

Reviewing Two years of NRHM

October, 2007

Citizens Report

Compiled by
Centre for Health and Social Justice, New Delhi

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SAHAYOG

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Thank you all.

Abhijit Das
CHSJ

Jashodhara Dasgupta
SAHAYOG

Preface

The National Rural Health Mission (NRHM) is one of the most significant health policy initiatives in Independent India. It starts with a clear and unambiguous articulation of its goal 'to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children'. It was launched in April 2005 to provide a new and integrated direction to the implementation of health programmes in India. In the last two years, NRHM has slowly rolled out across the country. To share the experiences of this roll-out across 16 states in the country, the Centre for Health and Social Justice (CHSJ), in partnership with the Advisory Group on Community Action (AGCA) organised a National Stakeholders Consultation on two years of NRHM on 8 August 2007. This consultation was conducted on similar lines as the consultation reviewing the first year of NRHM in July 2006, which had been found very useful by all stakeholders.

Over 120 participants consisting of representatives of civil society, public health experts, representatives from national NGOs and networks, international organisations, development partners and international NGOs attended the consultation this year. The consultation was also attended by Dr Syeeda Hameed, Member, Planning Commission; Mr G.C. Chaturvedi, Mission Director, NRHM; Mr Amarjeet Sinha, Joint Secretary, MoHFW; Dr N. K. Sethi, Senior Advisor Health at Planning Commission, and Dr Tarun Seem, Director, NRHM, from the Government of India.

Civil society participants came from Bihar, Chhattisgarh, Delhi, Gujarat, Himachal Pradesh, Jharkhand, Karnataka, M.P., Orissa, Kerala, Maharashtra, Rajasthan, Tamilnadu, Uttarakhand, U.P., and W. Bengal. The consultation provided a space for dialogue between policy intent, community level experiences of implementation and expert opinions on issues of common concern like ASHA functioning and training, implementation of the RCH 2 programme, Integration and Decentralisation. The consultation has resulted in a comprehensive list of concerns and recommendations. The AGCA has forwarded these recommendations to the Ministry of Health and Family Welfare.

This report is divided into two parts. The first part covers the proceedings of the consultation and the concerns and recommendations that emerged from it. The second part includes the Citizens Report on implementation of the NRHM, or the evidence gathered from different states on the status of implementation. This process of evidence building took over six months to prepare and covered seven states and diverse issues like functioning of the Janani Suraksha Yojna (JSY), participation of the Panchayati Raj Institutions (PRIs), service availability and so on. This evidence forms the bed-rock of the recommendations and concerns that the civil society organisations shared with other stakeholders in the consultation.

The first paper in the collection is based on the review of NRHM conducted by the People's Rural Healthwatch, an initiative of the Jan Swasthya Abhiyan (People's Health Campaign) that covered seven

states. The findings from this broad based study reiterate many of the gaps highlighted by the other reports.

There are two papers from Bihar, one that shares the overall status of health services in the state from the point of view of quality of care, while the other focuses on maternal health services and the implementation of JSY. While many changes were visible, like the increased attendance at the PHC, and the selection of ASHAs, there were many gaps as well. Clearly the relationship between the community and the health services was still weak, the communitisation mechanisms which the NRHM hopes to achieve was far from satisfactory, and institutions were in no way equipped to support institutional delivery.

Two papers from Uttar Pradesh and Uttarakhand share the experience of Social Audit that was conducted over 8 districts in these two states. One important aspect that they highlight is the lack of clarity at the state and district level about the importance of accountability to the community. Sharing meetings at the district at the state level generated energy and interest in the community but the painful reality of a malfunctioning system was met with denial in some places and it has been dismissed as being unrepresentative in others.

The paper from Rajasthan clearly highlights the inadequacy of the Sub-Centres across the state for conducting safe deliveries. However at the same time the paper brings out the willingness of the community to avail such services. A similar story is repeated by the study from Uttar Pradesh that reviews twenty cases of maternal deaths and near misses in the last one year.

Himachal Pradesh is often called the Kerala of north India because of its socio demographic indicators. The study on the involvement of PRIs in state reveals that the panchayats have little or no information or involvement in the NRHM. Jharkhand is one state in the country where panchayats have still to be implemented. The study from this state highlights how state-level initiatives, like the Sahiya programme (ASHA) can get bogged down because of lack of continued bureaucratic support. The study in Orissa reveals that while there is considerable interest and energy on the part of the state to implement NRHM, lessons from the past are not being taken seriously. The state also continues to be hamstrung by serious lack of personnel in critical areas.

There is one strain that runs through all the papers, and that needs to be highlighted right at the outset. While the papers highlight many deficiencies in the implementation of the NRHM, there is a common concern for its successful implementation. All the papers are replete with concrete and specific recommendations for improving the situation. This is the one hope and the guiding spirit for the entire process.

Concerns and Recommendations

Emerging From

National Stakeholders Consultation on

Two Years of NRHM

August 8, 2007

Achievements

Reviewing the experiences of participants as well as the reports placed by the government officials associated with the mission, it was evident that there had been a number of achievements over the last two years.

- Accredited Social Health Activist (ASHA) selection had taken place in large numbers across the country. In all, more ASHAs had been selected than projected in the Mission document. However, the training and functioning of ASHAs needs to be reviewed.
- Communities are increasingly becoming aware of the Janani Suraksha Yojna (JSY), its associated financial incentives, and attending institutions for deliveries. There are many issues related to corruption and quality of care which need to be addressed urgently.
- Minor repairs were carried out in many places on Sub-Centre buildings through untied funds.
- District planning processes were evident in some places.
- Panchayat Pradhans were found to have some knowledge of NRHM and JSY, indicating an involvement of Panchayati Raj Institutions (PRIs).

Concerns and Recommendations

In spite of quite a few achievements, the progress of the Mission is not in line with anticipated midterm achievements, and the following concerns and recommendations emerged from the consultation:

(a) Public Health Infrastructure needs Strengthening for Effective Service Delivery

- (i) Services must be based on the principle of continuum of care. The health centres must be easily accessible and equipped sufficiently to meet local health requirements, more importantly with a well-established referral system and emergency transport facilities.

- (ii) Doctors and other health providers should not only be knowledgeable about their subject, but also culturally competent, with skills to deal with poor rural women and communities. Doctors should be trained for community-health orientation, empathy and gender sensitivity.
- (iii) Many CHCs, PHCs and Sub-Centres still need structural and functional upgradation. Lists of such upgraded PHCs and CHCs must be widely available, with the details of services available being displayed outside the centres.
- (iv) The prescribed levels of healthcare must be provided at all centres and this must be regularly monitored through a system of accreditation.
- (v) Health facilities must be equipped with essential drug lists and accordingly medicines must be made available. Medicine procurement and distribution mechanisms must be strengthened and free medicines ensured to the poor. Medicine kit must also be available with the ASHAs, and supplies replenished in time.
- (vi) Special focus must be given to developing systems and guidelines to provide special healthcare to the vulnerable and marginalised groups including dalits, tribals and other forest dwellers, people affected with HIV, migrant groups and so on, based on their cultural practices and socio-economic situations they live in.
- (vii) Similarly, special and immediate attention must be given to developing systems for ensuring effective healthcare services during natural disasters like droughts and floods.
- (viii) The role and functioning of AYUSH department within NRHM must be properly defined. Functions of AYUSH doctors in relation to allopathic practitioners (including nursing staff) at the health centres must be clarified immediately.
- (ix) Much resource goes into the Pulse Polio programme and it continues to affect regular service delivery at the periphery. Yet polio has not been eliminated. The programme thus needs serious and careful revision.
- (x) Vacancies, especially that of service providers, must be filled up on a priority basis. In some places, it may even be necessary to revise the staffing pattern according to the level of services that must be provided at various health facilities; accordingly, posts must be quickly sanctioned or training provided to the existing staff. Fresh appointments have to be made and contractual appointments must not be treated as a permanent staffing mechanism.
- (xi) A transfer policy must be formulated to prevent frequent and irregular transfers of providers and other key functionaries.
- (xii) Complete information about various NRHM programmes and schemes (e.g. RKS, IPHS) should be available with all Medical Officers and ANMs.
- (xiii) To ensure a regular presence of health staff in peripheral/remote areas, special steps need to be taken. To provide an enabling environment for them, the following methods were suggested: providing incentives for serving in rural/difficult areas develop a good system of referral and backup support (technical and functional) from higher institutions, continuing training module for ANM, revamping the cadre of male health workers.
- (xiv) The urban healthcare sector must be dealt with in more detail in the PIP. It is dominated by corporate players, and has been completely dissociated from the general healthcare system of the country. Integration between rural and urban health is important.

- (xv) Partnership with the private sector must be a thoughtful process, with considerations made to differentiate between engagement with for-profit and non-profit sector. Contractual appointments do not assure long-term quality performance and system stability.
- (xvi) Costs in the private sector are high and there are no regulatory mechanisms for quality assurance. Regulation of and setting of standards for the private sector need to be done on a priority basis.

(b) *Strengthening RCH Services under NRHM*

- (i) The following areas related to RCH services are not addressed adequately in the PIPs:
 - ❖ Adolescent reproductive and sexual health issues, which are addressed only superficially.
 - ❖ Gender training for healthcare providers, which has to be introduced immediately.
 - ❖ Equity and access issues for underserved population, including the urban poor, has to be defined clearly. The definition of vulnerable population in the PIP is inadequate.
- (ii) Issues related to maternal healthcare that need reconsideration include the following:
 - ❖ JSY is being seen as a scheme that covers out-of-pocket costs for safe delivery. It must be emphasised that the JSY cash assistance is for nutritional and other support and not for service delivery costs.
 - ❖ Promoting institutional delivery without first addressing or improving the quality of care in these institutions is leading to serious cases of denial of care and the strategy needs to be revisited.
 - ❖ JSY should be seen as a mechanism to strengthen safe delivery, delinked from institutional delivery.
 - ❖ Referral systems are very weak, almost non-existent, and women are 'ping-ponged' from one provider to the other.
 - ❖ Harmful practices like unsupervised use of Oxytocin injections before delivery have to be addressed in the programme.
 - ❖ The role of Dais/TBAs in facilitating access to health services has to be acknowledged and suitable capacity building and empowerment of dais has to be encouraged in remote and underserved areas.

(c) *Community Mobilisation and Community Participation*

- (i) Expand IEC activities at the village and community levels to provide information about available health services, schemes (including JSY) and other entitlements under NRHM, including the roles of ASHA, for improving community health. There must be wide publicity to the fact that all services mandated through the concrete service guarantees are free.
- (ii) In many places, ASHA selection and training has not taken place as planned. Ensure ASHA training as envisaged and perform regular evaluations of ASHA functioning.
- (iii) Information about membership, roles and responsibility of Rogi Kalyan Samiti, Village Health

and Sanitation Committees and other committees must be provided to all stakeholders through a public notice.

- (iv) District Action Plan is developed mechanically, without ensuring community participation for addressing the real needs of the community. VHSC has to be activated and village level planning and inter-sectoral coordination must be initiated immediately. PRI members must be provided with orientation / training on issues related to community health, village health planning & inter-sectoral coordination.

(d) Regulatory Systems - Governance and Monitoring Mechanisms

- (i) Information on NRHM functioning has to be publicly available at the district and state levels.
- (ii) Grievance redressal mechanisms and medical and social audits of adverse events and experiences must be instituted and publicized extensively.
- (iii) Corruption at all levels is a major problem. It is affecting the functioning of the system and implementation of several programmes. Departmental monitoring, oversight and accountability mechanisms still need to be developed further and strengthened for meticulous implementation.
- (iv) Monitoring should include regulation and performance assessment of NGOs and private providers as well.
- (v) Availability of JSY incentives to women has to be monitored intensively to understand how much money is being received by women and at what time.
- (vi) Community monitoring and social audits should be introduced at the soonest for responsible functioning of the public systems.
- (vii) The Right to Information must be recognised and used to strengthen governance and reduce corruption.
- (viii) Role and potential of civil society organisations as members of monitoring committees, institutions of capacity building and information gathering must be adequately explored and utilised.

National Stakeholders Consultation on Two Years of NRHM

August 8, 2007
India International Centre, Delhi

Detailed Report

Welcome – The Consultation began with Dr Abhijit Das of Centre for Health and Social Justice (CHSJ) and member, Advisory Group on Community Action (AGCA), welcoming all participants to the Consultation. Dr Das briefly laid out the preparatory and state level processes that had been going on for the past six months in different states to understand the ground level realities in implementing the NRHM.

SESSION ONE - TWO YEARS OF NRHM: AN OVERVIEW

Chair: Dr Syeeda Hameed (Member, Planning Commission)

Co Chair: Mr G C Chaturvedi, (Mission Director, NRHM, GoI)

Presentation I

Two Years of Implementing NRHM – by Mr Amarjeet Sinha (Joint Secretary, MoHFW, GoI)

Mr Amarjeet Sinha pointed out that although the NRHM has been operational for two years, the cabinet officially passed the implementation framework only in July 2006. He elaborated that earlier there was a flawed assumption that we had a functional public health system so only vertical programmes like those on T.B. and malaria were launched. However, NRHM is now actually trying to set up a fully functional system at all levels, i.e. from the village or community level, up to the district level. The NRHM's mandate is thus to push reforms that are resource-driven.

Quoting a study by Jean Dreze which showed the need for functional resident health workers, he said this concept has also found a place in Centre-State joint mandates for NRHM. He said that pushing for a culture of decentralisation was important, but it takes some time for the process to begin: for example untied funds of around Rs 2.5-6 lakh per CHC/PHC have been released, but it will take a while to instill confidence in the people to spend the money that was allotted to them. One needs to provide an enabling



Mr. Amarjeet Sinha making a presentation

environment to the service providers to do things differently. Thus Rogi Kalyan Samiti (RKS) shall have a patient welfare focus, it was not only constituted for generating resources locally. In the last two years of NRHM, around five lakh ASHA's have been selected and 3.8 lakh had received training. ANM schools have also been started in Bihar and now there are 6,600 Sub-Centres in India as against 1,500 previously.

According to Mr. Sinha, NRHM is a right or entitlement-based initiative, hence demand generation is important. For example, as in JSY, one must put pressure by demanding that women be made to stay in the hospital for 48 hours after delivery and not be released within 6-8 hours. Thus there is a need for provision of flexibility in the programme implementation, but also a need for an accountable and motivational work scheme.

Presentation II

NRHM- Taking Stock after 2 years – by Dr Abhijit Das (Director, CHSJ and Member, AGCA)

Dr Das' presentation was based on reviews and studies conducted by various civil society groups from different states. He began by stating that NRHM has made some headway in terms of ASHA selection, availability of some financial incentives under JSY and in generating demands for institutional delivery.

However, Dr Das pointed out that NRHM documents say that 2007 is a midway phase and some commitments were made in the beginning regarding the state of health indicators. The present indicators, however, state that reaching the stated aim by 2012 was going to be a tough task.

Other issues that he presented as major findings and concerns raised by the civil societies were as follows:

- ❖ Only the first round of ASHA's training has been done till now.
- ❖ Under JSY, the benefits come with harassment and there is a wrong assumption that the incentives were for service delivery, which is actually supposed to be free.
- ❖ How could one initiate institutional delivery without having the institutions in place?
- ❖ Providers do not have proper information on NRHM (e.g., IPHS is not known to MOs).
- ❖ Are the untied funds supposed to be used as a maintenance grant only?
- ❖ Village Health and Sanitation Committees (VHSCs) have not been formed.
- ❖ The causal relation between provision of JSY and institutional delivery, and linking it up with maternal safety is faulty.
- ❖ Adverse treatment accounting system and grievance redressal mechanisms are required.
- ❖ There was corruption in the system, for example, state Programme Implementation Plan (PIP) were not readily available.
- ❖ The cost in the private sector is at least three times higher, but there are no quality parameters.
- ❖ Quality parameters, e.g., Indian Public Health Standard (IPHS) -like standards, should be instituted in the private sector as well.

- ❖ Public Private Partnership (PPP) should differentiate between areas of profit engagement and those for non-profit engagement.

He also shared experiences on various community actions undertaken by various Civil Society Organisations (CSOs).

Presentation III

Training and Building Capacities in ASHA – by Dr Deoki Nandan (Director, NIHFV)

Dr Deoki Nandan described the training process that aims to establish ASHA as a change agent in health sector reform.

Some of the salient points of the presentation were:

- ❖ There are two types of ASHA training- Induction Training and Periodic Training.
- ❖ Induction trainings are supposed to be for 23 days, over a period of twelve months in five rounds, i.e., seven days training initially and thereafter four episodes of four days each. Periodic Training is accomplished through monthly meetings for which additional compensation is also given.
- ❖ The ASHA training follows a cascade model for training. The training was conducted through various groups at various levels. Thus there were State Training Teams, District Training Teams and Block Training Teams.
- ❖ The main aim of the training was skill upgradation of the ASHA. One of the main issues was the timely information for training. Also it was important that the training venue was within reach for the ASHA. Various kinds of material were available for training: IEC material, facilitation kits, charts and posters.

Stakeholders' Concerns

The three presentations were followed by discussions, queries and feedback from the other participants. The queries that were addressed from the floor covered the following issues:

- ❖ Ravi Duggal asked Mr Sinha to elaborate on the role of *Dais* (midwives) under NRHM. He also questioned how one could ensure autonomy of institutions where there was a bureaucracy in function that works by handing down the instructions.
- ❖ Subhash Medhapurkar from SUTRA raised the issue that while ASHA was supposed to be a change agent, why was her performance evaluated and incentivised on the basis of service delivery only. He also questioned if NRHM is functioning on only curative and vertical programs, then where is the scope of preventive health within a public health approach.



Ravi Duggal questioning Mr. Sinha

- ❖ Jashodhara from SAHAYOG expressed concern and questioned how and why the entire

government health system is engaged in the Pulse Polio campaign, a vertical programme whose very rationale is being challenged today.

- ❖ Renu Khanna from SAHAJ asked about the quality indicators to change the ongoing work culture within the public system. For example, is there a redressal mechanism for complaints of corruption and, if so, how is it functioning? She also raised the question of political influence and its effect on postings and transfers and asked how the mindset can be changed so that there is more openness.
- ❖ Dr Narendra Gupta from Prayas commented that while decentralisation is being attempted, decisions are still being taken in Delhi but there was a talk of making them locally adaptable. However it is still very difficult for the system to think openly, as the middle management still has to look above for directions. For example, state PIPs have still to be presented at the Centre.
- ❖ Dr. Gupta also opined that NRHM still has a very biomedical approach and the social and epidemiological approaches are missing. Moreover, empowering the grassroot level workers is very important.
- ❖ Dr Bulbul Sood from CEDPA raised a concern that due to frequent changes in the management, often a process has to be started again and again. For example, as the District Chief Medical Officer (CMO) changes, there is lack of coherent information regarding the implementation of various schemes. Also, frequent changes in the provisions of scheme like the JSY cause problems.
- ❖ Another concern that was raised was regarding the mismatch that is often visible between programme provisions, aims at the higher levels and its final implementation at the ground level. This mismatch coupled with poor experiences of service often lead to dissatisfaction at the lower level.
- ❖ Annie Namala from Indian Institute of Dalit Studies said that lot of indifference is rampant on the ground and is not being addressed. She questioned how the excluded communities were being taken into the fold under NRHM.
- ❖ Another issue raised was why management skills and good governance couldn't be ensured within NRHM. The technical package of NRHM is good but there are problems in its execution.
- ❖ The planning process within NRHM was questioned. 'Why is planning being outsourced? Such plans usually rely on secondary data, which by itself is not reflective of the reality at the village level.'
- ❖ Concern was expressed that information about NRHM has not gone much beyond the CMO's office; hence most women are not aware of the services they can avail.
- ❖ In terms of quality of care, it was said that if JSY was helping promote institutional delivery, then quality of care must be ensured.
- ❖ A participant raised the issue of AYUSH, asking, "Will the AYUSH doctors use Ayurveda or Allopathy as a treatment procedure?"
- ❖ Lack of clarity about the role of NGOs within NRHM was also another issue that was raised.
- ❖ Other concerns were about the non-functional status of RKS and Village Health Committee (VHC); and discrimination against the poor which gives them a feeling that services are not meant for them.

Responses from the Government

Mr. Sinha responded to the issue raised by other Satkeholders. He stressed that it was not right to consider all government services as bad. He clarified that any rights-based approach can only work if there is demand. Addressing the issue of TBA/Dai training, he said that while in RCH-II training did not help improve skills, NRHM aims to ensure a longer training period and skill upgradation.

About the process of decentralisation, he opined that it would be difficult to open up the system overnight. Now there is flow of money, but there have to be broad norms as one cannot be reckless about allocating money. It has to follow a system.

He said that undue attention to Pulse Polio is an issue, but one also needs solution to such problems and merely raising a problem is not enough. He added that public health also subsumes the preventive health component. For example, in Kerala, funds have been allocated for prevention of Chikungunya.

In conclusion, he stated that there would be an external evaluation of NRHM to analyze how effective it was and generate evidence of failure and understanding of the problems; however the government will definitely deliver the provisions under the mission as per the plan by 2012.

Following this, co-chair of the session, Mr Chaturvedi, Mission Director, NRHM said that the voices from the ground that have been presented and the concerns raised were being acknowledged, but one has to also think of solutions to these problems. For example, he said that if money is breeding corruption, then one could think of paying JSY incentives through cheque or paying it in installments, starting from the ante-natal stage rather than giving the full amount post-delivery. Addressing the issue of frequent transfers, he said that it does jolt the implementation process and the only answer to this is that it has to be transparent and the information flow to the periphery has to be speeded up.

Regarding the outsourcing of planning, he said it was well-known that compiling separate plans would be time-consuming, and it takes around three months for the information to percolate down from the government to the lower levels. Hence we would have to come up with an alternative solution together.

Joining Mr Chaturvedi, the chair of the session, Dr Syeeda Hameed also added that there is need to analyse why there is a mismatch between the presentations in Delhi and the implementation at the ground level. Moreover, there was a need to empower the NGOs as well. Talking about similar experiences of neglect she witnessed in other areas, she said that criticisms would not help; one has to make changes and run the system.

Dr. Hameed said that the Planning Commission is at least trying to ensure that there is a regular flow of money under NRHM. However one has to work within the NRHM provisions and make them enabling for both the women who receive JSY and ASHAs, who are becoming dissatisfied. She is of the opinion that JSY money should be available to all women, even if they do not go to the institution. In conclusion, she said that while field experiences are always the real voices, the government and the NGOs must work in collusion to see how best to run the system.



Dr Syeeda Hameed chairing the session

SESSION TWO - RCH in NRHM: An Overview

Chairperson: Ena Singh (Assistant Representative, UNFPA, India)

Presentation I

ASHA – After Two years of NRHM – *by Sashi Bindhani (SODA and NAWO, Orissa)*

The first presentation was on 'ASHA-After two years of NRHM'. It highlighted the state of ASHAs: their selection, how they find their training inadequate, the dissatisfaction generated among them due to lack of remuneration and how they are working in hope of getting something better in future.

Some of the concerns that were generated through discussion are as follows:

- ❖ How do we ensure the credibility of the ASHA?
- ❖ The work allocated to ASHAs was at one time part of the job description of the ANM. So has a new job description been given to the ANM?
- ❖ How do we handle the fact that ASHAs will change?
- ❖ Is there any specific procedure for the appointment of ASHAs and has the ASHA taken up the role of an activist as envisioned within NRHM?
- ❖ Participatory training is lacking in the ASHA training procedure.
- ❖ There is confusion about ASHAs' role. Their training modules are exclusive and not inclusive of learning from other training modules.
- ❖ There is a clear hierarchical relation between the trainer and the trainee, which is detrimental.
- ❖ What happens to the aspirations after training and whether there was some mechanism of training in soft skills for the Medical Officers (MOs)?
- ❖ If the Village Health plan is outsourced, how can one expect the ASHA to contribute to it?
- ❖ Gender has become just a section within NRHM, it is not pervasive within the NRHM provisions.
- ❖ Concerns were raised about how the ASHAs in UP are being used for sterilization targets.

Presentation II

Maternal Health - Experiences, Issues and Recommendations – *by Sunita Shahi (Prayas, Uttarakhand)*

This presentation discussed some of the changes that have been brought about in terms of increased awareness about various services and increase in their demand. The presentation also looked at the state of JSY services, its problems and dissatisfaction amongst communities. It also showed that infrastructure has improved in places where untied funds have been used.

Recommendations that were made after discussion on the presentation:

- ❖ One needs to look at the entire range of services, starting from Antenatal Care (ANC) to delivery, to the Postnatal Care (PNC).

- ❖ Similar roles are being allocated to different providers, e.g., ANM and ASHA.
- ❖ One needs to spell out their profiles more coherently.
- ❖ A redressal mechanism is required to address cases related to adverse effects of services.
- ❖ Knowledge and visibility regarding the citizens' charter is lacking.
- ❖ One needs to define which institution is being referred to when one talks about institutional delivery.
- ❖ Issue of cheque payments to the beneficiaries under JSY needs to be analysed.
- ❖ Dr Amitrajit Saha from PATH reiterated that putting accountability systems in place for adverse cases is important. He questioned what mechanisms have been instituted to see that all the adverse outcomes are being recorded and if there is some redressal mechanism in place to address these issues.
- ❖ If a woman delivers on the way to the institution, then she should be able to avail of the JSY benefits.
- ❖ The fact that NRHM is bringing some changes has been acknowledged, but attention must be paid to why there are problems.
- ❖ One needs to look at strategies to address some outcomes for anaemia and the scope of emergency obstetric care.
- ❖ Dr Sonia Trikha from WHO raised the issue of overuse of oxytocin during delivery to which Jashodhara also added that use of oxytocin in non-medical setting without prescription is rampant in UP.
- ❖ Praveer from Jharkhand raised the issue that if one is extending maternal health to the community level, then one needs to link the issue of domestic violence to health.

Presentation III

RCH-II in NRHM: Missing Issues – by Renu Khanna (JSA and SAHAJ, Gujrat)

Ms. Khanna expressed concern that some issues that RCH-II PIP has already stated are missing within NRHM. These are equity and access, gender mainstreaming, urban health, adolescent reproductive and sexual health, contraception and Medical Termination of Pregnancy (MTP). She highlighted the issue of vulnerable groups and how they need to be defined properly. The presentation also pointed out that next year's NRHM PIP would have a separate Reproductive and Child Health (RCH) chapter.

It was suggested that there was need for involving males within Reproductive Health (RH) programs, so there was a need to also look at male ASHAs. One needs to look at an implementation commission also besides the Planning Commission.

Summary of the Chair

The summary from the chair stated that problems in accountability are mainly due to lack of knowledge about roles and duties. This is also the problem with ASHAs as at the conceptualisation stage there was a lack of clarity in their roles and this lack of clarity remains till today. The ASHA and JSY were seen as a link between the community and the institution.

Earlier, the focus was primarily on family planning but today there has been a shift to maternal health, and that is good. However, if maternal health is the focus, the institutions need to be properly equipped.

Finally, the chair asserted the need for a collective action plan after the discussion to address the issues and take some forward action.

SESSION THREE - Strengthening Health Services in NRHM

Chair : Dr H. Sudarshan (Karuna Trust and Member, AGCA)

Presentation I

Public-Private Partnership (PPP)/ Public-Private Initiatives (PPI) and the Public Healthcare by Ravi Duggal

Mr. Duggal in his presentation mentioned that there was no case made for a partnership between the public and private sector in the health sector in India. The situation was skewed in favour of private sector with over 85 percent of the expenses and overwhelming proportion of curative care in this sector. Less than 10% of doctors were also in the public sector, while a substantial number of doctors were exported every year to advanced economies. However this has not been a historical trend and the major increase of private sector influence has happened after 1981 with a clear linkage with structural adjustment programmes, globalisation and privatisation. Some of the characteristics of the Indian private sector were that it lacks regulation, leading to wide variations in quality and qualifications, at the same time it lacks transparency and accountability, even though it receives huge subsidies from the state.

There are 103 PPIs documented by various organisations globally, e.g., GAVI, IAVI, AAI, GPEI, GFATM, GAIN. There is one even for washing with soap, and Procter and Gamble is one of the partners, for obvious reasons. So, the pharmaceutical industry is involved in a big way in all these partnerships. RCH/NRHM is seen as a vehicle for PPI institutionalisation in India.

The PPI in NRHM/RCH is very visible. From ad-hoc or sporadic initiatives, PPIs have moved to being organised and strategic initiatives. There is a wide range of engagement with the private sector across states by means of franchising, branded clinics, contracting in/out, social marketing, BOT, subsidies like capital/land and tax/duty waivers, free supplies, vouchers, CSR, capacity building, insurance schemes, privatisation, user fees, etc. Markets for the private sector are only expanding. The NRHM approach to PPI is that it is not universal in its approach. It is designed for a selected population and it does not work in the long run as it is a populist measure. The Assam health insurance scheme can be cited as an example. ICICI bank made a lot of money but the insurance policy has not been renewed. Only 14-15 per cent of the money came back in the form of benefits.

The private sector wants capital subsidies, leverage for existing assets, curative care monopoly, secured profits, supplies and new markets. The public sector does not know what it wants. It lacks clarity.

The speaker felt that the contracting in of services, as done in non-US OECD countries was the only viable model along with the adoption of a grant-in-aid model for hospitals, as done in the school sector in India. However these too wouldn't be successful without large scale restructuring, reorganisation and regulation needed, as well as political will to weather radical changes.

Stakeholders' Concerns

- ❖ Is the state itself in self-destructive trajectory where it is systematically handing over the responsibility of provision of health services to the private sector? Are we proposing any alternatives to the state? Where will we find the confidence to reverse the trend?

Response: The whole economy is in self-destruct mode. It's not just health, it's a larger issue. The whole political economy is changing rapidly, so how can the health sector be any different? We need to use NRHM to change that so that health does not follow the same trajectory. But is there a political will to do that? How do we mobilise public opinion? We need to make health a political issue and only then will the state start responding.

- ❖ Has anybody done any impact assessment regarding PPI in Central Government Health Scheme (CGHS) and Employee State Insurance (ESI)?

Response: CGHS and ESI are bad examples of public institutions. CGHS, in fact send their patients to Apollo Hospitals and other private hospitals as well. ESI has functions for ambulatory care through the private sector. ESI is a good example for ambulatory care but not for hospital care. The bed occupancy rate for ESI is a mere 12 per cent.

- ❖ Informal providers are formally illegal. What are the ways in which we can engage them for maternal health?

Presentation II

Integration in NRHM: Vertical Programmes and Health Determinants – by Dr Imrana Qadeer (Public Health Expert and Member, Mission Steering Group, NRHM)

Dr Qadeer said that integration of health systems is a neglected subject. Some of the issues within integration were conceptual integration, technical integration, organisational integration and of integrating manpower and finances.

The tragedy, according to Dr Qadeer, is that NRHM has transformed primary and secondary level institutions into RCH outposts. District health systems have been completely dissociated from the urban health system, which is today dominated by the corporate sector. Leprosy, TB, malaria and AIDS continue to be vertical programmes and only in case of vector-borne diseases is there integration simply because these diseases are transferred through vectors? However their regional distribution, seasonality and causes are not looked into.

The public health standards that NRHM has created should include the basic minimum food, drinking water, housing, minimum wages, Public Distribution System (PDS) at the primary health level and also at all other levels. Confusion caused by casualising paramedical workers and verticalising them into isolated programme personnel has to go. They should be regionalised and given multiple skills so that they can handle many problems in their region: five workers are not needed in the same population to knock five times on people's doors. Similarly, she said, NRHM must get out of the RCH consortium for financing. "Different international organisations are funding us for different things," she said. "It is high time that India realises its own priorities without an outside agency telling it where the funds should go. There is a need for a fluid bank of funds for equitable disbursement."

Stakeholders' Concerns

- ❖ Integration of social determinants is essential.
- ❖ Integration of programmes is at a very superficial level.
- ❖ Integration of work safety is needed.
- ❖ There is no integration of rural and urban health systems.
- ❖ Integration of traditional medicine and AYUSH among themselves and with allopathic medicine.
- ❖ Integration of socio-political realities that might exist in specific geographical pockets of the country, e.g. conflict-ridden areas of Jammu and Kashmir, North-East. Issues like mental health of the victimised children in these areas need to be addressed.

Response: Deep integration needs thinking. It will not happen if we just wait for the state to do it. We need to resolve and define what we mean by integration, then articulate it and translate it into practice and we have to demand it.

The state always likes to divide. The reason is that with the neo-liberal paradigm of development, the state has sold itself to privatised healthcare. The private sector demands that the state works as a steward and not as a guardian. So the state is doing stewardship. They are putting it in a platter and giving it to the private sector to make profits. That is why the divide between the rural and the urban is necessary. Rural is not a homogenous entity. There are very rich rural people who have diverted their capital to health and have built huge corporate hospitals.

If we ask this question to the NRHM people, they will say it has been done. The NRHM has a provision of appointing AYUSH doctors at the PHC level. This is not integration. For proper integration of the AYUSH doctors, the planners and the allopathic physicians have to shed a lot of arrogance, learn to interact and work together. That's a long haul.

Issues like mental health and other issues in conflict areas need to be integrated by regionalising and prioritising.

- ❖ One of the reasons integration is extremely difficult at the grassroot level is because there is no integration at the national level. In one of the JSY meetings in the ministry, the people from maternal health were not invited. Integration would not happen at the grassroot level unless health is viewed as a comprehensive thing at the national level.

Presentation III

Better Health Services Provision under NRHM: the Chhattisgarh Strategies – by Mr. V.R.Raman (State Health Resource Centre) on behalf of Mr. P. Ramesh (State Health Secretary, Chhattisgarh)

The state of Chhattisgarh was carved out of MP. While it was part of MP, it remained as an underserved region. An analysis revealed the gaps on the demand and supply side. The gaps on the demand side were inadequate awareness, poor utilisation of services, need for behavioural changes and greater community participation. On the supply side were huge infrastructural gaps; human resource gaps; drugs, supplies and equipments mismatches, programme design issues, lack of referral facilities.

Most Sub-Centres were not conducting institutional deliveries but now about 1,000 are doing so. Many PHCs had low daily Out Patient (OP) attendance of about 20. There was absenteeism of medical officers. Under Sector Investment Programme (before NRHM), community-based health reforms were initiated in 2002 in consultation with the community and CSOs. The staff set-up was enhanced according to national policy and norms and contractual appointments are still happening. 74 mobile medical units are operational in Chhattisgarh. A short-term six-month course for MBBS doctors, trains them in emergency obstetric care and anaesthesia. Now more skills like neonatal care and other management of emergencies is being included. All doctors were trained on essential drug list, Standard Treatment Guidelines (STGs) and Drug Formulary. There was insistence on rational drug use and norms for minimum services at each level. Paramedics were trained on symptom-based first contact care and multi-skilling in laboratory skills. A STG in Hindi was developed for this. Female paramedics were trained on Skilled Birth Attendance. Out of the CHCs in 64 blocks, 22 have started to provide Comprehensive Emergency Obstetric Care (CEmOC) services and 28 achieved the Basic Emergency Obstetric Care (BEmOC) level of services.

Jeevandeep Scheme on hospital reforms has been initiated. A Hospital Improvement Index was developed for facility assessment. Star grading of all (16) districts hospitals was done (three Silver Star hospitals and one bronze star hospital) and rest of the 11 are being supported to achieve minimum benchmarks. Assessment and action on CHCs is being initiated.

The Mitanins are assuming the activist role in a big way. Along with forming pressure on the health officials, they are touching on determinants of health, e.g. forestation. They have completed seven rounds of training and are going into the specialised training rounds. The Swasth Panchayat is a programme to support local bodies in achieving better health. Health- centred Human Development Index (HHDI) data collection was conducted as a massive community/PRI exercise and completed in more than 95 per cent of Gram Panchayats (GPs)/Blocks. HHDI was prepared with projection of gaps and given back to the GPs for follow-up. The Sarpanches and the other functionaries were trained and actionable Village/Panchayat health plans are under process. This programme helped in identification of weaker Panchayats and involves PRIs on health issues. Special grants were given for weaker Panchayats as well. The health infrastructure and the staffing have improved since 2003-04. A growth in budget outlays was also seen.

Stakeholders' Concerns

- ❖ It is good to see that revamping of training schools for MPW is talked about. The role of male Multi Purpose Workers (MPWs) has been sidelined for a long time. Since the salary of the MPWs comes from the state budget, they were always a low priority. To meet goals of male involvement in RCH and the convergence of RCH and the AIDS programme, the role of MPWs becomes very important.
- ❖ The Chhattisgarh health policy has not taken care of the primitive tribals. How does the ANM access them as they are not helpful in fulfilling her targets?

Response: It is true that nothing has been done regarding the primitive tribal population.

- ❖ People who are not associated with Salwa Judum don't get health facilities.
- ❖ Hunger is a major problem in Chhattisgarh. Can you stop someone's hunger by giving micronutrients?
- ❖ What is the reason for the increased maternal and infant mortality?

Presentation IV

Community Experiences of Service Delivery under NRHM – *by Praveer Peter (SANCALP Gender Resource Group, Jharkhand)*

The issues that emerged about strengthening service delivery were:

- ❖ Round the clock PHCs – lack of doctors. Arbitrary transfers, inadequate facilities and contractual staff were not serious about their duties.
- ❖ Equipment, Drugs and other supplies – Ensure supply through display of list of available drugs, decentralize procurement and create a flexi-fund for meeting the cost of drugs and other supplies during epidemics, natural disasters at the district level.
- ❖ Support facilities like transport, electricity, telephone, potable water, etc. will have to be ensured in all the centres if utilisation is to be improved.
- ❖ Referral System - Definition of referral to be clearly outlined. Just discharging the patient from the centre and asking her to go herself, is that referral? Referral chain needs to be built.
- ❖ Quality of Care – need to look into the issue of oxytocin injections given by ANMs without proper medical supervision. Counselling needs to be built for informing. Where to seek services for ANC, abortion and post-partum services?
- ❖ Funds and partnerships – Untied Funds utilisation needs to be made clearer. Framework should be given for involving NGOs and encouraging PPPs.
- ❖ Ensuring Standards - Monitoring and evaluation to be both internal as well as external.
- ❖ Charter of Patients' Rights has to be operationalised
- ❖ RKSs and District Health Mission have to be involved in improving accountability.
- ❖ Community Monitoring has to be implemented on an urgent basis as it will ensure equitable allocation and use of services, promote better communication with healthcare personnel. It will enable communities to take local action if the services that are provided do not fulfill their health needs.

Discussion

- ❖ The issue of transparency of utilisation of untied funds needs to be addressed.
- ❖ The reorientation and training of ANM regarding new advances in the medical field is not happening.
- ❖ A system needs to be inbuilt in the health system to keep a check on outdated equipments and their maintenance.
- ❖ We are talking of decentralisation and of giving decision-making into the people's hands. But is the process of giving everything to small committees driving us towards a form of privatisation? As CSOs we need to analyze this. Where do we draw the line that between community and private ownership?
- ❖ Within PPP there should be separate policies for RMP/private doctors, NGO's and corporate sector involvement.

SESSION FOUR - Decentralisation and Community Ownership

Chair: A.R. Nanda (Director, PFI & Convenor, AGCA)

Co-chair: Sushila Zietlyn (Senior Social Development Advisor, DFID)

Presentation I

Decentralised Planning, Monitoring and PRI involvement – by Dr Tarun Seem (Director, MoHFW, GoI)

Decentralisation has been one of the key concerns on NRHM. Some of the strategies adopted within NRHM for decentralization included state and district specific Programme Implementation Plan (PIP), Annual Maintenance Grants and Untied Funds, Contractual Appointments and Decentralised procurements. It must be remembered that prior to NRHM, funding was tied to vertical programme and had uniform national parameters. In 2006, state PIP was received, which showed the realities about what the state thinks is the best way to implement NRHM in their given situation. In 2007, many states have made district action plans and integrated them into the state PIPs. Many of these district plans were made by NGOs. They make interesting reading as they show how district authorities, with their limited exposure to the planning process, have arrived at a document that is internally consistent, has a timeline chapter, a budget line chapter and has even mentioned evaluation criteria. At the end of 2007, the district plans will be collated into the state health plan and by the beginning of March 2008, block desegregation in the integrated district health action plans would be done. By 2009, NRHM envisages that villages should be able to make a village health plan. That is where stakeholder discussions like this become extremely relevant. If there is a design anomaly in the situation, now is the time for participants and stakeholders to raise their voice and help us design something so that by 2009 we are ready to bring about the changes at village level.

What do we need for this? We need to create capacity, create quality and appraisal mechanisms and address uneven development.

As part of this exercise, the monitoring framework of NRHM involves sharing of data at all levels, displaying of agreed services at each level.

Many initiatives have been put in place for monitoring and evaluation. Annual Health Survey by the Registrar General of India has been proposed. For external evaluation, UNICEF does an immunisation survey; Unicef, UNFPA and GTZ cover ASHA and JSY; financial protocols come from the Institute of Public Auditors. Community monitoring facilitated by AGCA is also one of the initiatives.

The next planner's paradigm shift is on community participation at hamlet level with ASHA, at facilities with RKS and the health society at the higher level.

The next most important paradigm for a planner is to ensure a pro-poor focus. It is very easy to lose this focus when you are planning something for 35 states. The pro-poor focus and equitable system will have to be built up in the planning process. IPHS norms, or quality of care is an important component to keep the pro-poor focus.

The planner at the bottom level has to keep in mind convergence of water and sanitation, nutrition and education. This convergence will be monitored against benchmarks to show synergy, will not

always be budget-neutral, will need to involve stakeholders outside health, will need to start from inside the health department. Telemedicine is one way the government can scale up its training initiatives more easily. The Tele Training Centre at National Institute of Health and Family Welfare, MNGO training network and Medical College network are some telemedicine initiatives.

Presentation II

Decentralisation: Community Experiences – by Sandhya Gautam (SUTRA, H.P.)

Ms. Gautam presented the results of the deliberations of a civil society group that had reviewed the operationalisation of the decentralization process in a number of states. She said that while decentralisation is the key to achieving the goals of NRHM, in reality decentralised planning, implementation and monitoring are yet to be internalised by health managers. RKS/VHSC are not in place or functional. District health plans are being developed mechanically without reflecting the real needs of the community. Village Health Plans are not developed. Gender and equity perspective is yet to get focus. Members of various committees lack understanding of their expected roles and responsibilities. Inter-sectoral/departmental convergence is not yet actualised at every level. Monitoring mechanisms to review the processes are not in place. The target is to spend the funds without concern for health outcomes. There is no clarity about funding and procedural guidelines for utilisation pertaining to untied fund/VHSC fund/ maintenance fund/RKS fund. Rural health mission is still not on the agenda in Gram Sabha/ Panchayat meetings. Space for PRI representatives from Panchayat to district level is still to be provided. Seriousness in engaging civil societies in NRHM is missing. There is no drive, as expected, for engaging PRIs in implementation of NRHM.

Presentation III

Community Monitoring in NRHM: An AGCA initiative – by Dr Narendra Gupta (Prayas, Rajasthan)

Dr Gupta presented the work that had been undertaken by the Advisory Group on Community Action (AGCA) for implementing Community Monitoring in NRHM. The objective of Community Monitoring is to elicit regular and systematic information about community needs to guide related planning. Another objective is to get feedback on status of entitlements and functioning of various public health facilities and enable the community and CBOs to become equal partners in the planning process. The outcome of community monitoring is envisioned as a change in the status of community from passive beneficiaries to active rights holders.

According to the timeline of implementation proposed in the NRHM Framework of Implementation, the system of community monitoring is supposed to be implemented to the extent of 50 per cent by 2007.

Under community monitoring, community and community-based organisations will monitor demand, need, coverage, access, quality, effectiveness, behaviour and presence of healthcare personnel at service points and possible denial of care and negligence. The monitoring process will include outreach services, public health facilities and the referral system.

The community monitoring process was initiated under the AGCA, which is a standing committee under NRHM. The AGCA had proposed a detailed proposal for Community Monitoring to the Union

MoHFW, which has been accepted. The first phase of Community Monitoring was started from March 2007 and covered nine states - Assam, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Orissa, Rajasthan, Tamil Nadu & Karnataka. Only a selected number of districts in each state (depending upon the size of the state) will be covered.

For wider participation, a range of civil society networks and organisations with experience of rights-based activities and accountability-enforcing activities are sought to be involved in the first phase.

The PFI hosts AGCA and the technical support unit for it is CHSJ.

Stakeholders' Concerns

- ❖ What is this community? Have we learnt lessons from the past? In RCH there was a Community Needs Assessment (CNA) component that was systematically forgotten.
- ❖ What is the purpose of the reporting system? In a small venture in Gujarat, we are working with the VHSCs and have included a 'Reporting by exception' method wherein the work that was not done and the problems presented are reported. The Community Monitoring framework should be a mechanism of supportive supervision and problem- solving. We need reflexive systems. People need to know why we are collecting this data.
- ❖ What kind of representation the AGCA group and the whole Community Monitoring have from the excluded groups? What is the mechanism of data collection? What is the mechanism of increasing their stakeholderhip?
- ❖ What is the role of the Centre in decentralisation?
- ❖ Since past few years in UP, there is computerised record-keeping at the Block level from where information flows instantly to Geneva. When we ask the minister if this technology can be used for something other than Pulse Polio, he says that the computers have to be sent back. The trained personnel will only do work related to polio as our department cannot pay the polio personnel as the WHO does. Do we need another vertical information flow, which in itself becomes an end and will never be used for real public health issues of the people?
- ❖ Health system is a closed system. It keeps the NGOs at a distance.
- ❖ Central government's role is a facilitator's role and not to issue guidelines.
- ❖ AGCA should also promote community planning.



Participants from different states listening to the presenters

Responses from government representatives

It is very difficult to draft something that can be understood the same way all over.

Seeing financial reports as a basis of movement in physical activity is the norm in governance. One cannot look at money spent and think that all is working well but it has to be taken in the appropriate perspective.

Raising local funds is not synonymous with user charges. User charges are not an NRHM invention. User charges were directly taken to the state treasury and not retained at the facility. NRHM insists that if there is user charge, it should be used at the facility level. The under-privileged are not supposed to pay if the system is robust.

Input-based funding is not just determined by population but also by geography, road transport, and telecommunication.

The AGCA is right now involved only with Community Monitoring in nine states, but next year it will be involved in the other states as well. So not only the depth of the AGCA will increase but also the geographical reach.

Response from representative of bilateral organisation

The co-chair of the session, Ms. Zietlyn from DFID, raised few significant questions and gave some suggestions:

- ❖ Where are the ASHA's from? Are they from the *tola* or *basti*, which has the worst health outcomes? If we want to bring about a positive change, that is what we should do. ASHAs are supposed to be the link but whom are we linking with? We need more engagement with groups that have the worst outcomes and set targets for reducing gaps between groups.
- ❖ DFID has made a draft report that talks about two-pronged approach. We are asking all CSOs that we are funding to make a governance audit for themselves. If the aim is to reach women, for example, we see how many women do they employ in their organisation.
- ❖ NGOs and CSOs can contribute in deciding on geographical distribution of health centres. They need to push for fairer and more equitable spread of facilities.
- ❖ How can such representation happen at the district level, so that resources are pushed to the underserved blocks? In the district action plans, we need to see where the resources are changed/rearranged.
- ❖ Capacity building of PRIs is essential.
- ❖ In privatisation, no attention is given to exemption of fees for the poor.

VOTE OF THANKS –The Consultation ended with a Vote of Thanks to all participants that was proposed by Ms Renu Khanna on behalf of the organizers.

Health Services and the NRHM: An Interim Stock-taking¹

People's Rural Health Watch-JSA

Introduction

The NRHM was announced in April 2005, by the United Progressive Alliance (UPA) government, to acknowledge the promises made under the Common Minimum Programme regarding rural health and access to primary health care. The vision of the mission is to provide effective health care to rural populations throughout the country, with special focus on 18 states that have weak public health infrastructure. It aims to bring about dramatic improvement in the health care system and health status of the people and also seeks to provide universal access to equitable, affordable and quality health care.

This is not the first time that the government has acknowledged the problems afflicting the public health system and the public health services in the country. Since the beginning of the Bhore Committee (1946) and the first Five Year Plan (FYP) period (1951-56), many committees have identified such problems. In turn, many recommendations have been made since the 1970s in order to develop a well-functioning comprehensive primary health care structure in the country, tailored not only to the needs of our rural population, but also to provide free and universal health services to all sections. However, this objective has remained largely unrealised.

The mission also comes during a phase of health sector reforms being implemented in many states. These reforms were initiated in the early 1990s and are being financed by international institutions such as the World Bank (WB) and the European Commission (EC). They are being carried out at several levels: structural and functional, reforms in financing, governance-related, and involvement of the private sector through PPPs. Instead of improving the health services, such measures have only further weakened the existing fragile primary health infrastructure and also encouraged and reinforced the growth of an unregulated private health sector. Additionally, policy developments formulated by the WB and other international agencies, such as EC and WHO ('development partners') have been working to restrict public health to provisions of certain selective 'cost-effective' interventions and packages through the rural health infrastructure, which unfortunately works against comprehensive primary health care.

It is at this juncture, characterised by a looming crisis in the public health system and the health of large sections of people and a retreat of the State from the goals of providing universal access to primary health care, that the NRHM has been launched and is being projected as a major government undertaking.

Several members of the Jan Swasthya Abhiyan (JSA) were involved in the consultative process of drawing up the objectives of the NRHM. However, the incorporation of their suggestions and recommendations has not been satisfactory. Moreover, there has been no systematic analysis of the previous policies and lessons have not been learnt from the past.

Peoples' Rural Health Watch (PRHW)

The concept of PRHW was conceived by JSA following its Right to Health Care campaign and after the launch of the NRHM. It became evident from the public hearings during the Right to Health Care campaign, that the problems were more systemic rather than simple isolated cases of denial of health care by some health functionaries. Given the objectives of the NRHM to improve rural health services, the PRHW was viewed as a way of looking at the status of the rural public health infrastructure and the changes taking place therein, and also of analysing and assessing issues arising out of the implementation of NRHM. The PRHW would be an activity to document and assess the areas that were getting the most attention in the implementation process, whether better health services were reaching the people following the introduction and implementation of the NRHM, and provide some feedback for improvement. The exercise was also expected to provide some lessons and directions to move towards a system of community/people's monitoring of health care services.

The PRHW initiative was planned as a two-year activity in January 2006-08. It began with the collection of primary information through periodic surveys and studying relevant policy documents. This report brings together and analyses the information collected over the 2006-07 time period. The survey was carried out in various districts of MP, UP, Bihar, Rajasthan, Jharkhand, Chhattisgarh and Orissa.

In each state, the survey has been carried out in selected districts by partners/constituents of JSA and other NGOs. It was designed to provide qualitative information about some aspects of the rural health services and not intended to be quantitative or statistically representative. It was important to note that a one-time survey could only serve as a baseline, and hence, a limited purpose. Therefore, a repeat survey in keeping with the above objectives was planned in the second year.

Questionnaires were framed to cover the areas relevant to rural health services – namely for CHCs/PHCs/Sub-Centres ASHAs, and experiences of patients and of the community. The questionnaires were designed bearing in mind the comprehensive primary health services that should be available at these health centres. Apart from the three levels of rural health services, ASHAs were also included in the survey as they are being projected as a major strategic intervention under the NRHM. Since these are the basic components of the rural health system across the country, the same questionnaire for each level has been used in all the states in order to provide a standardised framework to elicit information and guide the observations. Primary information has, thus, been collected through observations and interviews of health functionaries, as well as from patients and community interviews.

There was a purposeful sampling of districts/villages and institutions for the survey - namely selection of districts within states had been based solely on willingness and ability of the local organisation/partner to undertake the survey in the concerned district. A minimum of at least two blocks and two villages in each block were to be surveyed. This kind of sampling meant the following: in each block one CHC, PHC under this CHC and two Sub-Centres under this PHC were to be surveyed. In addition, at least two ASHAs in the selected villages were to be interviewed and a village discussion was to be conducted.

Secondary information about the entire district, specifically information about demographics, health status, health services, and implementation of the NRHM was also to be collected. The survey was conducted by the state JSAs between the months of September 2006 and January 2007.

A large amount of information (e.g. location of health care institutions, condition of buildings, availability of infrastructure, personnel, services, medicines etc.) was collected from the survey because it served as a baseline. The following sections will only present significant findings indicative of trends in the NRHM. Information on Chhattisgarh is culled from a report prepared by the JSA, Chhattisgarh – *Status of Health and Healthcare in Chhattisgarh*, based on the PRHW survey and other sources.²

1. FINDINGS OF THE ASHA PROGRAMME

In November 2005, shortly after the launch of the NRHM, JSA had expressed concerns regarding the conceptualisation of the role and function of the ASHA programme.³ The findings of the implementation of the ASHA programme are proving that many of those concerns and questions are valid.

- (a) The selection of the ASHAs shows that the educational criterion (class VIII pass) is being rigidly adhered to – nearly 100 per cent of the ASHAs have studied up to class VIII. Furthermore, very few village-level meetings have been held in order to have an informed, consultative selection process and most of the ASHAs are being selected largely by the ANM/AWW or village leaders.

The main questions that arise from this are:

- i) What is happening to the money that is being allocated for the ASHA selection process (about Rs 55,000 per block, for a unit of 100 ASHAs), for the facilitators' visits and village meeting expenses?
- ii) Why are women giving 'applications' to the Panchayat, with their school marksheets and caste certificates?
- iii) Whom will the ASHAs so selected be accountable to?

In states like Orissa, selection has been through Self-Help Groups (SHGs), and JSA members have raised the issue of conflict among SHGs over the selection of ASHAs. There is also reluctance on the part of women selected as ASHAs to work as there is no payment involved. In such cases, MOs are being instructed to let 'reluctant ASHAs leave' and choose the next woman for the task. There were also plans to issue identity cards to ASHAs.

- (b) The ASHAs in the village are engaged solely in RCH-related work, including mobilising for immunisation and Pulse Polio. They are village level workers for the health system and largely assist the ANMs/AWWs by: tracking, surveying, making lists of pregnant women, children and neonates, and gathering them for immunisation/Pulse Polio, ANC, health days, etc.

This information is also corroborated from the responses of ANM (in the Sub-Centre survey) regarding the impact of the ASHA's presence in the villages. The ANMs have reported that ASHAs help in the immunisation of pregnant women and children, in getting women together, and so on.

Compared to Chhattisgarh, where more than 80 per cent of the *Mitanins* surveyed reported having a drug-kit with twelve essential drugs, very few ASHAs in other states even possess drug-kits. Most of these drugs were being distributed quickly, unlike the earlier situation when drugs simply expired with

the depot holders because they were not being distributed. However, the drug-kits are not being refilled regularly as promised in the scheme and there are frequent shortages of Chloroquin and IFA.

The trends thus far indicate that ASHAs are going to end up as unpaid village-level assistants, providing only RCH services. This ultimately goes against the very conceptualisation of the idea of an ASHA as an 'activist', as she was not meant to provide services other than some basic ones.

Developments Since the Inception of the ASHA Programme – As far as the future of the ASHA is concerned, confirmation needs to be provided that an ASHA will ultimately become an unpaid village level provider of RCH-related services. Under the *Training and Enabling ASHA for Newborn and Child Care under the Indo-Norway Joint Initiative*, ASHAs are to be trained in order to provide home-based newborn and childcare; in fact, this is to be a universal component of ASHA training and intervention package irrespective of the place of child birth. Furthermore, it states that ASHAs should also attend home births along with the TBAs.

2. UNTIED FUNDS TO SUB-CENTRES

At least 50 per cent of the Sub-Centres have not received the untied grant. Of the Sub-Centres that have received the grant, only about 50 per cent have spent it. These funds have been spent on items such as building, repairs, purchase of furniture like tables, almirahs, fixtures, buckets, stationary, bleaching powder, a few medicines, weighing machine, thermometer and stethoscope.

In Chhattisgarh, the untied grant has been increased to Rs 18,800. As per the survey in Chhattisgarh, out of the 81 Sub-Centres, 60 had received untied funds, but the amount they have received varied from Rs 5,000 to Rs 13, 800. At least 25 per cent of the ANMs said that they had been given only Rs 5,000 and another Rs 5,000 had been given to them in the form of equipment purchased at the district level without any consultation with the ANM or Sarpanch. In many cases, like in Raigarh District, the ANMs had to return the money to the district for centralised purchase of equipments. Some of the equipments purchased by the districts included electrical sterilisers for centres without electricity and bed pans for centres which do not have beds or in-patients. In addition, the equipments purchased were often of very poor quality. Only 52 per cent of the ANMs had started spending the untied funds on items such as stationery, referral transport, maintenance of the Sub-Centre and so forth. In the Manendragarh block, the total untied fund amount disbursed was Rs 4.51 lakh, out of which only 14 per cent had been spent over the entire year.

Untied funds, if available and utilised, are of limited use in addressing the varied problems at the Sub-Centre level such as the following pointed out by the ANMs:

- a) Lack of building, water, electricity and toilets.
- b) Irregular supply of medicines, syringes and vaccines. In addition, the ANMs have to go to the PHC to pick them up.
- c) Slide reports unavailable on time.
- d) Lack of doctors and other staff especially MPWs.
- e) ANMs have problems in traveling from village to village, especially to isolated areas. They also have to walk long distances.
- f) Lack of cooperation from the panchayat.
- g) Not getting their salary on time.

Untied funds alone cannot be expected to solve the problems (i.e. lack of staff, medicines and infrastructure) that affect the Sub-Centres. These funds can, therefore, be expected to serve a purpose only when some ground work has been done, namely gathering sufficient staff to provide services, making people aware of the availability of funds, developing capacities of VHCs and ANMs to utilise appropriately and creating village health plans that reflect the requirements. In the absence of these pre-requisites, it is inevitable that the funds will be wasted, or worse, misused.

3. JANANI SURAKSHA YOJANA (JSY)

Chhattisgarh has seen a significant rise in institutional child births after the introduction of the JSY, largely due to the presence of the Mitans. But this trend is in danger of reversing due to the lack of payment/delayed payment of the JSY entitlements and the harassment the beneficiaries have to undergo to receive it.

Field data from around the state reveals that in most of cases, the JSY money for institutional child birth is not given immediately to the mother or to the Mitans. In all the facilities conducting institutional child births, there is a huge backlog of JSY payments. For instance, in the Nagari block, the ANM reported that out of twenty institutional child births, only 8 women and Mitans received the JSY entitlement. Along the same lines, in the Batauli block, the JSY money has not been paid for an entire year. In the Pratappur block, the Block Medical Officer (BMO) does not give the money at the facility. Instead, he goes to the beneficiaries' house and gives them the money, while keeping part of the amount for himself.

As evident from the ground reality, women opting for institutional child births have to incur huge expenses. Along with the purchase of medication, even the nurses' demands for money have to be contended with. Money charged by nurses at the facility range from Rs 200 to Rs 1,500. For example, in the Ambikapur district, hospital nurses charge maternity patients anything from Rs 1200 to Rs 1,400. This 'fee' is over and above the cost of medicines and supplies.

There have also been instances of women reaching a health centre at night with labour pains but refused services at the CHC/district hospital and instead referred to private hospitals. For example, in the Baikunthpur block, the gynecologist refers all cases coming during 'off hours' to a particular private nursing home, where the birth is inevitably by caesarian and the family ends up incurring an expenditure of more than Rs 20,000.

In fact, Mitans all over the state are bearing the brunt of disgruntlement, as they are the ones to persuade the family to opt for institutional child birth. An extreme form of this was seen in Rajnandgaon where in two panchayat meetings, the Mitans were publicly humiliated for taking pregnant women to hospitals where the patients subsequently incurred a heavy expenditure. Some panchayats have even barred Mitans from taking women to the hospitals for child birth.

In the case of home births, ANMs expressed their inability to provide payments due to the lack of funds. In the Manendragarh block, there is an accumulation of more than 200 eligible BPL women who have given birth but still need to receive their JSY entitlement. The other issue which was vehemently brought up by the community is that of ANMs charging anything from Rs 200 to Rs 2000 for attending home births. There have been cases where the ANM has kept part of the JSY money for herself. For example, in the Premnagar and Sonhat blocks, the ANM had kept Rs 200 and Rs 100 respectively, from the JSY entitlement. Situations like this are rather isolated and in both the cases mentioned above, the ANM had to return the money due to community pressure.

Another issue of concern is the movement towards privatising delivery-related care under the pretext of expanding JSY support. The Chhattisgarh government has started accreditation of private nursing homes for child birth under JSY. This has already taken place in Gujarat, Jharkhand and Haryana.

4. BUDGETARY ALLOCATIONS AND FINANCING UNDER NRHM

- a) **As such, under the NRHM no new (structural) measures have been introduced**, which can be seen to contribute to strengthening the health infrastructure. **Budget heads have been merely shifted/re-positioned and placed under the NRHM.** The money continues to be spent on:
- (i) Family Welfare Programmes that includes RCH II, routine immunisation and Pulse Polio.
 - (ii) National Disease Control Programmes
 - (iii) A third category, 'Additionalities under NRHM' has been created within the NRHM category. Funds under this will be spent on the ASHA programme, untied funds for Sub-Centres-PHC, funds for CHC upgrades, annual maintenance grants for PHCs and CHCs, Mobile Medical Units, constitution of RKSs, district planning activities and health melas.
- b) **We see that the allocations continue to follow the earlier trends** – Family welfare is getting more than the health component. The RCH II component and the Pulse Polio programmes continue to be at the centre of all health allocations and receive substantially larger shares of the health budget allocations, when compared to disease control or routine immunisation programmes. While the allocations for the latter programmes are either minuscule or decreasing, actual releases/ expenditures are even less. Furthermore, the National AIDS Control Programme also receives comparatively larger allocations among all disease control programmes.

5. IMPROVEMENT OF HEALTH INFRASTRUCTURE: ADDRESSING SHORTAGE OF INFRASTRUCTURE AND PERSONNEL

Despite a massive and chronic shortage of infrastructure and personnel, as well as failure of the earlier reforms to affect improvements, it is evident that the NRHM has not undertaken any comprehensive measures or other significant inputs to address these issues. There are no valid or new measures in the direction of genuine strengthening of the rural health infrastructure other than releasing certain funds to Sub-Centres/PHCs/CHCs as untied funds, maintenance grants for upgrades and for management structures such as RKSs. No genuine measures have been made to recruit doctors and staff at all levels of the public health services and make the system functional, reliable and sustainable.

- a) **The basic problem of lack of adequate staff still remains to be tackled.** For instance, in 2006-07, of the 2,543 contractual specialists expected to be appointed; only 648 had actually been appointed. Of the expected 2,301 contractual doctors to be appointed, only 1,825 were appointed. This situation is similar for other personnel such as staff nurses and ANMs. Our survey shows that almost all Sub-Centers have only one ANM and there is no MPW. Thus far, steps have not been taken to address the lack of staff at the Sub-Centre level.
- b) **Several piecemeal measures are being proposed.** Measures such as re-orientation, skill advancements, re-location/redeployment of existing doctors, hiring part-time or contractual staff

and involving the private sector are being proposed. Either non-governmental specialists are being paid on per-case basis for work done in government hospitals or non-governmental providers are being accredited under JSY.

In Rajasthan and Bihar, the governments have outsourced the task of recruitment of doctors to private agencies. While all these new appointments are contractual, the salaries offered (in Bihar) are a consolidated sum of Rs 20,000 for post-graduate specialists and Rs 15,000 for MBBS doctors. One wonders whether the government is serious about getting doctors to work in the public health services.

- c) **The other basic problem of lack of essential medicines at Sub-Centers/PHCs/CHCs, is also not being addressed.**
- d) **Mobile medical units** are being promoted under NRHM despite the Planning Commission reporting that they are expensive and of limited use. This is largely being done for tribal areas.

6. DECENTRALISED PLANNING

A grant of Rs 10 lakh to every district for decentralised planning is underway and nearly all districts are expected to have completed preparation of the District Health Plan by March 2007.

However, the necessary groundwork for preparation of the district action plans does not exist. In our survey we found that in 75 per cent of the villages, even VHSCs have not yet been formed. Also, states like Rajasthan and Bihar have outsourced the task of preparation of district plans to private agencies.

7. EMPHASIS ON FINANCIAL MANAGEMENT ONLY

In terms of capacity building initiatives, almost 400 PMUs are reported to have been set up and 1,200 programme management, finance management and data management professionals have reportedly joined the system at state and district levels.

The PMUs being set up under the NRHM process are all primarily for the purpose of the RCH II programme – these PMUs will support not only the RCH, but the entire gamut of activities under NRHM.

8. ROGI KALYAN SAMITIS (RKSs)

RKSs are expected to improve the functioning of the hospitals to make them more accountable, transparent and need-based. They have been empowered to levy and utilise user charges.

Even the RKSs are plagued by several problems. These include the composition of the RKSs (those who pay can become members), measures by which the RKSs can raise resources and the extent that they have contributed to improving the quality of services.

A study of RKSs in MP shows the following:

- a) Hospitals with RKSs did not maintain any data on the socio-economic status of patients (even with respect to whether or not they belong to BPL families or SC/ST). So, it was not possible to assess the impact on patient care and on the poor.

- b) Data regarding income and expenditure of RKSs shows that the bulk of income in CHCs and PHCs comes from user fees only – 90 per cent and 98 per cent respectively. Construction/repairs, equipment and medicines are the top three expenditure items, forming 50 per cent of the total. Funds raised have been spent on priorities decided by the executive and governing bodies.
- c) There are cases where the RKS income, largely from user fees, is substituting for regular government spending on hospitals. It was observed that poor infrastructure, such as inadequate operation theatre facilities, badly maintained toilets and lack of needed equipment continued to exist in the RKS hospitals. Our findings from MP corroborate this finding and indicate that many of the above problems persist in most CHCs/PHCs.
- d) The vertically implemented national programmes do not appear to have been considered in the decision-making process of many of the RKSs, although monitoring and supervising them is one of its objectives.

Despite such evaluations, RKSs are being promoted under NRHM and money is being given for setting up RKS. More than 8,000 RKSs are reported to have been set up so far. Nearly all district/sub-district hospitals and CHCs are reported to have RKS with their own bank accounts. PHCs are also in the process of setting up RKS. Rs 5 lakh has been provided per District Hospitals RKS and Rs 1 lakh per SDH/CHC/PHC RKS.

9. PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA

While this is the situation with respect to rural primary health services, the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), proposed by the previous NDA (National Democratic Alliance) government for improving tertiary health care services, has been approved as of March 2006. This scheme will be implemented by 2009-10 at a total cost of Rs 3,552 crore.

10. MORE LOANS FOR THE HEALTH SECTOR

In this scenario, the Planning Commission has recommended that WB/IDA (International Development Association) credit be availed for the XI plan period (with preparatory work to commence in the X plan period) in order to augment financial resources for health and have a Sarva Swasthya Abhiyan, on the lines of the Sarva Shiksha Abhiyan.⁴

11. IMPLEMENTATION OF NRHM IN BIHAR – NRHM-COATED PRIVATISATION OF HEALTH SERVICES

The State Health Society (SHS) is implementing the NRHM in Bihar. As part of the goal of improving the government health services, private organisations and agencies (including NGOs), are being invited to run several components of the government health services. The tender put out on the SHS website gives an idea of how the primary health services are being handed over to private parties, in the name of 'improving the services'. These include:

- a) Setting up a generic drug store in each medical college, district and sub-divisional hospital, on a revenue sharing basis. Some of the conditions include:
 - (i) Rates to be charged from the patients shall be 50 per cent of the MRP.
 - (ii) Drugs should be procured necessarily from companies having GMP (Good Manufacturing Practices) certification and an average annual turnover of Rs 25 crore or above.

- b) Setting up a Static Medical Unit (SMU) for provision of health services in the 1,153 additional PHCs in the state. The SMUs are expected to provide basic services like: general OPD, infant & child monitoring, immunisation, adolescent & RH services, ante-natal/post-natal services, other similar services, and conduct minor and Family Planning (FP) operations.
- c) Creating operational Mobile Medical Units (MMUs) in all 38 districts to provide primary health care services in far-reaching areas of the district (and 'to provide a visible face of the mission').
- d) Setting up radiological (X-ray and ultrasound) facilities in order to operate, maintain and report 24-hour radiological centres in 25 District Hospitals, 25 SDHs, 76 referral hospitals and 398 PHCs. These centres would function under the RKS of the respective hospital and the DHS. For some basic examinations, the centres shall charge the government referred patients rates fixed by the SHS. They shall be free to charge market rate from other private patients and also set up any advanced facilities and charge market rates from them as well.
- e) Setting up diagnostic facilities (pathological and radiological) in 25 District Hospitals, 23 SDHs, 76 Referral Hospitals and 398 PHCs. For the patients referred by the government, the diagnostic centres will charge rates decided by the RKS. The DHS may decide to give special concessions to people from BPL families or certain similarly placed people.
- f) Empanelment of private nursing homes and NGO-run clinics for providing FP services. Subsidy towards transactional costs would be provided for tubectomy, vasectomy and Intra Uterine Device insertion as per the government guidelines. Some 20 per cent of the cases should be from BPL families (to whom services will be provided free of cost). Service charge may be taken from the remaining 80 per cent.
- g) Complete outsourcing to interested institutions/organisations/firms for upgrades as well as operation and management of CHCs, as per IPHS. Quality assurance is to be ensured by the RKS.

Conclusion

The measures proposed in the NRHM such as — deploying community health workers (Mitanins/ASHAs), RKSs for hospital management, re-orientation, advancing skills, redeployment of existing doctors, hiring part-time or contractual staff, PPPs, involvement of local practitioners in providing RCH services through franchising of NGOs/private providers and contracting out diagnostic and other services, decentralisation measures and contractual appointment of staff— have already been introduced in many districts over the past several years through the externally-assisted reform programmes, or as part of RCH-I.

From the operational framework of the NRHM and the developments in the field, it is clear that the NRHM combines all the elements of these reform initiatives scattered across various states/districts and seeks to implement them uniformly across all the districts in the country, rather than bringing in long overdue, genuine initiatives aimed at improving and providing accessible and quality health services.

According to the government's own submission, there is 'insufficient, inadequate systematic documentation and analyses' of the implementation and impact of these reform processes in each state. According to the Planning Commission, review of these reforms indicates that on the whole, the

content and coverage is very poor; the pace of implementation is very slow and uneven across the states⁵. Similarly, use of mobile health clinics is very expensive and has had limited success. Walk-in interviews for recruiting doctors also has had limited success; handing over of PHCs to NGOs reported success only in Karnataka. In addition, professional associations do not support training of MBBS doctors in other specialties, as quality of care may be suboptimal⁶.

Yet, under NRHM, it is these measures that are being implemented in the name of improving health services.

Under NRHM the trend apparent is:

- a) Provision of a limited package of services through the government health centres, rather than comprehensive services. This includes providing only RCH-related services, immunisation, some disease control programmes for TB and malaria, and organising periodic health melas or visits by mobile units.
- b) Many of the measures at the level of health services—provision of ASHAs, Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC) centres, additional nurses at PHCs, 24X7 PHCs—are aimed at providing institutional child birth and other RCH-related services for pregnant women, and are not for equipping the health centres for comprehensive health services. Therefore, the emphasis on RCH continues.
- c) Emphasis on management measures – financial management at the district level and RKS for hospital management. This defeats the purpose of focusing on comprehensive measures to address lack of medicines, staff, transport and other infrastructure at the Sub-Centre-PHC-CHC level.
- d) Promotion of outsourcing measures for activities such as recruitment and preparation of district plans.
- e) Measures are being implemented without necessary groundwork. Funds are being disbursed to Sub-Center/PHC/CHC without ensuring that there is staff able to utilise them. Funds are also being given for district plans without ensuring that VHSCs are in place and trained to prepare village plans.
- f) Promotion of privatisation: Ambulance services are already privatised and currently diagnostic services are also being privatized, Bihar being the extreme case in this matter.
- g) Involvement of the private sector in the running of the PHCs without any attention to regulating it.
- h) While there is no substantial increase in finances for health, what is currently taking place is an increase in family welfare. Under family welfare, RCH and Pulse Polio are getting the bulk of the allocations.
- i) Incentives for FP continue in several forms like under JSY and in camps.
- j) Intensification of the Pulse Polio continues to be a major concern. While JSA and others have repeatedly pointed out the problems in the programme, these serious concerns have been dismissed and the programme has grown.

Endnotes

- 1 This report is also available on the JSA website: www.phm-india.org
- 2 This report is prepared by the People's Rural Health Watch—Jan Swasthya Abhiyan in June 2007. This report is being published with permission.
- 3 Please see JSA's *Action Alert on NRHM* p. 5.
- 4 Mid-Term Appraisal of X Plan, p.124.
- 5 Tenth FYP, p. 89.
- 6 Tenth FYP, p. 89.

Quality of Care – The Bihar Experience

Sona Sharma, PFI

Bihar at a Glance¹

Indicators	Number
District Hospitals	26
CHCs	70
PHCs	1,641
Sub-Centres	8,858
VHSCs constituted & operational	0
Meetings of State Health Mission held ('06-07)	1
Meetings of District Health Missions held ('06-07)	0
RKs registered in CHCs	9
ASHAs who have received 1 st module of training	42,830
ASHAs who have received 2 nd module of training	0
ASHAs in position with drug-kits	0
Monthly health days held ('06-07) (expected)	0
Monthly health days held ('06-07) (achieved)	0
Sub-centres which are functional with at least one ANM	8,004
PHCs functioning on a 24x7 basis ('06-07)	0
CHCs where upgrades have been taken up and completed	0
District Hospitals where physical infrastructure is being upgraded	0
Beneficiaries of JSY (in lakhs) ('06-07)	1.13

Background

Bihar is still considered one of the 'Bimaru' states. The state's human and material resources are not properly managed. The state government health department is trying to develop the required infrastructure for the delivery of health services down to the Panchayat level, but due lack of adequate human resources and apathy among health department personnel, services do not reach the needy in the required quantity, quality and time. The surveillance system is still poor because an effective monitoring system has not been developed. A large section of the community is still unaware of the health facilities available at various levels.

Many diseases manifest due to reasons such as natural calamities and unavailability of safe drinking water. Besides, a lack of prompt response to these diseases causes a large number of deaths.

On the reproductive health front, the total fertility rate of Bihar has actually gone up between National Family Health Survey (NFHS)-2 and NFHS 3 from 3.7 to 4.0. As per NFHS 3, 58 per cent of children under the age of three are underweight and 42 per cent are stunted (too short for their age). The IMR is still at a high of 62 per 1,000 births and 62 per cent of women in the 15-40 age group are illiterate. The coverage of complete immunisation for children has seen a jump from 12 per cent in 1998-99 (NFHS 2) to 33 per cent in 2005-06 (NFHS 3); however, there is still a long way to go to ensure adequate coverage.

Statistics can tell us the overall health status of the region, but it is the stories and experiences from the people that truly reveal the stark realities and complex barriers that need to be tackled if we are to reach the elusive goal of 'health for all'. Let us begin by taking a look at a few stories from just one PHC area as reported by frontline workers:

- ❖ *Tetri Devi was married to Raju Paswan at the young age of 15. She gave birth to five children by the time she was 28. The first child had died and three were alive when she got pregnant for the fifth time. When Tetri Devi got to know of the pregnancy, she got herself immunised with two shots of TT from a private nursing home. During the seventh month, when Tetri Devi experienced pain in her abdomen, the ASHA worker took her to the Bidupur PHC. Here she gave birth to a premature baby on 17 February 2007. Within two days of the birth, Tetri was given the JSY compensation of Rs 1,200 and discharged from the hospital. At home, Tetri Devi could not survive beyond five days and she died on 24 February 2007. The newborn also could not survive beyond 45 days without the mother.*
- ❖ *Shanti Devi (about 27-years-old), the mother of the deceased child Roshan, has three children aged 3, 2 and 1 respectively. Shanti Devi got to know of her pregnancy only in the seventh month. Once she did, she got herself immunised with two shots of TT and on completing nine months, Shanti Devi gave birth to Roshan at the PHC Bidupur. About two hours later, Shanti Devi was given the JSY cash assistance and discharged from the hospital. Six days later, her son slept, never to wake up again.*
- ❖ *Some 15 days after her tubectomy, Samida Khatun experienced severe problems and was taken to the PHC on 8 April 2007. The PHC doctor gave her an injection and some medicine and referred her to PMCH Patna. Samida was admitted in the PMCH and put on a drip and oxygen and given injections immediately, but she could not survive. Her mother-in-law had taken a loan of Rs 10,000 for her treatment, all of which was spent to no avail. Samida died on 8 April 2007 at midnight in the hospital. Now there is no one to take care of the children and the father, Manjoor Alam, is also helpless. If he stays with the children, how can he work? Unless he works, how can he fend for the family?*
- ❖ *Manju Devi was seven months pregnant. Her entire family is illiterate. Manju did not go for ANC checkups*

as they could not afford a private doctor. The PHC is about 13-14 km away, so it was not possible for her to go there. PHC Madarna, which is only about 2-3 km away, had no provision for ANC services (as per the family). On 11 November 2006, at about 11.00 p.m., Manju experienced severe pain in her abdomen. The family brought some medication from the local quack but instead of providing relief, the pain escalated. They could not get their vehicle repaired and take her to the PHC. As a result, Manju was in severe pain all night and at about 5-6 a.m. she bled profusely and took her last breath...

The case studies mentioned above were collated from the field and while they do require an in-depth audit to really understand the circumstances and root causes, they are mentioned in this report in order to give an overview of the ground realities.

A fair analysis of the circumstances tells us that while the state government needs to gear up to get the vast health infrastructure to perform, we must also admit that the communities need a wake-up call to begin asserting their right to quality health services. There is also an urgent need to address the lack of knowledge among the masses about critical issues including the availability of services. For various reasons that have only intensified over the years, there is a great divide between the service providers and the service seekers. This has created strong mistrust among the community members on the quality of services provided and also disregard and complete apathy among the providers towards the community. The compassion scale, however, tilts towards the communities, as it is their right that is being impinged upon. Hence, the prevailing situation makes it very difficult to ensure quality reproductive services in the region. If implemented effectively, community action under the NRHM, inclusive of involvement of community members in planning and monitoring health services is a step in the right direction to help overcome the problems.

Project Rationale

UNFPA's Country Programme-6 (CP-6), draws its philosophy from the goals and Programme of Action (PoA) of the International Conference on Population and Development (ICPD) 1994, and the National Population Policy (NPP) 2000. The goal of CP-6 is to support the national goal of population stabilisation and improve quality of life by working towards the elimination of human poverty, inequalities and sustainable human development with full regard to NPP 2000 and ICPD principles and goals.

The ICPD PoA affirms that all RH facilities should have 'quality' as the paramount feature in service delivery. A review of the status of health services even ten years post ICPD revealed that the quality of health care services continued to be dismal in many parts of the country. Quality of care in RH services was, therefore, a key component of CP-6. As part of the MoHFW/UNFPA CP-6, the PFI undertook advocacy efforts to promote the quality of healthcare services beginning with regional level workshops. Recommendations from the workshops included the need to move from advocacy to action. A small-scale pilot project was subsequently launched in Bihar aimed at initiating community action with a focus on the quality of care.

Project Strategy

The NRHM was launched in Bihar on 14 July 2005 and resulted in the formation of the SHS, DHSs and RKSs.

The planning and monitoring process laid out in the 'NRHM Framework for Implementation 2005-

2012', mandates setting up of planning and monitoring teams at various levels. At the village, PHC and block levels, broadly representative committees would perform both planning and ongoing monitoring functions. A similar committee at the district level is to be involved in reviewing plans. The VHSC, to be formed in every revenue village are responsible for the Village Health Plans and monitoring at the village level. In order to develop the plan, the VHSCs would need to identify the health needs/issues concerning access and quality of services.

RKs to be constituted at the PHC/CHC/District Hospital levels, have the mandate to plan and ensure effective functioning of the health centre/hospitals. The VHSCs and RKs were recognised as potential routes that could be used to ensure quality of care in RH services.

However, implementation of NRHM in the state was in its initial stage and although the formation of the various committees was in progress, there was a need to accelerate their formation and activate them. In light of this, the key strategy adopted was to activate VHSCs and RKs at the PHC level to begin with and orient the members of these committees on the quality of care. The pilot on advocacy for quality of care in health services was planned and initiated in seven blocks of the two districts of Gaya and Vaishali in Bihar.

Objectives

The overall objective of the pilot was to set up a model within the NRHM framework to ensure quality of care in RH services. Specific objectives of the project were:

- a) To identify, form and activate VHSCs.
- b) To sensitise and motivate community leaders to advocate for quality health care services for the community through government health centres.
- c) To sensitise government health personnel at block and district levels, including members of the Health Society and RKs in order to provide quality care services for the people.
- d) To document the actions and changes and share them with state level government officials and policymakers so they can adopt this model in other districts.

Geographic Focus

The project was implemented in the Gaya and Vaishali districts of Bihar. A total of seven blocks were selected within these two districts. The four blocks selected from the Gaya district were Khijar Sarai, Chandauti, Bankey Bazar and Bodh Gaya and the three blocks from Vaishali were Pateri Belsar, Bidupur and Lalganj.

The Process

PFI undertook the pilot project and it was decided to build capacities at the state and levels below to ensure continuity in future. PFI, hence, joined hands with the Bihar Voluntary Health Association (BVHA) to implement the pilot project. PFI along with BVHA identified seven block-level NGOs as partners to implement the project.

Capacity building and training were critical inputs in the project. A planning and orientation exercise with the state and field level NGOs was held in Patna in August 2006. The NGOs were given an

elementary understanding about the concept of quality of care in RH. A special session was conducted for orientation of the NGO partners on the overall objectives of the campaign, strategies, activities and expected outcomes.

The NGO partners spanned out to 70 villages in seven selected blocks to identify, form and orient VHSCs. RKSs which were in existence at the PHC level were also approached and oriented on the quality of care in RH.

A planning exercise in progress in a village in Gaya district.

A mid-course review of the progress in the formation of VHSCs revealed that although the committees had been formed in all selected villages, activation of these committees (a key outcome of the project), was still a challenge. Therefore, a decision was made to involve the committee members and assist them in developing village advocacy plans focusing on the 'quality of care' and in the process, activate the committees. A Community Needs Assessment (CNA) using participatory techniques in 35 villages of the seven blocks and a facility survey of the PHCs was also carried out in the two districts.



The exercise, leading up to a village health plan focusing on quality of care, included two days of FGDs and village mapping exercises among the community members to assess the prevalence of diseases, the awareness levels of national programs, existing behavior related to health issues, private sector facilities available in the area and their perceptions and feedback on the government health services. The third day was a planning exercise which included the VHSC and other people from the community. Partner NGOs were oriented on the process and trained to carry out the CNA exercise and document the process and specific case studies related to the 'quality of care' in RH services.

Some Immediate Outcomes

- a) Some 70 VHSCs were formed.
- b) The process of developing village health plans initiated in 35 villages of seven blocks.
- c) An increase in the awareness of health issues in their area and the right to quality health care services among the VHSC members and community resulted from the needs assessment and planning exercise in 35 villages.
- d) Initial sensitisation of RKS and DHS members for providing quality health care services.
- e) Formats and protocols for conducting CNA and facility survey leading to village health plans have been developed which would be useful in scaling up the model to other areas.
- f) Field operating partners facilitated reconstitution of the RKS as per the norms and guidelines of the NRHM (which was earlier absent) in five blocks. The process of registration of the RKS was also initiated in all those blocks.

- g) The process and lessons learnt were shared with senior officials at the state level leading to planning for the next stage, including exploring options of scaling this up to other areas.

Challenges Faced

- a) The very concept of promoting quality of care in RH services was new to both the field level partners as well as the VHSC and RKS members and, therefore, required repeated orientation and close guidance throughout the project.
- b) VHSCs were not formed in any of the 70 villages under the project area, so in all these villages, the formation of committees took up a majority of the short, overall project time.
- c) A major effort was required in motivating the community to change the 'what can we do' attitude and a lot more effort is required to get them to initiate the planning themselves.
- d) Attempts were made throughout to involve and get the support of the government health functionaries at the district, block and village levels. The lack of written instructions from the government to support the effort proved to be a major hindrance in getting the health staff to participate in the process.
- e) Participation of ANMs, AWWs and ASHA workers in the planning process was minimal. Participation of PRI members, however, was quite enthusiastic in most places.
- f) Despite rigorous training and demonstration of the CNA, facility survey, planning process and reporting, not all reports from field partners were satisfactory and required many clarifications and modifications in order to bring them to a satisfactory level.
- g) In places where the VHSC members got active and demanded services, the Medical Officer refused to recognise the committee or its role in NRHM.

An Assessment of the Status of NRHM in the Project Area

The following assessment is on the basis of reports from the CNA and facility survey in the project area and also from published reports by MoHFW on the status of NRHM. A word of caution here: the project area is not representative of the state as a whole and the status mentioned in this report should not be considered as the status in the entire state.

In Bihar, the average number of patients visiting a PHC per month has reportedly increased from 39 in January 2006 to 3,015 in August 2006. Some 397 Block PHCs in Bihar have been made 24x7 for outpatient and emergency care. Of the seven blocks in the project area, only five had a PHC of which only four were functional. One PHC was a single room within the Block Development Office where no patients visited. One block had no PHC and another was under construction. However, all four functional PHCs had at least one ANM available 24 hours. The number of patients visiting the PHCs every month ranged from 145 to 1,200 as per the registers.

In capacity building initiatives, Bihar has selected Block Public Health Managers for every block in order to improve management of health programs. The introduction of these skills has improved program management, monitoring, evaluation, financial reporting and record keeping. The facility survey also showed that the records and registers were available and maintained.

It has been reported that private partnerships for diagnostic tests have been attempted by Bihar on a

large scale. In the project area, two PHCs had X-ray facilities run by the private sector whereas two did not have any such facilities. Where X-ray facilities were available, the feedback was that since it was a paid service, the doctors were getting unnecessary X-rays done to increase their own incomes.

As stated in the MoHFW report (2005-2007) on the progress made thus far, Bihar has a very efficient and effective drug procurement system for the essential drug list put in place. However, the facility survey in the four functional PHCs of the project area revealed that three of the four PHCs did not have all essential medicines in sufficient quantity.

Even though RKSs at PHC level had been formed at the beginning of the project, a number of committees had members only on paper and were not constituted as per the guidelines. Those that were constituted were not aware of their roles and responsibilities. RKSs were reconstituted, facilitated by the partner NGOs in the two PHCs under the project area and oriented on their roles and responsibilities in all four PHCs. Meetings of the Governing Board Members of RKSs are, however, not being regularly held to the present date.

ASHA workers have been selected in most villages and have been given one round of training, but the training is definitely not adequate and the workers are unclear about their roles. The CNA revealed that in most of the 35 villages, the people did not know what the ASHA does. In some places, they even reported that the ASHA was selected but did not venture out of her house. However, case studies collated by the field partners did show that the ASHA worker assisted in institutional child births in many places.

Most villages reported knowing who the ANM was, but their perception was that the ANM's work was only restricted to immunisation. The sub-centre rarely opened in most villages as per the CNA.

All villages across the two districts in the project area preferred to visit a private doctor (mostly quacks) for their health needs since they were easily accessible, inexpensive and had a good attitude. They even treated patients on credit if required. In contrast, most people reported that they did not wish to access the government services as the behaviour of the doctors and other providers was very rude and abrupt. They also did not get the medicines from government health centres.

DHSs have been formed with a view to channelise resources at the block level and to plan according to the needs and demands of the block. In DHS, there is a provision of formation of Quality Care Assurance Committee to monitor, supervise and check the quality care services at district and block levels. These committees have been formed in many districts, including Vaishali and Gaya, but are still inactive and a formal meeting of these committees have not taken place in these two project districts. Hence, there is an urgent need to sensitise the members of these committees and societies in order to ensure quality care services at the community level.

Overall, the NRHM has completed its second year and while there have already been some very significant gains in certain interventions there is still a long way to go in others. Addressing the issues that have surfaced since its implementation systematically and strategically will ensure its success on a large scale and make progress smoother.

Endnotes

- 1 NRHM status as on 31.4.07, published by Ministry of Health and Family Welfare as on 31 May, 2007.

Study of Maternal Health Care Services for the Rural Poor in Bihar¹

Amrita Gupta, CHSJ

Introduction

This study attempts to obtain some insight into the state of maternal health-related services, with special focus on the JSY in Bihar after two years of the NRHM. Bihar is part of the EAG (Empowered Action Group) states which are areas of high focus under the NRHM.

The study was conducted by the Centre for Health and Social Justice (CHSJ) as part of a two-year civil society review of the NRHM. The organisations that assisted in providing local support for fieldwork during this study were BREAD in Nalanda and Sacred Heart Action for People's Empowerment (SHAPE) at Betiah, West Champaran.

Objective

To assess the availability and accessibility of antenatal care, delivery, and postpartum healthcare services for poor rural women within NRHM.

Key Questions to be Answered:

- a) Are pregnant women and those undergoing childbirth receiving the services as mandated by RCH II and NRHM?
- b) Is the ASHA able to provide services related to maternal health as conceived under RCH II and JSY?
- c) Is the target audience for the services (women) and the ASHA able to access financial incentives made available under the JSY scheme?
- d) Are facilities at the local PHC/CHC upgraded to provide institutional child birth, BeMOC (Basic Emergency Medical and Obstetric Care) and BMOC (Basic Medical and Obstetric Care) services and are these services being utilised?

Methodology

a) Preparatory Phase

A literature review was done to acquire information about services that should be available to a poor/BPL rural woman, from pregnancy to childbirth and postpartum care as mandated by the NRHM. On the basis of the review, interview guides were developed for gathering field level data.

b) Field Work

Field work was done in two districts of Bihar. The key respondents for this study were poor rural women who had recently (i.e. in the last 6 months) gone through child birth. However, other respondents included rural women who were intended beneficiaries (namely pregnant women and new mothers) under NRHM, RCH II, the local ASHA, ANM, as well as the staff of the local PHC and CHC. The two study districts, Nalanda and West Champaran, were selected in consultation with members of the Healthwatch Forum. Bihar, keeping in mind both the geographic and cultural diversity as well as availability of a local anchor NGO.

c) Selection of Respondents

Within the selected districts, a total of 5 blocks were chosen, considering that they had functional Sub-Centres and a functional PHC. Within each block, up to 5 ASHAs were selected on the basis of their availability. From the areas covered by each of these ASHAs, (each ASHA covers a population of 1,000), 3 female respondents from the community were selected. These respondents were either selected through a focussed group discussion (FGD) wherever possible, or by directly approaching women, who had gone through child birth within the last 3-6 months, based on the information obtained from the village. Selection of other respondents followed from the areas selected (i.e. the ANM of the Sub-Centre under which the selected villages and ASHAs are covered, the service providers of the block PHC and PRI members of the hamlets that were covered).

d) Techniques for Data Collection

The study was qualitative and involved data collection mainly through in-depth interviews and FGDs. Wherever necessary, an assessment of the infrastructural facilities at the PHC/CHC was also undertaken through observation. The interviews were conducted by a primary researcher with support from a local person who acted as a translator for local terms, language and idioms. The interviews and discussions were taped (after taking consent) and transcribed into Hindi and the preliminary analysis used the Hindi transcripts as data. A simple framework of comparing responses/experiences of women against both the official proclamations (NRHM related documents) and official records and responses/experiences of officials was used for analysis.

e) Ethical Issues

The selection of communities was done in consultation with civil society organisations which were actively functioning in the selected areas and were known for their rights-based work. All interviews and discussions were conducted after getting verbal consent. Names of respondents were changed so that they would not face any consequences. The results of the study will be shared with communities and the district authorities so that a plan for improvement could be developed locally. The report will also be shared with the state government and the central government. Thus, any problems highlighted in the report can be solved and positive experiences can be widely shared to serve as lessons for others.

f) Limitations

The sample size is too small to make any representative claims. In addition, from reports and local experiences, it appears that the health system in Bihar has been energised in the last one and a half years since the new government came to power. This may make it difficult to understand the extent of the changes/findings effected by the NRHM and the new political and administrative setup.

FINDINGS

The study was conducted with the aim of gathering empirical data to study the ground realities from the perspective of the beneficiaries of maternal health services and the various stakeholders who are directly related to the provision of services and implementation of schemes like the JSY, referred to as JBSY in Bihar. The findings are presented in four sections-

The first section is on the provision of ANC (antenatal care) services, the second is about the ASHA, the third focuses on the implementation of JSY and the fourth puts forth the status of PHC/CHC in terms of infrastructure, staff strength and service provision.

a) Provision of ANC Services

Service guarantees for ANC under NRHM

- i) Early registration of all pregnancies ideally in the first trimester (before 12th week of pregnancy). However, even if a woman comes for registration late in her pregnancy, she should be registered and care should be given to her according to gestational age.
- ii) There should be a minimum of four antenatal checkups and provision of complete package of services. The first visit should be as soon as the pregnancy is suspected, the second between the 4th and 6th month (around 26 weeks), the third visit at the 8th month (around 32 weeks) and the fourth at the 9th month (around 36 weeks). Associated services like providing iron and folic acid tablets (IFA), TT injections, etc. (as per the “guidelines for ANC and skilled attendance at birth by ANMs and LHV’s).
- iii) Minimum laboratory investigations such as haemoglobin, urine albumin, sugar and RPR test for syphilis should be conducted.
- iv) Nutrition and health counseling should be done.
- v) Identification of high-risk pregnancies with appropriate management.
- vi) Chemoprophylaxis for malaria in high malaria endemic areas as per the National Vector Borne Diseases Control Program (NVBDCP) guidelines.
- vii) Referral of high-risk pregnancy beyond the capability of the MO of PHC to manage to FRU.

The ANC services are available at the Sub-Centre or at fixed areas where the ANM visits either on Wednesday or Saturday (as these two days are fixed as immunisation days for the districts of Nalanda and West Champaran and possibly for the entire state as well).

According to women who had recently gone through childbirth and their relatives and members of the community, ANC services are restricted only to immunisations (i.e. giving 2 injections of TT to the pregnant woman). Even abdominal check-ups are not conducted.

While both pregnant women and their family members said they were aware that the pregnant woman needs to get two 'sui' (injections), they could not elaborate on its benefits and said, "*Nurse kehti hai bacche ke liye jaarori hai, aur doosri aurten bhi lagwatin hain, to hum bhi lagwa leten hain*" (The nurse says it is necessary for the child and other women also take the injections, so we also take it).

However, there are pockets where women said they do not take the injection as they do not consider it important. They said during their previous pregnancies, their child was safe and healthy even though they did not take the injections. There are also cases where the family members have been exposed to some bad experiences either personally or by word of mouth, and hence, they have not allowed their women to take the TT injections. For example, in one case, the family members refused to send their daughter-in-law for immunisation because they said earlier some people had come and taken money for giving 'sui'. On approaching the daughter-in-law, she said, "*Guardian mana karega to hum kya Karen.*" (If the head of the family, the guardian, does not agree, what can we do?).

In remote areas, the pregnant women also stated they were unaware of the ANM visits in their area and the time she spent at the Sub-Centre. As a result, there are pregnant women who said they had not been immunised or had only received partial dosage. In other cases, mother-in-laws said they bought the 'sui' (vaccine) from the local doctor who sells it at a price of ten to twenty and sometimes even thirty rupees.

In one situation, the men folk of the village said it is the ANM's son or husband who visited instead of her. Therefore, the villagers were reluctant to send their women.

The ANMs also complained that since they have a very vast coverage area, it becomes difficult for them to provide quality services. Those who have to go to remote interiors also said that since the roads are in piteous condition and it is unsafe to travel alone, they have to depend on a male member (either from the family or a hired person with a two-wheeler for the purpose) to commute to these areas. Thus, according to them, devoting quality time at the centre suffers because of the time spent in commuting. In addition, sometimes women have to return from the centre without receiving the vaccination because by the time they reach, the ANM has already left. Moreover, the ANMs said that from time to time, there are polio drives and distribution of medicines for Filariasis, each of which requires their active participation which affects routine immunisation.

According to the ANMs, the hideous state of Sub-Centres also affects work. They say (and it was also observed by the researcher) that Sub-Centres consist of small rooms with only a chair and a table, a thatch and leaking roof and often with no ventilation. In addition, there is hardly any place for the women to sit and for the ANM to do her paperwork.

The government health officials and doctors also said that IFA tablets have not been available in the state for almost a year now. Even the pregnant women and their family members complained that when they ask for the tablets, the ANM says it is not available, while older women of the village also opined that "*Nurse ke paas aata hai, woh khud hi bech deti hai*" (The ANM receives medicine supplies, but she sells them).

However, asked if these women had consumed IFA tablets earlier when they were available, they said they did not, because it induced nausea. Now they demand it because they feel they are deprived of something that they are entitled to.

b) ASHA

ASHAs: Their Roles and Responsibilities as Mandated by the NRHM

- Registration of pregnant women.
- Ensure BPL certification.
- Mobilise and facilitate the community in accessing health services like ANC, PNC and immunisation.
- Counsel women on birth preparedness, contraception, prevention of infection and RTI/STI.
- Depot holder for essential services like IFA, OCP, condoms, ORS DDK, etc. (issued by AWW).
- Escort/accompany pregnant women to pre-identified PHC/CHC/FRU, in case of need.
- Organise Health Day once or twice a month at the anganwadi with the AWW and ANM.
- Bring the beneficiaries of the village to the anganwadi centre on specific days of health check-up and Health Day.
- Bring the beneficiaries to the outreach centre on the day appointed by the ANM/or to the Sub-Centre for initial check-up.
- Mobilise them for IFA/TT/OCP.
- Update eligible couple register.

According to the district health officials of the areas covered, ASHA selection and training is still underway.

However, while the ASHAs in areas of Nalanda had been working for the last six months (or probably a year), the selection and training was still taking place in West Champaran, with ASHAs just beginning to work in some areas. For villages in remote areas, the PRI members responsible for ASHA selection said the selection process could not proceed because no one was ready to volunteer to become an ASHA.

ASHAs were asked how they came to know that ASHA's selection was taking place and they could apply for it. They responded that the *Mukhiya* (the PRI representative from the area) told their husband or father-in-law (who was a frequent visitor to his house) about the position. Thereafter, they submitted their educational certificates and there was a village meeting where they were formally selected by a common vote.

However, when the women in the villages were asked about the selection procedure of ASHAs, they had a very vague recollection of the proceedings in the village meeting and they also said the *Mukhiya*

and others involved in the selection process were taking bribes from the candidates. This was also confirmed by some ASHAs who stated that although they had not paid a bribe, they had heard that bribes were being taken.

A PRI member stated that since he had some authority in ASHA selection, he helped a woman, he knew get selected. But this woman did not work as there was no fixed monthly remuneration.

ASHAs who had attended the training remembered the monetary benefits primarily because it was the only amount they had received. So when asked about what they learnt at the training, they said they were taught from a book (a copy of which was also given to them after the training). The book contained information about mobilising the pregnant women and children for immunisation and information on diseases like TB, AIDS etc. However, they could not elaborate on the information presented in the book.

The ASHAs who had been selected and trained said they had also been given a list of tasks and the incentives thereof. However, other than receiving money for training, they got occasional monetary benefit under JSY, that too after a long wait. Neither had they received the monetary incentives for attending the meetings at the beginning of every month, nor were they given the amount of Rs 100 for gathering a certain number of women for immunisation as mentioned in the list of incentives. In fact, ASHAs also lamented that due to the problems regarding the receipt of money under JSY, even women who opted for institutional childbirth preferred not to inform them because they thought the ASHA's incentives were being deducted from the cash assistance to which they were entitled. Due to this miscommunication, ASHAs were losing out on their incentives under JSY as well.

In areas where ASHAs had been working for a considerable amount of time (6 months to 1 year), people recognised them as the person who administers polio drops along with the ANM. People in these areas also say she is present with the ANM during immunisation. Questioned about their work, the ASHAs said they gathered women on immunisation days and assisted the ANM in addition to accompanying women to the institution for childbirth (if they were informed).

When asked whether people listened to them, ASHAs claimed it was difficult because before being selected as ASHAs, they had been confined to their homes. Sometimes, the villagers (especially the higher caste people or elders of the village) chastised them saying that by crossing the threshold of their homes and doing this kind of work, they have brought shame upon the family. Therefore, they called only those women who were ready to listen to them.

ASHAs said they were working in spite of such problems because they believed that with time, they might get a fixed remuneration. This feeling is echoed in the following lines, spoken by an ASHA: *"ASHA is asha se bani hai ki agey jakar kuch milega"* (One has become an ASHA with the hope that later she will surely get something in future).

The ANMs also acknowledged that ASHAs were serving as a helping hand. They also sympathised with ASHAs saying that it would be difficult for them to continue working without a fixed remuneration. However, ANMs also acknowledged that their approval is important for the ASHA to get her incentives. As one ANM said with reference to a new scheme according to which, for every complete immunisation starting from the pregnant woman to her child, motivated by the ASHA, she would receive Rs 300, *"Hum bata denge, aur dekhte hain agar thik se karenge to hum sign karke dilwa denge"* (I will tell the ASHA about the scheme and if she works accordingly, I will sign so that she gets the money).

c) *Janani Suraksha Yojna (JSY)*

JSY: The NRHM Mandate

JSY is meant to reduce maternal mortality and neo-natal mortality by promoting deliveries at health institutions by skilled personnel like doctors and nurses. JSY is a 100 per cent central government- sponsored scheme. It integrates cash assistance to women from poor families for enabling them to deliver in health institutions along with anti-natal and post-natal care. The monetary incentives include a sum of Rs 1,400 in the case of rural and remote areas and a sum of Rs 1,000 in case of suburban areas in an LPS state.

According to service providers and women who had received money under JSY, (called Janani aur Bal Suraksha Yojna) in the initial phase of the scheme, the monetary incentive was divided such that the women who came for TT injections got a sum of Rs 100 and received the rest of the amount if they opted for institutional child birth. However, at a later stage, a JSY card/coupon was made based on which money was divided under various heads such as transport, ASHA incentive and assistance to the woman. This card was made available to the woman when she got admitted in a health institution for child birth.

Some of the other issues and views around JBSY from both the beneficiaries and the service providers are as follows:

- i) During interviews and FGDs, women and their family members were asked why they did not avail of the JSY scheme. They said they thought the monetary benefits were available only in the case of the birth of the first or the second child and others would not be eligible for it. They also said if the scheme had changed, the ANM had not mentioned it. So they decided not to spend money on commuting to the hospital.
- ii) The doctors, however, were very critical about the changed version of the scheme and said JSY incentives should not be available to all irrespective of the number of children. According to them, this would cause the scheme to indirectly become an incentive for promoting more children per couple.
- iii) The relatives of the women who had previously delivered in institutions said they had to buy a new blade, soap, oil, thread and so forth, as these were not provided by the hospital. If the relatives of the woman did not fetch the same, they were chastised by the nurses, who often told them if they wanted 'royal' treatment they should go to a private hospital. Moreover, they also said they were asked to buy medicines from outside and sometimes even saline bottles for which they had to spend extra money. This caused problems because they were not prepared to spend so much money.
- iv) Family members of women who had been allured by the money incentive of JSY, to go to a government health institution for childbirth complained that the nurse/*dai* who delivered the baby asked for '*neg*' (gift). This could be Rs 100-500 or even a sari. If they were unable to give anything, the nurses threatened they would not hand over the baby.
- v) According to those living in remote and interior areas, it was difficult to bring pregnant women

all the way to the PHC due to poor road conditions. They said the woman could deliver midway and they would lose the JSY incentive. Also, hiring a vehicle to take the woman would cost up to Rs 200 during daytime and even more at night. Thus, they said they preferred home births. As the hospitals were not well-equipped for the women to stay for long periods of time, the pregnant woman could be taken to the hospital only when her labour pains start. There is no provision for food and the number of beds was inadequate. Moreover, the villagers did not have the requisite funds to keep the pregnant woman at the hospital for a long time. In contrast, the *chamrain* (women of low-caste who have been traditionally assisting in child birth) and even the local Registered Medical Practitioners (RMPs) provided home-based service. Additionally, the RMPs did not ask for payment immediately so the relatives could pay off the debt slowly in both cash and kind.

- vi) The family members of women who had received monetary benefits under JSY had a different story. They said that while they had received the money after 2-3 months. Even after receiving funds, they had to give some amount of money as bribe either to the PHC staff or the service providers who helped them. According to them, this process ended up costing as much money as they received.
- vii) Medical officers in PHCs also complained about the irregular flow of funds for JBSY. For example, according to a Medical Officer, his PHCs had no funds for the last three months and approximately 100-150 new mothers had to return empty handed, creating a sense of dissatisfaction among them. They would constantly come to demand money from the ANM and the hospital staff, causing problems.

d) Institutional Facilities

The institutional facilities refer mainly to the infrastructure, staff strength, equipment and medication that were available at the PHC/CHC in order to facilitate service delivery. The findings in this section are based on observations of PHC/CHC and interviews with the service providers.

Observations revealed that the infrastructure was in the process of being upgraded, meaning that the renovation of the building was completed or it was in the process. The medical staff, however, lamented that since the construction of the building had been handed over to a contractor, they had no say in the changes that were required and they did not have a clue when the building would be handed over to them after renovations. So, they could not start operating from the building until it was handed over by the contractor.

The situation was still wanting in terms of other facilities as the PHC did not even have an instrument to record blood pressure. When the doctors were asked why they were asking the patients to get their pressure checked from outside, they either replied that the blood pressure machine had broken some weeks ago and it was not replaced (in spite of having submitted a requisition for it) or there was no blood pressure machine available in the facility. Even regarding the provision of ambulance facility, the hospital staff said that since they did not have adequate funds for the petrol, only those who could afford to pay for the fuel could avail the service.

Also, there was a lack of basic services like running water. An ANM explained that since the delivery room did not have running water and the contractor was not listening to their demands, it was difficult for her to wash her hands during delivery. In fact, a senior government health official commented on

PHC- NRHM mandate

- i) Every PHC will get an annual untied grant of Rs 25,000 and annual maintenance grant of Rs 50,000.
- ii) Every PHC is being strengthened with provision of three staff nurses (as against one at present) and two doctors (one male, one female) and an AYUSH practitioner.
- iii) PHC untied fund to be used for instruments like haemoglobin meter, weighing scales for mother and child, delivery table to deal with intrapartum/postpartum complicated cases/emergency.

CHC as First Referral Unit

- i) All the CHCs will provide 24x7 services with appropriate referral transport service.
- ii) Basic requirements for making it a 24x7 service: There should be four general duty medical officers and seven staff nurses, one ANM and one LHV along with other support services and physical facilities.
- iii) A gynaecologist, anaesthetist, paediatrician, and round-the-clock services of nurses and general duty officers should be ensured.
- iv) Services that should be available round the clock: Blood storage facility and other supportive services such as laboratory, X-ray, OT, labour room, laundry, diet, waste management system, referral transport etc.
- v) Full range of family planning services including laparoscopic services, safe abortion services, treatment of STI/RTI, availability of blood storage unit or effective linkage facilities with blood banks, and referral transport services.
- vi) Grievance cell under RKS.
- vii) Charter of patient's rights to be displayed prominently.

the infrastructural situation: "NRHM is allotting money for improving institutional infrastructure, but here institutions are in such a dilapidated state. What about cases where the PHC has no proper building, is the money adequate to make a new building?"

In terms of the staffing and availability of doctors, there was a lack of qualified doctors, according to higher government health officials. Doctors also said that the lack of housing facility within or near the PHC premises made it unsafe for them to do night duty in rural areas. Moreover, they stated that they did not get adequate incentive to do their best. They did not have a proper seating room or a separate OPD area, and as one of the senior doctors of a district hospital said: "*Dal ko swadist banae ke liye ghee dalna padta hai, par sarkar to ghee dallne ko taiyar hi nahin hai*" (To make the curry tasty, one needs to add butter, but the government is not ready to put butter).

The situation has remained the same because according to the permanent doctors, contractual doctors

who have been hired for on 11-month contracts have either not joined, or did not want to stay overnight.

Commenting on the hiring of contractual doctors, one health official stated, *“Yeh sarkar public ko padha rahi hai, aur sarkari doctor sarkar ko ullu bana rahe hai, contract pe doctoron ko niyukt karke, bus yahi hai”* (It is just a ruse, the government is trying to pacify the people with such schemes, and the government is also playing along by fooling people).

Since most PHCs and district hospitals now have to run 24x7, the doctors had to do shift duties, but as per the ANMs, it was they who stayed overnight. Especially with JSY being functional, there were possibilities of people coming in for delivery at night. They also said that in case of any complications, the doctors could be contacted at their residence for help. The ANMs however complained about the dismal state of generators in the hospitals. According to the hospital staff, the generators were either not working or had been stolen.

In most hospitals and PHCs, it was observed that the OPD was running full swing, with a long line of patients everyday. As per the doctors, around 150-200 patients avail the services of an OPD everyday. However, there was usually a dearth of medicines as the hospital officials said that the demand greatly exceeded the supply. Moreover, they said that the procedure for replenishing medical stock was also very time-consuming and complicated, requiring the approval of the civil surgeon and in some cases, the signatures of the DM (District Magistrate). Hence, in most situations, not only the OPD patients, but even maternity patients have to procure medicines at their own cost, which led to a feeling of dissatisfaction and hostility towards the hospital officials and also the ANMs. An elderly village woman expressed this feeling as: *“Sarkari mein jaante hain ki muft mein dawayi milti hai, phir bhi who log bahar ki dawayi likh deten hain, to kya fayda hua sarkari haspatal jaane se?”* (We know that government hospitals should provide free medicines but when we go, they ask us to buy medicines from outside, then what is the use of going to a government hospital?)

Conclusion

In conclusion, one can say that these voices from the ground may not be representative of the reality of the state of NRHM everywhere or even for the entire state of Bihar, but it is definitely worthwhile to ponder over the issues that have emerged from the study.

Some of these overarching emerging issues discussed throughout this report are enumerated below:

- i) ASHAs in most areas are in a state of flux and there are many assumptions regarding the role of ASHA and her future prospects. Moreover, the ASHAs are becoming incentive-driven, which is a far cry from the essence of volunteerism that had been the idea behind the selection of an ASHA. For example, in some areas the ASHAs had permanently attached themselves to a certain PHC and were, therefore, making the best out of the JSY incentives scheme by promising to procure the JSY money for the beneficiaries and their families.
- ii) There is often a latent enmity between the villagers and ASHAs, as they think that she has grabbed a ‘sarkari’ (government) post by bribing the PRI member of the village and she does not have to do any work.
- iii) The concept of volunteerism has been marred by the institutionalised selection procedure and the education criteria that has been mentioned for ASHA selection. As a senior medical officer

commented, “The selection procedure for ASHA is wrong, the right people are not being selected, people are paying money and getting selected and this level of education criteria, that ASHA has to be educated up till class 8 or beyond is making it difficult for the right candidate, that is the village women who assist in delivering children, the low caste dais, to be selected, and we cant help it.”

- iv) The ANM and the ASHA have a power hierarchy which is quite evident from the fact that the ASHA is dependent on the the ANM’s approval for incentives other than what she is entitled to get under JSY.
- v) The provisions of JSY had undergone changes thrice. By the time the first system started functioning properly, changes were brought about. Hence, by the time women started receiving the sum of Rs 100 for the TT injections, the scheme was changed. As a result, only a few women got money, while the others were disappointed.
- vi) Irregular flow of funds under JSY is creating dissatisfaction among people and problems for the medical staff. It often happens that beneficiaries do not come to the PHC for delivery as they have heard from others that there is no money available. In fact, even those who finally got money under JSY do not have a pleasant experience to share. They had to spend money and put in a lot of time and energy in getting the cash assistance.
- vii) JSY was aimed at promoting institutional delivery through incentives. However, institutions are still ill-equipped for the purpose of handling so many maternity cases at the same time (PHCs still do not have an adequate number of beds and the delivery room is barren) or of handling complications. There is minimal or almost no-nexistent postnatal care services in the hospital and the women are discharged shortly after child birth mostly due to lack of beds.
- viii) The issue of unavailability of medicines is giving rise to a latent hostility between the ANMs and the villagers. The sense of dissatisfaction is also growing amongst the villagers as they have to buy medicines whenever they go to the government hospital for treatment.

Endnote

- 1 This paper is written by Amrita Gupta of CHSJ (New Delhi). The author acknowledge the support received from BREAD (Nalanda) and Sacred Heart Action for People’s Empowerment (SHAPE) at Betiah, West Champaran in conducting this study.

Participation of Gram Panchayats in the NRHM in Himachal Pradesh

Sandhya Gautam, SUTRA

Himachal Pradesh at a Glance¹

Indicators	Number
District Hospitals	12
CHCs	66
PHCs	439
Sub-Centers	2,069
VHSCs constituted & operational	0
Meetings of State Health Mission held ('06-07)	1
Meetings of District Health Missions held ('06-07)	2
RKs registered in CHCs	12
ASHAs who have received 1 st module of training	0
ASHAs who have received 2 nd module of training	0
ASHAs who are in position with drug-kits	0
Total number of monthly health days held in the state ('06-07 (expected)	88,248
Monthly health days held in the state ('06-07) (achieved)	27,835
Sub-Centers which are functional with at least one ANM	1,903
PHCs functioning on a 24x7 basis ('06-07)	50
CHCs where upgrades have been taken up and completed	0
District Hospitals where physical infrastructure is being upgraded	0
Beneficiaries of JSY (in lakhs) in ('06-07)	0.05

Background

SUTRA² launched a small study in its field area to assess the knowledge, participation and involvement of Gram Panchayat Pradhans in NRHM.

These are the preliminary findings of the study based on information from four blocks. Information from three more blocks from Una, Mandi and Bilaspur districts are awaited.

The report is comprised of three main sections:

- ❖ Findings from discussions with Panchayat Pradhans
- ❖ Problems faced by Women Pradhans
- ❖ Findings from discussions with female multi-purpose health workers (MPHWs)

Methodology

The study was conducted in July 2007 in the following four blocks:

- a) Dharampur (District Solan)
- b) Nalagarh (District Solan)
- c) Nahan (District Sirmour)
- d) Baijnath (District Kangra)

Interviews served as the main method of gathering information and two sets of interviews were conducted with the following people.

- ❖ 40 Panchayat Pradhans (10 from each block)
- ❖ 34 female MPHWs from the same Panchayats. The interviews with female MPHW were conducted in order to arrive at a more holistic understanding, taking into account the problems faced by service providers.

The Composition of the Pradhans interviewed is as follows

Gender: Out of the 40 Panchayat Pradhans, 33 per cent of the respondents were women.

Caste: Scheduled Caste: 40 per cent, Non-Scheduled Caste: 60 per cent.

Education: 42 per cent below class ten, 58 per cent above.

Age group: 78 per cent respondents were between 26-50 years and 22 per cent were between 51-65 years.

Limitations of the Study

Some issues that have emerged from the study, such as constitution of VHSCs and problems being shared by Women Pradhans, need more probing but due to time and resource constraint, could not be satisfactorily investigated.

Findings from Discussions with Panchayat Pradhans

a) Availability of Sub-Centres

All Pradhans said they have Sub-Centres in their Panchayats (100 per cent). As far as the availability of female MPHW is concerned, only one woman Pradhan said they don't have a female MPHW while the other 39 (97.5 per cent) Pradhans said the female MPHW was there at the Sub-Centers.

b) Untied Fund for Sub-Centres

Some 25 per cent of the Pradhans denied having any information about the untied fund of Rs 10, 000 granted to Sub-Centres, 7.5 per cent refused to reveal that Sub-Centres located in their Panchayats had received the fund and 67.5 per cent of the Pradhans agreed that their Sub-Centers had received funds worth Rs 10, 000. 62 per cent of the women respondents were aware that the Untied Fund was being received by the Sub-Centres in their Panchayats.

c) Utilisation of Untied Fund

Some 96.29 per cent of respondents were aware of how much money was spent and only one Pradhan denied to having any information.

Those who knew about the expenditure said it was utilised for following:

- i) Purchase of medicines.
- ii) Maintenance of the Sub-Center building (white wash, window and ceiling repairs, etc.)
- iii) Apart from items mentioned above, in some Sub-Centers, the fund was used towards repairing facilities like drinking water and toilets.

d) Discussion on Health-Related Issues

It was observed that discussions regarding health matters are held at two levels: first in Gram Panchayat meetings and then in Gram Sabhas.

i) Gram Panchayat Meetings

Some 93 per cent of the respondents said they discuss health matters in their Panchayat meetings. Only 7 per cent of the respondents refused to have any discussion involving health in their Panchayat meetings. All the women respondents (100 per cent) affirmed the discussion on health matters in the Panchayat meetings.

To better understand the gender perspective, health issues discussed by women and men Pradhans were listed separately.

Women Pradhans	Men Pradhans
<ul style="list-style-type: none"> ❖ Sex selective abortion and child sex ratio ❖ Anemia and women's health ❖ RTI/STI/HIV/AIDS ❖ Maternal and child health ❖ Family Planning ❖ Immunisation, Polio campaign ❖ De-addiction ❖ Adolescent health ❖ Seasonal diseases, etc. 	<ul style="list-style-type: none"> ❖ Total sanitation ❖ Total sanitation ❖ Seasonal diseases ❖ Waterborne diseases ❖ Family Planning ❖ De-addiction ❖ Construction of toilets and hygiene, etc.

ii) Gram Sabhas

Some 80 per cent of the respondents said health issues were being discussed in Gram Sabhas. These issues are similar to the ones discussed during the Panchayat meetings. Yet, 20 per cent denied having any specific discussion on health issues in the Gram Sabha and said it only happens if there is some complaint or a programme comes from the district.

e) Participation of Health Worker in Gram Panchayat meetings/Gram Sabhas

Some 20 per cent of Pradhans said Health Workers do not come to the meetings while 80 per cent of Pradhans affirmed their participation in Panchayat meetings/Gram Sabhas. Some 23 per cent of the women respondents said that health workers do not attend Panchayat meetings/Gram Sabhas.

f) Fixed Health Day

A Fixed Health Day means that provision of health services such as immunisation, ante- and postnatal checkups and services related to maternal and child health are given on a fixed day every month (to be decided by state) at AWCs. For example, in Himachal, Tuesday has been declared Fixed Health Day on which the Medical Officer conducts health checkups at AWCs.

Some 33 per cent of the respondents were not aware of any such day and among those who did know, 7 per cent did not know if the Fixed Health Day was conducted in the AWCs of their Panchayat. But 60 per cent affirmed that the Fixed Health Day is conducted in the AWCs of their Panchayat area. Out of the 13 women who responded 5 (38 per cent) were not aware about Fixed Health Day, one knew but said it was not conducted in AWCs in her Panchayat.

Regarding coordination between female MPHW and AWWs, 22 per cent were totally ignorant, 14 per cent said there is no coordination among the two and 64 per cent said AWW gets help from female MPHW.

g) Village Health & Sanitation Committee (VHSC)

The Mission states that the village would be an important unit for planning and a VHSC would be formed in each village where a proportionate representation from all the hamlets would be ensured with adequate representation of the marginalised communities. Untied funds would be made available to the VHSC for various health activities.

Some 25 per cent of the respondents expressed their ignorance regarding any such committee, 25 per cent had heard about it but were not aware if any type of committee was formed in their Panchayat area, and 50 per cent of the Pradhans affirmed the constitution of PARIKAS³ in their Panchayat area. Out of 13 women respondents, 4 (31 per cent) said that VHSC is constituted in their Panchayats, 5 (38 per cent) denied its constitution and 4 (31 per cent) were not aware about VHSC.

i) Meeting of VHSC

Out of those who responded positively, 68 per cent either did not have any information about meetings of VHSC or said the committee does not meet regularly, while only 32 per cent said the committee held its meetings on a regular basis.

ii) Participation of Panchayat Pradhans in the Meetings of VHSC

Some 58 per cent of the respondents never attended meetings of VHSC and only 42 per cent said they go to the meetings of the committee.

iii) Funds Released to VHSC

Some 70 per cent denied any release of funds to the VHSC, 30 per cent affirmed the receipt of funds by the committee. All the women Pradhans denied any fund release to VHSC.

h) Janani Suraksha Yojna

To promote institutional child births, JSY was introduced to provide monetary support to BPL families.

i) Awareness about JSY

Only 20 per cent of the respondents expressed their ignorance about the scheme and the rest said they knew about JSY.

ii) Benefits Received by Pregnant Women under JSY

Among those who knew about JSY, 30 per cent were not aware if any pregnant woman of their Panchayat received benefits under JSY, while 70 per cent responded affirmatively. Out of this 70 per cent, 37 per cent knew about the amount received by pregnant women. Among the women respondents, 23 per cent were ignorant about JSY, while 77 per cent said they knew about the scheme and women of their Panchayat had benefited from the scheme.

iii) Discussion on JSY in Gram Sabhas

Some 35 per cent of the Pradhans interviewed denied having any discussion on JSY in Gram Sabhas

held during the year (in H.P., Gram Sabhas are conducted four times a year on fixed days). Some 65 per cent said the scheme was discussed in Gram Sabhas of their Panchayats. And 54 per cent of the Women Pradhans affirmed discussion on JSY in Gram Sabhas, while 46 per cent denied it.

i) Charter of Citizen Health Rights

Some 83 per cent of the respondents were not aware of any such charter, 17 per cent (7 out of 40) said they had heard about it and affirmed its implementation in CHC/hospital in their area. Among the 13 women Pradhans, 2 (15 per cent) were aware of Citizen Health Rights Charter and affirmed the implementation of it in CHC/hospital in their area.

j) Problems Identified and Corrective Measures Suggested

Panchayat Pradhans were asked about the problems they faced and corrective measures needed to resolve issues regarding Sub-Centre Untied Funds, coordination between Panchayat and ANM, VHSC, health facilities, and JSY. Respondents came up with following problems and recommendations:

Problems Shared by Women Pradhans

- a) Lack of full and complete information on the untied fund because correspondence/information was not shared by the health department regarding the untied fund.
- b) Detail was not given by Health Workers on expenditure of the untied fund.
- c) For the expenditure of untied funds, the only Panchayat consulted is the one in which a Sub-Centre is located. However, this is not the case among other Panchayats served by the same Sub-Centre.
- d) The female MPHW does not come to Gram Sabhas, therefore, there is no sharing of the Plan of Action.
- e) There is a lack of coordination between the Panchayat and Health Workers.
- f) VHSC is not constituted.
- g) There is a lack of awareness among members of PARIKAS leading to irregular meetings and less participation by members.
- h) Health Workers do not disseminate thorough information on government schemes, like JSY, to Panchayats and women.
- i) Lack of awareness about JSY is depriving women of the benefits.
- j) Frequent changes in JSY guidelines leading to chaos at the community level.

Problems	Recommendations
❖ Unavailability of female MPHW (F) at sub-centres	It should be mandatory for the female MPHW to reside at the place of appointment.
❖ Lack of awareness among community and Panchayat members regarding government schemes and their rights leading to immature/inappropriate decisions by the VHSC.	Full, complete and timely information should be disseminated to Panchayat and Gram Sabhas. Mechanisms should be developed to reach women as a very small number of them come to Gram Sabhas.
❖ Lack of full, complete and timely information disseminated to the community and Panchayats by Health Workers regarding government schemes and programmes. Lack of awareness among women regarding government scheme as a very small number of them come to Gram Sabhas.	Health Workers should make strong efforts to inform the community. NGOs should be involved in disseminating information on health rights and government schemes. Members of Panchayats must be given training in a timely manner about their role and responsibility in the NRHM. JSY guidelines should be made clear and benefits should be given at the third trimester of the pregnancy.
❖ Lack of facilities related to ante-natal and postnatal care/services. ❖ Lack of quality health services.	Health check-up facilities should be made available specifically for maternal and child health.
❖ Lack of participation by female MPHW and Health Officers in Gram Sabhas (a female Health Worker comes only when she is summoned).	It should be made mandatory for Health Workers to participate in Gram Sabhas.
❖ Lack of coordination and communication between the Health Worker & AWW and the Health Worker & Panchayat and no effort was taken to develop coordination. ❖ No common action plan was developed by the community and the Health Worker.	
❖ No monitoring visits by Health Officers to ensure participation of MPWs in Gram Sabhas.	Medical and Health Officers should have meetings with Pradhans on a regular basis.
❖ Problems faced by the community due to the unavailability of basic medicines.	Untied Funds must be spent in consultation with Panchayats as per the requirement and need of the community and should not be left at the disposal of the Health Worker.

Problems Identified and Corrective Measures as Suggested by female MPHW

Problems	Recommendations
<ul style="list-style-type: none"> ❖ Frequent changes in guidelines of JSY is leading to distrust by the community. ❖ There is no timely release of money for JSY by the department. ❖ There is a lack of discussion on JSY in Panchayat meetings. ❖ Lack of awareness among women regarding their health, schemes etc. 	<ul style="list-style-type: none"> ❖ Reading material should be provided to Health Workers on JSY as well as other schemes. ❖ The Panchayat Pradhan should be involved in JSY and should keep the money in order to avoid any delay in giving it to the women. ❖ All expenditure incurred on institutional child birth should be reimbursed and more money should be given to women under JSY. ❖ JSY benefit should be given during the third trimester of the pregnancy. ❖ The department should equip Panchayat representatives, community and AWW on schemes. ❖ The department should draft proper mechanisms to make the community aware of NRHM so that they can be benefited.
<ul style="list-style-type: none"> ❖ Most cases are referred to higher institutions due to lack of appropriate facilities for childbirth at PHC/CHC. This leads to the community distrusting the MPWs and the community gets discouraged. As a result, efforts made by Health Workers to promote institutional childbirth suffer. 	<ul style="list-style-type: none"> ❖ Childbirth facilities must be made available at the PHC/CHC level. ❖ More money should be released for the maintenance of Sub-centers.
<ul style="list-style-type: none"> ❖ No participation of doctors on Fixed Health Day. ❖ Problems in conducting health days as there is no co-worker at the Sub-Centre. ❖ Lack of coordination with the AWW. 	<p>The MHO should conduct regular meetings with Panchayat Pradhans and take initiative to resolve these problems.</p>
<ul style="list-style-type: none"> ❖ No regular meetings of VHSCs. 	<p>VHSCs need to be constituted in villages where there aren't any and there should be fix days for meetings.</p>

Conclusion

Although the health infrastructure is comparatively better in Himachal Pradesh than in neighboring states and majority of Panchayat representatives interviewed have heard of NRHM, however they are not aware of their role in the mission. Government has not developed mechanisms to equip Panchayats to take up their expected role and participate actively to achieve the goals set in mission document. It is expected from state to ensure flow of information to the last person in marginalized community and develop capacities of Panchayats for their active role in NRHM.

Endnotes

- 1 NRHM status as on 31.4.07, published by Ministry of Health and Family Welfare as on 31 May, 2007.
- 2 SUTRA (Society for Social Uplift Through Rural Action) is a developmental NGO. It has been working with gender and rights perspective in Himachal Pradesh since 1977. Focus areas of SUTRA's work are women's health, violence against women, political participation of women, strengthening decentralization process through Gram Panchayats and organizing women collectives and adolescent groups.
- 3 PARIKAS means Parivar Kalyan Salahakar Samiti. After 73rd amendment, the Panchayati Raj Act 1994 provided for Health committee in Panchayats. These Samitis were formed by health department at village level in H.P during BJP government.

Implementation of the NRHM in Jharkhand: A Case Study of Achievements and Challenges¹

Devika Biswas and Ruth Vivek, CHSJ

Jharkhand at a Glance²

Indicators	Number
District Hospitals	22
CHCs	194
PHCs	330
Sub-Centres	3,958
VHSCs constituted & operational	7,249
Meetings of State Health Mission held ('06-07)	1
Meetings of District Health Missions held ('06-07)	22
RKs registered in CHCs	138
ASHAs who have received 1 st module of training	3,446
ASHAs who have received 2 nd module of training	0
ASHAs who are in position with drug-kits	0
Monthly health days held in the state ('06-07 (expected)	24,3468
Monthly health days held in the state ('06-07 (achieved)	13,818
Sub-centres which are functional with at least one ANM	3,958
PHCs functioning on a 24x7 basis during '06-07	0
CHCs where upgrades have been taken up and completed	0
District Hospitals where physical infrastructure is being upgraded	22
Beneficiaries of JSY (in lakhs) in '06-07	0.86

Introduction

The NRHM was launched in Jharkhand in April 2005. Jharkhand is among the eight EAG states where the NRHM promises to pay special attention and focus to bring positive changes in the health delivery system, to achieve the MDG on health within seven years (2005-12), by improving upon in all the health related indicators as well as other related issues.

It is also equally important to mention that the state of Jharkhand is comparatively a new state and is in its nascent stage. It came into as a separate state entity in 2000 from its mother state Bihar. So the cadre division and transfer of all legal power were going on slowly and the last batch of health service providers was relieved as Jharkhand cadre in August 2006. The political climate in Jharkhand is unstable and officials are often transferred. Vacant positions are a common feature in the state. Under such circumstances, a study was planned by the CHSJ, New Delhi as part of a two-year civil society review of the NRHM in Jharkhand. This study was conducted with the support of three other local organisations namely Trust for Community Development and Research (Ranchi), SANCALP (Ranchi) and Fontal Development Foundation (Deoghar).

Rationale

As already mentioned, Jharkhand is an EAG state with poor health indicators and unique health issues; therefore, there was a need to understand the preparatory activities and planning being undertaken in the state to achieve the NRHM goals and targets. There was also a need to understand how the specific health needs of the state are being incorporated into the NRHM plan and implementation activities through counting its achievements and challenges.

Objectives

The objectives of this study were:

- a) To note the improvements (achievements) in the services under NRHM.
- b) To understand the ground realities (experiences) of the communities related to the key components under the NRHM such as:
 - i) Improvement in maternal health services.
 - ii) Increased access to services at the community level, decentralisation and community participation.
 - iii) The implementation of the NRHM in these two years in the state of Jharkhand.
 - iv) It also tried to examine the challenges ahead of the NRHM implementation through seeking answers on these key issues.

Methodology

The Plan: The original design was to cover two districts (two District Programme Management Officers or DPMOs), ten village communities through FGDs, five village heads, three ANMs, ten Sahiyas³, two medical officers (MOs) and one state level SHS official through framed questions to elicit information as given below.

- a) Awareness and knowledge about the NRHM.
- b) Sahiya - their selection process, relationship with the community, the services they are providing and would provide in future, any improvements noted and problems faced.
- c) Support in maternal health - Awareness of JSY, whether women are receiving financial support as envisaged, problem faced and the role of Sahiya in maternal health and status of JSY.
- d) VHSC - whether any such committees are formed and active, whether the process of decentralised plan has been made by any village, their knowledge about untied fund and its utilisation, whether the community been involved in anywhere in the planning of its expenditure.
- e) Stakeholders' level of awareness of any new initiatives in the village or block.
- f) Key health issues of the community and how the issues are being currently dealt with and their expectation from the government on redress of those issues.

Actual Coverage: Two districts (one DPMO), ten village communities, three traditional (tribal) village heads, three ANMs, six Sahiyas, four AWWs, two MOs.

KEY FINDINGS

a) Awareness of the NRHM

All service providers were quizzed about their knowledge of the NRHM. The knowledge of all the ANMs and MOs was very superficial. They did not seem interested except to know what they are supposed to do practically as service providers. They seemed to be totally unconcerned about future positive changes in terms of reduction in maternal death and morbidity, or reducing IMR. Rather, they were complacent about the increased number of patients in the hospitals, availability of medicine to distribute and increase in institutional child births. But the DPMO had knowledge and insight about the NRHM and saw achieving its targets and goals as a challenge. He accepted that if the targets are to be achieved by 2012, then the progress made so far is too slow to bring the desired results. He also admitted that the desired level of information had not percolated down to the villages about the key objectives and targets of the NRHM as the fund for IEC per block was only Rs 10,000. He felt even the latest information about the NRHM does not percolate to the health service providers as laid down in the JSY criteria and sterilisation guidelines. He said he had acquired the information from the internet, the headquarters did not give any instructions, so the old criteria is still followed. Based on his internet research, the DPMO seemed to be aware of several factors but was unable to adhere to such instructions as he has to wait for orders from the state.

The DPMO felt that if all the stakeholders including the government staff and all beneficiaries are determined to achieve the objectives of the NRHM, then it would be possible to achieve the targets and desired results, but if it is left only to government staff, it is difficult to get a significant result. The MOs were very optimistic and they felt that with increase in services, the result ought to be positive and the desired end attained. But both MOs and ANMs felt there was an extra workload. They blamed people for their ignorance and lack of awareness about health-related matters. And for being 'over-demanding' about quality health services free of cost.

On the contrary, the community, namely the Pradhans, Sahiyas, NGO workers and other community members felt they did not get enough information or orientation about the NRHM and know very little

about its key features. What most of them are aware of are JSY and Sahiyas who are to be selected for helping the ANM in her work for drug distribution. Only those who were members of the VHSC knew that Sahiyas were selected in a Gram Sabha and they are members of committee. Hardly anybody knew about RKS/Hospital Management Committee (HMC), untied fund for the VHSC, Sub-Centre and village health plans. None was aware of the targets to be achieved by 2012 and the issues to be tackled. Even Sahiyas were ignorant of their role and responsibilities.

b) Sahiya Recruitment

In one district in the area where Sahiya selection did not take place, the people were not aware of their selection procedures, their function and role in the NRHM. Even AWWs were unaware about their work except that they heard that they would provide services from the AWC. Pradhans did not know the selection procedure nor had they heard of the VHSC but in the other district where Sahiyas were selected through Gram Sabhas, most of the community members could tell that one NGO representative had come and briefed them about Sahiyas who would serve the local community by helping the ANM on health matters and would be involved in drug distribution. So a meeting of the Gram Sabha was called on a fixed date and in that meeting, the VHSC was formed and Sahiyas were selected. In most of the cases, the selection was based on their education and leadership qualities or dynamic personality as nominated by the villagers. In some cases, the candidate was not even present in the village. No one contested the candidature of any selected Sahiya. Most of them did not know the exact role and work of the Sahiya or the members of the VHSC. Even the Sahiyas did not know as no training took place before or during the study. But most of the Sahiyas selected were young and eager to work. In Deoghar, till May 2007, 1,821 Sahiyas were selected and by June '07, about 25,000 Sahiyas were in place and out of them about 16,000 had received the orientation training as per the statement of the state level officials.

c) Role and Work of the Sahiyas

Most of the Sahiyas and community women didn't know much about their role and function, except that she is supposed to help the ANM in her work by distributing drugs in the village. This idea occurred to them when they saw her distributing drugs on Filaria Day and Pulse Polio day. But her services were not utilised on the Monthly Health Day at AWC. Providers such as the ANM and MO also did not know how the Sahiyas would improve maternal health.

d) Village Health and Sanitation Committees (VHSCs)

In Deoghar a total of 1,240 VHSCs were constituted. But the ANMs were unaware of its formation and functioning as they were not invited or informed, even MOs could not give any positive response about the VHSCs. Even the ANMs had no information about the members of these committees. The AWWs had a separate Mata Samiti to look after their Centre-related affairs and schools also had a Vidyalaya Shiksha Samiti. The community where VHSCs were formed, acknowledged its existence and said defensively that they meet regularly. When asked what resolution they took or when they met, they were unable to give details. Even members had not heard about their role in decisions about the sanction /approval on untied funds of Sub-Centre and VHSC. Only the DPMO could tell that the VHSC had the authority to approve the untied funds. The members even did not know about village health plan and their role in making that health plan. So when asked why they formed the VHSC, they said they were told that it would prove beneficial ("*Samiti banane se kuchh faide honge*"). They hoped some grant would come to them as happened with the Vidyalaya Shiksha Samiti.

e) Untied Funds

There are two types of untied funds:

- i) Untied fund for the VHSC.
- ii) Untied fund for the Sub-Centre.

The fund for VHSC was not released but the fund for the Sub-Centre was released to the ANMs with a new state-specific instruction to open joint account with the AWW headquarters. Thus, all three ANMs interviewed did open that joint account in banks, spending it as per the instruction they received from the office of MO-in-charge, on items suggested and approved by the MO. For instance, an MO could recall spending on maintenance of cleanliness of the centre, photocopying of reports and purchase of registers. She did not disclose information about this fund to anyone as she was not told to do so and she never felt any problem in getting the bill passed by her in-charge, as she never went beyond the limit. Between 2005-06 the VHSC received only Rs 10,000 and might have spent about Rs 3,000. Though MOs did not comment on this, the DPMO affirmed that such instructions were given by the state to avoid problems as no decision could be arrived at about the election of PRIs in Jharkhand. The monthly upper limit of expenditure could go up to Rs 850. The MOs and ANMs were totally unaware of the national guidelines as per which, to open such accounts with the Sarpanch, the heads of expenditure have to be approved by the VHSC.

f) Rogi Kalyan Samiti (RKS)/Hospital Management Committee (HMC)

The NRHM document gives prime importance to the RKS for decentralisation of power and fostering a sense of community ownership in the running of the health system and planning process. But this crucial samitis are not very operational although the state claims that each and every PHC/CHC had its RKS. As per the official information from Deoghar, in all the 13 PHCs, the RKSs were in place. The ANMs informed they had heard about it but were unaware of the members and the resolutions had been passed. Even MOs could not tell when the last meeting of the RKS took place and what resolution they took. So it appeared to be more on paper than in practice. None of the community members, Pradhans or AWWs was part of any RKS hence, they could not tell whether the RKS was running smoothly and whether the PHCs were being managed properly.

g) JSY

The JSY is basically an amalgamation of National Maternal Benefit Scheme and support for conveyance for institutional child birth. In the beginning, this was meant only for women from BPL families up to the second pregnancy. Later, to cover and protect all pregnancies for safe motherhood and service guarantee, the scope of this scheme was extended to all pregnant women irrespective of income or number of pregnancies. But this has not been followed in Jharkhand as the state headquarters did not amend its old instructions. Therefore, very few women were found eligible and even they have not received the benefits in time and often have to undergo harassment to get the reimbursement from the department. The community felt that they are unnecessarily harassed and coaxed to go to far away PHCs or accredited organisation for a petty sum of Rs 700 (in difficult cases/caesarean cases, the reimbursed amount is Rs 1,400), but their actual expenditure and inconveniences are much more. Even safe and quality services are not available. No immediate reimbursement is given. Transportation is difficult for the patient and for the relatives to stay in the PHCs is not easy. In the case of home births, nothing is paid. Hence, most people wanted to know whether they would be eligible for reimbursements in the cases of home births or deliveries en route. The concerns of the women was well

narrated by one ANM as “*Gor lagaichio didiji ghare me bachcha ho jay to achhcha ho*”, meaning, “I beg you, sister, it is better if the child is born at home”. Even the ANMs are more practical and sympathetic to the genuine concerns of the people as there is no means of stay for the relatives of the pregnant women, even transport is a problem. A substantial amount is required to make arrangements which are generally beyond the means of the people. Besides, the facilities are not up to the standards. Yet MOs and ANMs felt that they are prompt in early registration of the eligible candidates, making cash payment of Rs 100, giving a woman the reimbursement coupons for institutional child birth and instructing her to go either to the PHC, district hospital or accredited institutions. They do not bother whether the patient was able to reach the facility and was able to use the services without difficulty or if the child was finally born at home. The MOs all boasted of the arrangements but did not admit that reimbursement is not given immediately and one is forced to pay bribes to avoid further delay and harassment. But the DPMO indirectly admitted this fact saying that to avoid delay in procuring the reimbursement from accredited institutions, they have issued an instruction that the pregnant woman have to clear the full payments of the accredited institution through cash and in lieu get the reimbursement coupon countersigned by the accredited institution for payment from the government as per norm. So indirectly, he admitted that the reimbursement is generally delayed at the PHC or government establishments.

He also gave an account of JSY beneficiaries in Deoghar district. Registration and payment of Rs 100 was made to a total of 5,840 pregnant women, out of whom 247 were reimbursed Rs 700 for normal deliveries at the health centres and Rs 1,400 was given to 10 women who had undergone caesareans/ complicated deliveries at health centres. There were no records for the third and final payment of Rs 300 as the stipulated time line was not over. Thus, no woman had received the full amount as per the governmental record. Some only got Rs 100 as most of the cases were home births.

h) Running of PHCs 24x7

There are tall claims of 24x7 services in all PHCs /CHCs. But in reality, the outdoor service hours have merely increased from 8 a.m. to 3 p.m. After that hardly any doctor is available in the campus but ANMs and other paramedical staff are present. Due to contractual appointments of doctors and ANMs, now there is hardly any shortage of such staff and outreach services are attended by contractual doctors. So now doctors and health staff are available for longer duration and patients are coming in larger numbers due to improvement of facilities. But it is still very premature to say that this has enhanced quality service and morbidity load, MMR and IMR would reduce and safe maternal health would be ensured. But definitely, it is a good beginning after a gap of many decades. More attention and better governance are to be ensured, only then could it translate into positive impact on the community. Systematic and constant upgradation is still required to make the PHCs responsive to the health needs of the people. Good communication and transport facilities are essential conditions to reach these health centres. People are in need of more quality services as laid down in the IPHS. All these health centres are in need of upgradation as per the prescribed standard. Display of notice boards describing people's health charter and service guarantee in the centre as the right of citizens is essential to ascertaining the availability of services. Most of the health personnel need sensitisation training as they have a feeling that the public is demanding more than it deserves and do not consider that it is their basic human right to have standardised healthcare. Even MOs felt that the government is erring by giving free services to the public. In many health centres, there is a dearth of workable toilets and water facilities. This lack of basic amenities is a constraint for the public to turn out for hospitalisation.

i) Monthly Health Day

The ANMs are visiting AWC on the fixed Monthly Health Day and provide services like registration of pregnant women, check-ups, distribution of IFA tablets and other medicines, vaccinating children and also giving TT injection to pregnant women. One AWW complained that due to irregular visit of one ANM, the vaccination programme suffered. But in most of the cases, the ANM were regular in attending the MHD. The community women said that none of the ANMs do any physical check up. They only verbally ask the patient about their problems and prescribe IFA. They often do not give any counselling. This was denied by ANMs who said they do provide all services.

The registers and records show the poor maintenance of pregnancy records. Even the expected dates of delivery (EDDs) were not mentioned properly, only the probable month. Many women who were shown to complete their EDD have not delivered the child even after expiry of one month. And those who were shown to have their EDD in later months had full-term home births. This shows the callous attitude and lack of recognition of symptoms and accurate calculation skill of ANMs. Many pockets were not catered to properly and thus, do not get the benefits of services.

j) Upgrading of PHCs

Most of the PHCs were renovated and better equipped. Hence, the MOs made a generalised positive statement and said that all facilities have improved and most of the vacant posts been filled. The infrastructure such as the labour room and operation theatre have been renovated and equipped. All services are being strengthened, especially maternal health, which got primary attention through JSY, Sahiya, Family Planning incentives and 24x7 availability of nurses for maternal health. There is sufficient stock of medicines too.

Even contractual doctors are available. In some places, more doctors were available than the sanctioned posts. Two blocks, namely Sarath and Karon of Deoghar were sanctioned for upgradation as CHC. Thus, positive changes were evident in many areas.

Conclusion

a) Challenges

The challenges of the NRHM in Jharkhand are as follows. The message of seven years of structural reconstruction of the health system to be able to respond to the health needs of the rural poor had not reached the masses, not even to the key actors like the PRIs, SHGs, AWWs, Sahiya and ANMs. So it is very optimistic to expect that it should have percolated to villages automatically and that people could reap its benefits. As the message did not reach its key actors, expecting them to respond positively is pointless and hence is a big challenge to get the desired results. Awareness levels are quite low and need strengthening.

- i) Every level should be reinforced to cope with the pressures of unmet field needs particularly in Sahiya selection, training, engaging her so that she may be able to deliver her services and benefit her community.
- ii) The VHSCs still need to be oriented and properly activated so that they may take up ownership of the programme by planning and executing village health plans holistically. They should not be ornamental but should be actual performers for decentralised planning. They should have authority, powers and funds to pursue their health plan.

- iii) Untied fund is a posed threat if proper orientation and monitoring is not done. A mechanism of inbuilt transparency should be in place to make the system more accountable to people. Even the untied funds for VHSC should be released in a transparent manner.
- iv) The RKSs are still on papers and the biggest challenge is to have right persons in these samitis. Let them act on behalf of the public for their entitlement to quality ensured services. Till date they are used as rubber stamp to hide all anomalies of hospital management and promoting corruption.
- v) While implementing JSY, the latest national guideline should be followed and it should be ensured that women get their full entitlements. There is a need to study in more depth whether this scheme actually helps save the lives of mothers and children or promotes unnecessary trouble of institutionalisation at the cost our cultural, traditional values hampering our right of free choice. There is corruption, harassment, extra expenditure, discomfort, lack of safety and all these should be removed and replaced by ensured quality services with all facilities of CEmOC including blood bank and referral facilities within easy reach of community. Even preference for the women in question should be honoured by also having trained TBAs available for home births. In all manner, the reproductive health rights of citizens should be respected.
- vi) Availability of 24x7 services should mean the availability of doctors with emergency arrangements, all basic amenities, infrastructure and working equipment. Otherwise, it is a very harsh joke on the public for whom the services are intended. There is a dire need of strengthening the entire system.
- vii) Monthly Health Day - It is a real challenge to equip our ANMs and Sahiyas to upgrade their skills of recognising early pregnancies, to be able to ensure EDDs, to carry out the patient's physical check-up, to be able to identify all high-risk pregnancies and to be skilful enough to counsel them. They also need sensitisation training.
- viii) Upgradation of PHCs as per the IPHS is not known to MOs and ANMs or any paramedical staff of the health department. So the first challenge is to orient them and make them responsive to the public need. Then there is another huge task of making the public aware of his /her health rights as per the IPHS and service guarantees. The people's health charter, the service guarantees and IPHS should be displayed in the local language in hospitals at prominent places.

b) Achievements

The list of achievements is also not very short:

- i) The NRHM has already been launched and some headway has been made despite many hindrances and constraints. The momentum has begun.
- ii) After many years of neglect, the health infrastructure is being assessed so that holistic planning can take shape. Fortunately, many agencies are eager to help the government in this matter.
- iii) Recruitment, equipment, renovation and innovation are all taking place simultaneously, thus we can hope for the better.
- iv) This year, a state PIP has been made and we can hope for inclusion of state-specific needs.

- v) JSY is one intervention where we can suggest alternative models for safe maternal health services and we have found that the government is open to listening.
- vi) Lastly, the proverb goes, slow and steady wins the race. Though it is very difficult to achieve the targets with a very weak health infrastructure and a dilapidated system, Jharkhand, the young state, had the guts to accept the challenges before it and resolved to fight to improve the poor health scenario.

Endnotes

- 1 This paper is co-authored by Devika Biswas and Ruth Vivek of CHSJ (New Delhi). The authors acknowledge the support provided by Trust for Community Development and Research (Ranchi), SANCALP (Ranchi) and Fontal Development Foundation (Deoghar) in conducting the study and in the preparation of this paper.
- 2 NRHM status as on 31.4.07, published by Ministry of Health and Family Welfare as on 31 May, 2007.
- 3 ASHAs are known as SAHIYAs in Jharkhand

Two Years of the NRHM in Orissa: Looking through the Eyes of the People

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Introduction

In order to make any corrective measures to the programme for effective implementation of the NHRM, it is vital to review and track key achievements, outcomes, and benefits received by the community. The authors of this paper have attempted to review the progress of implementation of the NRHM in the state of Orissa from the peoples' perspective.

Methodology

The methodology for writing this paper consists of a review of reports and documents of both the state and central governments (like PIP along with Guidelines on the NRHM) rural health watch reports of network of civil society organisations (like JSA), reports of grassroots level consultations and rapid assessment of community perception undertaken by Kalinga Centre for Social Development (KCSD), Bhubaneswar. Content analysis, facts and figures have been triangulated through the findings of survey and consultation reports.

Structure of the Report

This report has been divided into three parts. The first part discusses conceptual issues, the overall health scenario of Orissa and status of implementation of NRHM in the state as per the official reports. The second part deals with the major findings of survey reports of JSA and KCSD as well as excerpts from grassroot level consultations. The last section discusses the critical analysis of findings and a suggested future course of action.

Overall Health Scenario of Orissa

Among all states, Orissa has the second highest IMR- 75 per 1,000 live births (as per the latest SRS 2005), which is next only to Madhya Pradesh (76 per 1,000). For many years (from 1991 to 2002), Orissa had the dubious distinction of having the highest IMR among the states. Orissa's NNMR is 53, which is the highest in the country and its MMR is also very high at 358 per 1 lakh live births, comparatively, the MMR for the whole country is 301 per 1 lakh live births (as per 2001-2003 special survey of deaths using RHIME methods, RGI, 2006). Malaria in Orissa is of considerable concern and has significant implications. The state is a major contributor of malaria cases. More than 15 per cent of the total 2 million cases and deaths due to malaria occur in India. Malnutrition still continues to be a leading

problem in Orissa as well and its manifestations and consequences are diverse and alarming as over one-third of Orissa's children are malnourished.

The prevalence of TB in the state is also high—about 60 per cent above the national average. The state continues to carry a high disease burden of which 59 per cent is due to infectious diseases, maternal, prenatal, and nutritional problems.

Orissa at a Glance¹

Indicators	Number
District Hospitals	32
CHCs	231
PHCs	1,279
Sub-Centres	5,927
VHSCs constituted & operational	0
Meetings of State Health Mission held ('06-07)	2
Meetings of District Health Missions held ('06-07)	80
RKs registered in CHCs	307
ASHAs who have received 1 st module of training	12,729
ASHAs who have received 2 nd module of training	0
ASHAs who are in position with drug-kits	0
Monthly Health Days held in the state ('06-07) (expected)	73,356
Monthly Health Days held in the state '06-07 (achieved)	24,452
Sub-Centres which are functional with at least one ANM	5,574
PHCs functioning on a 24x7 basis during 2006-07	0
CHCs where upgrades have been taken up and completed	0
District Hospitals where physical infrastructure is being upgraded	9
Beneficiaries of JSY (in lakhs) ('06-07)	2.19

Status of the NRHM in the State

The NRHM was launched in Orissa on June 17, 2005. The main components are RCH-II, Immunisation, National Disease Control Programme and the following new initiatives:

- a) Appointing ASHAs

- b) Mainstreaming AYUSH
- c) Allocating untied funds to Sub Centres
- d) Formation of RKS
- e) Launching Mobile Medical Units
- f) Strengthening PHC/CHC/UGPHC to IPHS

As per official sources, on 31 April 2007, the merger of societies was completed at the state level as well as in all 30 districts of the state. RKSs were registered in district hospitals of all 30 districts and 307 CHCs. However, there were no RKS formed at the PHC level.

A total of 46,246 ASHAs were selected, whereas the target was 47,529. Out of those selected, only 12,729 received the first part of the training. The ASHA training calendar has yet to be finalised and none of them had drug-kits.

A total of 6,090 joint accounts were operational in Sub-Centre and 82 per cent of the Sub-Centres have submitted utilisation certificates (UCs) for Untied Funds released during Financial Year 2005-06.

A total of Rs 445 crore was released to the state since 2005-06.

Under JSY, there were a total of 2.19 lakh beneficiaries during the 2006-07 financial year, 31 per cent of whom were assisted by ASHAs across the state. Out of the total child births, 151,921 (67 per cent) were institutional child births and rest deliveries (75,283 (33 per cent)) were conducted at home.

SURVEY FINDINGS

I Survey Findings on Issues of NRHM by CSOs

A survey was conducted by JSA, Orissa and spanned the following 10 blocks of eight districts in the state: Cuttack, Mayurbhanj, Ganjam, Khurda, Bolangir, Boudh, Anugul and Bolangir. The survey covered one CHC, one PHC under the CHC, two Sub-centres under each selected PHC, eight villagers, eight ASHA, eight outdoor patients (four male and four female), four pregnant women, four ANMs, and four new mothers, in each block. Below are the major findings of the survey.

a) Profile of ASHA

i) Family Income

The report shows that most of the ASHAs belong to the lower income group and almost half (48 per cent) have an income of less than Rs 10, 000 p.a. Another 28 per cent have an income ranging from Rs 10,000–15,000 p.a., followed by 18 per cent ranging between Rs 15,000-20,000 and only a meager 6 per cent have income above Rs 20,000 p.a.

ii) Selection

A very high percentage of ASHAs (85.71 per cent) were selected according to the norms prescribed. The report denotes that the selection processes of ASHAs in Orissa were transparent and accountable.

iii) Working Conditions

Approximately 38 per cent of the ASHAs were given information and clarifications about their work and other concerns primarily by the AWW, followed by ANMs (25 per cent), PRI members (17.85 per cent) and 18.75 per cent by other sources. This shows that though efforts were made in selecting the right candidates, there was not much concern in systematically communicating about work structure, tasks, honorarium, and so forth, with the ASHAs. There is no single system from where the ASHAs can garner information, which is reflected in the non-standardised information that ASHAs are receiving about their tasks, defying the whole purpose of the mission.

iv) Training

Very high percentages (71 per cent) of ASHAs have received training while only 14 per cent said they haven't received any and the remaining 14 per cent did not comment.

The training for almost all the ASHAs lasted for seven days. Almost half of the ASHAs said their training focused on vaccination/immunisation. The other 50 per cent said their training was concentrated on pre- and post-natal related information including pregnancy, childbirth and so forth. There was hardly any mention of the advocacy content of the NRHM during the training.

v) Grievances of ASHAs on training

The report also showed that complaints were made by the ASHAs about not receiving their drug-kits (30 per cent). Almost 40 per cent of the ASHAs stated that they did not receive the tour expenditure either.

vi) Work done in villages

It was reported that 35 per cent of the ASHAs adhere to the tasks of immunisation/vaccination and distribution of medicines. The rest are responsible for monitoring the child and mother's health and other related components including pregnancy, registration of birth, etc. This is closely in sync with the type of training they have received.

The ASHAs work in close collaboration with the ANM/AWW. The village community as well as the VHSC helps the ASHA workers to fulfill their targets. Approximately 78 per cent of the ASHAs agreed they work closely with the ANMs when required and all of them volunteer with the PHCs and other medical centres when the need arises. Another 62.5 per cent of ASHAs said they work closely with the Sub-Centres. In addition, about 46 per cent of the ASHAs said they have enough influence on the people, whereas 25 per cent said they don't have any influence and the rest 29.17 per cent did not comment.

vii) Problems faced by ASHAs

Some 40 per cent of the ASHAs believed their remuneration should be improved. It was revealed that since most of the ASHAs are from a lower income group, this role is mainly used as a source of earning income rather than being a health advocate. A huge percentage (over half) of the ASHAs believed they did not receive adequate training or equipment to accomplish their tasks.

b) Services available at Sub-Centres

The Health Watch report revealed that out of 18 Sub-Centres covered under the survey, 67 per cent did not have regular services for treatment of minor illness (i.e. cold, fever and cough). Along with the health functionaries, infrastructure and other health facilities are not optimal and without proper infrastructure, delivery of services does not receive proper attention. Hygiene and sanitation are in dire straits due to erratic water/electric facilities and dirty surroundings (In about 46 per cent of the Sub-Centres, the surroundings are filthy). Basic services like treatment for minor illnesses and check-ups for pregnant women were also unavailable.

c) Untied Fund under NRHM

Majority of the Sub-Centres (71 per cent) have received untied fund in the surveyed Sub-Centres as per the JSA report. And most of it has been spent on the repairing of equipment as well as the infrastructure. A proper procedure was not followed in most of the cases regarding spending norms.

d) Availability of Infrastructure and Facilities in PHCs

i) Infrastructure Availability at PHCs

The JSA report illustrated a dismal picture of the facilities available at the PHCs. The irregular electric supply (92 per cent), unavailability of ambulance facility (86 per cent), not having six usable beds (69 per cent) have been reported in the majority of PHCs covered under the survey. Other facilities such as labour rooms, minor operation rooms and refrigerator/deep freezers were also not up to IPHS. In addition, the PHCs also lacked adequate manpower.

ii) Availability of Medicines in PHCs

In PHCs where the patients are supposed to receive free medications, almost 20 per cent of the patients have to buy medicines from the chemist within the PHCs (in the PHCs where patients are supposed to receive free medications). However, not all medicines were available in these shops as 40 per cent had to be purchased from other chemists.

e) RKS in CHCs

About 30 per cent of the CHCs have RKS, which help in the early detection of diseases and educate people about the pros and cons of basic health services. They have played a major role in child and maternal health including safe pregnancy, safe childbirth and immunisation/vaccination for the child. These samitis have helped in safe institutional child birth, motivated parents to adhere to safe pregnancy and delivery mechanisms and see that parents follow proper immunisation and vaccination measures.

f) Village Health & Sanitation Committee/Other Village Body/Community

About 60 per cent of the surveyed villages have VHSCs and almost all of them have one female member. Only 25 per cent of the VHSCs meet regularly to perform activities enshrined upon them.

II. KCSD Survey on Community Perception & Advocacy Issues on NRHM

KCSD, Bhubaneswar, (wing of KIIT University) conducted a rapid assessment survey to understand the community's perception about decentralised health planning. This survey also sought to know how the district health action plans (DHAPs) represent the voices on the ground, in order to explore the scope of issues that need to be advocated at block level.

The community perception survey was conducted during the block level workshop (organised by KCSD) held at Puintala block of Bolangir district on 1 June 2007. About 200 participants including SHG members, ASHAs, ANMs, elected representatives and health service providers were present at the workshop. A pre-designed questionnaire was given to the participants and their responses were requested. The major findings of the survey relating to various issues are as follows.

a) Awareness of the Community on NRHM

It was found that one-third of the respondents were not aware of the NRHM. In regards to specific groups, it was found that all health functionaries have heard about the NRHM and its activities. However, the level of awareness is lowest among the SHG group members (68 per cent).

b) ASHA's Visits to the Respondent's Home

Over one-third of the respondents said that even though an ASHA has been posted in their villages, she has not visited their homes so far. The main reasons for this were that ASHAs are not getting timely incentives for their work, there is a lack of awareness among the community and there were delays in providing JSY money to the mothers.

c) First Preference for Seeking Advice and Treatment During Illness

The study reported that the respondents believed that both the AWW and ASHA (23 per cent respectively) were equally important for them in terms of seeking advice for treating their ill family members. Apart from the AWW and ASHA, the government hospital (22 per cent) and ANM (21 per cent) are also preferred destinations for the people in the Puintala block to seek advice. Dependence on private clinics (13 per cent) for treatment is lower than that of the government system.

d) People's view at the State, District, Block level Consultations/ Workshops on NRHM

In order to raise awareness about the NRHM and understand the people's perspective on NRHM, KCSD has organised a series of workshops and consultations at the state, district, block and community levels. The state-level workshop was organised on 4 September, 2006 at Bhubaneswar in which the Minister, Health and Family Welfare, GoO, Minister, Youth and Sports and Information and Public Relation, GoI, Mission Director, A.R. Nanda, Executive Director, PFI, New Delhi, participated along with national and state NGO functionaries, Zilla Parishad chairpersons, health experts and ASHAs. The district-level workshop for Balasore was held on 7 November 2006 and the combined workshop for the district of Koraput and Nawrangpur was held on 28 January 2007 at Jeypore where local MLAs, CDMOs, government officials, CBOs functionaries, ASHAs and ANMs participated. A block-level workshop was also held at Baliapal, Balasore on 2 December 2006, where along with generating awareness at the grassroots, efforts were made to ascertain feedback from the community about their level of knowledge about NRHM. The issues raised at each different level are as follows:

- i) Most of the stakeholders are unaware about their roles and responsibilities, thus hampering the overall performance of the programme at the grassroots level. Even a dignitary who attended the meeting did not know what the NRHM was.
- ii) Lack of proper training for ASHA workers is also major setback for the programme. In addition, transportation problems are creating difficulties in delivering health services in the rural areas. This issue needs to be addressed particularly in the context of NRHM success in remote areas. Attitudes by upper level staff towards ASHA workers is a matter of concern and needs to be clarified thoroughly in order to get the desired result. ASHA should not be the part of government mechanism. Appropriate remuneration to ASHA can motivate them to work for the community in the long run and vice-versa.
- iii) All the stakeholders associated with the NRHM programme had difficulties understanding the government document and guidelines on NRHM that affected the implementation process.
- iv) There is a need to initiate a mass awareness campaign and health orientation programme at the village level. Increased awareness among civil society and Panchayat representatives is also needed, so that they can guide the mission in their respective areas.
- v) There should be a bottom-level initiative by all the three partners such as NGOs, PRIs and the government, in order to address health-related problems.
- vi) There was a concern that over 40 positions of ANMs were reported to be vacant in the district of Bolangir. Some Sarpanches also said that ANMs are not staying in the Sub-Centers.
- vii) In the majority of cases, Sarpanches are unaware about the untied fund and in many cases the fund is not properly utilised. Also, because there are no ANMs in many Gram Panchayats, the fund has not been deposited yet.
- viii) There is an unnecessary delay (in some cases the delay is about 10-15 days) in payment to the mother of the newborn child under JSY.
- ix) Village/Panchayat health plans were not prepared anywhere, therefore, the health plan remains at the block level.
- x) It was reported that the RKS was yet to be formed at PHC level.

III. Critical Analysis

After reviewing the documents of the government, civil society and views of the stakeholders in the consultations, it is pertinent to look further into various activities under the NRHM in Orissa. If we review the earlier experiences on health system reform programmes undertaken by the state like the Orissa Health System Development Project (OSHSDP) and the Community Needs Assessment (CNA) in RCH-I, we find that ensuring proper implementation of the programmes and effective utilisation of the infrastructures and services cannot be accomplished solely by an increase in budgetary provisions. Therefore, following issues need to be approached carefully while planning, implementing and monitoring the NRHM in Orissa:

- a) **Learning from failures from the previous programmes is not being considered while formulating a new one:** Simply increasing budgetary allocation is not sufficient to ensure success

of a programme. For instance, making institutional child birth a reality would entail the availability of all-weather roads and transport facilities from the villages to the hospital, where patient-friendly trained proactive staff with proper facilities are available to conduct the deliveries. However, in reality, it is uncommon to find the Sub-Centres /PHCs/CHCs tangentially located in a rural area because political considerations override the population's needs. Beneficiaries still have to travel long distances to reach these health centres. The strengthening of infrastructure such as the FRUs under CSSM and RCH-I programmes remain under or non-utilised. In addition, the new mission is being launched without taking stock of failures with previous programs.

- b) **Frequent absence of regular health functionaries in rural areas:** The current village-level health functionary (employed at a salary of Rs 8,000-10,000 per month) is frequently not available. The hope is that this lacuna will be bridged by the ASHA who, being a local resident, would be available in the village and act as a link in the provision of primary health care services to the community. However, instead of enhancing the ANM's performance, the introduction of ASHAs may actually increase the existing lack of discipline among the regular village level health functionaries.
- c) **Lack of role clarity for ASHA:** There appears to be some ambivalence in the role and location of the ASHA. She is to act as a bridge between the ANM and the village and concurrently be accountable to the Panchayat. The question arises: when the ANM (who is a functionary of the health department) herself is not accountable to the Panchayat, how is the ASHA supposed to maintain the balancing act between the ANM and the Panchayat?

IV. Issues for Advocacy in NRHM, Orissa

Many of the issues mentioned above are of relevance to other states in India, but some issues, such as formation and functioning of RKS, involvement of PRIs and CSOs, community monitoring and advocacy are specific to Orissa. In order to develop an effective advocacy strategy, the GoO has taken some initiative to forge a partnership with CSOs. During the consultation meeting of CSOs for building 'advocacy strategy' for the state, the following issues emerged:

- a) Lack of awareness of the NRHM components among policymakers.
- b) Lack of monitoring of the NRHM progress by policymakers.
- c) Lack of convergence between different line departments related to health and development.
- d) Lack of access to quality and timely primary health care at various levels (including lack of transportation facilities, delaying/obstructing delivery of services).

V. Roads Ahead

a) Capacity Building of Stakeholders

The capacity building of stakeholders at all levels also needs to be considered. NGOs should be involved in the training and capacity building of ASHAs, PRIs and other stakeholders under NRHM to inculcate the spirit of activism. In order to begin activities required under decentralised health planning, resource mapping at all levels and capacity building at community level institutions (i.e. VHSC and other planning and monitoring committees) needs to be done.

b) Advocacy for Effectiveness

There is a need to build awareness among policymakers, media, and CSOs on NRHM components. To facilitate this, the state may choose to undertake the following activities:

- i) Developing and disseminating advocacy kits with the identified target groups.
- ii) Organising state-level sensitisation workshops for MLAs/MPs/administrators and Zilla Parishad Chairmen.
- iii) Organising sensitisation workshops for other target groups.
- iv) Bring out continuous press releases in print and electronic media by instituting media fellowships.

The CSOs may advocate a mechanism for periodical review of NRHM implementation by policymakers in their respective constituencies by:

- ❖ Undertaking policy audit/social audit and public hearings towards ensuring effective implementation of NRHM.
- ❖ Developing checklists of services under the NRHM.
- ❖ Formation of a House Committee and field visits by MLAs.
- ❖ Sensitisation of media on the NRHM and field visits for state media teams.
- ❖ Formation of House Committee on Monitoring NRHM implementations.

In order to address the problem of 'appropriateness of convergence' between different line departments related to health and development, the CSOs may advocate for a mechanism for regular and periodic inter-sector review on NRHM implementations and the sector's contribution to it (state and district-level).

Further, there is a need to address the lack of quality and timely primary health care at various levels (including lack of transportation facilities, delaying/obstructing delivery of services). The CSOs in partnership with the health providers may take measures such as:

- ❖ Physically monitoring the quality of services available at various levels in different districts/constituencies.
- ❖ Identifying the areas of improvement for adherence to IPHS.
- ❖ Ensuring the required number of doctors and medical staff at various levels.
- ❖ Ensuring transport facilities at various levels.

Conclusion

The progress of implementation of NRHM in Orissa may be regarded as satisfactory in quantitative terms but it has to be fine-tuned in terms of strategies and processes, to ensure progress in qualitative terms as well. While implementing, one should not forget that the ASHAs are the first port of call for

any health-related demands. It is observed from the current review that the ASHA as a woman has gained her much aspired role of working for the whole village rather than just looking after her children and family members. Now she has gained self-confidence and feels that people need and respect her and her opinions are important in both her family and the village. While all these are important from an empowerment point of view, the ineffective implementation of JSY, non-disbursal of cash assistance under JSY scheme to beneficiaries and delays in disbursement of honorarium to ASHA damages the credibility of the programme at the community level. These issues need special attention, and apart from addressing the capacity building issues, effective community monitoring and sustained advocacy also need to be undertaken in order to make it a success.

Acknowledgement

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Endnotes

- 1 NRHM status as on 31.4.07, published by Ministry of Health and Family Welfare as on 31 May, 2007

Assessing Sub-Centres for Skilled Birth Attendance by ANMs/LHVs in 10 Districts of Rajasthan

Vd. Smita Bajpai, CHETNA

Rajasthan at a Glance¹

Indicators	Number
District Hospitals	28
CHCs	325
PHCs	1,713
Sub-Centres	10,512
VHSCs Constituted & Operational	0
Meetings of State Health Mission held ('06-07)	0
Meetings of District Health Missions held ('06-07)	39
RKs registered in CHCs	333
ASHAs who have received 1 st module of training	34,843
ASHAs who have received 2 nd module of training	0
ASHAs in position with drug-kits	0
Monthly health days held in the state ('06-07 (expected)	5,58,443
Monthly health days held in the state ('06-07) (achieved)	4,49,634
Sub-Centres which are functional with at least one ANM	9,606
PHCs functioning on a 24x7 basis ('06-07)	0
CHCs where upgrades have been taken up and completed	6
District Hospitals where physical infrastructure is being upgraded	0
Beneficiaries of JSY (in lakhs) in '06-07	3.88

Introduction

The NRHM was launched in the state of Rajasthan on May 30, 2005 in order to carry out necessary architectural corrections in the basic healthcare delivery system. The goal of the mission is to improve the availability and access to quality healthcare for the people, especially those residing in rural areas, the poor, women, and children. The mission is expected to reduce IMR to 30/1,000 live births; reduce the MMR to 100/100,000 and reduce fertility rates to 2.1.

Sub-Centre Strengthening Strategy of the NRHM

Strengthening the Sub-Centres is one of the several strategies adopted by the mission to improve rural health care. The mission proposes development of Village Health Plans by the Village Health teams, which would aggregate into the Sub-Centre level plan, and in turn would feed in to the District Health Plan. Supplementary drugs and equipment kits for general ailments shall also be supplied. An additional ANM will be placed at the Sub-Centre level and a fund of Rs 5,000-10,000 shall be provided to be used in consultation with the Gram Panchayat in order to address the unmet needs for health.

IPHS lays down the following guidelines:

(a) Service delivery

- (i) All assured services as envisaged in the Sub-Centres should be available. This includes routine, preventive, promotive, some curative and referral services in addition to all the national health programmes as applicable.
- (ii) All the support services will be strengthened at the Sub-Centres level.

(b) Minimum requirement for service delivery

Maternal and Child Healthcare, immunisation, family planning and other services. Additional ANM and male Health Worker.

(c) Facilities

A layout of Sub-Centres indicating space for building and other infrastructure facilities. This entails creating a list of equipment, furniture and drugs needed to provide assured services, including skilled birth attendance by ANMs. A model citizen's charter for appropriate information to the beneficiaries, grievance redressal and constitution of VHSC for better management and improvement of Sub-Centre with involvement of PRI is needed. The monitoring process and quality assurance mechanism is also included.

Background for Assessment of Sub-Centres

Realising the need for skilled attendance at birth by health professionals to reduce maternal mortality, the MoHFW, GoI, released the guidelines for Skilled Birth Attendants (SBAs) by ANMs/ Lady Health Visitors (LHVs) in 2004. The Government of Rajasthan (GOR) initiated the process of implementation of guidelines in March 2006. A midwifery resource was initiated at the Janana Hospital, Jaipur to provide skill-based training to master trainers. A team of master trainers (LHV/MO/ANMTC tutors and Ob-Gyn and Paediatric experts) have been trained in all the 32 districts of Rajasthan. These trainers

will conduct cascade training of identified ANMs from 10 PHCs and 25 Sub-centres of each district in the pilot phase. Gradually, ANMs of all the Sub-centres will be trained.

There was a recognised need to support the district level authorities in order to identify appropriate Sub-Centres and ANMs where the training could be implemented. The criteria for identification included ANMs availability 24x7 at the Sub-Centre, ANMs attending to maternity patients. An additional criterion was added by CBO's willingness to participate in the training.

This assessment was conducted during 15-30 December 2006 on the request of the Department of Medical, Health and Family Welfare, GoR, to support the district health authorities in identification of appropriate Sub-centres and ANMs for the SBA training.

Methodology

Ten districts from the desert, rugged terrain and plains were identified based on the NGO presence, mandate to work on maternal health, and willingness to participate in the assessment. These districts are: Bikaner, Barmer, Churu, Chittorgarh, Jaisalmer, Jaipur, Jhunjhunu, Karauli, Kota, and Sawai Madhopur.

The draft checklist for monitoring Sub-Centres for IPHS, developed by the Director General of Health Services, MoHFW(GoI), was translated in Hindi and used for the assessment.

Twenty six PHCs, which were within the NGO operational area, were identified on a performance basis. All the Sub-Centres within the coverage of the PHC were identified and 226 Sub-Centres were assessed through observations, physical verification, and interviews with ANMs and Medical Officers of the PHC. Triangulation was done with the PHC and women who were enrolled in serial numbers 5, 10 and 15 in the MCH register of the Sub-Centre. A total of 607 women were interviewed.

Findings

Of the 226 Sub-Centres assessed:

- a) 62 per cent had inadequate infrastructure, access, and supplies.
Observations of the Sub-Centres and interviews with the ANMs and Sarpanch indicated that the untied funds were used to repair, paint, and ensure basic amenities.
- b) 70 per cent did not have ANMs staying 24x7. Some reasons for this include: unavailability of quarters, lack of security due to central location of the quarters, and proximity to a town/city.
- c) 58 per cent of the ANMs did not assist in child birth. The reasons given include: not staying at the Sub-Centre and their role in supervising the deliveries done by dais.
- d) 79 per cent of the ANMs expressed a willingness to take the SBA training.

The reasons for unwillingness include: ANM presently not conducting delivery, inclination to get transferred, and not enough support (infrastructure, supplies from the system and the community).

Observations at the PHCs

Visits to the PHCs indicated an increase in the number of institutional child births, particularly after the implementation of JSY in September 2006. However, the PHCs need to be strengthened in terms of skilled human power, infrastructure, drugs, equipments and supplies.

For example, two PHCs in Karuali and Kota district that were visited did not have ANM/LHV staying 24x7 at the PHC. In one PHC, there was only one LHV to attend to maternity patients and in another PHC, the ANMs had trained ward boys to conduct deliveries.

There was also a lack of labour rooms (deliveries were conducted in the verandah or in the dressing room) and labour tables (deliveries were conducted on the dressing table, window sill, IPD beds or the ground), as reported by the PHC staff.

Interviews with Women

Three women were identified in each Sub-Centre using their registration number in the multiples of 5 (i.e., 5, 10, 15, etc.) from the MCH register maintained by the ANM. Some of these identified women were not available. Hence a total of 607 women were interviewed to seek their responses regarding the services provided by the Sub-Centre and their views on enhanced skilled services provided by ANMs.

Of the 607 women interviewed:

- (a) 100 per cent of the women registered mentioned that they have received some service from the ANM.
- (b) 100 per cent of the women mentioned that during pregnancy, they received iron tablets and TT injections from the ANM.
- (c) 30 per cent of the women, particularly in the desert districts of Barmer and Jaisalmer, mentioned that ANM provided services during child birth. In these districts all the ANMs stayed at the Sub-Centre.
- (d) 30 per cent of the women mentioned that the postnatal services received were weighing of the newborn and immunisation of the child.
- (e) 100 per cent of the women mentioned that the ANM informed them about their entitlements from JSY.
- (f) 23 per cent of the women mentioned that they received benefits of JSY for an amount of Rs 500-700.
- (g) 53 per cent of the women mentioned that they spent an amount of Rs 1,000-5,000 on transport and medicines.
- (h) 70 per cent of the women mentioned that the ANM informed them about family planning methods.
- (i) 95 per cent of the women mentioned that it would be useful if the ANM received skills-based training.

Interviews with women also revealed the contradiction between the ANM report and women's report. For example, in the Kota district, the ANMs reported 100 per cent provision of ANC/INC/PNC services whereas, of the 55 women interviewed for receipt of services:

- (a) 58 per cent of the women mentioned receipt of services during pregnancy, delivery, and after childbirth (IFA, TT, delivery, ANC, PNC).
- (b) 4% per cent of the women mentioned that they did not receive any services from the Sub-Centre.
- (c) 22 per cent of the women mentioned that they only received ANC services.

Services Received by Women in Kota District

Services received from ANM	Total	No services received	Only ANC & PNC Services Received	ANC services received	Only delivery services received	Only PNC services received	ANC, delivery and PNC services received
	55	4	2	12	1	4	32
	100%	7%	4%	22%	2%	7%	58%

A similar picture was observed across the ten districts.

Dialogue with Stakeholders

- (a) Some 220 NGOs/CMHOs/PMOs/MOs PHC participated in 10 district-level orientation workshops. The Public Health Department representatives did not participate in workshops in the Churu, Jhunjhunu, Kota and Barmer districts due to preoccupation with the Swasthya Chetna Rath and year-ending processes.

A total of 3,880 community members participated in 44 meetings conducted in 265 villages out of the entire 226 Sub-Centres.

- (b) Some 465 dais participated in discussions on partnerships with ANMs, AWWs, and ASHAs for linkages with the Sub-Centres and referral centers, as well as a need for organisation.
- (c) A total of 2,460 ANMs, ASHAs, AWWs, and SHGs members participated to discuss their own roles and responsibilities and resolve conflicts to ensure better coordination.
- (d) Some 490 Panchayat representatives participated in seven districts to discuss their role in enhancing women's access to the public health services, particularly facilitating the stay of the ANMs in the Sub-Centre.
- (e) Some 187 young girls and boys in the Jaipur district met to discuss their role in saving women's lives and volunteering for blood donation.
- (f) Some 278 local media representatives and community women and men participated in the dialogue to appraise themselves on skilled assistance.

Conclusion

This assessment clearly indicates that communities are willing and want to avail the services provided by the public health system. The sub-centre being the first point of contact between the community and the public health system, has a critical role to play in image building and service provision. While the skill building and investing in human resources is important, there is also a need to equip the providers with the necessary and basic facilities in order to perform their services optimally. Training of ANMs for SBA must be accompanied by site preparedness and community partnership to achieve the goal of MMR less than 100 per 1,000 live births by the year 2012.

Recommendations

- (a) The IPHS for Sub-Centres need to be implemented on a priority basis and they must be strengthened in terms of infrastructure, supplies and human resource, as they are the first contact for community with the public health system.
- (b) It is vital to enhance community ownership of the public health system through regular interaction and dialogue with the service providers and key stakeholders. This must form the agenda of the Panchayat meetings and Gram Sabhas.
- (c) Community stakeholders (i.e. PRIs, Dais, SHGs and ASHAs) have shown an inclination and can play a major role in monitoring services and also supporting the ANMs to fulfill their roles and responsibilities. Greater opportunities must be provided to facilitate dialogue and communication between the service providers and stakeholders.
- (d) Regular and periodic monitoring of these Sub-Centres is essential to assess the progress of implementation of IPHS through the NRHM. The community-based monitoring mechanisms and the role of VHSC could serve as a critical aspect to strengthen the public health systems.

Districtwise Sub-Centre Assessment

Sr. No.	District	PHC	Sub-Centres in a PHC	Total Sub-Centres in a district	No. of Sub-Centres equipped for SBA training	No. of ANMs available 24x7	No. of ANMs conducting Delivery	ANMs willing for SBA training
1.	Churu	Somasi	4	8	Nil	5	3	8
		Binasar	4					
2.	Jhunjhunu	Birmi	6	14	Nil	4	13	14
		Ladusar	8					
3.	Bikaner	Gadiala	8	22	11	11	11	17
		Kolayat	14					
4.	Karauli	Shri Mahaveerji	9	23	1	1	13	18
		Kela Devi	14					
5.	Sawai Madhopur	Vajeerpur	6	16	Nil	0	8	15
		Choth Ka Barwada	10					
6.	Jaipur	Kadeda	6	36	34	9	10 Some times	33
		Mandavri	6					
		Bichun	9					
		Manda	7					
		Bagru	8					
7.	Kota	Kheda Rasulpur	5	19	Nil	1 Some times	Nil	8
		Manasgaon	8					
		Arandkheda	6					
8.	Chittorgarh	Karunda	7	15	13	8	9	13
		Bambodi	8					
9.	Jaisalmer	Deva	13	36	13	15	13	12
		Bhaniana	11					
		Mohangarh	12					
10.	Barmer	Ramsar	11	37	14	14	14	14
		Baytu	14					
		Bakhasar	12					
Total	10 Districts	26 PHCs		226 Sub-Centres	86	68	94	178
Percentage (%)					38%	30%	42%	79%

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Department of Medical, Health and Family Welfare, the CMHOs, RCH Officers, MOs of the PHCs, LHV, ANMs, AWWs and ASHA-Sahyoginis of the 10 districts.

Community stakeholders—women, men, young people, and elected representatives.

SUMA² members—URMUL (Bikaner); Sure (Barmer and Jaisalmer); Gramoday Samajik Sansthan (Jaipur), Prayas (Chittorgarh); Centre for Health Equity (Jaipur); Hadoti Hast Shilp Sansthan (Kota); National Institute of Rural Affairs (Karauli and Sawai Madhopur); Sikshit Rojgar Kendra Prabandhak

Samiti (Jhunjhunu and Churu); The White Ribbon Alliance (India), the John-T and Catherine-D MacArthur Foundation and the Women's Health and Rights Partnership, South Asia.

Endnotes

- 1 NRHM status as on 31.4.07, published by Ministry of Health and Family Welfare as on 31 May, 2007.
- 2 SUMA is Rajasthan State Alliance for Safe Motherhood initiated by CHETNA in 2002 to create awareness and to advocate for saving lives of mothers and newborns by alliance building. It has more than 50 members and presence in 29 districts of Rajasthan.

Meeting the Health Needs of the Poor: Two Years of the NRHM in Uttarakhand

*Sunita Shahi, Prayas
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Uttarakhand at a Glance¹

Indicators	Number
District Hospitals	16
CHCs	49
PHCs	222
Sub-Centres	1,631
VHSCs constituted & operational	0
Meetings of the State Health Mission held ('06-07)	0
Meetings of the District Health Missions held ('06-07)	13
RKs registered in CHCs	0
ASHAs who have received 1 st module of training	8,283
ASHAs who have received 2 nd module of training	0
ASHAs in position with drug-kits	0
Monthly Health Days held in the state '06-07 (expected)	79,668
Number of Monthly Health Days held in the state '06-07 (achieved)	0
Sub-Centres which are functional with at least one ANM	1,525
PHCs functioning on a 24x7 basis during 2006-07	23
CHCs where upgrades have been taken up and completed	22
District Hospitals where physical infrastructure is being upgraded	26
Beneficiaries of JSY (in lakhs) in '06-07	0.11

The NRHM has a provision for 'community monitoring' to provide feedback on the functioning of the health system. In keeping with this, the CHSJ conducted a social audit in three districts of Uttarakhand. CHSJ did this in partnership with three local NGOs, Mahila Kalyan Sansthan, Prayas and Heera, to gather evidence on developments on the implementation of NRHM at the grass-root levels.

Community-based Social Audit provides a way for citizens and community groups to assess the needs in their communities and report on how governments are performing towards fulfillment of these needs. Thus, the purpose of social audit in Uttarakhand was to review the progress of NRHM and build an accountability mechanism with the health system through community involvement, to ensure successful implementation of the NRHM, by providing a feedback to the planning and monitoring machinery of the programme about ground-level needs and realities.

Methodology

Social audit reviewed the progress of NRHM on some specific parameters related to:

- (a) ASHA – their selection and training processes; and their functioning as a link between the health system and the community.
- (b) Maternal Health Care – JSY, Referral Transport and ANC-PNC.
- (c) VHSC – its status and functioning, village health planning and utilisation of untied funds.
- (d) Curative Services – accessibility, availability and quality

These issues were discussed at the community level with health personnel, PRI members and the District Programme Manager. Methodology for social audit included interviews and FGDs, village meetings and observations of various health centres.

The audit was performed in three districts of Uttaranchal i.e. Nainital, Udham Singh Nagar and Pauri. One CHCs, two PHCs, three Sub-Centers and ten villages were selected for the purpose of social audit. Thus, in each district, separate interviews were conducted with 10 ASHAs, three ANMs, three AWWs, three PRI heads, three patients, staff of two PHCs and one CHC and one DPMU. 10 village meetings were organised and group discussions were done with 10 new mothers.

KEY FINDINGS

	<i>Nainital</i>	<i>Udhamsinghnagar</i>	<i>Paudi</i>
a) ASHA			
i) Selection Process	<ul style="list-style-type: none"> ❖ Took place between Dec '05 & Jan '06. ❖ Women's meeting were called in few places for selecting candidates, ❖ Pradhan or health department selected the ASHA. 	<ul style="list-style-type: none"> ❖ Took place from Jan to April '06. ❖ No village level meeting took place. ❖ Pradhan or the doctor did the selection amongst 1-4 candidates. 	<ul style="list-style-type: none"> ❖ Took place between Sept to Dec '05. ❖ Meeting was called by Pradhan where ASHA was selected with help from a facilitator. ❖ Half of the ASHAs were selected unanimously.
ii) Training	<ul style="list-style-type: none"> ❖ Training had been given once, for 7 days. ❖ Most of the respondents were of the opinion that ASHA training was weak and insufficient to explain the tasks properly. 	<ul style="list-style-type: none"> ❖ Majority got training once for 7 to 9 days. Few received the training twice. ❖ Most respondents opine that training was weak in – explaining roles and responsibilities of ASHA i.e.coordination with ANM, AWW & on-job training; community skills; technical inputs on ANC, PNC and preliminary treatment. 	<ul style="list-style-type: none"> ❖ Training had been given once, for 7 days.
iii) Coordination with ANM and AWW	<ul style="list-style-type: none"> ❖ Half the respondents said that ANM support ASHA in their work. It is a mutual process. ❖ None know that ASHA needs to coordinate with AWW also. ❖ ANM says no one is very clear about the work of ASHA. 	<ul style="list-style-type: none"> ❖ Half the respondents said that ANM & AWW support ASHA in their work. It is a mutual process. 	<ul style="list-style-type: none"> ❖ Most of the respondents see a satisfactory level of coordination. ❖ ASHA says it is a mutual process of cooperation. ❖ A few ANMs feel that AWW don't cooperate much.
	<ul style="list-style-type: none"> ❖ ASHAs are asked to get cases for vasectomy/ tubectomy that makes their work very difficult; and they can't tell their problems to ANM as well. 		
	<ul style="list-style-type: none"> ❖ ANM stays very far and rarely visits the village, so the healthcare she provides is not adequate. Her interaction with ASHA is not sufficient to provide her with guidance and adequate assistance. 		

	<i>Nainital</i>	<i>Udhamsinghnagar</i>	<i>Paudi</i>
iv) Compensation for her services	<ul style="list-style-type: none"> ❖ Rs 700 for receiving training; no other money is provided. 	<ul style="list-style-type: none"> ❖ Rs 700 for receiving training. ❖ Rs 600 for attending institutional child birth – but very few have received this amount. ❖ Cost of commuting daily to training centre is very high and not provided for. 	<ul style="list-style-type: none"> ❖ 7 of 10 ASHAs got no compensation for training. Others received different amounts. ❖ 2 ASHAs once received Rs 500.
	❖ Cost of commuting daily to training centre is very high and not provided for.		
v) Work done by ASHAs	<ul style="list-style-type: none"> ❖ Never organised a village health meeting or health day – ‘don’t know anything about this with just one round of training’. ❖ ASHA helps in Pulse Polio programme. ❖ ASHA says that they give advice on pregnancy care and safe delivery, but are unable to do it on regular basis. ❖ ANM, AWW and Pradhan opine that ASHA do not give any maternity counseling. ❖ ASHAs don’t have drug-kit; they are not sufficiently trained about the use of drugs. 	<ul style="list-style-type: none"> ❖ Hardly organise village health meeting or health day – don’t have enough knowledge of what to do and how to involve the villagers. ❖ ASHA provide full support to Pulse Polio programme, but AWW & ANM did not admit it. ❖ Few ANM & AWW said that ASHA helps in village health meetings. ❖ Very few counsel about pregnancy care – many respondents were of the opinion that they don’t have sufficient knowledge. ❖ Majority of ASHAs don’t have drug-kit; they are not sufficiently trained about the use of drugs. 	<ul style="list-style-type: none"> ❖ ASHA helps in Pulse Polio programme. ❖ 40% ASHAs share knowledge on health in meetings with women. ❖ 70% ASHAs help ANM / AWW in organising health day. ❖ ASHA says that they give advice on pregnancy care and safe delivery, but are unable to do it on regular basis. ❖ They also give advice on nutrition. ❖ Most of ASHAs have the drug-kit but they realise the need of more training inputs.
b. MATERNAL HEALTH CARE			
i) Antenatal and Postnatal Check ups	<ul style="list-style-type: none"> ❖ Complete ANC/PNC is not available on a regular basis; also not easily accessible due to great distances from sub-center/health facility or irregularity of ANMs visits to the village. ❖ Blood Pressure measurement and blood tests are almost never done for lack of facilities. The maximum that the ANM provides is immunisation and iron tablets. ❖ Lack of clarity of roles and responsibilities of ASHA leads to poor coordination with ANM, who often also fails to provide regular pregnancy/ post natal/ neonatal care/ counseling and also fails to convince villagers on matters like institutional child birth. Respondents said there is need for more training and financial support to ASHA. 		

	<i>Nainital</i>	<i>Udhamsinghnagar</i>	<i>Paudi</i>
ii) Institutional Childbirth	<ul style="list-style-type: none"> ❖ Almost everyone prefers home births by the <i>dai</i> (midwife), ANM, if available, is called only in case of emergency or the patient is taken to district hospital or nearest private practitioner. Both the latter options cost a lot of money and are not within the ambit of the JSY benefits. ❖ In almost all the PHCs natal care is available only through the ANM, if she is available. There also, only normal labor is conducted, with no special care for the neonates either. 		
	<ul style="list-style-type: none"> ❖ Childbirths in health centres are not free. Medicine must be bought from outside and the staff might also demand money. ❖ Behavior of staff is often not conducive for the patient. 	<ul style="list-style-type: none"> ❖ Village people said that ASHAs tell them about safe child birth and gives suggestions; but - ❖ Half of ASHA respondents said that they don't motivate or provide assistance to villagers for institutional childbirth. ❖ Those who try to assist don't get appreciation and support from public health staff. 	<ul style="list-style-type: none"> ❖ Village people said that ASHAs tell them about institutional/ safe child births and give suggestions; but – ❖ ASHAs, who tried to assist in institutional child birth, did not get appreciation and support from public health staff, nor are there proper facilities available in the hospital. Hence, it can be de-motivating.
iii) Referral Transport	<ul style="list-style-type: none"> ❖ CHC ambulance is out of order; only few PHCs have it. 	<ul style="list-style-type: none"> ❖ CHC has an ambulance; but no telephone facilities and referencing protocols 	<ul style="list-style-type: none"> ❖ No ambulance is available.
iv) JSY	<ul style="list-style-type: none"> ❖ ASHAs said that 4 women have received Rs 700 each for institutional child birth. ❖ ANM said that Rs 1,400 has been given to women. ❖ ASHAs have not assisted in institutional child births. ❖ Money for transport is not given. ❖ One ASHA who assisted in institutional childbirth has not got her share of compensation. 	<ul style="list-style-type: none"> ❖ ANM said that scheme is being implemented smoothly. Some 13 women got money. ❖ ASHA said that money is not obtained easily. ❖ The amount of money given varies widely. ❖ One village meeting (out of 10) indicated that only 4 women have got money. ❖ Others said they don't go to hospital for lack of services and so don't know anything about the scheme. 	<ul style="list-style-type: none"> ❖ 80% ASHAs said that they tried to assist women to the hospital but there they did not get enough care and support which result in distrust of ASHA as well. ❖ 70% ASHAs said that women have not received any money. ❖ ASHAs told that 4 women got Rs 500 & one got Rs 1,400. ANM said that 6 women received Rs 500 and 15 got Rs 1,400.
	<ul style="list-style-type: none"> ❖ Not everybody has the complete information about JSY, neither do the villagers or ANM have complete knowledge of the benefits offered (or means of availing them) nor is the PHC/CHC staff able to tell the actual functional status of the scheme. 		

	<i>Nainital</i>	<i>Udhamsinghnagar</i>	<i>Paudi</i>
c. VILLAGE HEALTH AND SANITATION COMMITTEE			
i) Formed & Functional	❖ No one knows anything about the committee.	❖ No one knows anything about the committee. ❖ ASHA has heard of it.	❖ Formed in 70% of the sampled villages. ❖ But ANM and ASHA knows nothing about its proceedings.
ii) Village level Planning and Intersectoral Coordination	❖ NA	❖ NA	❖ NA ❖ No attempts seem to have been made.
iii) Utilisation of untied funds available with the Sub-Centres	❖ One ANM said the Rs 7,000 have been spent in Sub-Centers maintenance/ repair. ❖ No one else talked about this– they refused to give any information.	❖ ANMs said the money has been spent in infrastructure development/ repair of the Sub-Centre. ❖ No one else has any knowledge about this fund.	❖ Not all the Sub-Centres have got the money. Of those who got, not all have used the money. ❖ Nobody, other than ANM has any knowledge about this fund.
d. CURATIVE SERVICES			
	❖ There aren't proper facilities for gynaecological care, special neonatal services and lab investigations. ❖ People don't get free medicines, though the health centres do have some drug supply. ❖ No facility for critical care or emergencies (including obstetric complications). ❖ Inadequate facilities for inpatient care and surgical procedures (in some places what is available, is often not provided for free). ❖ Whatever infrastructure does exist remains almost non-functional and most cases which do approach the local health centre for serious care often get referred to the district hospital. ❖ Whatever services are provided with all good intentions and meager resources available, are far inadequate for that required at community level. ❖ Almost all the respondents said that RKS has not been formed nor are grants for it received; they know nothing about it except the DPMU who says that RKS has been formed in few centres and part of grants received.		

Recommendations from Respondents and Stakeholders

The social audit also looked at the various public healthcare facilities, and studied in more detail the problems experienced in its successful functioning at the ground level. The process thus gathered some suggestions realised by the community, and also by the public healthcare providers at the village level – for better availability and accessibility to health services.

Some actions that can thus be demanded, and are necessary to be taken up seriously by the health authorities of Uttaranchal can be listed as follows:

- (a) Expand the IEC activities at the village/community level to provide complete and regular information about available health services, schemes (including JSY) and other entitlements under NRHM, including the roles of ASHA, for improving community health.
- (b) Enhance ASHA training and do the evaluation on a regular basis; ensure adequate compensation for the training they receive and the work they do; ANMs, AWWs and medical health officers must be sensitised in a better way to ensure coordination with ASHA and also provide on-the job kind training or guidance to her.
- (c) Regular meetings of various committees and health personnel/public administration/PRI members with the communities must take place to regularly provide information about new policies and other updates on its implementation process and also gather feedbacks.
- (d) Formation and facilitation of RKSs, infrastructure development and increase in health facilities and health personnel must be accelerated to make healthcare available closer to people – for better accessibility.
- (e) Government must take care of community or rural development activities by activating the VHSC and providing assistance for village level planning and inter-sectoral coordination; PRI members must be provided with orientation/training on issues related to community health, village health planning and inter-sectoral coordination.
- (f) There was also a suggestion from some communities that the policies of dolling out money, as done under JSY must be stopped because those who actually need that money rarely get it. What they require are 'services' that must be made available and accessible to them as and when needed.

Discussion

During the social audit process, discrepancies were often seen in the information provided at various levels of public health system and that gathered from the communities. This is an issue of concern and must be seriously looked into by the health administrators and policymakers; and also the citizens who are entitled for and are in great need of these services but fail to avail them due to poor performance of the system in programme implementation and catching up with the reform processes.

The rigorous process of social audit followed by a dialogue between health authorities and the communities have tried to put pressure on the system to respond – by realising the processes for reform as proposed by the NRHM and to deliver effective health services and community entitlements. Concrete efforts must be taken at the state and district levels to ensure compliance of the system for fulfilling such demands for successful implementation of NRHM and for meeting its objectives.

Endnotes

- 1 NRHM status as on 31.4.07, published by Ministry of Health and Family Welfare as on 31 May, 2007.

Meeting the Health Needs of the Poor: Social Audit in Uttar Pradesh¹

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Uttar Pradesh at a Glance²

Indicators	Number
District Hospitals	74
CHCs	386
PHCs	3,660
Sub-Centres	20,521
VHSCs constituted & operational	0
Meetings of State Health Mission held ('06-07)	2
Meetings of District Health Missions held ('06-07)	70
RKs registered in CHCs	0
ASHAs who have received 1 st module of training	98,240
ASHAs who have received 2 nd module of training	0
ASHAs in position with drug-kits	0
Monthly health days held in the state ('06-07) (expected)	0
Monthly health days held in the state ('06-07) (achieved)	0
Sub-Centres which are functional with at least one ANM	21,925
PHCs functioning on a 24x7 basis ('06-07)	225
CHCs where upgrades have been taken up and completed	0
District Hospitals where physical infrastructure is being upgraded	0
Beneficiaries of JSY (in lakhs) in '06-07	0.98

Introduction

Two years have passed since the launch of the NRHM and it is important to reflect on how much this programme is reaching and benefiting the common and poor people in the rural areas. Keeping these objectives at the forefront, two North Indian states, UP and Uttarakhand, were chosen for social audit. In UP, five districts were chosen for the purpose of social auditing keeping geographical diversity in mind. In each district, district level organisations were selected to carry out the social audit process. These organisations are as follows:

S.No.	Organisation	Districts
1	Tarun Vikas Sansthan	Banda
2	People's Action for National Integration (PANI)	Barabanki
3	Gramya	Chandauli
4	Shikhar Prashikshan Sansthan	Mirzapur
5	Astitva	Muzafarnagar

The social audit process was carried out between February and June 2007. This report explains in details the social audit process and the recommendations emerging from it.

Process of Social Audit

In the first week of March 2007, a planning meeting was organised in Lucknow with the CSOs of the selected states (UP and Uttarakhand). In this meeting, finalisation of issues, designing of training modules, selection of districts/blocks and the tools to be used were discussed and finalised.

In mid-March, a five-day training workshop was organised for the field investigators of 5 districts in UP and 3 districts in Uttarakhand in Lucknow. During this training session, the tools were field-tested and in the first week of April, the process of social audit began. One coordinator in each state was appointed to supervise the audit process, quality of work, deal with bureaucratic hurdles and provide technical support.

Methodology

The methodology used for the social audit was as follows:

- Focussed Group Discussions
- Interviews
- Observations

In every district one DPMU, one CHC, two PHCs, three Sub-Centres and 10 villages were selected for the exercise.

Tools for Social Audit

From the discussions that accrued during state level planning meetings, 17 tools were designed. These included:

Provider	Community	Managers	Focussed Group Discussion	Observation
Interview with ANM	Interview with women who have gone through child birth 6 months preceding the interview	Medical Superintendent	FGDs with community	CHC
Interview with AWW	Interview with Gram Pradhans	Medical officer		PHC
Interview with ASHA	Interview with ASHA candidate	VHC members		Sub-Centre
	Exit interview with patients	DPMU		
		Block Project management unit		
		State Rural Health mission		

Findings

The focus was on four main issues:

- Maternal Health
- ASHA
- Facilities
- Decentralisation of Panchayat and VHCs

a) Maternal Health

The NRHM's goal is to reduce the IMR and the MMR. The mission also aims to provide universal access to public health services such as women's health, child health, water, sanitation and hygiene, immunisation, and nutrition to the rural poor population.

In order to get information about maternal health and access to universal health services in each of the five districts, 10 FGDs were conducted and 10 women who had gone through child birth in the last six months were interviewed. Thus, a total of 50 FGDs were undertaken and a total of 50 women were interviewed. In FGDs with the community, the questions revolved around the total number of births that took place in the last six months, if prenatal care was provided when women were pregnant with their most recent child, the delivery care in the village, any complications during pregnancy and if postnatal advice was given. The individual interview guidelines focused on questions related to general information regarding child birth, PNC, natal care, JSY, difficulties faced during child birth, and experiences with public health facilities.

Findings from the FGDs with the Community

A total of 50 FGDs were conducted in 10 villages of five districts. These discussions revealed that

- There were a total of 832 children born in the six months preceding the FGD in the five districts.

- ii) Most of the children were born between October 2006 and April 2007.
- iii) In most of the cases, the women had home births (41 women out of 50 women).
- iv) The child births were assisted either by a *dai* (midwife), women in the neighbourhood, ASHA, mother-in-law or close relatives (in the case of 45 women out of 50 women).

The community was asked a set of questions regarding maternal health issues such as: the number of child births that took place in the six months in the village, whether or not check-ups were done by ANMs, if women got TT injections and iron tablets, if women received assistance as per the JSY, if there were any complications during childbirth and if ASHA/ANM had given advice about safe births. The findings are as follows:

- i) In most of the cases, ANC by ANM was not done.
- ii) TT injections were given during pregnancy.
- iii) In nearly 66 per cent of the cases, women were not given iron tablets.
- iv) Most of the childbirths were conducted by *dais*, women from the village and other family members.
- v) Out of the homebirths, only a few of them were attended by trained *dai*/health personnel.
- vi) Most of the women did not receive cash assistance as per JSY.
- vii) Most of the women did not receive any postpartum care (two days after child birth).
- viii) None of the women received any advice regarding safe births either from the ASHA or the ANM.

Findings from the Interviews

Care During Child birth

Women were asked questions related to care given during their childbirth. It was revealed that:

- i) Some 30 out of 50 women did not receive any kind of check-up while they were pregnant with their most recent child.
- ii) Among those who had undergone ANC check-ups, only few had it more than once.
- iii) Women who did go for check-ups were only given IFA tablets and TT injection, no other examination was conducted.

Advice for Safe Child birth

Women were further asked if they received any advice from the ANM, ASHA or any other health workers when they were pregnant. It was revealed that:

- i) Most of the women did not receive any advice about safe births.
- ii) None of the women received any advice from the ASHAs.
- iii) None of the women were visited by the ANMs within two days of the birth of her child.

Awareness of JSY

JSY integrates the cash assistance with the ANC during the pregnancy period, institutional care during childbirth and immediate postpartum care in a health centre, by establishing a system of coordinated care by field level health workers. This is a 100 per cent Central government sponsored scheme. The vision of JSY is:

- i) To reduce the overall MMR and IMR.
- ii) To increase institutional childbirths in BPL families.

The findings reveal that most of the women were not aware of JSY and almost all of them did not receive any cash assistances. Regarding JSY, the same question was asked from the ASHA and ANM - whether they knew if a woman was entitled to the JSY money and if ASHA was entitled to receive cash assistance from the scheme. According to the ASHAs and ANMs, in almost every district, women did not receive any assistance and in the few instances where they did get some assistance, it usually was less than Rs 1,400. One woman who got less than Rs 1,400 told the investigators, "Though I got only Rs 1,100, please say that I got Rs 1,400."

Most of the ASHAs did not get their share of Rs 600 and those who did receive some money stated that the time and energy spent was not equivalent to the amount they were paid. The ANM also said that not all women who had opted for institutional childbirths have obtained the JSY assistance. Asked why women have not gotten the money, the ANM said, "The money has not yet come."

Voices from the Ground

The NRHM states that its prime goal is to reduce maternal and infant deaths. However, many cases of negligence and carelessness in the delivery of public health care services, especially maternal healthcare, came to light during the social audit. In the course of FGDs and personal interviews with women who had gone through childbirth six months preceeding the interaction, community and mothers shared their experiences regarding health providers, facility and care during childbirth. A few selected experiences are given below.

Ground Reality – 1: A woman from the community said, "In our area, no ANM comes nor do we know the new ANM. If we face any problems during child birth, we go to a private hospital or to the village doctor. Even for small problems, we go to private doctors. We have not gone to the PHC and we don't know where it is located."

Ground Reality – 2: According to a pregnant woman of the village, "When I conceived, the ANM came and gave me injections. I asked her to give me the card and she said she would give it later. Till date, I don't know where she is."

Ground Reality – 3: A new mother said, "I came to know from the ASHA that if I deliver in a government facility, I would get Rs 1,400. I got all my vaccinations done and had made a card as well. Early morning on January 10, 2007 my labour pains began. My husband, the ASHA and other women from my village went along with me to the CHC 30 km from my village. We took an auto. We reached there around 11 a.m. I was in pain but nobody examined me. They gave me an injection and asked us to leave. We told them it is evening now and

we had no place to go. At about 1 a.m., I gave birth to a baby boy in a verandah. It was very cold that night and I've been sick ever since. In fact, my treatment is still going on."

Ground Reality – 4: A woman who went through child birth six months preceding the interview said, *"Who is the ASHA? I don't know her, I only know the ANM. During child birth, the ANM took Rs 30 from me to take me to the PHC. The PHC doctor was asking for Rs 500. I had no money so I came back home. Later, the ANM came to assist in the child birth. I had to give her Rs 300. After that nobody came to see me."*

b) ASHA

For the purpose of social audit, 10 selected ASHAs and five candidates (those who applied to become ASHA and were not selected) were interviewed in five districts. In total, 50 selected ASHAs and 25 ASHA applicants were interviewed. Questions regarding the selection process, roles and responsibilities, village functioning, economic support during childbirth and JSY were asked. The applicant ASHAs were asked about the process of selection, reasons why they were not selected, problems they faced, any bad or good experiences and any other specific issues that affected the selection process. To look at the coordination between AWW, ASHA and ANM, a total of 10 Pradhans, 25 AWWs and 15 ANMs were also interviewed.

According to the DPMU from these five districts, (except for the Barabanki district's DPMU, which was unable to provide the figures) 6,382 ASHAs were selected and all of them had undergone a minimum of seven days training. All of them are trained on immunisation, maternal and newborn care, iron tablets, how to create a village health plan, coordination between AWW and ANM, how to give advice, how to administer RTI and STI, accompanying patients to the hospital, the importance of collecting information on patients and maintaining records.

The NRHM's guidelines for ASHA selection clearly state that caution needs to be maintained. The District Health Society envisaged under the NRHM would oversee the selection process. The society would designate a District Nodal Officer, preferably a senior health professional, who is able to ensure that the health department is fully involved. The society would designate Block Nodal Officers preferably Block Medical Officers to facilitate the selection process, organise training for trainers and ASHA as per the guidelines of the scheme. A meeting of the Gram Sabha should be called to select one of the three shortlisted candidates and minutes of the approval process in Gram Sabha shall also be recorded.

The findings of the social audit reveal that in most cases the selections were not done as per the norm. In fact, there was no open meeting called, only one candidate's application was discussed and a list of the names of other candidates was not prepared. ASHA interviewed on their selection process said:

- (a) I was selected by the doctor and ANM.
- (b) I came to know about the ASHA scheme from the hospital. I applied and got selected.
- (c) I was selected by a CHC superintendent.
- (d) I was interviewed by the Gram Pradhan at the block level and then got selected.
- (e) I was selected on the basis of educational qualification.
- (f) My husband knows how I got selected.

- (g) In a neighborhood meeting, all the women said I should become the ASHA so I became one (the meeting was not called by the Gram Pradhan).
- (h) I was selected by a Health Inspector.
- (i) I was selected by consensus at a village meeting.
- (j) I was selected by a facilitator.
- (k) I was the only candidate.
- (l) I paid Rs 5,000 and only then was interviewed and got selected.
- (m) The PHC doctor selected me.
- (n) I was selected by AWW.
- (o) The ANM selected me.

The DPMUs had their version on the selection of ASHAs. For instance, one DPMU said, “The government has started ASHA scheme because ANMs can’t reach out to every village. With the help of ASHA, people will get total benefit of the health services. But his objective is still a distant goal as ASHA have not been selected in a transparent way. Political parties are playing a big role in selection and they are trying to place their own wives, daughter-in-laws and other relatives as ASHA. For example, at the Panchayat level, if Gram Pradhan has made his wife an ASHA, we all have to rethink how much work she will do for the community. On second thoughts, until the ASHA starts working unselfishly, the health system will not improve.”

In every district, the social audit reveals that ASHAs were lied to and told that they would be salaried employees of the government and in return were asked to pay anything between Rs 2,000 to 7,000 for their selection. One of the ASHAs said, “I had to sell off my cooking utensils and silver *payal* (anklet) that was around 250 grams as they (the ANM and Health Inspector) asked Rs 7,000 from me, but I was only able to give Rs 2,000 to them. They told me that I will get Rs 3,000 per month as salary.” Another ASHA had to borrow Rs 7,000 from the bank as she was told she would get paid Rs 3,500 per month and would have to give two months salary. The audit reveals that those who were not able to pay the money on time were sent for training a day late as punishment. The audit also states that ASHAs are selected from higher socio-economic groups, which will affect their work performance negatively as they would be less likely to visit poor, Dalits and underprivileged women and families.

Regarding the length of training, varied answers were given by the respondents. In all districts except for Barabanki, the training was provided for a maximum of 7 days. Whereas, in Barabanki, the selection of ASHAs was done between November 2006 and February 2007, but till date, no training has been undertaken.

The social audit also sought to understand why women wanted to become ASHAs. Under NRHM, the ASHA is envisaged as a community representative. Thus, it was important to know their motivations. Responses to this were as follows:

- (a) For the protection of the village.
- (b) For immunisation.

- (c) To accompany women to the hospital.
- (d) To work on the village's health-related problems.
- (e) For social work.
- (f) To help the masses avail the services of health facilities.
- (g) To look after the health of both mother and child.
- (h) "I had no work at home and I was not doing anything so I became an ASHA".
- (i) "I am very poor so I thought of making some money for my living".
- (j) "I used to work with the SIFSA. After leaving that job, there was no way to earn my bread, so I became an ASHA."
- (k) I had knowledge about health and a great desire to work, so I became an ASHA."

Regarding their roles and responsibilities, most of the ASHAs are involved in the Polio programme. When asked if they give advice to pregnant women and organise health meetings in the village, their answer was "No". Most of the ASHAs said they accompanied pregnant women to the hospital. None of the ASHAs has a *dawa peti* (drug-kit) and most do not even know how to treat minor illnesses.

There were a myriad of problems and recommendations that emerged during the ASHA interview. These are as follows:

Problems faced by the ASHAs

- (a) People in villages don't think we are important and they don't like to discuss their problems with us.
- (b) We don't have full knowledge about our work because our full 24 days of training has not been completed.
- (c) We are unclear about what we have to do and how we are supposed to do it.
- (d) The ANM takes money for immunisation.
- (e) The ANM does not cooperate with us. In fact, she treats us like her assistant.
- (f) The women don't get the JSY benefit, so there is a lot of pressure on us. The community thinks we have taken the money.
- (g) Our role is not clear.
- (h) We don't have any information about the JSY.
- (i) Problem in coordination with the ANM and AWW.
- (j) We visit every house and still don't get any money.
- (k) We lack practical knowledge.
- (l) The training was not very practical. It was bookish and not interactive.

- (m) Commuting every day was a problem. Food was not available and the training centre was poorly equipped.
- (n) We were not given any *dawa peti* (drug-kit).

The ASHAs were asked for suggestions for their effective involvement in the programme. They said:

- (a) After selection, the full 24 days of training is very important. This will help us understand our role and responsibilities.
- (b) Economic support is vital as this gives us incentive to work. We must get paid for our service as soon as possible.
- (c) People should be willing to share their problems with us.
- (d) The training should be held in the same area we live as we don't want to commute every day. It involves time and energy.
- (e) The PHC should provide us with clear guidelines as soon as possible.
- (f) The ANM should visit the village on a regular basis.
- (g) The ASHAs should get selected in open meetings.
- (h) The ASHA, AWW and ANM should meet every Wednesday at the AWC.
- (i) There needs to be better coordination between the AWW and ANM.
- (j) The ANM should give advice to the ASHA from time to time.
- (k) The training should be more practical.

Questions were asked from the community, ANM, AWW and Pradhan in order to know more about the role of the ASHA, selection and coordination with the ANM and AWW.

In various districts, the number of ASHAs, days of training and selection criteria differed from area to area and Pradhan to Pradhan. Most of the Pradhans were not clear about the ASHA's roles and responsibilities. They also expressed the need for better coordination between the ASHA, AWW and ANM and added that the ASHAs should be given a *dawa peti* (drug-kit) and trained as soon as possible.

c) Health Facility

In order to know about the status of health facilities, observation of centres, exit interviews and personal interviews were conducted. In each of the five districts, three Sub-Centres, two PHCs and one CHC were observed. Thus, a total number of 15 Sub-Centers, 10 PHCs and 5 CHCs were studied. Observations included: staff and administration, equipment and medicine, facilities available at the centre, the documentation system at the centre and RKS. Five superintendents of the CHC and seven medical officers of the PHC were personally interviewed. Some interview questions for the medical officers included information regarding maternal health, childbirth and delivery care, women's health problems, abortion facilities, facilities for other health-related problems and coordination between the

ASHA, ANM, AWW and RKS. Interview questions for the superintendent included general facility questions at the CHC level, names of the essential medicines and other related information.

i) Sub-Centre

The findings reveal that

- ❖ Not every Sub-Centre has a female health worker.
- ❖ Most of the centres do not have a male health worker.
- ❖ Not all of the centres are running in a *pukka makan* (brick houses).
- ❖ Not every centre has a safe drinking water facility.
- ❖ Most of the centres don't have a toilet facility.
- ❖ Most of the centres are not very clean.
- ❖ Most of the centres lack the following equipment:

BP machine, Weighing machine, Blood test kit, Test tube for urine test, Delivery facility, Fetoscope, ORS packets, Iron tablets, Vitamin A syrup, Copper-T facility.

But most of the centres **did** have:

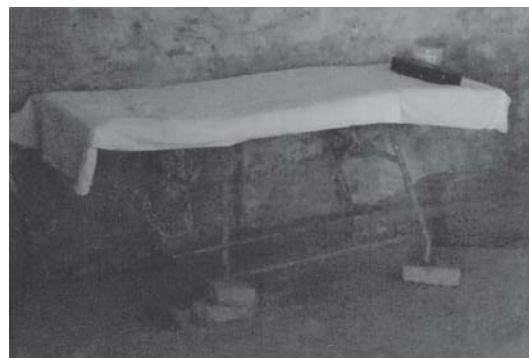
- ❖ Registration for pregnant women.
- ❖ Birth and death register.
- ❖ JSY register.

None of the centres had a notice board where working hours could be displayed. It has been observed that most of the centres have very poor infrastructure and are not up to the mark.

ii) Primary Health Centres

It was observed that all of the PHCs had notice boards and working hours of the PHC was written on it.

- * Most of the centres had a medical officer.
- * None of the centres has a staff nurse.
- * Most of the centres are running in government-owned buildings.
- * None of the centres were clean.
- * None of the centres had a 24-hour facility.
- * Most of the centres don't have a drinking water facility.
- * Toilets were not clean.
- * Most of the centres don't have an ambulance facility.



Examination table as seen in a Sub-Centre



Non functional hand pump

- * None of the centres have received untied funds.
- * None of the centres have a maintenance grant.
- * Most of the centres do not have OT facility.

Interview with the Medical Officers

The views and responses from them are listed below (district wise).

Banda

"The PHC doesn't have a doctor. Therefore, the compounder sometimes works as the doctor. The centre does not have electricity or water facility so we can only admit a patient for a day. In the village, one surgeon and female doctor must be appointed. We don't have any money for maintenance. The people from the CHC do everything, thus, we have to depend on them."

Barabanki

"In Barabanki district, the PHC does not have its own building, but some how we are managing. There isn't a facility for safe childbirth at the centre. There isn't even a medical facility at the centre."

Mirzapur

"There are not enough doctors in some places. Only one doctor is running the entire centre."

Muzaffarnagar

"Since there is a shortage of female health workers, women don't come here for child birth. The ANM comes to the centre once a week. Women talk about their problems only with the ANM and only the ANM knows about it."

iii) Community Health Centre

The conditions of most of the CHCs were not up to the mark. The findings reveal that centres do not have:

- ❖ Electricity
- ❖ Drinking water
- ❖ Toilet facilities
- ❖ Female doctors
- ❖ Specialists
- ❖ Surgeon
- ❖ Gynaecologist
- ❖ Paediatrician
- ❖ General Physician
- ❖ The centres don't have 24-hour services for child births (normal or complicated).
- ❖ A 24-hour facility where people can get medication.



Condition of PHC



Filthy toilets

However, the centres **do** have:

- ❖ Clean walls
- ❖ Brick building
- ❖ Exam tables
- ❖ Weighing machine
- ❖ Clean floors
- ❖ Clean surroundings
- ❖ Women health workers
- ❖ Boundary walls

The following are some direct observations from one centre in particular:

- ❖ The centre has a water facility but the tap is dry.
- ❖ It gets less than one hour of electricity.
- ❖ The centre is in a building, but the condition is very bad and the plaster is peeling off.
- ❖ Water from the tank is spilling everywhere.
- ❖ The dresser room is very dirty, the walls are covered with algae and the floors are broken.
- ❖ The centre has a lab but there is no lab technician.

Exit Interview with Outdoor Patients

In order to know the opinions of the patients regarding the health facility that they visited, a total of 13 exit interviews were taken from outdoor patients. The information was collected from the district hospitals and PHCs. A set of questions regarding cause of the visit, who recommended them, how much time it takes to get treated, do they have to pay for the services, the quality of the services, facilities that the centre provides and problems that are faced during treatment were asked.

The findings reveal that four out of 13 patients visited the centre for treatment related to fever, cold and cough. The rest came for following problems:

- ❖ Stone in kidney
- ❖ Blood sugar problem
- ❖ Treatment of TB
- ❖ Child birth
- ❖ Malaria
- ❖ Leprosy

When asked why they chose this particular facility, the answers were:

- ❖ My relative works here

- ❖ Someone recommended it
- ❖ I went to many places but didn't get relief so came here
- ❖ I heard that it is good.

When asked how much time it took to get treatment, five out of 13 patients said it usually takes long waiting hours, the rest of them said it takes one to two hours. Nearly half of the patients said they had to pay for the services besides the registration fee. The money was paid for the followings:

- ❖ IV fluid
- ❖ Blood test
- ❖ Ultrasound
- ❖ Urine test
- ❖ X-ray

Nearly all the patients said the centres provide medicine at the time of need but medicines are also prescribed from outside. In fact, personal expenditure on medicines ranges from Rs 50 to Rs 2,000 after a visit. All the centres have 24-hrs emergency services and almost all of them had waiting rooms. The behavior of the health provider was stated to be satisfactory by most of the patients, but a few were unhappy as money was demanded and they had to wait in long queues.

Asked about the problems they faced at the centre, they had the following answers:

- ❖ Have to pay money for correct blood and urine test report
- ❖ Delay in handing over the report
- ❖ Doctors are not available on time
- ❖ Medicines are not available
- ❖ The premises are very dirty
- ❖ No water
- ❖ No fan
- ❖ Have to buy medicines from outside
- ❖ Delay in releasing JSY money
- ❖ Not all tests are done at the centre
- ❖ Doctors don't listen
- ❖ Long waiting hours
- ❖ Harassment by the staff.

Indepth information on the condition of the facilities and providers' attitude was also collected from the patients. Some of the cases are:

Case No. 1

"I have come here to get treated for kidney stone. I have a relative who works here so I got all my tests done on government rates. The doctor is asking Rs 3,000 for the operation. I have been given only a few medicines from the centre and most of the medicines prescribed had to be purchased outside as they could only be found at one store."

Case No. 2

"My daughter is sick. She is admitted in the emergency department. I paid Rs 35 for emergency registration. I gave Rs 100 to the nurse. Others too are asking for money. My daughter is admitted for the last three days and till date I have spent Rs 2,000. I have had to buy medicines from outside. No doctor comes to see my daughter, when I ask the nurse; she scolds me and tells me to keep quiet."

d) Decentralisation of Panchayat and VHCs

To know about decentralisation at the Panchayat level, information was collected from PRI members, VHC members, AWW, ANM, and ASHAs. The findings reveal that in terms of decentralisation of the Panchayat, not much has been done. Most of the leaders are ignorant and uncertain about their roles and responsibilities.

Many of the villages do not have VHCs. Those who have VHCs expressed the following views:

- i) They have no information regarding their position
- ii) They are not called in any of the meetings and their signature is not taken
- iii) There is confusion about their roles and responsibilities

Most of the villages don't have any health plan. Furthermore, communities and villages do not have any information regarding the health plan. VHSCs are not running any health-related programmes. The village does not have a health register. The VHC doesn't supervise the work of ANM, MPW and AWW or take three-monthly reports on child births. The VHC doesn't discuss maternal and child health issues in its meetings. In addition, the committee has not yet received the untied fund.

Conclusion

The findings of this social audit in the five districts revealed alarming realities of the NRHM implementation. It is nearly impossible to achieve the NRHM goals and objectives if certain issues are not resolved as soon as possible. Two years have already passed and time is limited.

The ASHA who was supposed to act as one of the pillars of the rural health system has not established a relationship with the community due to lack of knowledge, training, clarity of objectives and other socio-economical reasons. The selection of ASHAs is not being done properly and not all norms have been taken care of.

Proper maternal healthcare is still out of reach in the state. Since 60 per cent of maternal deaths occur during the postpartum period, the care during this period is crucial. There is a great need for a health system where community and health personal collaborate in order to meet the goals of the NRHM. Health facilities at the Sub-Centre, PHC and CHC level are not up to the mark and hence unable to meet the needs of the people.

Recommendations

Based on the social audit, the following recommendations can be made:

Maternal Health

- (a) Cash assistance under the JSY should be given to women as soon as possible.
- (b) Advice must be given during pregnancy.
- (c) Postpartum care must be given.
- (d) Apart from TT injections, iron tablets should also be given.
- (e) The women must be informed about the JSY.
- (f) Women should be advised about safe births.
- (g) The childbirth must be conducted free of charge.

ASHA

- (a) All ASHAs should be trained as soon as possible.
- (b) The training should be residential which will save their time and energy.
- (c) Food quality and hygiene should be maintained at the training centre.
- (d) Training should be more practical.
- (e) The training must be pictorial not text-heavy.
- (f) Coordination between the ASHA, ANM and AWW is very much needed and there must be a meeting every week.
- (g) The ASHAs should be given money in return for their work as this will encourage them to work efficiently.
- (h) The ANM should not treat them as their assistant.
- (i) Selection of the ASHA should be done in open meetings.

Health Facilities

- (a) All vacant posts of doctors must be filled.
- (b) All centres should have female health workers.
- (c) All sub-centres should run in government-owned buildings.
- (d) Each centre should have a facility for safe drinking water.
- (e) Every centre should have clean toilets.
- (f) Every centre should have 24-hour service.
- (g) Every centre should have facilities for different tests and check-ups.

- (h) All PHCs should have facilities for surgery.
- (i) All health centres should get untied funds.
- (j) All centres should get maintenance grants as soon as possible.
- (k) All centres should have a 24-hour child birth facility.
- (l) All centres should be clean and hygienic.

Decentralisation of Panchayats and VHCs

- (a) Awareness regarding roles and responsibilities of PRI members should be given.
- (b) A regular meeting of PRI members, ASHA, ANM and others should be called.
- (c) Village health plans should be made as soon as possible.
- (d) Constitution of the VHCs should be done very soon.
- (e) Regular reporting should be done by the ANM, AWW and ASHA.

Endnotes

- 1 This paper is written by Sunita Singh of CHSJ (New Delhi) and Rajdev Chaturvedi, Gramin Punarnirman Sansathan (U.P.). The authors acknowledge the support of five organisations in conducting the social audit process in various districts of U.P. and in the preparation of this paper, namely, Tarun Vikas Sansathan (Banda), People's Action for National Integration (Barabanki), Gramya (Chandauli), Shikhar Prashikshan Sansathan, (Mirzapur) and Astitva (Muzaffarnagar).
- 2 NRHM status as on 31.4.07, published by Ministry of Health and Family Welfare as on 31 May, 2007.

Experiences with Janani Suraksha Yojana in Uttar Pradesh: Analysis of case studies by SAHAYOG and partners¹

Jashodhara Dasgupta, SAHAYOG

Introduction

Uttar Pradesh (UP) has among the highest maternal deaths in the country, with an MMR of 517 (2002-03)². According to this estimate, around 30,000 women needlessly lose their lives each year in UP alone, due to lack of appropriate and timely services. The government has made several programmes and schemes to address this. As part of the NRHM, the JSY³ has been in effect in UP from 31 August 2005, with a modification from 24 November 2006.⁴ The objective of the scheme⁵ was to reduce maternal mortality by providing a cash incentive to low income pregnant women to get registered with the public health system and to attend health institutions for childbirth, such as the Sub-Centre, PHC/CHC/FRU/ general wards of district and state hospitals or accredited private institutions. Currently, institutional deliveries in UP are increasing very slowly from 7.8 per cent in 1998 to 10.1 per cent in 2003 (Registrar General of India, *ibid*).

The logic behind providing the JSY was as follows: given that pregnancy registrations will enable tracking of outcomes, and maternal deaths occur especially during childbirth or immediately after, if all pregnant women are tracked by providers and motivated so that most deliveries occur in institutions, most women's lives can be saved through skilled care and appropriate management of the complications. However, this logic is based on the assumption that there is sufficient institutional capacity and willingness to handle the demand for maternal health services. This merits a close look at the demand and the supply of maternal health services in UP.

Extent of maternal health care in UP

In terms of the demands for institutional capacity, there are approximately 5-6 million births taking place in UP each year; apart from about 1 million complications⁶ in pregnancy, abortion, delivery and post-partum stage. In terms of facilities, UP has seven Government Medical Colleges & Hospitals, 53 District Hospitals, 13 Combined Hospitals, 388 CHCs, 823 Block PHCs, 2,817 Sub Block PHCs apart from 20,521 Sub-Centres. The private sector has four medical colleges & hospitals and 4,913 male / female hospitals/ nursing homes at district level (GoUP, 2005⁷). The question is whether these facilities can provide services for a total of roughly 7 million demands for institutional maternal services every year, including skilled or specialised services for the one million complications.

The quality and adequacy of services provided is also under question: according to the UP Facility

Survey⁸ conducted by GOI in 2002-2003, less than 20 per cent CHCs surveyed in UP had even 60 per cent of the basic equipment needed to handle an obstetric emergency, and barely a third had 60 per cent of the qualified medical staff required. In terms of accessibility, the State Planning Commission points out that – “the population covered by a Sub-Centre in the State is 7,080 and the average distance is 3.4 km. while the country average is 5,109 and 1.3 km. It is estimated that 11 per cent of people in UP are not able to access medical care due to locational reasons.” Further, “only 9 per cent of the State’s population actually makes use of this facility for treatment of ordinary ailments and people mostly have to depend on private healthcare.” (GoUP, 2005)

Assessment of the implementation of JSY in UP

The implementation of the JSY scheme in UP has been monitored by the group of organisations working within the WHRAP⁹ partnership in UP. These organisations, through the rural women’s network Mahila Swasthya Adhikar Manch in seven districts, were able to identify and conduct detailed documentation of around 20 cases of adverse maternal health outcomes (from October 2005 to April 2007) in which their maternal healthcare-seeking history was investigated in some detail. The documentation assessed:

- ❖ How far the JSY had succeeded in having pregnant women registered (and tracked)
- ❖ How far it motivated women to attend institutions for safe childbirth
- ❖ Whether the institutions are providing improved maternal health services within the NRHM.

A similar set of case studies¹⁰ was documented in 2003-04, when women’s organisations of six districts of UP had similarly identified twelve case studies that examined how maternal health services are being sought and received by rural women. The study of these twelve earlier case studies of 2003-04 showed denial of services and information to women, an absence of accountability of the public healthcare system, and women’s recourse to unregulated and unskilled private providers, all leading either to maternal death or prolonged ill-health. These earlier case studies may serve as a kind of baseline for the current post-NRHM assessment. A comparison of the two sets of cases can more clearly bring out the changes that have taken place within the state, since the NRHM was launched in 2005, the JSY scheme put into place, and additional workers like ASHAs were deployed.

Findings

The NRHM was meant to strengthen primary care in rural areas and improve women’s access. After it had been launched, these case studies indicate that in some cases, rural populations know about their entitlements (such as JSY), and families do decide to take women for institutional child birth. ASHA workers are present in certain villages, and some do accompany the women to the institutions. However, despite these changes at the level of community awareness, maternal health service provisioning has not significantly changed according to these case studies. The following is a detailed analysis of the cases that were documented.

Box 1

- ❖ Rani of Banda was pregnant for the ninth time (April 2007), yet received no special advice from the health provider who gave her TT injections. Although the ASHA took her to the CHC, the staff did not admit her or give her a referral, so finally she was compelled to have a home delivery and lost her baby for the third time. Despite having attended an institution, she did not get the JSY money. She developed a post-partum complication but there was no check-up by her local health provider.
- ❖ Maya of Kushinagar (Nov-Dec 2006) was seeking an abortion at the PHC, but was not given correct advice on where to get safe abortion services. As a result she died of post-abortion complications.
- ❖ Hazrat-un-Nisha of Azamgarh (September 2006) went to the PHC for her seventh delivery but like Rani and Maya she was a victim of the fatal lack of contraceptive information and services.

At the outset it appears several women do have contact with a provider as they get TT injections and are presumably registered with an ANM. However, women and/or their families in UP do not receive adequate information about routine care, danger signs or where to seek services in pregnancy, abortion, childbirth and post-partum stages. The women are also not receiving counselling or information about contraception which leads to unwanted multiple pregnancies, sometimes with fatal consequences. In the earlier set of pre-NRHM case studies as well, it is noted that accurate information about routine care, danger signs and where to seek health care services for pregnancy, abortion, delivery and post-partum stage was not provided to the woman and her family decision maker; neither was counseling provided on contraceptives: for example Ramadevi of Hardoi (June 2003) was in her seventh pregnancy when she lost her life (Women's Voices, 2004:15).

The withholding of accurate information on safe abortion is noteworthy as the ANMs appear to have a vested interest in misguiding women who are desperate to end the pregnancy. Abortion services are still being provided illegally by ANMs doing private practice. The ANMs demanded money with impunity from Nirmala of Baraipur as she went from one PHC to another: first Rs 500 for the abortion and then Rs 1,000 for treatment of complications. Maya of Kushinagar (December 2006) lost her life due to an unsafe abortion even though she went to her local PHC and then to the Mother and Child Health Centre. In the pre-NRHM case studies, the earlier case-studies also show that women lose their lives due to botched abortions provided by their local ANMs: -Munni of Kanpur and Radha of Sitapur both lost their lives after approaching their local PHC for abortion services (Women's Voices 2004: 18). Unfortunately, the earlier case-studies indicate that this silence extends even to complications arising from spontaneous abortions or miscarriages, which require medical care.

Box 2

- ❖ When Mamta of Chandauli went into labour (April 2006) her family took her to the PHC.
- ❖ When Babita of Chandauli went into labour in March 2007, the TBAs of the village took her to the PHC for referral and tried to prevent the ANM from demanding informal payments.
- ❖ When Nirmala of Azamgarh went into labour in February 2007, the family did call in an ANM from the local PHC.
- ❖ When Manju of Lucknow went into labour in January 2007, her family took her to the Maternal Health Centre (Urban PHC) twice, although it was quite far away.
- ❖ When Parvati of Banda started labour in November 2006, her family called in the local ANM Chintamani.
- ❖ When Jaydevi of Mirzapur had a retained placenta (October 2006) her family took her to the local PHC.
- ❖ Durmati (August 2006) and Susheela of Kushinagar were taken to the PHC by their families when they went into labour.

Despite this lack of information, the case studies above (Box 1 and 2) indicate that pregnant women's families do seek skilled providers and institutional care; either on their own, or as advised by TBAs (dais) or local informal (quack) providers. This belies the popular belief that it is the delay of decision-making at the level of the community or family that leads to maternal deaths. Similar behaviour has been noted in the earlier pre-NRHM case studies about Suman of Sitapur, Nankai and Fulmati of Lucknow, where the families although non-literate, knew the woman should be taken to a hospital for safe child birth (Women's Voices 2004: 19).

Box 3

- ❖ Susheela of Kushinagar (January 2006) visited a CHC, a private nursing home and a hospital during labour.
- ❖ Asha of Azamgarh (September 2006) visited three providers before she died of ante-partum complication.
- ❖ Meena of Mirzapur (October 2006) visited three providers while in labour.
- ❖ Alimun-nisha of Chandauli (October 2005) was treated by four providers for prolonged labour.
- ❖ Urmila of Mirzapur (August 2006) consulted three providers before she died of post-partum complications.
- ❖ Mamta of Chandauli (April 2006) was attempting to reach her third provider when she delivered her dead baby on the road.

It is of concern that families do not have accurate information on where to seek care in emergency or when complications occur and this has not changed even after the NRHM has been launched. The first provider contacted is often the one not capable of handling the complication; more often than not it is a local ANM or private doctor/quack. Thus precious time is wasted moving the women from one provider to another, in a situation of lack of proper transport and resources. In the pre-NRHM case studies, the case of Somari Devi of Mirzapur is a tragic story where even with scarce resources, she attempted to access five providers for treating her post-partum complication, and yet she died (Women's Voices 2004:17).

Box 4

Quality of institutional care

a. Refusal to admit into the institution

- ❖ Rani of Banda (April 2007) was an obvious high-risk case in her ninth delivery yet the CHC staff refused to admit or refer her.
- ❖ Gita and Rani of Banda had to deliver their babies at home since the CHC staff refused to admit them in labour.
- ❖ Manju of Lucknow and Mamta of Chandauli had to deliver their babies on the street despite attending hospitals for delivery.

b. Oxytocin injections

Oxytocin injections were possibly given during labour to several women without medical supervision by ANMs – Sahidun (Feb 07), Alimun-nisha of Chandauli (October 05), Savita of Chandauli (February 2007), Nirmala of Azamgarh (Feb 2007), Parvati of Banda (November 2006) and many others.

c. Lack of diagnostic skill and absence of timely referral

- ❖ 18-year-old Nirmala of Azamgarh (Feb 2007) and Jaydevi of Mirzapur (August 2006) both died because the ANM was unable to recognize a life-threatening complication (retained placenta) or refer it in time; in both cases the ANMs preferred to manually remove the placenta without anaesthesia, leading to almost immediate death.
- ❖ Hazrat died after her seventh delivery at the PHC because the providers were unable to refer her in time as a high-risk case.
- ❖ Asha of Chandauli died because the ANM consulted was unable to recognize her life-threatening ante-natal complication or refer her in time.
- ❖ Maya of Kushinagar died (December 2006) because the PHC was unable to treat her post-abortion complication.
- ❖ Savita and Mamta of Chandauli both lost their babies because the ANM was unable to recognize that labour had started.
- ❖ Parvati of Banda lost her baby because the ANM and the local informal provider (quack doctor) gave her an IV line for four hours causing shivering and discomfort, but not facilitating the delivery.

When providers are consulted or when women do reach institutions, they are either denied services, or the available services are largely unskilled or irrational. There is also a high incidence of the use of an injection for the woman in labour, which is possibly oxytocin. There continues to be poor diagnosis and management of complications in pregnancy, abortion, childbirth and the post-partum stage. Women continue to die of conditions that could have been managed if the providers had been prepared, willing and skilled. Unfortunately, this is similar to the pre-NRHM scenario where routine and emergency services for pregnancy, abortion, child birth and post-partum stage were not available, accessible, affordable, appropriate or sensitive. In addition, they were neither effective in saving lives nor ethical.

Box 5

Informal payments

- ❖ Babita of Chandauli (March 2007) was asked for Rs 500 as a share of the JSY money by the ANM at the PHC.
- ❖ Sharmila of Kushinagar was asked for Rs 500 by the ANM at the PHC for her delivery but never given the JSY.
- ❖ Jaydevi of Mirzapur (August 2006) was asked for Rs 600 by the ANM at the PHC to manage the retained placenta.
- ❖ Nirmala of Kushinagar was asked for Rs 500 by the ANM at the PHC to do her abortion and then Rs 1,000 by another ANM to treat post-abortion complications.
- ❖ Durmati of Kushinagar was asked for Rs 1,000 by the ANM at the PHC for doing her delivery.
- ❖ Alimun-nisha of Chandauli (October 2005) was asked for Rs 5000 by the doctor at BHU before he took her case.
- ❖ Manju of Lucknow (January 2007) was asked for Rs 10,000 by the doctor at the urban maternal health centre before her case could be admitted to the hospital.

Despite the trouble women take to reach the institutions for maternal health services, the demand for informal payments continues to be fairly high. Whether it is a normal child birth, a post-partum complication, an abortion or an operation, women are invariably expected to pay providers. Families who earn daily wages for a living cannot afford these payments and are pushed deep into debt when they try to access maternal health services, as with the families of Savita and Alimun. The demand for informal payments is also linked to denial of services, as with Manju (Lucknow).

It is an unfortunate repetition of the pre-NRHM scenario, where Nankai and Fulmati of Lucknow were denied health services and delivered babies outside the hospital as they could not meet the demand for informal payments. Bhori of Chitrakoot was denied services for her post-miscarriage complications and was verbally abused, Suman of Sitapur received physical and verbal abuse during her hospital delivery apart from demands for payments. As Suman said, these traumatic experiences of being asked for large sums of money when it is a desperate matter of life and death will deter future users from

approaching state health providers for maternal complications (Women's Voices 2004:19). Thus provider demands for informal payments enhance future risk of women dying at home without accessing skilled care.

Box 6

- ❖ Rani (April 2007) and Shyama (Nov 2006) of Banda both developed fever after delivery; both lost their babies.
- ❖ Rajmati of Banda has been bleeding since January 2007 after her still-birth.
- ❖ Mamta of Chandauli (April 2006) had bleeding and weakness after delivering a breech baby on the road.

Women who have had contact with providers for routine ANC (TT injections) do not receive proper PNC and follow-up, and are often compelled to seek post-partum care from private providers at their own cost. This indicates that the pregnant women have not been tracked for recording the outcome of the pregnancy, and their contact with the provider is an opportunity lost. Those women who had no contact with a provider during their pregnancy (for routine ante-natal care) also lost their lives, like some of those who did have contact with a provider: Asha of Azamgarh (September 2006) and Nanhaki of Mirzapur (August 2006) both developed ante-natal complication and finally died; Urmila of Mirzapur (August 2006) developed post-natal complications after her fourth delivery and died.

Conclusion

The above analysis of case-study documentation was meant to assess:

- ❖ How far the JSY has succeeded in having pregnant women registered (and tracked)
- ❖ How far it motivated women to attend institutions for safe childbirth
- ❖ Whether the institutions are providing improved maternal health services within the NRHM.

The case studies indicate that even after the launch of the NRHM and the implementation of the JSY scheme, the contact with providers for TT injections is not leading to registration and counselling for safe child birth or tracking fatal outcomes or near-misses. The ANMs continue to withhold information and engage in illegal and fatal practices, and are still not referring the women to institutions.

Even a year and a half after it has been announced in UP, the JSY is still not reaching all women. Therefore, it is not clear to what extent it is motivating women to attend institutions for safe childbirth. However, the communities appear to be readily prepared to attend institutions to ensure safe birth or safe abortion (see Box 2 above).

At the level of institutional willingness to handle deliveries, there are still cases of women being denied maternal healthcare although they arrive at institutions for child birth. The institutions are not providing skilled care and appropriate management including timely referral of complications. The private sector continues to be totally unregulated and provides irrational therapy. The demand for

informal payments continues to be fairly high. Poor diagnosis and management of complications in pregnancy, childbirth and the post-partum stage also persists. Abortion services are still being provided illegally by ANMs doing private practice. In addition, there is a high incidence of the use of an injection for the woman in labour, which is possibly oxytocin. Women continue to die of conditions that could have been managed if the providers had been prepared, willing and skilled.

Recommendations to strengthen maternal health service provision within NRHM

Based on the analysis of case studies mentioned above, the following recommendations are suggested in order to strengthen the provision of maternal health services under the NRHM:

1. At the point of first provider contact (such as routine ANC), the following information may be given to women and their families:
 - ❖ Entitlements under NRHM to women and their families, including the JSY and support of the ASHA.
 - ❖ Comprehensive information on safeguarding maternal health; this should include adequate information about routine care and danger signs.
 - ❖ Where to seek appropriate services in pregnancy, abortion, child-birth and post-partum stages.
 - ❖ Information about the dangers of oxytocin used without medical supervision to hasten child birth.
 - ❖ Couples and women also need counselling, information and services about contraception.
2. Widespread information dissemination on safe abortion – its legality and where safe services are available
3. Improvement of the quality of institutional care, including –
 - ❖ Systems of community monitoring of the services, facilities, service providers and feedback mechanisms.
 - ❖ Community monitoring of demands for informal payments, irrational drug use etc.; strict departmental action upon feedback.
 - ❖ Periodic social audit with the involvement of people's representatives.
 - ❖ Skill-building of ANMs and PHC staff to recognize and deal with complications and management of timely referral.
4. Creating a method to track each pregnancy and follow it through to six weeks after child birth or post-abortion, recording of adverse outcomes on a no-fault basis (ANMs will not disclose information that leads to punitive action).

Endnotes

- 1 This paper is written by Jashodhara Dasgupta (SAHAYOG, Lucknow). The paper acknowledges the contributions made by the partner organizations of SAHAYOG across several districts of UP in collecting the information in various districts of UP. The effort was supported by the WHRAP project managed by ARROW and supported by DANIDA.
- 2 Registrar-General India, Report of the Technical Group on Population Projections constituted by the National Commission on Population, Office of the Registrar General and Census Commissioner India, 2006.
- 3 This translated, literally, means 'maternity protection scheme'.
- 4 The related GO was passed by the Government of UP (GoUP) on 24 November 2006 ref no. 2916/5-9-06-9 (113)/05 signed by A.K. Mishra Principal Secretary GoUP.
- 5 It is described as "a safe motherhood intervention under the NRHM being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women" - As seen on the website of the MoHFW of the GOI on 7 April 07, http://mohfw.nic.in/dofw_per_cent20website/JSY_features_FAQ_Nov_2006.htm
- 6 Based on a rough estimate that 15 per cent of all pregnancies have complications.
- 7 Department of Planning (GoUP), Note on Health Sector in UP, Government of Uttar Pradesh, December 2005.
- 8 Facility Survey National Report under RCH Project Phase II 2003 (published on Internet at IIPS website on RCH – seen on 15 April 2007) - http://www.rchindia.org/fs_india.htm
- 9 WHRAP is the Women's Health and Rights Advocacy Partnership, South Asia, a project partnership anchored by ARROW Malaysia. SAHAYOG is one lead partner in India.
- 10 Women's Voices, KRITI and other organizations, Lucknow (SAHAYOG: unpublished) 2004, prepared towards the National Shadow Report for CEDAW.

Annexure I

National Stakeholders Consultation on two years of the NRHM

August 8, 2007

List of Participants

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Annexure-II

Glossary

AAI- Australian Aid International
AGCA- Advisory Group on Community Action
AIDS- Acquired Immuno Deficiency Syndrome
ANC- Ante Natal Care
ANM- Auxiliary Nurse Midwife
ANMTC- Auxiliary Nurse Midwife Training Centre
ARROW- Asian-Pacific Research and Resource Centre for Women
ASHA- Accredited Social Health Activist
AWC- Aangan Wadi Centre
AWW- Aangan Wadi Worker
AYUSH- Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BEmOC-Basic Emergency Obstetric Care Services
BHU- Benaras Hindu University
BMOC -Basic Medical and Obstetric Care
BOT- Build Operate and Transfer
BP- Blood Pressure
BPL- Below Poverty Line
BVHA- Bihar Voluntary Health Association
CBO- Community Based Organisation
CDMO- Chief District Medical Officer
CEDAW- Convention on Elimination of all forms of Discrimination Against Women
CEmOC- Comprehensive Emergency Obstetric Care

CGHS- Central Government Health Scheme
CHC- Community Health Centre
CHSJ- Centre for Health and Social Justice
CINI- Child In Need Institute
CMHO- Chief Medical and Health Officer
CMO- Chief Medical Officer
CNA- Community Needs Assessment
CSO- Civil Society Organisation
CSR- Corporate Social Responsibility
DANIDA- Danish International Aid Agency
DDK- Disposable Delivery Kits
DFID- Department for International Development, Overseas Development Organisation of UK
DH- District Hospital
DHAP- District Health Action Plan
DHS- District Health Society
DM- District Magistrate
DPMO- District Programme Management Officer
DPMU- District Programme Management Unit
DTC- District TB Centre
EAG- Empowered Action Group
EC- European Commission
EDD- Expected Date of Delivery
EPC- Empowered Programme Committee
EQUIP- Enhancing Quality of Primary Health Care
ESI- Employees State Insurance
EUSPP- European Union State Partnership Programme
FGD- Focussed Group Discussion
FRU- First Referral Unit
FYP- Five Year Plan
GAIN- The Global Alliance for Improved Nutrition
GAVI- The Global Alliance for Vaccines and Immunisations

GDP- Gross Domestic Product

GFATM- The Global Fund to fight AIDS, Tuberculosis and Malaria

GMP- Good Manufacturing Practices

GoI- Government of India

GoO- Government of Orissa

GoUP- Government of Uttar Pradesh

GP- Gram Panchayat

GPEI- The Global Polio Eradication Initiative

GTZ- Deutsche Gesellschaft für Technische Zusammenarbeit (German Development Organization)

HFW- Health and Family Welfare

HHDI- Health Centred Human Development Index

HMC- Hospital Management Committee

HR- Human Resource

IAVI- The International AIDS Vaccine Initiative

ICPD- International Conference on Population and Development

IDA- International Development Association

IEC- Information, Education and Communication

IFA- Iron Folic Acid

IMR- Infant Mortality Rate

INC- Intra Natal Care

INGO- International Non Governmental Organization

IPD- In-Patient Department

IPHS- Indian Public Health Standards

IV- Intravenous

JBSY- Janani aur Bal Suraksha Yojna

JSA- Jan Swasthya Abhiyaan

JSY- Janani Suraksha Yojna

KCSD- Kalinga Centre for Social Development

KIIT- Kalinga Institute of Industrial Technology

LHV-Lady Health Visitor

LPS- Low Performing State

MBBS- Bachelor of Medicine and Bachelor of Surgery
MCH- Mother and Child Health
MDG- Millennium Development Goals
MHD- Monthly Health Day
MIS- Management Information System
MLA- Member of Legislative Assembly
MMR- Maternal Mortality Rate
MMU- Mobile Medical Units
MNGO- Mother Non Governmental Organisation
MO- Medical Officer
MoHFW- Ministry of Health and Family Welfare
MP- Madhya Pradesh
MP- Member of Parliament
MPHW- Multi Purpose Health Worker
MPW- Multi Purpose Worker
MRP- Maximum Retail Price
MSG- Mission Steering Group
MTP- Medical Termination of Pregnancy
NDA- National Democratic Alliance
NFHS- National Family Health Survey
NGO- Non Governmental Organisation
NIHFW- National Institute of Health and Family Welfare
NNMR- Neo-Natal Mortality Rate
NPP- National Population Policy
NRHM- National Rural Health Mission
NVBDCP- National Vector Borne Diseases Control Program
OCP- Oral Contraceptive pill
OECD- Organisation for Economic Co-operation and Management
OP- Out Patient
OPD- Out Patient Department
ORS- Oral Rehydration Solution

OT- Operation Theatre

PARIKAS- Parivar Kalyan Salahakar Samiti

PATH- Program for Appropriate Technology in Health.

PDS- Public Distribution System

PFI- Population Foundation of India

PHC- Primary Health Centre

PIP- Programme Implementation Plan

PMO- Prime Minister's Office

PMU- Programme Management Unit

PNC- Post Natal Care

PoA- Plan of Action

PPI- Public Private Initiative

PPP- Public Private Partnership

PRHW- People's Rural Health Watch

PRI- Panchayati Raj Institutions

RCH- Reproductive and Child Health

RGI- Registrar General of India

RH- Reproductive Health

RHIME- Representative/ Re-sampled/ Routine Household Interview of Mortality with Medical Evaluation

RKS- Rogi Kalyan Samiti

RMP- Registered Medical Practitioner

RPR- Rapid Plasma Reagin

RRC- Regional Resource Centre

RTI- Reproductive Tract Infection

SBA- Skilled Birth Attendant

SC- Scheduled Caste

SHC- Sub-Health Centre

SHG- Self Help Group

SHRC- State Health Resource Centre

SHS- State Health Society

SIFPSA- State Innovations in Family Planning Project Service Agency

SIHFW- State Institute of Health and Family Welfare

SIP- Sector Investment Programme

SMU-Static Medical Unit

SRS- Sample Registration System

ST- Scheduled Tribe

STG- Standard Treatment Guideline

STI- Sexually Transmitted Infection

SUTRA- Society for Social Uplift Through Rural Action

TB- Tuberculosis

TBA- Traditional Birth Attendant

TT- Tetanus Toxoid

UN- United Nations

UNFPA- The United Nations Population Fund

UNICEF- The United Nations Children's Fund

UP- Uttar Pradesh

UPA- United Progressive Alliance

USA- United States of America

VHC- Village Health Committee

VHSC- Village Health and Sanitation Committee

W. Bengal- West Bengal

WB- World Bank

WHO- World Health Organisation

WHRAP- Women's Health and Rights Advocacy Partnership