of the village MSS group from which the Mitantin drew strength and sustenance and to which she was primarily accountable, was initiated. During the subsequent phases, the attempt was to carry the Mahila Swasthya Samitis along with the

Mitanins through the training programmes and other activities of the Mitanin. The MSS groups included women PRI members, members of women SHGs, women members of JFM committees as well as individual women known for their leadership qualities.

The training was organized in sections, each section being covered in one or more classes. Details of the training schedule are available from the programme documents of the SHRC as well as from individual members of the SAC. In some pilot programmes at least, intensive interactions took place with the Mahila Swasthya Samitis, the range of discussions covering health and other issues that had an effect on women's health. In a sense, the MSS interactions were parallel to the formal Mitanin training process. In a few cases, such as in Bodra village of Magarlod Block, MSS members spontaneously undertook action to stop liquor sales and consumption as they had made the link between its sale and the ill health and oppression of women.

Distribution of the Dawa Peti - Funds for the Dawa Peti or medicine kit were received from the SHRC in August 2004. The peti was furnished with a locally manufactured bag and medicines from LOCOST / and or local suppliers. The absence of dawa peti refills after the first issue was among the most serious setbacks faced by the programme. It caused considerable loss of morale and confidence among the Mitanin, many of whom had challenged the instruments of exploitation in their villages, such as ghumaiya 'doctors'. This failure on the part of programme administration gave the exploiters the requisite ammunition to attack the Mitanin.

In 2005-06, the process of convergence with the ASHA began. It resulted in a series of changes in which the Mitanin/ASHA came to be reconceptualised. From being rooted in the community, she began to be seen as rooted in the health service delivery system. The idea of community accountability, articulation of community rights and entitlements in health care enshrined in the original concept of the Mitanin will have to break through these notions in order to be reborn.

One Year of NRHM in Jharkhand

Compiled by Devika Biswas

Jharkhand at a glance

The state of Jharkhand was created in 2000, out of the earlier undivided state of Bihar. Despite having the largest proportion of mineral wealth in the country, it is among the poorest of states. Jharkhand is a predominantly forested and tribal state which has 31 tribal groups with distinct dialects and 9 primitive tribes.

Demographic profile

- Capital: Ranchi
- Districts - 22; Blocks - 211
- Area: 79,714 sq km
- Population: 26,945,829
- Population proportion: SC - 12 %, ST - 28 % (highest in the country)
- Per capita income-Rs 4161
- Literacy: Overall - 54.1 %, Female - 39.45 %
- Sex ratio - 941; Under-six sex ratio - 967

Health status

Jharkhand is one of the most backward states in the country with regard to the health status of its people and provision of health services. Many factors contribute to the poor health status including poverty, poor infrastructure, high morbidity and exposure to radioactive materials in uranium mines.

Poverty associated communicable diseases like tuberculosis and malaria, along with maternal mortality and morbidity, comprise a major portion of the disease burden of the state. Malaria is endemic with frequent epidemic outbreaks of Plasmodium falciparum malaria (about 50%). Over 60,000 deaths occur every year due to tuberculosis. Prevalence of leprosy is 10 per 10,000. HIV/AIDS poses another rising threat and lifestyle diseases too are on the rise.

Reproductive and child health status

The crude birth rate in the state is 9.1 per 1000 while the infant mortality rate is a high 70 per 1000 live births. 60% of these deaths are of neo-natals. Less than 10 % children are fully immunised and a third of all children never get any immunisation. 80 % of children are anaemic and more than 50 % of children below three years are underweight.

Maternal mortality is very high at 504 per 100,000 live births. 45 % women have reproductive health problems and 30% women complain of reproductive tract infections. Nearly three quarters of all women are anaemic and about 30% of them are moderately to severely anaemic. 40% of women are undernourished. According to state government figures, among all pregnant women, antenatal care was received by only 40%, 33% received Iron Folic Acid supplement and 50% received tetanus toxoid injection. Nearly 90% deliveries take place at home. Only 25% of all couples use modern methods of family planning. Female sterilisation dominates (88 %) and 20 % married women have unmet FP needs.

The Facility Survey conducted as part of the Reproductive and Child Health Project indicated that only 10% of all PHCs had adequate infrastructure, a little over a quarter (26.9%) had adequate staff, 50.5 % had equipment and supplies were available in 21.4% PHCs. According to the health department records, there is a huge gap in the current availability and proposed numbers of health facilities in the state. For PHCs, the current availability is 533 while the proposed number was 1443. The same is the case for CHCs. While current availability is 31, the proposed number was 228.

A tabular analysis of the current health problems and the key health players in the state is given below:

<i>Key Health Issues in Jharkhand: Problems and Players</i>		
Issues	Problems	Players
<i>Contraception</i> Unmet need for contraception (temporary methods), focus on sterilisation & low male sterilisation	Services not available, lack of Technical Skills, Service Providers do not provide counselling, target given (pressure), lack of technical staff	Corporate NGOs, Social Marketing agencies, Private Hospitals, NGOs, INGOs, Corporate sector hospitals
<i>Antenatal Care</i> Poor Antenatal coverage, only TT/IFA provided; high dropout from 1st to 3rd checkup, Late Registration, migration	Prevalence of myths, lack of equipments, lack of faith in Govt. System, uneven distribution of facilities, lack of faith in providers and their services.	
<i>Delivery</i> Done by untrained dais/ husbands / RMPs	TBAs not trained (wrong candidates selected), Institutions not available, referral system lacking, poor quality of care in institutions. Transport / terrain related problems ANMS not providing service - lack of ANMs. No home visits by ANMs / AWWs	
<i>Newborn Care</i> No newborn care low Birth weight babies, pneumonia	No home visit by ANW / AWW / No counselling / awareness on newborn - care	
<i>RTIs/STIs</i>	Sanitation / water availability, skills and providers not available	
<i>Public health</i> Communicable diseases, Health problems caused by Industrial pollutants, migration, HIV/AIDS	<i>General gaps:</i> Lack of staff/ institutions, lack of monitoring/ supervision/ accountability, political unrest. Terrain - inaccessibility	

Implementation of NRHM in Jharkhand

The official launch of the Mission took place in July 2005. The old State Health Society (formulated before NRHM) is overseeing the implementation of NRHM in the state. The mandate of the State Health Society is a little different from the NRHM. No new State Health Mission has been formed. There are no separate District Health Societies in place other than the earlier RCH societies. There are District Programme Managers posted in a few districts but most of them are not yet carrying out their assigned responsibilities as envisaged in the NRHM.

When asked about the present status, a senior state official said that the State Project Implementation Plan (PIP) was made after careful consideration of all basic health needs and a projection was made about the minimum fund needed to carry out that plan. The budget requirement for implementing the state PIP was Rs 300 crore for the year 2005-2006 but the state was allocated only Rs 45 crore. Thus, the State Health Society was unable to fully implement the PIP. It is gradually planning to implement the PIP in the desired direction. Only two (Lohardaga & Jamtara) have their district PIP made by district C.S. office/ R.C.H. office

- European Commission is providing support to Jharkhand for an 18- month project (extended to 24 months) of Rs 25 crore for implementing NRHM.
- USAID is providing support through the IFPS project and will also provide support through the NIP (National Integrated Child Survival and Maternal Health Program) that has currently been put up for bidding.
- The NIP will be operational in the two states of UP and Jharkhand. However, it will not be implemented as an integral part of NRHM but through private (INGO) parties. It is not clear whether the NIP will be open to being overseen by civil society.

ASHA

ASHA is called SAHIYA in Jharkhand. The selection criteria for SAHIYAs was different from the national norm of one per 1000 population and a minimum educational qualification of Class Eight pass. One SAHIYA was selected for every Tola/Mohalla and there was no educational restriction either. As per the norms, she was selected by designated NGOs and was not given any incentives. Since the launch of NRHM, selection has taken place in some places but even the selected SAHIYAs have not begun functioning as they have not been issued an appointment or letter of agreement. The selected SAHIYAs are not clear about their roles and responsibilities. Additionally, training has not taken place yet because the training modules have only recently been approved and finalised. Just the first training module is ready though the first draft of every module has been examined by peer reviewers. TOT of master trainers took place in June 2006.

Participation of local self-governing bodies

Since there are no PRIs in Jharkhand yet, only six districts of Jharkhand namely Jamtara, Hazaribagh, Ranchi, Gumla, East Singhbhum and Saraykela-Kharswan were chosen in the first phase. From the six districts, 34 blocks were chosen to implement the SAHIYA programme. There is some legal confusion about following PES A (Panchayats Extension to the Scheduled Areas Act of 1996) or any other PRI act. Thus, in tribal villages there are Traditional Majhi Munda and village heads without legal or administrative powers of the PRI system. The involvement of local self-governing bodies therefore seems very limited.

JSY scheme

According to reports and records, no cases of the JSY scheme were supported in 2005 - 06. On the contrary, there were reports that eligible candidates of JSY were compelled to make payments from their own pockets for obtaining the services. There is a huge shortfall in public health facilities in Jharkhand.

In addition, most PHCs and CHCs are not of a suitably desired standard to be able to cater to institutional deliveries. In order to get around this limitation, the Government undertook a process of empanelling nursing homes and private clinics as accredited institutions for conducting institutional deliveries. This process is currently underway. A decision was taken that instead of giving BPL pregnant women incentives in cash, they would be provided free antenatal care services and institutional delivery services. If these services are taken from empanelled institutions, the government would reimburse the cost of treatment of such referred BPL cases. The Jharkhand government's decision to do away with cash support not only goes against the principle of cash support for nutritional

supplementation, which is one of the main purposes of the National Maternal Benefit Scheme that JSY replaced, but it also ignores the fact that there are very few centres and that the culturally sanctioned practice of home deliveries is very strong and old.

Utilisation of untied funds

Providing untied funds to the sub centres was one of the key operational items of the NRHM in its first year. Unfortunately, no untied fund was released in 2005 - 06 and most of the ANMs were unaware of this fund. It is only very recently that some of them have come to know about the provision of this fund but they have not received the fund so far. Secondly, in the absence of a Panchayati Raj system there is lack of clarity on how the fund will be operated.

Contractual appointment of doctors

According to reports furnished by the State Health Mission to the Government of India, Jharkhand was to have appointed over 2000 doctors as part of NRHM. On investigation, it emerged that these doctors had been appointed through walk-in interviews before the NRHM was launched. Presently, there is a plethora of doctors posted at each PHC because additional PHCs have not been constructed. This has given rise to the phenomenon of Monday, Tuesday, Wednesday Medical Officers where doctors attend to patients on a specified day. PHCs continue to provide only outpatient services, so even with the addition of over 2000 doctors the public health system continues to provide the same quantum of services as before.

Essential drugs list and standard treatment guidelines

According to records, the Jharkhand Health Society has formulated and notified an essential drugs list, standard treatment guidelines and made provisions for prescription audit. However, there are no indications that these have been implemented.

Rogi Kalyan Samiti

The state authorities recently announced that 60 Hospital Management Committees (Rogi Kalyan Samitis) had been constituted, but they could not furnish the names of the members of the committees. Community experience points to the fact that such committees may have been constituted only on paper. Even members do not know that they are in the committee. Consent was not sought from members before their appointment nor prior intimation given.

Other provisions

- Almost no one has heard about the Quality Assurance Committee that was to have been constituted in each district
- Some funds were recently given to H.M.C
- There has been accreditation of health facilities
- Institute of Public Health Standards has been established and all Civil Surgeons will have to undergo six months training
- The upgradation of PHCs and CHCs is supposedly underway and new PHCs and CHCs are also under consideration. However, reports suggest that no PHC or CHC has been upgraded so far. Further, 44 FRUs are supposed to become operational

- According to an NRHM status report of June 1, 2006, circulated by the Ministry of Health and Family Welfare, the funds required to upgrade each CHC has not yet been finalised
- The man-power planning for IPHS is yet to be completed
- The Quality Assurance Committee has not yet been constituted in the state
- It is also stated in the report that though the protocol for alternate vaccine delivery is in place, micro plans for the districts have yet to be made
- The report also states that a total of 6,578 cases of Kala-azar were reported till June 2006.

Conclusion

It must be kept in mind that Jharkhand is a newly created state with very poor infrastructure and poor service delivery system. The existing system is also under-staffed. The Jharkhand government has recognised these shortcomings and is in the process of deploying additional staff through contractual appointment at various levels. Efforts have also been made for assessment of health needs and emergent management of some key services through catch-up rounds for routine immunisation, pulse polio, antenatal care, IFA supplementation and tetanus toxoid injections for pregnant women and so on. These catch-up rounds also include taking blood samples for malaria, sputum test for TB and providing de-worming tablets and Vitamin A doses for children.

Though there is a level of optimism and energy in the system, the average rural citizen can see very little change through NRHM. There has been no headway in the JSY scheme, selection of SAHIYA, upgradation of PHCs and CHCs, improvement in health services through the provision of untied fund, involvement of VHC or formation of Rogi Kalyan Samitis. There has been a failure in mainstreaming AYUSH, which has tremendous potential in a tribal dominated and forested state. The NRHM has not brought any additional support or services for maternal health. It has marginalised the Traditional Birth Attendants and their significant contribution to maternal health.

Jharkhand: A Grassroots Review

A survey was conducted with grassroots functionaries and beneficiaries to assess the status of NRHM in the state. Since the SAHIYA programme was functional in only six districts (Bokaro, Saraikela, East Singhbhoom, Gumla, Jamtara and Hazaribagh), these were the districts covered by the survey. Additionally, Dumka, a non-Sahiya district, was also covered. In these seven districts, 14 blocks and 14 villages were covered.

The survey covered DPM Unit, ANM, AWW, Village head/PRI member/Village Health Committee member, women who have had a delivery in the past three months and women who have undergone sterilisation in the past three months.

Survey forms were received from three district units, 7 ANMs, 11 AWWs, 11 Village heads/PRI members/Village Health Committee members, 16 women who had a delivery in the past three months and 17 women who underwent sterilisation in the past three months.

The key findings of the survey are:

DPM unit

Three district units (Jamtara, Gumla and Dumka) were surveyed. No DPM was posted in Jamtara and information was gathered from an assistant present in the office. In Gumla, the CS Office imparted some information after much persuasion but without disclosing their own names. In Dumka, the DPM was interviewed.

- According to the district units, District Health Society/Mission has not been constituted in any of the three

districts. In Dumka, the process of its formulation has begun. The District Action Plan (DAP) has not been prepared in Gumla and Dumka. In Jamtara it has been prepared on the basis of State & District PIP.

- In Dumka, the process of upgrading the PHCs is under consideration. However, no PHC has been upgraded in the other two districts.
- RKS have been formed in all hospitals in Gumla. In Dumka, the names of the hospitals where RKS have been formed were not available with the DPH.
- The Quality Assurance Committee does not exist in any of the districts.
- ASHA scheme has been launched in every district. But none of the District Units knew the number of villages that have been covered by the scheme so far.
- None of them had received any budget under the Untied Fund. Commenting on the Untied Fund Scheme, one of them said, "It is not practically possible."
- Two out of three surveyed had not heard about the Supreme Court guidelines on sterilisation. According to them, the main points of these guidelines were to obey all the rules while conducting sterilisation, OT should be as per the norms and complete care should be taken during sterilisation.
- All three of them agreed that targets for sterilisation existed for the current year too. Two of them gave details on the targets although detailed information for the third district was not available in the unit.
- None of them were aware of any woman becoming pregnant after sterilisation. They said no woman had received any kind of compensation as yet for complication or failure after sterilisation in the past few months.

Women who have Undergone sterilisation in the past 3 months

- Nine respondents were BPL card holders
- Most of the respondents had to spend money, ranging from Rs 100 to Rs 5000 to get sterilisation done. One woman spent as much as Rs 18,000. At least one third of the respondents did not mention the expenditure they had incurred on sterilisation.
- Only five respondents said that the form was read out to them in simple language before they put their signature on it
- Six women said they were given a certificate on being sterilised. Three respondents said they had received Rs 600 and some utensils as incentives for undergoing the operation
- Only three of the respondents took the decision for undergoing sterilisation on the advice of the ANM. The majority of them had taken the decision by themselves or with their husbands
- No case of humiliation was reported
- Very few respondents said that they had been told about the advantages and disadvantages of sterilisation in the clinic
- Only two women said they were assisted by the ANM and SAHIYA for the operation. The rest were assisted by their husband, mother-in-law or other family members.
- Only one woman had complications after the operation. She had severe pain after the operation
- Four women said that the ANM came to visit them within seven days of the operation
- The majority of the respondents were not told about the family planning insurance scheme
- Only one out of nine women who were BPL Card holders had received Rs 200 under the scheme.

ANMs

- Five out of seven surveyed had heard about the NRHM. The main points of NRHM, according to them, were universal immunisation and giving medicines. They did not mention anything about reducing MMR or other elements of NRHM
- All of them were aware about the Sahiya scheme
- ANMs of two villages, out of the five where Sahiyas were selected, were not aware about the selection process. One of the respondents said that the Sahiya is selected by AWW. Some of the respondents said that the Sahiya is chosen in a village meeting
- Most of them said that the selection of Sahiyas had been completed although training had not yet begun. Only two of them were happy with the work of Sahiyas
- Almost all respondents said that Sahiyas had not received any training as yet
- The majority of them did not know the roles and responsibilities of S AHIYAs. Only three of them knew about some duties such as informing family members, helping ANMs and AWWs
- All of them had heard about JSY but only two respondents said that they have received money to distribute under the JSY scheme
- Almost all respondents said that some complications after sterilization are common, such as abdominal pain and irregular periods
- Two respondents said that they knew of women who got pregnant after the operation
- Only three said that they had a VHC in their village. Out of the three, only two could mention the issues that were discussed in the last meeting
- None of the sub centers had received Untied Funds
- Four ANMs were aware of the SC guidelines but none of them knew much about them. All that they knew was that the doctor should be trained, hygiene should be maintained and rules should be followed
- Four out of seven said that they had got targets for family planning for the current year

AWWs

- Only 50 % of those surveyed had heard of NRHM although they could mention the main points of NRHM. According to them, NRHM is meant for strengthening the FP programme, for HIV/AIDS awareness and to ensure that health services reach every person
- Only nine said that they had heard about the Sahiya scheme. Four out of the nine were aware of the selection process. According to them, Sahiyas in their villages were selected in village meetings. One of them said that representatives of responsible LEO and NGO had selected them. Three respondents did not mention anything. Two said that the Sahiya selection process had not yet begun in their village
- Sahiya training had not started in any of the villages
- Four AWWs said that the VHC in their village existed and was functional. Two respondents said that it existed but was not functional. Two respondents said that it did not exist. Five did not mention anything. Only five could mention what had been discussed in the meeting

Women who have had a delivery in the past 3 months

- Out of 16 women surveyed, nine were BPL card-holders. Seven respondents did not mention if they had a card or not

- Eleven out of 16 women had delivered at home. The others had delivered at private clinics
- The majority of the home deliveries were conducted by midwives. Some of these deliveries were conducted by quacks or family members
- A check-up during pregnancy was conducted on the majority of the women. Just half of the women got a check-up by an ANM. The rest had themselves checked up at private clinics. Four out of 16 did not get any check-up done
- Almost all respondents got TT injection during delivery. Only half of the respondents said that their blood pressure was measured. Very few said that they had undergone urine examination
- Thirteen women were provided nutritional supplements during pregnancy. Most of them got the supplements only during the first and second trimester.
- Ten women said that the ANM visited them during pregnancy. The ANM informed them about nutrition and the need for regular check-ups.
- Half of the respondents said that they had spent Rs 200 to Rs 3000 on their deliveries. Seven respondents did not mention any amount
- None of them received any financial support from the government

PRI Members

A total of 11 PRI members were surveyed.

- Almost all of them had heard of NRHM but just three knew about the salient features of NRHM
- Almost all of them had heard about the SAHIYA scheme and most of them could mention the name of the SAHIYA selected from their village. Almost all of them responded that the SAHIYA was selected in the village meeting
- Only two out of 11 were not aware about her roles and responsibilities. The majority of them had superficial information about her work/They said that her work was to assist the ANM, provide health services, ensure outreach to every house, raise awareness on health and assist in the implementation of health programmes, particularly those related to mother and child health
- Only two had heard about Untied Fund. None of the sub centers had received the Untied Fund yet
- Almost all of them were aware about the existence of the VHC although half of them did not remember the issues discussed in its meetings. In some villages where the VHC had recently been formed, no meetings had been held.

Conclusion

The implementation of NRHM in Jharkhand is quite dismal. Functionaries do not understand the spirit of NRHM. PRI, ANMs & AWWs have heard about NRHM but are not aware of its main elements. Grassroots functionaries have not heard about Untied Fund. It has also not been disbursed to the sub centres. Women from BPL families have not received any benefits under JSY. Village Health Committees do not exist in most villages and health centers have not been upgraded. Sahiya training has not yet begun. ANMs & AWWs do not know much about the roles and responsibilities of SAHIYA. They consider them as their assistant. SC guidelines on sterilisation are being flouted almost everywhere and the target approach to family planning is still prevalent.



One Year of NRHM and RCH 2 in Madhya Pradesh

Compiled by Dr. Ajay Khare

Madhya Pradesh at a glance

Demographic profile

- Capital: Bhopal
- Area: 308245 Sq. km
- Population: 6,03,85,000
- Population proportion: SC - 20.3 %, ST - 15.2 %
- Population density: 196
- Decadal growth rate: 24.26 %
- Rural population: 73.54 %
- Literacy: Overall 63.7 %, Female 50.3%
- Sex ratio - 919; Under-six sex ratio - 932

Health infrastructure

There is a discrepancy at all levels between the required number of health posts and the sanctioned number. The discrepancy widens as one descends from district to sub centre level. The matrix below delineates a fair picture of the state's health infrastructure.

Name of Institution	Sanctioned No.	Govt. Building	Other Building	As per 2001 population no. required
District hospital	47	36	11 under construction	48
Civil Hospital	53	53	-	-
Community Health Centre	266	78	188	428
Primary Health Centre	1153	536	617	1691
Sub Health Centre	8835	3079	5756	10524

Reproductive and child health status

The crude birth rate in the state is 30.02 while crude death rate is 9.8. TFR stands at 3.8. The infant mortality rate is very high at 82 per 1000 live births. The maternal mortality rate is 498 per 100,000 live births. Haemorrhage and anaemia account for the largest causes of MMR, at 24% and 20% respectively. This is followed by sepsis (15%), unsafe abortion (13%) and eclampsia (12%). Obstructed labour accounts for 8% maternal deaths and another 8% constitutes other causes of MMR.

Implementation of NRHM in Madhya Pradesh

A State Health Mission has been formed. The Chief Minister is the Chair of the Mission and the Minister of Health and Family Welfare, Government of M.P. is the Vice Chair. Other members include the Ministers of Women and Child Development, Finance, Panchayat and Rural Development, Urban Development, Tribal Development, PHE, Chief Secretary, Secretaries of concerned departments, five MLAs and three health experts or NGO representatives.

District Health Society

District health societies have been formed in all the districts and district health plans have been finalized in the majority of the districts. However, the health plan did not evolve from village to district level. It was the other way round. Also, all health, hygiene and sanitation schemes require to be integrated.

Janani Suraksha Yojana

Under this scheme, women who live below poverty line and who have a maximum of two live children will benefit. The benefit for the third child is given only when the woman is ready to undergo tubectomy. Under the JSY, Rs 700 is to women in rural areas and Rs 600 to those in urban areas. Motivators in rural areas will receive Rs 600 and those in urban areas get Rs 200 under the scheme. Corruption in the scheme has been reported in some places in Dewas.

ASHA

Till June 2006, 15,000 ASHAs had been selected and were undergoing training. In Dhanwantari block it is targeted to cover all villages and remaining part from other villages to meet 40% of the target. There are reports that the selection had been carried out mainly on the recommendation of the Sarpanches and other influential persons. The community was not made aware about the ASHA scheme. In most places, CBOs were not involved. In general, ASHAs are considered government employees.

RCH 2

RCH 2 is a major component of NRHM. Various programmes have been started under RCH 2 :

Establishment of CEmOC Centres

170 institutions have been identified as CEmOC. They will provide the following facilities:

- 24 hours normal and assisted deliveries
- Emergency obstetric care including caesarean operations
- Neo natal care
- Safe abortion

- Family planning facilities
- 24 hour blood bank
- STD treatment •

They will be staffed by the following:

- Gynaecologist
- Child specialist
- Anaesthetist
- Medical officer
- Support staff

Establishment of BEmOC

Five hundred PHCs have been selected as BEmOC. The following facilities will be available:

- Ante natal and post natal immunisation
- 24 hour normal and assisted deliveries
- Complicated deliveries
- Neo natal care
- Family planning facilities
- Safe abortion
- Steady treatment

Deendayal Antyodaya Treatment Scheme

This scheme began on September 25, 2004. Under it, BPL families will be given financial assistance of up to Rs 20,000 for investigation and treatment. This benefit will be given to the husband, wife, minor children, dependent parents and separated or divorced daughters.

Transport and treatment scheme for delivery

In Madhya Pradesh, institutional delivery accounts for only 26 % of all deliveries. Under this scheme, SC/ST and BPL women will be given financial aid between Rs 150 to Rs 300 for travel to the nearest institution where deliveries are conducted. The motivator will receive Rs 200 for each woman she motivates for an institutional delivery.

Mobile health clinic

Mobile health clinics have been started in 11 blocks. These are Bhimpur (district Betul), Sendhawa (district Jhabua), Budhar (district Shahdol), Push Rajgarh (district Anooppur), Sheopur (Birsha district), Balaghat, Pali (district Umariya), Kusini (district Sheopur), Kundum (district Jabalpur). The clinic's vans will visit different parts of the blocks, six days in a week.

Madhya Pradesh: A Grassroots Review

The following are the key findings of a grassroots survey to assess NRHM in the state:

- Information about NRHM, including PIP, was not available to NGOs.
- Health statistics were available on the web but the data was unreliable - many districts show zero infant and maternal mortality.
- There was confusion regarding who would be most eligible to be an ASHA and there was a suggestion that all Anganwadi workers should be converted into ASHAs. However, this did not happen. There was confusion over the eighth class pass criteria as well, which meant that poor and marginalized communities might not get an ASHA from their own community.
- The state had decided to flood the Dhanwantari blocks with ASHA in the first phase. Dhanwantari blocks are special blocks (1 per district) where ideal health care facilities are to be provided by the state.
- There was a process of selection of 'Sugamkarta' or facilitator who was supposed to assist in the process of ASHA selection (In Shivpuri district NGOs had been designated as selectors of ASHA by the district collector).
- Village Health Committees have been constituted from pre-existing committees.
- District Health Societies have been formed.
- The Director of RCH is different from the Director of NRHM at the state level.
- Maternal mortality is recognized as an important issue but institutional action is poor.
- The District Collector has been asked to monitor the JSY in the Dhanwantari blocks.
- The instructions about disbursement are unclear so no money has been disbursed.
- Five districts have been taken up for introducing skilled birth attendants but the scheme has not been operationalised. District hospitals are following protocols.
- MP has a special scheme for referral transport support but there is little information about it. Therefore there is poor utilisation.
- One participant mentioned that they had asked the ANMs and Computer at Berasia block about the NRHM - they had not heard about NRHM but had heard of the Swasthya Mission. They had heard the name ASHA but did not know what it meant or anything more.
- The government has demolished the village level health samitis. The process of decentralized planning and monitoring has been discouraged.
- Corruption has been reported in schemes like Vijaya Raje Janani Beema Yojana at some places.

(Review of NRHM by participants at the Regional Workshop at Bhopal April 13 & 14, 2006)

One Year of NRHM in Orissa

Orissa at a glance

Demographic profile

- Capital: Bhubaneswar
- Population: 36.7 million
- Population growth rate: 15.94%
- Literacy : Overall - 64 %, Female - 51 %
- Sex ratio: Overall - 972, Under 6-950

Reproductive and child health status

Orissa has poor development indicators on many fronts, including the highest infant mortality rate (IMR) in the country, as well as a high maternal mortality rate (MMR). IMR stands at 97 per 1000 live births while MMR is 437 per 100,000 live births. The birth rate in the state is 22.7%. The total fertility rate is estimated at 2.5. This means that Orissa is poised to attain replacement level of TFR of 2.1 in 2011 - 2016, ahead of the "BIMARU" states as well as Gujarat, Punjab and Haryana.

Despite this, Orissa has a high prevalence of malnutrition among women and children. 48.5 % of adult women in Orissa are malnourished, with a body mass index below 18.5. This comprises the highest proportion of malnourished women in the country. Likewise, the state has the highest proportion of children who are wasted (24%), and the second highest proportion of children who are underweight (54 %). Anaemia, especially iron deficiency anaemia is very prevalent in the state (34 % of pregnant women and 46 % of children under three have moderate or severe anaemia). Iodine deficiency, as well as deficiency of vitamin A, is also a problem that the state is struggling to address.

According to NFHS 2, 47 % of married women currently use some method of contraception. The Contraceptive Prevalence Rate (CPR) in the state is 46.8, being higher in urban areas (54 %) compared to rural areas (46 %). It is also higher among high-school educated women (52.7 %) compared to those who are illiterate (45.2 %). Contraceptive use is lower among scheduled tribe women compared to other women. Female sterilisation is the most widely used method, accounting for 76 % of total contraceptive use. Only 2 % of women reported that their husbands were sterilised. Oral contraceptives, intrauterine devices and condoms account for 10 % of total contraceptive use.

The results of the RCH facility survey show that of the 505 PHCs surveyed, 33 % had labour room facilities, 34% had labour room equipment, 64% had blood pressure measuring instrument, 10% had normal delivery kits and only 1 % had EmOC drugs. The survey also revealed that while 17% of the PHCs had working vehicles, only 3 %

had telephone facilities. 12 % of the PHCs supplied IFA tablets while 71 % supplied ORS packets. It was encouraging to note that 95 % had Medical Officers. Orissa has an institutional delivery rate of 37 %.

Of the 69 FRUs surveyed, 72% had operation theatres, 12% had labour rooms and 46% had working vehicles. ObGyn specialists were available in 48% of the FRUs while an anaesthetist was present in only 1.4% of them. Regarding equipment, oxygen cylinders were available at 33 % FRUs, the standard surgical kit with 12%, EmOC drugs with 10 %, new born care kit with 10% and labour room kit with 38 %.

implementation of NRHM in Orissa

The Orissa state level National Rural Health Mission (NRHM) was launched on July 17, 2005. Delivering the keynote address, Union Minister for Health, Mr A Ramadoss said that 2,000 community health centres in 18 states including Orissa, would be covered under the NRHM and that around Rs 200 crore had been allocated for the state in the current financial year. Each block level community health centre would be provided Rs one crore for its up gradation to Indian public health standards by setting up well-equipped operation theatres, labour rooms and wards.

The Chief Minister, Mr Naveen Patnaik had said that his government had taken steps for the constitution of State and District Rural Health Missions. The formation of these missions, involvement of Panchayati Raj Institutions, voluntary organisations and eminent experts would contribute greatly towards formulation of policy measures and action plans under NRHM. He had called upon the district collectors, zila parishad presidents, chief district medical officers and other functionaries to work with sincerity and dedication for fulfillment of health needs of the rural areas.

Highlighting the measures taken by the state government, the state Health Minister, Mr Bijoyshree Routray had said that the infant mortality rate in Orissa had come down from 97 in 1999 to 87 in 2002. The leprosy prevalence rate had declined to 2.9 % in the state and below 1 % in five districts. No new polio case had been detected during the last year. However, the shortage of doctors, especially in rural areas, was a chronic problem. The state also required strengthening of its infrastructure he said, adding that he expected adequate support from the central government in this regard.

Mr PK Hota, Health Secretary, Government of India, said that around Rs 800 crore would be made available to the state in the next five years.

ASHA selection and training

The number of ASHAs to be selected in the next five years is 34,213. So far, 12,730 of them have been selected and trained. The central government had provided Rs 9,36,00,000 for training but only Rs 2,83,48,000 had been spent in the last year.

Upgrading of PHCs and CHCs

Thirty PHCs and CHCs at the block level have been upgraded under the Indian Public Health System (IPHS) model.

Disbursal and utilisation of funds

There have been complaints that last year the state government failed to utilise funds provided by the centre for NRHM. Around Rs 61 crore had not been utilised. Not a single paisa was spent under the following heads:

- Medicine kits to villages (sanctioned amount was Rs 92 lakh)
- » Upgradation of PHCs and CHCs (sanctioned amount was Rs 12,00,00,000)
- RCH 2 and National Rural Health Kit (sanctioned amount was Rs 19,11,00,000)

The central government had sanctioned Rs 102,62,85,000 to Orissa for 2005 - 06. The state government had allocated Rs 96,82,87,000 to various districts for the implementation of the NRHM. However, only Rs 41,63,00,000 were spent. The following is the break up of allocated funds and those utilised:

Funds allocated by Central govt.	Funds spent by State govt.
Funds for sub centres (Rs 5,92,70,000)	Rs 4,80,10,000
RCH 2 (Rs 40,50,000,00)	Rs 26,89,70,000
Immunisation programme (Rs 6,97,38,000)	Rs 4,7,30,000
Pulse polio (Rs 3,25,14,000)	Rs 2,60,51,000
Disease surveillance system (Rs 4,58,56,000)	Rs 42 lakh

Key issues highlighted in the first steering group meet of Orissa Health Mission, July 10, 2006

- Gram panchayats should be entrusted with the job of monitoring primary health centres for better health services in rural areas. The central government would provide Rs 33 crore to the state if it moved in that direction.
- The central government has relaxed the norms under the Mission for providing financial assistance to pregnant women under the National Maternity Benefit Scheme (NMBS). It has now decided to extend it for the third child-birth and to pregnant woman below 19 years.
- The centre will assist the state in improving the standard of 314 CHCs as per Indian Public Health Standard.
- In view of the shortage of doctors in rural health centres and specialists in sub-divisional and district headquarter hospitals, the centre has advised the state government to enhance the retirement age of specialists and professors to 65 years and add more seats in Burla Medical College.
- Formation of Patients' Development Committee in each PHC for better management. Its key members will be the respective MP, MLA, panchayat member and health staff.
- The government is to implement a National Policy that would make it compulsory for fresh MBBS passouts to work in rural areas for at least an year.

The steering committee meeting was presided over by Chief Minister Naveen Patnaik and attended by the Secretary for Health, GOI, Mr. Prasanna Hota, State Minister for Panchayati Raj, Raghunath Mohanty, Women and Child Welfare Minister, Pramilla Mallick, and ST and SC Development Minister, Chaitanya Prasad Majhi.

Orissa: A Grassroots Review

To assess the present situation of NRHM in Orissa, a study was conducted in four districts - Nuapada, Mayurbhanj, Keonjhar and Ganjam.

A total of five ANMs, five village heads and PRIs, five AWWs, five women who have had sterilisation in the past three months and five women who have had a child birth in the past three months were interviewed.

The key findings of the study are as follows:

ASHA

- None of the ASH As were asked to pay for forms. However, they were reluctant to say whether they paid any money for their selection.

- All of them said they knew their roles and responsibilities. Most of them thought that their role was limited to taking care of pregnant mothers, their registration, immunisation and motivating them for institutional deliveries.
- All of them received money for attending training programmes. Three out of five did not receive any payment for any other work except for training.
- All five ASH As say that they too are aware of JSY. Most of them are also aware that if a woman holds a BPL card then she is entitled to receive Rs 500.
- Four of them knew about the VHC and its role. But the majority of them did not know about the issues discussed in these meetings.

ANM

- The ANMs had heard about NRHM and ASHA. However, they were not aware of the details.
- Most of them knew about JSY and selection and training of ASHA.
- Three out of five did not know about untied funds.
- Only one was aware of AYUSH.
- The ANMs knew about ASHA chosen from their respective villages.
- Two ANMs said that ASHA was chosen in the village meeting by village panchayat members. One said that ASHA has been chosen by SHGs.
- Most of them knew about ASHA's roles and responsibilities such as registration of pregnant mothers, immunization and imparting information on prenatal and postnatal care.
- All ANMs said that ASHAs had received seven days training at PHCs.
- All five ANMs were aware of the JSY.
- All of them were aware of untied funds but not very sure of its use. Most of them thought that this fund was meant for maintenance of the sub centre.
- Two ANMs said that they had not used any part of this fund.
- Four were not aware of the Supreme Court guidelines on conducting sterilisation.
- Two said that they were given family planning targets to fulfill.
- Three out of five said that they knew of women who got pregnant after sterilisation.

AWW

- All five AWWs knew about NRHM and ASHA scheme.
- Most of them were aware about ASHA's roles and responsibilities.
- Nearly all of them said that ASHA got trained for seven days.
- Only two AWWs knew of the existence of a village health committee.

Women who have had a child birth in the last 3 months

- Four out of the five women were BPL cardholders.

- Four said that a complete checkup was performed during pregnancy.
- All said that ASHA did not visit them during pregnancy.
- Only one said that she received financial support from the government.

PRI

- Out of five PRI members, only two had heard about NRHM and ASHA.
- Only two could mention the names of ASHA chosen from their villages.
- Four out of five PRI members knew about untied funds. Three of them did not know anything about the usage of this fund.
- Two said that money from this fund has been utilised.
- Three members said that the VHC exists. However, only two could mention the important issues discussed in its meetings.

Women who had undergone sterilization

- Six such women were interviewed. Four of them said that blood and urine tests were not conducted before the sterilization operation
- Two of them said that doctor did not speak politely to them.
- None of them were advised to apply for insurance. Nobody had told them about the family planning insurance scheme.

Conclusion

The progress of NRHM in Orissa is slack as in many other states. There seems to be little coordination between AWW, ANM, ASHA, and PRI members. Also, there seems to be only a general awareness on the various components of NRHM and the roles and responsibilities under it. ASHAs are being seen as assistants to ANM and AWW. Untied funds have not been utilised. There are irregularities in the system. For example, untied funds were distributed in October 2005 but the guidelines were formulated only in February 2006.

One Year of NRHM and RCH 2 in Rajasthan

Compiled by Tej Ram

Rajasthan at a glance

Demographic Profile

The state was formed in March 1949, and took its present shape in 1956. The state is located in the northwestern part of the subcontinent. With an area of 342,239 sq. km, Rajasthan is the largest Indian state in terms of geographic area. It constitutes about 10.41 per cent of the total area of the country. Administratively, it has 32 districts, 237 development blocks and 41353 revenue villages.

According to Census 2001, Rajasthan has a population of 56,437,122, of which 29,381,657 are male and 27,091,465 female. It has a population density of 165 as against 324 recorded by the country in 2001. The state has shown a marginal decline in decadal growth rate from 28.44 in 1991 to 28.33 in 2001. This is still much higher than the national average 21.34 in 1991 -2001. The sex ratio has shown an increasing trend from 910 in 1991 to 922 in 2001, which is significantly less than the national sex ratio of 933 in 2001.

One third of the states' population lives below the poverty line. The state has a literacy rate of 61.03 in 2001, which is also lower than national average of 65.38 recorded in 2001.

Health status

The state spends about 6% of its Domestic Product on health care which comprises both public and private facilities. The government and all donors finance only 29% of the total health care expenditure; the remaining 71 % is financed by households as out-of-pocket payments.

The condition of health care services, especially in the rural and remote areas, is dismal. While it is believed that the public health system is being expanded and strengthened, at the grass-root level systematic and comprehensive quality reproductive health care services are virtually non-existent. Over half of all rural births in Rajasthan occur at home, as adequate health facilities and transportation are not available in many rural areas. The poorer households also try to keep costs down by avoiding hospital charges.

Reproductive health status

The health of women, especially their reproductive and sexual health, is a major area of concern in the state. The high maternal mortality ratio, high prevalence of reproductive tract related morbidity and poor knowledge and availability of birth spacing methods are glaring examples of the fact that health facilities and providers have not been able to build an effective reach.

The Maternal Mortality ratio is 670 per lakh live births; infant mortality rate is 67 per thousand live births; total fertility rate is 3.8 and couple protection rate is 40.

The percentage of female sterilization is 30.8 and that for males is just 1.5%. The use of other contraceptive devices viz. oral pills, condoms and IUDs is very little.

In addition to this, preference for male child, sex selective abortions, two-child norm etc. only increase the burden on the women's already deplorable health status in the state. Services for safe motherhood, safe abortion and contraception, which have a tremendous impact on the lives and health of women, are in an alarming condition here.

- Mean age at marriage (girls): 17.3%
- Three or more ANC visits: 33.3 %
- Delivery in govt, institution: 19.4%
- Delivery by skilled person: 44.4 %
- MMR: 670/1,00,000 per live births
- Complete immunisation: 25.4 %
- Infant mortality rate: 67 per 1000 live births
- Contraceptive use (any method): 46.9 %
- Unmet need: 21.8%
- Total fertility rate: 3.8
- Couple protection rate: 40
- Women suffering from anaemia: 48.7 %

Female Literacy: 43.9%

Source: District Level Household Survey (2002-04) & facility survey (2003) - Reproductive and Child Health, NFHSII (1998), MOH&FW, GOI (2002-03) and MOH&FW, GOR (2002-03)

Implementation of NRHM in Rajasthan

The National Rural Health Mission was launched in Rajasthan on May 29, 2005. The Union Health and Family Welfare Minister, Dr. Anbumani Ramadoss and the Chief Minister of Rajasthan, Smt Vasundhara Raje inaugurated it at a State Level Regional Consultation in Jaipur. All the District Collectors and the Chief Medical Health Officers of the districts attended the event. The consultation was aimed at helping the officers to properly understand the implementation of the mission and its objective. As part of the consultation, efforts were made to draw up a strategy as per local needs to ensure effective and successful implementation of the NRHM. Maternal mortality, infant mortality, reproductive and child health were some of the key issues highlighted during the launch.

Since May 2005, a State Health Mission has been constituted as have district level health missions in all 32 districts of Rajasthan.

The task of setting up the District Health Societies has been completed successfully and all societies related to health have been merged with them. According to government reports, district health planning has been carried out in eight districts. However, the district health planning was carried out without first conducting village and block level planning. The Jan Swasthya Abhiyan had raised this issue with the government. An activist alleged that this planning process was a mere formality that was far from the reality of local needs.

ASHA

The Government of Rajasthan has decided to appoint Sahayoginis to perform the function of ASHA and they will be known as ASHA-Sahayogini. Sahyogini is a female worker in the ICDS programme, who is appointed at the Anganwadi level to assist the Anganwadi worker. One Sahayogini has been appointed for a population of 750. Some areas, with low population density, have one sahayogini per 250 persons. ASHAs, as envisaged in the NRHM, will be selected in only those areas where there is no Sahayogini so far. Sahayoginis are to receive the same training as ASHAs elsewhere.

In the first phase (2005 - 06), 2,0785 ASHAs had been selected against proposed number of 2,1157. In the current year, 8661 ASHAs have been selected against the proposed number of 10,212. All 2,0785 ASHAs who were selected in the first phase have completed their first round of training.

Janani Suraksha Yojna

Implementation of the Janani Surksha Yojna is very weak. Till the end of March 2006, not a single woman had benefited from this scheme. This was reported in the media and the Mission Director of NRHM also accepted it in a public meeting on the occasion of the World Health Day 2006.

Untiedfunds

Untied funds of Rs 10000 have been allotted to sub centres and 9689 joint accounts (Sarpanch and ANMs) have been opened in banks. It has been reported that some sub centres have spent their first installment but many sub centres could not spend this money due to lack of clear directives.

Indian public health standards

200 model sub centers were strengthened last year in 15 districts to provide safe delivery services in rural areas. By the end of June 2006, 64 CHCs had been selected to enforce IPHS.

PRI and community involvement

Involvement of PRI and community in activities and programmes under the NRHM is weak as many elected representatives of PRIs are unaware of NRHM. Nor have Village Health Committees been formed.

Rajasthan: A Grassroots Review

Peoples' Rural Health Watch, a cell of the state Jan Swasthya Abhiyan, has been formed to strengthen community monitoring under NRHM in the state. It will conduct surveys and carry out analysis of government documents related to NRHM. These will then be published periodically as fact sheets on the health indicators. The first survey to assess one year of NRHM was conducted in 17 districts. Findings from three districts are presented below:

Jhunjhunu

Jhunjhunu is considered the most backward district with regard to the progress of NRHM.

- DPMU was set up in August 2005
- No district health planning has taken place as yet
- 50 % ASHA selection has been completed
- ASHA training has not been completed
- Untied fund disbursement has been completed. However, figures are not available.

- No usage statement of untied fund has been submitted as yet
- No PHC or CHC has been selected to be upgraded to IPHS
- No listing of PHC to be upgraded into CHCs
- JSY funds remain unutilised
- Dissolution of all societies in DHS completed
- Funds disbursed to RMRS out of allocations

(Source: Rajasthan Medical Relief Society)

Chittorgarh

Chittorgarh is a tribal dominated district. It has a higher sex ratio (966) as compared to the state's overall sex ratio of 922.

The District Programme Management Unit was set up in August 2005. Funds have been received from the State Project Management Unit. A district Health Society was constituted in February 2006, under the chair of the District Collector. All the societies at the district level have been dissolved and will henceforth remain as respective committees within the District Health Society.

Funds for various activities of these committees will be routed through the DHS. The CMHO, Dy CMHO and the Accounts Officer of the DHS will get funds directly from the state. District Health Society will also distribute funds to Rajasthan Medicare Relief Society (equivalent to the Rogi Kalyan Samiti) at the CHC-PHC level. The RMRS will have to take prior approval from DHS for unplanned expenditure.

The untied grant of Rs 10,000 to sub-centres has been sent to all the 391 sub-centres in Chittorgarh, as a cheque in the name of the ANM and the sarpanch. So far 150 Sub Centres had submitted usage expenses. The money has been spent largely on items like repair of SC-building and purchase of BP-instruments, stethoscopes and buckets. This untied grant of Rs 10,000 is a rotating fund, and the ANM can ask for money for various expenses.

Funds have been given to RMRSs in four PHCs, to be used for upgradation, and to make arrangements for privacy and for waste disposal. The Kanhera PHC is to be upgraded to a CHC. The PHC at Akola is to be developed as a Model PHC. A first installment of Rs 4.5 lakh each (from a total of Rs 18 lakh) has been given to four CHCs. In three CHCs including Nimbada, Kapasan and Begun, this money will be used for setting up Blood Storage Units. In some facilities Laboratory Technicians (LTs) and Public Health Nurses (PHNs) have been appointed on contract and in some cases through NGOs.

The Janani Surksha Yojna was launched in the district in December 2005. So far there have been 390 beneficiaries in the district under it. The district level authorities accepted that JSY has not been properly supervised and this figure has not been counterchecked.

According to the DPM, a website will be available soon on which district-wise updates on the status of implementation of the NRHM will be posted.

In the first phase of ASHA selection, 1354 ASHAs have been selected and the seven-day training is carrying on.

The district level authorities accepted that they have a target of 1,9707 sterilisation cases for the current year. They have completed 29 male and 1,625 female sterilisations. Additional Chief Medical & Health Officer, Chittorgarh, had heard of the Supreme Court guidelines relating to the Family Planning Insurance but she was unable to give details of provisions under these guidelines.

Source- Interview with District Programme Manager, NRHM and Additional CMHO, Chittorgarh

Bikaner

Like other districts, the DPMU was set up in August 2005. The district planning has been completed. However, inputs from rural areas were not taken. Rather, the planning was based on the state plan. Till July 2006, the number of beneficiaries from the JSY scheme was 170. All the Gram Panchayats have got untied fund of Rs 10,000 each but not a single paisa has been spent because of lack of clear guidelines. Additionally, information dissemination regarding the NRHM has been very dismal.

One Year of NRHM and RCH 2 in Uttarakhand

Compiled by Shakuntala Joshi

Uttarakhand at a Glance

The state of Uttarakhand was created in 2001 by combining the hilly districts of Uttarkashi, Chamoli, Rudrapur, Tehri Garhwal, Dehradun, Pauri Garhwal, Pithoragarh, Ranikhet, Bageshwar, Champawat, and Nainital with Udham Singh Nagar in the Terai region and Haridwar district in the foothills of Uttar Pradesh. According to Census 2001, Uttarakhand has a population of 8.5 million. The state contributes 0.82 percent of the total population of the country and is ranked twentieth among states and union territories in terms of population size. Women form the backbone of the economy of Uttarakhand. They do most of the household and agricultural work.

Demographic profile

- Population: 8.5 million
- Female Literacy : 59.6%

The overall sex ratio of 964 females per 1,000 males is higher than both the all India sex ratio (933) and that of Uttar Pradesh (898). However, the juvenile sex ratio has declined in Uttarakhand. It is now 906, while it was 948 in 1991.

Health infrastructure

The state has a total of 49 CHCs. According to norms for hilly areas, there is one CHC for 80,000 people and in the plains there is one for 120,000 people. The state has 225 PHCs and 1631 Sub centres. There are three government medical colleges in the state, of which two are Ayurvedic Medical Colleges (Gurukul and Rishikul) and one is an Allopathic Medical College (Migrant). Apart from this, there are two private medical colleges (Dr Susheela Tiwari Trust and Mahant Inderesh Medical College) in Nainital and Dehradun respectively.

The people of Uttarakhand are not able to access good health services due to adverse geographical conditions, since most of the state comprises either foothills or mountains. The state is mostly rural and villages are scattered, thus people live very far from hospitals. Doctors also do not want to be posted to the hospitals here as they do not want to stay in remote areas with poor connectivity.

According to the Facility Survey of 2003, only 27.8 % of the PHCs are adequately equipped with infrastructure, 40.5 % with staff and 27.1 % with equipment. Only 7.6 % of the staff had adequate training and the emergency obstetric kit was present in 13.2 % of the PHCs.

Reproductive health status

- Early marriage: 9.8 %
- Three or more ANC visits: 28.0 %

- Delivery in Government Institution: 10.7%
- Delivery by skilled person: 32.5%
- MMR: 300/1,00,000 live births (State Statistical Department 2006)
- Complete Immunization: 47.2%
- Infant Mortality Rate: 41/1,000 (SRS 2004)
- Contraceptive use (any method): 48.7 %
- Unmet need: 26.9%
- Women suffering from Anaemia: 46 %
- RCH rank: 24 (out of 35 states and UTs)

[Source: District Level Household Survey (2002-04) & facility survey (2003) - Reproductive and Child Health]

Implementation of NRHM in Uttaranchal

The National Rural Health Mission was launched in Uttaranchal on October 27, 2005, by the Union Health Minister Dr Ambumani Ramdoss. Chief Minister Mr N D Tiwari, Health Minister Mr Tilak Raj Behad and Joint Secretary of Government of India were also present.

The State Health Mission has been constituted with 11 members. The Principal Secretary (Health) Mr Alok Jain is the Director of the State Mission while the Chief Minister is the Chairperson and the Health Minister is the Vice Chair of the State Mission. Secretary (Panchayati Raj) is also a member of the State Health Mission.

The District Health Mission has also been constituted with 11 members. The President of District Panchayat is the Chairperson while the District Magistrate is Co-Chair and the Chief Medical Officer is the Convener of the District Health Mission.

According to state officials, the budget on health has been increased but the exact figure was not known. "The budget for 2005-06 was disbursed to districts but it was received late from the central government. This year the programme has not been implemented properly. A big amount of the budget was received in January. But now it has improved, we have already received budget for this financial year recently. Actually this is a new and big concept; it will take a little time for proper implementation. It's a very good concept, while people are taking it as old wine in new bottle, but I would say it is a good tool to improve the health situation in India, if implementation and monitoring will be proper", said Mr Ashutosh Kandwal, Senior Manager, (Programme Management & IEC) Uttaranchal Health & Family Welfare Society (Deptt. of Health and Family Welfare, Government of Uttaranchal).

ASHA

After the launch of NRHM, one of the first activities undertaken was ASHA Selection. The Central Government asked Uttaranchal to select ASHAs in three phases - 40 %, 40 % and finally 20 %. In the first phase 4104 ASHAs were selected. The first phase selection process has been completed and ASHAs have undergone the seven-day training. There will be four more 4-day training programmes. An NGO has observed that the quality of ASHA training was very poor. The Central government has recently suggested that the state complete the selection procedure in the second phase itself. According to a staff of Uttaranchal Health Directorate, there was no corruption in selection of ASHA. All rules were followed by the concerned people.

Untied fund

Because of its EAG status, Uttaranchal received untied fund for sub centres. A total of 1576 sub centres got untied money at Rs 10,000 each. 1506 Sub centres have opened their accounts. However, funds have not been utilised

yet. According to Uttaranchal Project Implementation Plan (PIP), there is a plan for capacity building and sensitization of Panchayats on NRHM, which will be addressed. They will be oriented about the village health plan, untied fund, and ASHA selection. The Panchayats are also involved in the District Health Mission.

An NGO has observed that the untied fund is being used for other purposes. For example, ASHA is being paid for her initiatives; women are getting money for JSY from untied fund and the regular revolving expenditure is being met from untied fund. The village pradhans had knowledge about untied fund only if their area had a sub centre. The others were not aware of NRHM and its components.

Indian Public Health Standards

A total of five Community Health Centres (CHCs) are functional as First Referral Units. These are in Doiwala, Vikas Nagar, Karanprayag, Jaspur, and Lohaghat. 26 CHCs have been selected for upgrading to IPHS (Indian Public Health Standards). The State Action Plan of RCH is complete while the action plan for NRHM is being processed. The Centre had given a deadline of September 2005.

"The Indian Public Health Standards (IPHS) have been made and distributed to the districts. The facility survey is also going on according to IPHS. A guideline is also there. There is lack of manpower; for example, we have lack of anaesthetics, due to which doctors are being given short term training on anaesthesia. So far ten doctors have been trained during a four month period, including a month's training on duty. Now they will give their final exam in Delhi," said Mr Ashutosh Kandwal, Senior Manager, (Programme Management and IEC).

District plans

There is a provision for decentralisation of NRHM, but in actual implementation this is a little problematic. The district action plans are being made while the village action plans are yet to be made. Panchayats are not aware of it. They need to be oriented. There is provision for their orientation in PIP.

THE HINDU: 28 October, 2005

Service in remote areas may be made compulsory for medical graduates

Staff Correspondent

DEHRA DUN: The Centre is considering making one-year service in the country's remote areas compulsory for all medical graduates before they are given a permanent registration. This is part of efforts to provide medical attention to people living in remote areas and also to inculcate among doctors the spirit of service to the poor.

Announcing this here while inaugurating the National Rural Health Mission (NRHM) in Uttaranchal on Thursday. Health Minister Anbumani Ramadoss said that a branch of the All-India Institute of Medical Sciences would be established in Rishikesh to cater to the super-specialty needs of the people of the region. A trauma centre will also be established soon, he added.

Appreciating efforts made by Uttaranchal in developing health care infrastructure Mr. Ramadoss hoped the State would develop into one of the foremost states in implementing NRHM that aims at reducing infant and maternal mortality, improving the health of both and checking population explosion.

Chief Minister, Narayan Dutt Tiwari, wanted more funds and technical assistance from the Centre for reaching medical aid to those living in highly inaccessible areas. Chief Secretary, M. Ramachandran, said that efforts were being made to develop various forms of medicines including innovations in mixed medicines as an affordable health tool for the common man.

Janani Suraksha Yojana

According to state officials, there were 1360 beneficiaries under Janani Suraksha Yojna (JSY) in 2005 - 06. Under JSY there is also a provision for accreditation of two private doctors, which is yet to be implemented. According to NRHM, every state has to constitute a regulatory body for private service providers. However, this is yet to be done in Uttaranchal. Some initiatives have started on public-private partnership, but the policy is yet to be put in place.

Essential drugs list

According to Mr Kandwal, an essential list of generic drugs has been prepared and sent to the government for ratification.

Uttaranchal: A Grassroots Review

The study done to assess grassroots realities of NRHM in the state threw up the following results:

ASHA

District Nainital

Ms Lalita Arya and Ms Padma Devi are ASHAs in Ramgarh and Bhimtal blocks. They said that ASHA selection was done by the Gram Pradhan, AWW and ANM. They were not asked for any money during selection. They received Rs 900 during the first phase of training. They said that village health committees had not yet been formed in their villages.

District Udham Singh Nagar

Ms Kaushalya Devi, Ms Neeta Devi, and Ms Nirmala belong to Sitarganj, Gadarpur and Khatima blocks respectively. They reported that selection was done in an open meeting of the Panchayat, after meeting with ANM, AWW, PHC and CMO. They were not asked for any money for selection. They received seven days training and Rs 700 for the training period. They said that the Village Health Committees had not yet been formed. No were they aware of the Janani Suraksha Yojna.

District Almora

Ms Pushpa Karki, Ms Neema Tiwari and Ms Reena Devi of Lamgara, Basiachana and Dhauladevi blocks respectively, were interviewed. They said selection was done by the ANM, PHC and Gram Pradhan in an open meeting. They had to fill out a form but were not asked for any money for selection. They have undergone the seven-day training programme. They reported that two of them received Rs 900 while one got only Rs 600.

ANM

District Nainital

Ms Deepa Pande and Ms Tulsi Arya are ANMs in Bhimtal and Ramgarh blocks. One said that three women received money under JSY. The other said that while forms had been filled out, money had yet to be received by the women. They have received Rs 10,000 for their sub centre in a joint account with the Gram Pradhan. According to them, this money is for BPL families and for the sub centre. They are aware of the Supreme Court guidelines relating to the Family Planning Insurance. They said that the family would get Rs 10,000 if the women were to die

during sterilization. They said that if a woman died within 10 days after the operation the family would get Rs 5,000, while Rs 2,000 would be given if she died within a month.

District Udham Singh Nagar

Interviews with three ANMs, Ms. Vimla Purohit, Balvir Kaur, and Ganga Devi, revealed that Rs 10,000 has been received for the sub centres. Sub centres which are attached with the CHC will not get this money. They responded differently when asked about the utilisation of this money, giving a range of responses. They said that the money was for BPL families, village people, and for the sub centres. According to two ANMs, no money has been received by any woman under JSY, while one ANM said that a few women in her area received Rs 500 under it. They did not know about the Supreme Court guidelines for sterilisation. They reported having fixed targets for sterilisation.

District Almora

Ms. Leela Dhaila, Ms. Hirma Devi, Ms. Sujata Singh work at Jaskote, Petshal, and Panuanaula sub centres respectively. According to two of them, no woman has received money under JSY yet, while one reported that five women had received some money under JSY. They reported having received Rs 10,000 for their sub centres, in a joint account of the ANM and Gram Pradhan. The money would be spent after a joint decision has been taken by the Gram Pradhan and the Health department. They said that the money would be used for BPL families and the sub centre. They were aware of the Supreme Court guidelines for sterilisation but did not know the details. They too reported having targets for family planning (35 cases for each ANM).

Women who gave birth to a child in the past 3 months

District Udham Singh Nagar

Asha Devi is a resident of Bhajpuri village, block Gadarpur. Susheela Devi is a resident of Khatima block in Majhola village. Both women are BPL card holders. They gave birth to their second child in May 2006 and June 2006 respectively. However, neither has received any money under JSY.

District Almora

Ms. Asha Devi lives in a village Anria Dot, block Lamgara. She is a BPL card holder. Delivery of her second child took place on 8 June, 2006, but she has yet to receive any money under JSY.

Interview with a district level trainer (NGO representative)

District Udham Singh Nagar

Ms. Heera Jangpangi works with Gramin Ekta. This is her account of ASHA training and other components of NRHM - "I am the district trainer for seven districts. The Deputy CMO, CDO and I gave seven days training to PHC doctors, ANMs, Anganwadi Supervisors, LHVs, teachers and NGO representatives, who were selected as trainers for ASHA training. It was a seven day training in which we gave them training on ASHA selection (mapping), role of ASHA, how to reduce maternal and infant mortality, immunization, nutrition, pure drinking water and herbal medicine etc. We were given Rs 200 per day and the participants also got Rs 200 a day. Now the first phase (7 days) ASHA training has been completed in Udham Singh Nagar. A module was made for their training. The ASHA got Rs 100 per day for the training period. When I went to the doctors and ANM for information, many of them were not aware about Janani Surakha Yojna and other information about the National Rural Health Mission. It was not shared during their training."

One Year of NRHM in Uttar Pradesh

Compiled by Ramakant Rai & Shakuntala Joshi

Uttar Pradesh at a glance

Uttar Pradesh, with a population of about 170 million, is home to one sixth of the country's population.

Demographic Profile

According to Census 2001, Uttar Pradesh has a population of 166.2 million and a population growth rate of 25.8 %. The overall sex ratio is 898 whereas the child sex ratio (0-6 years) is 916. The state has a female literacy rate of 42.2 % while its overall literacy rate is only 58 %, lower than national average of 65.38.

Health status

Uttar Pradesh has a fairly large public sector health infrastructure - Super Specialty Institution, namely, SGPGI, seven Government and four Private Medical colleges and hospitals, 53 District hospitals, 13 Combined Hospitals, 388 Community Health Centres, 823 Block PHCs, 2817 Sub Block PHCs and 20521 Sub Centres. Yet, only nine per cent of the state's population actually makes use of these facilities for ordinary ailments. People mostly depend on private healthcare. In the private sector, there are four Medical Colleges and hospitals and 4913 male/female hospitals/nursing homes at the district level. There are also a large number of registered and non-registered medical practitioners in the state who play an important role in providing medical service to the rural population.

Despite this, the physical health infrastructure in the state is still below the country's average. For instance, the population covered by a sub centre is 7080 and the average distance is 3.4 km, while the country average is 5109 and 1.3 km. It is estimated the 11 % of people in Uttar Pradesh are not able to access medical care due to the distance factor. Further, even when accessed, there is no guarantee of sustained care. Several other deterrents, such as bad roads, the uncertainty of finding a health provider, costs of transport and lost wages make it more feasible for a villager to get treated from the local quack.

The health sector's focus is on the curative rather than preventive aspect. This has led to the creation at a high cost of public health infrastructure that remains underutilized for several reasons in many parts of the state especially rural areas, while on the other hand the health infrastructure is bursting at the seams in certain urban areas.

The life expectancy at birth (LEB) in Uttar Pradesh is 56 years; the probability of the poor falling sick is 2.3 times more than that of the rich; and an increase of Rs 1,000 in the per capita income raises the LEB by three years.

3.3 % of the population is estimated to be getting pushed below the poverty line on account of high costs of medical treatment.

Reproductive and child health status

Uttar Pradesh has the highest maternal mortality rate (707 per 1,00,000 live births) in the country. Every year around 40,000 women lose their lives to causes of maternal deaths that can be prevented. Women do not receive

ante natal and post natal care. Auxiliary Nurse Midwives are under pressure to reach targets, because of which their main work of providing health services to the community is neglected. Women bear the burden of population control. 99.5 % of sterilisations are conducted on women, male participation being very low. Although there are several socio-cultural reasons behind this, it is a fact that very little has been done to mobilise men. Further, sterilisations are conducted under extremely unhygienic conditions. Women often die during a sterilisation because of the disregard of issues such as quality of care. Patriarchal structures add to a woman's woes - her health and well being is of little consequence to the family and very little money is spent on her.

Women in UP on Human Development Indicators

- Uttar Pradesh on the basis of total percentage of crime committed against women has Rank 1(14.1%)
- Uttar Pradesh constituted 32 % of the dowry deaths committed at national level in 2001.
- Sex Ratio in 2001:898
- Sex ratio of children below 6 years - 916
- MMR is 707
- Female Literacy rate: 43%
- Total Fertility Rate (1998): 5
- Percentage of Females in Labour Force (1999-2000): 29
- Gender Disparity Index Value (1991): 0.52
- Gender Disparity Index Rank (out of 32): 31
- Complete ANC: 4.4
- Institutional delivery: 15.5
- Births without health professional: 77.6
- Post natal care in home delivery: 7.2
- Women suffering from anaemia: 48.7
- Abnormal vaginal discharge: 28

In Uttar Pradesh, only 11 % of the population receives full antenatal care while the corresponding figure for Tamil Nadu is 75 % and for Kerala 85 %. Likewise, institutional deliveries (% per thousand live births) ????

Facts of Violence against Women

- Every 26 minutes one woman is a victim of violence
- Every 54-minutes, a woman is raped
- Every 48 seconds one woman is a victim of eve-teasing
- Every 4 minutes one rape takes place
- Every 10 minutes one woman is burnt for dowry
- Crimes against women reported an increase of 1.7 % over year 2000 and 24.2 % over year 1996.

The Infant mortality rate (IMR) is also very high in Uttar Pradesh. In the rural areas it is nearly twice as high as in the urban areas. Children in the rural areas experience 80% higher risk of dying before their fifth birthday than urban children. Nearly two-third of the deaths occur during the neo-natal period. The entire Health and Family Welfare Programme of the state is oriented towards sterilisation. The evidence given above suggests that spacing methods should have been a cornerstone of UP's programme..

Malnutrition is also very high in Uttar Pradesh. The government took an initiative to solve this problem through

the ICDS programme. But the reality is that the Anganwadis are dysfunctional. Those who are eligible cannot access the service as they do not have BPL cards.

In addition, adolescents in the state do not have access to information and quality of health services.

Implementation of NRHM in Uttar Pradesh

On September 7, 2005, Union Health Minister Dr Anubmani Ramadoss and Chief Minister Mr Mulayam Singh Yadav, launched the National Rural Health Mission in Uttar Pradesh. Secretary, MOHFW-GOI, Mr PK Hota, Additional Secretary, Ms Jalaja and Ms Panabaka Laxmi (State Minister, Health and Family Welfare) were also present. All District Magistrates and CMOs and some NGOs of Uttar Pradesh also attended the launch.

The State Health Mission has been constituted in UP. Dr LB Prasad (Director General, H & FW) is the director of this Mission, which has 16-17 members in it. These include PRIs, NGOs, Donors and representatives of ICDS, Education and Medical departments. The district health missions have also been set up in every district. In Uttar Pradesh, the departments of Health and Family Welfare have not yet been merged. The matter is still under discussion.

Till July 22, 2006, the state's Project Implementation Plan (PIP) had not uploaded on the website for public scrutiny.

The infrastructure norms set by the NRHM are as follows:

- CHC for one lakh rural population at the block level
- PHC for 30,000 population at the sub block level
- Sub centre for 5000 population in the plains and 3000 in Bundelkhand
- Health post for 50,000 slum population

The focus issue of the Mission is reduction of maternal and infant mortality in UP. This is confirmed by press reports too. While there is a Government Order for auditing of maternal deaths (March, 12, 2004), it is not being implemented due to alleged lack of resources and nor is it being considered a priority issue state officials themselves report. The Health Directorate is presently making a card for ASHA, who will audit the causes of maternal deaths and send that card directly to the directorate. This is being viewed as a good initiative if it works.

Hindustan Times, Lucknow, April 18, 2005 Pinning their health hopes on "Asha"

Under the Rural Health Mission, the Family Welfare Department had planned to launch an integrated health services in the 94,000 villages of the state. Director General Family Welfare Dr. LB Prasad said "we have decided to depute health workers in each village to ensure the proper execution of the programme".

Asha will get four weeks training on community and health delivery system. She would be trained about the methods of motivation, counseling and education. She would be an accredited social health activist of the village. She would not get any fixed salary, but performance based financial assistance, Prasad informed. The govt, has fixed the payment to 'ASHA' for each delivery, immunization, sterilization, cataract operation and treatment of the communicable disease patient. She would also take care of hygiene, nutrition, sanitation and safe drinking water campaign.

At the district level the DM or Chairman Zila Panchayat would head of the mission, while at the state level the CM would head of programme, he informed.

ASHA Selection and Training

A total of 64,350 ASHAs were proposed for 2005 - 06, but only 19,887 ASHAs were selected. This occurred

because of delay in distributing funds from the centre. The selection was to take place in open meetings of village Panchayats. It was proposed that there would be a Nodal Officer and a village health committee. Three names would be selected in these Panchayat meetings, and one ASHA would be selected on the basis of her ability. But in reality, the process was carried out very differently. Women filled up forms that were sold for Rs 5 to Rs10 in different places. ANMs and other government officials asked for bribes for ASHA selection. Alternatively, they selected their own relatives. There is also a misconception that ASHA will receive a salary.

In a laudable initiative, for the past two months the state's Directorate of Family Welfare has been putting out newspaper advertisements about ASHA , giving information about the selection criteria and roll. ASHAs are being trained in different villages. A training manual in Chandoli district talks about the following:

- How to make a Village Health Plan
 - Contacting families and mobilizing them on behavior change for using health facilities
 - Contact with ANM, Anganwadi worker, and Male health worker
 - Consulting families
 - Going to the hospital with patient
 - First aid
 - How to work as consolidators (Sangrahkarta)
- 0 Maintaining registers and registration

Interview with a facilitator in Chandoli District, Uttar Pradesh

(Date: July 8, 2006, 6 pm)

Name: Neetu Singh, Working in an NGO, Gramya, in Chandoli District

Four of us were asked to work as facilitators by the CMO during a district level dialogue organised by Gramya on Maternal Health Rights. Every person had to select six ASHAs in different areas. A total of 11 male and female facilitators are selected for the whole district. The four of us then selected 24 ASHAs and gave the list to the CMO office. We were given to understand that the minimum qualification for ASHA was 8th pass. In some of the villages there is no such woman; hence in such villages ASHA selection is still pending. We also submitted 16 certificates/ Mark sheets as proof of ASHA's educational background. We were told that we would get Rs 300 for each selection. Now the Health Inspector (HI) (Swasthaya Paryavechak) alleges that only 12 ASHAs were selected by us. He said, "You take honorarium for 12 ASHAs selection." The computer babu is also part of it. They did not give us any certificate after our selection. HI is trying to swindle the money, as he has taken money from other people to select their candidate. But we have decided not to make any compromise on money or take less money as we have worked hard. We will see the list which the HI will send [to the Medical Officer (MOI/C). Then we will take our next action.

We⁷ tried to call the Pradhan but he was reluctant to come. Finally we had a meeting with community people and other panchayat members and selected ASHA. In one place, a woman Pradhan was to come for the meeting but her husband stopped her. ASHA selection is almost completed. A total of 70 ASHAs were proposed to be selected from this district. Only 15 ASHAs are left to be selected.

ASHA is being trained; there are three trainers, two male and one female, who have come from Lucknow. It was a seven days training. ASHA is getting Rs 100 per day and the travel expense for one day. It is a residential training. There is a manual which is being used for training, but we did not receive a copy of the manual as all of them had been distributed already.

In Chandoli district work is being implemented, but in ASHAs' selection there is a big corruption. Naugarh PHC is upgraded into CHC. The PHC is shifting to a village called Amdhan.

Enhanced spending (3% of GDP) on health budget provision under NRHM

Since the Government of India has announced an increase in the health budget to 3 % of the GDP, a substantial provision is likely to be made under NRHM in the state budget. Ms Nayara Shahid, Additional Director RCH, Directorate of Family Welfare, Lucknow was contacted for more information on the enhancement but she said she did not know about it.

Regulatory body for private practitioners and providers

According to the NRHM, each state is supposed to form a regulatory body for private providers. It must also prepare regulatory norms and guidelines. Ms Nayara Shahid however said this was not in her knowledge. The Hospital and Nursing Home Registration Act is also not yet in place.

Provision of generic drugs

Provision of generic drugs is one of the most important provisions of NRHM. Almost all the essential generic drugs are supposed to be made available at with the ANM at the sub centre. Ms Nayara Shahid said this was not in the purview of family welfare and that the medical health department would decide on it. She had no idea as to the progress in this regard.

Public-private partnership

The modus operandi between private and public partnership is a crucial part of NRHM. State governments are to form guidelines for collaboration between private and public bodies. This is necessary to fill the gaps where there are lack of providers in remote areas. Ms Nayara Shahid said this process is on and it is likely to take some time to formalise.

Indian Public Health Standards

To ensure quality of care in reproductive health, medical protocols and guidelines are necessary. However general standards and norms to treat ailments are also necessary for the guidance of providers as well as the safety of patients. According to Ms Nayara Shahid, IPHS standards have been formulated in UP and capacity building is being provided at the district level.

Decentralised planning

Decentralised planning process is one of the key components of NRHM. We have accessed some documents from Azamgarh district and found that in most of the areas the district plans have been prepared without first making villages plans. This process was supposed to have taken place in a bottom-up manner.

Participation of Panchayati Raj Institutions

Panchayats and civil society were supposed to play a very important role in this programme. However, District Health Missions have been made in some of the districts but meetings in all the selected villages have not yet been completed.

Formation of Rogi Kalyan Samitis

Rogi Kalyan Samitis have been formed in most of the selected districts but the guidelines for their functioning are yet to be put in place.

SAINT RAVIDAS NAGAR EXPERIENCE

The Deputy Chief Medical Officer of the district, Dr D K Maurya who is also the officiating CMO, said during discussions:

The district health plan has been drafted at the district level. This has been carried out according to the state plan. It has nothing to do with the data and process of village plans. Hence, the entire process of decentralized planning seems to have been marred here.

The Deputy CMO also told us that the provisions and work of RCH-I is yet to be completed. For instance, the blood bank building is ready since the past one year but the supply of blood is not yet in place. Hence the blood bank is useless as the basic amenities and equipments have not yet been supplied to it. This leads to corrupt practices and the infusion of unscreened blood from private blood banks of the area.

He also said lady doctors are not posted at the district hospital, because of which emergency obstetric care is not possible and the very purpose of a district level referral hospital is defeated.

Mainstreaming of AYUSH

There has been no official declaration of mainstreaming of AYUSH till now. Only a few Ayurvedic doctors have been posted in CHCs, which is all that has been understood of AYUSH mainstreaming.

Citizen's Charter

The Citizen's Charter has not been drafted nor has there been any public debate on this issue. It did not seem to be on the priority list of the government.

Janani Suraksha Yojana (JSY)

According to the State Family Welfare Directorate, the Janani Suraksha Yojana is being implemented in the state. Funds under it have been transferred to all the districts. While data at the CMO office shows that several women have received money from the JSY scheme, interviews with eligible women by local NGOs indicate that women have not received any money. In some places, even ASHAs are not aware of JSY.

Untied funds

Untied funds for sub centres have been received in the joint accounts of ANMs and Gram Pradhans.

Upgradation

On June 6, 2006, the Health Directorate informed that a total of 50 PHCs and CHCs had been upgraded to FRUs.

Monitoring mechanism

Transparency and decentralized planning are the key words of NRHM. Despite this, as one can see from the above reports, a proper democratic mechanism has not been put into place by the authorities in some districts.

SAINT RAVIDAS NAGAR EXPERIENCE

The Deputy Chief Medical Officer of the district, DrDK Maurya who is also the officiating CMO, said during discussions:

The district health plan has been drafted at the district level. This has been carried out according to the state plan. It has nothing to do with the data and process of village plans. Hence, the entire process of decentralized planning seems to have been marred here.

The Deputy CMO also told us that the provisions and work of RCH-I is yet to be completed. For instance, the blood bank building is ready since the past one year but the supply of blood is not yet in place. Hence the blood bank is useless as the basic amenities and equipments have not yet been supplied to it. This leads to corrupt practices and the infusion of unscreened blood from private blood banks of the area.

He also said lady doctors are not posted at the district hospital, because of which emergency obstetric care is not possible and the very purpose of a district level referral hospital is defeated.

Mainstreaming of AYUSH

There has been no official declaration of mainstreaming of AYUSH till now. Only a few Ayurvedic doctors have been posted in CHCs, which is all that has been understood of AYUSH mainstreaming.

Citizen's Charter

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Community experiences about ASHA

Several rural women presented their experiences of the ASHA selection process and NRHM Implementation on April 12, 2006, which was the first anniversary of the launch of NRHM by the Prime Minister.

Asha from Kushinagar- We had a meeting in our village; five of us women were nominated. But when I went to submit the form at the PHC, the Computer Babu demanded 5000 rupees to submit the form whereas it was announced in the Panchayat meeting that no money has to be deposited with the form. I initially paid rupees 1000 to him, but I got my money back. He wouldn't accept so little. Five other women were nominated at this meeting but none of them have been selected for ASHA so far.

Bhavani from Mirzapur - We spoke to the Pradhan regarding the ASHA selection process but no meeting was called. It is said that one has to pass class 8 to be eligible for ASHA, but Dalit women have not studied up to class 8 so how would they apply. Therefore this criterion should be removed. Anyway, no one in our village has any idea what are the roles of ASHA, the Panchayat has not informed anybody. Three women have paid 2000 rupees each to the ANM so that they are chosen.

Parvati from Gorakhpur - We filled the ASHA form and went to the block, but the Pradhan is demanding 1000 rupees from each of us and has sent the forms back.

Meena from Gorakhpur - I came to know about the ASHA selection process through the Mahila Mandal in the village. The ANM demanded 1500 rupees from a woman who was working with her for a long time, she agreed to give rupees 500. The ANM told her to pawn her jewellery to get the money. She says the doctor at the PHC will not accept less than 1500. Those of us who really want to work are not selected because we do not have the money.

Source

1. *Note on Health Sector in Uttar Pradesh, 2005, Deptt. Of Planning, Govt, of Uttar Pradesh*
2. *Information collection from: The Health Directorate (Uttar Pradesh)*
3. *Information collection by NGOs of seven districts from CMOs, Dy. CMOs, CMO, Clerk, Computer Babu etc.*
4. *Status as on' June 1, 2006 (data from Ministry of Health & Family Welfare)*
5. *Women's presentation on a dialogue on April 12, on NRHM anniversary.*
6. *Press clippings*

Uttar Pradesh: A Grassroots Review

Ten months after the launch of NRHM in UP, a review was conducted in seven districts (Muzzaffarnagar, Azamgarh, Mirzapur, Chandoli, Bhadohi, Kanpur and Gorakhpur) to assess the ground reality. This review was conducted in 21 villages of these seven districts.

The key findings of the review are as follows:

ASHA

- In 12 out of 21 villages, ASHA had not been selected
- At the district level, a total of 8075 ASHA are said to have been selected in 6 Districts, (no information is available from Muzzaffarnagar)

- The Gram Pradhans were not clear about the selection process of ASHA. Even where ASHAs are selected, they did not know who they were.
- Eight out of 21 ANMs did not know about ASHA
- 11 out of 21 Anganwadi Workers do not know about ASHA
- In some places, the ANM has taken Rs 200-2000 for the selection of ASHA
- There is a lack of clarity on the role of ASHA

Janani Suraksha Yojna (JSY)

- Eight out of 21 ANMs were not aware about the Janani Suraksha Yojna
- Majority of deliveries take place at home with the help of a midwife, relative, or friend
- There are many women who have neither undergone a checkup nor been given a tetanus injection during pregnancy
- Most checkups during pregnancy are carried out by unregistered medical practitioners/ quacks
- ANMs do not provide any information to women relating to pregnancy and delivery
- The majority of the women were BPL card holders but had not received any financial support from the government under JSY

Untied Fund

- Most sub centers have received the untied fund
- The untied fund had not been used anywhere as yet
- Some Gram Pradhans were not aware about untied fund
- Some ANMs too did not have an idea about the use of this fund
- According to Gram Pradhans and ANMs who knew of this fund, they felt it was meant for buying furniture and repair of the Sub center or for the needs of BPL families

Target free family planning with improved quality of care

- A number of CMO offices were not aware about the Supreme Court (SC) guidelines on family planning or the Family Planning Insurance Scheme (FPIS)
- None of the ANMs were aware about the SC guidelines of the FPIS
- All districts had set a target for female sterilizations for the year. A total target of 94,533 cases was computed for six districts (Muzzaffarpur district not included)
- According to ANMs, their target was between 36 to 40 cases in a year
- ANMs do know of any cases where women have conceived after being operated for sterilization
- Women who had undergone sterilization were not explained about the contents of the consent form in simple language that they could understand, before being asked to sign the form or give their thumb impression
- Women did not get any certificate after sterilisation
- Women were not informed about the Family Planning Insurance Scheme

- One woman said the ANM's behaviour was not appropriate as she left soon after the operation and the woman had to go back alone
- After the operation, a woman developed an abscess on which she has spent Rs 7000-8000 for treatment.

Village Health Committee

- Village health committees have not been set up in most places.
- In the places where these committee have been set up, neither the Gram Pradhan nor the ANMs have attended any meeting
- Anganwadi workers are not aware about the village health committees
- In Muzzaffarnagar, Kanpur, Azamgarh and Gorakhpur, Rogi Kalyan Samitis have not yet been set up

Conclusion

While the NRHM process has begun, there are still many start-up activities that need to be initiated. There is a lack of information and a need for widespread dissemination of information on all aspects of the NRHM, especially ASHA. Community-level stakeholders like the Gram Pradhan, ASHA and Village Health Committes need to be involved in planning, implementation and monitoring of the NRHM through systematic inputs and capacity building.

- To collect all documents regarding NRHM, policies and programmes and disseminate this to grassroots organizations & community
- To form joint committees at all levels
- Identify persons from government who are sensitive and will listen
- Create pressure groups
- Capacity building of apex bodies

Annexure
Stakeholder's Consultation on One Year of NRHM
26-27 July 2006
List of Participants

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