

Rapid Assessment of the District Health Profile

(Under Community Health Fellowship Programme)

PHRN Orissa

A Brief Report

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1.1 Introduction: The rapid assessment of the district health profile was part of the on-going community health fellowship programme of PHRN. The purpose of this rapid assessment was to understand the gaps in different community level processes of public health programmes in the districts and take up selected interventions on pilot basis and on the basis of the findings the district level public health authority can be approached for initiating similar approach as far as communitization agenda of NRHM is concerned.

The rapid assessment was started in February-09 in five districts of Orissa (Angul, Dhenkanal, Mayurbhanj, Nayagarh and Rayagada) and ended in the 1st week of April-09. A total of ten blocks (Two blocks from each district) and 20 villages (four villages from each block) were taken as sample size. The rapid assessment was done with specific tools designed at the national level. The Community Health fellows (CHF) were properly trained through national induction programme held at SEARCH, Gadchiroli. At the state level a demonstrative PRA workshop was held to practically expose the CHF in using the rapid assessment tools.

The frame work focused on three major aspects of the survey. These include: a) Rapid assessment of the functioning of various components under NRHM b) Preparation of village profile and c) Rapid appraisal of the district.

2. Background

2.1 About the fellowship programme:

The Community Health Fellowship (CHF) programme has been launched in the state of Orissa from 1st of January-2009 to promote action research in community based health planning and management. This is a civil society initiative to support the National Rural Health Mission (NRHM) in partnership with National Health Systems Resource Centre, the apex technical support institution for NRHM; SEARCH, a pioneering NGO; and the ICICI centre for Child Health and Nutrition, a funding and research group.

The National Rural Health Mission (NRHM), Government of India's flagship programme for health aims to improve the quality of public health services by encouraging community participation and decentralizing public health planning and implementation. The community health fellowships are being

launched to strengthen the capacities of field level civil society participation in the NRHM and in the process build a team of young professionals and dedicated youth with the perspectives and skills to contribute to pro-poor community development work throughout the rest of their careers.

2.2 Objective of the programme:

The community Health fellowship Programme is a two year full time programme which provides young development professionals a strong background in the field of community health. The programme shall nurture, groom and educate the fellows towards enhancing and strengthening of various community processes in NRHM at the district and grassroots level.

The fellowship programme imparts multidisciplinary knowledge to the young professionals that is relevant to the context through a learning process that has action and reflection inbuilt into it. The focus is on creating community health professionals with high motivation and technical competencies to work with people, civil societies and the state to further the ideals of "Health for All".

2.3 Areas of Operation:

CHF programme has been initiated in eight districts of Orissa - Angul, Baragarh, Dhenkanal, Koraput, Mayurbhanj, Nayagarh, Rayagada and Nuapada

2.4 The need of Rapid Assessment:

The need of having a rapid assessment of the district health profile was a part of the National Programme design for the CHF activities in the five states. In this context there was a need to bring about a parity of understanding of the CHF's on various facets of intervention to be initiated through the fellowship programme. Further it was also envisaged that a common framework shall help to collate the findings of each state by collecting information of respective districts against the stated parameters while also comparisons can be made basing on the findings of various states. This resulted in the initiation of a national level induction cum orientation programme for the CHF's at SEARCH of Gadchiroli, Maharashtra.

The planning was entirely participatory and a lot of inputs were given by the young CHF's who were there in the workshop for the entire period. The National induction thus came out with a set of guidelines and support/feeder materials for the rapid assessment which eventually helped the CHF's in doing the appraisal work at the ground level.

The reason behind undertaking such a rapid assessment was to

- Bring a basic and common understanding about the district public health system in the mind of the CHF's so that they can contribute to the process and the purpose effectively.
- To bring clarity in the understanding regarding their interventions, equip them with tools and skills for rapid assessment, and get them exposed to various replicable public health models, programmes and facilities.
- To have a firsthand understanding on the levels of community participation in various ongoing health initiatives under NRHM and the current district health situation
- To understand the gaps in different community level processes in due course of their research during the two years and help take appropriate community level actions to bridge up the gap
- To share the findings with key stake holders at the district and community level for sensitizing them on various emerging health issues while also initiating collaborative actions including training, action research, monitoring, developing replicable models, ensuring better coordination and documenting case studies leading to the strengthening of various communitization initiatives of NRHM
- To get accepted by the public health system run by the district health administration and influence them for supporting their initiatives at the district and community level.

The rapid assessment survey was an initiative by the CHF's in their respective districts.

3. Methodology of Rapid Assessment Survey

3.1 Training through a national induction programme:

The induction programme for the Community Health fellows was held on the campus of SEARCH, Gadchiroli between 15th and 21st January, 2009. This induction programme was jointly organized by Public Health Resource Network (PHRN); Society for Education, Action and Research in Community Health (SEARCH); National Health System Resource Centre (NHSRC) and ICICI Centre for Child Health and Nutrition (ICCHN)(**Annexure-I**)

3.2 Evolution of a common tool for rapid assessment survey:

The workshop at Gadchiroli resulted in the evolution of a common frame work for rapid assessment to be done at the district level by respective CHF's. The frame work focused on three major aspects of the survey. These include

- A) Rapid assessment of the functioning of various components under NRHM
- B) Preparation of village profile and
- C) Rapid appraisal of the district.

A) The rapid assessment of various components under NRHM included

- a) Community perceptions on ASHA
- b) Assessment of functioning of ASHA
- c) Quality of services received through Maternal Health Guarantee schemes-
- d) Quality of service delivery of Janani Suraksha Yojana
- e) Awareness on Janani Suraksha Yojana
- f) Assessment of the functioning of Rogi Kalyan Samiti
- g) Assessment of the functioning of GKS

B) Preparation of village profile- The village profile was to be compiled for the sample villages using specific PRA tools of Social mapping, seasonality mapping, matrix ranking, time analysis, formal and informal interview with health service providers (ANM/AWW/TBA/Doctor/Traditional healers)and focused group discussions.

C) Rapid appraisal of the district- The relevant information on various aspects was to be collected from various departments. The focus was on collection of district specific a) Health Infrastructure and Human resource b) Details of the NGO's and other Civil Society Groups working on public health c)status of RKS d)Identifying potential resource persons and individuals interested in public health e)Comparing DLHS-2&3 with State level DLHS-2 &3 data to analyze the current situation.

The details of the tools for rapid assessment is attached in **Annexure-2**

3.3 Criteria for selecting the sample:

The sample size selected was on the basis of convenient sampling. Looking into the very short time line of the completion of the report two blocks were chosen from each district for the survey. One block was close to the district head quarter and the other was around 25-50km from the head quarter. Further 2 villages were selected from each block. One village was chosen close to the facility level at the block (PHC/CHC) and the other around 20km from the block. It can be noted that consideration was given in selecting villages where we had key stakeholders who volunteered to support our initiatives instantly and there were existing PHRN person/course participants.

The details of the list of villages are attached for reference in **Annexure-3**

3.4 Involving stakeholders for the survey at various levels:

The rapid assessment survey marked the involvement of multiple stakeholders at various levels to ensure credibility of the findings and to get a legitimate space for sharing the findings among the critical mass at the community, block and district level for necessary action. The following steps were involved to ensure complete participation of stakeholders:

- a) Issue of letter from the Mission Director to the district health administration regarding the support to be extended to the CHF's of the respective districts.
- b) Issue of letters from the CDMO to the respective BPMU, MOI/Cs, and ICDS members for support.
- c) Identifying potential individuals including MOI/Cs, AWWs, ANMs, ASHAs, BPOs, BEE who have a social blend of mind and interest in public health and subsequently appraising them regarding the rapid assessment survey and its purpose.
- d) Appraising all the key stake holders at the district and block level regarding the fellowship programme and the rapid assessment survey for support and involvement
- e) Establishing linkage with identified and potential active NGOs working in the public health domain and who voluntarily expressed their interest in supporting our initiatives. The NGO professionals were appraised about the rapid assessment and they extended their support in mobilizing the community for seeking information.

f) Potential volunteers were also identified through the ASHA, AWW and ICDS supervisors who played a critical role in mobilizing the community and facilitating the process of collection of Information.

3.5 Demonstrative PRA-A state level Pilot Initiative:

A two day rapid assessment workshop was held in Mayurbhanj district on the 17th and 18th of March-09 to develop a shared understanding on the application of various PRA tools among CHF's and other potential stake holders from the respective districts.

The application of various tools were field tested and practical experiences regarding mobilizing community, art of seeking information and transacting various PRA tools were learned. The details of the workshop is attached in

Annexure-4

3.6 Collection & compilation of information:

The data were collected from primary sources through FGD, personal interview and PRA techniques. The secondary information was collected at the district level from the office of DPMU, DSWO, RWSS, PR department, BPMUs, ICDS, and DIO. At the state level information were primarily collected from SIHFW (State Institute of Health and family Welfare) and state NRHM office.

The information collected from primary sources was immediately validated with the support of stakeholders of the respective villages who were involved in facilitating the rapid assessment survey. The secondary data were also collected from reliable sources. Thus the reliability and authenticity of the data collected were maintained. (NFHS-3, DHAP, DLHS, SRS)

District specific information was collated by taking the findings of the 4 sample villages. The findings were compiled as per the components specified in the rapid assessment formats. Basing on the findings of the respective districts the state specific report has been compiled by assimilating the information of the specific districts.

3.7 Limitations of the Rapid assessment Survey:

The following limitations of the rapid assessment survey were identified:

- a) Less sample size was taken on the basis of convenience and the size might not represent the entire universe of the study.

- b) There was scope for more in-depth probing of various components making the study more interesting.
- c) Short time available for completion of the report

4. Findings

The findings of the rapid assessment have to be understood in the context of:

- a) Analyzing the current status of various components of communitization processes of NRHM
- b) The issues at the community level and the possible bottle necks in ensuring equitable, accessible and affordable health care services.
- c) The current situation at the district level regarding the management of effective health care delivery.

The findings are direct observations and do not compare with any previous findings or recommendations.

4.1 Analyzing the current status of various components of NRHM

4.1.1 Community perceptions on ASHA: The flagship of the community participation is undoubtedly the ASHA programme. It is pertinent in this context to know the reflections of the community on the functioning of the ASHA. The group discussions were initiated with 10-15 women members in each sample village who represented the community. In some cases more than one group discussion was initiated in the same village to capture the entire social configuration.

The **general findings** of the perceptions of the community are as given below:

- In the five districts where rapid assessment was done it revealed that before the intervention of ASHA the situation was grim and no one was able to even think of accessing public health care facilities. Especially the children remained neglected and it was due to lack of information and proper counseling.
- The only information they received was from the ANM which was completely inadequate. The ASHA has been a solace to many of their wives as they have been able to get an opportunity to interact frequently on care during pregnancy and newborn care.

- There has been an overwhelming response of the community in stating that the ASHA is playing a critical role in facilitating the process of registration, administration of TT, consumption of IFA, chemoprophylaxis, colostrum feeding, exclusive breast feeding, immunization etc besides giving routine counseling. Further the intervention of ASHA has resulted in dispelling various blind beliefs and they are able to avail of proper medical counseling and services on time regarding care during pregnancy and new born care.
- ASHAs not only accompany all the pregnant women for delivery but also remain during the delivery and till the mother reaches home. In many cases the ASHA was reported to have stayed for more than 3 days due to complicacy and delay in pregnancy. It can be further noted that barring few exceptions in almost all the cases the ASHA has reached the household within 6 hours of delivery and have counseled on new born care including colostrum feeding, exclusive breast feeding, immunization and basic hygiene.
- The ASHA also has played a major role in organizing monthly health days for immunization and other health services. The ASHA collected the names of beneficiaries for the health day and informed them in advance to ensure maximum participation.
- The community further responded that though ASHA plays her role in providing medicines on time for simple illness like fever, diarrhoea, cough etc there is a perennial problem of shortage of medicine.

District specific findings- The above findings are a generalization of the information collected from the above mentioned sample size. There are no marked specific findings or any exceptions in any of the districts where the survey was undertaken.

4.12 Assessment of functioning of ASHA: ASHA has been the potential wheels in carrying forward the communitization agenda of NRHM. In this context direct interviews were organized with ASHA's in the sample villages to assess their current functioning and analyze its relevance to the mandate of NRHM as envisaged through ASHA. Further inputs were also taken regarding the problems that they encounter in functioning effectively.

The following are the general findings on the functioning of ASHA:

- The Village Health and Nutrition days (VHND) were observed every month where ASHAs participated in collaboration with the ANMs and AWWs in almost all the villages. In few villages the SHGs also joined the Village Health and Nutrition Days. The ASHA gets the information of pregnant and lactating mothers, Grade-III and Grade-IV children from the ANM and AWW before the day is observed to have effective coordination. In general the following activities are done in the VHNDs including: a) Weight measurement of pregnant woman and Children with the age group of 0 to 3 years. b) BP and abdominal check up of pregnant women, c) Referral checks up of sick children and d) medicine distribution.
- No specific refresher training has been given to the ASHA by any resource person or the ANMs. It was stated by the ASHAs that they sometimes try to clarify certain doubts during the ANMs visit. Though no refresher training programme has been done the 4th round training is completed.
- The observations revealed that ASHAs have accepted that advising pregnant women for institutional delivery has been one of their prime agenda and they have not failed in that aspect.
- It was also reported that the ASHA starts rigorous counselling after knowing the Expected Date of Delivery (EDD) of the patient regarding the benefits of institutional delivery.
- In all the cases the ASHA accompanies the pregnant women who go for institutional delivery. In most cases they had to stay with the patient in the hospital for 2-3 days till they are discharged and ultimately returns with the mother.
- The ASHA have timely referred the patients to the nearest PHCs/CHCs. Most of the cases included patients suffering from TB, Malaria, skin disease and leprosy. In most cases the follow up has not been possible and there was difficulty in knowing whether the patient received the right treatment or not.
- The ASHA received the financial incentives according to the norms fixed by NRHM. Though no substantial delay in payment was stated by the ASHA, however they raised the concern in the delay of payments in the case of slide collection, net impregnation and immunization.

The problems faced by the ASHA include:

- Non availability of drugs for the drug kits on time
- Mobility within the health centers due to lack of communication facilities.
- Lack of proper coordination with beneficiaries and other service providers due to non-availability of mobile phones.
- Gradual loss of skills as no refresher training is given.
- Problem in residing in hospital when they accompany the pregnant women to the hospital as there is no special room for use.
- No sufficient uniform given to them for daily use.
- Frequently moving to the respective PHCs/CHCs for collection of incentives which becomes extremely painstaking and incurs cost as payments are not made on the spot. In many cases they reported of travelling many times to a particular PHC/CHC to enquire the status of their incentives.

District specific findings: The above findings are a generalization of the information collected from the above mentioned sample size. However there are certain specific observations in particular districts. In the district of Angul the ASHA do face the problem of receiving financial incentives for slide collection and net impregnation. They have not received the incentives since the last 6 months. Further the immunization fees are also pending since the last I year.

In the district of Nayagada and Rayagada the referral of cases by the ASHA have been significant with constant follow up of the patients. In most of the cases the ASHAs have identified the TB symptomatic, have accompanied the patient to the PHC/CHC or DMCs (Designated Microscopic centres) for diagnosis and treatment. They have acted as DOTs providers and have successfully completed the treatment regime. The initiatives taken by the local civil societies in improving their capacity to address the issues relating to TB, HIV/AIDS and leprosy have made the referral of cases and follow up very effective.

The ASHAs have played a significant role in participating in the Village health and Nutrition Days (VHNDs) in the district of Mayurbhanj. The ASHA has been very effective in mobilizing the pregnant mothers and the children and have ensured that there is a) weight measurement of the pregnant women and children with the age group of 0-3 years b)BP and abdominal check up of the pregnant mother c)distribution of take home ration(THR) d)referring of sick children and e)distribution of medicines.

4.13 Quality of services received through Maternal Health

Guarantee scheme: To assess the quality of services received by the beneficiaries of the maternal health guarantee scheme, group discussions were initiated with women in the sample villages who have delivered in the last 3 months either in an institution or at home. The beneficiaries were made aware about the various entitlements in the context of maternal and child health.

The following are the general findings:

- The beneficiaries reported that the ANMs registered the beneficiary's name after confirmation of pregnancy. Further the study revealed that ANMs do not significantly contribute to the recommended 4 times examination of BP and abdomen prior to delivery. In most cases the beneficiaries did their examination at the sub divisional /district head quarter hospital. In cases where ANM has done the examination the BP checkups have been the most neglected.
- The Beneficiaries have received the right dose of IFA from the ANMs. In many cases it was stated by the beneficiaries that the ASHA played a critical role in following up the actual consumption of IFA of severely anemic cases. Apart from IFA, chloroquine has also been given to prevent malaria during pregnancy.
- All the beneficiaries have received TTs from ANMs on time. However in cases of beneficiaries who have done their ANC's in hospitals they have received the TTs directly from the hospital.
- In almost all the cases it was reported that the blood and urine of the beneficiaries were not examined by the ANMs.
- Though the ANMs have referred the beneficiaries for institutional delivery they stated that they were more influenced by the ASHA.
- Further the ANMs attended the beneficiaries at least once after delivery.
- The ASHA has attended all the home deliveries and all the beneficiaries have received regular diet from the AWW.

District specific findings: There are no marked specific findings or any exceptions in any of the districts where the survey was undertaken.

4.14 Quality of service delivery of Janani Suraksha Yojana (JSY):

The Janani Surakshya Yojana was pioneered with a view to increasing institutional delivery. In this context to assess the quality of service delivery of Janani Suraksha Yojana, the JSY beneficiaries were interviewed in the sample villages.

The general findings are:

- All the beneficiaries who had institutional delivery were accompanied by the ASHAs.
- Though all the beneficiaries who had institutional deliveries received the amount there has been a concern in its timely disbursement. In many cases the payment has been delayed even beyond a month.
- In case of home delivery the beneficiaries who were in the category of being a BPL, were above 19 years of age, had a maximum of 2 live births and were attended by an ANM/TBA during delivery received an amount of Rs.500/-.The amount was not paid in case of still births as per the norms. The beneficiaries reported of the delay in receiving money due to procedural bottle necks. After the delivery the ANM registers the birth and then takes all the details including the BPL cards, the birth registration certificates to the MOI/c. The money is drawn from the account where the sarpanch and the ANM's are joint signatories. The Sarpanch certifies the documents after proper verification.

District specific findings: There are no marked specific findings or any exceptions in any of the districts where the survey was undertaken.

4.15 Awareness on Janani Suraksha Yojana: The increase in institutional delivery can be envisaged if the beneficiaries are aware of the programme. In this context group discussions were initiated to know the level of awareness of the beneficiaries on JSY.

The general findings are:

- The respondents were aware about the JSY scheme but the awareness was mostly confined to the financial benefits that they shall be receiving. The ANM and the ASHA have not discussed with clarity regarding the entire benefits envisaged through the scheme.
- The JSY coupons are available with the ANMs and they are filled up during the time of registration. After registration maximum of the beneficiaries reported of not possessing the coupon as it was in the possession of the ANMs. In most of the cases the ANMs handed over the JSY cards to the beneficiaries after the first ANC.

District specific findings: There are no marked specific findings or any exceptions in any of the districts where the survey was undertaken.

4.16 Assessment of the functioning of Gaon Kalyan Samiti (GKS): The Gaon Kalyan Samiti acts as the unit of planning, monitoring and implementation of various public health initiatives at the village level. In this context it is pertinent to assess the current

status with respect to its existence, formation, composition, capacity building, funding, activities and monitoring. Focussed group discussions were initiated among the GKS members of the sample villages.

The **general findings** of the functioning of the GKS on the basis of the above mentioned components are mentioned below:

Existence: At the village level there is the Gaon Kalyan Samiti(GKS).In very few villages the GKS are registered under the Societies registration Act-1860.Besides the GKS the other committees which exist at the village level include Village Education Committee(VEC),Banasurakshya Samiti (BSS),School Sanitation Committee(SCC),Village Sanitation Committee(VSC),Parent Teacher Association(PTA) and the Mother Teacher Association(MTA).These committees do not focus on health related activities. There is no Panchayat or hamlet level health committee in existence.

Formation: The formation of the GKS was the responsibility of the ANMs. Almost all the GKS were formed by a democratic process through active participation of the villagers. The ANMs in consultation with the ward members fixed suitable dates to organize village level meetings where all the ward members, president and secretary of all the SHGs, president and secretary of youth clubs, NGO representatives and 10-15 influential members of the village were invited to attend the meeting. The information regarding the meeting was given at least 7 days before the meeting. The ASHA and AWW workers assisted the ANM in mobilizing the people to participate in the meeting.

In most of the cases NGOs were given responsibility of the formation of the GKS. They worked in association with ANM, AWW and ASHA. On the date of the meeting information was shared regarding the aims, objectives and roles and responsibilities of the office bearers of GKS members. However the GKS members stated that they could not have clarity on their roles and responsibilities and required more orientations for proper functioning. A resolution was passed in the meeting regarding the formation of the GKS and the nomination of the president, secretary and other members. The signatures of the participants were maintained in the register. The respondents stated that there is a detailed guideline in place regarding the formation of the GKS and that there was no significant problem regarding the formation of the VHC.

Composition: The Gaon Kalyan Samiti is headed by the ward member of the village. The other members of the committee are the following: a) Convenor-Anganwadi Worker, b) ASHA c) SEM (Self Employed Mechanics under RWSS) of the area c) President or Secretary of 3 women SHGs d)

President of watershed development committee e) Representative of any NGO working in the village .The study revealed that the members have very minimal clarity on the roles and responsibilities of the GKS and the members as clearly stated in the guidelines.

Capacity Building: There has been no structured capacity building initiative taken to strengthen the GKS. However there have been sporadic attempts in building capacity on record maintenance, preparing village health plans and maintenance of accounts. The MOs, BPOs, BEEs and BADAs were the trainers.

Funding: The GKS is designated to receive Rs.10000/- as untied funds per year. These funds are deposited in their bank accounts where the chairman and the AWW are the joint signatories. They are authorized by the committee for financial transactions. The withdrawal of the money was only after the approval of the members of the GKS. The AWW maintains the accounts. The MOI/C is the certified authority for the funds utilization. The members lacked in awareness about financial transparency like social audit. All the GKS maintains registers which contains resolutions and expenditure details. Recently they have been given printed resolution and accounts books to ensure transparency in financial transactions. However they are unable to maintain the records as no training has been given in this regard. As maximum of the GKS were formed at the last quarter of the previous financial year the spending has been limited to Rs.2, 500/- on an average. This year the transfer of money has not been uniform and seems erratic due to lack of timely release of money to the DPMU by the state mission directorate. Therefore the spending has not been significant. The amount spent has been mostly towards preparing the Swasthya Kantha, conducting monthly meetings, giving honorarium to AWW & ASHA and cleaning of village drains and minor repair and cleaning of drinking water sources. There has been no prior estimation of expenses done by maximum of the GKS.

Activities: The monthly meetings of the GKS were not regular. No major activities have been planned nor taken up at this stage as they do not have clarity on how to plan their spending. However there have been sporadic activities on developing swasthya kantha, organizing cleanliness drives, repairing and cleaning drinking water sources.

Monitoring: There is no mechanism to monitor or supervise the VHC.

4.17 Assessment of the functioning of Rogikalyan Samiti (RKS): The RKS is constituted with the objective of ensuring compliance to minimal standard for facility, hospital care and protocols of treatment as issued by the government; ensure accountability of the public health providers to the community; introduce transparency with regards to management of

funds and upgrade and modernize the health services and infrastructure of the hospital. Thus it is pertinent to assess the effective functioning of RKS which plays a critical role in bettering the quality of health care services.

To assess the functioning of the RKS the interviews were taken with MOI/Cs. In each district at least two RKS one at the district level and the other at the block level were taken.

The general findings of the functioning of RKS are as follows:

- **Meeting of RKS**-The meetings of the RKS are not regular in almost all the cases. In most of the cases the governing body meeting is more irregular than the executive body meeting.
- **Patient Charter**-There is no patient's charter in any of the RKS under the study. The MOI/Cs also reported of not having any knowledge on having a patient's charter and no one has sensitized them in this regard. However it was observed that sporadic attempts were made in some cases to display public information on services provided and the user fees and the current stock of drugs available.
- **Collection of feedbacks from the patients and redressal of grievances**-There is no specific mechanism initiated by the RKS for collection of the feedback and redressal of grievances of the patients. However there are few exceptions where complaint and suggestion boxes are placed but the RKS has not been effective in attending to the concerns on time.
- **Important decisions taken at the RKS for proper functioning of the hospital**-The decisions taken by the RKS members in general was mostly confined to renovation of old buildings, construction of toilets, ensuring safe drinking water, providing uninterrupted electric supply to Operation theatres, labour rooms and for maintaining cold chains, appointing contractual non-technical support staffs for better functioning of the hospital and maintenance of hygiene within and outside the hospital campus and collection of user fees.

There were no such significant decisions taken on developing systems for enhancing transparency, accountability and credibility of the public health initiatives. Further the decisions also did not reflect any initiatives for collection of feedbacks and suggestions of patients for redressal of grievances.

- **Expenditure of RKS funds**-The study revealed that maximum RKS under study were formed in 2006-07. The transfer of money as per the norms has been timely but the expenditure was sporadic in the initial phase of its formation. However as the frequency of

meetings increased the decisions on patient's welfare were taken and various activities initiated. This year the expenditure has been mostly on infrastructure development and renovation activities.

District specific findings:

A) The RKS of District Head Quarter Hospital, Dhenkanal has made significant achievements since its constitution way back in 26th October 2006. The 1st meeting was held on 26th of July 2007. The subsequent meetings were held on 17th of April, 20th of June, 28th of August and 20th of December 2008, 21st of January and 24th of March 2009. The RKS members are proactive and have taken effective measures for ensuring patients welfare while also ensuring transparency.

The details of the innovative activities completed by the RKS so far included: a) Outsourcing of cleaning & security services b) Engagement of contractual electrician, plumber, attendants in DHH for better service c) Engagement of contractual help desk coordinators in the DHH to ensure the central registration and enquiry d) Installation of A.C at heat stroke room and outdoor e) Installation of inverter at O.T, outdoor & eye ward and another three invertors are to be installed at labor room, CDMO's office & PPC f) Installation of Water filters in all the wards g) Repairing of water cooler machines ,repairing of all the toilets in the hospital, Boyle's apparatus, cardiac monitor, tube wells in the hospital campus h) revision of laboratory charges & merger with RKS funds i) auction of depreciated articles i) Installation of Complaint box, intercom telephones, installation of display board showing facilities available at the main gate of Hospital j) Fixing of flex showing rate chart of different tests k) Proper light arrangement inside the wards & hospital campus and repairing of fans & electrical fittings in all the wards l) Provision of sitting arrangements for visitors in different wards.

The activities in Progress are: A) Construction & renovation- a) Construction/renovation of boundary Wall, latrine & bathroom for staffs in different wards b) Security Control Room at the Main-Gate c) Provision of consulting chambers for medicine, Paediatric and Orthopedic wards d) Iron Gate at main entrance e) Streamline the accounts system and cash collection f) Construction of new drainage system & concrete road within the hospital campus g) Development of waste management system g) Rest Shade for ASHAs coming from outside g) New construction renovation & repair (cycle stand, kitchen, dressing room for surgery ward, septic tank for female medicine ward, generator room, h) Installation of a telephone for public at outdoor) Fixing of nets for

prevention of mosquito. **B) New purchases & repair-**a) AC for PPC, b)Invertors for CDMO's Office, Gynecology ward, PPC and Eye ward c)Repair of old OT to use it as sunstroke room d)purchase of slit lamp, Wet field cattery for Eye ward e)Purchase of big dustbins to make hospital premises clean.

The major activities proposed for 2009-10 and approved by the governing body are given below: a) Approval for providing identity card to all the hospital staffs b) Collection of users fees for outdoor and indoor patients c)Imposition of penalty for spitting & open defecation d)Functioning of Bio medical waste management e)Renovation of male medicine ward & cabins.(Construction of toilet for staffs for male medicine ward, construction of septic tank for cabin f)Repair & renovation of other wards as & when required and g)renewal of contractual staffs engaged by RKS

The RKS of Khamara UGPHC of Pallalhada Block in the district-Angul has initiated the system of installing complaint/suggestion boxes for the patients. The box is opened on the 10th of every month when the executive body meeting is held. Basing on the suggestions appropriate actions have been initiated. Further there is an effective grievance redressal system in place. Every Monday between 12 to 2 pm the patients are given an opportunity to directly discuss their problems and get it redressed immediately.

4.2 The issues at the community level and the possible bottle necks in ensuring equitable, accessible and affordable health care services.

To identify various health related issues at the community level it is pertinent to understand the entire profile of the village. The village profile shall give information on various dimensions which has a lot of bearing on the health situation of the village. In this context village profiles were developed using the PRA techniques. The PRA techniques were used to prepare social and resource maps, understand the disease burden in a village and assess the seasonal changes in the health status of the community through seasonality mapping, prioritize issues through matrix ranking, understand the health history of the community through time analysis, understand the quality of health care services provided through formal/ informal interview and group discussions with service providers.

The PRA exercise was conducted in all the sample villages. In each district a sample size of 4 villages were taken from 2 blocks. The district wise general findings on various issues at the community level are given below:

4.21 District- Angul-The prevalence of malaria is very high and is throughout the season. It is more prevalent in the months of June and July. The other diseases which are also seen are dysentery, gastritis, joint pain, anaemia, leprosy and TB. Skin diseases are highly prevalent among children due to usage of polluted water.

The deaths of the children (under 5) in the last one year in the sample villages were due to malaria and death within a week of delivery. In case of women the deaths were due to complications during delivery, HIV/AIDS, TB and malaria

The issues identified were: a) Lack of safe drinking water sources b) High prevalence of malaria with low awareness on prevention and control c) Poor sanitation facilities d) Low level of awareness on the roles and responsibilities of the GKS members e) Low level of awareness of the community on various health related entitlements f) Accessibility to health institutions

The details of the profiles of the 4 sample villages are attached for reference **(See Annexure-5)**

4.22 District-Dhenkanal-The major diseases identified were malaria, dysentery, joint pain, worm infestations and skin diseases. The diseases mostly seen in women were anaemia, white discharge, pain in abdomen, fever, vomiting and diarrhea. The diseases like pneumonia, fever and cough, worm infestations, diarrhoea, vomiting and skin disease are mostly seen among children. The drugs including chloroquine , ORS, Oral contraceptive pills, iron tablets are available in the sub-centre while there is a perennial shortage of paracetamol tablets, pediatric drops and bleaching powder.

Due to inaccessibility there is substantial problem in carrying children for immunization. In many cases the ANMs do not turn up on the scheduled dates. All the children (0-6) years go to the AWCs. There is very low level of awareness on family planning measures.

The issues identified were: a) Strengthening of the sub-centre's with regular availability of drugs and presence of ANM b) Accessing immunization on time c) Access to safe drinking water d) Lack of knowledge of GKS members on their roles and responsibilities e) High prevalence of malaria with low awareness on prevention and control f) Lack of awareness on various health related entitlements

The details of the profiles of the 4 sample villages are attached for reference **(Annexure-6)**

4.23 District-Mayurbhanj: The incidence of malaria is high and is throughout the year with its peak periods are in the month of June and July. The problem of dysentery is also prevalent especially in the months of January to July. The problem of anemia and white discharge is widely prevalent among women. The deaths of children (0-6 years) have been primarily due to Preneonatal jaundice, suspected pneumonia and measles. The traditional healers and witch crafts are generally the first consultants for any disease primarily in the tribal villages.

The issues identified are: a)Non availability of safe drinking water b)Non availability of AWC building c)lack of proper communication facilities c)PHC not functioning effectively d)Lack of awareness on prevention and control of various communicable diseases d)Migration to nearby states e)Non availability of medicines at sub centre f)Delay in receiving blood reports

The details of the profiles of the 4 sample villages are attached for reference **(Annexure-7)**

4.24 District-Nayagarh: The major diseases prevalent are diarrhea, malaria, worm infestations, typhoid, angular stomatitis, anaemia, eye infections, cough, scabies, arthritis, TB, irregular menstruation, white discharges and piles. The most prevalent diseases were diarrhea, malaria, typhoid and worm infestations. The traditional healing practices though exists the preference is now given to the mainstream health care services. No deaths due to delivery related complications have been reported in the last 3 years in the sample villages.

The major issues identified are: a) Non availability of drugs at sub centre b)low level of awareness on the health related entitlements c)GKS members not aware of their roles and responsibilities d)Lack of awareness on prevention and control of malaria e)lack of proper communication facilities f)Lack of awareness on prevention and control of various communicable diseases.

The details of the profiles of the 4 sample villages are attached for reference **(Annexure-8)**

4.25 District-Rayagada: The major diseases prevalent are malaria, dysentery, cold and cough, scabies, measles and eye infection. The traditional healers were given priority by the tribal community in case where the mobile health units (MHUs) were not reaching them on time in the inaccessible areas. In other cases tribal community tries to access the mainstream health facilities

and refer cases to PHC and ANMs. The traditional culture which was earlier a barrier for the tribal community has changed due to constant counseling by the service providers including ASHA, ANM and AWWs. They are now availing of the main stream facilities and putting into practice as specified by the service providers. The traditional practice of not taking IFA tablets, restricting the pregnant women in taking foods ,not giving colostrum, taking up hard works during pregnancy, depending on unskilled local dais for delivery have been changed.

The major issues identified are: a) High prevalence of malaria and very low awareness on its control and prevention b)Delay in getting blood reports for malaria test c)DDC(Drug distribution centre not working effectively d)GKS members lack in awareness regarding their roles and responsibilities

The details of the profiles of the 4 sample villages are attached for reference **(Annexure-9)**

4.3 The current situation at the district level regarding the management of effective health care delivery.

The district health profiles were prepared to understand the current situation and the key stake holders working towards improving the quality of health care services in the district. In this context a detailed appraisal was done on the following major components in the sample districts including: a) Demography/population b) Current health infrastructure and manpower as per IPHS norms c) Status of RKS, GKS and ASHA d) Details of civil society groups and potential individuals who are working on public health e) ICDS details f) drinking water and sanitation infrastructures f) Current status of the districts against various indicators given in DLHS2-3 and NFHS2-3.

The data were collected from secondary sources available at the DPMU and District health administration. Further information was also collected by direct interaction with civil society groups, ICDS, RWSS, Research institutions and Individuals who are contributing towards public health.

4.31 A comparative statement detail of various Health indicators from National Family Health Survey (NFHS 3 and NFHS 2 which were conducted in 2005-06 and 1998 - 99 respectively) is given below:

Sl. No.	Indicators	India		Orissa	
		NFHS 3	NFHS 2	NFHS 3	NFHS 2
	Marriage and Fertility				
01	Total Fertility Rate (Children per women) (%)	2.68	2.85	2.37	2.46
02	Women age 20 – 24 Married by age 18 (%)	44.5	50.0	36.3	37.6
03	Men age 25 – 29 married by age 21 (%)	29.3	NA	22.2	NA
	Family Planning				
04	Any Method (%)	56.3	48.2	50.7	46.8
05	Female sterilization (%)	37.3	34.1	33.1	33.9
06	Male sterilization (%)	1.0	1.9	1.0	1.7
07	IUD (%)	1.8	1.6	0.6	0.8
08	PILL (%)	3.1	2.1	7.0	3.0
09	Condom (%)	5.3	3.1	3.2	0.9
	Maternal and Child Health				
10	Mother who had at least 3 ANC visit for their last birth (%)	50.7	44.2	60.9	48.0
11	Birth attended by a health	48.3	42.4	46.4	33.4
12	Institutional delivery (%)	40.7	33.6	38.7	NA
13	Mothers who received PNC with 2 days	36.4	NA	38.3	NA
14	Children of 12 – 23 months fully	43.5	42.0	51.8	43.7
15	Children of 12 – 23 months have	78.2	71.6	83.6	84.7
16	Children of 12 – 23 months have received 3 doses of Polio (%)	78.2	62.8	65.1	68.4
17	Children of 12 – 23 months have	55.3	55.7	67.9	61.9
18	Children of 12 – 23 months have received Measles vaccine. (%)	58.8	50.7	66.5	54.0
	Child feeding Practices				
19	Children under 3 years breast fed within one hour of Birth (%)	23.4	16.0	40.5	48.0
20	Children of age 0-5 months exclusively	46.3	NA	50.2	NA
21	Children under 3 years who are	38.4	45.5	38.3	44.0
22	Children under 3 years who are	19.1	15.5	18.5	24.3
23	Children under 3 years who are	45.9	47.0	44.0	54.4

	Knowledge of HIV/AIDS				
24.6	Women who have heard of AIDS (%)	57.0	40.3	62.1	39.0
25	Men who have heard of AIDS (%)	80.0	NA	72.6	NA
26	Women who know that consisted condom use can reduce the chance of	34.7	NA	30.5	NA
27	Men who know that consisted condom use can reduce the chance of getting	68.1	NA	59.4	NA

The details of the rapid appraisal of the districts are attached for reference (See **Annexure-10 to 15**)

5. Recommendations

The recommendations are on the basis of the findings from the rapid assessment undertaken in the 20 villages of the 5 sample districts. The recommendations are:

- A) **Ensuring regular supply of drugs with ASHA**- The drug kit supplied to ASHA should always have the essential drugs to ensure timely distribution to the community. The MOI/Cs and ANMs should play a critical role in ensuring the timely supply of drugs to ASHA and maintenance of stocks.
- B) **Making the VHNDs more effective**-The coordination of ANMs and AWW with the ASHA should be made more effective for ensuring greater participation of the beneficiaries. The participation of SHGs can be initiated as they can be potential agents to follow up the activities of the VHND, discuss issues at a more closer circuit and with regularity and can advocate for certain causes which emerge at the village.
- C) **Enhancing the skills of ASHA**- There should be a refresher training of the ASHA on all the 4 rounds of trainings given to them. This shall help in upgrading their skills by bringing more clarity on their responsibilities.
- D) **Strengthening of referral & follow up of cases by ASHA**-Trainings on specific diseases like TB,HIV/AIDS, Leprosy and other ailments can help the ASHA in identifying symptomatic and refer cases on time. The GKS can play a critical role in recording the referral cases done by ASHA and monitor the follow up of ASHA in ensuring that the patient gets the right treatment.

- E) **Streamlining the payments of ASHA-** The payments of the ASHA with respect to slide collection, net impregnation and immunization should be streamlined. Further in case of additional incentive based work if designed to be given, it should be clearly defined and budgetary provisions made clear to keep the morale of ASHA intact.
- F) **Providing mobility support to ASHA-** The ASHA can be given minimum mobility support to ensure timely interventions and reduce the difficulty in her operation.
- G) **Upgrading the skills of ANMs-** Specific refresher trainings of the ANMs on BP measurements, examination of blood and urine is required to have more qualitative interventions. Further they should be provided with new instruments for measuring BP and weighing machines.
- H) **Increasing awareness on JSY-** The awareness on JSY should be organized at the community level involving the GKS, ASHA and ANMs so that institutional delivery is enhanced.
- I) **Strengthening the GKS-** There is a need for a structured capacity building programme to sensitize the GKS on their roles and responsibilities, preparing health micro plans, maintenance of financial transactions and social audit for monitoring the service delivery. The NGOs support the capacity building programme to a larger extent.
- J) **Developing systems for monitoring the performance of GKS-**A proper system for monitoring the performance of GKS needs to be developed in consultation with various stake holders including the community. The mechanism should be developed in a participatory approach so that it is viable and sustainable.
- K) **Strengthening the RKS-**The RKS member's needs to be sensitized on their roles and responsibilities. They need to be transformed to a vibrant body which breaks from the traditional pattern of initiating infrastructural development and renovations to a group which is into insuring transparency and accountability of the services, establishes effective monitoring mechanisms of health care delivery, make systems of grievance redressal, make strategies for financial sustainability using a pro poor approach.
- L) **Developing understanding of the community on health related entitlements-**To empower the community so that they advocate for their

health related entitlements, massive awareness needs to be generated involving the GKS, ANMs and the ASHA.

M) Strengthening of sub centers- The sub centres needs to be well equipped with proper availability of drugs, timely immunization, facility for proper ANCs etc. This shall ensure better service delivery to the tribal community who are unable to access the PHCs/CHCs as they are inaccessible in many cases.

N) Mainstreaming traditional healers in tribal areas- The traditional healers needs to be sensitized on various diseases, their prevention and control. Further they need to be made aware of the consequences of retaining patients for longer period of time. The strategy should be such to stimulate them for immediate referral while also not rejecting their traditional healing methods.

O) Emphasizing on Malaria prevention and Control- There is high prevalence of malaria and low awareness among the community on prevention and its control. In this context there is a need for a proper strategy involving the GKS to ensure effective implementation of the malaria control programme. Further there should be effective mechanisms in ensuring timely receipt of the blood reports.

6. Actions initiated on the basis of the findings

6.1 District- Angul

1.Type of Action- Strengthening of GKS in the sample villages.

a)Village-Shankhpur, GP-Shankhpur, SC-Bantala,PHC- Bantala,Block- Angul

b)Village-Talsira,GP-Bolanga,SC-Bolan

c)Village-Odasa,GP-Khamara,SC-Khamara,Block- Pallalhada,UGPHC-Khamara

d) Village-Jamardihi, GP-Bandhabhuin,SC-Jamardihi

The situation of GKS in the sample villages were mostly similar and therefore the interventions and possible outcomes are generalized and are given below:

Situation of GKS prior to intervention

- a) Irregularity in meeting
- b) Minutes of the meeting not recorded
- c) The funds utilization was only up to Rs 500/-

- d) The members were unaware of their roles and responsibilities.
- e) There was no plan with estimated budget.

Actions Initiated

i) Organizing a meeting with the GKS members to share a) the village health profile prepared from the PRA exercise, b) the objectives behind the formation of GKS and c) the Un-tied Fund given to the GKS and its probable use with the villagers.

ii) Sharing with the DPM and District ASHA coordinator about the status of the GKS and the need for organizing orientation and capacity building of the GKS members for better functioning.

iii) Imparting training to the convener about the writing of minutes, maintaining the Cash Book and preparation of SOE in association with BPO and BADA.

iv) Assisting the GKS members in preparing a health plan with an estimation of Rs10, 000/-.

v) Meeting with District Manager of OVHA, an MNGO working for the strengthening the GKS in Angul Block with the support from UNFPA.

vi) Presentation of the finding in the District Coordination meeting of MO I/Cs and CDPOs as well as in the monthly meeting of the BPOs/BADAs regarding the intervention and the follow up support required.

vi) Discussion with the GKS members for taking steps for Nutritional activity like promoting the kitchen garden, promotion of sanitation drive etc.

vii) A letter suggesting possible interventions for enhancing the performance of the GKS was sent to the M & E consultant, NRHM, Orissa

viii) Intensive discussions were initiated with the DPM regarding the preparation of Health Plan in every GKS in the district with the help of OVHA, the MNGO and the DPMU with technical guidance from the CHF.

ix) It has been planned to do Village micro plan in five villages on a pilot basis for scaling up of the same in the entire district.

Current Status

i) Improvement in the regularity of the meeting.

ii) Regular writing of Resolution about the decision taken by the members.

iii) Involvement of the GKS members in the campaign against the Liquor consumption.

iv) Involvement of the members in some well fare activities like organizing the “Jalachhatra” for heat stress management.

V) The expenditure of Rs 10,000/- is done and the SOE and UC are submitted. The next amount for this financial year has not been received yet.

vi) Members are aware about their role and responsibilities.

2. Type of action: Enhancing the quality of functioning of ASHA

Situation prior to intervention

i) No structural body in existence for redressing the Problems of ASHAs. There should be a help desk working for ASHA in the District for immediate redressal of their grievances.

ii) Some ASHAs having low educational background have no clear cut ideas about their financial incentives prescribed for various services. There should be a written chart with individual ASHA showing the details of financial incentives.

iii) Irregularity in payment of incentives to ASHA.

iv) There is a need for skill up gradation through ASHA refreshers training.

Actions initiated

i) Discussion with the District ASHA coordinator regarding the current situation.

ii) Presentation of the finding in the District Coordination meeting of MO I/Cs and CDPOs as well as in the monthly meeting of the BPOs/BADAs and explaining the need of a strategic intervention for strengthening the ASHA activity in the district.

iii) Discussion with the concerned District Programme management Unit and BPMU for streamlining the ASHA payment.

Current situation

i) The findings during the Rapid Assessment have been addressed in the District PIP 2009-10.

ii) A printed leaf let explaining the work with prescribed financial incentives has been supplied to all the ASHAs by the DPMU only due to the Intervention of the CHF.

iii) Though there is no ASHA help desk but the Mobile No. of ASHA coordinator and the Contact no. of the DPMU have supplied to each individual ASHA through BPMU.

6.2 District- Dhenkanal

1. Type of action- Strengthening the GKS

Village-Kanpur

Situation before intervention- a) Irregularity in meeting b)No clarity on their roles and responsibilities c)No village health plan existed d)Proceedings of the meetings and financial transactions not recorded as per the norms

Actions initiated- a) A meeting was organized where the MOI/C, BPO and CHF participated. They were made aware of their roles and responsibilities and record keeping. A village health plan was prepared by sharing the village profile prepared during the rapid assessment survey.

Current status-a) Regular meeting & participation can increase the level of understanding, about GKS activities, so they plan to sit in every month b) They discussed with the BPO and ensured the release of the funds c) The GKS members took special initiative to provide free safe drinking water during the scorching summer where sun stroke was prevalent.d) The record is being maintained regularly e) The activities are taken up as per the plan.

2. Type of action: Strengthening of GKS

Village- Bidharpur

Status before intervention- GKS completely non functional.

Actions Initiated- Orientation meetings were organized where discussions on their roles and responsibilities, record keeping and preparing village health plan were initiated.

Current status-a)The meetings are conducted regularly with active participation of all the members b)The GKS members mobilized the adolescent girls to organize awareness drives on sanitation and accessing health care services in the PHC/CHCs in the tribal hamlets. The tribal's are dependent on traditional healers and avail the mainstream health care services at a later stage. c) Activities like sanitation drives, health wall, cleaning of drinking water sources and proving medicines and transportation facility to the needy are taken up by the GKS members.

3. Other activities- The findings of the village profile and rapid assessment has been shared with the community in all the villages and other stakeholders at the block and district level.

6.3 District- Mayurbhanj

Type of action: **Enhancing the functioning of ASHA**

In the 4 sample villages of chhelikani, sansarasposi, Gopinathpur and Nuhamalia in the blocks of Kuliana and Saraskona the actions were initiated to strengthen the functioning of ASHA.

Situation before intervention

- a) Non availability of drugs on time
- b) No timely disbursement of incentives
- c) Delay in referring of cases by the MOI/Cs to the SDH and DHH

Actions initiated: Discussions were initiated with the concerned ANM, BPO and BEEs of both the blocks and the ICDS Supervisors on the following aspects:

- Discussion with ANM for ensuring availability of essential drugs with ASHA.
- Discussion with the BPO and ICDS Supervisor for streamlining medicine supply.
- Discussion with DPM and concerned the BPO regarding the quick release of the incentives of ASHA.

Current Situation: In Nuhamalia and Gopinathpur village of Saraskona block ,ASHA is receiving essential medicines regularly.ORS is received both from ANM and ICDS regularly while the ANM is supplying essential drugs including paracetamol and dysentery regularly.

2. Making JSY effective

Situation before intervention-In Sansarasposi village of Kuliana block and Gopinathpur and Nuhamalia village of Saraskona block, the beneficiaries were facing problems in substantial delay in getting the JSY money.

Actions initiated: A discussion was initiated with BEE, BPO and MOI/C about the issue. They assured to have appropriate action in releasing the money on time.

Current status: After the discussion 2 delivery cases have been reported of receiving their JSY money within 7 days.

3. Making Maternal Health Guarantees effective:

Situation before intervention-In the village of Gopinathpur and Nuhamalia of Saraskona block, the ANM was reported of not visiting the PNC cases on time. Further the ANM and AWW were also not filling up the IMNCI formats.

Actions initiated: Discussions were initiated about the issue with the ANM and AWW and requested them to visit the PNC cases at least three times within 10 days.

The issue was also discussed in the ICDS sector meeting and orientation was given to the AWWs on filling up of the IMNCI format. The ICDS Supervisor was requested to follow up the matter.

Current Situation: The ICDS supervisor is following up regularly in the sector level meetings.

4. Initiating formation of Rogi Kalyan Samiti:

Situation before intervention: There were two RKS which were not formed in Kuliana block due to lack of initiation.

Actions initiated: 1) Discussions were held about the issue of formation of 2 nos. of RKS in Kuliana block with the CDMO, DPM and ASHA Coordinator. 2) At block level discussions were initiated with the MOI/C, Sector Medical Officers, BEE and BPOs to chalk out a mechanism for its formation. 3) The RKS was formed with support of the BPO of the concerned block as per the norms.

Current Situation: All the related documents have been submitted to the District ASHA Coordinator for registration purpose.

5. Strengthening the GKS

Situation before intervention

In the 4 sample villages of Saraskona and Kuliana blocks, the GKSs have been received money within the months of January and February 2009. However they have not initiated any activities. The GKS members had low level of

awareness on their roles and responsibilities. There was no regularity in the meeting and no orientation was given on record keeping, financial transactions and preparing village health micro plans.

Actions initiated: In Saraskona block, with the help of BPO and ICDS Supervisor and in Kuliana block with the help of BPO orientations were done for the GKS members on the GKS concept and their roles and responsibilities of the members. The findings of the PRA exercise were used to develop village health micro plan on a participatory approach with GKS members. Around 9 nos. of GKS of Kuliana block have been oriented and health plans prepared in association with the BPO.

Current status- In Chhelikani and Sansarasposi villages of Kuliana block, 'Swasthya Kantha'(Health wall) has been written. The drinking water sources have been cleaned. The meetings are conducted regularly and registers are updated.

In Gopinathpur and Nuhamalia villages of Saraskona block, The GKS members are sitting at least twice in a month and keeping their registers updated. They have cleaned the surface of drinking water sources and used bleaching powder, they actively participated in the VHND sessions, the SHG members are taking initiative part for the 'Annaprasanna' activity (Starting of complementary food for above 6 months old baby), 'Swasthya Kantha' has been written, prepared a kitchen garden in AWC and are using dustbin and maintaining hygiene.

The nearest village 'Panijia' of Saraskona block also has been oriented in GKS concept. The SHG members are playing a significant role. They have cleaned various drinking water sources including village wells, despite the non cooperation of the male members. They themselves entered the wells for cleaning and now they have become examples for other GKS also.

The village micro plans have been prepared in 9 GKS of Kuliana block and the GKS are functional.

6. Participation in IRS activities: As per the rapid assessment findings malaria has been one of the major problems affecting the community. The pregnant women and the children are the worst victims.

Actions initiated: As per the suggestion of the CDMO, there was participation in the block level sensitisation meeting on IRS activities at Bangiriposi block. Further one Sub-centre level GKS sensitisation meeting on IRS activities at Chandua S/C of Kuliana block was also conducted. The monitoring of the IRS

activities were done on village level sensitisation meeting on IRS activities and rally at Bangiriposi block. The IRS programme at Samakhunta block and Kuliana block were also monitored and reports submitted to the CDMO.

Current Status- Basing on the monitoring report and the immediate actions initiated as per the suggestions of the CDMO, the GKS members were sensitized on IRS activities. In Chandua village of Kuliana block and in Rangamatia village of Samakhunta block, the spray activities are 100% successful. The GKS members supported the IRS activities and now the message of IRS spray has been reflected in the village health walls.

6.4 District- Nayagarh

1. Type of Intervention- Strengthening of GKS in all the 4 sample villages of Nayagarh.

Situation before intervention:

- a. No capacity building initiatives taken to make the GKS members aware on their roles and responsibilities, maintain their meeting records and financial transactions.
- b. Irregularity in monthly meeting
- c. Delay in transfer of money to GKS account.
- d. GKS not playing active role in the vector control activities and other community process (like community monitoring etc)

Processes followed for initiating actions:

- a. Discussions initiated on the findings and recommendations with CDMO, DPM, Dist. ASHA Co-ordinator, Child Health Manager , BPOs and host organization NISWARTHA .
- b. Possible interventions were discussed with MOI/C, BPO, DPM, District ASHA Co-ordinator , Hospital Manager, CDMO, ADMO (FW), ICDS staff and the Staffs of host organization.

Actions undertaken

- a. The rapid assessment findings were shared with the GKS members especially on health related issues. A monthly meeting was organized where their roles and responsibilities were discussed. In the meeting major heads of expenditure and the record keeping procedures were discussed.
- b. The transfer of money was ensured to the GKS accounts after continuous persuasion with BPOs.
- c. A meeting was organized to prepare a village health micro plan.
- d. Sharing the findings with DHS and discussed the immediate need based intervention like capacity building, transparency in fund mechanism, follow up etc about the GKS
- e. Participating in the state malaria training programme and discussion with CDMO for developing a strategy in involving the GKS in the malaria prevention and control programme.

Current Situation

- a. The GKS members are having regular monthly meeting.
- b. The proceedings of the meetings and financial transactions are recorded in the records provided.
- c. The expenditure is continuing as per the plan prepared.
- d.** The decisions regarding a viable strategy for involving the GKS in the malaria prevention and control programme is awaited.

2. Strengthening the initiatives of ASHA: The following actions have been initiated in the sample villages to strengthen the initiatives of ASHA:

- a) Sharing Gadchiroli and Mitadin experience in monthly sector level meeting.
- b) Demonstration on ASHA drug kit and its utility
- c) Suggestion is given to DPM unit for timely payment of incentives and JSY money
- d) Suggestions given to establish ASHA help desk at PHC/CHC level, so that there can be speedy redressal of grievances.

3. Other actions initiated

- a) Sharing the findings of the rapid assessment with community and other key stake holders.
- b) Informal meeting with CDMO/ DPM on making of a Village Health Plan in every GKS in the district with the help of Host Organization, NISWARTHA and having technical support from the CHF.
- c) Participating in the TOT on malaria and acting as a district level trainer on malaria
- d) Facilitate the malaria plan in Gania & Daspalla block of Nayagarh
- e) Facilitating payment of JSY money of cases where the payment was substantially delayed.
- f) Initiating discussion with DPMU and staffs of DHH for disbursement of money in many cases where transfer of money was substantially delayed.
- g) A report on situation analysis of ASHA program in Nayagarh district is prepared and same is shared with key stakeholder in the district

6.5 District- Rayagada

1. Type of intervention- Strengthening of GKS

Village-Gadi Seshkhal, Panchayat-Gadi Sheshkhal, Block-Kolnora under Rayagada Sub-Division of Rayagada District.

Situation before intervention:

- a) The monthly meetings were not held regularly.
- b) The meetings were not recorded properly and there was no health micro plan
- c) The members were not aware of the spending pattern and record the financial transactions.

The actions initiated

- a) Organizing a meeting with GKS members where clarity on their roles and responsibility were discussed. Further the PRA findings which were done earlier in the village were shared with the members. Basing on the findings

village health action plans were prepared in which the BPO and the MOI/C participated. A local development agency named SHAKTI working in the village also supported in the preparation of village health micro plan.

b) SHG members were motivated in a separate meeting to monitor the activities of the GKS members.

Current Situation: Now the GKS is sitting every month and are discussing various health issues. They are monitoring the village sanitation system. They are involved in activities like cleaning of drains, putting mud in uneven areas to avoid stagnant water. They even had a discussion about the low cost latrines for all the house holds. The meetings are regular and the proceedings are recorded. They have recently received Rs. 10000/- and invited the BPO to assist them on how to use the money. A follow up meeting regarding the expenditure has been planned. Further looking into the positive response a plan has been developed in consultation with the BPO to take up one sub-centre (containing 10-15 villages) for replication of the same activities. The plan is in progress and shall be executed soon.

2. Type of intervention-Making the ASHA acceptable to the community- A case of Khamapadar village of Padampur block of Rayagada district.

Situation before intervention

Biripadar is a village which is situated in Khamapadar G.P of Padmapur Block. The distance of the village from the Block H.Q is around 10km. In this village the ASHA was not accepted by the villagers. The reasons can be attributed to the ASHAs unavailability at the time of need. The community reported that the ASHA was not proactive and did not address their concerns on time. Citing an example they said that despite repeated requests she did not advocate for the mobile health unit to come to the village with the MOI/C which was coming earlier despite her repeated visits to the PHC for various works. The villagers expressed their dissatisfaction regarding the performance of the ASHA.

Actions initiated: A discussion was done with the BPO regarding the issue. It was decided that an attempt can be made to rebuild the confidence of the community on ASHA as she had all skills and deliver quality services. In this context a discussion was initiated with the ASHA to understand her problems. She said that she had recently been staying at the block head quarter as her children and husband had shifted for business. She expressed that she is motivated and wants to regain the communities' confidence again. A discussion was initiated with the MOI/C to send the mobile health unit immediately to the

village. The MOI/C discussed with the MHU doctor and the mobile health unit reached the village and addressed the concerns. The BPO and CHF accompanied the MHU. A mini special health camp was organized where the ASHA was asked to be present. After the health camp a small community level meeting was organized where all the members including vibrant SHG groups were present. They were addressed that the ASHA had mobilized the MHU camp. The community benefited from the special camp and realized that the ASHA can be of great help and can be trusted further.

The community was assured that ASHA shall address their concern and stay with them to attend to their health related concerns. The ASHA was staying in the block head quarter as her family had shifted there. She was motivated to stay in the village.

Current status: The ASHA continues to stay and work with full dedication. The community now continues to get all the services from the ASHA and do have complete faith on her.

3. Type of Intervention: Strengthening of RKS in Ramanaguda Block.

Situation before intervention: Ramanaguda is one of the block of Rayagada District which is situated 60Km away from the DHQ. It has a population of around 90 thousand. It has its PHC which is situated in the village, Ramanaguda. The RKS was not functional. There was poor attendance of the members which was evident after verifying the attendance records. The proceedings of the meetings were also not recorded. The meeting was irregular and no significant decisions were taken.

Actions Initiated: After several informal meeting and discussion with MO and BPO, a meeting was organized for the RKS members. The local NGO named SHAKTI also expressed interest in supporting the initiative of sensitizing the RKS members. Two rounds of training were conducted for the RKS members where the MO, BPO, individuals from SHAKTI, and CHF acted as resource persons.

Current Status: The meeting is conducted by the RKS with full attendance. Decisions regarding patients' welfare are getting featured in the meeting. The local agency SHAKTI which is also a member of the RKS is taking the lead in ensuring full participation. Further they are also monitoring the activities of RKS regularly. The RKS is in its initial stage and has taken the right course for ensuring patients welfare in the future. Regular follow up shall be done by the CHF to ensure its effective functioning.

7. Impact of the whole process vis-a-vis the objective of rapid assessment.

The community health fellowship programme was envisaged to nurture, groom and educate the fellows towards enhancing and strengthening of various community processes in NRHM at the district and grassroots level. The rapid assessment was an entry point activity for the CHF's to develop their understanding on the situation of various public health initiatives at district level. In this context the following impacts can be looked into as a consequence of the rapid assessment process:

- It has developed a firsthand understanding on the levels of community participation in various ongoing health initiatives under NRHM and the current district health situation. The rapid assessment process has given a base for the CHF's to identify their area of interest for action research which are relevant and the findings can benefit the district health administration.
- The sharing of the findings and actions initiated of the rapid assessment with various stake holders at various levels has sensitized them on various emerging health issues and the possible remedial measures. The district administration has felt the need for initiating collaborative actions including training, action research, monitoring, developing replicable models, ensuring better coordination and documenting case studies leading to the strengthening of various communitization initiatives of NRHM
- Basing on the findings of the rapid assessment various actions have been initiated on a pilot basis in the sample villages at the community level which has borne positive impacts and has given an indication of the possibility of its success in further large scale interventions.
- The involvement of key stakeholders during the rapid assessment has helped in identifying key resource persons, individuals interested in public health who can support the future initiatives of PHRN and can be potential support base to advocate for the cause that we work for.
- Effective collaborations could be established with potential civil society organizations who supported the rapid assessment survey. They have expressed their interest to support our future endeavours of strengthening the communitization processes of NRHM.

8. Establishing linkages with key stakeholders at block and district level for appropriate action and scaling up

The rapid assessment survey was an entry point activity to understand the district health situation and initiate actions on a pilot basis to experiment its efficacy. As the rapid assessment shall be followed by more systematic and intensive engagement with various community process for strengthening the public health initiatives, it was felt to develop viable groups at various levels who can support our initiative in terms of community mobilization, action research, resources, logistics, evidence based advocacy and act as pressure groups. In this context during the rapid assessment process key stake holders were identified and various possibilities were explored to form viable groups at the block and district level who shall support the CHF and the mandate of PHRN in general. Though the individuals are identified the process is on to develop block resource group comprising of key stake holders including ASHA, AWW, ANM, BPO, BADA, MOI/Cs, Block chairman, BDO and ICDS supervisors. At the district level there shall be a review and mentoring group comprising of key stake holders including Collector, CDMO, ADM-Public health, ADM-FW, ADM-Medical, DPM, ASHA Coordinator, DHIO, RWSS engineer, DSWO and Civil society organizations. The details of the formation of the review and mentoring group in Dhenkanal is attached for reference. **(See Annexure-15)**

9. Conclusion: The rapid assessment survey though had inherent limitations however it has brought into light various current bottle necks inhibiting the success of the communitization initiatives of NRHM. It has tried to understand the current situation and make small pilot initiatives to activate various processes and build a group of potential individuals interested in strengthening public health initiatives. The rapid assessment shall be followed by more intensive engagements with support from the district health administration, civil society, potential individuals, research institutions, media and the community.