# Empowering the Poor

## for

## Claiming Their Health Rights

Social Audit of NRHM in Two States

A REPORT

*Report by:* **Sunita Singh, Abhijit Das, Jyoti Gupta**

*Cover Design:* **Anand Pawar** (SAMYAK, Pune)

*Printed at:* **Impulsive Creations** - 9810069086


C/o Dr. A. Das, 3C, H Block, Saket, New Delhi - 110 017.
Phone: 91-11-40517478; Telefax: 91-11-26536041
Email: chsj2006@gmail.com
Website: www.chsj.org

# Contents

# Preface

The process of Social Audit has gained prominence in India after the series of public hearings around the implementation of block level plans brought out the huge extent of financial irregularities that were part of the income generation schemes at the block level. Mazdoor Kisan Shakti Sangathan (MKSS) in Rajasthan have been pioneers in using this methodology in raising the awareness of the community about their (communities') entitlements that were not reaching them. This Social Audit process lead to the demand for greater transparency from the state regarding information relating to development works. This demand led to the National Campaign on Right to Information and subsequently the Right to Information Act was passed by the Parliament. This journey of a demand resulted in the passage of a law is unique process and it can be said that this demonstrates the success and the power of the process of Social Audit.

Subsequently the Social Audit methodology has been tried out in the health sector with pioneering work being done by SAHAYOG and Healthwatch Forum in UP around population policies and maternal health. SATHI -CEHAT ( In Maharashtra) and Jan Swasthya Abhiyan ( all over the country) have used this methodology for broad range of issues relating to delivery of services and for articulating the right to health. The National Human Rights Commission has also partnered in this process, acting as the tribunal and has passed orders for protecting the right to health care. The National Rural Health Mission has an embedded mechanism for conducting social audits through the incorporation of Community Monitoring and Public Hearing mechanisms within its Implementation Framework.

The Centre for Health and Social Justice (CHSJ) had been already engaged in a process of facilitating community level feedback on the implementation of the NRHM, from the very first year of its inception. A two state, eight districts Social Audit of the implementation of NRHM was conceptualized in the context of this earlier work and the built in provisions within the NRHM. This report shares the findings of the Social Audit process in the two states as well as presents the methodology used in the form of a Toolkit. Detailed district reports were also prepared for sharing at the district level and can be provided on request. The Social Audit process has also led to some immediate and short-term results at the local level and we have also shared a brief glimpse of this impact in the report. These results clearly indicate that Social Audit initiates a process of community empowerment and 'passive rights holders' become active 'rights claimants' and the status-quo and hierarchy between provider and citizen gets challenged. However there are also examples of increased efficiency in the system.

The second part of the report provides details of the tools and methodology that was used in the process of conducting Social Audit in the eight districts. The tools were prepared keeping in mind the promises made within the NRHM for its eighteen high focus states, especially around maternal health (including Janani Suraksha Yojna), ASHA, Untied Funds, Village Health and Sanitiation Committees and upgradation of facilities. These can be used as ready-made tools for conducting Social Audit in other districts of the country as well. We encourage civil society groups to adapt these tools for use in their own social reality health related realities.

We look forward to forward to receiving your feedback on the use of this methodology.

# Acknowledgements

At the very outset we would like to acknowledge the inspiration that we have received from the Social Audit and Jan Sunwai processes of MKSS which have been instrumental in our attempting to recreate a similar methodology in the health sector. We would also like to acknowledge our friends in the health sector who have used this methodology earlier and have freely shared their experiences with us. This includes Jashodhara Dasgupta and her colleagues at SAHAYOG, Lucknow, Abhay Shukla and his colleagues at SATHI - CEHAT, Pune, Narendra Gupta and his colleagues in PRAYAS, Chittorgarh. We would also like to thank Madhu Bala-Nath and her colleagues of IPPF SARO, New Delhi for providing an opportunity to work with IPPF to develop the Social Audit methodology in the context of its work on Sexual and Reproductive Health and Rights in South Asia. We would also like to acknowledge the partnership and support of Healthwatch Forum who brought into this process the strength of their earlier experiences. We wish to thank all our partners in this process which includes among others;

Rajdev Chaturvedi for taking the responsibility to coordinate the process across the five districts across the breadth of Uttar Pradesh

Sunita Shahi for not only providing inspiration to others with her earlier experiences but for supporting the process in Uttarakhand

Bindu and her colleagues in Gramya

Hira and her colleagues in Mahila Kalyan Sanstha

Prakash and his colleagues in PANI

Uma and her colleagues in Tarun Vikas Sansthan

Sandhya and her colleagues in Shikhar Prashikshan Sansthan

Rehana and her colleagues in Astitva Samajik Sansthan

Dileep and his colleagues in Mahila Kalyan Sansthan

Utkarsh Sinha, Dharmendra Rai and other colleagues of Healthwatch Forum

Shakuntala, Susheela and others from SAHAYOG

We would also like to thank Oxfam ( India ) Trust and in particular B Muralidharan and Avinash Kumar for supporting us in this endeavour.

Sunita Singh has been the anchor of the Social Audit process providing inputs and collating information from across eight districts. Without her constant vigilance and support the process would never have been complete. Jyoti Gupta stepped in when necessary assisting in coordinating the processes in Uttarakhand and in collating the review of short term results. All colleagues at CHSJ deserve our gratitude for supporting the study team and meeting all their requests within the stipulated time.

Thank you all!

**Dr. Abhijit Das** (Director)
Centre for Health and Social Justice - New Delhi

Oct 2007

# Part 1
# Social Audit in NRHM - Report from Two States

Part 1

# Social Audit in NRHM - Report from two states

## Introduction to Social Audit in NRHM

The National Rural Health Mission (2005-12) was launched in April 2005 by Government of Indai (GOI). It seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. The novel attribute of the National Rural Health Mission (NRHM) is that it emphasizes upon continuous public vigilance in terms of 'Social Audits'. The basic objective of Social Audit has been to ensure public accountability in the implementation of the health projects and policies at the grass roots level. Most simple way of Social Audit is a public assembly where all the details of the project are scrutinized. Therefore, Social Audit is an ongoing process through which the potential beneficiaries and other stakeholders of a development or welfare project are involved at every stage i.e. from planning to implementation, monitoring and evaluation.

**What is Social Audit**

Social Audit is a process through which an organization or agency is able to understand the social impact of its activities and programmes. This impact can be within its own organizational sphere or in the larger society. A Social Audit process is usually initiated by the management of an organization, to understand its social effectiveness and impact, much like a financial audit. Social Audit requires the participation of stakeholders, which can include employees, volunteers, clients, and the community at large.

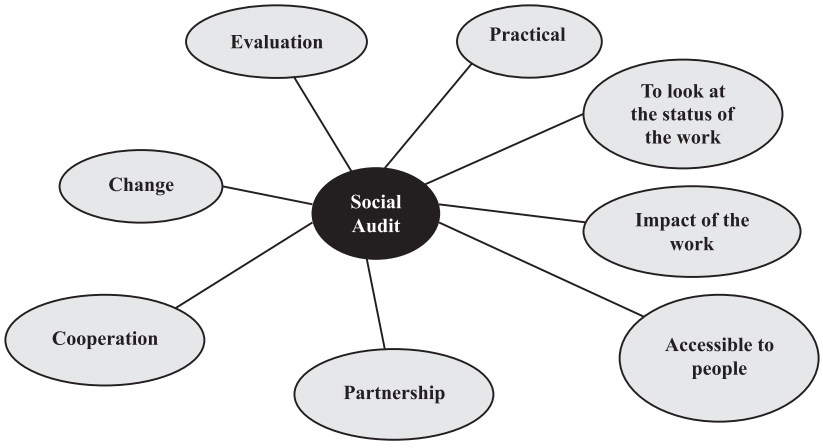
The practice of Social Audit has been further refined in India by various community based groups ( eg. MKSS social audits through 'Jan Sunwai' or public hearing) where by it has become a mechanism for communities to gain a greater understanding and control over the processes that influence their lives, especially government development projects.

In a Social Audit process an audit team conducts an investigation into the functioning of the organization as well as into the community at large to understand the needs of the community as well as the satisfaction of those needs. This investigation is conducted using a set of simple tools that are easy to administer and interpret. The tools for a Social Audit, can be developed by adapting PRA tools and the Self Assessment Tools used in the QoC project. The results of the Social Audit are jointly shared and become the basis for further planning and mid-course corrections.

The advantages of the Social Audit are as follows:

1. Social Audit empowers marginalised section of society specially Women, Dalits and Adivasis
2. Social Audit strengthen local democracy
3. Social Audit prepares the community on participatory local planning
4. Social Audit encourages community participation
5. Social Audit promotes collective decision making and sharing responsibilities among community
6. Social Audit develops human resources and social capital

### Components of Social Audit



**What are Health Rights**

According to the World Health organization (WHO) "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..."

As with every human right, the right to health entails the following obligations[1]

**Respect -** the obligation to respect requires governments to refrain from interfering directly or indirectly with the enjoyment of the right to education

**Protect -** the obligation to protect requires governments to prevent third parties, such as corporations, from interfering in any way with the enjoyment of the right to education

**Fulfill -** the obligation to fulfill requires governments to adopt the necessary measures to achieve the full realization of the right to education

**What are the minimum requirements?[2]**

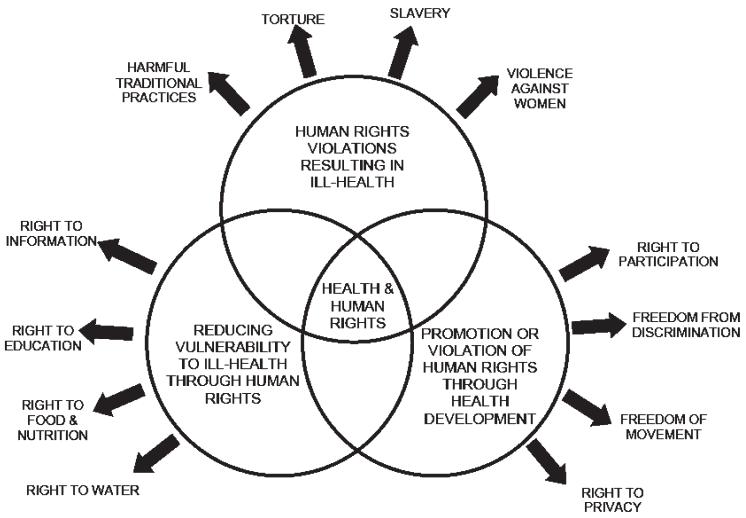
**Availability -** public health care facilities must exist in sufficient quantity. At a minimum, this includes safe drinking water, adequate sanitation, hospitals and clinics, trained medical personnel receiving domestically competitive salaries, and essential drugs

**Accessibility -** health care must be physically and economically affordable. It must be provided to all on a non-discriminatory basis. Information on how to obtain services must be freely available.

**Acceptability -** all health facilities must be respectful of medical ethics, and they must be culturally appropriate

**Quality -** health facilities, goods, and services must be scientifically and medically appropriate and of good quality. At a minimum, this requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe water and adequate nutrition (within the facility)

**Linkages between Health and Human Rights[3]**




## NRHM Healthrights and Social Audit

The National Rural Health Mission (NRHM) has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The mission seeks to provide accessible, affordable and quality health care which is accountable at the same time respective to the need of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance.

**Principles of the NRHM**

- Promote equity, access, efficiency, quality and accountability in Public Health Systems
- Enhance People oriented and community-based approaches
- Decentralize and involve local bodies
- Ensure Public Health Focus
- Recognize value of traditional knowledge base of communities

1 Taken from Centre for Economic and Social Rights website - http://cesr.org/health

2 Taken from Centre for Economic and Social Rights web site- http://cesr.org/health

3 Adopted from http://www.who.int/hhr/en/

- Promote new innovations, method and process development

**Core Strategies of NRHM**

- PRI- To own,control and manage public health services
- Female Health Activist (ASHA)- Promote access to improved healthcare at household level
- Health Plan - For each village through Village Health Committee
- Strengthening SCs,PHCs and CHCs- more MPWs, more funds, improved standards
- Inter-sectoral District Health Plan- Prepared by the District Health Mission, including drinking water sanitation & hygiene and nutrition
- Technical Support
- Evidence based planning, monitoring and supervision

**Concrete Service Guarantees in NRHM**

- Skilled attendance at all Births
- Emergency Obstetric care
- Basic neonatal care for new born
- Full coverage of services related to childhood diseases / health conditions
- Full coverage of services related to maternal diseases / health conditions
- Full coverage of services related to low vision and blindness due to refractive errors and cataract
- Full coverage for curative and restorative services related to leprosy
- Full coverage of diagnostic and treatment services for tuberculosis
- Full coverage of preventive, diagnostic and treatment services for vector borne diseases
- Full coverage for minor injuries / illness (all problems manageable as part of standard outpatient care upto CHC level)
- Full coverage of services inpatient treatment of childhood diseases / health conditions
- Full coverage of services inpatient treatment of maternal diseases / health conditions including safe abortion care (free for 50% user charges from APL)
- Full coverage of services for Blindness, life style diseases, hypertension etc
- Full coverage for providing secondary care services at Sub-district and District Hospital
- Full coverage for meeting unmet needs and spacing and permanent family planning services
- Full coverage of diagnostic and treatment services for RTI/STI and counseling for HIV - AIDS services for adolescents
- Health education and preventive health measures

**Monitoring outcomes of the Mission**[4]

The NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring.

Right to health is recognized as inalienable right of all citizens as brought out by the relevant rulings of the Supreme Court as well as the International Conventions to which India is a signatory. As rights convey entitlement to the citizens, these rights are to be incorporated in the monitoring framework of the Mission. Therefore, providing basic Health Services to all the citizens as guaranteed entitlements will be attempted under the NRHM.

4 National Rural Health Mission - Meeting people's health needs in rural areas; frame work of implementation 2005-12; Ministry of Health & Family Welfare - Govt. of India

**Role of Civil Society Organizations**
The Civil Society Organizations are critical for the success of NRHM. The Mission has already established partnerships with NGOs for establishing the rights of households to health care. These include

- As stakeholders in institutional arrangements at all levels
- Member of Task Groups and Standing Committees
- Provision of Training, BCC and Technical Support for ASHAs/DHM (District Health Mission)
- Health Resource Organizations
- Service delivery for identified population groups on select themes for Monitoring, Evaluation and Social Audit

## Community Monitoring Framework within NRHM[5]

Community Monitoring is an important component of incorporating a rights based framework within NRHM. In addition to traditional MIS based monitoring and periodic surveys NRHM provides for regular community monitoring. The Social Audit process can be seen as a community sponsored monitoring mechanism beyond the formal NRHM framework. The frameworks against which community monitoring may be done are provided within the NRHM Implementation framework and these are as follows:

- Village Health Plan, District Health Plan
- Entitlements under the Janani Suraksha Yojna (JSY)
- Roles and responsibilities of the ASHA
- Indian Public Health Standards for different facilities like SubCentres, PHC and CHC
- Citizens Charter

These frameworks were used as far as possible in designing the tools and formats for the Social Audit process.

There are also provisions for committees at different levels as described below.

**At the CHC level**
A Charter of Citizen's Health Rights would be prominently displayed outside all the CHCs. While the Charter would include the services to be given to the citizens and their rights in that regard, information regarding grants received, medicines and vaccines in stock etc. would also be exhibited. Similarly, the outcomes of various monitoring mechanisms would be displayed at the CHCs in a simple language for effective dissemination. The transparency would help the community to better monitor the health services.

**PHC Health Monitoring and Planning Committee**
Ensure that the Charter of citizen's health rights is disseminated widely and displayed out side the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action.

**Block Health Monitoring and Planning Committee**
Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The committee may also recommend corrective measures to the district level.
*Constitution of the Block committee*
20% members should be representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the block, and involved in facilitating monitoring of health services.

**State Health Monitoring and Planning Committee**
Institute a health rights redressal mechanism at all levels of the health system, which will take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports

5 National Rural Health Mission - Meeting people's health needs in rural areas; frame work of implementation 2005-12; Ministry of Health & Family Welfare - Govt. of India

***Composition of State Health Monitoring and Planning committee***

20% members would be representatives from State health NGO coalitions working on Health rights, involved in facilitating Community based monitoring

***District Health Monitoring and Planning Committee***

Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal.

*Constitution of the District committee*

20% members should be representatives from NGOs / CBOs and People's organizations working on Health rights and regularly involved in facilitating Community based monitoring at other levels (PHC/block) in the district

## Social Audit in Uttar Pradesh (U.P.) and Uttrakhand

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.

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

### *a) Findings from Uttar Pradesh*

The focus was on four main issues:

*a) Maternal Health*

*b) ASHA*

*c) Facilities*

*d) 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

i) 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.

FGD in a village

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 tables, 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 money.

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 (Women who delivered six months preceding interview)***

**Care During Child birth**

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

i) 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.

**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.

**Awareness of JSY**

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 was 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 interview, 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."

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."

3: A new mother said, "On January 10, 2007, my baby was born on a verandah. 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, 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 on a verandah. It was very cold that night and I've been sick ever since. In fact, my treatment is still going on."

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

One of the key strategies under the NRHM is having a Community Health Worker i.e. ASHA for every village with a population of 1000. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.

**Roles and Responsibilities of ASHA**

The guideline of NRHM says that ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

In order to see whether or not ASHAs are functional in the community, thus 10 selected ASHAs and five candidates (those who applied to become ASHA and were not selected) were interviewed in five districts for the purpose of Social Audit. 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 AWW 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.

**Selection of ASHAs**

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."

**Payment of ASHAs**

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.

**Training of ASHAs**

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

**Motivation to become ASHA**

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, 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."

**Roles and Responsibilities of ASHAs**

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 AHSAs 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.

**Community/AWW/Padhan/ANM perception:**
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-center 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

Sub Centre

Primary Health Centre

- 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

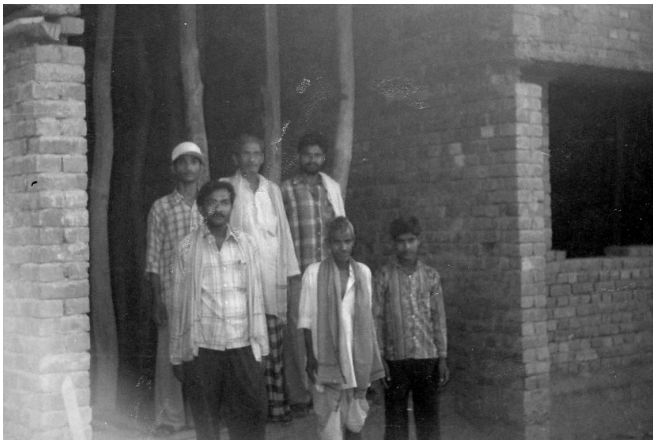
None of the centres had a notice board where working hours could be displayed. It has been observed that most of the centres have very poor infrastructure and are not up to the mark.

**ii) Primary Health Centres (PHC)**

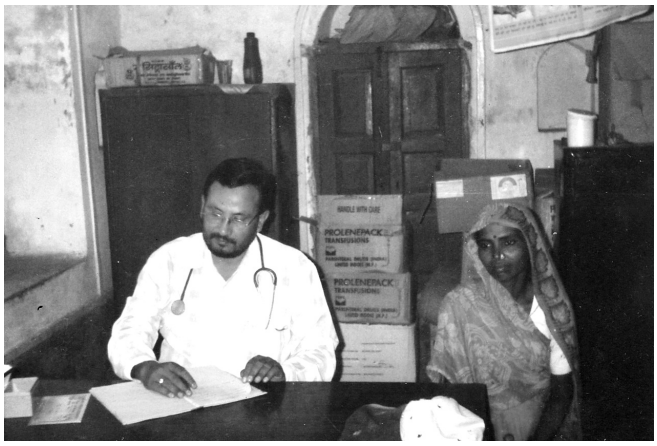
It was observed that all of the PHCs had notice boards and working hours of the PHC was written on it.

- 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

Sub Centre



Primary Health Centre



A Doctor in PHC

- Toilets were not clean
- Most of the centres don't have an ambulance facility
- 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."

***Muzzaffarnagar***
"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 (CHC)**
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.

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
- The centre 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 paitents. 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. Patients were further asked if they had to pay tor services, 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 in the waiting room

- 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 daugther, 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.

**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**

(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.

**Sharing the findings:**

Findings of the social audit were shared at the district as well as the state level. The overwhelming presentation from Media, Government, MLA, Civil Society Organisation, Government officials, women's


A district level sharing


Govt. official responding to the audit issue

group, Doctors and Panchyat members was appreciable. Women, ASHAs and other stakeholders shared their problems in front of the concern officials. Several recommendations emerged during sharing meeting.

| District/ State | Date of Sharing |
|---|---|
| Barabanki | July 18th |
| Muzzffar Nagar | July 19th |
| Banda | July 21st |
| Chandauli | July 23rd |
| Mirzapur | July 26th |
| Lucknow<br>State Level Sharing | -<br>August 1st |

### *Findings from Uttarakhand*

The audit was performed in three districts of Uttaranchal i.e. Nainital, Udhamsingh Nagar and Paudi. 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**

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.

### ASHA

***Selection of ASHAs***

- In all districts selection of ASHAs was done in between September 05 to April 06
- Two out of three districts called meeting before the selection of ASHA
- Only in one district selection was done unanimously
- In two districts the selection was done by pradhans or doctors or the health departments

***Training of ASHAs***

- Most of the ASHAs got seven days training
- Most of the respondents were of the opinion that ASHA training was weak and insufficient to explain the tasks properly.
- The training failed to explain roles and responsibilities of ASHA i.e. coordination with ANM, AWW & on-job training; community skills; technical inputs on ANC, PNC and preliminary treatment.

***Coordination with ANM and AWW***

- Most of the respondents said that ANM support ASHAs in their work.
- There is lack of clarity about the coordination between AWW and ASHAs
- A few ANMs feel that AWW don't cooperate much.
- Most of the ASHA says that coordination is a mutual process
- ANM says no one is very clear about the work of ASHA.
- None know that ASHA needs to coordinate with AWW also
- 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.
- 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.

***Compensation for services and training***

- One out of three districts none of the ASHAs got any compensations
- Two out of three districts most of the AHSAs received Rs 700
- Only very few received Rs 500 against institutional delivery
- Cost of commuting daily to training centre is very high and not provided for.

***Work done by ASHAs***

- None of the ASHA know about village health day
- None of them have organized village health meeting
- Most of the ASHAs help in pulse polio programme
- Very few of them said that they share knowledge on health in meetings with women
- Almost all of them said that they give advice on pregnancy care and safe delivery, but are unable to do it on regular basis.
- Majority of ASHAs don't have drug-kit; they are not sufficiently trained about the use of drugs.
- ANM, AWW and Pradhan opine that ASHA do not give any maternity counseling.
- 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.

## MATERNAL HEALTH CARE

***Antenatal and Postnatal Check ups:***

- 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 coordinatation with ANM, who often also fails to provide regular pregnancy/ post natal/neonatal care/counseling; also fails to convince villagers on matters like institutional child birth. Respondents said there is need for more training and financial support to ASHA.

***Institutional Childbirth***

- Almost everyone prefers home births by the dai (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.
- Childbirths in health centres are not free. Medicines are prescribed from out side also the staff demand money.
- Behavior of staff is often not conducive for the patient

***Referral Transport***

- Most of the centers don't have ambulance facility, those who have it is out of order
- There is no mechanism of referral

***JSY***

- Very few women received JSY money
- Those who received money for institutional delivery, got only Rs 700
- Women didn't received money for transportation
- When asked if women know about JSY scheme, they replied, they don't go to hospital for lack of services and so don't know anything about the scheme.
- The amount of money given varies widely.
- 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.

***Village Health and Sanitation Committee***

- No one knows anything about the committee.
- No attempts seem to have been made Village level Planning; Intersectoral Coordination

***Utilisation of untied funds available with the sub-centres***

- Knowledge about the untied fund is grim
- Money has been spent in infrastructure development/ repair of the sub-centre.
- 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.

***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; ANM, AWW 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.

**Sharing meeting:**

Findings of the Social Audit were shared in three districts of Uttarkhand; Powdi (July 29th, 2007), Udham Singh Nagar (July 17th, 2007) and Nanital

(July 19th, 2007). The meeting was attended by Community, ASHA, Gram Pradhan, President of Farmer Club, AWW, Supervisor, People from Government, Health Providers, MLAs, In-charge of district project management unit, In-charge of PHC, Doctors and Representatives from Non-governmental Organizations. The participants shared their views regarding social audit, NRHM and problems that are faced by the community in reaching out the health facility.

The Chief Medical Officer (CMO) said that, "The process of social audit is commendable, this has provided a common platform for all of us to come together and to join our hands. The process helps in increasing public dialogue".

The In-charge of district project management unit said that -"untied fund has been disbursed to all the centers. Panchayat has a very important role to play under NRHM. At the district level, all public health facilities are improved. Staffs are getting trained and skills are enhanced so that at every level facility of delivery could be provided. Further he added that proper utilization of united fund is not done; there is lack of information at every level. Due to deficient coordination between ANM and AWW the work is suffering".

## National Sharing of Social Audit Process

The National Sharing of the Social Audit process took place over two days on the 7th and 8th of August at New Delhi. On the 7th of August, health activists from across 12 states shared their experiences of the implementation of NRHM in their home states. The findings from the social audit process was shared along with findings from other states by the state level groups that had participated in this process. At the conclusion of this meeting. Small task groups were formed to consolidate the findings from across the states for presentation at the National Stakeholders Consultation that was scheduled to be organized on the following day. State level organizations that had participated in the Social Audit process in UP and Uttarakhand played lead roles in finalizing these presentations.This sharing meeting was organized by CHSJ in partnership with Healthwatch Forum.

On 8th of August over 120 participants representing civil society organizations, networks, experts, international NGOs, UN organizations, and representatives from the Union Government took part in the National Stakeholders Consultation on 2 years of NRHM. Dr Syeeda Hameed, Member Planning Commission and Mr G C Chaturvedi, Mission Director NRHM attended the Consultation along with other senior officials of the Planning Commission and the Ministry of Health and Family Welfare. The summary presentations emerging from the civil society discussions on the earlier day formed the core of the National Stakeholders Consultation.

A list of concerns and recommendations were drawn up from this process and these have been forwarded to the Union Government for action.

## Short Term Impact of Social Audit Process

The fieldwork for Social Audit took place in March-April; the district and state level sharing of the findings happened in July end. To get a brief on the impact of Social Audit process on the communities and other involved stakeholders, some of the team-leads from local NGOs who conducted the social audit were interviewed for following questions -

*Review questions:*

1. Do communities remember the social audit process? Why do you say so?

2. Any action taken by the government after Social Audit process?

3. Any action taken by community women after Social Audit process?

4. Any changes in the ASHA-Govt. interaction taken place after Social Audit process?

5. Any changes in the way ANM/ ASHA-community interaction taken place after Social Audit process?

6. Any change in the relationship of NGO with the community after Social Audit process?

7. Any changes in the NGO-government interaction taken place after SA process?

8. Any changes in the response of PRI after Social Audit process?

9. Would you recommend Social Audit process? Why?

These interviews were done in mid-October (5-6 months after completion of fieldwork). The responses to the above questions were as follows:

***Mirzapur, UP (Sandhya, Shikhar Prashikshan Sansthan)***

Social Audit has created awareness among the masses - they have started to realize their rights and are actively demanding them. This creates pressure on local health workers / officials and it does work (to an extent) in getting the services; but is very difficult though to say that things have changed. There is lot of corruption that has yet to be dealt with... (e.g. will ask the women who delivered in the hospital to tell everyone that they delivered at home.)

The process of pressure building at the local level gets negated if the medical officer gets transferred. And this happens quite often - you have to start the process of dialogue all over again to get that officer to work / perform for the communities.

We are recognised as a pressure building group so if we approach the health facility, our demands are taken care of - 'they do listen to us'. But for rest of the communities, their attitudes have not changed - and this is what we want but is actually not at all happening. This time during the diarrhoea epidemic, we were able to get the health department to come to the villages and take care of the situation.

The village women now continuously dialogue with the ANM for demanding the JSY money (they did not know anything about it prior to Social Audit). This is putting pressure on the ANM etc. and in some places women have received the benefits - but is not of satisfactory levels. Often the ANM would say that they don't have the money.

Mahila Adhikar Manch and Mahila Swasthya Adhikar Manch are continuing the work of pressure building and for the next Pulse Polio day they have planned to protest before the heath team that comes to the village. They will refuse to take the vaccine until the senior official comes to them and promises to continuously provide them with other vaccines and medicines.

Social Audit has also created awareness among the ASHAs and they are also getting together to claim their rights. Post-Social Audit not much improvement is seen in their co-ordination with the ANM or AWW; in fact it might be viewed as a bit negative as ANM would often threaten them or be overtly bossy, but otherwise they do their work, as much as they can at their levels.

All this i.e. increased awareness about schemes/ entitlement or rights has resulted in increased involvement of communities' etc. but it is far from being said that things have 'changed'.

With the PRI members, Social Audit process has increased their knowledge about NRHM and VHSC - nothing beyond that. They are busy managing money available under UEGS, and have time for nothing else.

Social Audit is a good method for pressure building. It shakes the government machinery and creates some kind of fear for them that they have to take care of. But there is still a lot to achieve - may be if the process is repeated again and again, at some time the government would get serious about it and decide to change its attitude.

***Muzzaffarnagar, UP (Sadab, Astitva)***

Among the government staff there has been a bit of resentment for the Social Audit process, but through our continuous efforts and dialoguing they now understand that our purpose is not plain confrontation or enquiry of their work - so they have become milder.

But, they are 'double-faced' - only if we accompany the case, they give the JSY money. We have two people who mostly work to monitor these cases and help them get the JSY money. Even they have to go 4-5 times to the PHC to get this money. Otherwise they would not pay them the full amount - they give 900 in urban and 1000 in rural areas.

The Social Audit process also created awareness among the ASHAs and we were able to help them link up with the ANM and AWW, which was not happening so well

earlier, though this has also created an environment of confrontation between them - but overall ASHAs have become active.

We provided a training (sort of) to the ASHAs about JSY, nutrition, immunization, Agan Waadi Centre etc. that has helped them in their work. Earlier when they accompanied the women to the health centre they would get only Rs.100; so they would not go with them. Now they know that they get Rs.600 so they do accompany the women and also get their money.

Earlier also we were holding village meetings for building awareness on health issues and about ASHAs involvement - but the Social Audit process provided us with clarity of issues related to health services and NHRM, it gave us a structure and helped us recognise people we need to collaborate with to address our health needs. The Social Audit helped us build linkages with the government officials too.

From the Social Audit process we have got the idea and an opportunity to call a common meeting of the PHC staff, ASHA, ANM, pregnant / recently delivered women etc. We have done this for one village and plan to do it (strategically) for villages where situations are bad.

In the district sharing the CMO had promised compensation and treatment for Sankalesh (who had received sever injuries to her birth canal from the long nails of the doctor), though, till date nothing has been done.

Social Audit had no influence on the PRI - difficult to get them to talk to us. At face they would say they will provide full support, but at the back they say that we do unnecessary interference.

Social Audit appears as a very effective tool for advocacy through demand generation because -

- It provides a common platform
- Helps in sharing
- Interaction with health officials is facilitated
- Helps in review of work (esp. ANM)
- Provides a redressal mechanism
- Monitoring mechanism, that can't be ignored (by doctors)

***Chandauli, UP (Bindu Singh, Gramya)***

Impact of Social Audit as seen after 4-5 months of its implementation is seen maximum in terms of JSY and maternal health care service guarentees. People have become more aware and are demanding that deliveries happen free of cost.

Village women have listed the deliveries that have not got the JSY money and have gone to the CMO to get their share of JSY. They have also filed a coupled of RTIs to get information about untied funds, JSY funds flow, status of various committees and the medical supplies sent to the PHC.

The women are also demanding that where ASHAs are not working, they be replaced and those who work get their compensations regularly.

The MLA had come for the district sharing of Social Audit that has resulted in filling up of all the vacancies of ANM, and the process of regularising the doctor posts has also started.

These activities have put much pressure on the health department and now JSY money is made available to the women, not immediately though, but unlike the way it was before the Social Audit processes when no money was being given. Also, this has created a lot of resentment among the health officials. The CMO often gets agitated when he sees the NGO staffs that were involved in the Social Audit process.

With the very poor training that ASHAs had received, now after the Social Audit process they are better equipped with information about JSY and maternal health services, and about their roles and links with the ANM and AWW. They have thus become bit more active.

Thus, Social Audit has been successful in reaching out to the communities but NGOs have their limitations in reaching out to the government or the panchayat institutions. The health workers do their job in front of the NGO workers / activists, else they are not bothered. Resources from senior officials or panchayat support limit the services that ANM can deliver, and getting

them to become responsive to the processes has been a challenge.

The Social Audit has provided a solid base / structure to the work we have been doing around health issues and the NRHM. It also provided us with much information about various schemes and the roles of ASHAs etc.

It will be a good idea to do a Social Audit again or expand it further, but situations are varied - we can't expect consistencies in results that depend on how the local people are able to take it forward. - The Social Audit processes have to be individualised according to the local context.

***Uddhamsingh Naga, Uttarakhand (Hira Jangpangi, Mahila Kalyan Sanstha )***

Social Audit has created awareness among the people / communities and they now express their concerns for services. They have got active and getting together to claim for better health services and facilities. Through the process of Social Audit ASHAs have realised their work and linkages with the health system; so have got together to claim their space of work and rights, which was earlier neither very clear to them nor was it actually provided to them.

The Social Audit is over but the wave it has created among the communities and the ASHAs is incredible.

One lady doctor of the PHCs where we performed the Social Audit is highly aggresive. She would scold everyone, especially the ASHAs. Demanding services from her doesn't work. This has instead made her more rude and inconsiderate. Post-Social Audit people have got together to voice against her behaviours. ASHAs have written a request letter (about her behaviour and facilities required at the sub-centre and PHC) to this PHC doctor and will send a copy to the CMO.

Because of the behaviour of this doctor the local environ has become so bad that sometimes we feel whether it was a mistake on our part to have done this audit. But it is important anyways to get the health system working - if we complain to some one there will be anger for sometime, it is understandable, but this does not mean that we become frightened and withdraw our work.

At the moment, the need is to support ASHAs who have been empowered with knowledge through the Social Audit process. We have now got into the supportive mode - backing up communities and ASHAs with guidance and information they need for claiming the services and their rights. This is a struggle of ASHAs and we plan not to confront the health department on their behalf - instead we are trying to maintain our cordial relations with the government officials who might otherwise be angered by our too much agitations that could hamper our communication channels with them.

I am a member of the PCPNDT committee and the health officers give us due recognition and regards, but they might be talking against us or be feeling threatened with the pressure we have created on them through the Social Audit process.

ASHAs roles and work was sort of neglected by the health staff, Social Audit have awakened the ASHAs but the government staff has not been responsive in a responsible manner so has not had much impact on their collaborative functioning with the ANM. ASHAs can't be very harsh or forceful for claiming their space from the ANM - even not feasible.

***Nanital, Uttarakhand (Anand Shahi, Prayas)***

The most remarkable impact of Social Audit process has been seen on the facilities available at the PHC. There were two doctors posted at the PHC but the lady doctor never came to the PHC. After the audit, she sits in the PHC regularly and attends the patients. The audit has increased awareness among the community about their health entitlements and they have started to demand services. Now medicines are also available in the PHC, to the extent that the private medical store keepers are disturbed from their reduced sale of medicines and raising their voice against us.

The grass-root health workers, ANM and PHC doctors do show some apprehensions with the people involved with the audit but the CMO was quite cooperative and gave necessary orders for improvement of services. ASHAs have started receiving compensations now, though not to the desired extent. However the situation is much better than before. This has also resulted in 40-50% increase in the work that ASHAs are doing compared to what they did earlier. Their links with the

ANM have also been established or improved. But now that CMO has been transferred and we will have to again dialogue with the new CMO when any need arises.

The money disbursed and received under JSY has also increased, especially ASHAs now know that they are entitled to Rs.600, their payments have improved. ANMs are also provided with JSY funds before hand which had never happened earlier.

The panchayat has not shown much impact. They are suspicious why we are collecting information and fear that we might use it against them. They are interested if some construction work is required to be done, but remain indifferent to the absence of doctors or ANM.

With all these changes, definitely Social Audit must be seen as an effective tool for activating the system that has been unable to implement all the government schemes properly. Audit does bring out the weaknesses in the schemes and the system is forced to put in efforts for effective implementation - they can't ignore it totally.

This is the second time we have done a Social Audit, and we feel that it is an important process that must be given due space in the system. The findings must be shared at all levels, from communities' right up to the centre. It should not remain contained in files, but be taken up as an important issue and be discussed at all levels, to take these effects forward for service improvements.

# Part 2
# Conducting Social Audit : a Tool Kit

Part 2

# Conducting Social Audit on NRHM - A Tool Kit

## The process of social audit

This section describes in detail the process that was adopted in these two states. The process began in first week of March 2007, with a planning meeting that was organized in Lucknow with two selected states' CSOs (Uttar Pradesh and Uttarakhand). In this meeting finalization of issues, training design, selection of districts/blocks and tools were discussed and finalised.

A collection of the Tools was followed and the seventeen formats used in the social audit process. In most cases the information was collected in a Yes/ No format. In others the answer was written down next to the question. In addition to these seventeen formats, if during the field level information gathering process, the Social Audit team prepared case studies when it came across cases where people from very poor and marginalized communities were either denied services, faced harassment and in case there were adverse health outcomes because of these.

In addition to the seventeen formats a simple summary sheet proforma has also been provided which allows for the preparation of the District Social Audit report. The summary report, along with testimonies from the case studies emerging out of the social audit process was shared with district collector, health authorities ( CMO and DPMU), PRI members and community level women among whom the social audit was conducted at the block or district head quarters.

**Training for Social Audit**

Between March 14th - 18th, 2007, a five-day training was organized for the field investigators of five districts in Uttar Pradesh and three districts in Uttarkhand at Lucknow. During this training event the tools were field-tested and in the first week of April the process of Social Audit began. The training design as follows:

*Objective(s) of the training:*

i. To develop a conceptual understanding on rights based approach to health

ii. To increase knowledge of NRHM and its provisions

iii. To develop a conceptual understanding on Social Audit

iv. To develop skills on how to conduct Social Audit

v. To understand the importance of Community Monitoring

**Training design for Social Audit**

| | **Topic** | **Timings** |
|---|---|---|
| **Day One** | Welcome and Introduction | 30 Mints |
| | Expectation and objective(s) of the training | 30 Mints |
| | Knowledge about<br>National Rural Health Mission What is NRHM | 1 hrs 30 mints |
| | Group work - ASHA Selection and Role of ASHA | 1 hrs |
| | Presentation on Janani Surksha Yojan | 1 hrs |
| | Involvement of PRIs in NRHM | 1 hrs |
| | Importance of Community Monitoring | 1 hrs 30 mints |
| | Health Rights and NRHM | 30 Mints |
| | Discussion | 30 Mints |

| | | |
|---|---|---|
| **Day Two** | Review of Day One | 1 hrs |
| | Principle of community Assessment | 1 hrs |
| | Methods of Community Assessment | 1 hrs |
| | How to make format | 1 hrs 30 mints |
| | How to carry out the interview | |
| **Day Three** | Field Visit | One day |
| **Day Four** | Field Visit | One day |
| **Day Five** | Feedback from field visit, Suggestions, discussion on the tool | 2 hrs |
| | Work planning | 2 hrs |
| | Evaluation | 30 mints |
| | Valedictory session | 30 mints |

To ensure the smooth process of Social Audit, quality of work, time to time technical support and to deal with bureaucratic huddles, one coordinator in each state, Uttar Pradesh and Uttarkhand, was appointed to supervise the audit process.

**Methodology:** The methodology used for the Social Audit was as follows:

- Group discussions
- Interviews
- Observations

**Tools for Social Audit:** From discussions that accrued during state level planning meetings, 17 tools were designed. These tools are as follows;

| **Beneficiary** | **Community** | **Providers** | **Managers** | **Facility** |
|---|---|---|---|---|
| Interview with women who have delivered 6 month preceding interview | Interview with Gram Pradhan | Interview with ANM | Medical Superintendent | CHC Observation + Checklist |
| | Interview with ASHA candidate | Interview with AWW | Medical officer | PHC Observation + Checklist |
| | Ten FGDs with community | Interview with ASHA | VHC members | Sub Centre Observation + Checklist |
| | | | District Project Management Unit (DPMU) | Exit interview with patients |
| | | | Block Project Management Unit | |
| | | | State Rural Health Mission | |

In every district, one district project management unit (DPMU), one CHC, two PHC, three Sub Certres and ten villages were selected for the purpose for the Social Audit.

**Issue wise - Information was collected from following respondents**

| S/L | Issues | Information was taken from | No. of the interviews |
|---|---|---|---|
| 1 | Maternal health | PHC | |
| | | CHC | |
| | | ASHA | 10 |
| | | Community | 10 |
| | | Who have deliver babies with 6 months | 10 |
| 1.1 | ASHA role | ASHA | |
| | | Pradhan | |
| | | Community (FGD) | 10 |
| 1.2 | Referral transport | ANM | 3 |
| | ASHA | Any complicated pregnancy (Case study) | |
| 2 | Village health and sanitation committee | PHC | |
| | | Pradhan | |
| | | Area Head | 10 |
| 2.1 | Untied Fund (planning utilization and availability) | PHC | |
| | | ANM | |
| | | Pradhan | |
| 3.1 | ASHA selection and training | ASHA | 10 |
| | | Pradhan | |
| | | Facilitator | 2 |
| | | MOIC | |
| | | Area Head | 1 |
| | | Community | |
| | | Applicant Asha (contestant) | 5 |
| 3.2 | Stages of training | PHC | |
| | | CHC | |
| | | District | |
| | | ASHA | |
| 3.4 | Coordination between ASHA, ANM and AWW | ASHA | |
| | | AWW | |
| | | ANM | |
| | | Community | |

**FORMAT OF TOOLS THAT WERE USED DURING SOCIAL AUDIT**

## 1 - Information from Beneficiary

**I - Interview with women who delivered within last 6 months**

| | | |
|---|---|---|
| 1 | Name of the Village | |
| 2 | Name of the Block | |
| 3 | Name of the District | |
| 4 | Name of the Sub-centre | |
| **General** | | |
| 5 | When did you deliver? | |
| 6 | You gave birth to a Girl child or a Boy? | |
| | Girl Boy | |
| 7 | Where did the delivery take place? | |
| 8 | Who attended the delivery? | |
| **Ante-natal Care** | | |
| 9 | Did you take a medical check up during your pregnancy? | Yes/ No |
| 10 | If yes - How many time? | |
| 11 | Where did you get the check-up done? | |
| **From the ANM / at the PHC / CHC / Private / Dist hospital** | | |
| 12 | Were the following investigations performed? | |
| | i Blood pressure | Yes/ No |
| | ii Per-abdomen examination | Yes/ No |
| | iii Examine for edema | Yes/ No |
| | iv Urine test | Yes/ No |
| | v Blood test | Yes/ No |
| 13 | Did you receive 100 tablets of iron? | Yes/ No |
| 14 | Did you receive two TT injections? | Yes/ No |
| **Care during Delivery related information** | | |
| 15 | Did you receive any counseling from the ANM? With regards your delivery? | Yes/ No |
| 16 | Did ASHA give you any counseling for delivery? | Yes/ No |
| 17 | Did ANM come to see you within two days of your delivery? | Yes/ No |
| **JSY** | | |
| 18 | Have you hear about JSY? | Yes/ No |
| 19 | Did you receive any financial assistance for your delivery? | Yes/ No |
| 20 | If Yes - how much? | |

| **Delivery** | | |
|---|---|---|
| 21 | Did you face any problem during your delivery? | Yes/ No |
| 22 | If yes - who did you tell or go to for help?<br>ASHA / ANM / Others | |
| 23 | Did they take you somewhere?<br><br>PHC / CHC / Private / district hospital | Yes/ No<br>If yes - where? |
| 24 | Did they take you to more than one place? | Yes/ No |
| 25 | Were you satisfied from government services that you received? | Yes/ No |
| 26 | Did you face any problems in receiving the services in a public hospital? | Yes/ No |

**Problems faced during delivery in a public health facility**

| **Issue** | **Problem** | **Suggestion** |
|---|---|---|
| Promptness of care | | |
| Facilities for blood and medicines | | |
| Surgical care | | |
| Care of mother and child after delivery | | |
| Behavior of the hospital staff | | |

## 2 - Information from Community

**II - Village / Community level Meeting (FGD)**

1. Village
2. Block
3. District
4. ANM
5. ASHA

**Maternal Health**

1. In your village, how many deliveries have taken place in last 6 months?
2. Was the antenatal checkup done by ANM for all these deliveries?
3. Did ANM give the TT injection to all of them?
4. Had all of them received iron tablets from the ANM?
5. Did they receive the benefits of JSY?
6. Who received these benefits?
7. Who often conducts deliveries in the village?
8. ANM / Dai (TBA) / Hospital / others
9. In last 6 months was any case of difficult labour encountered?
   If yes - How many?
10. Names of the women who experienced difficult labour
11. Does the ANM make a home visit - within two days of the delivery?
12. Does ASHA provide counseling for post-natal health care?
13. Does ASHA provide guidance for safe delivery practices?
    Role of ASHA
14. Does ASHA give health education to the villagers?
15. Does ASHA help in Pulse-polio programme?
16. Does ASHA organize for Village Health Day?
17. Does ASHA provide medicines for minor ailments / illnesses?
18. Are the following items often available with ASHA -
    ORS / delivery kit / iron tablets

**Views about PHC / CHC**

19. Where is the nearest PHC located?
20. Where is the nearest CHC located?
21. Do the village women often go to the PHC - on a regular basis?
22. Are delivery services available round the clock at the PHC?
23. Are the medical services available round the clock at the PHC?
24. Are the necessary medicines provided by the PHC?
25. Are there facilities for surgery too available, in that PHC?

26. Are there in-door facilities available in the PHC?
27. Does the PHC regularly / always provide the medicines?
28. In the last 6 months has anyone witnessed some bad experience at the PHC / CHC?

    If yes - note the names of those affected:

**Village health Planning**

29. Is the Village Health Committee formed in your village?
30. Do you know anything about its meetings?
31. Has the committee received its share of untied funds?

    If yes - what amount is received?

**Issues/Problems/Suggestions/Recommendations**

| | Issue | Problems | Suggestions/ recommendations |
|---|---|---|---|
| 1- | Maternal Health | With the Public System/systemic<br><br>At the level of community | With the Public System / systemic<br><br>At the level of community |
| 2- | Role of ASHA | With the Public System/ systemic<br><br>At the level of community | With the Public System/ systemic<br><br>At the level of community |
| 3- | Experiences with PHC and CHC | With the Public System/ systemic<br><br>At the level of community | With the Public System/ systemic<br><br>At the level of community |
| 4- | Health Insurance | With the Public System/ systemic<br><br>At the level of community | With the Public System/ systemic<br><br>At the level of community |

**III - Outline for case-study of ASHA candidate**

**Main Pointers**

1. Name
2. Age
3. Education / qualification
4. Name of the village
5. District
6. How was selection of ASHA done? Describe the full process and if interview had taken place.
7. Describe the kind of problems faced - if any.
8. Describe the probable reasons for non-selection
9. How was the overall experience? What do you think about them?
10. Any other issue that came forth during the selection process?
11. In your opinion why were you not selected?

**IV - Interview with the Pradhan**

| | | |
|---|---|---|
| 1- | Name of the Village | |
| 2- | Name of the Block | |
| 3- | Name of the District | |
| 4- | Name of the Pradhan | |
| **ASHA selection and her Roles** | | |
| 5- | Do you have ASHA in your village? | Yes/No |
| 6- | If Yes - how many? | |
| 7- | How many candidates were there for ASHA selection? | |
| 8- | Who selected the ASHA? | |
| 9- | Has ASHA received any training? | Yes/No |
| 10- | If Yes - How many times has she received this training? | |
| 11- | Does ASHA help in Pulse-polio programme? | Yes/No |
| 12- | Do ASHA counsel the pregnant women? | Yes/No |
| 13- | Do they help them during delivery? | Yes/No |
| 14- | Do ASHAs have a drug kit with them? | Yes/No |
| 15- | Do ASHA provide treatment for minor illnesses? | Yes/No |
| 16- | Do they organize a 'village health day'? | Yes/No |
| 17- | Do ASHAs get support from the ANM? | Yes/No |
| **Village Health and Sanitation Committee** | | |
| 18- | Has the VHSC constituted in your village? | Yes/No |
| 19- | Does this committee meet regularly? | Yes/No |
| 20- | If Yes - Do you go to attend these meetings? | Yes/No |
| 21- | Did the committee receive Rs.10, 000 as untied fund? | Yes/No |
| **Sub-Centre** | | |
| 22- | Is there a sub-centre in your village? | Yes/No |
| 23- | Does the ANM stay at the Sub-centre? | Yes/No |
| 24- | Has your sub-centre received Rs.10, 000 as untied fund? | Yes/No |
| 25- | If Yes - how much of it has been expended? | |
| 26- | On what all things / activities has the money been spent? | |
| 27- | Are health related matters discussed at Village Panchayat? | Yes/No |
| 28- | Do you have any knowledge, if health matters are discussed at Block Panchayat (BDC)? | Yes/No |

**Issues/Problems/Suggestions**

| Issue | Problem | Suggestion |
|---|---|---|
| ASHA's Role | At the community level | |
| | At the level of health department | |
| Co-ordination between ASHA, AWW and ANM | At the community level | |
| | At the level of health department | |
| Village Health and sanitation Committee | | |
| Adequate Health facilities / infrastructure for the village | | |

**(V)- Interview Member Village Health & Sanitation Committee**

| | | |
|---|---|---|
| 1 | Name of the Village | |
| 2 | Name of the Block | |
| 3 | Name of the District | |
| 4 | Name of the PHC | |
| 5 | Name of the Sub-centre | |
| | Name of the person interviewed and his designation - | |
| 7 | Have you heard of the National Rural Health Mission? | Yes/No |
| 8 | Has ASHA selection taken place in your village? | Yes/No |
| 9 | If Yes - how many ASHAs have been selected? | |
| 10 | Can you tell us their names? | |
| 11 | Do you know about the VHSC? | |
| 12 | IF Yes - Can you innumerate 5 important functions of the committee? | |
| 13 | Does the VHSC promote health and related activities in the village? | Yes/No |
| 14 | Has the village health plan been prepared in your village? | Yes/No |
| 15 | If Yes - who made this plan and how? | |
| 16 | Has the village health register been made? | Yes/No |
| 17 | Is there a board for providing health information to the villagers? | Yes/No |
| 18 | Does VHSC ensure the work of the following health workers?<br>1) ANM 2) MPW 3) AWW | |
| 19 | Does the VHSC monitor the Village health and nutrition official? | Yes/ No |
| 20 | If yes- Whom it monitors?<br>1) ANM 2) MPW 3) AWW | |
| 21 | Does the committee ask for the two monthly health report during monitoring? | Yes/ No |
| 22 | Does the VHSC discuss (or investigate) about the maternal or infant deaths that happen in the village? | Yes/ No |
| 23 | Has the committee received the Rs.10, 000 as untied funds? | Yes/ No |
| 24 | If Yes - on what activities / materials has this money been expended? | |

## 3- Information from Provider(s):

**VI- Interview with ASHA**

| | |
|---|---|
| 1 | Name of the Village |
| 2 | Name of the Block |
| 3 | Name of the District |
| 4 | Name of ASHA |
| **Nomination/ election and selection** | |
| 5 | When were you selected as ASHA? |
| 6 | What was the process of selection for you? |
| 7 | How many more nominees ere there for selection? |
| 8 | Why did you decide to work as an ASHA? |
| 9 | How many times training has been given to you? |
| 10 | For a total sum of how many days did you receive the training? |
| 11 | Did you get compensation during the training? |
| | How much? |
| 12 | Do you participate in pulse-polio programme? |
| 13 | Do you call village meetings to give health education? |
| 14 | Do you organize the 'village health day'? |
| 15 | Do you provide counseling to pregnant women? |
| 16 | Do you accompany them to the health facility for their delivery? |
| 17 | Do you have the drug-kit? |
| 18 | Do you know treatment for minor ailments? |
| **Village process** | |
| 19 | Is there a Village Health & Sanitation committee present ? |
| 20 | Do you attend the meetings of these committees? |
| 21 | Do you get regular help from the ANM? |
| 22 | Do you get regular support from the AWW? |
| 23 | Has your village received the untied fund of Rs. 10, 000? |
| **Financial support / assistance** | |
| 24 | Do you get any financial support / compensation for the work you do? |
| 25 | If yes - how much? |
| 26 | Do the women get the benefits of JSY? |
| 27 | If yes - how much? |
| 28 | Have you received assistance from the JSY? |
| 29 | If yes - total how much amount have you received? |

| Issue | Problem | Suggestions |
|---|---|---|
| Roles | | |
| Training | | |
| Co-ordination with the ANM | | |
| Coordination with AWW | | |
| Financial support | | |

**VII - Interview with Anganwadi Worker**

| | | |
|---|---|---|
| 1 | Name of the village | |
| 2 | Name of the Block | |
| 3 | Name of the District | |
| 4 | Name of Anganwadi Worker | |
| 5 | Have you heard of National rural Health Mission? | Yes / No |
| 6 | Have you heard of about scheme on ASHA? | Yes / No |
| 7 | Has ASHA been selected in your village | Yes / No |
| 8 | If yes - can you tell me her name? | |
| 9 | How did ASHA selection take place in your village | |
| 10 | How many candidates were there to be selected as ASHA | |
| **Co-ordination between AWW and ASHA** | | |
| 11 | Do you know about the work-list of ASHA? | Yes / No |
| 12 | If yes - can you tell about the work she has to do? | |
| 13 | Did you work with ASHA on the 'village health day'? | Yes / No |
| 14 | Do you know anything about the 'drug kit'? | Yes / No |
| 15 | If yes - does AW function as the depot center for the drugs? | Yes / No |
| 16 | Does ASHA help you with any of your following works? | |
| | ■ Nutrition advice to pregnant women or the one who has recently delivered. | Yes / No |
| | ■ Help in giving health education about child nutrition | Yes / No |
| | ■ Does she bring people for immunization to the Anganwadi center? | Yes / No |
| | ■ Does she bring people to the Anganwadi center for their health check-ups? | Yes / No |
| | ■ Does she help in organization of the 'village health day'? | Yes / No |

**VIII- Interview with the ANM**

| | |
|---|---|
| 1 | Name of the Sub-centre |
| 2 | Name of the Primary health Centre |
| 3 | Name of the block |
| 4 | Name of the District |
| 5 | Name of ANM |
| **Maternal Health care services** | |
| 6 | In your sub-centre, are all the following services available for the pregnant women? |
| i | Four ante-natal check-ups |
| ii | Measure blood pressure |
| iii | Examination of abdomen |
| iv | Investigate swelling |
| v | Urine test |
| vi | Blood test |
| vii | 100 tablets of iron |
| vii | 2 shots of T.T. |
| 7 | Are following services available for you? |
| i | Delivery at home or in the sub-centre |
| ii | Free delivery |
| iii | Taking the women to PHC/ CHC for delivery |
| iv | Meet the women at her home - within two days of her delivery |
| 8 | Have all the deliveries that took place in last 6 months got the benefits of JSY? |
| 9 | How many women have got it? |
| 10 | How much amount have they got under the JSY? |
| **ASHA -ANM-AWW** | |
| 11 | Who selected the ASHA? |
| 12 | How many rounds of training has ASHA received ? |
| 13 | On the whole, total how many days of training has ASHA received? |
| 14 | How much compensation has she received for attending the trainings? |
| 15 | Does ASHA provide counseling to the pregnant women? |
| 16 | Does ASHA accompany women to the health facility for her delivery? |
| 17 | Do ASHA organize the 'village health day'? |
| 18 | Do you meet the AWW and ASHA on a regular basis? |
| 19 | On an average, how many times in a month do you meet them? |

| **Sub-centre and village health and sanitation committee** | |
|---|---|
| 20 | Has the sub-centre received the sum of Rs.10, 000 as untied fund? |
| 21 | How many times has it been received? |
| 22 | What amount has been spent till now? |
| 23 | On what things has the money been spent? |
| 24 | Is the Village Health and Sanitation Committee formed in your area? |
| 25 | Does the committee meet on a regular basis? |
| 26 | Hs this committee received any untied funds? |

| **Issue** | **Problem** | **Suggestions** |
|---|---|---|
| Maternal health care under JSY | At the community level<br><br>At the level of health facility / health department | |
| Co-ordination between ASHA-<br><br>Anganwadi worker and ANM | At the community level<br><br>At the level of health facility / health department | |
| Untied funds to the Sub-centre | At the community level<br><br>At the level of health facility / health department | |

## 4 - Information from Manager(s):

**IX- Interview with the Medical Officer**

| | | |
|---|---|---|
| 1- | Name of the PHC | |
| 2- | Name of the Block | |
| 3- | Name of the District | |
| 4- | Name of the Health officer | |
| 5- | There are services available for ante-natal check-ups | |
| | Daily weekly | |
| 6- | Are the services for normal labour available round the clock? | Yes/ No |
| 7- | How many deliveries took place in the PHC last month? | |
| 8- | Is care for malnourished children available in the PHC? | Yes/ No |
| 9- | Are the facilities for internal examination of gynaecological cases? | Yes/ No |
| 10- | Are there services available for treatment of problems like white discharge and menstrual disorders? | Yes/ No |
| 11- | On an average, in a week how many women come with these problems? | |
| 12- | Are there services for abortion available in the PHC? | Yes/ No |
| 13- | If Yes - do women have to pay something for the services? | |
| 14- | Does PHC provide free medicines to the patients? | Yes/ No |
| 15- | Are the women patients examined in the presence of a lady? | Yes/ No |
| 16- | During the examination is care taken for maintaining the privacy of the patient? | Yes/ No |
| 17- | Are there indoor facilities available for the patients? | Yes/ No |
| 18- | If NO - then are ther services to take the patient immediately to other health facility? | |
| 19- | Doe PHC have a functional ambulance? | Yes/ No |
| 20- | Are blood hemoglobin measurements done in the PHC? | Yes/ No |
| 21- | Are services for diagnosing malaria available? (MP blood slide) | Yes/ No |
| 22 | Are the sputum tests done for TB? | Yes/ No |
| 23 | Are urine tests done for pregnant women? | Yes/ No |
| 24 | Is the Rogi Kalyan Samit (RKS) constituted in the PHC? | Yes/ No |
| 25 | Has the PHC received Rs.50,000 for repair work? | Yes/ No |
| 26 | Are there services for gathering feedbacks or providing redressal to their problems? | Yes/ No |
| 27 | What has RKS done for patient welfare? | Yes/ No |
| 28 | Can you tell us about ASHA selection, Training and execution? | |
| 29 | Can you tell us about coordination between ASHA, ANM and AWW? | |
| 30 | Can you tell us a bit about JSY scheme? | |

**X- Interview with the Superintendent or Medical Officer of the CHC**

| | | |
|---|---|---|
| 1 | Name of CHC | |
| 2 | Name of the Block | |
| 3 | Name of the District | |
| 4 | Name of the Medical officer / Superintendent | |
| 5 | Are there separate male and female wards? | Yes/ No |
| 6 | Total how many beds are there?<br>For Males -<br>For Females - | |
| 7 | Does the surgery department of the CHC provide regular services? | Yes/No |
| 8 | If Yes - are emergency services provided by the surgery unit? | Yes/No |
| 9 | Is the doctor available round the clock at the centre, to attend to Emergencies? | Yes/No |
| 10 | Are services for normal delivery available round the clock? | Yes/No |
| 11 | How many deliveries took place in last one month<br>or In past three months | |
| 12 | Were any cases of difficult labour referred elsewhere? | How many? |
| 13 | How many cesarean deliveries (by operation) took place in -<br>Last one month or In past three month | |
| 14 | Which of the National Health programmes are implemented in this CHC? | |
| 15 | Which are the services available in the ICU? Name them. | |
| 16 | Is there a Blood Bank at the CHC? | Yes/ No |
| 17 | Does the CHC have functional ambulance service? | Yes/No |
| 18 | Give the numbers of following medical specialists available in the CHC -<br>■ Surgeon<br>■ Physician / internal medicine<br>■ Obs-Gynae<br>■ Pediatrician<br>■ Anesthetist<br>■ Ophthalmics | |
| 19 | Give the numbers of following staff available in the CHC -<br>i) Nurse / ANM<br>ii) Dresser<br>iii) Compounder<br>iv) Lab technician<br>v) Radiographer<br>vi) Ward Boys<br>vii) Cleaner<br>viii) OPD assistant<br>ix) Security guard<br>x) OT assistant<br>xi) Registration clerk<br>xii) Computer operator<br>xiii) Statistical Assistant/Data entry operator | |

| | | |
|---|---|---|
| 20 | Is there a refrigerator available? | |
| 21 | Charter of Patient Rights has been made? | Yes/No |
| 22 | Has the RKS constituted in the CHC? | Yes/No |
| 23 | If Yes - Is the RKS functional? | Yes/No |
| 24 | When did the last meeting of RKS take place? | Yes/No |
| 25 | What were the main decisions that took place in that meeting? | |
| 26 | Are there Internal management facilities available in the CHC? | |
| 27 | Are the essential drugs / medicines available in the CHC? | Yes/No |
| 28 | If Yes - name the medicines available - | Yes/No |

**XI - Interview with State Health Mission**

1. Name of the District
2. Name of the NRHM director
3. What support you all are providing to District Health Mission?
4. In order to ensure the development of capacity at all level what steps have been taken from your end?
5. Have you evaluate the District Health Plan?
6. Have you finalized the district health plan on the basis of available resources?
7. Do you determine planning norms and suggested intervention for the state?
8. What resources do you release to districts?
9. To meet the standards of accounting and audit what steps are ensure from your end?
10. In order to meet the needs of the mission what steps have been taken from your end?
11. So far how many health teams have you trained? And which level?
12. Have you done any independent study to see the progress benchmark?
13. If yes can you tell us a little bit about that study eg what was that and what you did in the study?
14. In order to procure timely and quality things in the departments what steps have been taken by your end and also what do you do to maintain the transparency?
15. Are you involved in the finalization of the survey formats and in the preparation of the report?
16. Are you involved/have converge other departments, if yes how many of them you have done sofar and for effective actions what steps have been taken from your end?
17. To promote culture of transparency, accountability and effectiveness what steps have been taken from your end?
18. In order to effective risk pooling what model have been made by you and have you involved non-governmental people in this?

**XII- Interview with District Programme Management Unit**

| | | | | |
|---|---|---|---|---|
| 1 | Name of the District | 3 | Number of PHCs | |
| 2 | Name of the Block | 4 | Number of Sub-centres | |
| **General** | | | | |
| 1 | Has the District Health Committee or Mission been formed? | | | Yes/No |
| 2 | If yes - when was it formed? | | | |
| 3 | Is the work plan made for the year 2007-08? | | | Yes/No |
| 4 | How was the work plan made? | | | |
| | On the basis of state PIP / on the basis of any study / some other way? | | | |
| 5 | How many CHCs were up-graded in the first phase of PIP? | | | |
| | Please tell the names of those CHCs - | | | |
| 6 | Of these how many PHCs will be functional 24x7? | | | |
| | Please tell names of those PHCs - | | | |
| 7 | How many 'Rogi Kalyan Samitis' have been formed? | | | |
| | Names of the hospitals where they have been formed - | | | |
| 8 | Is there a District level Quality assurance Committee? | | | Yes/No |
| | Names of Committee members - | | | |
| **ASHA** | | | | |
| 9 | In your district, has the scheme of ASHA started? | | | Yes/No |
| 10 | How many villages have been included in this sheme | | | |
| 11 | How many ASHAs have been selected? | | | |
| 12 | Did the ASHAs receive any training? | | | Yes/No |
| i | If Yes - From where? | | | |
| ii | For how many days? | | | |
| iii | What were the subjects that they were trained on? | | | |
| 13 | Your views / comments on ASHA scheme | | | |
| 14 | Have the facilitators been selected? | | | |
| | If yes - how many? | | | |
| | Janani Suraksha Yojana | | | |
| 15 | When was JSY introduced in your district? | | | |
| 16 | Have you received a budget for JSY? | | | Yes/No |
| 17 | For JSY, Have you given an advance to the ANM? | | | Yes/No |
| 18 | How many women have received the benefits of the scheme? | | | |
| 19 | What benefits did they receive? | | | |
| 20 | Your views or comments on the implementation and monitoring of JSY | | | |

| | | |
|---|---|---|
| **Sub-Centre** | | |
| 21 | Has a budget for united funds of sub-centre been received? | Yes/ No |
| 22 | When was it received? | |
| 23 | Have these funds been distributed? | Yes/ No |
| 24 | How many sub-centres have received these funds? | |
| | All / most of them / few of them/very few / none | |
| 25 | Where dose the united fund money is deposited? | |
| 26 | Who all can utilize these funds? | |
| 27 | Do you have a report to indicate the utilization of these funds? | |
| 28 | What are procedures / processes for deciding on where to expend these funds? | |
| 29 | Any comments on this scheme of United Funds | |
| **Family Planning** | | |
| 30 | In your district do you have any targets for family planning services? | Yes/No |
| 30-A | IF YES - What is the target for this year?<br>..... | |
| 30-B | Are you successful in achieving these targets? | |
| 30-C | If No - What is the average number of female sterilizations that take place in your district? | |
| 31 | Do the women face any problems after sterilization operations? | |
| | Many a times / sometimes / rarely or hardly ever / never | |
| 32-A | Do you know of any women who got pregnant after sterilization? | Yes/No |
| 32-B | Do you perceive this as something usual, or you think it is unusual?<br>Usual/ sometimes it happens / quite rarely / never | |

**XIII - Interview with Block Level Health Mission**

| | | |
|---|---|---|
| 1 | Name of the block | |
| 2 | Name of the District | |
| 3 | Name of officer | |
| 4 | Has the block coordination committee been formed? | Yes/No |
| 5 | Has a network been formed among the block officers, which works for redressal of health related problems of people? | Yes/No |
| 6 | Is there adequate integration and co-ordination taking place between the primary, secondary and tertiary levels of health care facilities? | Yes/No |
| 7 | Ensuring integration of AYUSH and Allopathic system of medicine | Yes/No |
| 8 | Do you supervise or monitor the work of following health staff - | |
| | ■ ASHA | Yes/ No |
| | ■ Multipurpose worker (MPW) | Yes/ No |
| | ■ ANM | Yes/ No |
| | ■ Anganwadi | Yes/ No |
| 9 | Do you ensure a regular supply of following equipments / items? | |
| | ■ Mosquito net | Yes/ No |
| | ■ Medicines in the villages | Yes/ No |
| | ■ Medicines in the hospitals | Yes/ No |
| 10 | Do you work to provide following services in an adequate and prompt manner? | Yes/ No |
| | ■ Arranging transport to ensure access to the sub-centre, PHC and CHC. | Yes/ No |
| | ■ District level or tertiary level health care services | Yes/ No |
| | ■ Services that are available at block level hospital or CHC | Yes/ No |
| 11 | Do you organize any the following events in your block? | |
| | ■ Trainings and multi-skilling of social workers/ activists and other health | Yes/ No |
| | ■ Health camp | Yes/ No |
| 12 | Do you provide support for the following? | |
| | ■ Household survey | Yes/ No |
| | ■ Formation of village health registers | Yes/ No |
| | ■ Preparation of the village health plan, with involvement of communities | Yes/ No |
| | ■ Facilitation of health facility survey | Yes/ No |
| 13 | Till now what work have you done that relates to the National Rural Health Mission? | |

## 5 - Information from Facility

**XIV - Observations at the CHC**

| | | |
|---|---|---|
| 1 | Name of CHC | |
| 2 | Name of the PHC | |
| 3 | Name of the Block | |
| 4 | Name of the District | |
| | Checklist for the facility | |
| 5 | Adequate arrangements for the electricity | Yes/No |
| 6 | Arrangements for drinking water | Yes/No |
| 7 | Toilet facility | Yes/No |
| 8 | Health center building is well constructed and in proper shape | Yes/No |
| 9 | Walls are good and clean | Yes/No |
| 10 | Table for examining the patients | Yes/No |
| 11 | Weighing machine | Yes/No |
| 12 | Floor is also cemented and clean | Yes/No |
| 13 | Overall cleanliness | Yes/No |
| 14 | Number of female workers in the premises | |
| 15 | Total number of female doctors in the health centre | |
| 16 | Condition of boundary wall of the hospital | |
| 17 | Total strength of hospital staff | |
| 18 | Total numer of beds | |
| 19 | Total number of specialist doctors | |
| I | Surgeon | |
| II | Obstetrician/ gynecologist | |
| III | Pediatrician | |
| IV | Physician/ internal medicine specialist | |
| 20 | Operation Theatre | Yes/No |
| 21 | X-ray machine | Yes/No |
| 22 | Labour room | Yes/No |
| 23 | Pathology lab | Yes/No |
| 24 | Emergency facilities for surgery available round the clock | Yes/No |
| 25 | 24 hrs services at medicine department | Yes/No |
| 26 | Facilities for normal labour is available for 24 hours | Yes/No |
| 27 | Facilities for difficult labour is available for 24 hours | Yes/No |
| 28 | Abortion facilities | Yes/No |

| | | |
|---|---|---|
| 29 | Health Care for the neonate | Yes/No |
| 30 | Diagnostic and health care facilities for the sick child | Yes/No |
| 31 | Blood storage facility | Yes/No |
| 32 | Ambulance facility | Yes/No |
| 33 | Laproscopic tubectomy services | Yes/No |

**XV- Observation at the PHC**

| | | |
|---|---|---|
| 1- | Name of the PHC | |
| 2- | Name of the Block | |
| 3- | Name of the District | |
| 4- | Notice board present | Yes/ No |
| 5- | Timings of when the PHC starts are written | Yes/ No |
| 6- | Total time is at least for six hors | Yes/ No |
| **Staffing** | | |
| 7- | Medical officer is present | Yes/ No |
| 8- | Staff nurse is available | Yes/ No |
| 9- | Female health worker (ANM) is available | Yes/ No |
| 10- | Lab technician is available | Yes/ No |
| 11- | Has Government building | Yes/ No |
| 12- | OPD has separate room and a curtain for examining female patients | Yes/ No |
| 13- | Have 4 to 6 beds | Yes/ No |
| 14- | OPD is clean | Yes/ No |
| 15- | Toilets are clean | Yes/ No |
| 16- | Whole of the PHC campus is clean | Yes/ No |
| 17- | Services are provided round the clock | Yes/ No |
| 18- | Has a functional labour room | Yes/ No |
| 19 | OT is functional | Yes/ No |
| 20- | How many days ago did the last delivery take place? | Yes/ No |
| 21- | Electric supply is present | Yes/ No |
| 22- | Generator is functional | Yes/ No |
| 23- | There are arrangements for drinking water | Yes/ No |
| 24- | Functional ambulance | Yes/ No |
| **Services at the PHC** | | |
| 25- | In the last month, count the number of days when the OPD received more than 40 patients | |
| 26 | How many deliveries took place in the last month | |
| 27 | Last month how many patients were seen during emergency hours? | |
| 28 | In last one month, how many patients were admitted to the inpatient department? | |
| 29 | Last month, how many times was the ambulance used? | |
| **Rogi Kalyan Samiti** | | |
| 30 | Does the PHC have RKS? | |
| 31 | When did the last meeting of RKS take place? | Yes/No |
| 32 | Has the PHC received a grant of Rs.25, 000 as untied funds? | |
| 33 | Has the PHC received Rs.50, 000 as maintenance grant? | |

**XVI- Observation at the Sub-centre**

| | | |
|---|---|---|
| 1 | Name of the Sub-centre | |
| 2 | Name of the PHC | |
| 3 | Name of the Block | |
| 4 | Name of the District | |
| 5 | Name of the ANM | |
| | Staff and available infrastructure | |
| 6 | Number of female health workers available | |
| 7 | Number of male health workers | |
| 8 | Condition of the building - kuchha / pukka / other | |
| 9 | Government building? | Yes/ No |
| 10- | Facility for water? | Yes/ No |
| 11- | Electric supply? | Yes/ No |
| 12 | Toilet is present? | Yes/ No |
| 13 | Cleanliness? | Yes/ No |
| **Equipments and medicines** | | |
| 14 | BP instrument | Yes/ No |
| 15 | Examination table / bed | Yes/ No |
| 16 | Facility for killing insects/ insect control | Yes/ No |
| 17 | Weighing machine | Yes/ No |
| 18 | Instruments for blood testing | Yes/ No |
| 19 | Test tube to take urine samples | Yes/ No |
| 20 | Facility for normal delivery | Yes/ No |
| 21 | Instruments for Copper-T insertion | Yes/ No |
| 22 | Car with Battery | Yes/ No |
| 23 | Foetoscope | Yes/ No |
| 24 | ORS packets | Yes/ No |
| 25 | Iron tablets | Yes/ No |
| 26 | Vitamin A syrup | Yes/ No |
| **Registers** | | Date of last update |
| 27 | Pregnancy register | |
| 28 | Birth & Death register | |
| 29 | JSY register | |
| 30 | Register for Untied funds | |

| **Are following services available** | | |
|---|---|---|
| 31 | Pregnancy test | Yes/ No |
| 32 | Services for normal labour | Yes/ No |
| 33 | Referral services for cases of difficult labour | Yes/ No |
| 34 | Notice board | Yes/ No |
| 35 | Working hours indicated | Yes/ No |

**XVII- Exit Interview with patients**

| | | |
|---|---|---|
| 1 | Name of the health centre | |
| 2 | For which of your health problem have you come here? | |
| 3 | Why did you choose to come to this health center only? | |
| 4 | Have you been to this health center before? | Yes /No |
| 5 | IF YES - how many time? | |
| 6 | How much time does (or did) it take here to get treatment or investigation done? | |
| 7 | Apart from the registration fee, were you required to pay for anything else? | Yes /No |
| 8 | If Yes - then for what all things? | |
| 9 | When you needed them, did you get the necessary medicines here in the health centre itself? | Yes/No |
| 10 | Were you asked to buy medicines from outside? | Yes /No |
| 11 | IF Yes - how much money did it cost? | |
| 12 | Were you referred to a private doctor? | Yes/ No |
| 13 | Did you require ambulance services at any point of time? | Yes/No |
| 14 | IF Yes - was the service easily available? | Yes/No |
| 15 | Here in the emergency department do you get services of the doctor for all 24 hour? | Yes/No |
| 16 | Is there a waiting room for the patients? | Yes/No |
| 17 | Are you satisfied with the behaviours of all the doctors, nurses and other staff of this hospital? | Yes/No |
| 18 | If No - what is the reason? | |
| 19 | In this hospital what is the real problem that you had to face? | |

**Analysis proforma for information gathered during the Social Audit investigations**

| Community Perspective | Provider Perspective | Manager Perspective |
|---|---|---|
| **JSY** | | |
| What women who delivered say? | What ANM says? | What Superintendent of the CHC says? |
| What Community Women say ? ( from FGD) | What AWW says? | What DPMU says? |
| What Pradhan says? | What MO PHC has to say? | What State Health Mission says? |
| What ASHA says | Facilities at SC / PHC /CHC | |
| **ASHA Functioning** | | |
| What Community Women say ? ( from FGD) | What ANM says? | What Superintendent of the CHC says? |
| What Pradhan says? | What AWW says? | What DPMU says? |
| What ASHA says | | What State Health Mission says? |
| **Facility** | What ANM says? | |
| What Community Women say ? ( from FGD) | What AWW says? | What Superintendent of the CHC says? |
| What Pradhan says? | What MO PHC has to say? | What DPMU says? |
| What ASHA says | Facilities at SC / PHC /CHC | What State Health Mission says? |
| **Decentralization** | | |
| What Pradhan says? | What ANM says? | What DPMU says? |
| | What AWW says? | |
| What ASHA says | What MO PHC has to say? | What State Health Mission says? |
| What member of the VHC says? | | |

Please record the information from the primary source eg. Interview record, FGD record, Facility observation checklist etc. into the proforma given above.

Summarise the information for each theme comparing the information across columns - eg. community, provider or manager. Since this is a community driven process, the community perspective should be seen as the major perspective and the provider and managers perspective should be compared against it to see whether there is a match or not.

This summarised record forms the district social audit report. The district social audit report can be further strengthened by including case studies of gross rights violations, service denial especially those which are with marginalized communities or lead to serious adverse outcomes.

# Annexures

Annexure - I

# Social Audit - What the Newspapers Say in Different Districts

| | | |
|---|---|---|
| Title of the News | : | **Trouble stated even before the program got going! The social audit revealed the secrete** |
| Name of the Newspaper | : | Hindustan |
| Place of Publication | : | Lucknow |
| Date - August | : | 2nd 2007 |

हिन्दुस्तान

लखनऊ

योजना लागू होने से पहले ही शुरू हो गई गड़बड़ी

निजी संगठन के ऑडिट ने खोली पोल

| | | |
|---|---|---|
| Title of the News | : | **Chief medical officer went on surprise visit** |
| Name of the Newspaper | : | Royal Bulletin |
| Place of Publication | : | Muzzaffarnagar |
| Date | : | July 19th 2007 |
| Title of the News | : | **No provision of salary for ASHA - CMO** |
| Name of the Newspaper | : | Royal Bulletin |
| Place of Publication | : | Muzzaffarnagar |
| Date | : | July 20th 2007 |

मुख्य चिकित्साधिकारी ने किया औचक निरीक्षण

प्रे.वि.
मुजफ्फरनगर, 19 जुलाई।

मुख्य चिकित्सा अधिकारी डॉ. प्रदीप कुमार जैन ने प्राथमिक स्वास्थ्य केन्द्र छपार का औचक निरीक्षण किया। जहा प्रभारी चिकित्सा अधिकारी डॉ. रफल सिंह उपस्थित थे, श्रीमती किरण बाला एएनएम, श्रीमती संतोष रानी एचवी, जगमोहन सुपरवाईजर व आरके सैनी अनुपस्थित मिले।

इसके बाद उन्होंने बरला प्राथमिक स्वास्थ्य केन्द्र के निरीक्षण में प्रभारी चिकित्सा अधिकारी डा. विपिन ठकराल व रामलालित वर्मा सुपरवाईजर अनुपस्थित मिले। इसके उपरान्त मुख्य चिकित्सा अधिकारी डॉ. जैन ने प्राथमिक स्वास्थ्य केन्द्र पुरकाजी का निरीक्षण किया जहां प्रभारी चिकित्सा अधिकारी डॉ. आशी उपस्थित पाये गये तीन दिन से उपस्थित नहीं थी। श्रीमती ममता शर्मा एएनएम, श्रीमती रति दाई, श्रीमती सुलक्षणा भट्ट चपरासी, सावन कुमार एएनएम, रमेश चन्द एचएस, पीके सिंघल क्षेत्र सहायक, धर्मवीर त्यागी, अजब सिंह आईसीसी अनुपस्थित मिलें। सभी अनुपस्थित अधिकारियों, कर्मचारियों के वेतन रोकने के आदेश मुख्य चिकित्सा अधिकारी ने दिये। नियमित टीकाकरण हेतु एएनएम टीसी कूकड़ा पर यूनिसेफ द्वारा प्राथमिक स्वास्थ्य केन्द्र के

**अनुपस्थितों का रोका वेतन**
**टीकाकरण का तीन दिवसीय प्रशिक्षण प्रारम्भ**

चिकित्साधिकारियों का तीन दिवसीय प्रशिक्षण प्रारम्भ हुआ। प्रशिक्षण सत्र का शुभारम्भ मेडिकल कॉलेज, मेरठ से आई डॉ. पीके जैसवाल ने किया। यूनीसेफ के मंडलीय कार्डिनेटर अनिल नागेन्द्र आदि उपस्थित थे। उपस्थित भागीदारो को सम्बोधित करते हुए डॉ. जैन ने कहा कि आप लोग 3 दिवसीय प्रशिक्षण सत्र में पूर्ण मनोबल से भाग ले। विशेषज्ञों द्वारा प्रदत्त जानकारी का अपने-अपने क्षेत्रों में क्रियान्वयन कर नियमित टीकाकरण को सुदृढ बनाये ताकि बच्चों को छः जानलेवा बीमारियों से बचा जा सके।

अस्तित्व संस्था द्वारा स्वागत होटल मुजफ्फरनगर में ग्रामीण स्वास्थ्य मिशन के सफल क्रियान्वन हेतु कार्यशाला का आयोजन किया गया। कार्यशाला को सम्बोधित करते हुए मुख्य चिकित्सा अधिकारी डॉ. पीके जैन ने महत्वपूर्ण कड़ी 'आशा' के कार्यो पर प्रकाश डालते हुए उनके द्वारा किये गये कार्य पर दिये जाने वाले मानदेय की जानकारी दी। जननी सुरक्षा योजना में लाभार्थी को दी जाने वाली धनराशि व आशा को दी जाने वाली प्रोत्साहन राशि की विस्तृत जानकारी दी। आशा को निर्देश देते हुए उन्होंने कहा कि सभी अपने क्षेत्र में योजना का व्यापक प्रचार-प्रसार करें ताकि जनसामान्य जननी सुरक्षा योजना का लाभ उठा सके।

स्वास्थ्य मिशन योजना के तहत गोष्ठी को संबोधित करते मुख्य चिकित्सा अधिकारी पी.के. जैन।

आशा योजना में वेतन का कोई प्रावधान नहीं: सी.एम.ओ

संवाददाता
मुजफ्फरनगर, 19 जुलाई

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन पर जिला स्तरीय स्वास्थ्य संवाद गोष्ठी का आयोजन आज महावीर चौक स्थित एक होटल में किया गया।

गोष्ठी का आयोजन सामाजिक संस्था अस्तित्व एवं महिला अधिकार मंच द्वारा हैल्थ वॉच फोरम एवं सेन्टर फोर हैल्थ एण्ड सोशल जस्टिस नई दिल्ली के सहयोग से किया गया। गोष्ठी में मुख्य अतिथि के रूप में उपस्थित हुए सीएमओ डा. पी.के. जैन ने कहा कि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन योजना अभी अपने प्रथम चरण में ही है। वर्ष 2004 में प्रधानमंत्री मनमोहन सिंह ने नई दिल्ली के विज्ञान भवन में इस योजना का शुभारंभ किया था। यह योजना केन्द्र सरकार ने शुरू कर प्रदेश सरकार को सौंप दी थी, जहां से यह योजना जिले में भेजी गई लेकिन इसमें कुछ विसंगतियां है। उन्होंने बताया कि इस योजना के अन्तर्गत एक हजार की आबादी पर गांव में आशा का चयन किया गया था।

**स्वास्थ्य संवाद गोष्ठी आयोजित की**

उन्होंने कहा कि इस योजना से जुड़ी आशाओं ने ट्रेनिंग में या तो पूरी बात नहीं सुनी या उनकी समझ में नही आई है। उन्होंने बताया कि यह एक स्वैच्छिक योजना है और इसमें वेतन का कोई प्रावधान नहीं है। उन्होंने बताया कि आशा को जननी सुरक्षा योजना के अन्तर्गत गर्भवती महिलाओं का जिला चिकित्सालय अथवा अन्य सरकारी चिकित्सालयों में प्रसव कराना, एक साल में बच्चे को छह जानलेवा बीमारियों के टीके लगवाना, पल्स पोलियो प्रतिरक्षण अभियान में कार्य करना, नसबंदी कराना आदि कार्यो की मूलतः जिम्मेदारी सौंपी गई थी, जिसमें निर्धारित पारिश्रमिक देने का प्रावधान है।

उन्होंने बताया कि एक आशा को एक महीने में एक बार इस कार्य पर लगाया जा सकता है। इसके लिए अलग से मानदेय निर्धारित है। उन्होंने कहा कि जिस आशा को अभी भी कोई बात समझ में नही आ रही हो, वह सम्बंधित स्वास्थ्य केन्द्र के चिकित्सा अधिकारी अथवा पीएचसी कार्यालय आकर पूरी जानकारी प्राप्त कर सकती है। अस्तित्व संस्था की संयोजक रिहाना अदीब ने बताया, कि उनकी संस्था पुरकाजी क्षेत्र में महिला अधिकारों की लडाई लड़ रही है। क्षेत्र के दस से ज्यादा गांव इस योजना में शामिल है, जिसमें झबरपुर, हरिनगर सोथना, फलौदा, छपार, पुरकाजी, बरला, भूराहेडी, भौजाहेडी, अब्दुल्लापुर, तुगलकपुर शामिल है।

इस अवसर पर जिला कार्यक्रम अधिकारी दीप्ति भाटिं, जनकल्याण उपभोक्ता समिति के संयोजक मनेश गुप्ता एडवोकेट, वरिष्ठ अधिवक्ता श्रीमती मीरा सक्सेना, महबूब आलम, सुधीर शर्मा, राजदेव, वी.के. चौधरी, श्यामवीर शर्मा, आदि ने भी अपने विचार व्यक्त किये। कार्यक्रम में स्नेहलता, शशीकला, अंजू, मंजू, राजबीरी, रेखा, संगीता, रानी गुलिस्ता, बालेश, हिना खान, अंजना, सीमा शर्मा, अब्दुल हमीद आदि का सहयोग रहा।

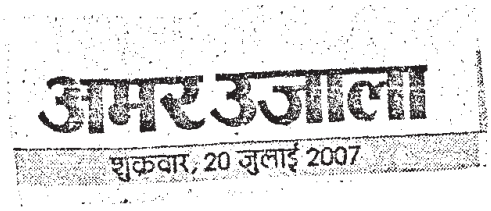
रॉयल बुलेटिन
शुक्रवार, 20 जुलाई, 2007

Title of the News : **Doctors found absent on duty hours - Salary will deducted**

Name of the Newspaper : Amar Ujjala

Place of publication : Muzzaffarnagar

Date : July 20th 2007


अमर उजाला
शुक्रवार, 20 जुलाई 2007

# ड्यूटी से नदारद मिले डाक्टर, कटेगा वेतन

मुजफ्फरनगर। सीएमओ द्वारा किए गए निरीक्षण में कई चिकित्सक अनुपस्थित मिले। चिकित्साधिकारी ने अनुपस्थित अधिकारियों एवं कर्मचारियों का वेतन रोकने के आदेश दिए हैं।

मुख्य चिकित्साधिकारी डाक्टर प्रदीप कुमार जैन ने प्रातः प्राथमिक स्वास्थ्य केंद्र का निरीक्षण किया। जिसमें प्रभारी चिकित्साधिकारी डाक्टर रफल सिंह दो दिन अनुपस्थित मिले। एएनएम किरण बाला, एचवी संतोष रानी व जगमोहन सुपरवाईजर, आरके सैनी अनुपस्थित मिले। प्राथमिक स्वास्थ्य केंद्र बरला के निरीक्षण में प्रभारी चिकित्साधिकारी डाक्टर त्रिपिन ठकराल व रामललित वर्मा सुपरवाईजर नदारद मिले। इसके उपरांत मुख्य चिकित्साधिकारी डाक्टर जैन ने प्राथमिक स्वास्थ्य केंद्र पुरकाजी का निरीक्षण किया। प्रभारी चिकित्साधिकारी डाक्टर बीके ओझा अनुपस्थित मिले। डाक्टर जेपी त्यागी की तीन दिन की उपस्थिति अंकित नहीं पाई गई। सरला शर्मा एचवी, रति दाई, सुलक्षणा भट्ट चपरासी, सावन कुमार एसटीएस, रमेश चंद एचएस, पीके सिंघल नेत्र सहायक, धर्मवीर त्यागी, अजब सिंह आईसीसी अनुपस्थित मिले। मुख्य चिकित्साधिकारी ने उपरोक्त सभी का वेतन रोकने के आदेश दिए हैं।

उधर, नियमित टीकाकरण सुदृढ़ीकरण के लिए एएनएमटीसी कूकडा पर यूनिसेफ द्वारा प्राथमिक स्वास्थ्य केंद्र के चिकित्साधिकारियों का तीन दिवसीय प्रशिक्षण प्रारंभ हुआ। प्रशिक्षण सत्र का शुभारंभ मेडिकल कॉलेज मेरठ से आई डाक्टर भटनागर ने किया। इस अवसर पर सीएमओ, जिला प्रतिरक्षण अधिकारी डाक्टर वीके जौहरी, यूनिसेफ के मण्डलीय क़ार्डिनेटर अनिल नागेंद्र आदि उपस्थित थे। उपस्थितजनो को संबोधित करते हुए सीएमओ ने तीन दिवसीय प्रशिक्षण सत्र में पूर्ण मनोबल से कार्य करने का आह्वान किया।

Title of News : **Dialogue on National Rural Health Mission**

Name of the Newspaper : Rastriya Sahara

Place of Publication : Banda

Date : July 22nd 2007

राष्ट्रीय सहारा - दिनांक - 22.07.07

# राष्ट्रीय ग्रामीण स्वास्थ्य मिशन पर स्वास्थ्य संवाद कार्यक्रम आयोजित

**सहारा न्यूज ब्यूरो**

**बांदा,** 21 जुलाई।

तरुण विकास संस्थान के तत्वाधान में नगर के बलखंडीनाका स्थित एक मैरिज हाल में राष्ट्रीय ग्रामीण स्वास्थ्य मिशन पर जिला स्तरीय स्वास्थ्य संवाद कार्यक्रम का आयोजन किया गया। जिसमें स्वास्थ्य योजनाओं की जानकारी एवं स्वास्थ्य व्यवस्था पर विचार विर्मश किया गया।

इस मौके पर मुख्य चिकित्साधिकारी डा0 अमरेंद्र सिंह कुशवाहा ने कहा कि स्वास्थ्य मिशन के तहत जननी सुरक्षा योजना के लिये प्रत्येक प्राथमिक स्वास्थ्य को दो दो लाख रुपये दे दिया गया है। अब किसी गर्भवती महिला को प्रसव के बाद सात दिनों के अंदर 1400 रुपये तथा उसका सहयोग करने वाली आश बहू को 600 रुपये दिया जायेगा। संस्थान की निदेशक उमा कुशवाहा ने कहा कि जिले में महिलाओं की स्वास्थ्य स्थिति बहुत खराब है। अस्पतालों में बगैर पैसे के उपचार नहीं किया जाता है। मधू कुशवाहा ने कहा कि क्षेत्र में स्वास्थ्य व्यवस्था एनएचआरएम के अनुरुप नही चल रही है। इसका लाभ आम आदमी को नहीं मिल पा रहा है। इस कार्यक्रम में नयना संस्थान के निदेशक अरविंद सहित लगभग आधा सैकडा महिलायें उपस्थित रहीं।


राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के कार्यक्रम में विचार व्यक्त करते संस्थान के पदाधिकारी।

*(फोटो : एसएनबी)*

Tile of News : **In Public Hospitals treatment is not possible without money**

Name of the Newspaper : Aaj

Place of publication : Kanpur ( reporting Banda Public sharing)

Date : July 22nd 2007

बांदा आज

कानपुर, 22 जुलाई, 2005

# अस्पतालों में पैसा दिए बगैर नहीं होता मरीज का उपचार

(आज समाचार सेवा)

बांदा, 21 जुलाई। राष्ट्रीय ग्रामीण स्वास्थ्य मिशन पर शहर के यादव मैरिज हाल में आयोजित जिला स्तरीय स्वास्थ्य संवाद गोष्ठी में वक्ताओं ने महिलाओं के गिरती स्वास्थ्य की स्थिति पर नाराजगी जताते हुए कहा कि अस्पतालों में पैसा दिए बगैर किसी मरीज का उपचार नहीं होता। इस गोष्ठी में शिरकत करने पहुंचे सीएमओ डा. अमरेंद्र सिंह कुशवाहा ने भरोसा दिलाया कि प्रत्येक व्यक्ति को सरकारी चिकित्सा सेवाओं का लाभ दिलाया जाएगा।

गोष्ठी को सम्बोधित करते सेंटर फॉर हेल्थ संस्था के राजदेव।

गोष्ठी को सम्बोधित करते हुए सीएमओ डा. कुशवाहा ने कहा कि राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के तहत प्रत्येक स्वास्थ्य केन्द्र को जननी सुरक्षा योजना का दो-दो लाख रुपया आवंटित कर दिया गया है। गर्भवती महिला को प्रसव के बाद सात दिनों के भीतर चौदह सौ रुपए दिया जाएगा। यदि किसी आशा बहू ने सहयोग किया तो छह सौ रुपए दिए जाएंगे। कार्यक्रम में आई दर्जनों महिलाओं ने जेएसवाई का पैसा न मिलने और अस्पतालों में स्वास्थ्य कर्मियों के दुर्व्यवहार की बात रखी। जिस पर सीएमओ ने सभी मामलों की जांच कराकर तुरन्त पैसा दिलाने का आश्वासन दिया है।

**■ संवाद गोष्ठी में महिलाओं के गिरते स्वास्थ्य की स्थिति पर वक्ताओं ने जताई नाराजगी**

**■ सीएमओ बोले- प्रत्येक व्यक्ति को दिलाया जाएगा सरकारी चिकित्सा सेवाओं का लाभ**

तरुण विकास संस्थान की मधु कुशवाहा ने कहा कि क्षेत्र में स्वास्थ्य व्यवस्था एनएचआरएम के अनुरूप नहीं चल रही है। इसके लिए संयुक्त रूप से संघर्ष करने की आवश्यकता है। सेंटर फार हेल्थ सोशल दिल्ली से आए राजदेव ने कहा कि इस योजना के अन्तर्गत सामाजिक निगरानी का प्राविधान है। जिस पर अमल नहीं किया जा रहा। तरुण विकास संस्थान के निदेशक उमा कुशवाहा ने कहा कि जिले में महिलाओं के स्वास्थ्य की स्थिति बेहद खराब है। अस्पतालों में पैसा दिए बगैर उपचार नहीं किया जाता। गोष्ठी में डा. मदन गोपाल बाजपेई, आशा बहू गीता, बरछा की निर्मला, बदौसा की ललिता आदि ने हिस्सा लिया।

Tile of News : **Rural Health Mission Declining steadily, state oblivious**

Name of the Newspaper : Express NewsLine

Place of publication : Lucknow

Date : August 2nd 2007

The Indian EXPRESS
EXPRESSNewsline
LUCKNOW | THURSDAY | AUGUST 2, 2007

# Rural Health Mission declining steadily, state oblivious

TARANNUM MANJUL
LUCKNOW, AUGUST 1

ON February 12, Kanwal Singh's wife delivered a baby at the Purkaaji Primary Health Centre in Muzzafarnagar.

But during the delivery, her urinary tube was damaged. The Auxiliary Nursing Midwife Geeta Sharma, despite being told that the patient was in great pain, discharged Singh's wife Salenta immediately.

Ever since, Singh, Singh, a brick kiln labourer in Jhabarpur village, has been running from pillar to post to get is wife treated. He has sold off his house and spent around Rs 50,000 so far.

"I have reported the matter to the Chief Medical Officer of my district, but no action has been taken against the erring ANM," said Singh. He has sent applications to the health minister and Chief Minister's Office too, but to no avail.

"My wife is still writhing in pain, but there is no one to listen to us. I want to commit suicide. I have nothing left to spend on my wife's treatment," said Singh.

Singh came all the way to Lucknow to be part of a day-long discussion on the social audit of the National Rural Health Mission (NRHM), organised by the NGO Healthwatch. And it was here that he got to know that his wife can be treated free of cost at any government hospital and the erring ANM has to be punished.

"This is an essential component of the NRHM, which says that more and more women should go for institutional deliveries and the NRHM gives 'concrete service guarantee'. But see what happens when a poor woman goes to a public health centre," said Dr Abhijit Das of Healthwatch.

Singh is not alone in his complaint of poor services. The social audit, conducted in the districts of Chandauli, Mirzapur, Barabanki, Muzzafarnagar and Banda, reveals that the state has failed to provide basic facilities under the NRHM.

Not just the people, but even the ASHAs (Accredited Social Health Activist) too are complaining.

Said Rajpyari (name changed), an ASHA from Gorakhpur: "Women who had paid to be selected as ASHAs get their dues cleared well in time. But women like us still haven't got anything under the Janani Suraksha Yojna, where we have assisted in institutional deliveries."

Another ASHA from the same district said that though deliveries are done free of charge in government hospitals and PHCs, fees of Rs 348 is being charged in her district.

Malti, from Atrauli, Azamgarh, complained that a staff of the Community Health Centre took Rs 3000 from her as a 'fee' to get her appointed as a ASHA. This took place a year ago and she is still waiting.

**Kanwal Singh shows the hospital slips of his wife (above).** *Shashi Bhusan Pandey*

Talking about the audit, coordinator Rajdev Chaturvedi of Grameen Punarnirman Sansthan said the worst district was Barabanki.

"We could not find a single PHC where institutional deliveries could be conducted. This district is next to the state capital and yet the government cannot ensure proper healthcare for the people here."

The audit, he said, revealed that charging money for deliveries and no incentives to ASHAs despite promises are some of the common factors in all districts. "I want the government to show me one district which they consider model, and I can do an audit there too," he said.

The audit was conducted by Pani in Barabanki, Gramya in Chandauli, Shikhar Pradhikshan Sansthan in Mirzapur, Astitva in Muzzafarnagar and Tarun Vikas Sansthan in Banda.

The state government was represented by additional director, Family Welfare, Naira Shakeel. Social activists like Utkarsh Sinha of Centre For Contemporary Studies, Arundhati Dhuru of National Alliance of People's Movement and Dharmendra Rai from Varanasi, alongwith the representatives from supporting NGOs were present on the occasion.

Tile of News : **Government to help Singh**

Name of the Newspaper : Express NewsLine

Place of publication : Lucknow

Date : August 2nd 2007

EXPRESS News The Indian EXPRESS

Nagar Lucknow-226010 | E-MAIL: lucknownewsline@expressindia.com | Phone: 0522-2391233, 2391434, 2391302 (fax)

# Govt to help Singh

**NEWSLINE IMPACT**

EXPRESS NEWS SERVICE
LUCKNOW, AUGUST 2

FINALLY, Kanwal Singh of Purkaaji village in Muzzafarnagar may get some relief.

Following the August 2 *Newsline* report on Singh, who came all the way from Muzzafarnagar to Lucknow to get help for his wife, the authorities have promised action.

Singh's wife had sustained injuries during her delivery, due to negligence by the Auxiliary Nursing Midwife.

The principal secretary, health, Arun Mishra has assured that they will probe the case and said Singh's wife will be treated free of cost in a government hospital. He also said the department may try to get some relief for Singh too.

Dr Abhijit Das of Healthwatch, who had bought Singh to the state capital to present his case at the social audit of the National Rural Health Mission, said the government should own up the responsibility for Singh's wife. "Because of the ANM's negligence, his wife is suffering and the poor man is running from pillar to post. The government should ensure that he be able to get his wife treated free of cost."

Tile of News : **Mahila Sawathy Manch took responsibility for safe delivery**

Name of the Newspaper : Rashtriya Sahara

Place of publication : Lucknow

Date : August 2nd 2007

राष्ट्रीय सहारा

www.rashtriyasaha

यानी पूर्ण सत्य

लखनऊ, बृहस्पतिवार, 2 अगस्त, 2007,

# महिला स्वास्थ्य मंच ने लिया सुरक्षित प्रसव का जिम्मा

सहारा न्यूज ब्यूरो

लखनऊ, 1 अगस्त।

ग्रामीण क्षेत्र में सुरक्षित प्रसव की जिम्मेदारी महिला स्वास्थ्य मंच के कार्यकर्ताओं ने ली है। इसके लिए तैनात कार्यकर्ता स्वास्थ्य सेविका 'आशा' से मिलकर महिलाओं को सरकारी योजनाओं का लाभ पहुंचाने का काम करेंगी। यह जानकारी आज होटल क्लार्क्स अवध में आयोजित राष्ट्रीय ग्रामीण स्वास्थ्य मिशन पर आयोजित बैठक में स्वयंसेवी संस्था हेल्थ वाच के कार्यकर्ता राजदेव चतुर्वेदी ने दी।

हेल्थ वाच के तत्वावधान में आयोजित बैठक को सम्बोधित करते हुए श्री चतुर्वेदी ने बताया कि एक सर्वे में यह उजागर हुआ है कि गर्भवती महिलाओं को स्वास्थ्य सम्बंधी जानकारी देने के लिए तैनात की गयी कार्यकर्ता आशा की नियुक्ति में तमाम खामियां है। इन कार्यकर्ताओं को प्रशिक्षण नहीं दिया गया है न ही इन्हें सरकारी योजनाओं की जानकारी दी गयी है। यही कारण है कि प्रदेश में हर साल चालीस लाख महिलाएं प्रसव में होने वाली परेशानियों के कारण मौत के मुंह में चली जाती है। इसके मद्देनजर संस्था द्वारा तैयार मंच महिला स्वास्थ्य कार्यकर्ताओं ने सुरक्षित प्रसव की जिम्मेदारी ली है।

## राष्ट्रीय ग्रामीण स्वास्थ्य मिशन की समीक्षा बैठक

कार्यक्रम में डा. अभिजीत ने कहा कि प्रदेश में मात्र सवा दो लाख महिलाओं को ही पूर्ण जांच व देखभाल मिलती है। चालीस लाख से ज्यादा महिलाएं बिना प्रशिक्षित दाई के ही शिशु को घर में ही जन्म देती है। यही नहीं अस्पताल में शिशु को जन्म देने वाली महिलाओं को जननी योजना का लाभ नहीं दिया जा रहा है। बैठक में परिवार कल्याण महानिदेशालय के अधिकारियों, सिफ्सा, यूनिसेफ, पाथ व अन्य संगठनों के प्रतिनिधि शामिल

Tile of News : **NGO sees no "asha" in NRHM**

Name of the Newspaper : City Pioneer

Place of publication : Lucknow

Date : August 2nd 2007

city pioneer

Lucknow | Thursday | August 2 | 2007

# NGO sees no 'asha' in NRHM

Pioneer News Service | Lucknow

A social audit conducted by a non-governmental organisation (NGO) in five districts of Uttar Pradesh exposes truth regarding the functioning of the accredited social health activists (ASHAs) under the National Rural Health Mission (NRHM) programme.

The NGO shared its report on the districts of Muzaffarpur, Banda, Barabanki, Mirzapur and Chandauli with the media on Wednesday.

It states that there is no transparency in the selection of ASHAs and points to many discrepancies in the disbursement of funds to them.

While releasing the report, the members of the NGO alleged that transparency was not maintained in the selection of ASHAs and at most places money was demanded for it. Besides, they said, proper training was not given to these health activists as a result of which they were still not aware of their roles.

While talking to The Pioneer, the social health activists of various districts of the state pointed out the anomalies in their districts.

An activist from Saharanpur said that she was given only Rs 300 and was forced to sign a receipt for Rs 600. An activist from Mirzapur complained of inadequate training and lack of any facilities due to which the villagers refused to recognise them.

NRHM additional director Nayara Shakeel said the audit was done in the five districts where the NRHM project had been implemented in a slipshod way.

"There are 70 districts in the state but the audit has been done in only five, therefore its findings do not reflect reality. To see the true face of the programme, one should go to other districts also were it is a big success. The Planning Commission has sanctioned the fund for the project but, it will take some time to show the desired the result," she added.

Tile of News : **Weak infrastructure of NRHM in remote rural areas**

Name of the Newspaper : Dainik Jagaran

Place of publication : Lucknow

Date : August 2nd 2007

दैनिक जागरण

विश्व का सर्वाधिक पढ़ा जाने वाला अखबार

लखनऊ, 2 अगस्त, 2007

# 'छोटे शहरों में ग्रामीण स्वास्थ्य मिशन का ढांचा कमजोर'

कार्यशाला को सम्बोधित करते डा. अभिजीत सरकार

लखनऊ, 1 अगस्त (जास) : राज्य के पांच जिलों में राष्ट्रीय ग्रामीण स्वास्थ्य मिशन (एनएचआरएम) के ढांचे की पड़ताल के लिए किये गये अध्ययन को स्वास्थ्य विभाग और तकनीकी संस्थाओं के साथ बांटने के उद्देश्य से आज एक कार्यशाला का आयोजन किया गया। स्वयंसेवी संस्था 'हेल्थयाच' द्वारा आयोजित कार्यक्रम में विशेषज्ञों ने बताया कि छोटे शहरों में एनआरएचएम का ढांचा काफी कमजोर है।

होटल क्लार्क्स अवध में आयोजित कार्यक्रम में चन्दौली, मिर्जापुर, बाराबंकी, बांदा और मुजफ्फरनगर में किये गये अध्ययन की जानकारी राजदेव चतुर्वेदी ने दी। श्री चतुर्वेदी ने बताया कि छोटे शहरों में एनएचआरएम के क्रियान्वयन में कुछ खामियां निकली हैं। उन्होंने बताया कि हर जिले के मुख्य चिकित्साधिकारी ने कई स्तरों पर कमियों को स्वीकार भी किया है।

**• राष्ट्रीय ग्रामीण स्वास्थ्य मिशन पर कार्यशाला**

कार्यक्रम में 'ग्राम्या संस्थान' की प्रमुख बिन्दु ने बताया कि 'समन्वित स्वास्थ्य कार्यकर्त्री' (आशा) के चयन की प्रक्रिया में पारदर्शिता नहीं बरती गयी। मुजफ्फरनगर से आयी आशा कार्यकर्त्री रेखा देवी ने बताया कि अस्पताल में प्रसव के लिए महिला को ले जाने पर तीन से चार सौ रुपये दिये जाते हैं जबकि हस्ताक्षर छह सौ रुपये पर कराये जाते हैं। मिशन की अतिरिक्त निदेशक डा. नाजरा शकील ने बताया कि सीएमओ और अन्य अधिकारियों के साथ परिवार कल्याण निदेशालय की बैठक हुई है जिसमें आशा कार्यकत्रियों को तुरन्त मानदेय देने के निर्देश दिये गये हैं। बैठक में परिवार कल्याण महानिदेशालय, केयर पाथ, समेत कई स्वयंसेवी संस्थाओं के प्रतिनिधियों ने भाग लिया।

Annexure: II

# Social Audit and Concrete Service Guarantees - The Case of Salenta from Muzzaffarnagar, UP.


The sharing meeting of the Social Audit conducted in UP was organized in Lucknow on August 1, 2007, by Healthwatch Forum in partnership with CHSJ. At this meeting Kawal Singh from village Jhabarpur, in Muzzaffarnagar presented the case-study of his wife's delivery and subsequent complications.

Salenta, is the 32 year old wife of Kawal Singh. The couple belongs to the Chamar Caste (Scheduled Caste/ Dalit/ Untouchable ) and Kawal works as a daily wage labourer in a local brick kiln. They came to the PHC at Purkazi in Muzzarnagar District on the morning of the 12th of February, 2007 when Salenta felt her labour pains coming. Earlier they had come thrice to get antenatal care for Salenta from the same clinic. They had come to the clinic for Salenta's delivery on learning that they would get Rs 1400 for getting her delivery conducted there . The ANM Gita Sharma asked them to get an injection and intravenous infusion from the market. This was Salenta's sixth delivery. Gita administered the injection and infusion and went about her work. In the evening she went off to her quarter. The baby was born next morning at 10 am. The ANM asked for Rs 450 for conducting the delivery but they were able to pay only Rs 250 after getting the sum from the owner of the brick kiln where Kawal worked.

After returning home Salenta had the sensation of constant leaking through her birth canal. They went back to the PHC on the 17th where they met the doctor Dr Tyagi in the presence of the ANM and he assured her that this was normal and would become okay soon. Getting no relief they went back to the PHC again on the 22nd of February to be told that this was the treatment that was possible at the PHC, they could opt to go to a private doctor if they wanted better treatment. Between February and July Kawal took Salenta to hospitals ( government and private) and nursing homes in Laskar, Rookee, Muzzaffarnagar, and even the medical college in Meerut, but no one would help them. Kawal met the District Magistrate and the CMO office in Muzzaffarnagar. He met the local MLA who gave him a letter requesting help for Salenta. When he came to learn of the Social Audit in Muzafarnagar he came there and presented his story. The government officials asked him to visit the District Women's Hospital where he went immediately thereafter. There he was told he would need to arrange for about Rs 20,000. He had already spent over Rs 50,000 and was deeply in debt. He came to Lucknow for the state sharing on the social audit on August 1 hoping to get some help.

Salenta is now suffering from Vesico Vaginal Fistula - a rare situation where there is a passage between the birth canal and the urinary bladder. This is caused by prolonged labour due to bad obstetric management. Usually it happens when the delivery takes place at home and when it is the first delivery of a young or stunted mother. Salenta's delivery took place in a PHC, she was delivered by a ANM who mismanaged the case.

Healthwatch Forum took up Salenta's case immediately. A newspaper article appeared highlighting the plight of Salenta on the next day. The state Health Secretary when contacted by the newspaper agreed to support the treatment. Kawal was asked to get back to the district hospital. Healthwatch Fourm activistes continued to be in touch with the state health secretariat but no clear response was forthcoming. Kawal went to Agra Medical College but they did not promise free treatment he had to come back. On 28th September 2007 Healthwatch Forum

activists took Salenta to King George Medical College Lucknow where they examined her and then asked her to come back for surgery as there no beds vacant. Salenta is still waiting for her surgery at the time of going to press.

Healthwatch Forum activists have presented this case to the State Health NRHM directorate, the National NRHM directorate, as well as to the Member Planning Commission. Prominent newspaper articles have appeared have in national dailies.

Healthwatch activists will continue to pursue the case because if the Government promises Concrete Service Guarantees then it makes no sense for the system to ignore cases like Salenta's. Seeing the plight of Salenta and Kawal the promises of NRHM ring hollow and show that there is no real concern for the poor and marginalized women who are the supposed to be central concern of NRHM. If pursuing Salenta's case bears fruit (through free treatment and compensation, and guidelines ensuring appropriate referral for Emergency Obstetric Care and Complications) then the social audit process will have made a very important contribution to the realization of health rights for the poor.

*From: Healthwatch Forum Secretariat*

## Annexure III

# Study Team

**Overall Supervision :** Abhijit Das and Sunita Singh , CHSJ- New Delhi

**Technical Inputs :** Jashodhara Dasgupta, Shakuntala Joshi, Susheela D Singh, SAHAYOG- Lucknow

**Field Support :** Sunita Shahi, Prayas, Nainital and Rajdev Chaturvedi, Grameen Punarnirman Sansthan - Azamgarh

**Field level Implementation and Social Audit :**

| S.N. | Name of the Organisation | Name of the concerned person |
|---|---|---|
| 1 | Tarun Vikas Sansthan- Banda (U.P.) | Uma Kuswaha |
| 2 | People's Action for National Integration (PANI )- Barabanki (U.P) | Prakesh Bhushan |
| 3 | Gramya- Chanduli (U.P.) | Bindu Singh |
| 4 | Shikhar Prashikshan Sansthan- Mirzapur (U.P.) | Sandhya Jha |
| 5 | Astitva Samajik Sansthan- Muzzaffarnagar (U.P.) | Rehana Adeeb |
| 6 | Prayas - Nanital (U.K.) | Sunita Shahi |
| 7 | Hira Sansthan - Rishikesh (U.K.) | Dileep Singh |
| 8 | Mahila Kalyan Sanstha - Udham Singh Nagar (U.K.) | Hira Jantangi |

State Level and National Level Sharing : Healthwatch Forum, Mahila Swashtya Adhikar Manch

Report : Sunita Singh, Abhijit Das, Jyoti Gupta

## nnexure IV

# Glossary

| | |
|---|---|
| **AIDS** | Acquired Immuno Deficiency Syndrome |
| **ANC** | Ante Natal Care |
| **ANM** | Auxiliary Nurse Midwife |
| **ASHA** | Accredited Social Health Activist |
| **AWC** | Aangan Wadi Centre |
| **AWW** | Aangan Wadi Worker |
| **AYUSH** | Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy |
| **BCC** | Behavioral Change Communication |
| **BEmOC** | Basic Emergency Obstetric Care Services |
| **CMO** | Chief Medical officer |
| **CHC** | Community Health Centre |
| **CHSJ** | Centre for Health and Social Justice |
| **DHM** | District Health Mission |
| **DPMO** | District Programme Management Officer |
| **DPMU** | District Programme Management Unit |
| **FGD** | Focussed Group Discussion |
| **FRU** | First Referral Unit |
| **HIV** | Human Immuno Deficiency Virus |
| **IMR** | Infant Mortality Rate |
| **JSY** | Janani Suraksha Yojna |
| **MMR** | Maternal Mortality Rate |
| **MPW** | Multi Purpose Worker |
| **MKSS** | Mazdoor Kisan Shakti Sangathan |
| **NGO** | Non Governmental Organization |
| **NRHM** | National Rural Health Mission |
| **PCPNDT** | PreConception and PreNatal Diagnostic Test |
| **PRI** | Panchayati Raj Institution |
| **PHC** | Primary Health Centre |
| **RKS** | Rogi Kalyan Samitee |
| **RTI** | Reproductive Track Infection |
| **SC** | Sub Centre |
| **STI** | Sexually Transmitted Infection |
| **UEGS** | Universal Employment Guarantee Scheme |
| **UP** | Uttar Pradesh |
| **VHSC** | Village Health and Sanitation Committee |