

Analysing Strategies for Community Participation in National Rural Health Mission: A Documentation of Action Research in Four States

A Project Report Submitted to the Indian Council of Social Science Research

By

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Abbreviations

ANM	Auxiliary Nurse Midwife
APL	Above poverty line
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AWW	Anganwadi Workers
BPL	Below Poverty Line
BTT	Block Trainers' Training
CBO	Community based Organizations
CDR	Crude Death Rate
CHV	Community Health Volunteer
CHW	Community Health Worker
CPR	Couple Protection Rate
DOTS	Directly Observed Treatment, Short course
DPMU	District Programme Management Unit
DTT	District Trainers' Training
GKS	Gaon Kalyan Samitis
ICCHN	ICICI Centre for Child Health and Nutrition
ICDS	Integrated Child Development Services
ICMR	Indian Council of medical Research
ICSSR	Indian Council of Social Science Research
IEC	Information, Education and Communication
IMR	Infant Mortality Rate

IPHS	Indian Public Health Standards
IVM	Integrated Vector Management
JSY	Janani suraksha Yojana
KEM	King Edward Memorial Hospital
MDR-TB	Multi-Drug Resistant Tuberculosis
MFC	Medico Friends circle
MPW	Multi-purpose worker
NFHS	National Family Health Survey
NHSRC	National Health Systems Resource Centre
NRHM	National Rural Health Mission
NVBDCP	National Vector borne disease Control Programme
OTC	Over the Counter
PHC	Primary Health Care
PHRN	Public Health Resource Network
PRI	Panchayati Raj Institutions
RKS	Rogi Kalyan Samiti
RNTCP	Revised National Tuberculosis Control Programme
SAP	Structural Adjustment Programmes
SEARCH	Society for Education, Action and Research in Community Health
SHG	Self Help Group
SLI	Standard of Living Index
SOCHARA	Society for Community Health, Awareness, Research and Action
SPHC	Selective Primary Health Care
TFR	Total Fertility Rate

UNICEF	The United Nations Children's Fund
VHAI	Voluntary Health Association of India
VHND	Village Health and Nutrition Day
VHP	Village Health Plans
VHSC	Village Health and Sanitation Committee
VHW	Village health worker
VSRC	Village Health Committee and Sahiyya Resource Centre
WDR	World Development Report
WHO	World Health Organization

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Introduction

This manuscript is a result of a collaborative project between the Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia and the Public Health Resource Network, an organisation working on public health issues in four states. PHRN's main objective is to contribute and strengthen all efforts directed towards the goal of 'Health for All' through promotion of public health, social justice and human rights related to the provision and distribution of health services, especially for those who are generally left underserved. It is currently working directly in the states of Bihar, Chhattisgarh, Jharkhand, Orissa and Rajasthan and has contributed to the on-going work of strengthening public health systems in other states through its partnerships. In the context of their larger work the PHRN set up a two year Fellowship programme that aimed to strengthen systems for participation of civil society in NRHM. The ICSSR project aimed at doing a process documentation of the Community Health Fellowship Programme and their interface with the 'communitisation processes' set up by the whose National Rural Health Mission (NRHM) in selected districts of four states.

The National Rural Health Mission sought to provide an effective health care to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children. Community participation is one of the core strategies of NRHM to achieve this goal. Community participation in NRHM is to be realised through:

1. Decentralized planning,
2. Hospital Management Committees with Panchayat Raj Institutions at all levels,
3. Untied grants to community/Panchayat Raj Institutional Bodies,

4. ASHA/Village Health Worker Programme,
5. Village Health & Sanitation Committee,
6. Community monitoring processes to improve facilities and services.

The introduction of these five processes was a significant improvement over earlier systems of technocratic and centralised decision making. In the past these factors have created considerable wastage of scarce resources and have failed to deliver significant health improvements. In this context it was expected that such measures would initiate processes to democratise the health management system and make it more effective by structuring people's perceptions and needs into it. The Fellowship Programme of the PHRN was to aid and strengthen these processes through two interrelated roles that they were expected to play at the district level. The first of these roles was the support that the Fellow provided in terms of their actions in assisting the district health societies that had been set up by the NRHM. The second role that Fellows were expected to perform was that of doing action research which fed into some of the district health planning processes. The main focus of the ICSSR project was on this second aspect of the community health Fellowship programmes and its implications for a larger understanding of the impact of the processes unleashed by NRHM

Many of the studies pursued by these Fellows show that while 'community participation' as an approach has been addressed by the NRHM in a systemic way, it has not been properly strategized and facilitated at the local level. One effort that aimed to use community participation and involvement as a strategy for effective delivery of health services was the "mitanin" (Village Health Worker) programme in Chhattisgarh. This programme was conceived and implemented by the State Health Resource Centre, Raipur much before the launching of the NHRM. Its main focus was the development of a cadre of village health workers supported by district and sub district facilitators who acted as an interface between the system and the community and played an important role in the community health workers' identity as 'health activists'. However, when the

programme was scaled up in the NRHM, this cadre of well-trained facilitators were left out. This has been a critical gap in realising community participation in NRHM and many states have started realising the acute need for facilitators. The community health Fellowship programme also aimed to fill this critical gap.

Thus, these Fellows worked with the district health system to help set up the newly institutionalised 'communitisation processes', assisted the ASHA programme in particular and also generated local level research projects that led to interventions on the ground and gave some valuable inputs about social determinants and the impact of people's perceptions of public health management systems.

The first volume of the report deals with the background, process and analysis of the Fellowship programme. It also includes the papers resulting from the studies conducted by the Fellows. While the projects of the research Fellows studies are documented in the second volume of the report.

Objectives

The context of the above discussion this project aimed

- To highlight common problems in community participation in NRHM across states and districts and to analyse the local factors that impact on health delivery systems through documentation and analysis of the micro studies of the community health Fellows.
- To document the actions and studies of community health Fellows and to analyse and demonstrate potential of programmes like the community health Fellowship programme in finding effective corrective measures in existing health delivery systems in order to build effective, equitable and responsive health systems to be created in rural India through community participation.

- To evaluate whether a cadre like the community health Fellow can make community processes in NRHM more effective and examine the feasibility and implications of scaling up this strategy.

Methodology

The project followed a methodology of participatory research and analysis where twenty four community health Fellows engaged in different districts in the states of Bihar, Jharkhand, Orissa and Rajasthan were integral to providing the research inputs for this study. A four stage procedure followed for completing this study was:

Analysis of Secondary Sources and Documentation:

The project began with the analysis of secondary materials and documentation of existing scholars and organisations committed to facilitating community participation in health systems. Here it documented the impact of existing studies in order to do a fuller analysis of existing and past experiences.

Workshops for Community Health Fellows:

Three national workshops were held for community health Fellows. These workshops provided training to the community health Fellows in methods of research and also helped to collate their experiences and need based assessments at different stages.

Collation of Experiences, Research Outputs and Analysis:

Research associates also interviewed community health Fellows and documented their experience of the Fellowship programmes. Questionnaires and interviews were done to get social profile and perceptions of Fellows. Districts offices of the PHRN were visited to do process documentation of the work done by the Fellows. Faculty members from Centre of Social Medicine and Community Health, Jawaharlal Nehru University and Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia aided this process.

Report Writing:

An editorial team involved with mentoring the Fellows came together and put together this report in two editorial meetings. The team prepared thematic papers based on the studies of the Community Health Fellows.

Structure of the Report

This report consists of two volumes. The first volume consists of a manuscript that was prepared by the editorial team and is the main report of the project. The second volume consists of a collation of studies that were done by the community health Fellows, and from which the thematic section of volume one is derived. The structure of volume one consists of the following:

1. The background of NRHM and Community Participation in Post Independence Era: This part largely looks at the way community participation has been visualised in different periods of independent India. It attempts to make a broad brush review of previous experiments that have been done.
2. The second part of this volume is largely a process documentation of the community health Fellowship programme. It presents an analysis of the work and the perceptions of the community health Fellows.
3. The third part of the report consists of themes on which the community health Fellows did their research. These themes consisted of the factors affecting the working of the ASHA and the Village Health and Sanitation Committees. It also has two chapters on the social determinants and perceptions of local communities with regard to communicable diseases and reproductive and child health programmes.
4. The conclusion summarises the insights from the larger study and evaluates the community health Fellowship programme as a way of facilitating decentralisation

within health management. The implications of the programme for health planning and public policy are also discussed in this chapter.

Overall, this project provides us with some insights into the ground realities of the relationship between local societies and public health management systems. It also shows the importance of local level action research in deepening our understanding of public health. In doing so it does a critical evaluation of the processes involved in doing socially determined research projects and their implications for public policy.

SECTION ONE

CHAPTER ONE

Public Health and Community Participation: A Historical Background

While some equate public health with medicine, hospitals and doctors others tend to emphasise the role of preventive services, sanitation and hygiene. The boundaries of public health go beyond doctors, medicine and technology. It includes access to basic needs like food security, safe water supply, sanitation and housing in a given population. It is well known that most societies, developed and developing are stratified and marked by inequalities. Therefore, a core question and concern in public health is whether the access to basic needs is equitably distributed across social groups in a given population and if not then how does one reach out to the population especially the poor and marginalised.

Community participation in health is not a recent concept. It has been in public health discourse since long. In India it was the Bhore Committee of 1946 that laid out a blue print for the health system of our country. Amidst a very comprehensive situational analysis, it placed recommendations for a health system best suited to our country's aspirations and economic realities. It emphasized that at the core of all these efforts should be an attempt to develop local effort, to promote a spirit of help and to ensure the active participation of the people. Therefore, even before independence there was a focus on community participation in ensuring public health.

"No permanent improvement of public health can be achieved without the active participation of the people in the local health program. We consider that the development of local effort and the promotion of a spirit of self help in the community

are as important to the success of the health program as the specific services which the health officials will be able to place at the disposal of the people.”¹

Bhore's recommendations remained unimplemented and the initial decade post-independence was influenced by the Nehruvian vision of welfare. This period of time was very closely interlinked and interconnected to the experience of post-colonial society and there was a very strong influence of Fabian socialism. The influence of Keynesian economics with its emphasis on state intervention for capitalist development was seen in the economy and social sectors. The Beveridge Committee report soon after World War II which was influential in the founding of a welfare state in UK emphasised the role of the state in the financing and provisioning of welfare services.²

The idea of the welfare state was to minimise the role of market in areas that are seen as required for human development and for building capabilities of the population at large. These are areas that touch human lives - education, welfare, old age, disability and support for maternal services. The idea of welfare services does not advocate abolishing the market but instead seeks to minimise its role in provisioning of services.

It is well known that there are different models of the welfare state with varying proportion of market and state. In the writings of the post war period, one finds that welfare states were very strong. This was largely due to the strength of the working class movements. The left and socialist parties saw welfare services as the right of the working class. So you had to 'buy in' into the welfare state both for the middle class and the working class. These influences are found in the approach to welfare even under the Nehruvian period and this is well articulated in the introduction to the second Five Year Plan. The introduction to the second Five Year Plan spells out clearly the reciprocal relationship between economic growth and development. It further argues that poverty is an impediment to growth and human development. It also emphasised the need for redistributive justice and the important role of the State in maintaining a

¹ Health Survey and Development Committee, 1946

² Report of the Inter-Departmental Committee on Social Insurance and Allied Services, UK, 1942

balance between growth and development. Growth does not mean that it is equally distributed in a population and therefore, the idea of redistributive justice was a very important and a significant element of the Nehruvian vision of welfare.³

Public Health in Five Year Plans

From the first Five Year Plan there is the idea of building the capability of the labour, increasing productivity of labour but there is also the notion of social justice informing it. So welfare in that time did take into account fairly centrally the importance of the role of the state in investing in health. It was primarily looking at investing in health services. In fact, the first and second five year plans draw a lot from the Bhole Committee, to look at the very high levels of infant mortality and maternal mortality. It talked about anaemia, the condition of children and under nutrition. Hence, all this was taken into the five year plan. It also said that adequate food, sanitation and water supply need to be ensured. In a sense it stopped there, saying that the state should provide health services, build health service institutions that are self reliant and that are not dependent on import. The Nehruvian period therefore, was the period of building institutions both in education and in health which meant the whole goal was that we needed to build a self-reliant health service system. Although there was a systemic view of the health services development and adequate emphasis was given to institution building, self-reliance and addressing needs of the poor, community participation was not a priority and was missing from the framework of the initial five year plans.⁴

As health services began to be developed in the country to reach all those people and areas and regions that had not been reached by the health services developed in the country under the British rule, the community development block concept was evolved and at the care of each of these development blocks the ideas of a primary health centre was developed to cater to the health needs of the community especially women and children. The Community Development Programme was launched on a pilot basis in 1952

³ Baru, R. Public Lecture on Public Health and Nehruvian Vision of Welfare, 5th Workshop on Research for Social Actions, CJNS, JMI, 2010

⁴ Ibid.

to provide for a substantial increase in the country's agricultural programme, and for improvements in systems of communication, in rural health and hygiene, and in rural education. The community development programme was rapidly implemented. In 1956, by the end of the first five year plan period, there were 248 blocks, covering around a fifth of the population in the country. By the end the Second Plan period, there were 3,000 blocks covering 70 per cent of the rural population. By 1964, the entire country was covered. In the words of Nehru,

*"These community projects appear to me to be something of vital importance, not only in the material achievements that they would bring about, much more so, because they seek to build up the community and the individual, and make the latter a builder of his own village centre and of India, in the larger sense."*⁵

In 1957, Balwantrai Mehta Committee studied the Community Development Projects and the National Extension Service and assessed the extent to which the movement had succeeded in utilizing local initiatives and in creating institutions to ensure continuity in the process of improving economic and social conditions in rural areas. The Committee held that community development would only be deep and enduring when the community was involved in the planning, decision-making and implementation process. The suggestions were as follows:

- An early establishment of elected local bodies and devolution to them of necessary resources, power and authority,
- The basic unit of democratic decentralization was at the block/ samiti level since the area of jurisdiction of the local body should neither be too large nor too small. The block was large enough for efficiency and economy of administration, and small enough for sustaining a sense of involvement in the citizens,
- Such body must not be constrained by too much control by the government or government agencies,

⁵ Karunaratne, G. "The Failure of the Community Development Programme in India" in *Community Development Journal*, Vol. 11, No. 2, 95-119. 1976

- The body must be constituted for five years by indirect elections from the village panchayats,
- Its functions should cover the development of agriculture in all its aspects, the promotion of local industries and other services such as drinking water, road building, etc.
- The higher level body, Zilla Parishad, would play an advisory role.⁶

The PRI structure did not develop the requisite democratic momentum and failed to cater to the needs of rural development. There are various reasons for such an outcome which include political and bureaucratic resistance at the state level to share power and resources with local level institutions, domination of local elites over the major share of the benefits of welfare schemes, lack of capability at the local level and lack of political will.⁷

The report of the Health Survey and Planning Committee headed by Dr. Mudaliar in 1962 again emphasized on the need of including citizens in preventive and promotive health. Given below are some excerpts from the report:

*"Unless the conscience of the citizens as a whole is stimulated to demand and accept better standards of health... Unless the principles of sound hygiene are inculcated into the masses through health education and other efforts, and ...Unless government feels strengthened in taking positive measures to promote health, it will be difficult for health authorities alone to ensure that the measures contemplated are actually implemented..."*⁸

Despite these discourses at the policy level the focus of the initial two decades were on vertical programmes, mainly family planning and malaria. During the First Plan only 3.3 percent of the total plan outlay was on health. In the Second Plan, it was only 3

⁶ GoI, Balwantrao Mehta Committee, 1957

⁷ Karunaratne, G. 1976

⁸ GoI, Report of the Health Survey and Planning Committee, 1962

percent. These were well below the minimum of 10 percent recommended by the Bhore Committee. Though the Indian government accepted the recommendations of the committee, in the first plan itself only a third of the funds were allocated to public health while 55 – 60 percent of the budget was allocated to curative health services and medical education.⁹ Table I shows the focus of the initial plans on infrastructure.

Table 1.1: Planned Expansion of Health Infrastructure

5 Year Plans	Hospitals & Dispensaries
First	10,000
Second	12,000
Third	14,000

Source: CBHI, 1977. Pocket Book of Health Statistics, DGHS, Ministry of Health and Family Planning

Most approaches adopted to improve the health of populations use top down systems which have largely been unsuccessful in involving communities. However, community involvement has shown to make health service delivery systems more effective as it builds the community's capacity to identify and address its own health problems. A community can be defined as 'a group of people with diverse characteristics who are linked by social ties, share common perspectives and engage in joint action in geographical locations or settings.' The objective of community involvement is to generate awareness and create demand for good quality services. This calls for community mobilization where in members are empowered to demand for effective health systems followed by their sustained participation. A continuous and interactive process exists between health services and the community availing these services. Therefore for effective service delivery, community participation is crucial. Community participation occurs when a community organizes itself and takes responsibility for

⁹ VHAI, Report of the Independent Commission on Health in India, New Delhi, 1997

managing its problems. Taking responsibility includes identification of problems, finding solutions, translating them into actions and sustaining changes.¹⁰

Experiments with Community Participation

It is generally accepted that improvements in Primary Health can be made only through the involvement of communities in the delivery of health services. However different people mean different things when they talk of community participation.

Community participation does not imply that people respond to services which are planned and implemented from outside. It means that people are fully involved in the whole process of planning, implementing, monitoring and reviewing health programs. Ultimately, community participation is about increasing individual and community control over people's own lives. In terms of health, community participation means the ability to make informed health decisions and be an active participant in improving one's own health. It also means active participation in the health sector at the community and national level to create, influence and mobilize public opinion for improved public policy on health.¹¹

To some the meaning of community participation is wholehearted acceptance of Government schemes by the people. They feel Government knows what is best for the people, and therefore makes the policies and programmes, which are best suited for their good. If people do not benefit from such programmes it is their own fault, as they do not participate fully in Government schemes.

Some feel that community participation means demand generation for the services provided by the Government. If this view is accepted it will mean that though all services are readily available to the people, they do not make use of these services, as they do not know what is good for them. Government should therefore launch

¹⁰ Chandra, Urvashi & Singh, Sangeeta; Role of Community Participation for Maternal and Child Health: Case Studies from EC Supported Sector Investment Programme in States of Chattisgarh and Haryana, in K V Ramani, Dileep Mavalankar & Dipti Govil (ed.) Strategic Issues and Challenges in Health Management, New Delhi, 2008

¹¹ VHAI, 1997

Information, Education, and Communication (IEC) programmes, so that people understand the importance of using the services. According to this view also the blame rests squarely at the people for not using services.

There are others who feel that the community can participate in Government programmes in service delivery as well. These people acknowledge that the service delivery mechanism of the Government may not be foolproof, and therefore people may not have access to services. They thus feel that Community can help the Government in service delivery. The concept of depot holders of simple medicines, and contraceptives is such a concept. Most planners in Government now realize that the outreach of Government staff is limited. They also accept that increase in the numbers of Government employees to increase the outreach to all the habitations is not cost effective. The decision of the Planning Commission of India to freeze the number of Sub-Health-Centers at the 1991 population level is the result of such realization and a very real resource crunch.¹² Still these people do not really accept the ability of communities to plan and work for their own good. They do not believe in the 'empowerment approach'.

There is a group of people who believe in the ability and the power of the communities to shape their own destiny. This group of people feels that community participation should mean empowering the community to plan and work for their development. They feel that Government should help the community in making their own village health plan, and implement it. This should however not become an excuse for withdrawal of the Government, but should lead to a more meaningful partnership between the Government and the Community. 'Right to Health' is an inalienable right of the people, and it is the duty of the Government not only to make all the services available to the people, but also empower the communities so that they can demand, and get what is due to them.¹³

¹² GoC, The Mitanin Programme: the context, rationale and policy perspective, 2002

¹³ WHO, Alma Ata Declaration, 1978

It is imperative to look at some previous experiences of community initiatives on public health to understand the kind of contribution it can make to public health in general. In the 1970's and 1980's, many non-governmental organizations that emerged were involved with work surrounding community health. Till the mid 1960's voluntary effort was confined to hospital based care. Many started as charity work. Post independence there was a rise in NGOs. By mid 1960s it was realized that charity was not enough and 'development' was the key word. Many professionals moved towards the NGO sector. It was a response to the growing disillusionment with the public sector. The characteristics of a non-governmental organization also underwent a change when these professionals entered the field. The projects called for more involvement from the community and making them more self-reliant than giving way to paternalistic attitude as in charity.¹⁴ Many NGOs also represented various dominant political ideologies of the time, like those from the Janata Party (started by Jayaprakash Narayan) or the Left movement (Maoist-Leninist). Many of the Gandhian institutes developed in the West of India as part of the rural development programme. Institutes like the Students' Health Home were a result of the Left movement. There was also a rise of separatist movements in Punjab and Kashmir that gave rise to several non-profit organisations and institutions and then those by the Hindu political organisations like the Rashtriya Swayamsevak Sangh (RSS).

Around the early 1970's under the inspiration and exhortation of Jayaprakash Narayan a small band of medicos and their non medico friends started the Medico Friends Circle which gradually became a national network of doctors and health activists, concerned about the irrelevance of the present forms of medical education and health care to the poor and marginalized.¹⁵ The MFC through its annual meetings, rural camps, bulletin and anthologies became a thought current that not only upheld human and humane

¹⁴ Sundar P, NGO Experience in Health: An overview, in Pachauri S (ed.) Reaching India's Poor: Nongovernmental Approaches to Community Health. New Delhi, 1994

¹⁵ Narayan Ravi, Community Health: Search for a new Paradigm, Health Action, Vol 12, No 11, 1999

values in health care but consistently discussed debated on community health alternatives and ways and means to reorient the present system of health care and medical education.

*"MFC is trying to critically analyze the existing health care system which is highly medicalized and to evolve an appropriate approach towards developing a system of health care which is humane and which can meet the needs of the vast majority of the population of our country."*¹⁶

Community involvement and participation was seen as an essential process to attain the goal of health for all. Some of the alternative approaches to health care by these organizations were to integrate health with development activities, focus on preventive and promotive services, use of appropriate technology, utilization of local resources and healers, introducing village based health cadres, community participation and community organization, local finances through cooperatives, education for health, decentization and political action.

CHW programmes in India

Most community health worker programmes that were initiated in 1970s were seen as synonymous to the primary health care approach spelt in the Alma Ata. They were recognised as one of the means to attain comprehensive primary health care. Many countries introduced community health worker (CHW) schemes post Alma-Ata though the origins of the idea of CHWs at the global level emerged from the success of the barefoot doctors in China in the 1950s.

Lehmann and Sanders write,

"the early literature emphasises the role of the village health workers (VHWs), which was the term most commonly used at the time, as not only (and possibly not even primarily) a health care provider, but also as an advocate for the community and an agent of social change, functioning as a community

¹⁶ Medico Friends Circle, Perspective, 1971

mouthpiece to fight against inequities and advocate community rights and needs to government structures - in David Werner's famous words, the health worker as "liberator" rather than "lackey" ".¹⁷

While earlier the community health worker was seen as an agent of social change and intervened on issues related to the larger health system and not merely the health services, post-80s, CHWs started being seen as the only feasible and acceptable link between the health sector and the community that was developed to meet the goal of improved health.

Community health workers programmes in India in the past have had limited success especially the large scale government run programmes. In India, the first major programme was the Community Health Worker Programme of 1977, whose name was changed to Community Health Volunteer Programme soon after and then again in the year 1983 the name was further revised to the Village Health Guide Scheme. But this programme never took off and did poorly in most states and soon faded out. There were several reasons for its failure. One of the primary reasons was that the selection of the health volunteer was not through a democratic process but was left to the discretion of the panchayat. These volunteers were mostly men and were not given continuous training and there was almost no support given to them. The CHVs were supposed to be the forerunners of the primary health care and were to be chosen by the community to handle minor ailments, thus serving as a link between the primary health centre and the community. Evaluations by two independent researchers of the socially oriented stream found major flaws including inability of the CHV to act as a two way channel because issues of social structure and biases of the health professionals were not given due consideration in its planning and implementation.¹⁸

¹⁷ Lehman, U and D. Sanders (2007), *Community Health Workers: What do we Know About Them?*, WHO, Geneva

¹⁸ Bose A & Desai P.B. (Ed) (1983), *Studies in Social Dynamics of Primary Health Care*. Delhi, Hindustan Publishing House.

Qadeer I. (1984): 'Dynamics of People's Health in People's hands- A study of the CHW Scheme in Shahdol District, Madhya Pradesh', *Socialist Health Review*, Vol. 29, No. 5, p 665-83.

The 70s and 80s as mentioned before saw an upsurge of these voluntary organizations that were more actively embedded in their community of work rather than being just an institution providing curative services. Some of the NGOs that came up during these years were: VHAI, Sewa Rural in Bharuch, RUHSA project in Vellore, Comprehensive Rural Health Project in Jamkhed, SEARCH in Gadchiroli and KEM Rural Health Project, to name a few.¹⁹ Sanjeevani programme in Haryana in 1990's and Mitani programme of Chattisgarh in 2000's, which were government programmes were also such initiatives.²⁰ A review of existing CHW programmes in India revealed that most, especially the ones led by NGOs, had their own referral linkages which usually included a rural hospital run by the NGO itself. In very few CHW programmes, was any attempt made to link the CHW to the public health system. The reason for this was that most of these groups saw the public health system not only as not functioning but also as a 'lost cause'.²¹

There appear to be eight essential features listed that make a CHW programme successful – women as CHWs, selection by community, continuous training and support, curative care essential but not only element, part of empowerment process, carefully selected motivated leadership, good quality referral support, needs to be sustained and built upon – more than 5 years – before results become apparent. All the NGOs running CHW programmes listed below are success stories in implementing a CHW programme in their respective areas and have fulfilled the eight essential features.²²

¹⁹ Nundy M, Social Transformation of not-for-profit Hospitals in Delhi, Unpublished PhD thesis, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi, 2010

²⁰ Chandra Urvashi & Singh Sangeeta, 2008

²¹ SHRC (2003), State Health Resource Center (SHRC) (2003), *Mitani Programme: Conceptual Issues and Operational Guidelines*, SHRC, Raipur.

²² PHRN (2008), Book 4 - *Community Participation and Community Health Workers with Special Reference to ASHA*, PHRN, Delhi.

Table 1.2: Population Coverage by Different Projects

S.No.	Name of the Project/ Area	Population/Area covered
1.	Comprehensive Rural Health Programme, Jamkhed, Aurangabad district, Maharashtra	100 villages
2.	Comprehensive Rural Health Project, FRCH, Mandwa and Parinche, Maharashtra	30 villages
3.	SEWA-Rural, Bharuch, Gujarat	35,000 population
4.	RUHSA project, Vellore district, Tamil Nadu	84 hamlets of about 1 lakh population
5.	SEARCH, Gadchiroli district, Maharashtra	102 villages
6.	KEM Rural Health Project	One block – 186,442 population
7.	Vivekananda Girijana Seva Samithi, Billi Ranga Hills, Karnataka	
8.	Comprehensive Labour Welfare Scheme and United Planters Association of Southern India, Idukki, Munnar	2.5 lakh tea garden workers
9.	Raigarh Ambikapur Health Association	150 villages, 2.5 lakh population

Source: PHRN, Book 4 on Community Participation and Community Health Workers: with special reference to ASHA

Lessons from these success stories resulted in the Government of Chhattisgarh taking the initiative to launch the Mitandin programme in 2002 and scaling it up strategically across the state.

Alma Ata and Primary Health Care

A paradigm shift in bringing community back in to health discourse, program and planning was the Alma-Ata declaration of 1978 that for the first time brought in the

community participation discourse as central to development globally. Alternative approaches from Cuba, China, Tanzania, Venezuela, Nigeria, India, Bangladesh and so on were studied by the WHO and UNICEF. These experiences culminated into the Primary Health Care Declaration of 1978. These experiences show that there were some principles to achieve primary health care. Communities should be involved in the designing, staffing, and functioning of their local primary health care centres and in other forms of support; the primary health care workers should be selected when possible by the community itself or at least in consultation with the community; respect for the cultural patterns and felt needs in health and community development of the consumers.

The Alma Ata Declaration in 1978 gave a very insightful understanding to Primary Health Care. It viewed health as an integral part of the socioeconomic development of a country. It provided the most holistic understanding to health and the framework that States needed to pursue in order to achieve the goals of development. It spelt out the importance of inter-sectoral collaboration, hence addressing all the determinants of health. Also at the same time the Declaration emphasized on complete and organized community participation, and ultimate self-reliance with individuals, families and communities assuming more responsibility for their own health, facilitated by support from groups such as the local government, agencies, local leaders, voluntary groups, youth and women's groups, consumer groups, other non-governmental organizations, etc.

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system

*bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*²³

The Sixth Plan (1980–84) was influenced by two policy documents: The Alma Ata Declaration and the ICMR/ICSSR report on 'Health for All by 2000'. This was followed by the National Health Policy, 1982.

*"The existing model of a highly centralized and bureaucratic system which treats people as objects of health services and does not allow participation should be substituted by another model which would look upon the people as subjects of health and would be democratic, decentralized and participatory. For this purpose, we have suggested that all the integrated health services up to and inclusive of the distinct health center should be placed under the Panchayati Raj institutions."*²⁴

*"The success of the decentralized primary health care system would depend vitally on the organized building up of individual self reliance and effective community participation."*²⁵

The impetus given to health care in the sixth plan is evident from the plan allocation it made. The revised total Fifth Plan outlay for the Health Sector was Rs. 681.66 crores and for Family Welfare it was a total provision of Rs. 497.36 crores.²⁶ In the Sixth Plan while Rs. 1821.05 crores was the total outlay for the Health Sector, it was Rs. 1010.00 crores for Family Welfare.²⁷ The Sixth Plan outlay made an almost three fold increase in the allocation for the Health Sector and more than doubled it for Family Welfare when compared to the Fifth Plan. Family Welfare expenditure which also included the population control measures was boosted because of the World Bank logic which said that rapid population growth was a major

²³ WHO, Alma Ata Declaration, 1978

²⁴ ICSSR/ICMR, Health For All: An Alternative Strategy, 1980

²⁵ GoI, National Health Policy, 1982

²⁶ Planning Commission of India, Fifth Five Year Plan, 1974

²⁷ Planning Commission of India, Sixth Five Year Plan, 1980

obstacle to development and argued that family planning projects are less costly than conventional development projects.²⁸

After the mid 1980's there is a dilution of initial objectives of planning due to penetration of markets. The Seventh Plan, under increasing pressure of neo-liberal policies scaled up investment in Family Planning and opened up to NGO and private sector partnerships.²⁹ The NGO movement was at its peak at this time and works of many professionals in this sector started coming in the public domain. 'People's health in people's hand'³⁰ was the new motto and successful experiences on decentralization and community involvement in health were documented. It was reiterated that health cannot be 'delivered' to the people and that decentralized people's based health care is desirable as well as feasible under the prevailing social and economic conditions and in a democratic set up. The People's sector can achieve both outreach and accountability, far more effectively and at much lower cost because, health like education lends itself best to people's small scale action, which is in their own interest.³¹

But this euphoria on primary health care waned out soon. It was not long before a strong lobby questioning the financial repercussions of the primary health care approach came up with the Selective Primary Health Care (SPHC). The selective approach stated that certain diseases needed to be targeted according to their prevalence, degree of morbidity, mortality rate, feasibility and effectiveness of control measures, and the cost of the intervention. It was concluded that the selective approach was to be aimed at children below 5 years of age and women in the childbearing age. Four interventions were suggested in the areas of immunization, oral rehydration, breastfeeding and antimalarial drugs³². The SPHC was seen as a technical solution even before comprehensive primary health care could be realized. So the thrust

²⁸ Rao Mohan, 'The Rhetoric of Reproductive Rights: Quinacrine Sterilization in India', in Imrana Qadeer, Kasturi Sen & K R Nayar (ed.) *Public Health and the Poverty of Reforms: The South Asian Predicament*, New Delhi, 2001

²⁹ Qadeer Imrana, *Public Health in India: Critical Reflections*, New Delhi, 2011

³⁰ Narayan Ravi, *Community Health: Search for a new Paradigm*, Health Action, Vol 12, No 11, 1999

³¹ Antia, N.H. and K. Bhatia, *People's Health in People's Hands: A Model for Panchayati Raj*, Foundation for Research in Community Health, 1993

³² Warren K S, *The Evolution of Selective Primary Health Care, Social Science and Medicine*, 1988

went back to vertical programmes. Public health and Comprehensive Primary Health Care both follow a systemic approach to viewing health. Both focus on health which is dependent on various processes at work. Both start with the community as the focal point and then expand their understanding. The state's responsibility is to provide for all and let the community take responsibility in organizing itself and planning by mobilizing its resources, prioritizing its needs. SPHC distanced itself from public health by talking of only prevention.

Panchayati Raj Institutions

While the government policies in health were again taken over by vertical programmes, the debates on decentralization were still prevalent. The fact that rural poverty was so widespread even after setting up institutions showed that existing government structures were not delivering. This brought into focus the Panchayati Raj system that were institutions of decentralization but had remained weak for decades.

The 73rd constitutional amendment meant to provide constitutional sanction to establish democracy at the grassroots level as it is at the state level or national level.³³ The amendment sought to ensure the following:

- The existence of Panchayats by making it mandatory for state governments to hold local government elections every five years, and within six months if it is dissolved.
- Panchayats in three tiers – village, sub district and district level; with the Gramsabha recognized as part of the Panchayati Raj.
- Reservation of seats for SC/ST representatives.³⁴

Panchayats have been assigned 29 rural development activities; some of these have a direct bearing on health like family welfare, drinking water, women and child

³³ T M Thomas Issac and Richard Franke, *Local Democracy and Development – Peoples Campaign for Decentralized Planning in Kerala*, New Delhi, Leftword Books, 2000

³⁴ The Constitution (Seventy Third Amendment) Act, 1992, The Gazette of India, Ministry of Law, Justice and Company Affairs, New Delhi, 1993

development, public distribution system and poverty alleviation programs.³⁵ To ensure community participation in the health sector, Panchayats can initiate organizations and institutions of people's participation that will help in programs like village sanitation, vector control, health campaigns for behavior change etc. Panchayats can also be instrumental in ensuring a Village Health Plan to identify goals, build indicators, monitor programs and decide on allocation of resources by creating an enabling environment. In terms of planning and managing health programs PRIs can play an important role through community and social audits. Addressing equity issues is a critical role of Panchayats whereby they can help marginalized sections organize and assert their rights. Community monitoring can be used as a tool by Panchayats to facilitate services and ensure accountability through monitoring health programs and facilities. At the level of district health administration and hospital management PRIs actually own and control hospitals through district health committees which gives them the right to even appoint and dismiss doctors.³⁶ Registration of births, marriages and deaths are also essential activities done by PRIs so as to ensure accurate statistics which helps in measuring health indices.

The Indian experience with decentralization is complex in the sense that although implemented during the SAP period, it did not primarily emerge as a response to reform package.³⁷ Decentralization in several states in India throws up a number of issues. The Karnataka experience shows transitional difficulties with regard to rural health care. The Maharashtra experience shows increasing groupism on the basis of parochial considerations, failure of panchayats to harness new resources, overdependence on government funds etc. West Bengal experience has been lauded for its effective implementation of some of the centrally sponsored programs.³⁸

³⁵ VHAII, Report of the Independent Commission on Health in India, New Delhi, 1997

³⁶ Ibid.

³⁷ Nayar K R, 'Politics of Decentralization: Lessons from Kerala' in Imrana Qadeer, Kasturi Sen & K R Nayar (ed.) *Public Health and the Poverty of Reforms: The South Asian Predicament*, New Delhi, 2001

³⁸ Rao S (ed.), *Panchayati Raj and Health Care*. Proceedings of the Seminar, 9 – 10 April, Bombay: FRCH, 1994.

Involvements of Gram Panchayats in delivering health in Kerala

The unique feature of Kerala's decentralization is that it is an effort to move forward from merely holding panchayat and municipal elections and merely implementing centrally sponsored schemes. The endeavour is to give power and resources to the people, especially at the lower levels in order to enable them to collectively participate in shaping their own future. This is achieved by the people themselves identifying their problems and formulating programs according to local needs. It is assumed that local self-sufficiency would provide a buffer against the negative elements of SAP and is less likely to lead to extreme forms of inequality as created by the market led initiatives. The kind of social mobilization that has taken place and the process by which people were engaged in understanding different dimensions of development, especially health are the major contributions of the Kerala experience.³⁹

It is mandatory for Gram Panchayats in Kerala to impart environmental awareness and as part of their functions on the health front they have to run PHCs, welfare centers (all disciplines), mother and child care centers, control diseases; provide preventive health and family planning activities; and implement sanitation works. Block Panchayats have to run Community Health Centers and Taluk Hospitals. District Panchayats have to control of district hospitals (all disciplines), establish centers for protecting physically and mentally challenged and integrate centrally sponsored and state sponsored health programmes at district level. Due to the involvement of PRI in providing health, Kerala is very near to achieving total immunization, total drinking water within 100 meters and total sanitation.⁴⁰

The output of this decentralized approach in Kerala has been improvement in public health institutions, integration of different systems of medicine, health education,

³⁹ Nayar K R, 'Politics of Decentralization: Lessons from Kerala' in Imrana Qadeer, Kasturi Sen & K R Nayar (ed.) *Public Health and the Poverty of Reforms: The South Asian Predicament*, New Delhi, 2001.

⁴⁰ T. Gangadharan, Decentralization and Health Reforms, KSSP

community efforts for system enhancement, participatory organizational systems, special care for marginalized, change in health habits (use of hot water, decrease in use of tonics, universal immunization, family planning etc), access to drinking water and so on which has improved public health systems and public health in the state. Kerala presents a unique experience among developing countries where a commitment to investment in social sectors such as health and education has reaped great benefits in the improvement of health status of its people.⁴¹

Health Care and Economic Reforms

In 1989 – 90, the Central Government expenditure on public health was Rs. 51.8 Crore as opposed to Rs. 86.5 Crore in 1985 – 86. There was a reduction of 40.1% in the expenditure in this period.⁴² The government further retreated from the social sector in the early 1990's. Soon after accepting the Structural Adjustment Programs (SAP),⁴³ World Bank came out with the World Development Report (WDR) in 1993 'Investing in Health'.⁴⁴ It stated that such adjustment is clearly needed for long run health gains. There were specific Public Health services listed by the WDR like immunisation, school based health services, information and selected planning for family planning and nutrition, programmes to remove alcohol consumption and regulatory action, information and limited public investments to improve household environment and finally AIDS prevention. Another component in the report talked of the essential clinical services which need to be privatised and which will be highly cost-effective. The assumption here was that the private sector already serves a large and diverse clientele in developing countries and often delivers services of higher quality without the long

⁴¹ Kutty Raman V, 'Reforms and Their Relevance: The Kerala Experience' in Imrana Qadeer, Kasturi Sen & K R Nayar (ed.) *Public Health and the Poverty of Reforms: The South Asian Predicament*, New Delhi, 2001

⁴² Source: NIPFP 1994, as quoted in Report of the Independent Commission on Health in India.

⁴³ Structural Adjustment Programmes (SAP) was implemented subsequent to the era of debt led growth of the 1970s and 1980s. The thrust was on reducing the role of state and allowing the market to shape the development process. Main features of SAP in India has been the devaluation of rupee, privatization of industries, doing away with 'excess' labour force, curbs on the distribution system, reduction on subsidies and cuts in education and health sector.

⁴⁴ World Bank, World Development Report, 1993

lines and inadequate supplies frequently found in government services. The World Bank made another assumption that there were more people using private services so it was a need of the people. This was misconstrued as people were willing to pay but in reality it was the inadequate services that were driving them to private practice as there was no other choice. Hence the Eighth Plan talked of privatization of medical care and of targeting the underprivileged for providing primary health care.⁴⁵ All this was despite Report of the Independent Commission on Health in India quoting figures that showed better health statistics in terms of lower infant mortality and higher life expectancy in states spending higher on health as compared to low expenditure states.⁴⁶ IMR in low expenditure states was 98 in comparison to IMR of 69 in high expenditure states according to 1989 figures. While the low expenditure states' per capita health expenditure in 1990 was Rs. 40, it was Rs. 65 in the high expenditure states.⁴⁷

World Bank had a major influence on the direction of planning in the 1990's. They reinforced privatization of medical care at almost all levels, promotion of vertical disease and population control programmes, rejection of even selective primary health care, delegitimization of the public sector institutions labelling them as inefficient, lethargic and corrupt, shift of subsidies from the public sector to the private sector in health and de-emphasizing the state's role in provisioning of health services.⁴⁸ Under the plan the social sector expenditure declined from 20.8 percent in 1985-91 to 17.7 percent when the economic reforms were introduced in 1991. Allocations to health sector as a percentage of the plan outlays declined from 3.3 percent during first plan to 1.7 percent in the seventh plan. They further declined to 1 percent during annual plan 1997-98.⁴⁹

⁴⁵ Qadeer Imrana, *Public Health in India: Critical Reflections*, New Delhi, 2011

⁴⁶ VHAI, Report of the Independent Commission on Health in India, New Delhi, 1997

⁴⁷ Reddy, K N and V. Selvaraju, *Health Care Expenditures by Governments in India: 1974-75 to 1990-91*, New Delhi, 1994

⁴⁸ Qadeer Imrana, *Public Health in India: Critical Reflections*, New Delhi, 2011

⁴⁹ Panchamukhi, P.R. 'Social Impact of Economic Reforms in India: A Critical Appraisal', in *Economic and Political Weekly*, March 2000

At the macro level, de-regulation and relaxation in imports has clearly strengthened the hand of private sector especially multi-nationals in the pharmaceutical and health insurance fields. The government failed to promote people's participation and involvement in their own health development and health was not a priority issue. The outcomes of structural adjustment policies of 90s started being reported by the end of the decade. There was evidence from world over about further impoverishment due to high out-of-pocket expenses, indicators like IMR showed an increase. A study by the Planning Commission showed that percentage of people below the calorie norm of 2,400 calories had increased from 65.8 percent in 1987-88 to 70 percent during 1993-94. The National Family Health Survey (NFHS, 1998-99) gave the state wise data on nutritional status of children. Four states had seen an increase in the proportion of underweight children, and five states saw a rise in proportion of stunted children, which implies chronic undernutrition and diarrhoea. The infant mortality rate had gone up in nine states in India.⁵⁰

By early 2000 there was again a realization within governments all over the world and World Bank itself that the public needs to be back in public health and governments need to play a greater role in investing in it. This led to the formation of the WHO led Commission on Macroeconomics and Health that led to the formation of a National Commission in India too. The focus was narrow because the idea was to invest in people for economic growth. So investing in health was a means and not an end in itself. But nevertheless, the debates centred around the importance of the role of the state in ensuring public health. Community participation was not talked of explicitly in these reports. Poor health conditions of people led some state governments in India to take initiative to scale up people's participation in health. Chattisgarh state's Mitandin experiment was such an initiative.

The Mitandin Programme in Chhattisgarh

⁵⁰ GoI, National Family Health Survey, 1999

Poor health education, poor access to health services and the prevailing cultural practices and socio-economic context of those living in rural areas of Chhattisgarh has led to high levels of disease and a low utilisation of health services. The community needed to be encouraged to address its own health needs by requesting and taking part in health programmes relevant to those needs and also using the health services already on offer. The first step was to organize and empower women in the community as well as Panchayati Raj institutions. This was done by establishing a state wide Community Health Volunteer (CHV) program⁵¹ (announced in December 2001) which trained and deployed a CHV in every single hamlet of this state. The CHV is called a Mitadin, (a special kind of friend in local tradition) and is a married woman from the local community, not necessarily formally educated though almost literate.

In the field of public health the Mitadin is to give health education to the community of the habitation, to take on the leadership role in all public health activities of the village and to encourage community service for public health, to provide first aid, and over the counter (OTC) drugs for minor ailments, to be trained in taking care of common illnesses in the village, and to gradually take on the responsibility for treating these diseases in the village, to be given the knowledge to refer all cases beyond her competence to the proper place where they can receive proper health care, to complement the work of ANM and other health staff, to work in close association with Panchayati Raj Institutions, to be the main link between the government and the people in a habitation.

Through the program the Chhattisgarh government was able to improve health education and public awareness on health issues, improve utilization of existing public health care services, initiate collective community level action for health and related development sectors, provide immediate relief for common health problems, organize women for health action and build up the process of women's empowerment, sensitize panchayats on capabilities building, local health planning and programmes.

⁵¹ GoC, Mitadin Programme, Chhattisgarh: A CHV Programme As Well As a Health Sector Reform, 2002.

Chhattisgarh showed marked improvements in its infant mortality rate in the years following the Mitnin programme. It was considered that this programme had contributed significantly to this achievement.⁵²

The State of Public Health in India and the Need for NRHM

Since independence India had registered significant progress in improving life expectancy at birth, reducing mortality due to Malaria, as well as reducing infant and material mortality over the last few decades. Table II shows how infrastructure has been provided and Table III shows the changing ratio of expenditure on health through the various plans. In spite of the progress made, a high proportion of the population, especially in rural areas, continued to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition. The rural public health care system in many states and regions was in an unsatisfactory state leading to pauperization of poor households due to expensive private sector health care. India was in the midst of an epidemiological and demographic transition – with the attendant problems of increased chronic disease burden and a decline in mortality and fertility rates leading to an ageing of the population. An estimated 5 million people in the country were living with HIV/AIDS, a threat which had the potential to undermine the health and developmental gains India has made since its independence. Non-communicable diseases such as cardio-vascular diseases, cancer, blindness, mental illness and tobacco use related illnesses had imposed the chronic diseases burden on the already over stretched health care system in the country. Premature morbidity and mortality from chronic diseases could have become a major economic and human resource loss for India. The large disparity across India places the burden of these conditions mostly on the poor and on women, scheduled castes and tribes especially those who live in the rural areas of the country. The inequity was also reflected in the skewed availability of public resources between the advanced and less developed states.

⁵² PHRN, Introduction to Public Health Systems, 2008.

Table 1.3: PHC and Sub-centre Development in India (1951- 2010)

S No.	Health Facilities	1951	1961	1971	1981	1991	2001	2010
1	PHCs	725	2695	5131	5568	22243	22370	23673
2	Sub-centres	-	-	27929	51192	131098	137311	147069

Source: 1. Health Statistics / Information of India, CBHI, GOI, various years,
2. Census of India Economic Tables, 1961, 1971, 1981, GOI,
3. Budget Papers of Central and State Governments, various years,
4. National Accounts Statistics, CSO, GOI, various years.
5. RHS Bulletin, March 2010

Table 1.4: Plan Expenditure on Health: First Plan to XI Plan (Rs. in Crores)

Plans	Period	Total Plan	Health	FW	Total Health	TH cent of TP	per of
First Plan	1951-56	19600	652	1	653	3.3	
2nd Plan	1956-61	46720	1408	50	1458	3.1	
3rd Plan	1961-66	85765	2259	249	2508	2.9	
Annual Plan	1966-69	66254	1402	704	2106	3.2	
4th Plan	1969-74	157788	3355	2780	6135	3.9	
5th Plan	1974-79	394262	7608	4918	12526	3.2	
Annual Plan	1979-80	121765	2231	1185	3416	2.8	
6th Plan	1980-85	1092917	20252	13870	34122	3.1	
7th Plan	1985-90	2202163	36941	29581	66522	3.0	

Annual Plan	1990-91	61518.1	960.9	784.9	1745.8	2.8
Annual Plan	1991-92	65855.8	1042.2	856.6	1898.8	2.9
8 th Plan	1992-97	434100	7602.2	6500	14102.2	3.2
9 th Plan	1997-2002	859200	20084.75	15120.2	35204.95	4.1
10 th Plan	2002-07	1484131.3	31795.3	27125	58920.3	4.0
11 th Plan	2007-12	2156571.0	140135		140135	6.5

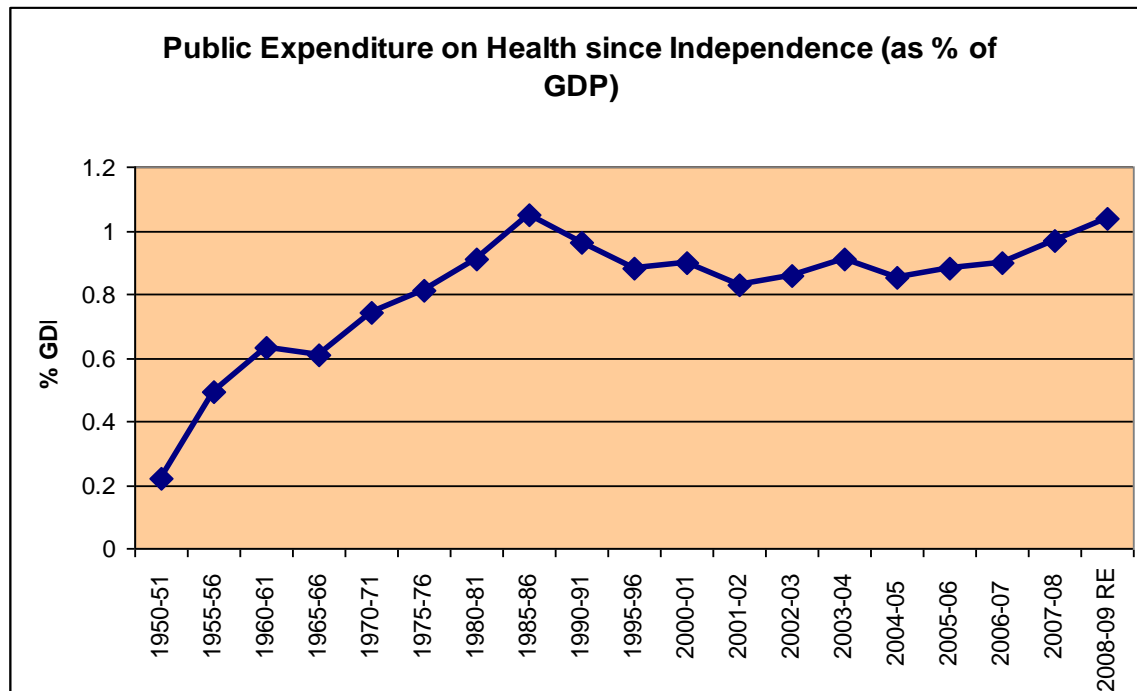
Note: Dept. of Family Welfare merged with Dept of Health since 2005.

Source: Figures up to 7th Plan are from Reddy (1993) and 1990-91 onwards Health Information of India

Public spending on preventive health services had a low priority over curative health in the country as a whole. Indian public spending on health (Figure I shows Indian public expenditure on health as a % of GDP) was amongst the lowest in the world, whereas its proportion of private spending on health is one of the highest. More than Rs. 100,000 crores⁵³ was being spent annually as household expenditure on health, which was more than three times the public expenditure on health. The private sector health care was unregulated pushing the cost of health care up and making it unaffordable for the rural poor. Persistent malnutrition, high levels of anemia amongst children and women, low age of marriage and at first child birth, inadequate safe drinking water round the year in many villages, over-crowding of dwelling units, unsatisfactory state of sanitation and disposal of wastes constitute major challenges for the public health system in India. Most of these public health determinants are correlated to high levels of poverty and to degradation of the environment in our villages. Thus, the country had to deal with multiple health crises, rising costs of health care and mounting expectations of the people. The challenge of quality health services in remote rural regions had to be met with a sense of urgency. Given the scope and magnitude of the problem, it was no longer enough to focus on narrowly defined projects. The urgent need was to transform the public health system into an accountable, accessible and affordable system of quality services. It was as a response to this state of public health in India that the NRHM was launched.

⁵³ GoI, NRHM: Framework for Implementation, 2005.

Figure 1.1



Source: Mukhopadhyay, I (2011): Public Health Care Expenditure in India: A study of Kerala, Tamil Nadu and West Bengal. Unpublished PhD thesis, Centre of Social Medicine and Community Health, JNU, New Delhi.

National Rural Health Mission and Community Participation

The National Rural Health Mission (NRHM) was launched in 2005⁵⁴ with a view to bring 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 sought to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals. In India public infrastructure on health had been decimated not just in the physical sense but at the level of the people who work in it. A situation was created where the public had lost trust in public

⁵⁴ GoI, National Rural Health Mission, Mission Document, 2005.

institutions. This trust had shifted to the market. With NRHM there has been an effort to resuscitate this dysfunctional public infrastructure. It also sought to bring back community participation into ensuring public health.

NRHM's vision was to provide effective health care to rural population throughout the country with special focus on states which have weak public health indicators, to increase public spending on health from .9% of GDP to 2-3% of GDP,⁵⁵ undertake architectural corrections of the health system, revitalize local health traditions, address inter-state and inter-state disparities, set time bound goals and report publicly on its progress. In terms of what it envisaged to achieve, NRHM aimed at reducing child and maternal mortality, providing universal access to public health care services, prevention and control of communicable and non-communicable diseases, population stabilization with gender and demographic balance and promotion of healthy life styles.

A five level strategy of communitising, improving management through capacity building, flexible financing, innovation in human resource management and monitoring progress against standard is followed in the mission. At Community level the Mission sought⁵⁶ to ensure the availability of trained community level worker at village level, with a drug kit for generic ailments, to observe Health Day at Aanganwadi level on a fixed day/month for provision of immunization, ante/post natal checkups and services related to mother and child health care, including nutrition, to ensure availability of generic drugs for common ailments at sub Centre and Hospital level, to provide access to good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level and assured referral-transport-communication systems to reach these facilities in time, to improve access to universal immunization through induction of Auto Disabled, to make available syringes, alternate vaccine delivery and improved mobilization services, to improve facilities for institutional deliveries through provision of referral transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the below poverty line families, to assure health care at

⁵⁵ PHRN, Introduction to Public Health Systems, 2008.

⁵⁶ GoI, National Rural Health Mission, Mission Document, 2005

reduced financial risk through pilots of Community Health Insurance under the Mission, to make safe drinking water available, to provide for household toilets, to improve outreach services to medically underserved remote areas through mobile medical units and to increase awareness about preventive health including nutrition.

Institutionalizing Community Led Action for Health - ASHA/VHSCs/RKS

NRHM calls for Panchayati Raj Institutions from the village to the district level to be given ownership of the public health delivery system in their respective jurisdiction.

The Accredited Social Health Activist (ASHA) is a health activism initiative within communities. This initiative creates awareness on health and its social determinants and mobilizes the community towards local health planning and increased utilization and accountability of existing health services provided by the government. ASHA also provides a minimum package of curative care as appropriate and feasible for that level and makes timely referrals. Under the National Rural Health Mission, the government envisaged appointment of a female ASHA in every village to act as an interface between ANM and the village and to be accountable to the Panchayat. The ASHAs would get performance based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets and other healthcare delivery programmes. Though Central government makes general guideline for appointment of the ASHAs, various States are free to follow their own models based on the requirements of the State.⁵⁷

NRHM clearly states that "The Village Health and Sanitation Committee (VHSC) will be formed in each village within the overall framework of Gram Sabha in which proportionate representation from all the hamlets would be ensured. Adequate representation to the disadvantaged categories like women, SC/ST/OBC/Minority Communities would also be given. The Sub Health Center will be accountable to the Gram Panchayat and shall have a local committee for its management, with adequate representation of VHSCs." VHSCs are expected to create public awareness on health

⁵⁷ PHRN, Introduction to Public Health Systems, 2008

programs, develop a village health plan, analyze problems related to village health and give feed back to the officials, maintain a village health register and health information board, ensure proper visit of ANM, audit infant and maternal deaths in the village, conduct Jan Samvad and manage the village health fund.⁵⁸

Rogi Kalyan Samiti or the Hospital Development Society is an institutional space where participation is possible other than in a village and Panchayat level committee. These Samitis were expected to improve quality of services by better management, be a vehicle of public participation and make public hospitals more accountable. Their objectives included maintenance and upgradation of health infrastructure, development of unused hospital assets for commercial purposes, ensuring ambulance services, safe disposal of hospital waste, providing free treatment for patients below poverty line, arranging quality diet and stay for patients and their relatives, improving hospital management with community participation, establishing public private partnership and organizing training and workshops for staff members. RKS has made management more participatory, enabled better inter-department coordination and greater interest by the district administration. It has also provided a very flexible fund pool for addressing small local needs.⁵⁹ All these initiatives are linked with PRIs ensuring that they function as the constitutionally sanctioned bodies that ensure coordination and financial support.

The discussions above have shown that the notion of community participation has been evolving since the early post-independence days. However, the crucial difference between the context in which earlier initiatives and the NRHM processes is two-fold. First, the state had been gradually withdrawing from the social sector and the second is the process of decentralization that has been introduced by the state without much support structures for these processes. The processes introduced are no doubt significant keeping in mind the ongoing debates in decentralization but they will not succeed without adequate budgetary, infrastructural and technical support by public

⁵⁸ Ibid.

⁵⁹ Ibid.

health systems. Decision making and monitoring of public health systems will have to include these institutional processes and build their capacities to be effective players within the health sector. Only then will the true democratization of the health system take place. Such a process will lead effective community participation within the NRHM and make the state more accountable to provide to all. The Community Fellowship Programme of the Public Health Resource Network, a subject of study of this project, has been an attempt to strengthen the processes of decentralisation set into motion by the NRHM at the district level. While the next chapter does an analysis of this programme, the rest of the report puts together a thematic analysis of the ground level realities as experienced by the Fellows.

CHAPTER TWO

The Community Health Fellowship Programme

The Community Health Fellowship Programme was conceived as a civil society response to the urgent need for trained and experienced public health professionals at the district and block levels, especially in states with poor health indicators.

With the largest absolute number of newborn⁶⁰ and child deaths⁶¹ (0-5 yrs) in the world reported to be in India, the Indian public health system requires systematic and comprehensive strengthening. Dominated by the private sector, health care and public health in India has suffered from decades of state apathy reflected in decreasing financial allocations⁶², crumbling infrastructure⁶³, non-functional equipment⁶⁴, unavailability of drugs⁶⁵ and finally, absentee medical and para-medical staff or vacant posts⁶⁶. In addition to such significant gaps in crucial inputs, public health, a state

⁶⁰ Throughout the period 1990-2009, India has been the country with the largest number of neonatal (0-1 month) deaths in the world. In 2009, India accounted for 27.8% of global neonatal deaths and 19.6% of global live births. Oestergaard, M.Z. et. al., (2011), 'Neonatal Mortality levels for 193 countries in 2009 with trends since 1990: A Systematic Analysis of Progress, Projections and Priorities'. PLoS Med 8(8).

⁶¹ In 2009, India accounted for 21% of under 5 deaths of children worldwide which is the highest proportion. You, D. et.al., (2010), 'Levels and Trends in Child Mortality 1990-2009', *Lancet*, Volume 375, Issue 9745

⁶² Prior to the launch of the NRHM, public health expenditure in India as a percentage of the Gross Domestic Product was at its highest at 1.05% in 1985-86. In the decade between 1985 and 1995, it fell steadily to 0.96% in 1990-91 and 0.88% in 1995-96. It recovered marginally in 2000-01 to 0.90% but fell again in 2001-02 to 0.83%, was 0.86% in 2002-03 to 0.91% in 2003-04. Rao, K.S. et.al., (2005), 'Financing of Health in India' in *Financing and Delivery of Health care services in India*, Background Papers for the National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Government of India.

⁶³ As of March 2007, there was a 13% shortfall in Health Sub-centres, 19% shortfall in Primary Health Centres and 39% shortfall in Community Health Centres at the national level. Sixty eight percent of the existing sub-centres in Bihar did not have regular water supply and 71% did not have an electric connection. For Uttar Pradesh, these figures were 59% and 75% respectively. *Bulletin of Rural Health Statistics*, March 2007, Ministry of Health and Family Welfare.

⁶⁴ As per an all India facility survey published by the Ministry of Health and Family Welfare in 2005, only 46% of Community Health Centres and 41% of Primary Health Centres were adequately equipped

⁶⁵ The same survey found that only 24% of CHCs had adequate supplies which include tubal ring, standard surgical kits, emergency obstetric care kit, newborn care kit, RTI/STI kits and delivery kits

⁶⁶ As of March 2007, 46% of PHCs in India were operating with only 1 doctor or without any doctor, 34% without any laboratory technicians and 14% without any pharmacists. *Bulletin of Rural Health Statistics*, March 2007, Ministry of Health and Family Welfare

subject in India, is dominated by vertically organized centrally sponsored schemes⁶⁷ leading to 'top-down' and centralized health policies and programmes⁶⁸. Thus, most public health programmes tend not to be need based and context specific with communities largely unaware of the services that they are entitled to, health facilities and service providers distant and/or inaccessible⁶⁹ and utilization levels low⁷⁰. Moreover, often such programmes have public health goals but lack a 'public health' orientation. They do not adequately address the socio-economic⁷¹ and cultural determinants⁷² of health and disease nor are they able to sufficiently take into account the gender⁷³, caste and class⁷⁴ specific differences in accessing and implementing modes of treatment and prevention.

The National Rural Health Mission (NRHM), launched in 2005, is an ambitious central government scheme that seeks to address several of these lacunae in the Indian public health system. Implemented in a mission mode, the NRHM aims to provide staff and

⁶⁷ Centrally sponsored schemes (CSS) are special purpose grants extended by the Central Government to States to encourage and motivate State Governments to plan and implement programmes that help attain national goals and objectives. Guidelines framed for Centrally Sponsored Schemes indicate the conditions that must be fulfilled, and prescribe mechanisms / procedures for drawing the grant money. CSSs are formulated by concerned Ministries and Departments and implemented through counterpart State level departments and para-statal bodies identified for the purpose.

⁶⁸ Duggal, R. (2001), *Evolution of Health Policy in India*, CEHAT

⁶⁹ Sixty percent of Primary Health Centres in Chhattisgarh do not have an all weather motorable approach road. Bulletin of Rural Health Statistics, March 2007, Ministry of Health and Family Welfare

⁷⁰ As per the National Family Health Survey 2005-06, only 34% of women received any antenatal care during their last birth in the five years preceding the survey in Bihar. Of these, only 17% received three or more antenatal care visits and only 19% received antenatal care in the first trimester.

⁷¹ While it is well understood that poverty is an important determinant of poor health and the poor have the highest mortality rates and lowest levels of health service utilisation, the design of public health programmes rarely account for the special needs of the poor. The simplest example would be organising maternal and child health camps at a time when poor communities are able to come for vaccination without having to lose their daily wage.

⁷² The early age of marriage and/or pregnancy is an important contributor to high levels of maternal and infant mortality. Public health programmes also need to be designed to raise the age of marriage or at least pregnancy in communities.

⁷³ Women patients of tuberculosis are more likely to face desertion, violence and death as compared to men. They also tend to delay care seeking and treatment because of lack of awareness, resources and fear of social rejection. A strategy of involving women peer educators in TB awareness and detection programmes would ensure timely detection in women.

⁷⁴ Traditional Information Education Communication programmes on child malnutrition advice communities on elaborate complementary feeding practices without taking into account that poor families often lack diversity in food and the time needed for child feeding and caring.

resource to public health facilities as per the Indian Public Health Standards and introduce 'architectural corrections' to move from vertical to comprehensive health programmes. It plans to decentralise health programme planning and budgeting through the development of village, block, district and state annual plans and budgets. Most importantly, the NRHM envisages the involvement of communities in planning and delivering health services through the development of institutions such as Village Health and Sanitation Committees (VHSC) at the village level and Rogi Kalyan Samitis (RKS) at Primary Health Centres, Community Health Centres and District Hospitals. These committees at both the community and facility level are empowered with 'untied' funds, disbursed annually. The NRHM also plans to train and support a woman from amongst every 1000 persons in rural India to be an Accredited Social Health Activist (ASHA). The ASHA is expected to create awareness and enable the adoption of available health services and appropriate health practices. Finally, the NRHM seeks to strengthen technical and programme management by setting up State Health Systems Resource Centres and introducing district level programme and finance managers⁷⁵.

However, achieving these essential but lofty goals, especially in the 18 high focus states with poor health indicators would require a significant reorientation in the perspective and functioning of existing public health staff as well as additional teams of qualified, experienced and committed public health professionals. As a public health expert eloquently said, "A mission needs missionaries and it needs them where the challenges are the greatest!"⁷⁶

The Public Health Resource Network (PHRN), a collective of public health doctors, activists and practitioners, several of whom were actively involved in shaping the policies of the NRHM, seeks to contribute to building public health capacity in India by developing courses and resource material and undertaking training programmes and

⁷⁵ National Rural Health Mission Framework for Implementation, Ministry of Health and Family Welfare

⁷⁶ T. Sundararaman, Executive Director, National Health Systems Resource Centre

research. Some of the distinguishing features of PHRN's capacity building initiatives, undertaken in the context of the NRHM, are:

- The training modules examine each issue comprehensively discussing and presenting the promotive, preventive, curative and rehabilitative aspects of health conditions and diseases. For each of these aspects, both the social and medical features are outlined and the needs of any special groups are highlighted. A critical history of programmatic intervention in the Indian context, both by the state as well as civil society groups, is discussed along with the politics of particular intervention choices and evidence regarding impact. Each concept is explained through examples and case studies based on field experiences. Finally, students are provided with several tools and frameworks to be used for analysing field conditions and developing and operationalising health programmes in participatory ways.
- The modules are designed for self study and are available in both Hindi and English.
- The courses are offered primarily to public health practitioners working at the district and sub-district level in the states of Bihar, Jharkhand, Chhattisgarh and Orissa. These include district health officials, NGO workers and field based activists. The objective is to equip them with the knowledge, skills and tools required to enable public health change in their domains. Rather than training students and then convincing them to work in poor, remote and underdeveloped regions, public health knowledge is made available to those already based and working for health improvements in such areas. Moreover, since the students are already working, it becomes possible to translate the knowledge gained into immediate improvements at the field level.
- Contact and training programmes are also organised to supplement self-study, facilitate group-based learning and respond to queries.
- The development of modules, facilitation of contact and training programmes as well as checking of assignments is based on the voluntary effort of PHRN members.

The predominant modes of training followed by PHRN are:

- An IGNOU certified one-year distance-learning programme “Post Graduate Diploma in District Health Management”.
- An 18 month PHRN certified distance learning programme on District Health Management
- An 18-day training programme for district health officials on District Planning and District Health Management.

PHRN started its initiatives in 2007 and soon realised the need for full time and dedicated persons to support the community participation agenda of the NRHM. Community participation and decentralisation are the cornerstones of the reform process initiated by the NRHM, but community members require significant capacity building and handholding support to participate in health programmes as planners and monitors and not just as beneficiaries. Moreover, public health staff who have traditionally looked down upon poor communities and lower caste/tribes as illiterate, ignorant, unhygienic, unwilling to change and largely responsible for their own plight, also need substantial intervention to transform their attitudes. They need to concede that they are accountable to the villagers and accord them due respect and dignity. While local civil society groups could potentially play a role in building capacity and supporting the public health system to interact and engage with communities in meaningful ways, often NGOs working in disadvantaged areas have limited capacity and require support.

Thus, PHRN conceived of a plan to identify motivated public health and development practitioners and train and support them to function as community health Fellows at the district level. The Fellows were expected to work with district level public health functionaries as well as local civil society groups to strengthen the implementation of the ASHA, VHSC and RKS programmes of the NRHM. The Fellowship programme was advertised in October 2008 and offered as a two-year programme from January 2009 to

December 2010 in 45 districts across the states of Bihar, Jharkhand, Orissa and Rajasthan.

The roles of a Community Health Fellow, as defined in the programme brochure, were:

- To support all community level processes in the districts through advocacy with district administration and panchayati raj bodies and with local NGOs.
- Assisting in training ASHAs and Village Health and Sanitation Committees members and members of local NGOs involved in assisting the NRHM.
- Appraisal and strengthening of all community processes.
- Formative studies for designing community programmes and improve training curriculum and documentation of ongoing processes

The deliverables of a Community Health Fellow included one or more of the following:

- A more effective ASHA programme and Village Health and Sanitation Committee.
- A more effective Rogi Kalyan Samiti.
- Identifying motivated individuals within and outside government and networking them to support institutions/organisations working in public health.
- Identifying motivated organisations and helping with their capacity building and networking them to institutional support at the state and national level.

The activities expected from a Community Health Fellow were:

- Attending training programmes and serving as trainers.
- Undertaking small evaluation studies to feed into local programme planning.
- Attending meetings of ASHAs or village health committees or of facilitators of such programmes and inspiring them as well as building up their capacity.
- Drawing the attention of authorities to gaps in the programme and support that local activists need, especially as regards incentive payments, drug kit refills and referral support.
- Facilitating visits by national and state mentoring group members.
- Analytic programme documentation.

The Community Health Fellowship Programme, when proposed by PHRN, received widespread support from national and state governments as well as a range of civil society groups including funders, technical resource agencies and field based organisations. The National Health Systems Resource Centre (NHSRC), the apex technical support institution of the Ministry of Health and Family Welfare for the NRHM supported the development and implementation of the programme, the Society for Education, Action and Research in Community Health (SEARCH), Gadchiroli provided training support for the Fellows and facilitated the implementation of the programme in the state of Rajasthan, the McArthur Foundation funded the costs of the programme for

15 Fellows in Rajasthan while the ICICI Centre for Child Health and Nutrition, Pune supported the development of the programme and funded the costs of 30 Fellows in the states of Bihar, Jharkhand and Orissa (McArthur Foundation's support for the Fellowship programme comprised of a 6-month preparatory period and an 18-month Fellowship period, hence the Fellowship programme in Rajasthan was only for 18 months.)

Besides being a multi-agency, state-civil society partnership designed to foster similar partnerships at the district and sub-district level, PHRN's community health Fellowship programme had several other unique features. These were:

- The Fellowship was designed to improve community participation under the NRHM in 45 districts.
- It was an innovative strategy to develop ways for facilitating and promoting effective community participation in the NRHM.
- The studies and action research undertaken by the Fellows would enhance knowledge on the status of health and health programmes across 45 districts and 4 states.
- The programme would strengthen decentralised and participatory working in the public health system across the selected districts.
- The Fellowship would ultimately build community health professionals with the motivation and technical competencies to work with people, civil society and the state to further the ideals of 'Health for All.'

The design of the PHRN Community Health Fellowship programme also differed significantly from other Fellowship programmes available during the same time. These were:

- *Ford Foundation International Fellowships Programme*: These Fellowships support individuals from marginalised communities to pursue a high quality postgraduate programme at an international university or in India.
- *MacArthur Fellows Programme*: This programme provides a five-year grant to individuals who show exceptional creativity in their work. The Fellowship is designed to enable the selected Fellow to pursue their creative activities without any specific obligations or reporting requirements. Fellows are nominated for this Fellowship.
- *Ashoka Fellows*: Ashoka Fellowships are awarded to individuals considered to be social entrepreneurs who have innovative solutions to social problems and the potential to change patterns across society.
- *Indicorp Fellowship*: This is an international Fellowship that supports persons of Indian origin staying abroad to volunteer for a period of one or two years with a grassroots service organisation.
- *America India Foundation's William J Clinton Fellowship*: This Fellowship supports young professionals from the United States of America to volunteer with credible non-governmental organisations and social enterprises in India for a period of 10 months.
- *Society for Community Health, Awareness, Research and Action (SOCHARA) Community Health Cell, Bangalore's Community Health Internship cum Fellowship Scheme*: This 4 year programme supported young professionals to explore a future in community health through a semi-structured placement opportunity in Community Health Cell in partnership with selected community health projects for a period of 6-9 months.

Thus, existing Fellowship programmes either supported deserving candidates to pursue higher studies or recognised and supported social entrepreneurs or facilitated young persons from abroad to volunteer in India. The SOCHARA Fellowship was closest in design to the PHRN Community Health Fellowship and had the additional feature of close direct work with poor communities, but the latter is rendered unique by its focus on taking public health knowledge to existing practitioners working in poor and remote

districts of underdeveloped states as well as its aim to position the Fellows to link communities with public health services by strengthening community participation programmes of the public health system.

Given its unique positioning, this chapter aims to describe the design and implementation of the Community Health Fellowship programme through an exploration of specific aspects. Each aspect is examined in terms of the plan and its execution including feedback of the community health Fellows where relevant.

Who were the Community Health Fellows?

a) Selection criteria and process

The announcement of the community health Fellowship programme was widely advertised through email networks, national newspapers and posters in major educational institutions and PHRN partner offices in the four states of Bihar, Jharkhand, Orissa and Rajasthan. The main criteria for application in all the advertisements were:

- Age range of 25-40 years
- Qualification and experience as follows:
 - Graduate in Health Sciences with a minimum of 5 years of work experience at the community level or
 - Post graduate in Social Sciences or
 - Graduate in Social Sciences with a minimum of 2 years of work experience in community health
- Willingness to work independently at the community and district level
- Readiness to lead and engage with a range of actors and sectors

The following qualities were preferred:

- Strong analytical and communication skills
- Fluency in local language and familiarity with the state of work
- Experience in development organisations

All interested candidates were asked to apply with their resume and a statement of purpose (SOP) detailing in 1000 words why they wanted to be a community health Fellow. The resumes were to be screened in terms of compliance with the age criteria and qualifications. The screened resumes were to be scored out of a total of 30 on the basis of educational qualification, work experience, leadership experience and co-curricular activities. The SOPs were to be scored out of a total of 10 on the basis of structure, clarity, language and likelihood of working in public health in the future. Candidates with scores of more than fifty percent were to be shortlisted for the next round of selection, which involved a written test, group discussion and personal interview. While the shortlisting of candidates on the basis of resume and SOP was done centrally, the interactive processes were conducted at the state level over a two to three day period.

The purpose of such a rigorous selection process was to identify versatile and motivated leaders who would be able to combine field based skills with the ability to analyse and advocate for health system policy and practice changes at the district level.

Selecting the Community Health Fellows

A total of 1200 applications were received of which 375 were screened for further shortlisting. Of these 13% were received from Bihar, 10% from Jharkhand, 25% from Orissa, 21% from Rajasthan and 25% from the rest of India (a few of the screened applications did not specify the address). These 375 applications and their SOPs were scored as per the determined process. Three was the lowest score received on a resume whereas 15 was the highest score. More than 75 per cent of candidates received scores in the range of 7-12 on their resumes. The SOP was graded out of a total score of 10 and nearly half the candidates received scores in the range of 5-7. One thirty five candidates with a score of fifty percent and above on their resumes and SOPs were shortlisted for interviews which were conducted by a panel comprising PHRN members from both the national and state office. One twenty five candidates appeared for the interview process conducted in Patna, Ranchi, Bhubaneswar and Jaipur of

which, 45 were selected to be community health Fellows. Of these, 3 candidates could not join the programme due to a variety of reasons.

Finally, in January 2009, 42 Fellows joined the Community Health Fellowship programme of which 15 were to be based in Rajasthan, 10 in Bihar, 8 in Jharkhand and another 9 in Orissa.

The 3 initial and subsequent vacancies that developed in the Fellowship programme due to some early dropouts were used to develop and offer a Post Graduate Diploma in District Health Management (PGDDHM) internship programme. Students enrolled in the IGNOU certified PGDDHM programme, offered in the distance mode, were supported to intern with the PHRN for 1 year, which was the duration of the course.

b) Completing the Community Health Fellowship

Since the Fellowship was for duration of 2 years⁷⁷, which is a significant period of time, not all Fellows who joined the programme were able to stay the course, and 31 percent of the Fellows dropped out of the Fellowship. For the purposes of this analysis, data for all Fellows who completed 12 of the 24 required months has been considered.

The Figures for Fellowship completion are as follows:

Table 2.1

S.No .	State	Number of Fellows who joined	Number of Fellows who completed 12 months	Number of Fellows who completed 24 months ⁷⁸	Number of drop outs ⁷⁹	Number of Fellows who submitted their research projects
1	Bihar	10	8	4	3	7
2	Jharkhand	8	8	8	0	6
3	Orissa	9	6	3	6	2
4	Rajasthan	15	13	11	4	7 ⁸⁰
TOTAL		42	35	26	13	22

⁷⁷ The Rajasthan Fellowship was for a period of 18 months.

⁷⁸ The Rajasthan Fellowship was for a period of 18 months.

⁷⁹ 'Dropout' is defined as those Fellows who left the programme without submitting their research projects. A few Fellows left one or two months before the completion of the Fellowship on receiving job opportunities but submitted their research projects. Such Fellows have not been categorised as 'drop outs'.

⁸⁰ Seven Fellows who were interested and had initiated research projects were given a 3 month extension by NHSRC to complete their research projects

c) Fellow profiles

Based on the socio-economic profiles of 29 of the 35 Fellows who completed one year of the Fellowship, it could be said that, in general, a community health Fellow was a post graduate, Hindu, high caste, male in his early thirties with some work experience. Nearly 62 percent of the Fellows were male. However, significantly, the highest proportion of female Fellows was in the Bihar and Rajasthan Fellowship programme – states that are traditionally infamous for the poor status of women. Seventy six percent of the Fellows belonged to the general caste category, 17 percent to the OBC category, with 1 Fellow from the scheduled caste and 1 Fellow from the scheduled tribe categories. Only 41 percent of Fellows were from religious minorities with the highest proportion of Fellows from minority communities in the state of Jharkhand. Half the Fellows were married, with nearly 60% of Fellows in Jharkhand and Rajasthan married and 83% of Fellows in Orissa unmarried. All the female Fellows from Jharkhand and Bihar except 1 were married and none of the female Fellows from Rajasthan were married. The Fellows ranged in age from 25-44 years with more than half the Fellows in the 30-35 year age group.

Eight Fellows lived in joint families and only 8 of the Fellows were principle breadwinners in their families. Those who were from a joint family were not principle breadwinners and there were two female Fellows who were principle breadwinners. Fellows from the general category had a tendency to report that they were from a 'forward category'. Most of them had parents who were educated or had government jobs. This was not the case for Fellows from the backward categories, barring a couple of OBC Fellows whose families were engaged in business.

Twenty-eight of the twenty-nine Fellows had a postgraduate degree/diploma. Most of the Fellows had completed their post graduation in rural development or social work. A few of the Fellows had a background in health management or administration while

three were trained homeopathic physicians. Almost all the Fellows had at least 2 years of work experience and a significant number had previously worked in public health.

Setting up the Community Health Fellowship in the district

The process of Fellow selection at the national and state level was supplemented by initiatives to set up the Fellowship at the district level. These included introducing the concept of the Fellowship to public health functionaries at the block and district level and to local civil society groups, especially those already involved in implementing the community participation programmes of the NRHM.

The objective was to position the Fellow at the intersection of state and civil society by enabling her to work in collaboration with the state but with a civil society agenda and perspective. The latter entails developing health programmes by involving communities and building on community knowledge for understanding the causes of disease and identifying solutions. It is understood in terms of a concern for the rights and entitlements of all citizens especially groups that have been historically deprived of economic resources, social dignity and political voice in family and society. It includes sensitivity to the role of social structure and identity in influencing an individual's sense of self, understanding of the world, access to resources and opportunity and thereby agency. Thus, health interventions are to be implemented without 'blaming the victim' and by creating enabling conditions for families and communities to adopt positive health behaviour.

However, achieving the delicate balance between state and civil society was not considered easy. An important concern was that, community health Fellows maybe co-opted by district health officials as their assistants. This could be prevented by affiliating the Fellow with a local civil society organisation that is already engaged in or is planning to work on the ASHA, VHSC and RKS programmes. Such positioning would enable the Fellow to contribute to improvements in the implementation of community processes. On the other hand, the NGO could also co-opt the Fellow for the implementation of

their existing programmes, which may not necessarily be related to the mandate of the Fellowship. The Fellow might also have to negotiate the NGO's existing relationship with district officials, which may not always be very positive.

Moreover, different states were involving NGOs in different ways. In Orissa, it was found that civil society groups were only involved for managing the logistics of the ASHA training. In Jharkhand, a state level resource centre had been set up to lead the implementation of the VHSC and ASHA programmes in October 2008 through a state-civil society partnership and hence district and sub-district partnerships with NGOs were being discontinued. In Bihar, ASHA training had been out-sourced by the Department of Health and Family Welfare to the Department of Public Health Engineering. Hence, it was not considered ideal to develop a standard template for the positioning of the community health Fellow at the district level. At the same time, the community health Fellows also needed some kind of a base at the district level from which they could operate.

Given all of these considerations, it was agreed that the community health Fellow should not be affiliated intimately with either the District Health Society or a local NGO. Rather, the community health Fellow should represent the PHRN as much as possible in interacting with both district officials as well as local NGO leaders. PHRN would facilitate the Fellow's engagement with public health officials based on the context of particular states. The Fellow would be encouraged to network with local civil society groups to understand the health issues of the area and benefit from their experience of intervening in health matters. The Fellow could operate from the office of a cooperative NGO, when required.

Accordingly, in Jharkhand, the community health Fellows were positioned to support the state level Village Health Committee (VHC) and Sahiyya Resource Centre (In Jharkhand, VHSCs are known as VHCs and ASHAs are known as Sahiyyas) to strengthen the implementation of the Sahiyya and VHC programmes in 8 districts. Each Fellow was also

linked with a district level NGO. These NGOs were selected based on their presence in the district in which the Fellow was expected to work, existing health programmes, membership in the PHRN network and willingness to support the Fellowship programme. The NGOs supported the Fellows by providing them office space and introducing them to their field area. Each NGO received an amount of Rs.2000/- per month from PHRN as an appreciation amount towards the support provided.

Most Community Health Fellows from Jharkhand reported little or no interference from district level NGOs in their work. One of the Fellows supported the NGO by orienting and training field level staff on public health and strengthening the monitoring of their health programmes. Another NGO, benefitted through training of their staff on public health by PHRN, which was facilitated by the community health Fellow. Only in one of the districts did the Fellow work more closely with the NGO than the district health system. This was reportedly the Fellow's choice since he felt more comfortable working in a more structured environment. Some of the notable district level NGOs with which the Fellows were associated included AROHAN Trust, Godda, EKJUT, Chakradharpur and Khunti, DevNets, Jamshedpur and Zilla Saksharta Samiti, Dhanbad.

In Bihar, the Fellows were positioned to strengthen the decentralisation agenda by providing inputs to the district planning processes in 8 districts. They were also associated with district level NGOs. The NGOs were selected on the basis of their presence in the district, existing health programmes and their positive relationship with the public health system. They supported the Fellows by providing office space and introducing Fellows to the field area. In turn, they benefited through the technical knowledge of the Fellows in developing proposals and strengthening their existing health programmes. Fellows reported no interference in their work from the district level NGOs. One Fellow worked closely with the District Health Society and operated from their office while another Fellow operated out of the PHRN state office in Patna as she was allocated a nearby district.

In Orissa, the Fellows were to be supported by a Review and Mentoring Group set up at the district level comprising the District Programme Manager, NRHM; the District ASHA Coordinator, a Civil Society leader and a PHRN State Coordinator. The Review and Mentoring Group was expected to advise the Fellow on her terms of reference and actively guide its implementation through regular quarterly meetings.

Of the 6 Fellows who completed the Fellowship in Orissa, review and mentoring groups were set up and met regularly in 5 cases. The mentoring groups comprised of personnel from the Chief District Medical Officer's office as well as the District Programme Management Unit (DPMU) of the NRHM and often the mentoring group meeting was combined with the district monthly meeting and hence took place largely on a monthly basis rather than a quarterly basis. However, despite their formal inclusion in the Review and Mentoring Group meeting, civil society leaders' participation in the meetings was limited. Three Fellows operated from the DPMU office while the other three visited the DPMU office daily.

In Rajasthan, the Fellowship was managed by SEARCH and NHSRC for the first 15 months. Since SEARCH is based in Gadchiroli, Maharashtra and NHSRC in Delhi, the Fellows were to be supported and positioned vis-à-vis the public health system by the district level NGOs. Three large, established and experienced NGOs – ARAVALI, Prayas and Doosra Dashak – were selected for this purpose. ARAVALI supported 5 Fellows across 4 districts and the city of Japur. Prayas supported 3 Fellows and Doosra Dashak supported 2 Fellows.

In addition to the mechanisms for supporting and positioning the Fellow at the district level, initiating the Fellowship also involved determining the processes for fixing the honorarium of each of the Fellows and providing travel and communication facilities. For finalising the honorarium for each of the Fellows, three honorarium levels were determined for Fellows in Bihar, Jharkhand and Orissa. These were:

- (a) Level 1 of Rs.18,000/- per month
- (b) Level 2 of Rs.20,000/- per month
- (c) Level 3 of Rs.23,000/- per month

Fellows were allocated to each of these levels based on age, experience, qualification, last salary drawn and the recommendation made by the respective PHRN state coordinator. Sixty percent of the Fellows were allocated to level 1, 17 percent to level 2 and 23 percent to level 3. In these three states, it was decided that Fellows would be reimbursed on actuals for their travel and telephone costs. Fellows were also offered a scheme by which they received a zero interest loan of up to Rs.25,000/- for the purchase of a laptop of their choice. The Fellows could return the loan through monthly deductions from their honorarium. Leave rules governing the Fellows were the same as those for other PHRN employees.

The Fellows in Rajasthan received a uniform monthly stipend of Rs.20,000/- per month and an allowance of Rs.1400/- per month towards internet charges and travel costs.

Training and Mentoring the Community Health Fellows

The Community Health Fellowship Programme was essentially a capacity building initiative and hence the process of training and mentoring the community health Fellows was fundamental to its objectives. At the same time, the Fellows were also expected to contribute to positive health change in their allocated districts within the Fellowship period of 2 years. Therefore, their training process was expected to enable them to theorise from their existing field experience, apply theory to understand the current field area, act towards health improvements, reflect on the experience and learn from their actions. A mix of methods was adopted to achieve such a combination of theory and practice. It included a blend of classroom training, self-study, small field based projects and studies, peer group learning and mentoring by public health experts. The objective was to enable the community health Fellows to acquire public health knowledge, skills and perspective.

The training process included:

- An initial one week orientation at Gadchiroli intended to introduce Fellows to build perspectives on public health concepts and community processes and to initiate a discussion on the research that the Fellows were to do in the community.
- Series of workshops at the National level through the Centre for Jawaharlal Nehru Studies of the Jamia Millia Islamia, New Delhi. These workshops were to build the capacity and skills of the CHF's on research methods and for organizing action research. Five workshops were held.
- Academic mentoring by national mentors, often from outside the state and few State level mentors.
- Field level mentoring through network partners and other civil society members.

(a) Induction training at Gadchiroli

A seven day induction training was organised for all the community health Fellows based across the four states at the Shodhgram campus of the Society for Education, Action and Research in Community Health (SEARCH), Gadchiroli. The training was organised jointly by SEARCH, PHRN, NHSRC and ICCHN from January 15-21, 2009. The objectives of the training were:

- Introduce basic public health concepts, perspectives and debates.
- Introduce the NRHM – its potential and critique.
- Discuss community participation in health – its potential, approaches and experience.
- Build technical capacity on women's health and child health and nutrition.
- Discuss strategies for strengthening and working with the public health system.
- Discuss social movements in health.
- Introduce the community health Fellowship – its goals, expectations and provisions.

A total of eighteen 1-2 hour sessions were conducted utilizing participatory learning

techniques and based on adult learning principles. Speakers and/or facilitators were identified for each session based on the training plan and resource as well as reference material was provided. Several sessions were organised as debates to present both sides of an argument and facilitate discussion. Some of the issues discussed included “Public provision of health services versus Private provisioning and public financing”, “Technical assistance: Externally funded, consultancy based and diffusion model, or internally funded, institution based and capacity building model” and “Community Health Workers as link workers or Community Health Workers as Health Activists”.

Group work was organised in nearly all sessions to enable participants to apply their learning through exercises and assignments as well as discuss their experiences and derive lessons from them. Field visits were organised within Gadchiroli as a part of the technical session on child health to understand the home based newborn care programme of SEARCH. Field visits were also organised to Rajnandgaon in Chhattisgarh to meet community health workers and observe the workings of public health facilities.

The induction was enriched through inputs and sharing by several eminent public health experts from both the state and civil society⁸¹.

An important component of the induction was the inculcation of a spirit of volunteerism amongst the Fellows and motivation to work towards a cause. The Shodhgram campus provided opportunities for ‘*shramdaan*’ in the morning whereas several nighttime meetings were facilitated for Fellows with civil society leaders who shared their personal journeys, trials and tribulations in initiating and implementing health programmes.

Fellows appreciated the induction training for the orientation that it provided to public health, clarity on their roles and positioning at the district level as well as the opportunity to meet and interact with eminent public health experts of the country.

⁸¹ See (Annexure: Report of the Induction Programme)

(b) Field mentoring

In the states of Bihar, Jharkhand and Orissa, the State Programme Coordinators of the PHRN provided field level mentoring. In each of these states, PHRN has 3 State Programme Coordinators to manage all its public health capacity building initiatives. One of the Programme Coordinators was especially assigned to coordinate the Fellowship Programme.

Monthly meetings were conducted of the Fellows with all Programme Coordinators and the PHRN State Convenor in all state offices. In these meetings, Fellows reported their progress at the district level, shared achievements, difficulties, challenges and raised queries on their work. Work plans for the next month were also discussed and finalized at these meetings. Given this agenda, often these meetings were conducted over two days. In addition, the Programme Coordinators visited the Fellow in the district every month, met the district level public health officials and helped resolve difficulties.

In Rajasthan, field level mentoring was to be provided by the field level NGOs managing the Fellowship programme namely, Prayas, ARAVALI and Doosra Dashak.

Several Fellows identified 'mentoring' as an area that needed improvement in the programme. In Rajasthan, almost all Fellows said that mentoring needed to be improved whereas in Bihar, two Fellows felt that mentoring and monitoring could have been better. In Jharkhand, two Fellows expressed the need for greater supportive supervision, on-field support and administrative support whereas in Orissa, one Fellow identified the need for greater follow up.

(c) Research training

One of the important roles expected from the Community Health Fellows was the undertaking of small studies to improve health programme planning and implementation. For instance, Fellows could study the implementation of the Janani

Suraksha Yojana programme to understand the quality of care received at public facilities or the delays in receipt of payments, or reasons for the poor utilization of the scheme and so on. Such findings could be used to strengthen the implementation of the programme at the district level.

A rigorous process of research training was planned for all the Fellows. This included working out the research spiral timeline across the period of the Fellowship and conducting classes at different points to facilitate the implementation of crucial steps. So the Fellows were taught about a research step and then expected to implement it, after which they would be taught about the next step. For instance, they would be trained to design a study and then be required to develop their study design before the next class in which they would receive feedback on their study designs and be taught how to select their sample and so on. The objective was to train the Fellows to practically undertake a research project.

The research training was conducted in partnership with the Centre for Jawaharlal Nehru Studies, Jamia Millia Islamia at the campus. The training workshops were titled 'Research for Social Action' and the first workshop was held over 5 days from April 17th - 22nd, 2009. The first workshop introduced basic concepts in social epidemiology, qualitative and quantitative research methods as well as the basic steps in the research spiral with a specific focus on formulating the research question and conducting a literature review⁸².

The second workshop was held over 3 days from August 7-9, 2009 at the Jamia Millia Islamia campus. The workshop introduced participants to the different ways in which research has been used for social action especially for social audits of the Mahatama Gandhi National Rural Employment Guarantee programme, the Integrated Child Development Services and the School Mid Day Meal Scheme. Resource persons from

⁸² See Annexure: Report of First Workshop on Research for Social Action

the Right to Food campaign and the Jan Swasthya Abhiyan (People's Health Movement) conducted these sessions. There were resource persons who shared issues involved in planning, designing and implementing large scale evaluations. The workshop focused on teaching data collection techniques. A session on conducting '30x7' cluster survey method was also held. After the workshop, over the next three months, the Fellows were expected to finalise their data collection tools, complete the pilot study and initiate the data collection process⁸³.

The objective of the third workshop conducted from January 28th – 30th, 2010 was to strengthen the understanding of estimating sample sizes, finalizing research designs and data collection tools and to teach data processing using Microsoft Excel. All the community health Fellows presented their progress on their research project in terms of the research objectives, questions and methodology – sampling, tools and respondents. They received feedback on their work from the other Fellows and resource persons. A session on health policies relating to traditional midwives or *dais*⁸⁴ was organised.

The fourth Research for Social Action workshop was conducted from July 27th- 30th, 2010 and focused on teaching data analysis skills and providing feedback to the community health Fellows on their data collection process. The Fellows received further inputs on sampling and quantitative data analysis techniques and qualitative techniques. The Community Health Fellows presented their progress on their research projects and received feedback. At the end of the workshop, the work plan for the next three months was determined. In terms of health policy inputs, a session on 'Decentralisation and Health Refoms' was conducted and a session on 'Health Management Information Systems in District Health Action Plans' was also taken up by resource persons⁸⁵.

The fifth and final Research for Social Action workshop was held from December 13th –

⁸³ See Annexure: Report of Second Workshop on Research for Social Action

⁸⁴ See Annexure: Report of Third Workshop on Research for Social Action

⁸⁵ See Annexure: Report of Fourth Workshop on Research for Social Action

15th, 2010. The Fellows presented the findings of their research studies. As this was also the final workshop of the Fellowship, eminent public health experts were invited to share their views on the status of public health in India. The workshop began with a keynote address on 'Public Health and the Nehruvian Vision of Welfare' followed by 'Issues in improvement of Public Health System'. The Fellows then presented their research projects and performed role plays on given situations. The workshop ended with a session facilitated by the community health Fellows themselves on the way forward as well as a valedictory session in which the Fellows received certificates from PHRN⁸⁶.

Each workshop had a feedback and evaluation component in which the Fellows were given half an hour to fill out a questionnaire on the content, methodology, length and applicability of various sessions. The Fellows were also administered questionnaires to assess their learning from the workshop.

Each workshop also allocated time for Fellows to meet and interact with their academic mentors to discuss their research projects.

Almost all Fellows appreciated these research workshops and identified the training they received as a positive element of the programme.

(d) Academic mentoring

Given that most of the Fellows were undertaking a research project for the first time, each Fellow was allocated an academic mentor. The academic mentor was expected to provide individual guidance to her mentee based on the mentee's familiarity and experience with the research process. Thus the academic mentors were expected to respond to the Fellow's technical difficulties on research and also suggest and provide readings to the Fellow on both the research process as well as the topic.

⁸⁶ See Annexure: Report of Fifth Workshop on Research for Social Action

The academic mentors included eminent public health experts from the field of health. There were a total of twelve academic mentors. The academic mentor was not necessarily based in the state of the Fellow's work and was expected to guide the Fellow through email and over the phone. Meetings between the academic mentor and the Fellow were also facilitated during the 'Research for Social Action' workshops.

Several Fellows identified academic mentoring as an area of the programme that needed improvement. While one Fellow from Bihar felt that the academic mentor did not provide proper guidance, another Fellow said that her mentor lacked field orientation. A Fellow from Jharkhand felt that academic mentorship was not accessible; another felt the need for more consistent support from the mentor.

Working as a Community Health Fellow

The Fellows started operating from their allocated districts soon after the induction training at Gadchiroli. Over the Fellowship period of two years, they undertook fairly significant projects at the district level⁸⁷.

In Bihar, all the Fellows were involved in the preparation of District Health Action Plans for the financial year 2010-11. Towards this, they conducted facility surveys of the Community Health Centres (CHCs), Primary Health Centres (PHCs) and Health Subcentres (HSCs) in the district and recorded the status of infrastructure, human resources, drugs and equipment. Through this process, the Fellows understood and identified several issues of accessibility, availability and quality of health services. One of the Fellows initiated a survey on facilities provided to above poverty line (APL) and below poverty line (BPL) patients in the public health system and on the basis of the data, the state government made radiology and pathology tests free for BPL and APL from September 2009 at facilities such as District Hospital, Sub-Divisional Hospital,

⁸⁷ See Table 2.1: Research and Action Work by Fellows

Referral Hospital and Primary Health Centres. Another Fellow was instrumental in the initiation of an adolescent health clinic at a Primary Health Centre. Fellows also conducted orientation workshops on the annual planning process at the block and district levels and facilitated the preparation of Block Health Action Plans as well as a few Village Health Action Plans. Some of the Fellows were officially designated by district officials to support the district planning processes. But almost all Fellows reported that their involvement in this process enabled them to build links with district and block level officials as well as understand the issues with the functioning of different facilities.

Given that implementing district plans successfully is affected by several state and district level factors, the Fellows utilized their understanding of the factors leading to the poor quality of health services as well as the unavailability of health services to strengthen community demands for accountability and quality. Almost all Fellows in Bihar were involved in activating Rogi Kalyan Samitis (RKS) and Village Health and Sanitation Committees (VHSCs). Some of the Fellows even enabled and facilitated the formation of these committees in their district. Fellows worked to ensure the opening of bank accounts of VHSCs and the receipt of untied funds. They advocated for regularizing the meetings of these committees and supported members for the utilization of Health Sub-centre and VHSC untied funds. One of the Fellows was successful in facilitating several improvements at the PHC level through the working of the RKS such as ensuring regular water supply, proper wiring and ground filling to avoid water logging in front of the PHC.

In the ASHA programme, Fellows were involved in monitoring the training programmes and regularizing monthly meetings of all ASHAs at the PHC level. One of the Fellows supported the National Health System Resource Centre in collecting data for a National Evaluation of the ASHA programme whereas some of the Fellows were involved in strengthening the holding of Village Health and Nutrition Days at the village level.

All the Fellows worked to advocate for health system improvements at the district and block level. Several Fellows reported that they perceived their role as a link between communities and systems and within systems, between the block and the district, and the district and the state.

In Jharkhand, the Community Health Fellows were positioned to support the newly constituted state level Village Health Committee and Sahiyya Resource Centre (VSRC) to strengthen the community participation programmes of the NRHM. All Fellows conducted detailed assessments of the status of Village Health Committees and Sahiyyas in their district. This included identifying the total number of Sahiyyas selected, the number of days of training received, the number of currently active Sahiyyas and the reasons for non-performance of the inactive Sahiyyas. For VHCs, it involved identifying the total number of VHCs that were set up against the number that were expected to be set up as per the programme norms as well as the status of opening of VHC bank accounts, receipt and utilization of untied funds. Fellows facilitated the opening of bank accounts and trained VHC members and Sahiyyas across the district on operating the bank account, village health planning and utilization of untied funds. Some Fellows were selected to be a part of the State Training Team for the Sahiyya programme. As a part of this, they trained Block Trainers to conduct Sahiyya training, supported the development and implementation of block level training plans and monitored training quality. Some Fellows were trained to be a part of the National Training Team for the ASHA programme and even visited other states to provide training to the state level teams. Fellows also organised Sahiyya *sammelans* at the district level.

Community health Fellows in Jharkhand also actively supported the implementation of related campaigns on the right to food and the right to information. They supported surveys on the implementation of food schemes, assessed the extent of undernutrition amongst under six year olds in the state and conducted social audits on the functioning of the Integrated Child Development Services programme. One of the Fellows

supported women in Gola Block to organise and use the provisions of the right to information act to demand and achieve improvements in the functioning of the local PHC.

Fellows supported the development of District Health Action Plans, especially the development and field-testing of formats and other resource material that could be used in the planning process. A few Fellows were intensively involved in the development of the State Programme Implementation Plan especially for the year 2011-12. Fellows also contributed to efforts to build public health capacity at the district level. They conducted contact classes for the PHRN distance-learning programme for participants from their district.

Besides this, all Fellows developed a comprehensive profile of the districts in which they were based, including details of the district level health system, health indicators, demographic data, administrative structure and NGOs active in the area.

In Orissa too, the Fellows were involved in strengthening the functioning of the Village Health and Sanitation Committees known as Gaon Kalyan Samitis (GKS), the Rogi Kalyan Samitis and the ASHA programme.

Fellows trained GKS members on their roles and responsibilities, book keeping and preparing micro plans for utilisation of untied funds. As a result of interventions by Fellows, these committees are meeting regularly and have improved their utilisation of untied funds. Fellow advocated for and enabled the setting up of RKS committees in public health facilities. In the ASHA programme, Fellows were involved as district level trainers and supported the functioning of the ASHA by facilitating greater collaboration between the ASHA and the ANM, ensuring availability of essential drugs with the ASHA and the timely release of her incentives. Fellows also prepared district health profiles and supported the district programme management unit in monitoring and improving the implementation of Village Health and Nutrition Days.

In Rajasthan, Fellows worked to strengthen the functioning of VHSCs. This included training of VHSCs and supporting them to plan the utilization of untied funds. It also involved generating awareness amongst community members, ASHAs, ANMs and Panchayati Raj Institution (PRI) members regarding the importance of VHSCs. Fellows also worked to strengthen the ASHA programme. They identified the difficulties experienced by the ASHA at the village level and intervened to resolve them. This included improving ASHA knowledge and skills through training, improving coordination between ASHAs, ANMs and Anganwadi Workers (AWWs) and supporting the ASHA to receive the incentives due to her. One of the Fellows focused her efforts on improving adolescent health in her district. She worked to strengthen Adolescent Reproductive and Sexual Health (ARSH) services by training adolescents, AWWs and ANMs and organised an adolescent health day. Another Fellow conducted orientations at the block, district and state level on various health issues like polio and HIV/AIDs.

One of the Fellows in the Rajasthan Fellowship worked on urban health issues in the city of Jaipur. She conducted visits to slums to observe health care facilities for the urban poor and prepared a document on the need and importance of urban health. She developed training material for VHSC training and was also a facilitator at the ASHA training of trainers' workshop.

Almost all the Fellows identified gaps in the existing health services and advocated with district officials for improvements.

Positive experiences of Fellows

At the end of the Fellowship period, Fellows were asked for feedback on their experience. All the Fellows from Bihar said that the Fellowship enhanced their understanding of public health and helped them grow as professionals and individuals. While some appreciated the opportunity to work with communities and felt that the

Fellowship sensitized them to community issues in health, others said that the Fellowship exposed them to the wider framework of the health system and helped them identify their role in it. One of the Fellows shared that the unique aspect of the Fellowship was that it provided field based public health practitioners in underdeveloped states the opportunity to learn. All Fellows appreciated the support that they received in terms of regular meetings, workshops and training. While some mentioned the study material provided, others identified interaction with public health experts as the highlight of the program. Freedom to work, be creative and express their views was a positive element in the program for some. All the Fellows from Bihar were satisfied with their experience and reported being respected as individuals.

Fellows in Jharkhand said that the Fellowship gave them an opportunity to improve their understanding of public health. One of the Fellows said that the Fellowship enabled her to learn about the National Rural Health Mission as well as other related programmes and campaigns such as the Integrated Child Development Services (ICDS), Right to Food and Right to Information. Another said that he was able to understand both local health issues as well as a national programme's initiatives to address them. A third said that the Fellowship helped him understand various public health issues, the public health system, maternal and child health concerns, community processes in health, communication, planning and the challenges experienced in implementing health programmes at various levels. Fellows said that this experience had helped them grow both personally and professionally and would enable them to plan their future in public health.

Fellows also appreciated the emphasis on research in the Fellowship and said that in states like Jharkhand where the health status is poor, such initiatives are essential for making individuals qualified in social research and management available to the local health system. They saw the Fellowship as an effective way of enabling like-minded people to work on public health issues and support the health system as well as conduct small research studies to present the situation of the district and in doing so to influence the policy decisions of the state.

All Fellows said that it was a satisfying experience that they were respected as individuals and all but one said that they had space for freedom and creativity. While some said that the Fellowship helped them inculcate networking skills, working with the community at the grass root level, combination of academic and field exposure and workshops were positive elements in the program for some.

In Orissa, most of the Fellows felt that exposure, knowledge on public health, workshops, networking and flexibility were the positive elements of the Fellowship program. One of the Fellows said that Fellowship gave him an opportunity to explore different dimensions of public health and enhance his knowledge base, skills and competencies. All, but one found the experience satisfying and said that they were respected as individuals in the Fellowship. However, only two Fellows felt that they had space for freedom and creativity in the Fellowship.

In Rajasthan, most of the Fellows felt that learning about public health, the workshops and trainings they attended were positive elements in the program. The Fellows said that the program enhanced their understanding of health and related issues and improved their capacity in documentation, analysis, reporting and research. Some mentioned that the freedom to work on their own was a highlight of the programme. One Fellow opined that the combination of research and action and the link between academics and practitioners were positive elements of the programme. Another appreciated the Fellowship for the opportunity it provided to both advocate on behalf of the community and provide inputs from within the system. All the Fellows said that in the Fellowship they experienced growth, that they were respected as individuals and that they had space for freedom and creativity

Difficulties and challenges

The Community Health Fellowship Programme was a fairly large and ambitious initiative in terms of both scope and size. It aimed to combine field based work with academic learning and research with policy advocacy while attempting to link communities with public health systems and vice versa. It was implemented across 4 states and 45

districts by a group of organisations working in coordination and involved district level work along with state and national level coordination. Thus, the programme was multi layered in its complexity and given that this was the first batch of community health Fellows being trained and supported in this way, there were many aspects of the programme, which needed to be realigned and strengthened. The Fellows provided constructive insights into the ways in which the programme could be improved. These were:

Positioning:

Fellows from Jharkhand and Rajasthan spoke about the difficulties they experienced in working with government functionaries. A Fellow from Jharkhand attributed this to a lack of recognition for the community health Fellowship identity. A Fellow from Rajasthan complained about the lack of institutional support and said that there should at least be some sitting arrangement at the district level. The Fellow felt that district health officials had little interest in or understanding on how to utilize the Fellow as a human resource and the Fellow needed to find his/her own direction of work. The Fellow, he said, thus needed institutional support to be effective in the district health system.

Honorarium and Human Resource policies:

While most Fellows were satisfied with the honorarium that they received, one Fellow from Bihar felt that it was not adequate and two Fellows, one from Bihar and the other from Jharkhand, were not pleased with the policy of differential honorarium, given that the tasks were similar. Another Fellow from Orissa felt that he had not been fairly compensated.

A Fellow from Bihar felt that the terms and conditions of work were not clear whereas three Fellows from Jharkhand said that the human resource policies of the programme needed improvement.

Training and mentoring:

A significant number of Fellows identified mentoring as an aspect of the programme that needed improvement. This included both academic and field based mentoring. Three Fellows from Bihar felt that mentoring could have been better; another said that the Fellows should have been better monitored and their work plans more closely aligned to their capacities. In Jharkhand also at least three Fellows identified the need for better mentoring, on field and administrative support. Two Fellows in Orissa said that there should have stronger follow up of the work and more specific mentorship should have been provided. All the Fellows from Rajasthan identified mentoring as an area of improvement for the programme.

One Fellow from Bihar also said that there should have been greater orientation and clarity during the induction programme on the nature of work. Some Fellows from Jharkhand opined that the program should have made stronger provisions for ensuring the accountability of Fellows.

Programme design:

Several Fellows identified problems in the design of the Fellowship programme. A Fellow from Jharkhand commented that the Fellowship involved too wide a range of activities and there was a need to focus on a few aspects to ensure that the Fellows acquired public health skills and knowledge. Another Fellow felt that the Fellowship programme stressed practice over theory and was not balanced. A Fellow from Bihar felt that the duration of the Fellowship was too short for its objectives whereas a Fellow from Orissa suggested that the programme should have academic recognition. Fellows from Rajasthan felt the need for greater clarity in terms of the tasks and deliverables while a Fellow from Bihar said that the programme should also support the Fellows to be placed.

To better understand the challenges experienced by the community health Fellows during the programme, interviews were also conducted with some of the Fellows who dropped out of the programme. These included Fellows from Orissa and Bihar, the states that experienced the largest number of voluntary dropouts from the programme.

Two of the Fellows from Orissa who quit the programme without completing it said that they left because of problems in the organisational structure and bureaucratic ways of working. Both said that there was not sufficient scope for creativity in the Fellowship. Another left for a higher paying job. Two Fellows from Orissa felt that the compensation in the Fellowship programme was not adequate and one of them commented that there were not sufficient facilities for Fellows to work. Fellows from Bihar dropped out on receiving better opportunities towards the end of the Fellowship period.

Future prospects and sustainability

One of the important aims of the Community Health Fellowship was to build public health capacity in states where the health status is poor and the health system needs urgent strengthening. The Fellowship Programme selected 42 existing public health practitioners from the states of Bihar, Jharkhand, Orissa and Rajasthan and improved their public health knowledge and skills through a combination of guided field work, self-study and classroom training over a period of two years. An important measure of success for the programme would be the kind of work that Fellows engage in, on graduating from the programme, since that would indicate whether the training received is being utilised for bringing about public health change.

Table 2.2: *Employment Status of Fellows Completed 12 – 24⁸⁸ Months of fellowship*

States	NRHM associated	Job in allied service	Own NGO	In PHRN	Not Finalised	Total
Bihar	5	2		1	2	10
Jharkhand	4	2	1	1 (received Fellowship for higher studies abroad)		8
Orissa	2	2				4
Rajasthan	1	4	2	2	3	12
Total	12	9	3	4	6	34

⁸⁸ For the Rajasthan Fellowship, the period is 18 months.

It is notable that a majority of Fellows were engaged by the National Rural Health Mission after graduating from the Fellowship. It is hoped that they would be able to use this opportunity to contribute to improved health outcomes in these states. It is also significant and nearly all Fellows have continued their involvement in public health and their membership of the Public Health Resource Network after the Fellowship.

Fellows were asked for their suggestions on the form and design of the Fellowship programme in the future. These were as follows:

- Role of the community health Fellow: the community health Fellow was seen as a bridge between the community and the administration at the district level – thinking, planning and acting for change in community health. S/he was conceived as an innovator who generates evidence, provides vital feedback on current programmes, develops models and advocates for public health change at the regional level thereby contributing to the reinvention of health systems at the grassroots.
- Positioning: the role of the community health Fellow should not be institutionalised within the district health system as that would take away the Fellow's ability to engage with both the community and the system. The Fellow should be enabled to work autonomously for the benefit of the community. As far as possible, funds for the programme should not be taken from the state since that would influence the acceptability and independence of the Fellow.

Conclusions

In all, the community health Fellowship of the PHRN was an intense and valuable experiment that generated a wealth of understanding of how such Fellowships may contribute to the objectives of community participation in the public health system. The experience also gave rise to a number of perplexing challenges for such programmes in the future.

The impact of the programme was assessed through the evaluation of the Fellowship as well as the perceptions of the Fellows and could be viewed as follows:

1. Individual Level Development:

Development of individual skills or human resources is one of the important criteria to support and strengthen the health services. It is based on the principles that trained and capacitated individuals with practical knowledge of public health management with right attitude will be instrumental in bringing about changes in which they have been trained. The CHF programme envisages, and, in its nineteen months of implementation in the field, has observed the following improvements in the Fellows who have successfully undergone through this programme at individual level:

Most of the Fellows are now proficient with the use of Computer. Similarly, their knowledge of English language for communication (both written and oral) has also improved. This was achieved by providing opportunities to them as well as through the capacity building for the action research. The action research component of the programme helped them develop the analytical (statistical), presentation and process documentation skills. This was further supported by developing their organizing and mobilizing skills for any events in the community. There has been a visible development of skills in better communication, networking, coordination and documentation. These are evident in their programme management skills and outputs in the districts. This could further be substantiated with the fact that the district health authorities seek their support in the respective districts.

2. District level organizational development and networking:

The CHFs are instrumental in expanding the activities of PHRN and taking forward the vision of PHRN at the district level. The Fellows have facilitated enrolment of new people for the distance learning programme (DLP), set up of district level PHRN units, represented the organization in districts and different forums, trainings, and created space in the district health systems. The initial findings of their action research, though not final have been instrumental in bringing up local issues to the notice of health officials.

One more important area of CHF programme's contribution is the enhanced capacity of

the Fellows in providing inputs to other organizations or individuals working in similar areas. For example, many of the CHF's have become state and national trainers for various ASHA modules. In some cases they have acted as district programme managers for the DPMU and district programme coordinators for the ASHA programme.

3. Role in Health Plans:

CHF's have played an important facilitator role in the process of preparation of district and state health action plans. Further, the CHF's have been influential in developing VHC training guides and modules, creating examples of good and active VHCs, and initiating and devising the models for village health plans. Also in some cases they have initiated and facilitated Rogi Kalyan Samitis (RKS). CHF's participation in fast track capacity building programmes have developed their health planning skills and also helped them develop good rapport with the district health personnel and, the results of which reflect in the improvement of services in the districts and places where they are associated.

4. Action Research, Study Reports and Case Studies:

One of the most important areas of the Fellowships programme is to impart research knowledge and skills among the Fellows along with actions on the ground. The field reports, case studies, and reports of action research are important outcomes in the Fellowship programme.

5. Societal or Community Level:

While the Fellows were placed in the districts, they were also placed in villages and were closer to the community. In almost all the cases Fellows have developed a deep understanding of the people, community and their needs. The training on understanding tools of PRA, using them for identifying health and other associated issues and finding out solutions at local level and linking them with the resource agencies have created a small but important changes in the lives of people. This could be one of the important areas of their contribution towards the society. We can count on the number of VHCs and ASHA's trained by them with follow up. These impacts have

reflected in health system changes in the sub-centres, PHCs and even at the district levels.

The challenges for the future include reaching a greater clarity on the precise role of the community health Fellow who was frequently caught between differing responsibilities and tasks and answering to PHRN on the one hand, and the district health system on the other. The concepts of research also were not found to be very clear by the end of the Fellowship programme and the curriculum for such programmes needs to be re defined to suit the categories of people inducted into the Fellowship. While mentors played an important role in expanding the vision of the Fellow and facilitating rigor in their work, their participation was not uniform. The organisation needs to reflect on processes to facilitate the participation of these voluntary mentors and their invaluable contribution to the Fellowship programme. Similarly, field organisations also performed variably with respect to providing guidance and support to the Fellow. Greater attention would be required to carefully select, induct and facilitate such field organisations.

Table 2.3: *Research and Action Work by Fellows*

S. No.	Name of Fellow	Research	Action work	Academic Mentor
		Studies in Communicable Diseases		

1	Sandip Kumar Mitra	Role of Sahiyya and Village Health Committee towards elimination of Kala-azar: A Study in Sahibganj District	Participated in VHC Sahiyya appraisal in Sahibganj district. Provided training to 43 VHCs in Taljhari, Borio and Rajmahal block and also supported in opening bank accounts for the VHCs . Prepared the District Health Profile of Sahibganj district and carried on Village assessment for understanding the villages in detail. Participated and supported mentoring organisation in Child Survival project in the district. Supported the GoJ to successfully organise the Samadhan Shivar in Khunti for delivering the services related to development programmes especially health programmes.	Mr. V.R. Raman, Consultant, ICICI-Child Health and Nutrition and Dr. Prabir Chatterjee, UNICEF Consultant, West Bengal
2	Gajendra Singh	A Study on Awareness and Behaviour towards Malaria Prevention and Treatment amongst Paharia Tribe of Godda District	Conducted Sahiyya and VHC appraisal in Godda district to understand the situation of community processes in the district. Training organised for 187 VHCs in Sunderpahari block of Godda district for developing understanding on the roles and responsibilities and untied fund. Prepared district health profile of Godda district and carried on village assessment in 3 villages of Sunderpahari block. Participated in Mega health mela	Ms. Shilpa Deshpande, President, ICICI-Child Health and Nutrition

			in Godda and in Samadhan Shivir in Khunti.	
3	Shefali Kuntal (supported by Mr. Manish Mani, Intern)	Community Participation in the Control of Kala-azar and its Impact: An Action Research in Jehanabad District of Bihar	Facilitated by regular orientation and the formation of VHSC in Kalpa gram panchayat. CHF advocated at the PHC level and also at the village level and thereby with the participation of PRI, ANM, ASHA, AWW and villagers this committee was formed and first proposal was passed; Meetings and Group Discussions with ASHAs for finding out problems faced by them in the work and initiating and organising ASHA with MOIC so that ASHAs could get a platform to keep their problems and get the solutions of it; met different members of RKS at the block PHC and prioritising needs - regular water supply, proper wiring has been completed and ground filling to avoid water logging in front of PHC. Work on Kala-azar: <ul style="list-style-type: none"> • Discussion and providing information about the causes and prevention strategies of 	Mr. Rafay E. Hussain, Consultant, ICICI Child Health and Nutrition and State Convenor, Public Health Resource Network, Bihar

			<p>Kala-azar to the villagers.</p> <ul style="list-style-type: none"> • FGD for pre preparation of houses and community monitoring of Spray in the villages. • Kala-azar mapping • Visited the spraying activity in the villagers to find out the need for BCC. • Meetings with the MOICs, in charges, spray man, villagers and NGOs for finding out the Gaps in the action of spraying. • Sensitizing villagers for early detection and complete treatment of Kala Azar. • Meeting with villagers and formation of team for monitoring Kala Azar spraying 	
4	Jay Krishna	A Survey of Knowledge and Attitude of Community about Tuberculosis and Revised National Tuberculosis Control Programme (RNTCP) in District Rohtas, Bihar	<p>Conducted orientation programme on RKS, strengthening of VHSCs and streamlining the untied funds, facilitated the process of first DHAP of the district, wrote an article on Role of ASHA in RNTCP. Facilitation in DHAP workshop at district level at Rohtas. Meeting with PRI members, staffs of DPMU, ASHA. Network meeting with NGOs, facilitation of workshop of Rogi Kalyan Samiti members and members of Village Health and Sanitation Committee. Advocacy</p>	Dr. K. R. Antony, Director, State Health Resource Society, Chhattisgarh

			at district level for ensuring medicine to the clients.	
		Studies on ASHA		
5	Kumari Shweta	Assessing the Capacity of ASHA to meet the health needs of Community	Facilitated DHAP workshop at District level. Meeting with PRI members, functionaries of District Programme Management Unit Samastipur, Meeting with ASHA, Members of Self Help Group.	Dr. Archana Prasad, Associate Professor, Centre of Jawaharlal Nehru Studies, Jamia Millia Islamia
6	Farhat Yasmin	The Role of ASHA in the community as an activist or link worker at Rajapkar Block in Vaishali District	Facilitation of DHAP workshop at Vaishali District. Meeting with PRI members, Functionaries of District Programme Management Unit, Vaishali, Aangan Wari Workers and members PRIs.	Ms. Shilpa Deshpande, President, ICICI – Child Health and Nutrition
7	Arvind Pandey	Assessment of Implementation of JSY Scheme in Dausa Block of Dausa District	In Dausa the Fellow evaluated ASHA pilot project; strengthened VHSCs through discussions with ASHA and regular visits of PHCs, helped in preparing VHSC training; training of ASHA orientations and engaged with DHS.	Dr. Madhurima Nundy, Senior Programme Coordinator, Public Health Resource Network
8	Indu Gupta	Role of ASHA as Social Health Activist: An exploratory case study of ASHA scheme, Rajasthan	In Alwar the Fellow enabled the strengthening of VHSCs, worked with ASHAs to understand their difficulties and informed them about role of VHSCs, brought AWW, ANM and ASHA together to achieve NRHM objectives,	Ms. Sulakshana Nandi, State Convenor, Public Health Resource Network, Chhattisgarh

			ensured that their payments are made regularly, informed the community about NRHM and enabled them to decide on expenditure of untied funds through VHSC and coordinated with other NGOs to assess health scenario of villages and to create a village health plan.	
		Studies on VHSCs/RKS/PRI		
9	Rajeev Ranjan	Improving Service Quality and Outreach Coverage at Health Sub-centre level by mobilising Community and ensuring proper utilization of untied funds in PHC Manpur (Gaya)	Facilitated District Health Action Plan workshop at Gaya District. Worked on the proper use of untied fund at facility Meeting with PRIs, Mr. Rajiv initiated a survey for collecting data on facilities provided to the BPL and APL at Gayanad, Darbhanga in the public health system and those functioning within PPP mode. They submitted their findings to the state government as well as NHSRC and on the basis of data, the state government made radiology and pathology tests free for BPL and APL from September 2009 at facilities such as District Hospital, Sub-Divisional Hospital, Referral Hospital and Primary Health Centre in Bihar state.	Mr. V.R. Raman, Consultant, ICICI-Child Health and Nutrition
10	Jalaluddin	A study on the role of	Facilitated District Health Action	Dr. Ganapathy,

	Khan	Pramukh in effective functioning of Rogi Kalyan Samiti(RKS) at district Muzaffarpur	Plan workshop at District Muzaffarpur. Meeting with PRI members, members of Rogi Kalyan Samiti, functionaries of District Programme Management Unit at Muzaffarpur. Initiated advocacy with District authority for regularization of meeting of the members of Rogi Kalyan Samiti.	Senior Programme Coordinator, Public Health Resource Network
11	Shiv Kumar Acharya	Assessment of Village Health & Sanitation Committees (VHSC) in Bikaner: A qualitative research for VHSC Strengthening in NRHM in Bikaner	At the village level in Bikaner VHSC meetings were convened regularly and awareness was generated among members of PRI and ANMs about VHSC and other issues related to NRHM. The Fellow sensitised ASHAs about VHSC and at the block level awareness was created on untied funds and its usage. At the district and state level the Fellow engaged with government officials to give light of the real situation on the ground vis a vis public health systems and force officials into action.	Dr. Vandana Prasad, National Convenor, Public Health Resource Network, Delhi And Prof. Shiv Chandra Mathur, State Health Resource Society, Jaipur
12	Anwar Hussain	To study the formation, role and working of the VHSC and to strengthen them: Action research in Laxmangarh, Alwar	In Alwar the Fellows enabled the strengthening of VHSCs, worked with ASHAs to understand their difficulties and informed them about role of VHSCs, brought AWW, ANM and ASHA together to achieve NRHM objectives,	Ms. Sarovar Zaidi, Programme Officer, ICICI-Child Health and Nutrition

			ensured that their payments are made regularly, informed the community about NRHM and enabled them to decide on expenditure of untied funds through VHSC and coordinated with other NGOs to assess health scenario of villages and to create a village health plan.	
13	Pooja	Assess the roles and functioning of Village Health Committee (VHC) in Ichak block of Hazaribag District - A case study	VHSC and Sahiyya strengthening, preparation of DHAP	Dr. Archana Prasad, Associate Professor, Centre of Jawaharlal Nehru Studies, Jamia Millia Islamia
14	Manir Ahmad	Community Participation in VHC – Improving Health Care Services at Health Sub Centre (A case study of Ghatsilla Block)	VHSC and Sahiyya strengthening, preparation of DHAP	Mr. V.R. Raman, Consultant, ICICI-Child Health and Nutrition
15	Arup Abhishek	The functioning of Gaon Kalyan Samities and the enabling factors to play an active role in Village Health Planning	District Dhenkanal. Strengthening GKS; facility mapping and reporting the gaps to CMO.	Ms. Dipa Sinha, Advisor, Supreme Court Commissioner's Office, Right to Food
		Studies on RCH issues		

16	Seema	Prevalence of awareness on RTI/STI/UTI and health seeking behaviour in adolescent girls of one block in Nalanda	District Nalanda -Facilitation in DHAP workshop at District level at Biharsharif. Meeting with members of Panchayati Raj Institution, meeting with District Programme Management Unit at District level, ASHAs, AWWs, Adolescent girls on continuous basis. Advocacy with MOIC for running Adolescent Health Clinic at Noorsarai Block of Nalanda District. She had a meeting with Education Dept., Health Dept and ICDS for ensuring visit of adolescent girls in Health clinic on Saturday every week. After her regular intervention, Adolescent health clinic was started at Primary Health Centre, Noorsarai Block of Nalanda district.	Dr. K. R. Antony, Director, State Health Resource Society, Chhattisgarh
17	Annie Kurian	Barriers to institutional Delivery in Government Facilities: A Short Case Study on two Blocks of Khunti District, Jharkhand	VHSC and Sahiya appraisal of the district Khunti; 155 VHSCs trained in Khunti; Requisition for Untied Funds for the next three years have been placed by VHCs	Dr. Vandana Prasad, National Convenor, Public Health Resource Network, Delhi
18	Surat Chandra Biswal	Identifying factors leading to poor post natal services: A study in the Paikamal sub-centre of Bargarh district of Orissa	District Bargarh a) Participation in the middle level managerial training programme on village health and Nutrition day. It was followed by visits to a sub centre in Boden block where 6 VHND sessions were monitored and	Mr. Rafay E. Hussain, Consultant, ICICI-Child Health and Nutrition and State Convenor, Public Health Resource

			<p>systematic feed backs were given for proper functioning.</p> <p>b) Participation in the regional TOT on ASHA module-5, Attended 4 days Regional level ToT on ASHA Module-5 held at Bolangir.</p> <p>c) Supporting the NVBDCP staffs in the monitoring of the effective distribution of LLIN in Paikamal GP of Paikamal block.</p> <p>d) Monitored the LLIN-BCC campaign in the Paikamal block of Bargarh district.</p> <p>e) GKS strengthening activities were taken up involving training on roles and responsibilities, book keeping and preparing micro plan for utilization of untied funds. The GKS are now regularly meeting every month, maintain records and have prepared plans for spending the untied funds.</p> <p>f) Documenting case study of an ASHA for sharing with the District health officials</p> <p>g) Acted as a district level trainer for ASHA 5th module training programme in Bheden block for 12 days. A total 92 ASHAs in 3 batches were imparted with the</p>	Network, Bihar
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			<p>Module-5 training.</p> <p>h) Participation in the preparation of district PIPI of NVBDCP-2010-11</p> <p>i) GKS strengthening efforts initiated in 3 villages of Padmapur block where there was no utilization of funds. Systematic interventions have led to the development of VHMP and proper utilization of funds.</p>	
19	Trishna Pani	A Study on the factors affecting the food intake of pregnant women in a tribal dominated block of Mayurbhanj district of Odisha	<p>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.</p> <ul style="list-style-type: none"> • 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. Helped in timely release of JSY money. PNC services improved after meetings with ANM and ASHA. 	Dr. Vandana Prasad, National Convenor, Public Health Resource Network, Delhi

			<p>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.</p> <p>Helped strengthening GKS in 4 villages where they received money and held regular meetings. ; Helped in preparing district health profile</p>	
20	Vibha Upadhyaya	Adolescent Reproductive and Sexual health in Garasia Community: Social and Cultural Context	District Pali. Action on strengthening ARSH services by training adolescents, anganwadi workers and ANMs; organised a adolescent health day; network with health services	Ms. Laboni Jana, PHRN, Rajasthan
21	Neelima Aggarwal	Objective assessment of Urban RCH centres	Jaipur was the only urban centre covered in the entire Fellowship. The Fellow conducted visits to slums to observe health care facilities for urban poor and participated in various meetings and workshops, based on various community health issues. She developed training material for VHSC training and was also a	Prof. Shiv Chandra Mathur, Director, SHRC, Jaipur

			<p>facilitator at the ASHA ToT workshop. A profile of the city and a document on the need and importance of urban health based on the city was prepared</p>	
22	Julie Swarnakar	<p>Present status of VHND (also called MCHN day-mother and child health and nutrition)</p>	<p>District Bhilwara. The Fellow engaged in orientations at the block, district and state level on various health issues like Polio, HIV/AIDS; including members of PRIs, ASHAs and ANMs. ASHA and ANM were encouraged to work together and VHSC meetings were made proactive.</p>	<p>Mr. Haldhar Mahto, Senior Programme Coordinator, Public Health Resource Network, Delhi</p>

CHAPTER THREE

The Status and Role of the Accredited Social Health Activist (ASHA)

This chapter looks at the ASHA programme that got implemented as an important component of the National Rural Health Mission in 2005 at the national level. The first section introduces the programme and gives an overview of its various components and the present debates surrounding the programme. It then discusses findings from the four studies on the ASHA programme by the Fellows. The findings are categorised into issues that have been brought forth by the studies.

Introduction to the ASHA programme

Today the ASHA programme is an inherent part of the health system brought about with the National Rural Health Mission in 2005. This saw the scaling of the community health worker/Mitanin programme to the national level. The NRHM envisages that access to healthcare at household level will improve through the female health activist. Every village will have a female Accredited Social Health Activist (ASHA) who will be a bridge between the ANM and the village and be accountable to the Panchayat.

The conceptualisation of the ASHA was based on lessons from the past experiments in Community Health Worker Programmes. There were eight essential features that were drawn out from these experiences that were seen as pre-requisites for a successful CHW programme –

- CHWs should be women,
- Selection of the CHWs must be by the community,
- The CHWs must receive continuous sustained and on-going training and support for many years they should be provided with continuous training and support,
- Curative care was an essential component but not the only or central element to the CHWs activities,

- Most success stories saw this as an opportunity to empower communities to take care of their own health and this was to spread to other spheres,
- Most of the success stories had a motivated and capable leadership,
- There was good quality referral support available for the CHW
- The projects had enough time and flexibility to go through a learning curve and in most cases took 5 years before results become apparent.⁸⁹

The ASHA and her interface with the Community

The ASHA has been conceptualised as an activist / volunteer at the village level. She is selected from the village itself and accountable to village health and is trained to work as an interface between the community and the public health system. The ASHA is not seen as part of the system but more a representative of the community who engages with the system on the behalf of the community. Therefore, her role is that of a volunteer from the community who does not receive a salary.

The primary role of the ASHA is to create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She is a promoter of desired health practices and provides a minimum package of curative care as appropriate and feasible for that level as well as makes timely referrals.

At the conceptual level, as was in the Mitandin programme, social mobilisation is seen as a strong component of the programme to ensure continued community ownership. The ASHA should emerge as the coordinator of such mobilisation, especially of weaker sections and grow into a greater role in decision making. The ASHA does not function in isolation but receives support from other village level processes. She is not to be seen as the only possible wheel of community level activities. The available partners are the PRIs, VHSCs, CBOs and other politically linked organisations. It was also envisaged that the spirit of solidarity amongst ASHAs must be built through regular meetings, songs

⁸⁹ PHRN, Book 4 - Community Participation and Community Health Workers with special reference to ASHA, PHRN, Delhi, 2008

and the spirit of community services should be sustained through role models, encouragement and constant supportive supervision.

The NRHM programme design for ASHA

Following are the basic key components of ASHA:

- ASHA must primarily be a woman resident of the village – married/ widowed/ divorced, preferably in the age group of 25 to 45 years.
- She should be a literate woman with formal education up to class eight. This may be relaxed only if no suitable person with this qualification is available.
- ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.

Strengthening of rural hospitals for effective curative care and accountability to the community and Integration of vertical health and family welfare programmes

There would be one ASHA for a population of 1000. Though she would not be paid any honorarium, she would be entitled for performance based compensation. It is expected that on an average an ASHA working with reasonable efficiency would be able to earn Rs. 1000 per month.

The ***roles and responsibilities*** defined for the ASHA include – knowing the village people; participating in the VHSC and village health plan; communicating for health behaviour change by creating awareness and providing information to the community on determinants of health, health services and their timely utilisation; mobilise the community and facilitate their accessing health and health related services; making linkages with ANM, AWW, TBA, MPW, escorting patients to a hospital, providing primary medical care (includes treating simple illnesses and early identification of diseases), acting as a depot holder for essential provisions, recording and registration of births, deaths, and maintaining a regular diary of work done. ASHAs functions would be

integrated with the ANM and AWW and would supplement but not substitute or duplicate their functions.

The **selection** criteria of an ASHA includes – an ASHA must be a woman, should have passed her eighth grade, must be resident of the village, should have some past experience in social work, some leadership quality and communication skills. The selection should take place through community mobilisation and repeated community meetings that would include participation from all sections. The selection should be endorsed by Panchayat. One important feature of the Mitadin programme has been that of the facilitator which has been missing till now in the ASHA programme. A facilitator (*prerak*) is there for every 20 Mitadins and receives separate training for his/her role. The facilitator has roles over and beyond selection, advocacy, training and troubleshooting.

Training is an essential component of the programme. ASHA modules and reading material are created on the specific tasks of ASHA that set the perspective and detail out her tasks. Training includes 23 days induction training spread over a period of 12 months; periodic training is kept for 12 days in a year.⁹⁰

The training is residential and is periodical. Master trainers are trained at the national level and the cascade model of training is used. Trainers are full time and their skills also need constant upgradation. There are issues relating to transmission loss but a lot of this depends on quality of key resource persons, adherence to resource material at every level, evaluation of trainers, and on the job training. The on the job training is something that must be done by facilitators who are at present absent in the ASHA programme.

The ASHA has been conceptualised as a volunteer who will get task based incentives linked to National Programmes. She would also be **compensated** for loss of livelihood for full day training camps that she has to attend. Currently most are getting JSY, DOTS

⁹⁰ Ibid.

and immunisation incentives. Based on the incentives and compensation it was expected that the ASHA would be able to earn on an average Rs 1000.

Table 3.1: Number of ASHAs

	Year	India	High Focus	Non-high focus – large	Non-high focus – small and UT
Number of ASHA selected during	2005-06	130315	119642	0	0
	2006-07	300636	252391	18606	0
	2007-08	171327	57805	107702	239
	2008-09	105176	16664	81982	2266
	2009-10	93890	26428	63624	777
	2010-11	47987	19854	26372	1360
	Total	849331	492784	298286	4642

Source: NRHM (2011), MIS

The **financial guidelines** of the ASHA programme were laid out by the Ministry of Health and Family Welfare in 2006. The financial norms included costs for the selection processes including community mobilisation, training, drug kits and untied funds to the village. This amounted to Rs 7415 per ASHA. The incentive payments were to come from the respective programmes and were not part of this amount. A supplementary set of provisions were added later in the year to include support structures from state to sub-block levels, identity cards, bags and badges. The amount was then increased to Rs 10,000.⁹¹

⁹¹ NHSRC, 2011.

**Table 3.2: Fund Releases and Expenditure for the ASHA Programme
(in crores) – 2005-2010**

Details	Andhra Pradesh	Assam	Bihar	Jharkhand	Kerala	Orissa	Rajasthan	West Bengal
Total Fund Released	8.5	73.93	105.07	46.85	21.74	56.48	79.16	10.89
Expenditure	12.15	36.13	24.08	30.1	33.04	32.65	32.46	19.52
% expenditure over total fund released	142.94	48.87	22.92	64.25	151.98	57.81	41.01	179.25
Total fund spent per ASHA (in Rs)	1719	12546	3373	7348	10689	9532	7529	8300

Source: NHSRC (2011), ASHA – Which way forward: Evaluation of ASHA Programme, NHSRC and NRHM, New Delhi.

The present debates around the ASHA

Selection, training, supportive supervision are important components of the programme that need strengthening. The selection process determines who the ASHA is and whether she has been selected through a democratic process and more importantly whether she represents all the sections in the community and specially the marginalised and weaker sections.

Two important debates around the ASHA programme is to do with her roles and responsibilities and linked to that is the issue of compensation. The questions raised - Is the ASHA a link worker or an activist? While some would like to see the ASHA's role go beyond that of a link worker, most see a functional ASHA as a link worker. There has been a continuous debate to get more clarity on her role. There are concerns raised on

increasingly diverse roles that get thrust on the ASHA in the state and from the centre so can the ASHA be called a volunteer.

Following this has been the issue of compensation to the ASHA and its relationship to motivation. Does the ASHA need to be given a fixed payment or compensated by an honorarium or should not be given any payment as she is viewed as a volunteer. Most NGO led CHW programmes always had a modest honorarium for its CHWs. The Mitadin programme does not provide for any honorarium. After the first year there was an understanding that for each day of training a livelihood compensation loss of Rs 50 per day would be given but nothing beyond that. Her participation is sustained by motivation and support. The considerations behind not paying an honorarium for the Mitadin programme was – the amounts considered for payment are too meagre to amount to a livelihood; the introduction of a small payment would make the entire burden solely her task and the community would not participate to the extent that it has been envisaged; and not paying her safeguards the selection process from pressures that would otherwise be inevitable and most damaging.⁹²

But this decision not to pay in the Mitadin programme was made along with other decisions – the CHW should not have to face any loss of livelihood on account of her participation; there must be a strong component of social mobilisation to ensure continued community ownership; there has to be a strong component of training and support.

In the following section we attempt to put together the findings from the studies done by Fellows on ASHA. The main issues are discussed with evidence from the studies.

Studies by Community Health Fellows

During the *Fellowship Programme*, four Fellows worked on issues surrounding the ASHA. Two studies were from Bihar and two from Rajasthan.

⁹² PHRN (2010 reprinted), *Community Participation and Community Health Workers: with Special Reference to ASHA*, PHRN.

The ***four studies*** were:

1. Assessing the Capacity of ASHA to meet the health needs of Community by Kumari Shweta
2. The Role of ASHA in the community as an activist or link worker at Rajapkar Block in Vaishali District by Farhat Yasmin
3. Assessment of Implementation of JSY Scheme in Dausa Block of Dausa District by Arvind Pandey
4. Role of ASHA as Social Health Activist: An exploratory case study of ASHA scheme, Rajasthan by Indu Gupta

District Profiles

The two districts in Rajasthan were Alwar and Dausa and two districts in Bihar were Samastipur and Vaishali.

Alwar, Rajasthan

Alwar has a population of over 3 lakhs and is located at 170 kilometres from Delhi. The sex ratio is 887 females per 1000 males, which is lower than state average of 897. The density of the population is 357 per sq/km. Alwar has 18.01 and 8.02 percent SC and ST population respectively. The district has a literacy rate of 62 percent.

Table 3.3: Availability of Health Facilities in the District

Name of Institutions	<i>Number</i>
District Hospital	01
Community Health Centres (CHC)	24
Primary Health Centres (PHC)	72
No. of Additional posts	09
Sub-Centres	489
Licensed Blood Bank	General Hospital

Most health indicators in the district are above state average.

Dausa, Rajasthan

The district is situated in the eastern part of Rajasthan. It is bound in the north by Alwar district, in south by Sawai Madhopur district, in the west by Jaipur district and in the east by Bharatpur district. Dausa District was constituted on 10th April 1991 by separating 4 Tehsils namely Dausa, Baswa, Sikrai & Lalsot of Jaipur district. Mahwa Tehsil of Sawai Madhopur was included in this district on 15th August 1992. The district of ASHA is adjacent to Jaipur and has a population of 1.5 lakhs. Dausa has 21 and 26 percent SC and ST population respectively. The district has a literacy rate of 62 percent.

The major communities in the district are Brahmins, Rajputs, Mahajans, Jains, Kayasthas, Sikhs, SC & ST. Besides these, there are major communities such as Jats and Gujars who were engaged in agricultural activities and animal husbandry. Others engaged in their professional activities were Khatri, Nai, Teli, Luhars, Dhobi, Darji etc. According to present analysis, some of these castes have shifted to agriculture and service sectors because, in rural areas, most of them do not get gainful remunerations from their ancestral activities.

The preventive, promotive and curative services are provided through a vast infrastructure of 220 hospitals which include the 24 hospitals attached to the Medical Colleges and 32 District hospitals, 325 Community health centers, 1743 Primary health Centers, 118 MCH centers, 204 Dispensaries and 10512 Sub centers and 40187 beds. There is also a large network of the private sector clinics and hospitals

Table 3.4: Health Institutions

District Hospital	1
Dispensary (TB clinic)	1
Community Health Centre	7
Primary Health Centre	29
Sub-centre	237

Samastipur, Bihar

Samastipur has an SC population of 18 percent and a literacy rate of 62 percent. The district comprises of 4 sub-divisions, and 20 Community Development Blocks. It has 5 towns and 1248 villages. Infrastructure wise Samastipur is very strong. It is the Divisional Headquarters of the North Eastern railway. The DLHS-3 data depicts that 87.6% people fall in low SLI (Standard of Living Index) group. Only 4 % of people fall in high SLI category. Only 19.8% population is reported to have a BPL card. The society is almost rural in outlook with agrarian association for income. The farming is largely dependent upon monsoon rains that is unpredictable and beyond the control of farmers and hence the major cause of poverty in the region. In addition to this, the devastation caused by floods each year completely ruins the economy of the region. Thus, poverty, illiteracy, lack of accessibility to better opportunity coupled with devastating flood makes it one of the underdeveloped regions of India.

Health Profile

Samastipur district ranks 512 though on the basis of under-five mortality it ranked 313. Filaria, Malaria, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. The overall prevalence of tuberculosis in India is 544

per 100,000 populations while in Samastipur it is reported to be close to 618 per 100,000.

Health Status and Burden of Disease

Table 3.5: Case Fatality Rate

Sl. No.	Disease	2007		2008		2009	
		Case	Death	Case	Death	Case	Death
1	Gastroenteritis	67	6	166	0	17328	0
2	Diarrhea/ Dysentery	1515	5	882	2	26544	0
3	Cholera	0	0	0	0	0	0
4	Meningitis	0	0	0	0	3	0
5	Pneumonia	0	0	0	0	4008	0
6	Malaria	0	0	0	0	0	0
7	Measles	0	0	0	0	228	0
8	A.R.I.	NA	NA	NA	NA	6067	0

Table 3.6: Morbidity due to Major Disease

Sl.No.	Disease	2007	2008	2009
1	Kala-azar	12603	5312	1172
2	T.B. (NSP)	997	575	1586
3	Leprosy (PR/10000)	1.15	1.30	.91

Table 3.7: Basic Health Indicators

Indicators	Samastipur	Bihar
Couple Protection Rate (CPR)	33%	-
Crude Death Rate (CDR)	8.1	8.1
Crude Birth Rate	31.9	30.4
Infant Mortality Rate	56	56
Maternal Mortality Rate	371	371
Total Fertility Rate (TFR)	4.6	4
Under 5 Mortality Rate	85	85
Still Birth Rate	2%	NA
Abortion rate	NA	NA

Vaishali, Bihar

The villages of Vaishali have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden. 20.7% of the population belongs to SC and 0.1% to ST. There are at least 13% percent villages where the SC population is more than 40%. Some of the most backward communities are *Mushahar, Turha, Mallah* and *Dome*.

Vaishali district ranks 460 though on the basis of under-five mortality it ranked 274. Filariasis, Malaria, Dengue, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Vaishali district. Hepatitis, Diarrhea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar. As per DLHS 2002-2004 the prevalence percentage of kala-azar is 11.4% and TB is

4.3%. The overall prevalence of tuberculosis in India is 544 per 100,000 populations while in Vaishali it is reported to be close to 618 per 100,000.

Health Status and Burden of Disease

Table 3.8: Case *Fatality Rate*

Sl.No.	Disease	2007		2008 (Till Nov)	
		Case	Death	Case	Death
1	Gastroenteritis	67	6	166	0
2	Diarrhea / Dysentery	1515	5	882	2
3	Cholera	0	0	0	0
4	Meningitis	0	0	0	0
5	Jaundice	0	0	0	0
6	Tetanus	0	0	0	0
7	Kala-azar	3275	6	2632	3
8	Malaria	0	0	0	0
9	Measles	0	0	0	0
10	A.R.I.	NA	NA	NA	NA

Table 3.9: Morbidity due to Major Diseases

Sl. No.	Disease	2007	2008
1	Kala-azar	3275	2632
2	T.B. (NSP)	997	575
3	Leprosy (PR/10000)	1.15	1.30

Table 3.10: Basic Health Indicators

Indicators	Vaishali	Bihar
Couple Protection Rate (CPR)	33%	-
Crude Death Rate (CDR)	NA	8.1
Crude Birth Rate	31.9	30.4
Infant Mortality Rate	61	61
Maternal Mortality Rate	371	371
Total Fertility Rate (TFR)	4.6	4
Under 5 Mortality Rate	NA	85
Still Birth Rate	NA	NA
Abortion rate	NA	NA

Objectives

Three of the studies look at the role and capacities of the ASHA in general on the ground in reference to the conceptualisation of ASHA at the policy level. Two of these also look at the dimension of activism in ASHAs work. The fourth study specifically looks at the role of ASHA with respect to *Janani Suraksha Yojana*.

Methodologies and their limitations

The sampling of the villages in most studies was based on the villages around health sub-centres and the ASHAs were selected from these villages and were either purposive or convenient.

All four studies have used interviews as a tool to elicit responses from ASHA. Two studies have also interviewed beneficiaries (structured and unstructured) to get their perceptions vis a vis role of ASHA. In two studies observation is also one of the tools used. The researches lacked rigor and had a small sample size, hence making generalisations difficult. Presented below are the important findings that are coming out from these studies relevant to the contemporary debates surrounding the programme.

Table 3.11: Sample Size for the Studies

Districts	Number of ASHAs interviewed	ANMs/AWWs/PRIs	Beneficiaries
Alwar	40	-	-
Dausa	15	-	30
Samastipur	30	-	-
Vaishali	8	8 – AWW; 4-ANM 8- PRI	80

The Status of the ASHA programme: Evidence from the studies

In this section we present key findings from the four studies. The National Health Systems Resource Centre (NHSRC) which is the technical support unit for NRHM did an eight state evaluation (Andhra Pradesh, Assam, Bihar, Jharkhand, Kerala, Orissa, Rajasthan, West Bengal) of the ASHA programme in 2010. While presenting the

findings of the micro studies we also corroborate the findings with those from the larger study.

Who is the ASHA?

There are several norms stated in policy as to who can be the ASHA. She should be from the village, should have at least passed eighth standard, and should be representing a marginalised community.

Many of the ASHAs are within the age group of 20-30 years.

Table 3.12: Age Groups of ASHAs

Name of districts	20-30 yrs	31-40 yrs	41-50 yrs	Total number
Alwar	29	10	1	40
Samastipur	9	18	3	30
Total	38 (54.3 %)	28 (40 %)	4 (5.7%)	70

From three of the studies it is found that all ASHA's are literate and at least had completed their eighth grade.

The combined figures from the three studies:

Table 3.13: Literacy Amongst ASHAs

School year	Alwar (N=40)	Samastipur (N=30)	Vaishali (N=8)	Percentage (N=78)
Eight	24	5	4	42.3
Tenth grade	10	17	3	38.5
Twelfth	6	5	1	15.4
Graduate	0	3	0	3.8

The combined SC and ST population in these districts are significant but ASHAs are mostly from the other castes. There seems to be a lack of representation from the SC community especially in the districts in Bihar.

Table 3.14: The Social Background of the ASHAs

Caste/tribe	Alwar (N=40)	Samastipur (N=30)	Vaishali (N=8)	Percentage (N=78)
OBC	18	16	0	43.6
SC	16	5	0	27
ST	6	1	0	9
General	0	8	8	20.5

There are not many ASHAs from the BPL category.

Table 3.15: *Economic Background of ASHAs*

District	APL	BPL	Total Number
Alwar	31	9	40
Samastipur	20	10	30
Total	51	19	70

In *Samastipur* 23 out of 30 work only as ASHAs and the rest also performed some other work as ASHAs. In *Alwar*, 28 out of 40 work only as ASHAs and rest are involved in agriculture, tailoring.

Table 3.16: Reasons for Being an ASHA in Samastipur

Detail	Hope of govt job + economic reason + social recognition	Hope of govt job + economic reason + self-dependency	Hope of government job + economic reason	Economic reason + social recognition
All ASHAs 30	7	4	15	4

In *Samastipur*, the hope for a government job and economic reason seemed to be the major influencing factor in becoming an ASHA in one district and desire to serve the community and financial reason seem to be the reason in *Alwar*.

Table 3.17: Reasons for Joining as an ASHA in Alwar

Detail	Desire to serve community	Financial reasons	Opportunity to seek knowledge	Was idle at home	Providing health services in the village
40 ASHAs	24	24	13	4	6

In *Alwar*, 32 ASHAs said that the families were cooperative of their work as an ASHA. Only 4 said that the family was against it. 27 also said that they were able to influence the community and their own families with their views and hence felt empowered being an ASHA.

The findings from the eight state evaluation of the ASHA programme by NHSRC shows 60 percent ASHAs are in the age group 24 to 35 years. In most districts there has been adequate representation from the marginalised communities in the villages but Bihar,

West Bengal and even Kerala lag behind. This study also states that desire to serve the community and financial aspect as the first two reasons for being an ASHA.⁹³

Selection of ASHAs

In *Vaishali* district, the selection of ASHA took place through active participation of Gram Sabhas, health department and PRIs. According to the finding by the Fellow it was not a transparent process as community involvement was absent.

In *Alwar*, out of the 40 ASHAs, 23 were selected by AWWs who are called Sahayoginis, 12 were selected by Panchayat members without consultation and only 4 were selected with consultation with community.

In the NHSRC evaluation study across eight states, findings show that the selection process varies. In Andhra Pradesh, West Bengal, Kerala, Orissa and Assam, the process of selection was structured by defining a committee of three to five persons. In most of the cases the ANM who was part of the committee took the decision. In Rajasthan, *panchayat* played a major role in selection process. In Bihar 46% of the selection was by the Panchayat and 26 % by the ANM.⁹⁴

Hence there is no uniformity in the selection process and the process needs more community participation and must include the voice of the marginalised.

Training

In *Alwar*, 39 of the 40 ASHAs had received some training. About 50 percent have received complete round of trainings till the latest module. The topics that the ASHA recalled from the training were maternal health, new born care, family planning, HIV/AIDS, diarrhoea, TB and malaria.

In *Vaishali*, all the 8 ASHAs had received only 12 days of training till date. They were not provided any further training. Here, the ASHA recalled institutional delivery,

⁹³ NHSRC (2011), ASHA – Which way forward: Evaluation of ASHA Programme, NHSRC and NRHM, New Delhi.

⁹⁴ Ibid., (2011)

HIV/AIDS, TB, antenatal check-ups, child care and routine immunisation as some topics covered during the training.

In *Samastipur* all 30 ASHAs had participated in the 7 days induction training but they were yet to get training on further topics. Janani Suraksha Yojana (JSY), Family Planning, routine immunisation and TB are the four topics that the ASHAs recalled as part of training and this correlates with incentives given. All these programmes give incentives. In terms of material available, other than ASHA module 1, no other printed material was made available to carry out their work in the field. According to the ASHAs the training was participatory and trainers encouraged them to ask questions and the method used was lecture method based on the modules.

The NHSRC study on ASHA evaluation in eight states shows that training has been slow in eight states. As of the time the survey was conducted i.e 2010, nearly all of ASHA in West Bengal, 82% in Orissa, 91% in Assam, 62% in Jharkhand, 42% in Rajasthan, and 9% in Bihar had been trained upto Module 4. Over 95% of ASHA reported that they had received training material. The central issue behind the slow pace of training is the limited capacity to spare appropriate human resource for training at regular intervals. In Rajasthan it seems that NGOs have brought about innovations in training methodology and material and have attempted to ensure that knowledge of ASHA meets a basic standard. In Bihar the training was given to one NGO in Bihar but there were no mechanisms to ensure quality of training. Officials at all levels perceive that training has been of poor quality. In Bihar 87 % ASHAs have received less than 10 days training in a four year period.⁹⁵

Knowledge Levels of ASHAs

In two of the studies the Fellows tested the knowledge levels of the ASHA on specific topics. These have been highlighted below.

⁹⁵ Ibid., 2011

In *Samastipur* the ASHAs were tested on dangerous signs of pregnancy where only 4 out of 30 were able to give up to 3 danger signs out of seven.

Table 3.18: Knowledge of Dangerous Signs of Pregnancy in Samastipur

Signs	Responses
Swelling in feet	7
Swelling in feet + bleeding	13
Swelling in feet + bleeding + convulsion	4
Other signs (vomiting)	3
Don't know	3
Total	30

For danger signs in the post delivery period – 11 of the ASHAs were able to say up to 3 danger signs (excessive bleeding, high fever, and convulsion); 13 were able to give up to one sign.

15 out of 30 had knowledge relating to precautions relating to home delivery.

Table 3.19: Knowledge of Precautions to be taken During Home Delivery

Precautions during home delivery	Responses
Clean hand + New thread	6
Clean hand + New blade + Clean clothes	15
Don't know	9
Total	30

7 ASHAs had no knowledge of danger signs in a new born.

28 had complete knowledge on signs of diarrhoea but 11 did not know about prevention of diarrhoea. Only one ASHA knew about hand washing as a preventive method and 11 ASHAs said keeping surroundings clean and eating freshly cooked food as two preventive methods.

Since the study in *Dausa* focused on ASHAs role in JSY, her knowledge vis a vis JSY was mapped. The purpose of JSY is defined here as in the policy document. The main objectives are - aiming for decrease in maternal and child health; safer delivery through institutional delivery; proper care and attention during pregnancy and delivery and provision of minimum nutritional food after delivery. JSY itself has some 7 features – early registration, micro-birth planning, referral transport, institutional birth, post-delivery visit and reporting, family planning and counselling, behaviour change communication for promoting institutional delivery. The ASHA is involved in all these activities.

Only 4 out of 15 ASHAs interviewed here had adequate knowledge of JSY i.e. ASHA knew about the purpose of the scheme and features of the scheme. 6 ASHAs had average knowledge where they were able to give two objectives of the scheme and three features of JSY.

4 out of the 15 ASHAs had adequate knowledge of ANC services.

Table 3.20: Knowledge of ANC Services

S. No.	Level of knowledge about roles to be performed for ANC	Response
1	Adequate knowledge (early registration, all three ANCs, motivate pregnant women and follow up)	4
2	Average knowledge (any three of the above features)	7
3	Less knowledge (reported only two features)	3
4	No knowledge	1
All	Total	15

About 10 had negligible to no knowledge about their role in PNC services thus suggesting that PNC is one area where there is limited knowledge and activity by the ASHA.

Services provided by ASHA

As mentioned in the review of the programme, there are several tasks listed for the ASHA at the policy level but these micro studies show that ASHAs work centres around MCH services and much of it is around institutional delivery. The retention of knowledge of the topics covered during training as seen in the previous section is directly related to work performed by them.

The main works of ASHA in *Samastipur* revolved around pregnant mothers and counselling their families about the potential danger sign during pregnancy, delivery and post-delivery. Skills regarding diarrhoea management, like preparation of ORS are negligible.

In *Alwar* district study, among 40 ASHAs over 90 % of ASHAs performed the following tasks related to pregnancy: registration of pregnant women, counselling on nutrition intake and supplementary ration from Anganwadi, providing information on JSY and its benefits, helping to see that ANC includes two TT shots. 85 % were motivating for institutional delivery; over 70 % were counselling women on all aspects of pregnancy and accompanying her for delivery; over 50 % were encouraging ANC service. Only 30 % were ensuring monitoring of BP; less than 20 % were accompanying women when ill and less than 10 % were referring to any case of illness during pregnancy.

In *Vaishali* district, all ASHAs were counselling women on IFA tablets and nutritious food and assisting in immunisation and weighing. ASHAs visit the pregnant women quite frequently. 4 ASHAs were providing support to malnourished children but mostly through counselling. 7 of the ASHAs are providing medicines for TB and only 3 are creating awareness on TB. 5 provide support for minor ailments such as diarrhoea, fever and minor injuries.

Beneficiaries Perceptions on Delivery of Services by ASHA:

Two of the studies from district Vaishali and Dausa give some view on the beneficiaries.

In *Vaishali*, 77 of the 80 beneficiaries (women who were pregnant) reported that ASHA accompanies for institutional delivery and 61 said that ASHA assists in immunisation.

In *Dausa*, 16 out of the 30 beneficiaries said that ASHA provided with knowledge and information on JSY; 17 said that ASHA visited in the initial days of pregnancy; 20 said that ASHA contacted to motivate for institutional delivery out of which 7 decided to go for institutional delivery due to ASHAs motivation. In 12 cases ASHAs helped in preparing for the vehicle before delivery.

In 24 cases, the ASHA accompanied them to the facility for delivery.

Table 3.21: Duration ASHA Stayed with Beneficiary at the Time of Delivery

S. No.	Duration ASHA stayed	No. of beneficiaries
1	One or two hours after reaching hospital	4
2	Till the delivery performed	13
3	Overnight	4
4	Two or five hours after reaching hospital	3
All	Total	24

16 out of these 24 said that ASHA took care of the new born in the hospital.

The NHSRC study shows that the vast majority of ASHAs are functional, (i.e. carry out a defined task) irrespective of context and other constraints. There is however a wide variation in the exact set of tasks that an ASHA carries out (*range*), the percentage of potential users of these services who are reached (*coverage*), and the *effectiveness* with which this task is undertaken. *Effectiveness* is defined in terms of achieving desired behaviour changes (largely the preventive and promotive role). Variation in range, coverage and effectiveness occurs within and between districts and makes generalisation of any sort difficult. This wide variation is largely due to the fact that although at one level, the ASHA is tasked with many functions, in practice she is limited to the tasks for which she gets support and is monitored. Effectiveness is further defined by the skills in which she has been trained and the extent of the response of the health system.

One of the tasks, where there is complete consensus that ASHA has a role, is the promotion of institutional delivery. Over 90% of ASHAs are *functional* on this task. One reason for this good performance on this task is incentivisation as this is the most consistently incentivised activity. It is also one of the most supervised elements of the

programme. A third contributory factor is that this activity requires relatively little knowledge or skills, on the job supervision or any other form of support. The functionality and effectiveness of the ASHA with respect to three ANC check-ups, post partum care and other aspects of pregnancy management, is much lower than the promotion of institutional delivery in six of the states that include Bihar and Rajasthan. In family planning, the ASHA's effectiveness in terms of knowledge on family planning as judged by a response on contraceptive advice to be given to a newly married couple is uniformly high in all states. The one disease control programme that the ASHA plays some role in is TB. In the case of TB, functionality among the ASHA is high when considering the number of TB patients she reports.⁹⁶

The evaluation shows that in Rajasthan the programme appears to be institutionally focussed on facilitation for JSY and immunisation. ASHA are functional in responding to illness but there are no drugs in the kits. Other skills and supervisory support have to be built up.

In Bihar there is a complete lack of training supportive supervision and drug provisioning. But this is not accidental but rather is a result of an understanding where the ASHA is seen as a passive link worker for two functions – institutional delivery and immunisation. Despite this the ASHA has exercised some agency of her own and supported by peripheral health worker has been active in fair number of functions.

ASHA and support systems

To make the work of a functional ASHA effective it is important that support systems be responsive. While at the conceptual level, the role of the facilitator is critical for the programme it is absent in most states. In Rajasthan though, since 2009 there is a district ASHA coordinator per district; block ASHA facilitators and sector level ASHA supervisors at the PHC. In Bihar, district community mobilisers and block community mobilisers have been introduced in 2010. But the other support structures like functional referral services with responsive providers who are part of the system – ANM,

⁹⁶ NHSRC (2011)

AWW, medical officers at the health services, ASHA support structures at the block and district level and VHSCs at the community level are equally important for the ASHA.

The following are some key findings from the study that reflect on the hurdles that ASHAs face with the system.

In *Alwar*, the ASHAs faced problems related to referral. Out of the 40, 31 ASHAs faced problems during referral for institutional delivery.

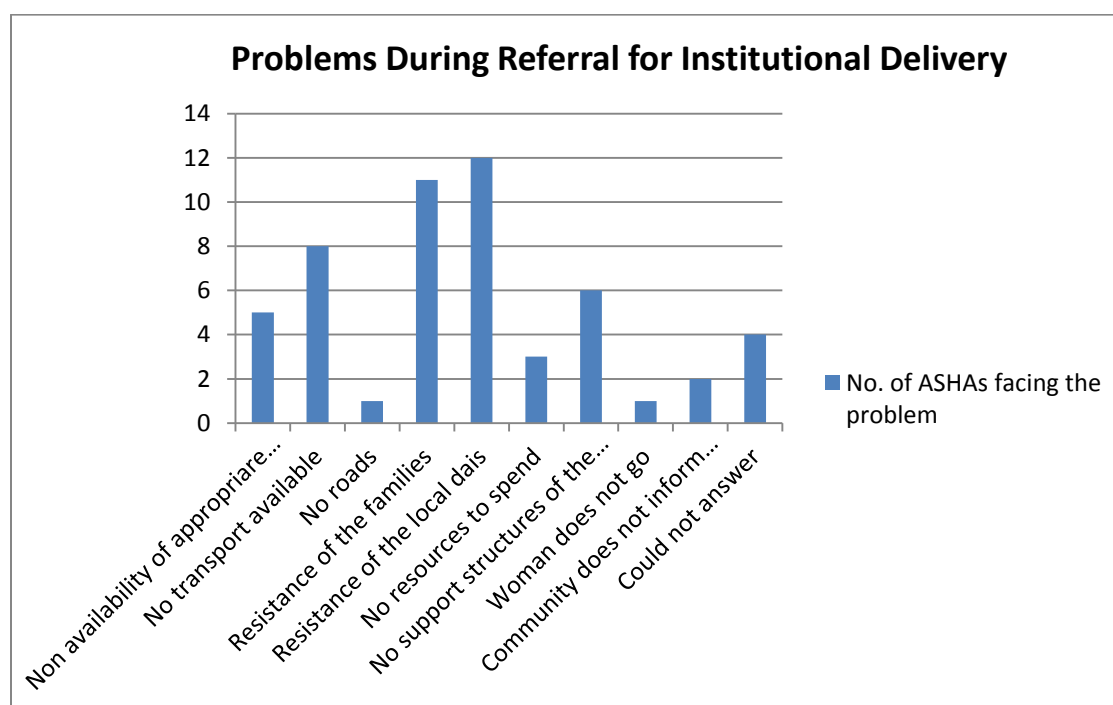


Figure 3.1

16 ASHAs also reported harassment faced at CHC/PHC/district hospital during delivery. These included non-availability of medicine, doctors, misconduct by providers at the facility.

29 out of the 40 ASHAs also faced challenges for availing JSY benefits.

Table 3.22: Challenges Faced for Availing JSY Benefits

Problems	No. of responses
Late registration of pregnant mothers	1
Unavailability of transport	2
Non availability of staff at the time of delivery	2
In case of no previous ANC registration	1
Unofficial charges	4
Buy medicines from private shops	9
Misbehaviour of doctors/nurses	5
Blood tests from private facility	4
2-4 visits for payment	1
Total	29

As part of the sector level meetings at the PHC, topics mainly focused on VHSCs, water and sanitation, RCH issues. In both the blocks of the study the VHSCs were functional and some ASHAs reported having received support from them for their field level activities.

In the study on ASHAs role in JSY in *Dausa* district, 7 ASHA out of 15 shared that ANM helps in motivating pregnant women, 8 said that they had not received any kind of support from ANM. The 7 who said they received some kind of support reported that the ANM counselled on their behest and then provided with the usual counselling that she has to during the ANC. 12 ASHAs said there were delays from the system in paying the incentive. 9 ASHAs have shared their concerns in sector meetings and these have

centred around payments. They feel there was no outcome of these meetings and the support structure was non-responsive. Even though 6 ASHAs have participated in panchayats meetings they have been unable to share their issues as they felt no one will listen, nobody will care and if they raised their voice against them the panchayat members may feel angry and threatened.

In *Samastipur*, ASHAs faced several hurdles in the field – lack of transportation and ambulance facility, no space for ASHA in the facility when she accompanies the women, no grievance or redressal system for them, and most importantly they felt that the government officials did not value or respect them. They also felt that there was lack of convergence as there was no coordination between ASHAs and PRIs. They lacked support from ANMs and AWWs – 22 ASHAs revealed that they had no support from ANMs and 20 said that they did not receive any support from the AWWs.

The NHSRC study states that there is no evidence in the NHSRC study of any major conflict between ANMs, AWWs and ASHAs.

A study conducted by PHRN in Chhattisgarh⁹⁷ on Mitadin referral systems shows that the referral rate in the Mitadin programme is effective and they go beyond the protocols of a referral system to make it facilitated than simply verbal. Mitadins are also able to cater to the most vulnerable population and accompany patients to the referrals. They have effectively used their capacities in treating the community, identifying illness and conditions and have made referrals based on availability of services, quality of the facility, distance and cost. But the gaps lie with the government system. There does not seem to be much support from the government side for these referrals. The referral slip is not respected and there is a weak feedback system. Making the referral slip work, written feedback by the providers and a functional Mitadin help desk are all the protocols of the referral system that need to be in place but are not. The public health system, therefore, has to be more responsive and supportive to make the referral system effective as the efforts from the Mitadin seem to be in place. Chhattisgarh is

⁹⁷ PHRN (2010), A Study to Assess the Mitadin Referral System in Chhattisgarh, PHRN, Raipur.

considered the best practice state of the CHW programme and was a major influence for the ASHA programme, but even here supportive systems are missing.

Incentives

As discussed before much of the tasks the ASHA is engaged around incentives. Incentives have been a major concern issue in the programme. It is an important support for the ASHAs and since economic reasons are one major reason for them joining as an ASHA then it must be treated as an important component here. Across the states, most ASHAs are receiving Rs. 500 to Rs. 1000 per month. There is a debate that this undermines the other important issues that also need to be tackled and the role the ASHA should play over and above the tasks that are incentivised. In some states like Rajasthan there is a fixed amount paid to the ASHAs though poorly implemented while in Bihar it is performance based.

Action by ASHA: ASHA as an Activist or Link worker

The work of an ASHA has several dimensions. In most cases it is found that she works as a good link worker between the health services system and the community even if she is mostly functional in two activities – institutional delivery and immunisation. As part of the larger conceptualisation, the ASHA is expected to function as a community mobiliser or activist. This refers to her function of mobilising the community towards realisation of their entitlements on health which goes beyond health services and especially for the marginalised and vulnerable population in the village. The ASHA could do this mobilisation through her role and participation in the VHSCs.

From the studies we find that very few ASHAs pick up issues that are over and above their regular work as an ASHA.

A case study from *Alwar* describes the process of mobilisation of one ASHA to prevent an epidemic through use of untied funds.

A Case study of ASHA mobilising VHSC members demand untied fund to prevent the village from an epidemic

ASHA sahayogini, Pushpa Devi is conscious of convening regular VHSC meeting. She takes pain in mobilising VHSC members for meeting and is also conscious of replacing members who are not coming for the VHSC meeting. She is little frustrated with the ANMs attitude, who does not co-operate with her. A proposal for spending of untied fund was taken but ANM does not give her money. In the VHSC meeting conducted in December, ANM produced the bills of VHSC untied fund which were as follows:

4 chairs- Rs. 1,860

Repair of table- Rs. 400

Mattress - Rs. 1,290

Transportation cost- Rs. 150

The expenditure was taken down in VHSC meeting minutes. It was revealed that the ANM was hesitating in giving the money because she had already spent the VHSC fund and she was not telling this to ASHA.

In the meeting conducted in February, 2010 ASHA sahayogini replaced all the members who were not coming for the meeting and reformed the committee with new panch in the meeting. One noteworthy thing seen in the meeting was ASHA sahayogini was very much concerned for the repair of broken pipe supplying drinking water in the village. The pipe was broken in such a manner that it was lying 1 foot under the dirty water. She told that the children also excrete there and there is a danger of spread of diarrhoea in the village if the pipe does not get fixed on time.

The VHSC members saw the actual site where the pipe was broken and understood the gravity of the issue and estimated the cost on health villagers would have to bear if it is

not repaired on time. But ANM did not give money for repair of pipe because of which ASHA was frustrated. There are two ANMs in the sub centre and the ANM whose bank account operates was not present in the meeting. Therefore, the VHSC members decided to speak to ANM for untied fund and also took the record of untied fund spent last year.

The VHSC members & ASHA spoke to ANM for the untied fund. ANM gave the money and the MPW of the village supported in getting the broken pipe repaired. This way ASHA saved the village falling prey to an epidemic.

In Alwar, complaint was made by an ASHA regarding misbehaviour of doctor, nurse, BMO, SDM and also against bribes in the PHC. Other social issues like alcohol abuse were discussed through the VHSCs and village meetings were convened to stop sale of illegal alcohol.

In Vaishali district, it clearly shows that there are a lot of gaps in the work of ASHA and she is not involved in any kind of community mobilisation whether through women's groups or VHSCs or PRIs.

In the NHSRC study evaluating the programme, the mobilisational tasks on which the ASHA is most functional are related to water and sanitation, availability of services from AWW and ANM, domestic violence, enabling access to ICDS and picketing against alcohol. In Bihar there is a strong understanding of limiting the role of ASHA to facilitator roles.

Mobilisation of the community has to address issues of exclusion. In Rajasthan the caste system and distribution of villages into hamlets appear to dominate the accessibility of services. ASHA of upper castes refuse to accompany lower caste women for services. Similarly higher caste women refuse to have lower caste ASHA accompany them to access services. Other issues like gender discrimination and child marriages are still rife in this society. Perception on exclusion was weak amongst officials in Bihar.

Some officials reported that there were no disadvantaged sections in the state but block level informants felt that ASHA was able to reach to the marginalised.⁹⁸

Conclusion

It is difficult to make comparisons between districts or arrive at generalisations from these studies due to methodological limitations, small sample size and lack of robustness in terms of information gathered. The studies are able to throw some light on the profile of the ASHA, the process of selection, quality of training, her capacities in terms of knowledge and practice, and her support systems but there is little evidence from the beneficiary side and whether the ASHA is able to reach out to the weaker sections. Nevertheless, some key findings from the studies are listed below:

- Most of the ASHAs are in their 20s and early 30s. Economic reasons, social recognition and desire to serve the community seem to be the reasons for their becoming an ASHA.
- Going by the district profiles and the SC/ST population, there could be better representation of the ASHA from the marginalised community. Selection process varies and lacks community participation.
- The findings show that there are gaps in the stipulated training schedule. Though the training itself is good, the training calendar is not followed and there are delays. Further, material is not available to the ASHAs in Bihar and there is no on-the-job training.
- There are concerns regarding the knowledge and capacities of the ASHA as they are limited to RCH activities and within that focus on the JSY, immunisation. The only disease control programme in which there is some activity is Tuberculosis.
- The facilitator component in the programme has only recently been introduced. In Rajasthan where sector level meetings are happening at PHCs with ASHA supervisors lacks structure and follow-up.

⁹⁸ NHSRC, 2011

- It is also clear from the studies that the ASHA finds little support from other health staff and PRI/VHSC members. They are critical support structures and can help in the smooth and effective functioning of the ASHA and also build in convergence.
- The findings also raise concern about the identity of ASHA in the system. She feels that she is undervalued and is not respected.
- There are delays in incentives and compensation as seen in the study in Rajasthan.
- ASHA is engaging with the system to some extent but less with the community. Not much work is done on community mobilisation and reaching out to the weaker sections as a priority. These micro studies show that the ASHA's role varies and in most cases she is a functional link worker to some selected health programmes. In rare instances she takes up other issues of concern.

The interpretation of the ASHA, while naming her as an 'activist' has tended to treat her as the lowest rung of the health services system while paradoxically disregarding her rights as a worker. There is a need to retain the concept of the ASHA as an activist to make her effective as a change agent for the empowerment of people to achieve their health rights. At the same time her own empowerment and in effect, her rights as a worker need to be supported at various levels to enable her to help people. She needs support of other community members to mobilize so as to be able to address other determinants that also includes issues related to social exclusion. She should be equipped with proper knowledge and skills through continuous training and supportive supervision to create awareness about health and nutrition practices and services, people's rights and entitlements. She should be provided with opportunities to acquire more technical skills to grow to a different level of function in the health system/society.⁹⁹

⁹⁹ PHRN (2011), Convention Resolutions, PHRN Report of the First National Convention, PHRN.

The ASHA programme is definitely a watershed with reference to attempts made to scale community health worker programmes in the past. At the policy level, it has attempted to incorporate lessons from past experiences and has built in essential features that make a CHW programme successful. The challenges are many but it is essential to support and strengthen the programme.

Recommendations

The issues raised in the studies are very pertinent and bring forth the current debates in the ASHA programme. Following are some key recommendations for the programme:

- Selection process needs to be more transparent with increased community mobilisation and participation
- Support structures are important for the ASHA and there is a need for constant supportive supervision, on-the-job and facilitation for effective implementation of the programme.
- Training needs to happen on time with proper follow-ups. There is a need for refresher and on the job training.
- ASHAs knowledge levels must be enhanced through better training. Consequently improved knowledge should lead to better skills in practice to make the ASHA more effective in the field.
- There is a need to restate the comprehensiveness of her role as a health worker and not limit her to simply RCH functions.
- Delays in payments should be minimised and subsequently there needs to be a decision to move from a performance based incentives for some programmatic activities to a fixed payment. The payment could be made through the VHSCs.
- The system needs to be more supportive and responsive to the ASHA. She will just remain a functional health worker and not an effective one if there is an unresponsive public health system.
- There is a need for a grievance redressal system for the ASHA.
- ASHA could play an important role in the VHSC to address other determinants and issues of convergence.

- The importance of social mobilisation in the work of the ASHA must be restated.

CHAPTER FOUR

Decentralization of Health under NRHM: The Village Health and Sanitation Committees

This chapter looks at the process of decentralization introduced under NRHM. The Village Health and Sanitation Committees are an important component here. The following sections look at the conceptualization of VHSCs in the NRHM and then discuss the findings of the six studies conducted by the Fellows on VHSCs and one study on RKS in the four states of Jharkhand, Bihar, Rajasthan and Orissa.

VHSCs and NRHM

The NRHM intended to achieve national public health goals within a given timeframe, through a set of innovative approaches, programs and strategies, with a focus on states with low levels of achievements in public health and related development issues. It assured enhanced financial allocations from the centre for these states, in order to address the gaps that caused poor performance, whether related to infrastructure, human resources or facility standards. Community participation was another crucial strategy to achieve these goals since it can enhance the utilization and quality of primary health care services as well as the accountability of the providers. The NRHM framework included a number of measures to strengthen community participation such as selecting an Accredited Social Health Activist (ASHA) for all villages, setting up a Village Health-Sanitation Committee (VHSC) to plan for and achieve local health priorities, participatory management structures for health facilities, decentralized health planning and implementation, community based monitoring, etc. While many of these community initiatives have been started in the state of Bihar, they need significant strengthening to ensure required implementation and desired results.

National Rural Health Mission envisaged the community to take leadership at local level, related to health and allied issues. And this is possible only when the community is sufficiently empowered to take leadership in health matters. National Rural Health Mission has put a great emphasis on the decentralized planning and implementation and communitization for improved program delivery. The decentralization and community participation focus has been for a transformed public health system which is accountable, accessible and available to people.

Clearly, it requires involvement of Panchayati Raj Institutions in the management of the health system. This was made possible if a committee is formed in each village under the chairmanship of Gram Panchayat member and representative from the community such as gaon budha, women's group, and SC/ST/OBC / minority communities etc. Hence, for the development of the village in each village wherever there is an ASHA Village Health and Sanitation Committee has been formed by providing untied grant for village level activities.

As a core strategy of NRHM, significant focus has been made on creating and supporting Village Health and sanitation committees (VHSCs) to promote decentralization and participation. The VHSC is intended to be a part of the local self-governance structure of the Panchayati Raj Institutions. VHSCs are created to build and maintain accountability mechanisms for community-level health and nutrition services provided by the Government.

Decentralization and People's Participation is amongst the key strategies for making health care services effective and this has been reiterated in all significant documents articulating people's rights to health . The Bhole Health Survey and Development Committee (1945) had in its recommendations mentioned that "No individual should fail to secure adequate medical care because of inability to pay for it" and " the health services should be placed as close to the people as possible in order to ensure the maximum benefits to the

communities” . The report further mentioned, “it is essential to secure the active cooperation of the people in the development of the health program”.¹⁰⁰

Key quotes from NRHM document supplementing the case for VHSCs under NRHM

“The Village Health and Sanitation Committee (VHSC) will be formed in each village (if not already there) within the overall framework of Gram Sabha in which proportionate representation from all the hamlets would be ensured. Adequate representation to the disadvantaged categories like women, SC / ST / OBC / Minority communities would also be given. The Health Sub Centre will be accountable to the Gram Panchayat and shall have a local Committee for its management, with adequate representation of VHSCs”.¹⁰¹

Block Health Plans are to be prepared by an aggregation and consolidation of Village Health Plans. Block Plans will be the basis for the District Plan.¹⁰²

“Village Health and Sanitation Committee (VHSC) will be responsible for the Village Health Plans. ASHA, the Anganwadi Sevika, the Panchayat representatives, the SHG leader, the PTA/MTA Secretary and local CBO representatives will be the key persons responsible for the household survey, the Village Health Register and the Village Health Plan.”¹⁰³

The Gram Panchayat Level Health Plans, comprising a group of villages in many states and a single village in a few, will be worked on at the Sub Health Centre Level. The Gram Panchayat Pradhan, the ANM, the MPW, a few Village Health and Sanitation Committee representatives will be responsible for the Gram Panchayat Health Plan. They will also be responsible for over view and support for the household survey, preparation of Village Health Registers and preparation of Village Health Plans- the Gram Panchayat /SHC level would also organize activities like health camps to facilitate the planning process.¹⁰⁴

¹⁰⁰ Sir Joseph Bhole Committee Report, 1946

¹⁰¹ NRHM Mission Document : Institutionalizing Community led Action for Health

¹⁰² NRHM Mission Document : The Planning Process, MOHFW, GOI

¹⁰³ PHRN Module # 10 :District Health Planning

¹⁰⁴ PHRN Module # 10: District Health Planning

“The NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring”.¹⁰⁵

“While the process of communitization of the health institution itself would bring in accountability... Health Institutions to prominently display information regarding grants received, medicines and vaccine stock, services provided to the patient, user charges paid (if any) etc as envisaged in Right To Information Act . The community would be expected to monitor the performance of the health facilities on those parameters...”¹⁰⁶

To institutionalize community led action for health, NRHM has sought amendments to acts and statutes in States to fully empower local bodies in effective management of the health system. NRHM would attempt to transfer funds, functionaries and functions to PRIs. Concerted efforts with the involvement of NGOs and other resource institutions are being made to build capacities of elected representatives and user group members for improved and effective management of the health system. To facilitate local action, the NRHM will provide untied grants at all levels [Village, Gram Panchayat, Block, District, VHSC, SHC, PHC and CHC]. Monitoring committees would be formed at various levels, with participation of PRI representatives, user groups and CBO/ NGO representatives to facilitate their inputs in the monitoring planning process, and to enable the community to be involved in broad based review and suggestions for planning. A system of periodic ‘Jan Sunwai’ or ‘Jan Samvad’ at various levels would empower community members to engage in giving direct feedback and suggestions for improvement in Public health services.¹⁰⁷

In Bihar, the VHSC have been formed at the Panchayat level and one of the standing committee of Panchayat under the Panchayati Raj Act and Rules 2006 has been co-opted as VHSC in the state. Though, this is desirable to involve PRIs in the community processes under NRHM but one needs to pay heed to the fact that the VHSC under NRHM is expected

¹⁰⁵ Monitoring and Accountability Framework, NRHM: Framework for Implementation.

¹⁰⁶ NRHM: Framework for Implementation ; Monitoring and Accountability Framework

¹⁰⁷ NRHM – Framework for Implementation ; Institutionalizing Community led Action for Health

to be formed at every revenue village level. In the guidelines issued by the State Health Society of Bihar it requires a "Nigrani Samiti" to be formed at the revenue village level. Similarly other states have different experiences with VHSCs which need to be studied and strengthened. The studies conducted by the Community Health Fellows of PHRN try to throw some light on these important aspects of community participation towards ensuring health for all.

Studies on VHSCs and RKS

Given the importance of VHSC, the Community Health Fellows of PHRN did some research around it in different states. During the Fellowship programme, seven fellows worked on issues surrounding VHSC, RKS and PRI involvement in improving the health services system under NRHM. The studies were conducted in the states of Bihar, Jharkhand, Orissa and Rajasthan.

The **seven studies** were as follows:

1. Improving Service Quality and Outreach Coverage at Health Sub-centre level by mobilizing Community and ensuring proper utilization of untied funds in PHC Manpur in Gaya district of Bihar by Mr. Rajeev Ranjan Singh.
2. A study on the role of Pramukh in effective functioning of Rogi Kalyan Samiti(RKS) at district Muzaffarpur of Bihar by Md. Jalaluddin Khan.
3. Assess the roles and functioning of Village Health Committee (VHC) in Ichak block of Hazaribag District - A case study by Ms. Pooja.
4. Community Participation in VHC – Improving Health Care Services at Health Sub Centre (A case study of Ghatsilla Block in East Singhbhum District of Jharkhand) by Manir Ahmad.
5. The functioning of Gaon Kalyan Samities and the enabling factors to play an active role in Village Health Planning in Orissa by Arup Abhishek.
6. Assessment of Village Health and Sanitation Committees (VHSC) in Bikaner: A qualitative research for VHSC Strengthening in NRHM in Bikaner district of Rajasthan by Shiv Kumar Acharya.

7. To study the formation, role and working of the VHSC and to strengthen them:
Action research in Laxmangarh, Alwar district of Rajasthan by Anwar Hussain.

District Profiles – VHSCs

There were two studies on VHSCs from Rajasthan; two from Jharkhand, two from Bihar and one from Orissa.

The two studies from Rajasthan were from Alwar and Bikaner district.

Bikaner is the desert district situated at Pakistan border in Rajasthan. It is a deprived district of the nation in terms of its population structure, economic status etc. Bikaner District has total area of 27244 squares Km., which is divided in 6 sub-divisions and in 3 Tehsils. In this District, there are total 886 settled villages and 219 Gram Panchayats. According to census survey 2001, the population is 16, 74,271. There are 886075 male and 788196 female. The Schedule Caste population is 20 % of the total. Rural population is of 1079235 and urban population is of 595036. In health institutions, here is a medical college, hospital (PBM) at district headquarter which is well reputed among nearby districts. In the district, there are working 5 Block PHCs, 8 CHCs, 40 PHCs and 300 Sub-centers. There are not only the less facilities of public transportation in some of the desert villages due to its geographical situations but there cannot reach by other means also. Because of this situation there raise hurdles in effective deliveries of health services.

The two studies from Jharkhand on VHSCs were from the Ghatsila Block in East Singhbhum and Ichak Block in Hazaribagh. About 53% of the total area of the East Singhbhum district is covered by residual mountains and hills consisting of granite, gneiss, schist and basalt rocks. It is a part of Chhotanagpur plateau. There are 231 panchayats and 1810 Revenue Villages out of which 1669 Revenue Villages are inhabited and rest 141 Revenue villages are unhabitated. The population is over 22 lakhs. Approximately 49.32% people are engaged in agriculture and agriculture related

works and 2.45% persons are engaged in industrial field. More or less tribal population is found throughout the district.

Hazaribagh also has a population of over 22 lakhs with an SC population of 15 percent and ST population of 4.5 %. Mica and coal are the major minerals found in this district. This significant coal deposit reserves of this district include Charhi, Kuju Ghato Tand and Barkagaon or North Karnpura. The coal mines are the main source of livelihood for the residents of this district.

The two studies from Bihar were from the districts of Gaya and Muzaffarpur.

As of 2001 India census, Gaya had a population of 3,473,428. Males constitute 53% of the population and females 47%. Gaya has an average literacy rate of 51.07%, lesser than the national average of 59.5%; male literacy is 63.81%, and female literacy is 37.40%. 30 % of the population is Scheduled Caste.

Table 4.1: Study of Gaya and Muzaffarpur

S. No.	Variable	Data
1	Total area	4937.75 SQ. KM
2	Total no. of blocks	24
3	Total no. of Gram Panchayats	333
4	No. of villages	2925
5	No of PHCs	22+2
6	No of APHCs	46
7	No of HSCs	439
8	No of Sub divisional hospitals	0
9	No of referral hospitals	2
10	No of Doctors	116R+69C
11	No of ANMs	531Regular+300C

The total population of Muzaffarpur is over 37 lakhs and has a 16 percent SC population. The land use around Muzaffarpur is mainly agricultural and horticultural. While litchi and mangoes are abundantly grown, principal crops are rice, wheat, pulses, jute, maize and oil seeds. Vegetables like cauliflower, cabbage, tomato, radish, carrot, beetroot, among others, are also grown. Sugar cane, potato and barley are some of the non-cereal crops grown. Muzaffarpur town has several industries, big and small. The railway wagon industry is one of the town's landmarks. Muzaffarpur is an important centre for the wholesale cloth trade. In a study of 513 districts of the country in terms of overall rank in health it was found that Muzaffarpur district ranks 460 though on the basis of under-five mortality it ranked 274. Whereas a study on Composite Index was done by the same agency in all districts of Bihar, Muzaffarpur stood 6th in State. Filariasis, Malaria, Dengue, Kala-azar, skin diseases, and Tuberculosis are some of the most common diseases in Muzaffarpur district. Hepatitis, Diarrhoea, Typhoid, Blindness and Leprosy are other high prevalence diseases. Kala-azar is an endemic problem in Bihar. As per DLHS 2002-2004 the prevalence percentage of kala-azar is 11.4% and TB is 4.3%. The overall prevalence of tuberculosis in India is 544 per 100,000 populations while in Muzaffarpur it is reported to be close to 618 per 100,000.

Table 4.2: Health Care Institutions in the District

S.No.	Type of Institutions	Number	No. of Beds*
1.	District Hospital	1	318
2.	Referral	1	30
3.	Block PHCs	16	96
4.	APHCs (Old)	43	0
5.	APHCs (New)	14	0
6.	Sub-centres (Old)	473	0
7.	Sub Centre (New)	5	0
8.	Anganwadi Centres	3701	-
9.	Others (Pvt. Facility accredited)	5	70

The one study from Orissa was done in Dhenkanal where the fellow was placed. The population of Dhenkanal is over 10 lakhs with an SC population of 19 % and ST population of 13%. Some large and medium scale industries have established their base in the district apart from agriculture.

Table 4.3: Health Institutions in Dhenkanal

No. of District Hospitals (DHH, Dhenkanal)	1
No. of Sub-Divisional Hospitals (Kamakhya Nagar and Hindol)	2
No. of Community Health Centres(CHCs) (<u>Sriramchandrapur</u> CHC, <u>Analaberini</u> CHC, Parjang CHC, Mathakargola CHC-II, Jiral CHC-I)	5
No. of Primary Health Centres (Block PHC) (Birasal PHC, Odapada PHC, Beltikiri PHC, KhajuriaKata PHC)	4
No First Referral Unit (FRU) (DHH Dhenkanal, Hindol CHC, Kamakhya Nagar SDH)	3
No. of 24 x 7 Hospital (Analaberini CHC, Parjang CHC, Sriramchandrapur CHC, Bhuban Area Hospital)	4
No of PHC (N)	31
No. of Urban Family Welfare Centres	4
No. of Postpartum Centres (Dhenkanal PPC, Hindol PPC, Bhuban PPC, Kamakhya Nagar PPC)	4
No. of Sub-Centres	167
No. of A.N.M. Training Schools	1
No. of Ayurvedic Dispensaries	22
No. of Homoeopathic Dispensaries	19

Objectives

The objectives of most of these studies were to assess the functioning of the VHSCs and RKS and to assess their effectiveness in strengthening systems.

Methodology

Samples were mostly selected purposively. One study selected the villages randomly from the total list of VHSCs. Most of these studies used qualitative method of in-depth interviews, focus group discussions with VHSC members and participant observation during VHSC meetings. One study from Gaya district used a quantitative tool, an interview schedule.

Table 4.4: Samples for Interviews in Gaya

Districts	Villages / sub-centres/ PHCs	VHSC/RKS members interviewed (ASHA, Gram pradhans, office bearers etc.)	Community people
East Singbhum	5 villages	17	10
Hazaribagh	25 villages	200	
Muzaffarpur	3 PHCs	15 (3 pramukh, 12 members of RKS)	30 (patients)
Gaya	4 health sub-centres	68 (29 AWW, 22 ASHAs, 9 P 8 members)	
Alwar	5 villages	All members	
Bikaner	5 villages	39 (all members)	
Dhenkanal	6 villages	36 (ANM, ASHA, AWW and 3 nd providers)	

Findings from the studies

The details of their findings are as follows:

Though the research of the fellows were not linked with each other but the topic they chose were somehow linked to the issue of VHSCs and PRIs. The finding of the research thus is by far not linked but throw some light on the functioning of the VHSCs in different states. Like a study from Jharkhand found that the Gram Panchayat elections have not been held since long, yet the VHSCs have been formed in such a way that the committee could be linked with the respective Gram Panchayat when it is

created. The VHSCs have been formed separately and is different from the hamlet level committees; however, the members of the committee are from the village/hamlet. Function wise and constitution wise its roles are different from the hamlet level committees and the members are also different from other hamlets level committees. VHSCs formed in the first phase were characterized by irregular meetings. No training has been organized for VHC members.

Similarly in Hazaribagh district of Jharkhand it was found that a total of 1321 VHCs have been formed in 1358 villages. Out of the formed VHCs till date 519 VHCs have opened their bank account. There are 11 blocks in Hazaribag district. Ichak is the nearest block from Hazaribag. There are 116 revenue villages and about 123 Village Health Committees had been formed by the support of local NGO. Till this September 7, 2010 about 90 VHCs out of the 123 had opened their account. Out of them only 38 VHCs got their Untied Fund of Rs.10000/- each.

In the 116 villages of Ichak block a total of 123 VHCs have been formed but according to MOI/C, that no fund for VHC was received for Ichak Block, on the other hand out of 11 blocks of Hazaribag 6 blocks have been able to mobilize resources for VHCs. However, Six months earlier two cheques (Chengra VHC and Garga VHC) was received from District but not distributed to them as no proof of VHC members or VHC office bearers was available to the officials. It would be also imperative to know that out of the total 123 VHCs formed only 90 VHCs have so far been able to open their bank A/Cs. The block also has 285 Sahiyyas selected some 2 years ago and have undergone 3 phases of training.

So, the context presents on the one hand a myriad of challenges and at the same times expose to us a big opportunity to capitalize on the closeness of the block with the district, available resource of VHCs and its competency to ensure better community health services to the community as per the provisions and guideline of NRHM policy documents. Government was earlier fully dependent on NGO reporting to check the

progress. The government had partnered with NGOs to form VHCs through a facilitated community led process in the 1st and 2nd phase. However the government had withdrawn support to the NGOs and also had not placed an alternative since July, 2007.

No funds have been given from the governments. However many of the VHCs have been able to mobilize funds from government for other developmental purposes. No accounts have been fully opened so far except in the VHCs where the water and sanitation committee is also functional. The delay in disbursement was firstly due to delay in formulating and issuing guidelines and secondly a lack of readiness in state level decision making to pass the funds on. Now the funds have still not been released on the grounds that only after all bank accounts in a district are opened would the funds be given by cheque to the VHCs. In summary Jharkhand is a slow and steady situation - but rather too slow and not quite steady.

VHSC Formation and Meetings

In Laxmangarh block of Alwar the study found that there were irregular meetings of VHSCs, no documentation of minutes, apart from ANMs no other members were informed about the meetings. The interesting fact that came into light was the highest most attendance in the meeting that was meant for the formation of the VHSCs. ANMs played a major role in selection of the members of VHSC Apart from ANM no other frontline workers are informed about VHSC. The selection of members was done by ANM with the consultation of AWW. There is almost negligible participation by PRIs. In block meetings no discussion on VHSC formation and strengthening is done.

In Bikaner, the findings conclude that basically association process with VHSCs is influenced by ANMs. Though membership from PRIs was also seen in most of the VHSC but the representation from the community was quite low mainly due to the unwillingness from the Block. It was found that in many VHSC Government teachers were also associated with the VHSC. It is also seen during field visits that monthly

meeting are not organized regularly. Problems exist with selection process of VHSC members as well, un-equality of distribution of the responsibility among VHSC members, Lack of monitoring, limited fund provision, lack of initiatives by government. VHSC Constitution meeting was attended by many members, interestingly afterwards meetings was not attended by most of the members. It was also discovered that MCHN Day is also not organized monthly still VHSC members are not aware about MCHN Day as well as their role in organizing the MCHN day. The discussion in the meetings usually have the components of Sanitation, seasonal diseases, institutional delivery and polio eradication, It was found that all members did not actively participate in the meeting as few members dominate the meetings.

It was found that in most of the VHSC the discussion pivoted on their priorities such as water and sanitation works; second malaria control and then; works on seasonal diseases, Institutional delivery and polio eradication. It was usually seen that some members are participating actively while few are passive members. Thus it can be said that not all are contributing in VHSC in terms of Meeting organization and discussion held and action works after discussion in the meeting. Some members think regular meeting and conversation build bond within the VHSC. It is much more important to sit together and held conversation on local health issues

The important point that emerged was the understanding among the VHSC members on the VHSC as Institution as they said that Meetings and discussions are the key point to strengthen the VHSCs. Action works at local level will make these VHSC activated. Promotion to the each member by the government as some honorarium or some post for each the members. Some members think that there should be qualified and responsible people as it its members while four members think that distributions of responsibilities to each member will make VHSC strengthen. One respondent feel that monitoring should be strong, one respondent feel that fund provisions along with recognition will make VHSC sustainable

In Hazaribagh the study revealed that VHSC formation was facilitated mostly by local NGOs in the area and was formed during Gramsabhas. Community was informed about the meeting. Though few members harped that in the meeting only selected members were informed. The venue and time was decided in consensus with the members. Sahiya (ASHA) was the key person who was conferred the responsibility of organizing the meetings. The number of Participants in the meetings varies from 4-15 persons. Most of the Participants are women this shows little interest of men-folk in Health issues

The Participants shared that guideline for the formation of VHC has been shared and discussed with them, while some where ignorant about the guidelines but the community articulated criteria for a sound institution on representation from various marginalized issues. The study revealed that the formation of VHSC have few discrepancies such as less attendance, low representation of marginalized community, less clarity on the objective of the meetings etc

One of the interesting facts that was highlighted during the study was the symbiotic relationship between the VHC and the youth committees in few villages where both committees took joint action for regularizing ANM Visits. It is evident that the ASHA / Sahiya are playing a key role in mobilizing community and strengthening VHC in her villages and community too has faith on her. Mostly the discussion of the meetings is untied funds, Health and Hygiene, Government facilities, but they are not properly documented though some meetings were documented when meetings was facilitated by the local NGOs.

Another finding from East Singhbhum in Jharkhand was that monthly meetings are very irregular in the whole sample villages and even in the VHSC meetings community participation is very low. All responder said that in meetings they discussed on use of untied fund. Community participation is less in meeting due to lack of information about date of meeting.

The data from the district revealed that only Sahiyya and ANM have good knowledge about the formation of VHC all responder indicated that they all were not aware about the formation of VHC. It was also found that there was less community participation in VHC formation even in some place community have own conflict in formation of VHC.

Knowledge about Role and Responsibility Along with Representation

In Jharkhand it was found that all the respondents knew were the names of three office bearer but none knew of the roles and responsibilities that they are conferred. Even VHC members have lack of knowledge on their responsibilities. Only Sahiyya has little knowledge on VHC role and responsibilities. On representation of marginalized community, all said that there is less participation of vulnerable communities in VHC. Even in one VHC top two positions are being held by the men.

In Orissa, findings reveal that the members carry incomplete knowledge on VHSCs. They are not fully informed on the structure or processes of VHSCs but they have little knowledge on the functions of VHSCs. Though in some areas after facilitation VHSC have done unique activities for using VHSC untied fund, It was very interesting to note that despite the VHSC are not well formed and do not have much knowledge on functions well some VHSC have taken initiatives such as Cleaning the sewerage, Cutting of the 'kikar', Cleaning the village and checking the sanitation problems, Campaign for cleaning the village , Spray for malaria control, Gambusia fish and chlorine in the water tanks in the village, medicine dropping in drainage, Collective convincing to the people for cutting the *kikar* for malaria control.

In Orissa where the study was conducted in Sadar block, the meetings are regular and are conducted monthly. Some members take keen interest and also reflect on the resolutions made and action taken, though some members do not participate in any process of the meetings. The venues of the meeting usually are AWC or primary

schools. The information regarding the meeting is also not regularly communicated to block Program management unit for information and further action mainly due to unawareness. One of the facts that came into light was the absence of ANMs in most meetings, but there was regular presence of ASHA, AWW, PRI, SHG and CBOs. The members mostly discussed on the issue of Health and Nutrition, untied funds with very less discussion on the role of the frontline Health workers and Village plans.

Regarding initiation of meetings it is revealed that all the meetings were initiated by the AWW. But during the course of the meetings the PRIs have leading role in the discussion, responded to the queries of the members, participated in the discussion and discussed about implementation of different proposals made during the meeting.

After verification of secondary data of 6 GKS it was revealed that the ANM is not a member of any of the GKS. The ASHA and AWW are member in all the GKS, representation of PRI members, SHG groups, CBOs are ensured while formation of GKS. In all the GKS elected PRI is chairman. There were also many the chairperson is a women or from SC or ST community. From the data it is also revealed that there is no representation from Users' Group or PTA/MTA.

In Orissa while enquiring about their knowledge on GKS it was revealed that all the members are aware about the existence of GKS but are not aware about its roles and responsibilities.

While enquiring about training to the members of the GKS it is revealed that there was no sensitization training regarding the roles and responsibilities of GKS, health entitlements, maintenance of registers, assessment techniques or preparation of village health plan.

In Jharkhand, discussion on the issue revealed that in many cases only selected people were invited during the VHC formation process representation from marginalization sections were not invited during the VHSC Constitution meeting even the selection of

many VHSC Members was made without consensus, though the role of the Local NGOs was very crucial in the VHSC Constitution process. The most prevalent scenario that existed universally was the low awareness among the community on the roles and responsibilities of the VHSCs.

The members are ignorant as they are not aware about the objective behind the formation of VHSCs or under which Government Flagship program VHSCs has been constituted. They are even not aware on the status of Bank accounts and untied funds. The educated among them though have the knowledge regarding the untied funds sanctioned to VHSCs as untied fund, almost all the VHSCs are untrained, in some VHSCs still no untied fund has been allocated despite of regular visits to the centre. No monitoring mechanism has been developed for the performance as well as untied fund of the VHSCs

Though local NGOs have played a major role in the orientation of the VHSCs but unanimously member of each VHSC realized creating awareness among the community on Health and sanitation as their prime role.

Village Health Plans (VHPs)

In Orissa awareness regarding the Village Health Plan is very low. Very few VHSC members have knowledge on health priority and VHP. It is also a proven fact that no one has any idea about inclusion of the VHP in the block health plan. Few members have the information regarding discussion of the VHP in the Gram Sabhas. In Hazaribagh district of Jharkhand, findings show that till date there has been no village health plan. Community was unaware about the Village Health Plan preparation and its importance. There was no training and awareness on VHP to VHSC along with Sahiyya, ANM and Sevika. In Bikaner, Rajasthan the Block program manager (BPM) showed his concerns that a good concept like VHSC may lose its worth due to the gap between villagers and health workers. Block ASHA Facilitator (BAF) responded that it is a village level structure for development of the village and health while NGO representative

responded that VHSC can do make village health Plan and can do monitoring of health services but it requires good PRI representatives with ideology and education also. In East Singhbhum it was seen that village health planning was a distant dream as till now most of the VHSC are unaware about any such process though very few had been oriented by Local NGOs. In Alwar district of Rajasthan it was found that most of the VHSCs are not aware about their roles and functions though in some areas of Alwar it was found that some of the members are aware about the existence and objectives of VHSC. No one is aware about the decentralized planning hence no health plan has been made. No support has been extended by PHC/CHC.

Village Health and Nutrition Day (VHND)

In Hamirgarh, Bhilwara district of Rajasthan, VHSC members were aware of their membership but VHSC Members did not have knowledge about the VHND/MCHN Day and they did not play any role in organizing and monitoring of it. Though meetings are being conducted and in some places some instruments have been purchased with the VHSC Untied Funds, but all the members of VHSC are not aware on the utilization of fund on instruments. There is dire need to capacitate the VHSC on use of untied funds and MCHN Day. Similarly in Jharkhand, VHND is not organized as per guideline. All believe that VHND is same as Routine Immunization. Respondents said that during VHND, immunization and growth monitoring along with THR and sometime family planning counseling was organized in AWC. All believe that THR and immunization day is same of VHND. So all believe that this is a part of service and ANM duty to conduct the VHND/immunization on due date not by community.

Strikingly similar finding was in Bikaner district of Rajasthan where most of the VHSC members were informed about the VHSND but they were not willing to participate as most of them said that they are aware about the activities that are being conducted on VHSND. Though, many of them recognized the VHSND as Immunization day.

In Orissa, the study highlighted that some VHSC/GKS members did not attend the VHND and they did not associate with the service providers for ANC and Immunization services whereas majority of them have attended the VHND and most of the times they have informed others for immunization. But regarding ANC services the response is very low.

Untied Funds

In Bikaner the expenditure patterns of VHSC fund came as following:

1. Equipments at ICDS Centers and Sub-centers
2. Toilet constructions
3. Water Cooler, RO, Mats, Table- chairs etc.

All of these expenditures have been done at district or block level which was directed by the CMHO and higher authorities. The essence of such decentralized concepts will be worthless unless untied fund is being utilized at village level on VHSC consensus. While conducting meeting the community needs emerged like sanitation, toilet constructions, eradication of different type of diseases, health improvements, and convincing the people to work collectively on child health and institutional deliveries. About the fund sufficiency for VHSCs, BPM responded that the fund is sufficient and after it there should be participation of other departments also to provide funds to these VHSCs like Gram Panchayat, ICDS Department and Education department etc. while BAF responded that it is not sufficient and it should be based on the population. NGO representative responded that it is not sufficient to cover all health needs while there is not available any other source of fund to these VHSCs.

In Alwar district, it was found that only ANM is aware about the untied funds and in most of the places the untied funds remain unutilized.

In East Singhbhum all VHCs have bank accounts and have received VHC untied fund (Rs. 10000.00) except in one VHC of Kitadih due to dispute between community and

Gram pradhan. Available Fund was utilized in health and sanitary services. As per respondents nearly 20% of available fund has been utilized for stationary and cleanliness purpose. The reason behind was inactiveness of president, gaps in coordination and internal conflict. All of them suggest that lack of awareness in community regarding the untied fund is the reason behind less utilization of fund for common good.

In Gaya district of Bihar, the study suggested that annual untied grant at HSC is very meager amount in solving health related problem of all villages under HSC. It is also a bone of contention if ANM wished to help any poor for medical assistance the other member of community will also demand the same. This untied amount can be used in day to day maintenance of HSC like housekeeping, security, alternate arrangement of electricity, purchase of consumables, and maintenance of gardening or organising meeting at HSC level or in case of any emergency.

Capacity Building

In Rajasthan's Bikaner district all the respondents had received orientation about VHSCs as BPM and BAF have received the Block trainers' Training (BTT) for VHSC while NGO representative have received District Trainers' Training (DTT) for VHSCs but it need to be penetrate down to VHSC members

Monitoring mechanism of the VHC

Unanimously all respondents said that till now no mechanism had been developed by the VHSC on community based monitoring. In Muzaffarpur district of Bihar, the study focused on role of PRI in the functioning of Rogi Kalyan Samiti (RKS). Since this study was different from VHSC studies by other fellows, the findings are being put here separately. The follow up actions based on these recommendations will provide

impetus to achieve the stated objectives of this committee. These recommendations are presented below:

- a) There should be a complain box installed in every PHC for the patients and this boxes to be opened on three days before commencing of executive body meeting of RKS .Based on the suggestions/complaints the agenda of RKS should be decided
- b) 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.
- c) There should be a re-constitution of RKS and orientation of all members including chairman and secretary to achieve its goal in terms of improvement in quality of services.
- d) There should be a Development Plan for the hospitals to reach the Indian Public Health

Standards (IPHS) standards and an improved quality of service delivery in this ways:

1. Infrastructure Development and Management – Identify all gaps in civil works, furnishings and conveniences, uninterrupted electricity supply, water supply and sanitation, and in waste management.
2. Assessing requirements, Maintenance and Utilization of equipments
3. Medical and non-medical human resource requirements-
 - RKS will assess the requirement for human resources and make efforts to provide services managing the available manpower. It can re organize the available staff in hospital as per the requirements. Wherever possible, the old

staff will be trained for multi-skilling so that the financial pressure by the new appointments can be reduced.

- The Samiti could also make appointments on short term or on contract basis taking into account its own financial condition.
- The Samiti can take help from private sector and local units to fill the gaps in absence of trained staff.

4. Availability of medicines - The Samiti will ensure the availability of the medicines on the basis of the Essential Drug List specified by the state government, and make arrangements for their free distributions to poor patients. The Samiti will also make sure that the high-quality medicines are available for the other patients on reasonable price. Besides, the Samiti will be entitled to run a 24 hours medicine shop to provide medicines on reasonable rates.
5. Help and guidance to the patients – Providing information about available facilities in the hospital, if necessary, appointing a social worker for the purpose.
6. Catering Service: The Samiti is also to ensure availability of nutritious food for the admitted patients. The outdoor patients and their family members are being provided with food on subsidized rate.
7. Motivation of hospital staff - The Samiti contributes to keeping up the morale of all officers and employees, on the high level, and to develop a team spirit in them. The Samiti will encourage the performance by trainings, and giving recognition or awards.
8. Periodical review - All the work plans prepared by the Samiti would be reviewed by the Samiti itself and by technical assistance and supervisor bodies, at periodical intervals, so that their utility and effectiveness can be evaluated and improved upon. The annual plans also provide a useful reference point for community monitoring but it should tried to include representatives from NGOs and organizations working for peoples interest, respected citizens, individuals and organizations who willfully donate for the hospitals, representatives from industrial sector, who show their interest in the cause of doing welfare work for the patients.

9. There should be publicities about the services the RKS provide and broadcast its achievements. So that a sense of public ownership over public services for the quality of public services to be defended and built on.

Conclusions

It is clear from the findings of the researches undertaken by the Community Health Fellows in the four states that the concept of VHSC as envisaged under NRHM requires some more emphasis within the functioning of the public health services system to improve the objective of enhanced community participation and ownership of the health programs and services in all the states where the researches were done. The following conclusions were made through the studies of the Community Health Fellows:

It is seen that ANMs and CBOs / NGOs have played a crucial role in the formation and to some extent in formalizing the activity of VHSCs. CBOs / NGOs are the only support institution available at the community level for these VHSCs. Members responded that regular meeting/ participation of people and mutual coordination is still the challenge for VHSCs. There are other committees existing in the village level and there are some instances of collective actions, which is good for converging community actions.

There is a big challenge of knowledge about VHSC as even some of its members are not informed about it. Lack of responsibility and interest, motivation is also a challenge for village level committee. Community people were well informed about the objective of the meeting for VHC formation but the guideline and objective as to why the VHC is to be formed or what is the future role of VHC and its officials and members was not at all shared or informed. Majority said that the community members attended the meeting but the disadvantaged section could not attend because they were not encouraged to participate. The meeting of the VHC is irregular, besides that it's functioning is also affected by less and inactive attendance of the people. The ASHA is usually ignored in the meetings held at PHC. To activate VHSCs, the ASHA needs to be

given guidance. The representation of the SC, ST, Women, and Minority and Disabled is not adequate, as they are not getting proper space in the VHC.

Action works at local level is also required for strengthening the VHSCs. But There are problems with selection process of VHSC members as well, unequal distribution of responsibility among VHSC members, lack of monitoring, limited fund provision, lack of initiatives by government. The understanding about the role and responsibility of the VHC in improving the public health condition is not clear to the VHC officials and members. The larger role of VHSC is not clear to the officials and members; they just see that VHSC as to create awareness about health issue. Knowledge on untied fund is missing in almost all VHSCs .Majority of the respondent said that they don't know about the bank account opening status and also they have poor knowledge about untied fund.

No coordination or linkages of VHSC is being established with any other departments. Even at the community level the ASHA in many instances has been entrusted with the responsibility of taking the VHSC work forward and the involvement of community level front line workers like; ICDS, health, education etc was found to be negligible.

No training has been given to VHC officials and members regarding the role and functions of VHC. Because of which VHC is not able to play the critical role it is supposed or envisaged in the NRHM policy documents. The quality of documentation / report keeping of the VHC proceeding was not up to the level and it was not being done on a regular basis.

The VHSCs have no Village Health Plan and majority of the VHSCs don't have any monitoring and supervision mechanism.

Recommendations

- Almost all the studies have emphasized the need for capacity building of the members of the VHSC, use of untied fund, training developing the Village health plans and RKS. Training plan should be according to feasibility and available facilities and to be decided at district or block level not at state level.

The VHCs formed should be given training on phase wise manner (on role and responsibility of the VHC functionaries', objective of the VHC, guideline for the functioning of VHCs, reporting and documentation, use of Untied fund, structure of health departments, convergence and linkages, developing village health plan etc) for the proper functioning of VHCs to meet the need and aspiration of the people. VHSCs are in very loose form, they need to be capacitated on their roles, authorities and responsibilities. Should send guideline to the districts (for monitoring) and to the grass-root workers (for implementation).

- The processes such as regular monthly meetings, ensuring attendance, etc will improve the functioning of the institutions such as VHSC and RKS and help in improving Community mobilization for demand generation with the support of ASHA and VHSC. Members should be encouraged for 100% attendance with active participation in the meetings.

Formation of cluster of VHCs in which review and planning meeting should be organized on quarterly basis to review the progress of VHC work and sharing of learning.

- Mechanism should be established for better convergence and linkages with line departments. Interdepartmental convergence on issue of Health, ICDS and education along with Sanitation is what is desired at each level of government functioning.
- Efforts should be made for inclusion of largely excluded communities and the marginalized and minority communities should be given space in the VHSCs wherever possible. Representation from users' groups, VEC should also be ensured. Others members need to be motivated on their role for community development.

- A set of performance (monitoring and supervision) indicators should be developed and VHCs should be properly oriented on it so to monitor their performance themselves. Some external agency should also be deployed for measuring the performance and doing supportive supervision.
- Expediting the process of bank account opening and early release of untied fund. Untied fund should be increased.
- It should be ensured that the VHSC should discuss about the functioning of service providers as well as co-operate them in service delivery. There should be provision of sensitization training to the members of the GKS regarding the roles and responsibilities of GKS, health entitlements, maintenance of registers, assessment techniques or preparation of village health plan. VHSC can be strengthened when different interventions are made at various levels such as Village level block level, state level. During training it should be ensured that every member of the GKS is well conversant in prioritizing village health needs and preparation of village health plan. There should be orientation and sensitization to ASHA Supervisors and MO/ICs on VHSCs. How they can play an important role to support these VHSCs and its members including ASHAs and ANMs.
- State should give the parameters to the district and blocks to choose the members of VHSCs. Monitoring system should be stronger with tools of frequently field visits, participation in VHSC. Meetings, verifications of works, going at the place and generating monitoring reports for further evaluation toward betterment etc. it will facilitate regular Monthly meetings, appropriate use of untied fund of VHSC and innovations for community health.
- PRI members of the VHSCs need to be sensitized. The role of Swasthya Mitra (Students) can also be envisaged in the functioning of VHSCs. There should be an interdepartmental approach. For the purpose of making VHSC strengthen there is a need to capacitate each unit of the department which is associated with VHSCs. There are needs to capacitate ASHA, ANM, PRI Representatives, other members of VHSCs, ASHA Supervisors etc. PRI Representatives needed to

sensitize on the issues of health and VHSCs. There should be acknowledgement like appraisal cards etc by the department to the chairperson for forming a strong VHSC. Communication with the Block need to more strengthened

- ASHAs are needed to be updated and trained on VHSCs. ASHAs should have specific roles in VHSCs excluding meeting organization. It has been found that ANMs do not cooperate with ASHAs. They do not want to share authority regarding the use of untied funds
- ASHA supervisors can have additional responsibility of monitoring the VHSC function. Blocks to ensure that each letter or circular reach down to the ANMs and ASHA. Blocks should review of the reports of VHSCs and do monitor to MOs and ANMs also. Block can do more intensive monitoring rather than others. PHC/CHC and Sub-centers should ensure that Guideline of VHSC should reach in Hindi language till each the VHSC and its members. Each circular or letter which is relevant to the ASHA and ANMs should reach to them.
- Health department should ensure monthly meeting of AWW and ASHA with ANM on HSC .so, that they can share experiences, problem and achievements. It will be convenient for ANM to prepare monthly report and make plan for next month.
- Technical knowledge and Village Health Planning and for other processes of VHSCs, there should be one person (Coordinator- VHSC) minimum at block level. There should be fund provisions for VHSC monitoring. The monitoring reports should be generated at each level and send to higher authorities for further evaluation and improvements in the VHSC program. Technical person for VHSC development should be placed at each block of the state. ASHA Supervisors should be responsible for VHSC visits and to send its reports at higher level. This cadre of supervisors should be placed at each PHC and CHC for monitoring and support. Quarterly reports should send at block and district about meeting processes. UC of the fund should be produced after each quarter therefore misuse of the fund can be minimized.

- There should be a re-constitution of RKS and orientation of all members including chairman and secretary to achieve its goal in terms of improvement in quality of services.

SECTION TWO

INTRODUCTION

As is evident from the preceding section, most of the people selected as Fellows came from modest rural backgrounds and had chosen to work in the development sector, especially health, due to various reasons. Though all were graduates, the selection process clearly indicated the limitations of their education in terms of quality and depth, as a background against which basics of public health could be delivered.

The main objective of the Fellowship was also not to provide an academic input, but to create a human resource that was grounded in action while having the capacities to think afresh about the public health problems being encountered on a daily basis. The main objective was that Fellows could be made instrumental in the planning and implementing of health services based on local level or region specific needs.

The initiating PHRN team spent quite a lot of time during the preparatory phase deliberating upon the curriculum for the Fellowship as well as the idiom of capacity building to be used, as discussed in the preceding section. All things considered, it was decided that the methodology of Action Research was the most appropriate idiom for building the public health capacities of the Fellows though their baseline orientation to research was poor. Not only would this provide the tool or lens of research to be able to deal with real-life problems, it would also allow for action to be taken to facilitate change during the period of their Fellowship. It was planned that the academic inputs and support through the capacity building workshops and the provision of academic mentors would lead the Fellows through the phases of their action research, from identifying a topic, to framing aims and objectives, to selecting methodology and methods, creating tools, through their field work and analysis to finally creating a report.

As it transpired, during the two-year period of the Fellowship, most Fellows were only able to complete their baselines with rigour. Many proceeded to take action upon their findings. However, none could achieve a documentation of the 'endlines' of this action as a part of their research. The documentation of the action, thus, was only available through the process documentation of the entire Fellowship experience.

Fellows were free to choose topics of their interest, and it was also hoped that many would depart from health systems strengthening to other areas of work that linked them more directly to the community. Interestingly, most elected to remain in the safe territory of their regular and daily work with the health systems for communitisation. Thus, many Fellows chose topics related to the ASHA programme and the VHSCs and RKSs. However, a few, mainly the women Fellows, did choose to work on gender and nutrition related topics. As evident from the table below, many of the Fellows took

action to support community processes related to NRHM during the course of their Fellowship and studies.

As is the want of students newly enthused by the concepts of research, the Fellows were over ambitious and over confident regarding the scope and methodology of their research. Many, in their initial proposals, projected research across large geographical areas, multiple issues, sections of populations and facilities simultaneously. Though the academic mentors were able to convince most of them to focus and adopt more realistic sample sizes and methods, methodological confusions were found to persist over the entire course of the study and proved recalcitrant to corrective measures through the concurrent workshops.

Specifically, the differences between the overall perspectives and objectives that distinguish qualitative and quantitative research methodologies were not well understood. The Fellows showed an eagerness to demonstrate quantitative data, even from very small samples using purely qualitative methods, perhaps as a reflection of the value placed upon quantitative data in public health in their perception. Simultaneously, the trainers noted that simple mathematical concepts and calculations (such as 'mean, medium, mode' or 'percentages') were difficult for the participants to understand and caused much anxiety. Thus, while there was a value placed on quantitative analysis, skills in this area were poor. One Fellow used a questionnaire and delivered it successfully to a large sample and used it well for quantitative analysis as planned.

While most of the Fellows used qualitative methods such as FGDs and Semi Structured Interviews, they used these to derive numerical data. Thematic analysis was done as an additional commentary to the numerical data rather than to arrive at the primary findings. During the workshops on data analysis, the Fellows showed a genuine befuddlement and lack of conviction regarding analysis of qualitative data. Concepts of representing data through thick rich descriptions were not employed though the settings were particularly appropriate for the use of such techniques. Since the Fellows did not necessarily have a background of academic work in the areas they had chosen, or even in public health, it was understandably difficult for them to discuss their findings. In other words – they could not ably demonstrate the value of their own work though its potential and value was quite evident to the academic mentors.

In all, fairness, a two-year non-academic Fellowship programme that is related primarily to action can only introduce concepts of research methodology. However, experience suggests that the curriculum needs attention to deal with methodological issues better for future courses. In the final analysis, the Fellows did not deliver research that was of

the rigorous quality that could result in publications. However, as an introduction to research, the exercise was more than fruitful for all the Fellows.

"A positive aspect of Fellowship was the combination of academic and field exposure"
Shiv Kumar Acharya, Rajasthan

Many interventions were made on the ground as a result of the action research exercise.

A Fellow who did her research on Kala Azar in Bihar also worked through the VHSC to create awareness about preventive measures for Kala Azar thus ensuring community participation. Two Fellows whose research topics focused on adolescent reproductive and sexual health supported the NRHM processes by creating awareness on reproductive health and in the second case starting an adolescent health clinic in a PHC. Five of the Fellows whose research work focused on VHSCs worked towards strengthening them in some of the villages. In a study on RKS, the Fellow attempted to regularise RKS meetings through advocacy. Another research study that focused on improving quality of services in health institutions ensured free radiology and pathology tests for BPL and APL patients in as District Hospital, Sub Divisional Hospital, Referral Hospital and Primary Health Centre.

Some Fellows from Rajasthan have gone on to participate later in subsequent research that builds upon their learnings during the Fellowship. These studies were to do with the NRHM processes in Rajasthan.

Notwithstanding the limited academic rigour of the research done during the Fellowship, it does throw up new information and perspective which is entirely local and contextual to the district in which the research was housed. As the subsequent sections demonstrate, the cumulative evidence derived from the research done by the Fellows forms an interesting juxtaposition with existing theory on the public health issues that are currently being hotly discussed and debated in India. We bring you analysis of the issues revealed by the research done by the Fellows in their districts, and its relationship with the existing discourse on these issues in India in the subsequent sections.

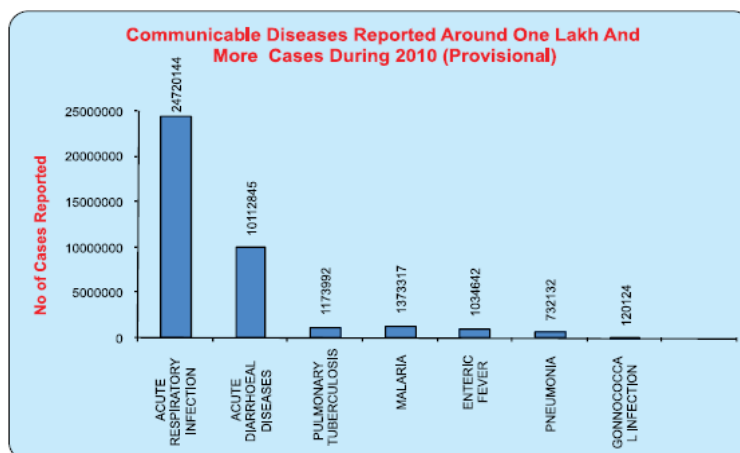
CHAPTER FIVE

People's Participation and Communicable Diseases Programmes

This chapter looks at communicable disease programmes in reference to the four studies on this theme conducted by the Fellows. Three diseases have been highlighted – Malaria, Tuberculosis and Kala-azar. Kala-azar is endemic in Bihar and Jharkhand and two fellows from each of this state have taken that up as a topic for action work and research. The chapter focuses on the importance of social determinants of diseases and the importance of prevention at the community level through participation and improved awareness on these diseases.

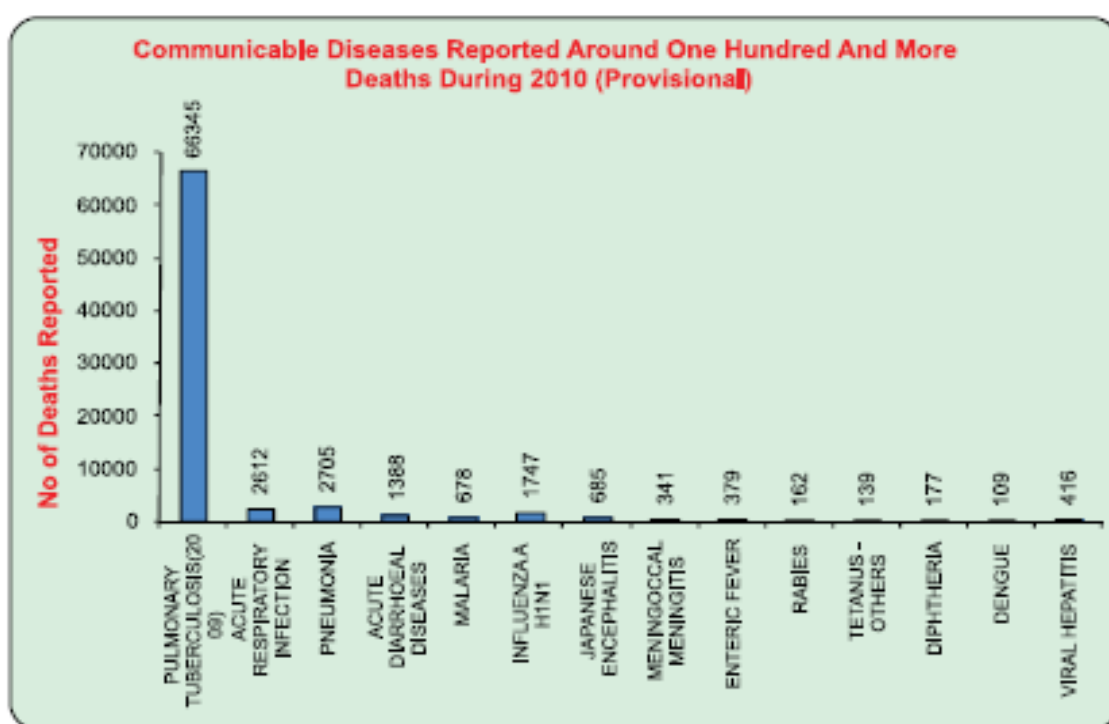
The Communicable Diseases Situation

The burden of communicable diseases is huge in the country. Despite non-communicable diseases emerging as the major cause of all deaths in the country, communicable diseases continue to be a significant challenge. Respiratory and enteric infections are major challenges among children (accounting for most of the mortality), while TB and vector borne diseases are serious problems among adults. As part of our national health programmes we have had vertical programmes for communicable diseases – mainly for vector borne (Malaria, Kala-azar, Dengue, Filariasis, Japanese encephalitis and Chikungunya), Tuberculosis and Leprosy. **Figure 5.1**



Of deaths from communicable diseases, pulmonary TB emerged as the largest cause of death. Deaths (per 100,000 population) from all major communicable diseases show a declining trend in the last decade except for TB that shows a sharp increase.

Figure 5.2



Deaths due to TB exceed the combined deaths from all other communicable diseases and accounted for 26% of all avoidable adult deaths. TB is also the leading killer of women, causing more orphans than those produced by all causes of maternal mortality combined¹⁰⁸.

Incidence rates and death rates due to Malaria have been on the decline during the last decade. Kala-azar also shows a similar decline.

108 GOI, TB Annual Report, Ministry of Health and Family Welfare, New Delhi, 2009.

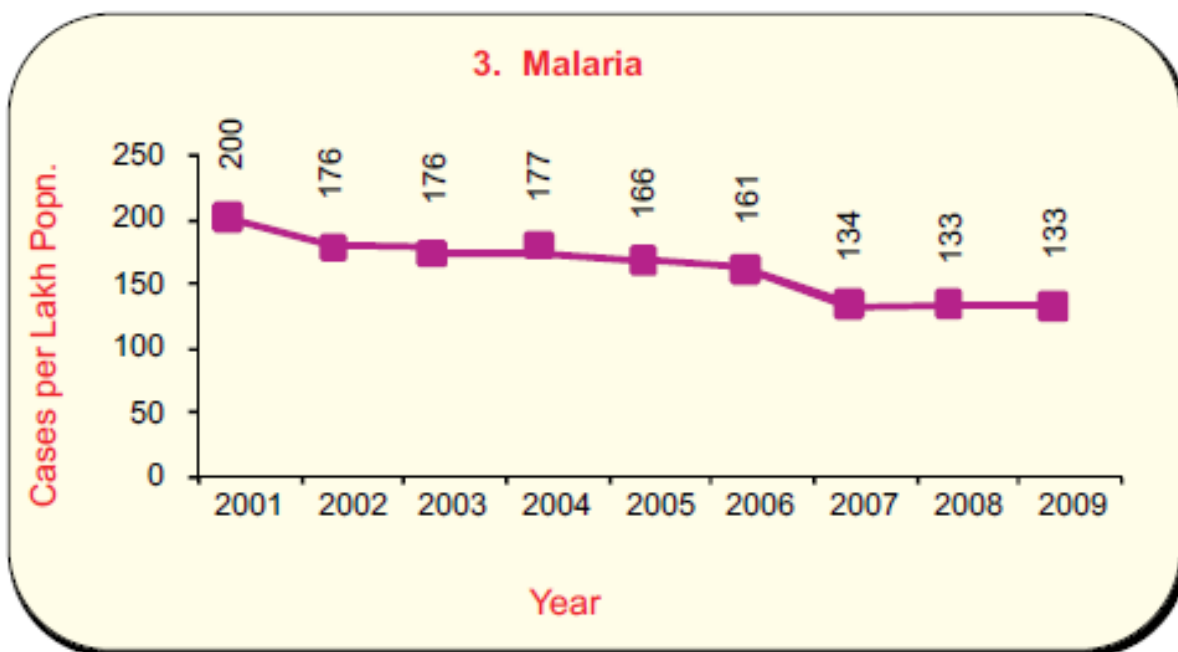
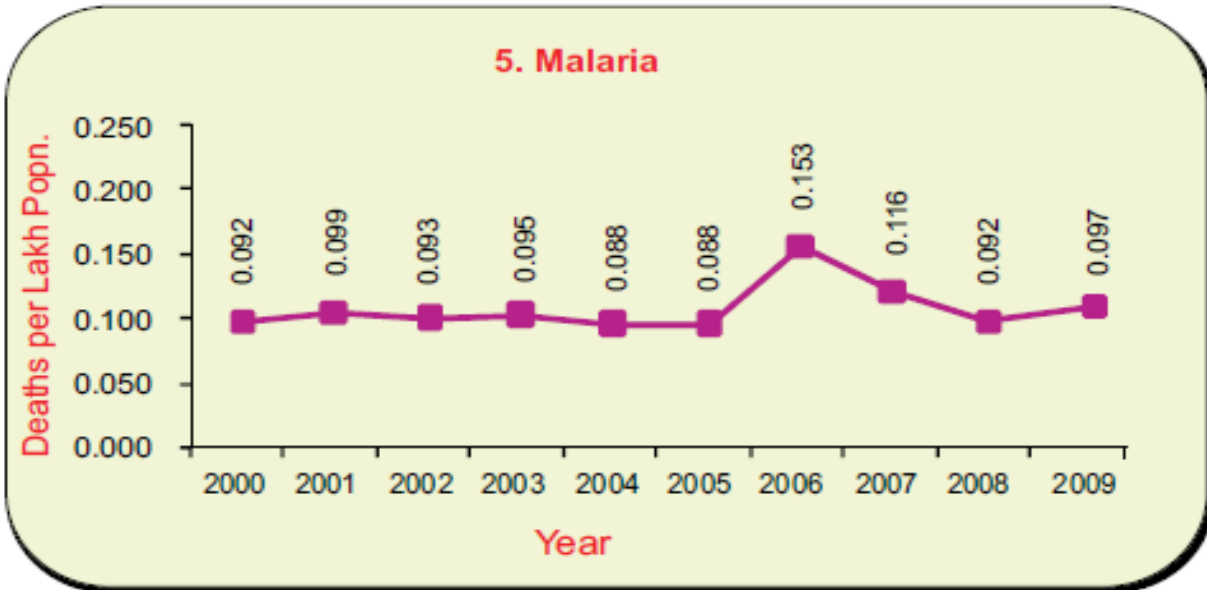


Figure 5.3: Malaria Deaths in 2001-09

Figure 5.4: Malaria Cases in 2001-09

The Fourth Common Review Mission¹⁰⁹ of the National Rural Health Mission (NRHM) made the following observations about these diseases:

- Case detection of TB should improve and for this the private sector needs to be roped in more pro-actively.
- The slow implementation of MDR-TB control measures was also a cause for concern.
- Rogi Kalyan Samiti (RKS) and untied were being innovatively used in Orissa to provide for nutritious food to TB patients.
- ASHAs were contributing to both RNTCP anti-Malaria programmes in many states.
- Low case detections of TB were reported from Arunachal Pradesh, Punjab, Jharkhand, and Uttar Pradesh while improvements were reported from Orissa, Madhya Pradesh, Rajasthan and Maharashtra.
- Treatment completion rates of TB were a matter of concern in Uttar Pradesh and Jharkhand.
- Lack of microscopy centres, staff and consumables were reported from Jharkhand.
- It was recommended that the posts of male workers should be filled up to strengthen control of both Malaria and Kala-azar. Completion of training of male workers and ASHAs were recommended to be considered as a priority. In Madhya Pradesh, for example, ASHAs have been trained in preparation of Malaria slides in 9 districts (where the programme is supported by the World Bank project).
- Several states were reported to have completed training in use of Rapid Diagnostic Kits and management of Fever Treatment Depots, with favourable outcomes.

¹⁰⁹ GOI, Fourth Common Review Mission, National Rural Health Mission, Ministry of Health and Family Welfare, New Delhi, 2010

- Shortages of insecticide treated nets were reported from major states such as Chhattisgarh, Maharashtra and Kerala.
- Though an overall decline for Malaria has been reported, infection was spreading to newer areas and populations on account of large scale movements of migrants.
- ASHAs were being paid incentives for vector borne diseases activities in a few states.

Addressing the Social Determinants of TB

Most of the risk factors of increased exposure to TB and of increased progression from infection to disease relate to social determinants. Malnutrition is the most critical of these and closely linked to poverty, particularly chronic poverty. With a large section of the population below the poverty line, high tuberculosis prevalence is inevitable. Poverty acts not only through malnutrition but also acts through living and working conditions. Where housing is poor and people live in overcrowded settlements and where the conditions of work are such that the atmosphere is dusty and the lungs are compromised due to this, tuberculosis is far more frequent. Where there is in addition high physical stress, the risks of TB mount. Thus in addition to the programme for identifying and treating TB cases there needs to be a set of social measures that allow the poor and the sick, the minimum conditions of life. This should be independent of their earning capacity, knowing full well that their earning capacity would be compromised by the disease. There is also a need to improve occupational health through regulation of working conditions and the possibility of employers having to pay compensation for TB incurred in their premises. In the long run, reduction of malnutrition and poverty and improved working and living conditions in combination

with access to good diagnostic facilities and chemotherapy are the only sure way of eliminating TB.¹¹⁰

The main control strategy that is used today is called DOTS (Directly Observed Treatment, Short course). Its major components are:

1. Government/political commitment to sustained TB control activities.
2. Case detection by Microscopic Examination of Sputum smears among symptomatic patients who self-report to health services.
3. Standardised regimens of six to eight months treatment at least for all confirmed sputum positive cases, with directly observed treatment (DOT) for the initial two months. A regular, uninterrupted supply of all essential anti-TB drugs.
4. A standardised recording and reporting system that allows assessment treatment results for each patient and of the TB control programme overall.

Preventing and Controlling Malaria

About 95% of the population in the country live in areas that are endemic for Malaria. However, 80% of Malaria cases are reported from among populations located in hilly, tribal and inaccessible areas. Over the last 15 years (1995-2010), Malaria cases and deaths declined from 1.14 million to 0.77 million and from 1151 to 767 respectively. Annual Parasite Index (API) reduced to about a third from 3.29 to 1.3. Significantly, the proportion of falciparum cases has steadily increased from 38.84% to 52.12%.

The programmatic approach has largely emphasised early diagnosis and prompt treatment. Early diagnosis is important because in the early stages the infected persons have only asexual forms of plasmodia in his blood – which are not infective to mosquitoes. If the blood is cleared of the parasites in time then the transmission from that person is reduced. It takes about 4 to 5 days after the person has developed fever to develop the sexual forms of *P. Vivax* in the blood. For *P. falciparum* infections it takes 10 to 12 days before the blood becomes infective. The aim of this strategy is to suspect

¹¹⁰ PHRN, Book 8 - *Disease Control Programmes*, Public Health Resource Network, New Delhi, 2008

and treat cases of Malaria as early as possible. Chloroquine is the most commonly used drug for this role. In low transmission areas, i.e. where the Entomological Inoculation Rate (EIR) is low, there is a much greater effect of early diagnosis and prompt treatment. Since most infective people are also symptomatic for the disease, i.e. they have fever, treating all cases of fever within the first week would be able to cut transmission dramatically. In high transmission areas however, many of the persons who are carrying the sexual forms of plasmodia in their blood are not having fever or any other symptoms of disease and therefore if this is the only measure used – it would not be as effective¹¹¹.

The transmission of Malaria is facilitated when:

- a) There are less infected people available, who have sexual forms of protozoa in their blood, for mosquitoes to get Malaria infested.
- b) There are not enough mosquitoes that are Malaria-infested because the total population of mosquitoes have decreased.
- c) There are not enough infectious bites delivered because people have taken measures to prevent themselves from being bitten by mosquitoes.

The NVBDCP program also introduced Rapid Diagnostic Kits (RDks) in remote and inaccessible areas reporting more than 30% *P. falciparum* cases among all cases diagnosed by the government health services. Though a valuable technological development, this is costly (over Rs. 30 per test) and hence the need to limit it to remote areas where there are no laboratory technicians. Unfortunately often this is used only in those areas where such services are available. High ambient temperatures (over 30 degrees Celsius) affect the efficacy of RDks. Hence, there is need for proper cooling at lower levels to maintain the quality of RDks, especially in summer and rainy seasons. The choice between using the kits and microscopy is contingent upon several factors: health worker skills, optimising use of microscopes for other diseases and case load. If the case load is high, microscopy may be the method of choice.

¹¹¹ Ibid, 2008

Integrated Vector Management (IVM) is a critical component of Malaria control and involves focussed application of vector control measures. An understanding of the eco-epidemiological situation of the disease and its vectors is important. Insecticide Treated Bednets are being advocated where the vector is exophilic while Indoor Residual Spray (IRS) is the method of choice for endophagic vectors. Long-lasting Impregnated Nets have a life-span of three to five years and is increasingly being used. The impregnated nets are being supplemented in areas where coverage with IRS is below the desired level.

Coping with Kala-azar

As is fairly well known, Kala-azar is endemic in four eastern states of the country: Bihar, Jharkhand, Uttar Pradesh and West Bengal. An estimated 165 million population across 48 districts are at risk, most of them belonging to disadvantaged sections of the population. In the last five years, all states reported a decline in cases except Jharkhand where cases have nearly doubled in the last three years. The National Health Policy set 2010 as the target date for the elimination programme which is a fully supported by the central government. Key components being implemented under the Kala-azar elimination program include:

- State and district-level action plans
- Templates for district action plan
- Communication and media plans
- Patient coding scheme
- Kala-azar treatment cards
- Monthly Kala-azar reporting formats
- Introduction of rK39 diagnostic kits and Miltefosine
- Free diets to patients and incentives for loss of wages

- Construction of *pucca* houses for Musahar communities in collaboration with the Ministry of Rural Development¹¹²

In India, the disease primarily affects adults and children under 10 years. Infants are spared but have been reported from some countries such as Malta. Human migration is increasingly leading to the spread of the disease from non-endemic to endemic areas, and can emerge as a serious limiting factor to the elimination initiatives. The living and working conditions of migrant labour may facilitate transmission. Some of the necessary conditions include: heavy rainfall, high ambient environmental temperature, vegetation and subsoil water. Poor health service infrastructure and performance add to delays in diagnosis and treatment, thereby facilitating onward transmission. Evidence from some of the poorest rural communities of Bihar has underscored the importance of bridging the gap between the outbreaks of the disease and failure to reach the information to the authority. Effective anti-poverty and housing schemes for the poor need to be complementary to health service inputs as the failure of three earlier initiatives of elimination have demonstrated.

The milestones in the Kala-azar control/elimination activities include:

- Marked decline during 1953-58 as a collateral gain of DDT spraying under the Malaria eradication activities
- Resurgence during 1970s, following the withdrawal of indoor residual spraying; starting initially in four districts of Bihar and then spreading to adjacent states
- 77,000+ cases and 1000+ deaths in 1992 that led to the initiation of the centrally supported control program
- Expert's committee's recommendation for an elimination programme in 2000
- Inclusion of 2010 as the target date for elimination in the National Health Policy 2002
- Tripartite Memorandum of Understanding between India, Nepal and Bangladesh for elimination by 2015

¹¹² Ibid., 2008

Studies by Community Health Fellows

Four studies by Community Health Fellows highlighted some of the grassroots level aspects of three communicable diseases programmes in Bihar and Jharkhand – TB, Malaria and Kala-azar:

- A survey of Knowledge and Attitude of community about Tuberculosis and Revised National Tuberculosis Control Programme (RNTCP) in Rohtas District, Bihar
- A Study on Awareness and Behaviour towards Malaria Prevention and Treatment amongst Paharia Tribe of Godda District, Jharkhand
- Community Participation in the Control of Kala-azar and its Impact: An Action Research in Jehanabad District, Bihar
- Role of Sahiyya and Village Health Committee towards Elimination of Kala-azar: A Study in Sahibganj District, Jharkhand

District Profiles

Rohtas, Bihar

The social and economic profile of the district is as follows. Rohtas district has a strong hold of tradition with a high value placed on joint family, kinship, caste and community. The villages of Rohtas have old social hierarchies and caste equations still shape the local development. The society is feudal and caste ridden. The main occupation of the people in Rohtas is Agriculture and daily wage labour. A large number of the youth

population migrates in search of jobs to the other states like Delhi, Kolkata, Punjab, Maharashtra, Gujarat. The main crops are Wheat, Paddy, Pulses, and Oilseeds. Rohtas has a population of 2.5 lakhs with 18.8 % Scheduled Caste population.

Table 5.1: *Health Services in Rohtas*

S. No.	Characteristics	No. in district
1	District hospital	01
2	Sub divisional hospital	01
3	Referral hospital	02
4	Primary health centre(PHC)	19
5	Additional primary health centre(APHC)	32
6	Health sub centre(HSC)	186
7	Blood bank	01(Non Functional)
8	Aids control society	NA
9	Doctors	122
10	ANM	476(190 Contractual)
11	Grade A Nurse	28(14 Contractual)
12	Block Extension Educator	03
13	Pharmacist	04
14	Lab Technician	04
15	Health Educator	27
16	L.H.V	08

Jehanabad, Bihar

Jehanabad has a population of 1.6 lakhs with an 18.4 % SC population. The female literacy rate is 40.1 %. The main occupation in Jehananbad is also agriculture.

Table 5.2: *Health Care Infrastructure*

S. No.	Health Facilities	Number
1	District Hospital	1
2	Sub-Divisional Hospital	1
3	Referral Hospital	2
4	Block P.H.C.	7
5	Addl. PHCs	32
6	Sub-centre	92
7	T.B. Sanitarium	1
8	Leprosy control unit	1

Godda and Sahibganj, Jharkhand

Godda has a population of over a lakh with 23.6 % ST population and 8.5 % SC population. The main economic activity is agriculture. According to the latest census the population is over 13 lakhs.

Sahibganj district population is around 9.5 lakhs with a population 30 % and 6.5 % SC population.

Table 5.3: *Health Facilities in Sahibganj*

S.No.	Type of Units	No. of Units	No. of Beds	No. of Doctors
1	Sadar Hospital	1	60	9
2	Referral Hospital	2	60	5
3	Primary Health Centre	7	42	17

4	Addl. Primary Health Centre	10	60	10
5	Health Sub - Centre	141	---	---
6	Family Welfare Centre	7	---	---
7	Maternity & Child Health Centre	2	---	---
8	District T.B. Centre	1	---	1

Objectives

The first two studies assessed knowledge and awareness about the two diseases – one a respiratory infection and the other a vector borne infection. The studies on Kala-azar examined community participation in a district in Bihar and the role of communization processes in a district in Jharkhand.

Methodology

These studies involved two to eight villages at each of these sites. While the TB study collected quantitative data through structured questionnaires and randomly sampling respondents, the other three studies chose respondents purposively and employed a variety of methods (mapping, semi-structured interviews, focus group discussions, case studies and observations) to collect qualitative data. The respondents for all these methods were members of the community – ASHAs, PRIs, VHSCs and beneficiaries (affected and those not affected by the disease). In some cases, providers at the facility were also interviewed.

Table 5.4: *Sample Size for Interviews*

Districts	Patients/ Beneficiaries	ASHAs/Sahiyas	VHSCs (members)	ANMs	Officials at the facility
Rohtas	200				
Godda	80				
Jehanabad	22				2
Sahibganj	6	6	6	3	1

Findings from the Studies

Perceptions about Infections (TB and Malaria)

In the study from Rohtas district, the major source of *knowledge about TB* was through family, friends, neighbours and colleagues, as against the media (16%, N= 200) and health worker/health staff (3%). A huge unmet need emerged, dispersed through media regarding TB and various program related to it. Further, the health staff was not playing much role in imparting information about TB. Information about the disease obtained through family and friends was mostly incorrect. Since media (both print and electronic) did not seem to be contributing to imparting information in an effective way, it was concluded that literacy (or illiteracy) did not affect access to information about the disease in the studied sample of respondents.

Regarding the *perception of seriousness of TB*, a major proportion of respondents felt that it was a serious ailment. On being asked which parts of the body were generally affected, 72.4% correctly identified the chest as being most prone to TB. However, 21% did not have any knowledge about this.

A very small number of the respondents rightly identified all the *symptoms of TB* from a given list. 41% of the respondents said that continuous cough for more than 2 weeks was a sure sign of TB.

Regarding the *spread of disease*, only a small percentage could rightly identify that it spread through sneezing and/or coughing. Most people believed that TB spread either through physical contact or sneezing and/or coughing or both. 17% of the respondents did not know how it spread. Only 4 out of 156 (2.56%) people said that if left untreated TB could lead to further spread of the infection in the community apart from causing death of infected persons.

The idea of *prevention of TB* was also misplaced; a large proportion responded that avoiding physical contact with an infected person was the best way to prevent spread of TB; others were not aware of any method of prevention. A majority of the respondents were aware that it was an infectious disease but a third considered TB to be hereditary.

The *diagnosis of TB* in RNTCP is based on sputum examination; only 2% of the respondents knew that it was the currently used method of diagnosis. The rest believed that X-ray, blood, urine and stool testing was necessary for diagnosis. Only a fourth of the respondents knew about a public health facility that provided diagnostic services for TB and most did not have any idea about the RNTCP though this is a well functioning programme. About 96% of the respondents knew about DOTS though. These *facilities* thus remained underutilized due to lack of awareness. About a fifth of the respondents said that they did not like to visit a public health facility because they did not trust the doctor. Private treatment of TB was very costly as admitted by the majority of respondents; despite this, a large proportion of the population did not know about the free treatment of TB in public facilities.

For assessing *people's attitude towards TB*, respondents were asked how would they react if they were diagnosed with TB, most said that they will feel hopeless and afraid. Interestingly, there was no difference of opinion between literate and illiterate

respondents on this issue. Almost an equal number of respondents shared their preference for visiting a PHC and a private facility for the treatment.

In the study on malaria in Godda district that had responses from 80 beneficiaries, 87.5% of the respondents opined that Malaria *was preventable*. Preventive methods included - mosquito net (58.75%), fire wood (20%) or both (7.5%). Less than a third of the sample (28.75%) reported having seen or heard of Malaria campaigns. When probed about DDT spray, 81.25% mentioned having heard about it. The median frequency of DDT spray in these villages is 4 years. 75% believed that severe Malaria can be fatal. 25% of the respondents knew someone who had died of Malaria and 71.25% of them (respondents) had at least an episode of Malaria in the last one year. About 10% were never treated. 40% of those treated visited RMPs and some others, faith healers. Nearly three-fourths felt that most of the mosquito bites occurred inside the home, after darkness. The survey was conducted during March (winter) and 81.25% responded sleeping inside the house, on cots. Only a third of the adult respondents and an eighth of the children reported wearing full-length clothes (*pajama, lungi* and full sleeve shirt) during sleeping. Utilisation of mosquito nets is high, but they are not able to buy additional nets due to costs.

Most community members were unaware about *causes, preventive and curative aspects of Malaria*. They did not have information about the facilities provided for these diseases in government hospitals. Further, they were completely unaware about their role and contribution in control and prevention of the disease.

The wide gap between the number of reported and estimated cases constrains planning of elimination. At present, diagnosis and treatment have been limited to large hospitals. The poor often seek treatment from private doctors or even 'quacks', which provide expensive, incomplete or inappropriate treatment leading to continued transmission of the disease. The currently used drugs show variable efficacy and are toxic. Patients with only skin signs (resulting from delayed or incomplete treatment) are reservoirs of

infection responsible for continued transmission. These patients are difficult to diagnose and treat.

Responding to the threat of Kala-azar

In Jehanabad district, Kala-azar affected respondents reported the following symptoms: continuous fever, swelling in the liver, loss of appetite, abdominal pain, problem in stool, cough and cold. Only 3 out of 22 accessed treatments from the District Hospital; most of the others were unaware of the free facilities and incentives available at the district hospital. The predominant reason for not seeking care in government facility seemed to be a perceived lack of medicines, care and faith.

Interviews with MO of PHC and Block health educators on Sahibganj district revealed that the PHC was the weakest link for effective management and control of the disease. Diagnostic and inpatient facilities at the PHC were conspicuous by absence. Discussion with PRI members also brought forth the lack of knowledge on the disease though they are aware of the high prevalence.

In terms of *accessibility to health services*, local informal practitioners were the most accessed since they visited sampled villages almost every day. For most villages, nearest SCs were at a distance of 3 to 6 kms. The farthest of the three sampled villages had no idea of the services available in the SC. The VHC members of the non-SC villages had no idea of the SC and it is the block hospital which is 13 kms away that the people go to. There is no regular transport facility available.

Cerebral malaria, Kala-azar, TB and diarrhoea were considered as the most prevalent diseases in the community. Kala-azar was ranked as the second in terms of occurrence by all Sahiyyas and VHSC members after cerebral malaria. Dark and black body colour, enlargement and swelling of stomach and abdomen were the most identified symptoms among the Kala-azar patients. Shrinking of body and emaciation were the second most identified signs.

The study focused on the following issues: perception of severity of the disease (period of suffering, case fatality); perceptions on prevention; knowledge on diagnosis and treatment; perceptions of time taken to treat and costs; knowledge about post-treatment manifestations; knowledge on government initiatives (incentives and IEC); and, perceptions of Sahiyya and VHC role to eliminate the disease. The study brings forth very low knowledge levels amongst Sahiyyas, VHC members and communities affected by Kala-azar.

Concluding Remarks

National health programmes are generally directed towards combating diseases and give more weight to curative dimension. One also needs to have a wider perspective and question the existing policies. Formulation of any programme should take into account both the components of health services and the socio-economic determinants of diseases. Prevention is an important component of these disease programmes. This includes community participation and increased awareness towards these diseases.

All the studies here discuss the importance of the role of community in preventing communicable diseases. Community participation brings in the involvement of all communitisation processes introduced with NRHM – hence, role of ASHAs, VHSCs, RKS are critical in disease prevention and care. These studies show that there is lack of involvement by these members on communicable diseases. Only the ASHA is involved to some extent in the curative component of Tuberculosis. The communicable diseases addressed through these four inquiries are endemic and often fatal. Intricately linked with poverty and marginalisation, it is no surprise that these are major problems among the states of Bihar and Jharkhand. TB, Malaria and Kala-azar have large, well-funded programs; further Kala-azar is a candidate disease for elimination. While RNTCP can be considered to be quasi-vertical in nature, the others are delivered through the primary healthcare service system. Media campaigns and social mobilisation strategies are key components of these programs. The lack of knowledge or sensitisation among healthcare workers, as well as community members, is significant but perhaps not

surprising given the state of functioning of these programmes in these states. These high-focus programs are delivered through the general health services, which as each of these studies bring out is extremely weak. The NRHM has sought to strengthen infrastructure and human resources. Much of the focus has been RCH-centric and has not been able to transcend this conventional wisdom. The emergence of non-communicable diseases (NCDs) is as real as enormous. Clearly primary healthcare is still deficient and people are dependent on unqualified informal practitioners or having to travel to urban centres. The inability to cope with the unfinished agenda of communicable diseases has been brought out by these studies as a stark reality. Communitisation processes have emphasised on governing the structural aspects of the NRHM (such as, untied funds or decentralised planning) but not engaged itself with human suffering (communicable diseases, in this instance). And that is a sad testimony as the NRHM (in its first *avatar*, 2005-12) draws to a close.

Recommendations

The studies on Kala-azar *recommend* the following strategies to be included for reaching the goal of elimination of Kala-azar - Develop a pragmatic training module for Sahiyya and VHC on Kala-azar and impart training to Sahiyyas and VHCs; Develop a community level plan for Kala-azar elimination; Orientation of the all the front line government health workers on Kala-azar and strengthening linkage with the community.

Proper strengthening of the information system between the district administration, PHC and village level is needed to bridge the gap between the outbreaks of the disease and failure to reach the information to the authority. District authorities must be more responsive to the needs of the patients, arranging for better diagnostic tests and drugs, and good housing programme for the poor. Effective antipoverty programme will help the affected families to improve their economic condition. Only if the present programme is enriched with these inputs for at least 10 years can the elimination of Kala-azar be possible as short duration programmes in the past have failed.

In another study knowledge on malaria is fairly high but the preventive measures are not taken up because of poor behavior and attitude toward malaria prevention. Better BCC programs and capacity building of VHSCs and Sahiyyas are recommended.

When discussing about uses of TB services it is found that people lack trust in the public health system and hence approach the private facilities. The present improvement in the facilities at PHC is not enough to address the health need of the people. There is a need to strengthen the system up to a point where the faith of the people is restored. Spending on building physical infrastructure alone is not enough, it is equally important to ensure patient satisfaction by taking care of the qualitative aspects of service delivery in public health facilities.

In general communicable diseases still take a large toll [mortality as in TB or morbidity as in malaria or Kala-azar] among significant populations. It should continue to be on the radar and involve and mandate case detection and reporting by private sector, initiate nutrition interventions among TB patients, recruit/fill up male workers, particularly for care of communicable (and non-communicable) diseases; strengthen incentivising ASHA for communicable diseases; use untied funds for addressing communicable disease requirements and innovate IEC strategies for both front-line health workers and communities.

Chapter Six

Status of Reproductive and Child Health

Reproductive and Child Health (RCH) is an area of work in health policy and programmes that relates to health issues associated with the processes of reproduction and the survival, growth and development of the child born. Reproduction is an essential aspect of human life, the outcome of sexual activity and hence is intimately linked to individual sexuality and sexual health. It is not a disease, but is enmeshed into the social and cultural fabric of communities - controlling and managing reproduction and sexuality is the organising principle for many fundamental institutions of society such as gender, marriage and family.

The scope of Reproductive and Child Health (RCH) programmes extends across the entire human lifecycle – from the period of sexual maturity and the initiation of sexual activity during adolescence to conception, childbirth and the growth and development of the child. Moreover, since health during all of these stages of life is determined by resources and practices framed by social structures, norms and cultural traditions, reproductive and child health programmes, more than any other health programmes need to be sensitive to and engage with the socio-cultural determinants of health.

Reproductive health and child health are usually linked in health policy and programmes because of the intergenerational biological continuity between the mother and the child – evidence indicates that the health of the child is determined to a large extent by the health of the mother not only during pregnancy but also during her own childhood, adolescence and as an adult. Further, it is now well established that the social status of the mother is a crucial determinant of child health and has a greater impact on child health in South Asia than in other regions of the world.

Given the intimate biological and social links between mother and child, RCH programmes are often interpreted and implemented largely as maternal and child health programmes concerned with the health and survival of the mother during

pregnancy and delivery and then focused on the survival and health of the child. However, a comprehensive RCH programme should ideally create an environment and provide services that enable men and women to take control of their bodies and lives in sexual and reproductive matters. It should, therefore, include components on adolescent nutrition and sex education, family planning, antenatal care, safe delivery, postnatal care, reproductive tract infections, sexually transmitted infections and child health. Additionally, given that men are equal if not dominant participants in the reproductive process, their involvement is crucial in improving attitudes towards and practices of reproductive health. RCH programmes should therefore ensure an appropriate focus on both men and women and not resort to the undue targeting of women especially in family planning and sexual health matters, which has unfortunately been the tradition in Indian RCH programmes.

Status of Reproductive and Child Health in India

The status of reproductive health and child health in India is poor with nearly 212 mothers dying during childbirth for every 100,000 live births¹¹³ and 50 infants of every 1000 born live, dying during the first year¹¹⁴. While these figures represent an improvement over the past decade when the maternal mortality ratio (MMR) was 318¹¹⁵ and the infant mortality rate (IMR) was 68¹¹⁶, they are still much higher than a MMR of 40 and IMR of 17 for China, 200 and 39 for Asia and 14 and 5 respectively for the industrialised world^{117,118}. In fact, given that India has the highest number of live births

¹¹³ Special Bulletin on Maternal Mortality in India (2007-09), June, 2011, Sample Registration System, Office of the Registrar General and Census Commissioner, India, Ministry of Home Affairs, Government of India

¹¹⁴ SRS Bulletin - 2009, January, 2011, Sample Registration System Office of the Registrar General and Census Commissioner, India, Ministry of Home Affairs, Government of India

¹¹⁵ Hogan, M.C. et. al., (2010), 'Maternal Mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5', *The Lancet*, Volume 375.

¹¹⁶ SRS Bulletin - 2000, April, 2002, Sample Registration System Office of the Registrar General and Census Commissioner, India, Ministry of Home Affairs, Government of India

¹¹⁷ International Maternal Mortality Ratio data from Trends in Maternal Mortality: 1990-2008, World Health Organisation, 2010.

in the world, the highest absolute number of maternal and infant deaths also occurs in India.

a) Reproductive Health

Reproductive health in India mirrors the poor status of Indian girls and women. Half the 25-49 year old women across the country give birth to their first baby before the age of 19 whereas 16% of 15-19 year olds are already mothers or expecting their first child. Nearly half the 15-49 year olds do not use any method of family planning and only 12.8% feel an unmet need for family planning, implying that a significant proportion are not even aware of the importance of contraception. Female sterilization continues to be the predominant form of contraception used with 37.3% of currently married women opting for it.

A third of ever-married women are chronically undernourished. Thus most women enter pregnancy undernourished and suffer the burden of poor nutrition, little or no rest and limited health care throughout the pregnancy period. Nearly 60% of pregnant women are anaemic. Only one in two mothers receive/make the required number of antenatal care visits and 60% deliver their babies at home. During the postnatal period that is quite crucial for preventing maternal mortality, only 37% of mothers receive any care.

Regarding awareness of sexually transmitted infections, only 1 in 3 women know the importance of condoms as compared to 70% of men.

Table 6.1: Comparison of Reproductive Health Indicators

¹¹⁸ International Infant Mortality Rate data from The State of the World's Children 2011: Adolescence An Age of Opportunity, UNICEF, 2011

Indicator	NFHS¹¹⁹ 3 (2005-06)	NFHS 2 (1998-99)
Reproductive Health		
% of women age 20-24 married by age 18	47.4	50.0
% of women age 15-19 who were already mothers or pregnant at the time of the survey	16.0	na
Median age at first birth for women age 25-49	19.8	19.3
Total fertility rate (children per woman)	2.7	2.9
% of currently married women age 15-49 using any family planning method	56.3	48.2
% of total unmet need for family planning	12.8	15.8
% of ever married women age 15-49 with below normal body mass index	33.0	36.2
% of mothers who had 3 ANC visits for their last birth	50.7	44.2
% of pregnant women age 15-49 who are anaemic	57.9	49.7
% of institutional births	40.8	33.6
% of mothers who received postnatal care from a health provider with 2 days of delivery for their last birth	36.8	na
% of ever married women age 15-49 who know that consistent condom use can reduce the chances of getting HIV/AIDS	34.7	na
% of ever married men age 15-49 who know that	68.1	na

¹¹⁹ NFHS stands for the National Family Health Survey, a large scale, multi-round survey conducted in a representative set of households throughout India every few years to understand the status of health and nutrition. It is conducted by the Ministry of Health and Family Welfare with technical and financial support from the United States Agency for International Development. Three rounds of the NFHS have been conducted till date with the first in 1992-93.

consistent condom use can reduce the chances of getting HIV/AIDS		
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b) Child Health

A third of Indian babies are born undernourished and nearly 45% experience chronic undernutrition by 3 years due to sub-optimal feeding and caring practices, which increases their susceptibility to illness, enhances their risk for mortality and affects their physical growth and cognitive development.

Only 23% of Indian babies receive their first feed within an hour of birth and more than 50% are not exclusively breastfed in the first six months of life. The introduction of water, other liquids and milk during the first six months when the baby's immunity is still low enhances the risk for diarrhoea and mortality. A recent international study has suggested that the practice of exclusive breastfeeding by itself can reduce 13% of child mortality. And while the practice of exclusive breastfeeding for the first 6 months has nearly doubled in India over the past few years, it is still only prevalent in one of two cases. Mortality due to diarrhoea can be easily prevented through the use of simple interventions such as Oral Rehydration Salts (ORS). However, only 26% of under 3 year olds with diarrhoea in India receive ORS.

Child feeding in India is characterised by delay in initiation of breastfeeding, lack of exclusive breastfeeding and finally delay in the initiation of complementary feeding. Thus breastfeeding starts late, is not exclusive and continues for longer than it should. Nearly 45% of 6-9 month olds do not receive any solid or semi solid food along with breast milk and other milk, which compromises their growth. Forty percent of under 3 yrs olds in India are underweight and an alarming 23% are wasted. Wasting is an indication of acute undernutrition and wasted children are at a higher risk for illness and death. It is significant that the proportion of children with undernutrition in India has

remained nearly constant across 8 years from 1998-99 to 2005-06. Eighty percent of children are anaemic and only 44% are fully immunised.

Table 6.2: *Indicators of Undernutrition*

Indicator	NFHS (2005-06)	NFHS (1998-99)
% of children under 3 years breastfed within 1 hour of birth	23.4	16.0
% of children age 0-6 months exclusively breastfed	46.4	24.8
% of children 6-9 months receiving solid or semi-solid food and breast milk	55.8	na
% of children 12-23 months fully immunised	43.5	42
% of children under 3 years with diarrhoea in the last 2 weeks who received ORS	26.2	26.9
% of children under 3 years with acute respiratory infection or fever in the last two weeks taken to a health facility	70.5	na
% children under 3 years who are stunted	44.9	51.0
% children under 3 years who are underweight	40.4	42.7
% children under 3 years who are wasted	22.9	19.7
% children age 6-35 months who are anaemic	78.9	74.2

Reproductive and Child Health programmes in India: from the First to the Tenth Five Year Plan

Health is a state subject as per the Indian constitution, but controlling and managing reproduction through family planning programmes has been a focus of central planning since the first five-year plan. India was the first country to launch a family planning

programme in the 1950s to lower fertility and stabilise population growth. The programme started with a focus on creating awareness and providing client centred clinical services but transmuted in the 1960s into a time bound and target driven programme in which the Central Government set method specific acceptor targets for states based on certain calculations for achieving replacement level fertility rates by a particular time period. Services under the programme were largely limited to sterilisation. Under the Third and Fourth five-year plans, the programme was merged with general health services to extend its reach and subsequently it was merged with maternal and child health services based on the realisation that child survival was also important for limiting child birth, but family planning remained the predominant focus of the state. During the emergency in 1975-77, family planning acquired a coercive character with people forced to undergo sterilisation.

The backlash of the emergency was that the family planning programme evolved into the family welfare programme which focused on the provision of family planning and maternal and child health services through the three tiered structure of Health Sub-centres at the 5000 population level, Primary Health Centres at the 30,000 population level and Community Health Centres at the 100,000 population level. Family planning continued to be target driven with the introduction of incentive payments to encourage adoption of family planning measures.

The Universal Immunisation Programme for improving child health was started under the Seventh five-year plan in 1986, whereas the Child Survival and Safe Motherhood programme under which interventions for improving maternal health and reducing maternal mortality were considered, was initiated in 1992 under the Eighth five year plan. The Eighth plan acknowledged several limitations of the family planning component of the family welfare programme including non-achievement of targets, over-reporting of achievements, lack of adaptation to the context of different states due to centralised planning, lack of community participation and insensitivity to the needs of clients. The plan document for the first time acknowledged that adoption of the small

family norm was a personal decision. Concurrently, an international consensus developed through the International Conference on Population and Development (ICPD) held in 1994 in Cairo and the World Conference on Women held in Beijing in 1995 on the understanding that reproductive health be understood in the context of reproductive rights. It emphasised voluntary choice in family planning, action to support couples achieve their reproductive goals and quality of care in reproductive health services. Indian civil society, especially some women's groups which had already been protesting against the government's family planning programme drew support from this international consensus and the Government of India decided to introduce a paradigm shift in its family welfare programme - from a target oriented way of working to a target free approach in 1996. The main idea was that the Central Government would no longer provide method specific targets to states and the State Governments were expected to develop their own methods of planning and monitoring based on a decentralised assessment of community needs.

Building on this paradigm shift in family planning, the Ninth five-year plan launched the first phase of the Reproductive and Child Health (RCH-I) programme. RCH -I was characterised by a focus on improving quality of care to achieve client satisfaction. It involved community participation in planning, client centred approach, upgradation of facilities and health provider skills, absence of targets and incentives and the introduction of a gender sensitive approach. The programme sought to integrate the prevention and management of unwanted pregnancy, the promotion of safe motherhood and child survival, and the prevention and management of reproductive tract infections and sexually transmitted infections.

The second phase of the RCH programme (RCH-II) was integrated into the National Rural Health Mission started in 2005 under the Tenth five-year plan.

Reproductive and Child Health under the National Rural Health Mission (2005-2012)

The National Rural Health Mission (NRHM) is an ambitious central government scheme that seeks to introduce 'architectural corrections' in the Indian public health system.

The key features of the NRHM are:

1. Integration of vertical programmes
2. Decentralisation of health planning and budgeting through the development of annual village, block, district and state health plans
3. Upgrading health facilities as per the Indian Public Health Standards
4. Staffing health facilities as per the Indian Public Health Standards
5. Flexible financing of health facilities through the provision of untied funds
6. Improving programme management capacity and technical capacity of the health system
7. Setting up Patient Welfare Committees (Rogi Kalyan Samitis), empowered with untied funds to improve the management of all public health facilities
8. Enabling community participation in public health programmes through:
 - a. Setting up Village Health and Sanitation Committees at every village with annual untied funds
 - b. Selecting and supporting a woman from amongst every 1000 persons to function as a community health worker known as the Accredited Social Health Activist (ASHA). She would create awareness about appropriate health behaviour, support communities to access public health services and mobilise communities to demand accountability from public health services.
9. Community monitoring of public health programmes
10. Increasing public health expenditure from 1% of GDP to 2-3% of GDP

The Reproductive and Child Health component of the NRHM has introduced some crucial innovations to improve maternal and child health. These are:

a) Janani Suraksha Yojana (JSY)

The JSY is one of the most significant interventions by Indian policy for improving maternal health and reducing maternal mortality. It is based on the understanding that safe motherhood and newborn health can only be achieved through the promotion of institutional delivery. It provides cash incentives for mothers to have their babies in public health facilities including the cost of transport. It also incentivises the ASHA to encourage institutional delivery and support mothers to reach the hospital.

Table 6.3: The incentives available under the JSY

	Low Performing States ¹²⁰		High Performing States	
	Rural	Urban	Rural	Urban
For Mothers	1400	1000	700	600
For ASHA	600	200	Nil	Nil
Total	2000	1200	700	600

The beneficiaries in high performing states include all pregnant women belonging to below poverty line households, scheduled castes and tribes delivering in public health facilities or accredited private institutions. In low performing states the beneficiaries include all pregnant women delivering in public facilities or accredited private institutions.

The scheme is a modification of the National Maternity Benefit Scheme, which made available a sum of Rs.500.0 to pregnant women living below the poverty line towards improved nutrition and care during pregnancy. Like its precursor, the JSY also provides for an assistance of Rs.500.0 to below poverty line pregnant women, more than 19 years of age for two home deliveries.

¹²⁰ Low Performing States are the 10 states of Uttaranchal, Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa, Assam and Jammu and Kashmir where the proportion of institutional deliveries is less.

The ASHA worker, under the JSY, is expected to support pregnant women for timely registration of pregnancy with the Auxiliary Nurse Midwife (ANM), accessing 3 antenatal care visits during the pregnancy, organising transport to a health facility, institutional birthing, immunisation of the newborn as well as provide postnatal care including counselling for breastfeeding and family planning. However, the cash incentive is only provided for institutional delivery. Thus, the focus of the JSY programme is largely institutional delivery rather than a comprehensive package of maternal and child care.

b) Village Health and Nutrition Day

The VHND is a platform created under the NRHM to converge health and nutrition services for pregnant and nursing mothers, children in the 0-5 year old age group and adolescent girls. It enables Auxiliary Nurse Midwives (ANMs), the outreach workers of the public health system and Anganwadi Workers (AWWs), the village based workers of the Integrated Child Development Services (ICDS) programme to follow a case management approach in which each mother and child is tracked to ensure that they receive inter-related health and nutrition services. For instance, antenatal care which is provided to women during pregnancy to ensure improved maternal and child health outcomes includes both health and nutrition components and complete antenatal care is only possible through the convergent working of the public health system and the ICDS programme.

An indicative list of services provided on a VHND is:

Table 6.4: *Services Provided on a VHND*

Service	Beneficiary	Health (ANM)	ICDS (AWW)
Antenatal Care (ANC)	Pregnant women	<ul style="list-style-type: none"> • Registration • 3 ANC Checkups (2 doses of Tetanus Toxoid Vaccination, 	<ul style="list-style-type: none"> • Growth Monitoring • Supplementary Nutrition • Nutrition

		100 Iron Folic Acid tablets, Haemoglobin test, Blood Pressure check, Urine Test, Foetal exam) • Referral for complications	counselling
Child Health	0-6 year old children	<ul style="list-style-type: none"> • Immunisation • Health checkups especially for undernourished children • Counselling on management of newborns and undernourished children 	<ul style="list-style-type: none"> • Weighing of newborn babies • Growth monitoring • Supplementary Nutrition • Nutrition counselling
Maternal Health	Nursing mothers	<ul style="list-style-type: none"> • Counselling on family planning 	<ul style="list-style-type: none"> • Supplementary Nutrition • Counselling on exclusive breastfeeding
Adolescent Health	Adolescent girls	<ul style="list-style-type: none"> • Prophylactic Anaemia 	<ul style="list-style-type: none"> • Prophylactic Anaemia

The ASHA is expected to support the VHND by creating awareness, identifying and motivating beneficiaries to attend and by reinforcing the counselling received through home visits.

c) ASHA and VHSC

The Accredited Social Health Activist (ASHA) is a village based community health worker selected from amongst every 1000 persons through a community process and trained to create awareness, promote optimal practices and support communities to access services for health programmes such as maternal and child health and communicable diseases. As an activist, she is expected to represent community needs to the health system and support communities to demand accountability from the health system.

As a local person, rooted in the socio-cultural traditions of communities and familiar with nearly all families, the ASHA can play an important role in improving maternal and child health by influencing adverse health practices such as those relating to nutrition and rest during pregnancy and the post natal period, breastfeeding and complementary feeding. She can persuade families regarding the importance of accessing health services for the mother and child and be a much-needed support for mothers by accompanying them to facilities and helping them engage with an alien and forbidding health system. She can also identify danger signs and support the mother and child to seek health care in a timely way.

In all her roles, the ASHA is expected to be supported by the Village Health and Sanitation Committee (VHSC) and is in turn expected to enable the formation and working of the VHSC. The concept of the VHSC derives from the principles of decentralised local self-governance in which community members come together to identify their health needs and take appropriate action whether it be a village level cleanliness drive, spraying to control vector borne diseases or raising a voice against the absenteeism of health providers or poor quality of care. In the NRHM, VHSCs are expected to be set up through a suitable community based process for every revenue village, open and operate a bank account and receive and utilise a sum of Rs.10,000.0 annually towards local action. They are also expected to participate in preparing the

health plan of the block and district by developing village plans. Different states have developed their own guidelines for setting up VHSCs based on the status of Panchayati Raj Institutions.

Besides these demand side interventions, the NRHM also includes several measures to strengthen the supply of maternal and child health services. These include the designation of 24X7 Primary Health Centres and First Referral Units, provision of basic and comprehensive emergency obstetric care services, building capacities for skilled birth attendants, providing transport and referral services, providing facility and home based newborn care, development of the maternal and child protection card, mother and child tracking system and setting up and operating malnutrition treatment centres/nutrition rehabilitation centres.

However, it must be noted that the RCH programme under the NRHM is fairly focused on maternal and newborn health and does not represent a comprehensive approach to reproductive health.

Studies by Community Health Fellows on Reproductive and Child Health under the NRHM

The Community Health Fellowship programme of the Public Health Resource Network trained and enabled public health practitioners from the civil society to support the implementation of community participation programmes of the NRHM at the district level in the states of Bihar, Jharkhand, Orissa and Rajasthan. The fellows made systematic observations regarding the working of various components of the RCH programme of the NRHM. These provide significant glimpses into the working of the NRHM in states where health systems are weak and health indicators poor.

A total of seven studies were conducted on issues relating to reproductive and child health. Four studies examined maternal health issues, 2 studies researched adolescent health and 1 study was focused on RCH in urban areas.

Maternal Health

Four studies researched maternal health from pregnancy up to postnatal care. In Rajasthan, Julie Swarnakar of Bhilwara District studied the present status of the implementation of Village Health and Nutrition Days in Hamirgarh Block. Annie Kurien studied the barriers to institutional delivery in government facilities in two blocks of Khunti District in Jharkhand. In a related effort, Arvind Pandey assessed the implementation of the Janani Suraksha Yojana in Dausa Block of Dausa District in Rajasthan. Surat Chandra Biswal from Orissa identified the factors leading to poor postnatal services in Paikamal Subcentre of Bargarh District.

Thus, all studies researched issues related to the implementation of public health programmes to improve maternal health outcomes, rather than community based factors.

Methodology

All four studies followed a descriptive, cross-sectional study design with purposive sampling and convenient determination of sample size. The largest sample size was 171 respondents in the study conducted to identify the barriers to institutional delivery in government facilities whereas the smallest sample size was 45 respondents in a related study to assess the implementation of the Janani Suraksha Yojana (JSY). Three studies used a mix of qualitative and quantitative data collection methods whereas the study on the JSY used only structured interviews. The methodology followed by the four studies maybe summarised as follows:

Table 6.5: *Data Collection Methods used in the Study on JSY*

	Fellow	District	Blocks	Villages	Sampling method	Data Collection method	Sample size	Respondents
1	Julie	Bhilwara	Hamirgarh	10	Purposive	Structured Interviews	88	8 ASHAs, 10 ANMs, 9 AWWs, 10 Nehru Yuvak Kendra Workers, 41 Beneficiaries (11 pregnant women, 9 nursing women, 13 parents of children due for immunisation, 8 adolescent girls) and 28 VHC members
						Participant Observations	10	Village Health and Nutrition Days
						Focus Group	1	10 villagers

						discussions		
2	Annie	Khunti	Khunti & Karra	8	Purposive	Survey	171	Mothers who had delivered within the past 3 years
						In-depth interviews	15	Mothers
3	Arvind	Dausa	Dausa	3 PHCs	Purposive	Structured Interviews	45	15 ASHAs, 30 Beneficiaries - 15 from ASHA records and 15 escorted by ASHA
4	Surat	Bargarh	Paikamal	4	Purposive	Structured Interviews	57	52 Postnatal mothers, 4 ASHAs, 1 ANM
						Focus Group discussions	4	10 GKS members and nursing mothers in each group

Findings

Antenatal Care (ANC)

The quality of antenatal care available under the NRHM may be understood from the assessment of Village Health and Nutrition Days (VHND) or Mother and Child Health and Nutrition (MCHN) days conducted in 10 villages of Hamirgarh Block, Bhilwara District in Rajasthan.

Table 6.6: *Information about VHND*

Information about VHND given by	% Pregnant Women
ASHA	73
Nehru Yuvak Kendra Workers	18

Table 6.7: Availability of Service Providers on VHND

Service Providers available on VHND	% Beneficiaries
ASHA	68
ANM	68
AWW	54
Anganwadi Helper	24
Nehru Yuvak Kendra Workers	22

Table 6.8: *Quality of Care*

ANC Component	Number of Pregnant Women (11)
Tetanus Toxoid Injection	5

Iron Folic Acid (IFA) Tablets	11
Blood Pressure check	4
Weighing	8
Supplementary Nutrition	9
Counselling	2

Village Health and Nutrition Days were organised in all 10 villages under study. However of the 11 pregnant women interviewed, none reported receiving all the components of antenatal care. Counselling, a service which is essential for ensuring that the other services, which are provided, translate into improved health outcomes was only reported by 2 women. Thus, advice to ensure that IFA tablets are consumed every day, that the implications of current weight are understood and required diet changes implemented, that the supplementary nutrition provided is ideally consumed only by the mother and a birth preparedness plan is prepared to ensure safe delivery was only reported by two women.

It is also significant that two essential health services – checking of blood pressure and immunisation were reportedly received in only half the cases. The VHND is an important platform for the outreach of health services since the health system does not as yet have a village based service provider. It provides the Anganwadi centre as a base for the ANM's work, with the ASHA generating awareness amongst community members to attend the VHND. It is disappointing that despite such facilitation, the health system and the NRHM are unable to provide services to community members who come to the centre seeking the same.

Delivery Services

With the provision of a financial incentive to women to deliver in institutions under the NRHM, it was expected that institutional deliveries will rise and they have indeed done so in several regions, however the study on barriers to institutional delivery in government facilities in Jharkhand had the following findings:

Table 6.9: *Place of Delivery for Children Born Within 3 years*

Place of Delivery	% Respondents
Primary Health Centre	19.3
Health Subcentre	6.4
Private Clinic	12.3
On the way	5.9
Home	56.1

Despite the introduction of the Janani Suraksha Yojana, more than half the respondents (56.1%) who delivered within the past 3 years in Karra and Khunti Blocks of Khunti District, Jharkhand did so at home, with only 25.7% choosing to have their babies in government facilities (19.3 % at the Primary Health Centre and 6.4% at the Health Sub-centre). Collating all the respondents who did not deliver at government facilities, the figure rises to 74.3%. Thus only 38% of the respondents had an institutional delivery while 62% had their babies at home or on the way.

Of the 56.1 % respondents who delivered at home, 88% said that their family was not willing for institutional delivery as there were no complications and there was not enough money, 71.4% preferred their place of birth while 28.6% did not – 22.8% would have preferred to go to the PHC and 2.3% to a private clinic while 3.5% would have still preferred home.

Ninety three point six percent of respondents were aware of institutional delivery and 64% of these would have preferred to go for institutional delivery but could not do so for the following reasons:

Table 6.10: *Reasons for no Institutional Delivery among Those who Prefer Institutional Delivery*

Reasons	% Respondents
Family unwilling + no money for transport + organising transport difficult	21.64
No one to accompany at night	9.94
Hospital was not willing to provide services	4.68
Others	8.77

The respondents who delivered in government facilities (25.7%) did so because of the incentive under the Janani Suraksha Yojana and the support of the ASHA (known as Sahiyya in Jharkhand). All respondents (n=171) had the following observations on quality of care at government facilities:

Table 6.11: *Respondent Rating of Quality of Care in Government Facilities*

	Ratings by % Respondents			
	Good	Average	Bad	Don't Know
Cleanliness of the hospital	16.96	25.73	1.17	56.14
Facilities at the labour	15.79	19.30	7.02	57.89

room				
Availability of drugs	27.49	25.15	4.68	42.69
Competence of the service provider	31.58	24.56		43.86
Behaviour of the service provider	33.91	19.88	1.75	44.44

A majority of the respondents could not comment on the quality of care in government facilities since only 38% of respondents had opted for institutional delivery.

About 80% of the respondents were aware of the Janani Suraksha Yojana but only 32% had successfully availed it, 46.8% did not avail it since they delivered at home, 9.4% because of delivery in private clinics and 11.7% because they were not aware of the JSY.

In a related study assessing the implementation of the JSY in Dausa Block of Dausa District, all 30 respondents had institutional delivery and availed of the JSY. This study highlighted the role of the ASHA in creating awareness about institutional delivery and JSY. The main findings were:

Table 6.12: *Services provided by ASHA for the JSY*

Type of service	% Respondents reported receiving from ASHA
Providing information about the JSY	53
Visit by ASHA in the 3 rd , 4 th & 5 th month	57

Counselling	60
Visit to motivate for institutional delivery (6 th -8 th month)	67
Arranging vehicle for delivery	40
Accompanying patient for delivery	80
Selecting the hospital for delivery	60
Staying with the patient till the delivery	54

Fifty seven percent of respondents shared that they were discharged the next day after delivery whereas 43% of respondents said that they received the JSY incentive a week after delivery.

Postnatal Care

All 52 respondents had institutional delivery in a public facility. However 87% were discharged within 12 hours and none received any post natal care or visit in the first 48 hours nor the first three days after birth. Only 19% of mothers were visited by the ANM on the 7th day of delivery during which she conducted a check up, counselled on food and rest and advised 79% of mothers on contraception of which 54% were advised to go for limiting methods since they had already had two children.

Table 6.13: *Postnatal Care by ASHA*

Within 1 week		Within 6 weeks	
Frequency of Visits	% Respondents	Frequency of Visits	% Respondents
3	37	10	7
2	46	7-8	6
1	17	5-6	27

		As per requirement	41
		Don't remember	29

Table 6.14: *Counselling by ASHA*

Topic	% Respondents
On consulting the ANM	79
On birth registration, breastfeeding and contraception	41
On attending VHND	86

While all respondents reported receiving supplementary nutrition from the AWW, only 40% received any counselling.

Thirty five percent of respondents experienced complications during the postnatal period. These were:

Table 6.15: Complications Experienced During the Postnatal Period

Type of complication	% Respondents
Persistent fever, headache, abdominal pain	39
Vaginal bleeding, abdominal pain	39
Fever and foot swelling	22

78% of respondents with complications consulted a health provider of which 43% consulted the PHC doctor, 29% the ASHA and 21% the ANM

Discussion on study findings regarding the implementation of maternal health programmes under the NRHM in villages of Jharkhand, Orissa and Rajasthan

The four studies conducted on the implementation of maternal health programmes under the NRHM namely the Janani Suraksha Yojana, the Village Health and Nutrition Day and the ASHA raise several concerns about quality of care and service utilisation in Dausa and Bhilwara Districts of Rajasthan, Bargarh district of Orissa and Khunti District of Jharkhand.

While Village Health and Nutrition Days were conducted in all 10 villages studied in Bhilwara District, very few respondents received the entire gamut of Antenatal Care services. In particular, while nutrition services such as weighing, supplementary nutrition and iron folic acid tablets were provided to nearly all respondents, health services such as tetanus toxoid vaccination and checking of blood pressure were not provided to most. Additionally, counselling which is very crucial to ensure that the services provided actually translate into improvements in health was not provided to a majority of the respondents. Unfortunately, such a lapse reveals the provision of ANC to be a mechanical activity in which the conduction of tests/checks appears largely to be for the purposes of filling records and completion of tasks and not for understanding and improving the health of pregnant women.

Thus, the Village Health and Nutrition Day as a strategy appears to have the potential to increase the utilisation of health services, particularly antenatal care but will fail to improve health outcomes, unless the health system actively uses this platform for service delivery and the quality of both health and nutrition services improve.

In Jharkhand, a survey of a fairly large sample of mothers who had delivered babies in the past three years revealed a startlingly poor utilisation of institutional delivery services despite the implementation of the Janani Suraksha Yojana. Thus, only 38% of mothers opted for institutional delivery while 56% chose to deliver their babies at home. However, smaller studies in Dausa, Rajasthan and Bargarh, Orissa did report 100% institutional delivery amongst their respondents.

Of those, who had home deliveries, a majority shared that families were unwilling to invest in an institutional delivery but 70% also preferred their place of birth. On the whole, while a majority were aware of institutional delivery as a practice, only 64% said that they would opt for it. Family unwillingness continued to be an important factor influencing this decision and it appears that the costs represented by an institutional delivery, such as immediate availability of funds for transport, loss of time, loss of wage, costs of food, medicine, costs incurred to claim the JSY funds and other rents, even with the provision of the JSY, were too much for poor, daily wage earning tribals earning less than twenty thousand rupees a year. It also appears that in the absence of obvious complications, home deliveries are not perceived to be risky. Birth order may have a role to play in this, such that first time and younger mothers maybe be more likely to go to the hospital as opposed to mothers having their second or third child, as found in other studies. However, the Khunti study does not explore this variable. A poor perception of the quality of public health facilities could also be a possible factor influencing the decision for home deliveries, but very few respondents said that they found public health facilities to be of poor quality, nearly a third felt that public health services were either good or average in terms of cleanliness, facilities and behaviour and competence of service providers. In Jharkhand, therefore, it appears that much more needs to be done to encourage the adoption of in-facility births and the mere provision of JSY incentives may not be enough to change health behaviour.

The first 24 twenty-four hours after birth are the most crucial for both maternal and neonatal survival. One of the critical opportunities provided by the practice of

institutional delivery is care for the mother and child during this most vulnerable period. However, again the micro studies on maternal health reveal that most mothers are discharged within 24 hrs of delivery when the risk is the highest. The study in Bargarh district found that 87% of respondents were discharged within 12 hours of admission and the study in Dausa District, Rajasthan found that 57% of respondents were discharged within 24 hours. Moreover in Bargarh, even 7 days after the delivery only 19% of respondents were visited by the ANM for postnatal care.

Thus, yet again, there is a significant lapse in translating improved health behaviour into improved health outcomes through the provision of timely services. In Jharkhand, a majority of pregnant mothers are unable to avail of institutional delivery services and hence are at risk for increased mortality and morbidity but in Dausa in Rajasthan and Bargarh in Orissa, hundred percent of respondents opted for institutional delivery but without postnatal care, these improvements could not substantially reduce the risk for mortality and morbidity.

So it appears that the various strategies deployed by the NRHM have been successful in increasing the utilisation of services, at least in Rajasthan and Orissa but without concomitant improvements in quality of care, health outcomes are unlikely to change.

An important and positive finding in all four studies has been the active role of the ASHA in creating awareness, mobilising people to access services and even in conducting home visits. Thus 74% of respondents in Bhilwara said that they were informed about the VHND by the ASHA, the 26% who delivered their babies in public health facilities in Khunti did so with the help and support of the ASHA, in Dausa more than half and in some instances a majority of respondents affirmed the support of the ASHA throughout the pregnancy and delivery – making visit, counselling and supporting for institutional delivery. Again in Bargarh, the entire burden of postnatal care appears to be borne by the ASHA through visits and counselling. At least from these glimpses into the lives of communities in parts of these four states, it appears that the ASHA has

been very effective in presenting a caring face of the health system to communities and in linking health systems with communities.

Adolescent Health

Two studies examined adolescent health issues. Seema conducted a study on awareness regarding reproductive tract infections (RTIs) and sexually transmitted infections (STIs) as well as health seeking behaviour of adolescent girls (10-19 yrs) in one block of Nalanda District, Bihar. Vibha Upadhyay explored adolescent reproductive and sexual health amongst the Garasiya Tribe in Bali Block of Pali District, Rajasthan.

Methodology

Both studies followed purposive sampling and convenient determination of sample size. While the Nalanda district study had a fairly large sample, the study in the Garasia community was more in-depth and smaller.

Table 6.16: *Sample Size in Nalanda and Pali*

Fellow	District	Block	Villages	Sampling method	Data Collection method	Sample Size	Respondents
Seema	Nalanda	-	5	Purposive	Survey, Case Study, Observations	200	100 Adolescent Girls, 100 mothers of adolescent girls
Vibha	Pali	Bali	2	Purposive	Interviews	52	10 School going boys, 10 school going girls, 10 non school going boys, 10 non school going girls, 2

							Mothers, 2 Fathers, 1 Female Teacher, 1 Male teacher, 1 ANM, 2 AWW, 2 ASHA Sahyoginis
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Findings

Sixteen percent of the 10-19 year olds interviewed in Nalanda district were married.

Table 6.17: *Knowledge of STDs and Menstruation*

	% Know	% Don't Know
Causes of STDs	23	77
Menstruation	95	5

Table 6.17: *Have symptoms of RTIs/STIs*

Symptom	% Respondents
Abnormal discharge	12
Burn during urination	17
Itching on genital organs	8

Ulcer	1
Pain in pelvis	19
More than one	5
No symptom	38

Fifty two percent had never visited the nearest primary health centre and 80% said that they has transport problems in accessing public health facilities. Thirty six percent felt shy about visiting the primary health centre and 18% said that they lacked faith in the government health system.

Amongst the Garasia tribe, 55% of girls and 65% of boys said that they did not have any objection to premarital sex but 72% felt a child conceived through pre-marital sex should be aborted. Their knowledge on reproductive matters was as follows:

Table 6.18: *Knowledge of Contraceptive Methods and Abortion*

	% Respondents
Knowledge of condom as a contraceptive device	55
Knowledge of pills as a contraceptive device	55
Aware of abortion services in hospital	20
Aware that Doctor/ANM conducts abortion	35
Abortion possible upto 2-3 months	35

HIV/AIDs is caused by unsafe sex	50
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Forty percent of adolescent boys and girls complained of itching and burning in genitals and 35% of girls complained of pain during menstruation. However 73% admitted that they never shared these problems with anyone and no one had heard of adolescent friendly health services.

Discussion on findings in Adolescent Health

Both studies highlight the urgent need for focused programmes to create awareness amongst adolescents regarding reproductive health issues and to support them to access health services. Knowledge of STDs amongst adolescent girls in Nalanda was poor and knowledge regarding abortion services amongst a group of sexually active adolescent boys and girls in Bali block was quite poor. It is also a matter of concern that nearly half the respondents in both groups reported symptoms of reproductive infections but had not accessed any health care for it. Moreover, it is worrying that 16% of 10-19 year old adolescent girls were married. The study does not provide the age distribution and it is quite possible that most girls cluster around 18-19 yrs. This is something that needs to be explored.

Unfortunately, reproductive health under the NRHM has largely represented a focus on maternal and newborn health and a comprehensive approach to reproductive health has been missing.

Reproductive Health in Urban Areas

An objective assessment of Urban Reproductive and Child Health Centres was conducted by Dr. Neelima Aggarwal, a community health fellow based in Jaipur, Rajasthan. This study was conducted in 11 urban health centres in 6 slums of Jaipur. The objectives were to understand the available health care facilities at urban RCH centres; challenges to the effective working of these centres and community perception of urban RCH centres.

In 2008, 14 urban RCH centres were started in the slum areas of Jaipur city to provide regular and qualitative RCH care facilities to urban poor free of cost and to improve health status of slum dwellers. The objectives of a RCH centre include integrated health package to urban poor; to disseminate the concept of RCH among the community; to promote immunization and family planning services and to increase community awareness on ANC and PNC checkups and other health issues. Activities include formation and monthly meetings of women's organizations; monthly meeting of men's participation camp; monthly meeting on women's participation camp; counseling of in-school adolescent girls; health camps in slum areas.

The study was mostly based on observation of the urban health centres and focused on challenges – large coverage area; poor access and utilization of resources; weak coordination; target oriented approach; inadequate community level activities; dominating role of NGOs. It briefly highlights that the community is not aware of the facilities and the services provided by these centres and that there is a general lack of faith in public facilities.

In summary, the main observations derived through this review of seven studies are:

1. Reproductive and child health under the NRHM has largely been focused on maternal and newborn health and a comprehensive framework encompassing, adolescent health, abortion services and infections is absent.
2. The NRHM has been successful in increasing the utilisation of health services through strategies such as Village Health and Nutrition Days and Janani Suraksha Yojana, which have proved effective platforms for linking communities with health services.
3. However, there are still poor and vulnerable groups that are unable to access institutional care during birthing due to lack of understanding of its significance and limited resources. Many poor women also make a choice for home deliveries based on a rational 'cost-benefit analysis'.
4. Additionally, poor quality of care, reflected in the non-provision of a complete package of antenatal care during VHND and absence of postnatal care even in case of institutional delivery remains an important concern. Without strengthening the quality of health services, positive health behaviour is unlikely to translate into improved health outcomes.
5. The ASHA has been fairly effective in creating awareness about optimal health behaviour and supporting communities to access the health system. Even in the absence of clear financial incentives the ASHA is found to make home visits during the antenatal and postnatal periods.

6. Adolescent health has been quite neglected under the NRHM and there is a distinct absence of peer educator based strategies or adolescent friendly clinics to reach out to this vulnerable group.

Recommendations

The recommendations that emerge from this analysis are as follows:

1. State policy and agencies need to provide for a comprehensive set of reproductive services through the ANM, ASHA and systems such as the VHND at village level.
2. Comprehensive and good quality reproductive health care services are also needed at the level of the PHC and CHC. In particular, greater focus is needed for post natal care, adolescent health care services and abortion services.
3. Antenatal care has become limited to one or two elements such as provision of iron and folic acid and TT injections. The package of eight essential services needs to be reinforced and delivered through better capacity building and monitoring.
4. While institutional deliveries have a distinct strategic importance in preventing maternal and neonatal mortality, community perceptions and choices need to

be respected and supported so that home deliveries do not entirely remain outside the purview of the reproductive health programme.

5. Assistance and services for safe home deliveries need to be considered in special circumstances where mothers choose to have non-institutional deliveries because of lack of access to services, the cost effectiveness of home deliveries or other socio-cultural factors. Innovative approaches to achieve this objective should be adopted with the involvement and collaboration of trained traditional birth attendants. However, such integration also necessitates excellent back-up services of transportation and referral in case of complications. Measures may dramatically improve maternal mortality amongst poor tribal women in particular.
7. Reproductive and child health under the NRHM has largely been focused on maternal and newborn health and a comprehensive framework encompassing, adolescent health, abortion services and infections is absent.
8. The NRHM has been successful in increasing the utilisation of health services through strategies such as Village Health and Nutrition Days and Janani Suraksha Yojana, which have proved effective platforms for linking communities with health services.
9. However, there are still poor and vulnerable groups that are unable to access institutional care during birthing due to lack of understanding of its significance and limited resources. Many poor women also make a choice for home deliveries based on a rational 'cost-benefit analysis'.
10. Additionally, poor quality of care, reflected in the non-provision of a complete package of antenatal care during VHND and absence of postnatal care even in case

of institutional delivery remains an important concern. Without strengthening the quality of health services, positive health behaviour is unlikely to translate into improved health outcomes.

11. The ASHA has been fairly effective in creating awareness about optimal health behaviour and supporting communities to access the health system. Even in the absence of clear financial incentives the ASHA is found to make home visits during the antenatal and postnatal periods.

12. Adolescent health has been quite neglected under the NRHM and there is a distinct absence of peer educator based strategies or adolescent friendly clinics to reach out to this vulnerable group.

CHAPTER SEVEN

Conclusion

This collaborative project has attempted to demonstrate how a cadre of district health activists can work towards facilitating 'community participation' in public health management systems with particular focus on the National Rural Health Mission. Within this broad theme, the project focused on the community health fellowship programme of the Public Health Resource Network. It has documented and evaluated the usefulness of the fellowship programme in terms of the links it provides between public health management systems and local societies. These links have been provided by the community health fellows in at least two ways and are embedded in the roles that were conceived for the fellows once these programmes were conceived. The first of these

roles was the support that the fellow provided in terms of their actions in assisting the communitisation processes in the district health societies that had been set up by the NRHM. These actions helped to set some participatory processes into motion and also facilitated the systemic processes that are essential to make decentralised health planning (one of the processes that NRHM is to set into motion) a reality. The documentation of this experience has important lessons for the way in which the NRHM is functioning at the ground level. Some of these lessons have been captured through the analysis of the programme in the first volume of this report.

The second role that fellows were expected to perform was that of doing action research which fed into some of the district health planning processes. The twenty four studies conducted as a part of this fellowship programme have been compiled in the second volume of this report. They have also been thematically analysed in the first volume of the report. In the main, these studies concentrated on assessing and documenting the social determinants and perceptions of the community. The on going process of doing research went hand in hand with carrying out field level actions. Thus, there was a two way relationship between the measures initiated by the fellows and the research done by them. In some cases this relationship was stronger than in others. A large part of the project report goes into the details of these two aspects and tries to understand the usefulness and the nature of the programme.

The Context of the Community Health Fellowship Programme

The first section of the project report has described the nature of public health policy in the post-independence era and has attempted to contextualise 'community participation' within the structural changes in the public health system. As has been noted, the concept of 'community participation' was not new and existed much before the NRHM. As early as 1946, the Joseph Bhore Committee had expressed the view that "No permanent improvement of public health can be achieved without the active participation of the people in the local health program". Subsequently community development programmes were designed to facilitate the people's participation in

village development processes. Here the community was largely identified as the 'village' and health and hygiene was meant to be an important part of the programme. By 1964 almost the entire country was covered by these programmes and their evaluation revealed their limitations also. The Mudaliar Committee of 1962 emphasised that unless " the principles of sound hygiene are inculcated into the masses through health education and other efforts, and ...Unless government feels strengthened in taking positive measures to promote health, it will be difficult for health authorities alone to ensure that the measures contemplated are actually implemented...". This showed that the question of people's participation was being visualised largely in terms of "awareness building" and creating a demand for public health services. Decision making in these vertical programmes was centralised in character and people's participation was disassociated with planning.

However the situation had changed substantially by the middle of 1970s with movements for decentralisation in the institutions of governance. In this context the first community health worker programme was launched under the village guide health scheme which did not really take off because of the lack of capacity building and the fact that the selection procedure of worker was done at the discretion of the panchayat, and not with the active involvement of the local people. Subsequently, the Alma-Ata Declaration argued that "communities" should be involved in the management of their primary health care units and that "primary health care workers should be selected when possible by the community itself or at least in consultation with the community; respect for the cultural patterns and felt needs in health and community development of the consumers". Thus the nature of the 'community' had transformed itself from a local area based definition in health management to 'culture' and 'ethnically' defined community. But this understanding did not fully translate into a 'culturally determined' idea of the community within India. Rather the term 'community participation' came to embody decentralised health management with the greater involvement of panchayats in this period.

In line with this thinking and the alternative strategy document prepared by the

ICMR/ICSSR, 'Health for All 2000' also emphasised the importance of decentralised health planning. Along with the Alma Ata declaration, it also influenced the formulation of the sixth five year plan. However it was the National Health Policy 1982, which for the first time explicitly declared its intention to put primary health care centres under the control of the Panchayats. New initiatives in decentralised health care were also started by voluntary organisations in states like Maharashtra, Gujarat and Haryana to embed primary health care in processes involving the participation of communities. Hence efforts were meant to train 'traditional' midwives and selected volunteers from the local communities themselves, thus making early attempts to alter the relationship between local societies and health care systems. These experiments were also backed up by increased focus on health care in the Sixth plan in the early 1980s. The Sixth Plan outlay made an almost three fold increase in the allocation for the Health Sector and more than doubled it for Family Welfare when compared to the Fifth Plan. Thus experiments with decentralised health care systems were supplements to state initiatives and tried to create models that showed the future course of health policy implementation.

The discourse of 'community participation' received a new meaning with the relative withdrawal of the state from the social sector in the age of economic reforms. The expenditure on the social sector declined from 20.8 percent in 1985-91 to 17.7 in 1991. Allocations for the health sector from 3.3 percent of the total expenditure in the first plan to 1.7 percent in the seventh plan. They further declined to 1 percent during annual plan 1997-98. In this situation the argument for the increasing role of the community became a way of allowing the withdrawal of the state and did not necessarily mean that the democratisation of decision making. Two trends were experienced in 'community participation' since this period. The first was the 'Kerala model' of the 1990s where primary health care was made a subject under the panchayats. The 'gram sabha' thus formed the primary community through which health care was to be administered and this led to a significant improvement in the working of primary health care systems.

The second model was that of the community health volunteer or 'the mitanin' introduced by Chhattisgarh government in 2001. Here a community health volunteer was trained in every hamlet. While one of the objectives of the programme was to help in reaching health care to every nook and corner of the state, it also implied that the 'health of the community' was in its own hands. The programme tried to develop leadership qualities and carry out the health education of the 'communities'. But the working of the programme showed that the growth of public health infrastructure was required to support the health volunteer. While the 1980s were a highpoint in the development of health infrastructure, the 1990s saw a slowdown in growth of infrastructure, leaving much of the health care in the unregulated private sector. Further the changing orientation of health care from holistic primary health care to selective primary health care in which certain disease were targeted, enabled the state to turn its attention from preventive care (requiring the provisioning of basic needs) to curative health care. Hence, many of the state experiments in decentralisation did not yield the results they were expected to yield, and were largely dependent on positive individual rather than institutionalised interventions.

The interventions of the NRHM need to be seen in this context. The programme was launched in 2005 and aimed to universalise health care. It sought to place the management of health care under the supervision of local communities through structures involving the panchayati raj institutions. The processes institutionalising such participation were to be the creation of village health and sanitation committees, the appointment of an accredited social and health activist and the formation of health development or rogi kalyan samitis. The framework provided by and the working of these committees formed the subject of research and basis of intervention of the community health fellows.

The Community Health Fellowship Programme

As discussed in the second part of this report, the community health fellowship was a programme initiated by the Public Health Resource Network which is a collective of

public health doctors, activists and practitioners, several of whom were actively involved in shaping the policies of the NRHM, and which seeks to contribute to building public health capacity in India by developing courses and resource material and undertaking training programmes and research. The community health fellowship programme was part of the larger agenda to strengthen public health systems at the district level, create pool of public health workers with greater capacities and support systems and processes for community participation in NRHM. The fellows were to act as important links to strengthen implementation of all these measures.

The programme was an innovative one, expecting the fellows to strengthen system for people's participation at the district level on the one hand and generate a research project providing ground level insights on the other hand. There were 30 fellows in Bihar, Jharkhand and Orissa directly under PHRN and another 15 fellows from Rajasthan affiliated to the programme. At the district level, the fellows were positioned at the intersection of the state and local societies. The PHRN played a dual role in facilitating their work. At the district level it facilitated the fellow's engagement with public health officials based on the context of particular states. The fellow would be encouraged to network with local civil society groups to understand the health issues of the area and benefit from their experience of intervening in health matters. At the national level it held several trainings and at least five workshops in collaboration with the Centre for Jawaharlal Nehru Studies to impart training in methods of participatory research and build capabilities in fulfilling their research commitments. In order to facilitate this each of the fellows was linked to an academic mentor for this purpose.

In all, the community health fellowship of the PHRN was an intense and valuable experiment that generated a wealth of understanding of how such fellowships may contribute to the objectives of community participation in the public health system. The experience also gave rise to a number of perplexing challenges for such programmes in the future. First, the process documentation of the fellowship programme showed that fellows needed a greater clarity on their precise role as they were frequently caught between their differing responsibilities and tasks. On the one hand they were expected

to directly report to PHRN, while on the other hand the district health system attempted to exercise some control by expecting them to be answerable for their actions. The second challenge concerned development of individual skills of the fellows. The training programmes, field and academic mentoring raised their capabilities in terms of their use of technology and databases on the one hand and also increased their analytical skills on the other hand. District level authorities also started to take their help in these respects. However, despite these achievements the concepts of research also were not found to be very clear by the end of the fellowship programme. For future initiatives such as this, the curriculum for such programmes needs to be re defined to suit the categories of people inducted into the fellowship. The third impact of the fellowship programme was the development of district level organisational capabilities and networks. These were instrumental in expanding the district level PHRN network and also in providing inputs to other organisations and authorities of their assigned district and helping in the preparation of the district health plans. The fellows were placed in villages and helped to train the ASHA and VHSC members. In many cases they were also instrumental in raising awareness on local issues and linking them with resource agencies that could create small but important changes in the lives of people. However, field organisations also performed variably with respect to providing guidance and support to the fellow. Greater attention would be required to carefully select, induct and facilitate such field organisations as the contribution of these institutions was uneven in its impact. Fourthly, the fellows contributed in terms of their research projects which have yielded important field level data on the ground realities of the status of health the implementation of NRHM in selected districts which are presented in volume two of the report. Some of their action research projects reflected the local issues affecting the implementation of the NRHM “communitisation” strategies. These studies were prepared under the guidance of volunteer academic mentors who played an important role in expanding the vision of the fellow and facilitating rigor in their work. However feedback from the fellows showed that the participation of mentors was not uniform and needs to be facilitated in the future. This may also require a rethink on some of the curriculum and some of the processes that were followed under the academic training

programme.

Thematic Areas of Action Research and Their Implications

Section two of this project has analysed the research studies prepared by the fellows. Broadly speaking, the studies done by the fellows can be categorised into two broad frameworks. The first framework largely assessed the character and implications of the institutional framework provided by NRHM namely in terms of studies on the functioning of ASHAs and VHSCs/RKS. The second framework largely consisted of the studies of the social and cultural determinants and perceptions of specific programmes on control of communicable disease and the reproductive and child health. The broad conclusions out of each of these four themes are summarized below:

Studies on the Functioning of Accredited Social Health Activist (ASHA)

Four studies were conducted on the training and functioning of ASHA covering two districts each of Bihar and Rajasthan. The studies showed that the system, while naming her as an 'activist' has tended to treat her as the lowest rung of the health services system while paradoxically disregarding her rights as a worker. There is a need to retain the concept of the ASHA as an activist to make her effective as a change agent for the empowerment of people to achieve their health rights. At the same time her own empowerment and in effect, her rights as a worker need to be supported at various levels to enable her to help people. She needs to mobilize other community members so as to be able to address other determinants that also include issues related to social exclusion. She should be equipped with proper knowledge and skills through continuous training and supportive supervision to create awareness about health and nutrition practices and services, people's rights and entitlements. She should be provided with opportunities to acquire more technical skills to grow to a different level of function in the health system/society. Micro level studies show that if this is to be done then the role of the ASHA should be structured as a part of the larger public health system and the issues regarding her identity and role need to be resolved. In

order to facilitate a more meaningful role for the ASHA the following key recommendations have come out of these studies restated the importance of social mobilisation in the work of the ASHA must be restated:

1. Selection process needs to be more transparent with increased community mobilisation and participation
2. Support structures are important for the ASHA and there is a need for constant supportive supervision, on-the-job and facilitation for effective implementation of the programme.
3. Training needs to happen on time with proper follow-ups. There is a need for refresher and on the job training.
4. ASHAs knowledge levels must be enhanced through better training. Consequently improved knowledge should lead to better skills in practice to make the ASHA more effective in the field.
5. There is a need to restate the comprehensiveness of her role as a health worker and not limit her to simply RCH functions.
6. Delays in payments should be minimised and subsequently there needs to be a decision to move from performance based incentives for some programmatic activities to a fixed payment. The payment could be made through the VHSCs.
7. The system needs to be more supportive and responsive to the ASHA. She will just remain a functional health worker and not an effective one if there is an unresponsive public health system.
8. There is a need for a grievance redressal system for the ASHA.
9. ASHA could play an important role in the VHSC to address other determinants and issues of convergence.

Decentralised Health Planning and the Working of VHSCs

Studies by community health fellows in the four states show that the concept of VHSC as envisaged under NRHM requires some more emphasis within the functioning of the public health services system in order to enhance community participation and ownership of the health programs and services in all the states. Voluntary organisations and ANMs have played a crucial role in the formation and to some extent in formalizing the activity of VHSCs. Though members have responded by attending regular meetings, they are not aware of their own functions and responsibilities in many cases. The ASHA is usually ignored in the meetings held at PHC and needs to be given a more important role in the functioning of the VHSC. The representation of the SC, ST, Women, and Minority & Disabled is not adequate, as they are not getting proper space in the VHC. There is hardly any coordination between the VHSC and other departments, who are poorly aware of the manner in which the VHSC may be utilised to make district health plans. No supervisory or monitoring roles have been created for the VHSCs. Given this situation the following needs to be done:

1. There is an urgent need to have a state supported mechanism to sensitise and train the members of the VHSC. Similar sensitisation and training should also be done of the ASHA.
2. The ASHA should be accorded a greater role in the constitution and functioning of the VHSCs.
3. Decentralised health planning should be taken seriously and there should be at least one block level technical coordinator who can assist in formulation of a district level health plan.
4. Guidelines for the functioning of the VHSCs should be available at the sub-centre level and they should be made available to VHSCs in the local language.

5. State should give the parameters to the district and blocks to choose the members of VHSCs. Monitoring system should be stronger.
6. A cadre of supervisors should be placed at each PHC and CHC for monitoring and support. Quarterly reports should send at block and district about meeting processes. UC of the fund should be produced after each quarter so that misuse of the fund can be minimized.

People's Participation and Perceptions of Communicable Disease Programmes

Four studies done on programmes in communicable disease stressed the importance of the role of the community in preventing communicable diseases. Community participation brings in the involvement of all communitisation processes introduced with NRHM – hence, role of ASHAs, VHSCs, RKS are critical in disease prevention and care. These studies show that there is lack of involvement by these members on communicable diseases. Only the ASHA is involved to some extent in the curative component of Tuberculosis. The communicable diseases addressed through these four inquiries are endemic and often fatal. Intricately linked with poverty and marginalisation, it is no surprise that these are major problems among the states of Bihar and Jharkhand. TB, Malaria and Kala-azar have large, well-funded programs; further Kala-azar is a candidate disease for elimination. While Revised National Tuberculosis Control Programme can be considered to be quasi-vertical in nature, the others are delivered through the primary healthcare service system. Media campaigns and social mobilisation strategies are key components of these programs. The lack of knowledge or sensitisation among healthcare workers, as well as community members, is significant but perhaps not surprising given the state of functioning of these programmes in these states. These high-focus programs are delivered through the general health services, which as each of these studies bring out is extremely weak. The NRHM has sought to strengthen infrastructure and human resources. Much of the focus has been RCH-centric and has not been able to transcend this conventional wisdom. The emergence of non-communicable diseases (NCDs) is as real as enormous.

Clearly primary healthcare is still deficient and people are dependent on unqualified informal practitioners or having to travel to urban centres. The inability to cope with the unfinished agenda of communicable diseases has been brought out by these studies as a stark reality. Communitisation processes have emphasised on governing the structural aspects of the NRHM (such as, untied funds or decentralised planning) but not engaged itself with human suffering (communicable diseases, in this instance). And that is a sad testimony as the NRHM (in its first *avatar*, 2005-12) draws to a close. The studies therefore suggest the following remedies through their ground level experience:

1. Proper strengthening of the information system between the district administration, PHC and village level is needed to bridge the gap between the outbreaks of the disease and failure to reach the information to the authority.
2. District authorities must be more responsive to the needs of the patients, arranging for better diagnostic tests and drugs, and good housing programme for the poor. Effective antipoverty programme will help the affected families to improve their economic condition.
3. There is a need to develop a pragmatic training module for ASHA/Sahiyya and VHC on Kala Azar and impart training to ASHAs and VHCs;
4. A community level plan for Kala Azar elimination should be developed and orientation of all the front line government health workers on Kala azar and strengthening linkage with the community.
5. Better Behaviour Change Communications (BCC) and capacity building of ASHAs and VHSCs are recommended in the case of Malaria.
6. As in the case of TB it is also evident that spending on building physical infrastructure alone is not enough, it is equally important to ensure patient satisfaction by taking care of the qualitative aspects of service delivery in public health facilities.

7. Untied funds should be used for addressing communicable disease requirements and innovate IEC strategies for both front-line health workers and communities.

Status of Reproductive and Child Health

Seven studies were conducted on the status and factors affecting reproductive and child health under the NRHM. The analysis of these studies showed that within NRHM reproductive and child health programmes have largely focused on maternal and newborn health. It has been successful in increasing the utilisation of health services through strategies such as Village Health and Nutrition Days and Janani Suraksha Yojana, which have proved effective platforms for linking communities with health services. However, there are still poor and vulnerable groups that are unable to access institutional care during birthing due to lack of understanding of its significance and limited resources, and limited infrastructural facilities for complete package of antenatal care during VHND and absence of postnatal care. The studies also show that the ASHA has had limited success in creating awareness about optimal health behaviour and supporting communities to access the health system. Her role is however limited by the absence of clear financial incentives. Further adolescent health has been quite neglected under the NRHM and there is a distinct absence of peer educator based strategies or adolescent friendly clinics to reach out to this vulnerable group. Given these conclusions the studies recommend the following measures to ameliorate the situation:

1. State policy and agencies need to provide for a comprehensive set of reproductive services through the ANM, ASHA and systems such as the VHND at village level.
2. Comprehensive and good quality abortion, post natal and adolescent health care services are also needed at the level of the PHC and CHC.
3. Antenatal care has become limited to one or two elements such as provision of iron and folic acid and TT injections. The package of eight essential services

needs to be reinforced and delivered through better capacity building and monitoring.

4. While institutional deliveries have a distinct strategic importance in preventing maternal and neonatal mortality, community perceptions and choices need to be respected and supported so that home deliveries do not entirely remain outside the purview of the reproductive health programme. Involvement of trained traditional birth attendants needs to be facilitated to provide assistance and services for safe home deliveries in special circumstances

In sum, the analysis presented in this report reflects upon the process of learning that has taken place amongst the community health fellows. Five national level workshops were held to expose the fellows in the various methods of doing research. But such a training and exposure seems to have a limited impact as most fellows did not understand the difference between qualitative and quantitative methods while applying different tools to research projects. This impacted on the rigour of the research studies themselves. However, notwithstanding the limited academic rigour of the research done during the fellowship, it does throw up new information and perspective which is entirely local and contextual to the district in which the research was housed. Evidence derived from the research done under the fellowship programme forms an interesting juxtaposition with existing theory on the public health issues that are currently being hotly discussed and debated in India. Therefore these local research projects are able to point towards some implications for the overall strategies being employed by NRHM. Thus in an overall sense, the fellowship project was useful not only for the development of individual fellows, but for also providing a window into the way in which local contexts interface with a larger intervention in health management systems.

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Annexures

Profile of the Fellows

Annie Kurian (Jharkhand) is a post graduate in social work from Madras University and has rich experience in working with organizations like World Vision on community based and women's issues. As a fellow she worked in Khunti district and conducted a VHSC and Sahiya appraisal of the district. 155 VHSCs were trained in and requisition for Untied Funds were made through them by her.

Anwar Hussain (Rajasthan) is a graduate in Social Work and has an added diploma in computer hardware. He has worked extensively at the grassroots and his main work has been in training health workers at the district, block and village level. His work during the fellowship focused on strengthening VHSCs in Alwar and Bharatpur district of Rajasthan.

Arup Abhishek (Orissa) is a graduate in ayurvedic medicine and surgery and has a post graduate diploma in computer application. Fluent in English, Hindi, Oriya and Bengali, he has worked for over half a decade as Health Coordinator in a state level NGO supported by Oxfam in the state. He worked as a fellow in Dhenkanal district strengthening GKS, facility mapping and reporting the gaps to CMO.

Arvind Pandey (Rajasthan) has a Masters in Social Work and has a degree in Law too. He has several years of experience in issues surrounding health and has worked directly with micro-credit groups; he has also worked on projects with VHAI and SOS villages. As a Fellow, Arvind was placed in Dausa and during this time he evaluated ASHA pilot project; strengthened VHSCs through discussions with ASHA and regular visits to PHCs, helped in preparing VHSC training. He also was part of orientation training of ASHAs and engaged with the DHS.

Farhat Yasmin (Bihar) is a graduate from Jamia Millia University and has worked on women's health issues and as a district trainer for UNICEF projects. She is proficient in all local languages in Bihar apart from Urdu, Hindi and English. During the fellowship,

she has facilitated DHAP workshop at Vaishali district; has held meetings with PRI members and other functionaries of District Programme Management Unit especially Aanganwadi workers and PRI members.

Gajendra Singh (Jharkhand) graduated in Psychology and obtained his Masters in Sociology, thus strengthening his understanding of behavioural issues. He has worked in several states in eastern India in different public health programs, the polio eradication and vitamin A supplementation, in specific. As a CHF, he conducted Sahiyya and VHC appraisal in Godda district to understand the situation of community processes in the district. He organised training for 187 VHCs in Sunderpahari Block, Godda District focusing on their roles and responsibilities and effective utilisation of untied funds. He contributed to the preparation of the District Profile of Godda and carried out village assessment in three villages of Sunderpahari Block.

Indu Gupta (Rajasthan) is a graduate in Economics from Delhi University and also completed Law. She has several years of hands on experience in the area of women's health, community monitoring of health services under NRHM and HIV/AIDS. She has been involved in project planning, execution and management and strategy development. As a Fellow she was placed in Alwar. She enabled the strengthening of VHSCs, worked with ASHAs to understand their difficulties and informed them about role of VHSCs, brought AWW, ANM and ASHA together to achieve NRHM objectives, ensured that their payments are made regularly, informed the community about NRHM and enabled them to decide on expenditure of untied funds through VHSC and coordinated with other NGOs to assess health scenario of villages and to create a village health plan.

Jalaluddin Khan (Bihar) worked as a fellow in Muzzafarpur. He facilitated in the District Health Action Plan workshop, conducted advocacy with District authority for regularization of meeting of the members of Rogi Kalyan Sammittee.

Jay Krishna (Bihar) is post-graduate in Chemistry with diploma in Hindi Journalism and Mass Communication. Proficient in Hindi, English, Urdu, Bhojpuri, Magahi he

worked as a journalist and later as a Senior Treatment Supervisor in the Revised National Tuberculosis Control Program (RNTCP) at Patna. He thus combines communication skills with technical competence.

Julie Swarnakar (Rajasthan) worked in Bhilwara District. The fellow engaged in orientations at the block, district and state level on various health issues like Polio, HIV/AIDS; including members of PRIs, ASHAs and ANMs. ASHA and ANM were encouraged to work together and VHSC meetings were made proactive.

Kumari Shweta (Bihar) is a post graduate diploma in rural health management and has a Masters in Botany. She comes from over a six year experience in the social field. She has been training on various health issues for several years and is proficient in all regional languages in Bihar apart from Hindi and English. During the Fellowship she played a role in facilitating District Health Action Plan, held meetings with PRI members, functionaries of District Programme Management Unit in Samastipur, held meetings with ASHA to strengthen them and with members of self-help group.

During the Fellowship, he conducted orientation programme on RKS, strengthened VHSCs and streamlined untied funds. He facilitated the process of first DHAP of the district and is credited with writing an article on the role of ASHA in the RNTCP.

Manish Mani (Bihar) joined PHRN as an intern and was involved in this study. He graduated in Psychology and obtained his masters in Rural Development. He comes with a varied experience in community development programs including the Total Sanitation Campaign and Livelihood Promotion Program.

Shefali and Manish have worked proactively on the issue of Kala Azar: discussing and providing information about causes and prevention strategies of kala azar to the villagers; conducting FGDs for pre-preparation of houses and community monitoring of spray in the villages; Kala Azar mapping; visiting villages during spraying activity and closely interacting with the villagers to find out the communication needs for BCC; facilitating meetings with different stakeholders, finding out gaps in spraying;

sensitizing villagers for early detection and complete treatment of kala azar and meeting with villagers and forming teams for monitoring kala azar spraying.

Manir Ahmad (Jharkhand) is a homeopathic doctor and is fluent in English, Hindi and local dialects in Jharkhand. He has had the experience of working as a medical officer as well as program coordinator with a few organizations on health related issues in Jharkhand. As a fellow he worked in Hazaribag and engaged in strengthening VHSC, Sahiyya and in the preparation of DHAP.

Neelima Aggarwal (Rajasthan) has a PhD from Rajasthan University in South Asian Studies. She is well versed in Hindi, English, Punjabi and Rajasthani. Having rich experience in the field of education she was part of the Board of Secondary Education in Rajasthan and has several articles and a book to her credit. Jaipur was the only urban centre covered in the entire fellowship. She conducted visits to slums to observe health care facilities for urban poor and participated in various meetings and workshopps, based on various community health issues. She developed training material for VHSC training and was also a facilitator at the ASHA ToT workshop. A profile of the city and a document on the need and importance of urban health based on the city was prepared.

Pooja (Jharkhand) is a post graduate in Gandhain Thoughts from Bhagalpur University and is fluent in Hindi, Bengali, English and Oriya. She has had hands on experience in field research with various organizations and is experienced in program management and on issues related to health, nutrition and sanitation. As a fellow she worked in Hazaribag and engaged in strengthening VHSC, Sahiyya and in the preparation of DHAP.

Rajiv Ranjan (Bihar) is a post graduate in rural development management and fluent in English and Hindi. Having experience with various organizations on health related topics, as a fellow he worked in Gaya district. He facilitated the formation of District Health Action Plan, worked on the proper use of untied fund at facility Meeting with

PRIs. He also initiated a survey that ensured free radiology and pathology tests for all in Bihar government run hospitals.

Sandip Kumar Mitra (Jharkhand) obtained his masters in Rural Development and has been trained in various components of HIV program. He is proficient in various local dialects of Jharkhand, clearly an asset in field based research/profession. He is experienced in public health programs, particularly the interface with communities. During his Fellowship, he participated in appraisals of Shaiyas and VHCs in Sahebganj District. He was involved in the training of members of 43 VHCs in Taljhari, Borio and Rajmahal block and also supported in opening bank accounts for the VHCs . He participated in the preparation of the District Health Profile of Sahebganj. He supported the mentoring organisation in Child Survival project in the district and supported organising the Samadhan Shivir in Khunti for delivering the services related to development programmes especially health programmes.

Seema (Bihar) is a post graduate in social work and has worked with a few organizations on issues concerning health. With the fellowship, she worked in Nalanda district and facilitated in DHAP workshop at District level at Biharsharif. She also met with members of Panchayati Raj Institution, with District Program Management Unit at District level on issues related to ASHAs, AWWs and adolescent girls regularly.

Shefali Kuntal (Bihar) obtained her Masters in Social Work working for her thesis on tribes and land alienation in Surguja, Chhattisgarh; she topped her batch. Later, she worked for women's empowerment in Ambikapur, Chhattisgarh, focusing on issues of health and development of leadership among tribal women. During her Fellowship she facilitated the formation and orientation of the VHSC in Kalpagram Pachayat. She worked towards establishing cordial relation between ASHA and other healthcare workers. She was particularly instrumental in facilitating infrastructure (solving problems of electricity and water supply) of the PHC she was working with the active support of the RKS.

Shiv Kumar Acharya (Rajasthan) is a post graduate in social work and is well versed in English, Hindi and Rajasthani. He has had an experience of working as a researcher and program coordinator with a few organizations on issues like social mobilization. As a fellow he worked in Bikaner and convened VHSC meetings regularly and awareness was generated among members of PRI and ANMs about VHSC and other issues related to NRHM. He sensitized ASHAs about VHSC and at the block level awareness was created on untied funds and its usage. At the district and state level he engaged with government officials to give light of the real situation on the ground vis a vis public health systems and force officials into action.

Surat Chandra Biswal (Orissa) is a post graduate in Social Work from Utkal University and can is able to deal in English, Hindi and Oriya. Having an experience of working on aspects of community mobilization and health with various organizations, he worked as a fellow in the Bargarh district. He participated in workshops and training on health issues, monitored the LLIN-BCC Campaign, initiated GKS strengthening measures and also was a district trainer for ASHAs on module 5.

Trishna Pani (Orissa) is a post graduate in Tribal Studies from Utkal University. She is fluent in English, Hindi, Oriya and can use Bengali as well. Having a very long experience in working at the block level on various issues including health concerns, she worked in Mayurbhanj district as a fellow. She enhanced 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

Vibha Upadhyaya (Rajasthan) is a post graduate in painting and is fluent in Hindi, Mewati, Garasia, Rajasthani, and English. She has a rich experience of working on adolescents' and women's issues with Doosra Dashak. During the fellowship she worked in Pali district. Action on strengthening ARSH services by training adolescents, anganwadi workers and ANMs was initiated by her. She also organised an adolescent health day.

