PHRN

MARCH 2018

VOLUME 2, ISSUE 1

EDITORIAL

The budget for 2018-19 has been a great disappointment. The hyperbole with which the budgets for agriculture and health sectors was announced is deeply flawed. There is also no focus on employment generation. There is a 15% increase in the allocation for MNREGA, which merely brings it on par with the revised estimate for 2017-18, which was then itself inadequate to meet backlogs of payments, and increasing compensation.

With regard to PDS, while the food subsidy has increased nominally, the subsidy for decentralized procurement has been reduced by Rs. 7000 crores.

The budget for ICDS has seen a very limited increase from Rs. 15,245 crores in 2017-18 to Rs. 16,334 crores (BE), a nominal increase of 7%. This is in spite of the fact that in September last year, the government announced an increase in unit costs for the Supplementary Nutrition Program (SNP) under ICDS that will require higher resource. In addition, there has been a drastic cut in the allocation for the National Creche Scheme; this will affect the nutrition and development of 36% of small children.

The allocation for MDM has seen a small increase which is not adequate to take care of inflation, let alone improve the nutritional value of the meals. The budgetary allocation for the National Nutrition Mission (Rs 3,000 crores) does not indicate how it will be utilized. The only positive is the allocation for nutritional supplementation for TB patients.

The budget for PMMVY, which was highly inadequate in 2017, even for the reduced number of beneficiaries, has seen a further reduction in 2018-19, down from Rs. 2700 crores to Rs.2400 crores. There has been a slight increase for pensions, but the contribution of the centre remains very little.

The health budget is extremely anti-people as it makes little provision for National Health Mission and to improve the infrastructure for primary health care. Instead of investing in these essentials, the finance minister has initiated the National Health Protection Scheme, where, 10 crore families will be insured for Rs. 5,00,000 per family for secondary and tertiary care in private hospitals. However, most of the out-of-pocket expenses are for outpatient treatment, which should be catered to by PHCs at the local level - tuberculosis that requires prolonged treatment, most chronic diseases (diabetes, hypertension, and heart diseases) or cancer treatments that do not call for hospitalization. Given the current state of the PHCs and the lack of budget for improving services, patients will be forced to seek extremely costly out-patient treatment from the private sector.

Similarly, in the context of agriculture, while some increase in allocation has been made for fisheries, animal husbandry and dairy, the focus has been to increase corporate presence in agriculture. The most disappointing part is the supposed increase in MSP to be 50% more than the cost of production, which does not take into account several costs including the imputed rent on land and interest on capital and actually results in a very low net income. It will be lower than the current MSP, which was 79% to 112% higher than the cost of production calculated with the same formula.

IN THIS ISSUE

NEWS FROM THE SECRETARIAT

Dr.Ganapathy Murugan

The Governing Body Meeting was held on 1st of December 2017, in New Delhi. The next GBM will be held in Delhi on February 26, 2018; the General Body Meeting will be conducted in New Delhi.

The micro site has been put in place for International Conference on Critical Public Health Consequences of the Double Burden of Malnutrition and the Changing Food Environment in South and South-east Asia to be held on 28th March to 30th March 2018. The link is: http://www.nutriconference18.com/

We have received many abstracts for the conference and are under the assessment of abstract review committee for the final acceptance.

PHRN in AMCCON 2018

Osama Ummer

A National Conference on "Health Inequities in India: Transformative Research for Action", organized by Achutha Menon Centre for Health Science Studies (AMCHSS), Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST), Trivandrum was held on 8-11 January 2018. Seven PHRN members (Dr. Vandana Prasad, Dr. T. Sundararaman, Dr. Ganapathy Murugan, Ms. Sulakshana Nandi, Ms. Smruti Sudha, Ms. Deepika Joshi, and Dr. Osama Ummer) participated and contributed to the conference as keynote speaker, paper presenter, etc.

PHRN Team @ AMCCON, 2018

Dr. Vandana Prasad (National Convenor, PHRN, New Delhi), presented the initiatives and activities of "The Right to Food Movement" in a plenary session: The role of social movements in equity in health and/or its social determinants.

Dr. Vandana Prasad with other speakers and the session Chair Dr. B. Ekbal (Neurosurgeon & Member, Kerala Planning Board)

Dr. T. Sundararaman (Governing Board Member, PHRN) delivered the concluding keynote speech on 'Towards Transformative Research for Health Equity in India'.

Ms. Sulakshana Nandi (State Convenor, PHRN, Chhattisgarh), presented a paper "Exploring Health Inequities Amongst Particularly Vulnerable Tribal Groups (PVTG): Case Studies of Baiga and Sabarun, Chhattisgarh and Jharkhand States of India".

Ms. Sulakshana Nandi with other speakers and the session Chair Ms. Renu Khanna (Founding trustee SAHAJ) during the discussion.

Dr. Ganapathy Murugan (Executive Director, PHRN, New Delhi), was a discussant in a session chaired by Prof. Sanghamitra S. Acharya (Indian Institute of Dalit Studies, New Delhi) on Tribal Health.

Dr. Sundararaman delivering the concluding keynote speech

Dr. Osama receiving the first prize from Dr. K. R. Thankappan (Professor Emeritus, AMCHSS, SCTIMST

Dr. Ganapathy Murugan, Dr. Vandana Prasad, Dr. Sundararaman, and Ms. Sulakshana Nandi participated in the priority setting exercise for finalizing short term and long-term research agenda to support policy makers to eradicate inequities in health care.

Dr. Osama Ummer (Programme Coordinator, PHRN, New Delhi), secured first prize in non-paper presentation category for the photo essay titled "Pathways to Hope".

Staff news

- Dr. Aditi Hegde (Master's in Public Health Dentistry) joined the PHRN Delhi office as a Programme Coordinator.
- Ms. Anjana Bal and Mr. Kishley Anand have been recruited as new Block Programme Coordinators for Sonua (Jharkhand) and Mohgaon (Madhya Pradesh) respectively.
- Two Block Programme Coordinators, Mr. Satish Kumar (Sonua, Jharkhand) and Ms. Sabita Chettri (Mohgaon, M.P) have resigned from their respective responsibilities.

NEWS FROM JHARKHAND

News from Gola

Rajesh Sriwatswa

A CV from Rakuwa conducted MM2 few months ago. The SHGs decided to purchase LOHE KI KADAHI. The SHG, to which this CV belongs, is yet to purchase the utensil. The CV bought it for herself few months back. She had a problem of constant pain in her ankle. Now after using LOHE KI KADAHI since last few months her pain has gone. She was advocating this during the meeting so that the SHG can purchase them soon.

During CV training on PB1 (TRI) in June 2017, the CV of Mandap Tolla was 4 months pregnant. She participated in the 1st batch of CV training. After returning home she went to register her pregnancy. The ANM asked for some money, which she refused to pay. She also refused to pay in the CHC for ultrasound. From then on, she started applying what she had learned during the training under MM4. She educated her husband regarding the care that is needed during ANC and her husband supported her. She delivered her fifth child as a healthy boy. He is now three months old.

She is facing some problem in having health meeting. Out of four SHGs, at her hamlet, two are under red flag (not regular in health meeting). At the last meeting, the CV was seated with two SHGs. They were waiting for remaining two SHG's members to come. The CV started telling the above story and showing her son. She recalled that

she was afraid during her pregnancy because the sibling of this boy was less than 2 years of age. But her husband supported her on applying everything on what she learned in PB1 (TRI). She was praising her husband that "after delivery of a healthy baby his trust on what I learnt has increased many times. He suggests that I do health meetings for the benefit of others." She had a genuine complaint- "I tried to apply certain things based on my memories of the training. Materials reached after delivery of the child. By looking at them (she was referring the ANC portion) my husband would have supported even better."

The CV and mentor from Malkhatua Tolla are still trying to get Pinki (see December 2017 edition) to attend health meetings, if not join an SHG. At the same time, CV Manju of the same village, after coming back from the CV training (PB1 TRI), shared what she had learnt from MM6 (family planning) with many women in her hamlet. She convinced 4 women, took the help of Sahiyya and ANM adopt the copper T method for family planning. In some sense she created live example for MM6 in her hamlet. Manju has completed MM3. In couple of months she will be doing MM6 and probably she will quote her own example during discussion session of MM6. She does not seem to be hesistant now.

One of the CVs took her eldest daughter's help for conducting health meeting MM1 Her daughter was taking care of her youngest sibling and she saw the meeting also. She took the

Chawal Daal and Bagh Bakri game to her school. Sita (mentor) and another CV after a gap of few days were facilitating MM1 at different hamlet. Adolescent school going girls were relating things very nicely. Sita asked them how did they know all this. Then she came know that CV's daughter had already conducted that game in school.

Tiranga Khana concept spreads

Rajesh Sriwatswa

The concept of a balanced diet is spreading through the villages of Gola district, thanks to the efforts of the change vectors (CVs). In Dandi Gachi village, one of the CVs complained of headache during training. Later on, she informed that "Training ke bad tiranga khana khana suru kiye ab to maatha darad bhi bhag gaya hai".

A CV of Auradih told her family members about balanced diet, etc. She changed the family diet accordingly. One day as she had to leave early for a meeting, she cooked food according to previous practice. Her family members complained to her "Aaj to Tiranga khana nahi banai ho. Tiranga khana banana chahiye tha". CV was laughing while telling this story, but also complained that she had added to her problems.

Yet another CV from Hulu village shared that from her rooftop, she saw one of the newly trained SHG members was conducting a similar training for her family under a tree.

Many school children start chanting "Ache khane ki thali...." and "Safed

safed khayenge" whenever they see the programme personnel. When asked where they had learned these slogans, the children said their mother had taught them after learning it during training.

The spread has reached men also. A man who never attended any health meetings, commented. "Aaplog khatte ko khane ka bat karte hain wo sahi baat hai".

Positive Modification of Behavior among community people of Jhalda……few Case Stories

Shampa Roy

The journey towards positive behavioral change among community people at Jhalda can be count on the basis of the little changes brought by the adoptability and inspiration of the change vectors. Meeting cycles 1, 2, 3 & 4 have already triggered not only the CVs, but it is also spreading to the other community people. They are influenced by the stories of Meeting Cycles and those stories stimulated them to maintain few action points in their life related to hand washing, regular checkups of pregnant women, encourage at least fundamental then high education of girls as well as boys, stop early marriage, have nutritious food, do kitchen garden and so on.

Few cases/short-stories are highlighted in the following:

During Meeting Cycle 4 (Silwanti's story), all the 64 CVs of Jhalda planned to do kitchen garden by using only bio-fertilizer named JIVAMRIT & bio-insecticide named NEEMASHTRA. So during kharif (July-August, 2017) 64 CVs did kitchen garden of 10 different vegetables - tomato, chilli, okra/ladies finger (bhindi), lablab been (Sim), basella (Poi sag), bottle gourd (Louki), sponge gourd (Nenuya), bitter gourd (Karela), cowpea (Boti), kang kong (kolmi sag) in 1 decimal area.

Af*ter observing these kitchen gardens and attending the health meeting (Meeting Cycle 4), 252 more women came forward and bought the seeds for kitchen garden. Overall 316 community people are doing kitchen garden in this rabi season (fully organic plantation) in 5 panchayats.

During the journey of their planning and implementation of kitchen gardens, various incidents took place.

While at the beginning men often did not support their women, they did so when they saw the results. Now even men are showing interest in learning organic farming techniques.

Almost 8 months ago (July, 2017), when one of the CVs, named Chinta Mahato was doing her kitchen garden at Putidih (Ilu Jargo Gram Panchayat), one Samiti member named Tushtobala Mahato had observed her kitchen garden since the beginning. One day she asked the CV "Without using inorganic fertilizer you are having such a good production, you are even able to have healthy vegetables. In the coming season I would like to do kitchen garden like you. Will you help me?" During the rabi season, this

CV helped her to do kitchen garden. She explained, "I am very happy, as now I am getting 10 types of healthy vegetables from my 1 decimal area. Even my husband is appreciating me for doing this and he told that he will help me in the next season for doing kitchen garden."

A CV named Urmila Mahato had to face pressure and de-motivation from her husband for maintaining a kitchen garden during kharif season. Her husband at the beginning used to tell her, "All these are useless, why are you wasting time? We are getting good vegetables from the market, then why are you wasting this land? Don't even think of doing it next time".

Urmila felt hurt as her husband didn't support her. But she did not lose hope and continued work on her kitchen garden using only bio-fertilizers and bio-insecticides. After the production,

she served the first produced two cooked vegetables (kang kong- kolmi sag, cowpea-boti) to her husband. Her husband stated, "I really like its taste. It is sweet". Urmila continued to cook vegetables from her kitchen garden instead of buying from the market. After few days, Urmila's husband told her, "Our children are having healthy food. Even our money is saved. I want to support you during the kitchen garden in the rabi season". During rabi, Urmila's husband fully supported her for the kitchen garden. Now they are again enjoying 10 types of vegetables (fully organic).

At village Olgara (Mathari Khamar Gram Panchayat), when during rabi (December, 2017) a CV named Ambika Mahato was giving demonstration of kitchen garden in her field, a woman named Khedni Mahato became interested and asked the mentor, "I want to control the health issues in my family. So, can I get a kitchen garden kit? I want to do kitchen garden". The CV provided her the kit. But returning home when she discussed the matter with her husband, he replied strictly, "Are you becoming mad? We are already earning more than 1 lakh a year cultivating the brinjal. We can buy vegetables from outside as usual. You just wasted Rs. 150 buying this kitchen garden kit. Do whatever you like for now. I will not allow it from next time."

Without the support of her husband, Khedni started her kitchen garden. Her husband tasted the vegetables, which was sweet in taste and completely different from the market vegetables. As time passed, Khedu's husband realized the importance of the kitchen garden. He told his wife, "You did this very nicely. From next time I will definitely support you to do kitchen garden".

During the Health Meeting (Meeting Cycle 4) at Putidih, a person named Bankim Mahato passively participated and was listening to Silwanti's story very carefully. He also heard the CVs' success story of kitchen garden and saw its pictures. His wife is not involved in any Samiti. So, he thought he could not do it. Gaining courage, he interacted with the CV after the meeting was over. He asked her, "Can I do kitchen garden? I want to feed my family healthy food. Can you help me?"The CV supported him. He bought seeds from the CV and did kitchen garden this Rabi.

The outreach stories of the Meeting Cycles are reaching beyond the SHGs.

One of the CVs of the village Sarjumatu named Mamata Kuiry did kitchen garden (fully organic) and produced 10 wonderful types of vegetables - tomato, chilli, okra/ladies finger (bhindi), lablab been (sim), basella (poi sag), bottle gourd (louki), sponge gourd (nenuya), bitter gourd (karela), cowpea (boti), kang kong (kolmi sag) in her 1 decimal area. After the vegetables were grown, the villagers within as well as outside the village used to visit the kitchen garden. Mamata's husband, Naren Mahato, loves to give a few vegetables to the visitors to taste. After seeing and tasting the vegetables of the kitchen garden and learning the process of it from Mamata, 9 women from village Jamlohor (nearby village of Sarjumatu, Ichag Gram Panchayat) started kitchen gardening in their 1 decimal area. The interesting point is that all these 9 women don't belong to any Self Help Group.

People are increasingly recognizing the benefits of organically grown vegetables in the kitchen garden, as compared to vegetables from the market. One day, Premnath Mahato from Gopalpur village (Jhalda Dorda Gram Panchayat) was interacting with the Mentor Hiran Mahato regarding the spreading of organic kitchen gardening in their village. He stated that, "You know, now whenever I go across Rajarhat of Jhalda (the vegetable market), I cannot just bear the smell of the vegetables of the

market. After eating organic vegetables, the smell of the vegetables grown by using lots of inorganic fertilizer is really creating irritation".

At Refresher training of CVs on Meeting Cycle 5 in the last week, during the Technical Session (Management of Anemia), the importance of cooking in iron utensils (Lohe ka Kadai) was discussed. During this discussion, one of the CVs named Putula Mahato shared her story: "I heard about the importance of cooking in iron utensils from sub-center, but I didn't follow it. After I attend the Meeting Cycle 3, I decided to try it out. Sometime in August, 2017 I requested my husband to buy the iron utensil. From that time I am using the kadai for cooking on a regular basis. My elder daughter used to suffer from

waist pain. But a few days ago, she told me that the pain had decreased. May be regularly eating food made in Lohe ka Kadai has helped to decrease the waist pain".

Kalpana Majhi is a 14 year-old girl from the village Potmadih (Jhalda Dorda Gram Panchayat) studying in Class VIII. She has a younger sister and brother. She belongs to a financially backward family, and her parents are daily laborers. Her parents decided her marriage in the month of March, 2017 as she was just like burden to them.

After Meeting Cycle 1 was started in the village, Kalpana's mother Lalita also participated in the meeting. There she came to know the negative effects of marriage before 18 years of age. After she heard the story of 'Soni & Madhav', she stated, "Soni's story is almost like my real life story, but I can't do anything now. My daughter's marriage is already fixed". This issue was discussed in Samiti at the initiative of CV Putula Majhi. Samiti members along with the mentors and CV went to the child's family and made them understand why they should not to conduct this illegal marriage, and should, instead, gift their child a wonderful future. At last, Kalpana's father agreed not to arrange her marriage until she is 18 years.old. Now Kalpana is going to school and continuing her studies. She shared her story with her peer group. According to Kalpana, her peers are also inspired hearing her story, and decided not to marry before 18 years of age.

Behavior changes in Torpa

Sunil Thakur

On 13th January, 2018, an SHG member of Chatakpur called mentor Sancharya Lakda, and said that they had purchased Lohe ki Kadai. On hearing this, I visited Chatakpur hamlet of Husir village and saw 12 Lohe ki Kadai in the hands of SHG members.

There are 9 groups in Chatakpur hamlet, 7 are connected to PRADAN and 2 are with Mahila Vikas, another organization in Torpa. Of these, two groups, Jivan Jyoti Mahila Mandal and Manjar Mahila Mandal are closely related to each other, as the members of the former are all mothers-in-law, and those of the latter are daughters-in-law. There are 12 members in Jivan Jyoti Mahila Mandal. Yesterday, all of them purchased Lohe ki Kadai together

Micro-module-2, in which Lohe Ki Kadai is discussed, was run on 8-12 December 2017 in Chatakpur hamlet. Since then, our mentor was moving around the hamlet trying to convince the women to purchase Lohe Ki Kadai and its importance. Now this has happened in one group. The women of Manjar Mahila Mandal (all daughters-in-law) wanted to know whether they too should purchase the kadai. So I told them one Kadai for one family is enough and they need not purchase another kadai in the same family.

Sanchari Devi of Manjar Mahila Mandal was having lunch around 10 am, and she showed her dish to the Mentor, saying "Didi dekhiye humlog ab tiranga bhojan karte hain." She was eating rice, pulse and vegetables. I asked other members of the groups about their dishes and they replied that right now they were not able to eat vegetables everyday but they had included pulses

On 12th February, the Hindi newspaper, ***Hindustan***, reported at length about the Lohe ki Kadahi Abhiyan and its benefits. Later in the day, the journalist called Sunil to say that BBC was interested in doing a special program on the campaign.

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क्षेत्र की महिलाओं को पब्लिक हेल्थ रिसोर्स नेटवर्क द्वारा बताया गया है कि लोहे की कड़ाही में खाना बनाने से शरीर में आयरन की मात्रा होती है पूरी

तोरपा बाजार से महिलाओं ने एक ही दिन खरीद लीं लोहे की सभी कड़ाही

खूंटी | अजय शर्मा

तोरपा बाजार के सारे बर्तन की दुकानों से लोहे की कड़ाहियां बिक गईं। महिलाओं ने एक ही दिन में 300 कड़ाहियों की खरीदारी की। चंद दिनों पहले विभिन्न गांवों की महिलाएं एक साथ कड़ाहियां खरीदने तोरपा पहुंच गई थीं।

वर्तमान में कई महिलाओं ने लोहे की कड़ाहियों के लिए एडवांस दे रखा है। लोहे की कड़ाहियों की बिक्री में अचानक आई तेजी के पीछे का कारण महिलाओं के स्वाथ्य से जुड़ा मामला है। पब्लिक हेल्थ रिसोर्स नेटवर्क द्वारा अपनी छोटी-छोटी आदतों को सुधारकर स्वास्थ्य को बेहतर बनाने की शिक्षा इस क्षेत्र में पिछले दो सालों से दी जा रही है। पीएचआरएन के प्रोग्राम ऑफिसर सुनील कुमार ठाकुर ने एक अनुसंधान के बाद गांव की दीदियों को बैठकों में बताया कि आयरन से भरपूर खाद्य पदार्थ भी अगर किसी और बर्तन में बनाया जाएं तो शरीर को उतना आयरन नहीं मिल पाता है जितना कि मिलना चाहिए। लेकिन उसी खाद्य पदार्थ को अगर लोहे के बर्तन में बनाया जाए तो 90 प्रतिशत अधिक आयरन प्राप्त होता है। लोहे की कड़ाही में साग-सब्जी बनाकर खाने से शरीर के अंदर कुछ लौह तत्व चले जाते हैं, जो खून की कमी को दूर करने में मददगार साबित होता है। ऐसे में लोहे के बर्तन में खाना बनाकर अनीमिया जैसी बीमारी को दूर भगाने के लिए प्रयास किया जा सकता है। स्वास्थ्य के प्रति जागरुकता लाने के लिए पीएचआरएन ने तोरपा प्रखंड के 121 टोलों की 150 दीदियों का चयन कर उन्हें स्वास्थ्य एवं पोषण का प्रशिक्षण दिया है।

अब ये दीदियां महीने में एक बार लोहे के बर्तन में खाना पकाकर खाने से आयरनयुक्त भोजन की गुणवत्ता बढ़ती है, यह शरीर में आयरन की कमी को दूर करने में सहायक होता है।

डॉ विनोद उरांव, सिविल सर्जन, खूंटी।

अपने टोलों में बैठक कर स्वास्थ्य को बेहतर बनाने पर चर्चा करती हैं। बैठक में गर्भवती महिलाओं का आंगनबाड़ी में पंजीयन, एएनसी जांच, बच्चों का टीकाकरण जैसे स्वास्थ्य सुविधाओं के साथ खान-पान पर चर्चा की जाती है।

रविवार को लोहे की कड़ाही के साथ तोरपा की महिलाएं। • हिन्दुस्तान

in their meals. They said that they have started to create kitchen gardens and after two months they would be able to eat tiranga bhojan. Later in the month, 20-25 groups from Fatka, Urikel and Ukrimari planned to get their Lohe Ki Kadai from the market.

Rekha Devi, CV of this hamlet, took me to her house and showed her kitchen garden. Though only the circular boundary has been laid out till now, after two-three months she will

get vegetables from it. She has used the same technique that was used in CVs' training in forming the kitchen garden, which is near the place where pots are washed and all water goes into the garden.

There are visible changes among the community especially in terms of health and nutrition. Our mentors and community both are gradually gearing up. It would not been possible without the support of PRADAN.

Capacity building of Chaupal team

Rajesh Sriwatswa

The second phase of capacity building of the Chaupal team occured during 21st to 23rd Dec'2017at Ambikapur. The team members were mostly engaged in livelihood, system strengthening, legal issues including forest rights, etc. Public health was comparatively new for them. So it was decided to transact PB1, adolescent health from PB2 and PBn1.

We started with reflection exercise (written and oral) with participants. During this session participants shared many success stories. It was heartening to know that many things are happening in the field.

In Kanker district, one adolescent unmarried girl was pregnant. The family and neighbours were hiding it due to shame. Her pregnancy was in the last stage. After hearing the Soni and Madhu story, the family decided to change their stand. Her ANC started. The community supported the family and the girl very positively. The culprit is now in jail. The girl delivered a boy child. The Chaupal team is still following the case.

In another village, adolescent girls are prone to sexual exploitation at the construction site, with many becoming pregnant and hence leaving their maternal home and opting to live in cohabitation. After hearing Soni and Madhu's story, the village decided to restrict the adolescent girls from working at the construction site. Even if some were compelled to work, they are restricted from using mobile phones.

In most of the cases shared by participants, the community, after listening to the Soni and Madhu story, identified the families and girls who are at risk. They shared many cases where mothers/family decided to postpone the marriage of her daughters.They also shared about the cases where the girls decided to postpone their marriage/ cohabitation, keeping the age factor in mind.

A participant managed to convince one of the Baiga families and delayed the bath of newborn. The community has a practice of bathing baby on the 1st day itself.

We discussed home visits which they are doing but mostly for advising. We also discussed indicators for choosing suitable families. At the end of MM3 (food group) we discussed about the opportunity of linking the home visits with MM3 and other components of the project. The participants said, "Now we understand why we doing these interventions"

NEWS FROM CHATTISGARH

Sulakshana Nandi presenting a paper at AMCON (also see page 2)

Action plan developed for Sabar and Baiga communities

Sulakshana Nandi and Deepika Joshi

In 2016-2017,Public Health Resource Network and State Health Resource Centre with the support of Achutha Menon Centre for Health Science Studies, Trivandrum undertook a research study on "Exploring health inequities amongst Particularly Vulnerable Tribal Groups: Case studies of Baiga and Sabar in Chhattisgarh and Jharkhand states of India".

The findings were shared with Mission Director National Health Mission who requested PHRN and SHRC to develop an action plan for the area based on the study. Over the next month PHRN and SHRC once again visited the area and interacted with the Baiga community, health workers, NGO workers, health staff and district health administration. The draft plan was shared with the CMHO who gave his suggestions and ratified the plan. The plan has been submitted to Chhattisgarh NHM office and it is hoped that certain provisions will be made in the 2018-19 NHM PIP. The plan suggested the following strategies:

- Selection of Baiga (PVTG) mitanins in Baiga hamlets.
- Relaxing population norms for higher coverage- eg. additional Sub centres, opening phulwaris in hamlets too small for anganwadi centre.
- Recruitment of ANMs from local pool of Mitanins who've undergone the ANM course.
- Actively enrolling Baiga women (non-mitanins) for ANM course, with scholarship.
- Provision of referral transport- Bike ambulance at sub-centre, Doli, Drop back transport ensured.
- Opening of new primary health centre and strengthening of existing one.
- Operationalisation of health & wellness centres.
- Improving facilities at all health facilities for better responsiveness to community - eg. help desk, food to family, choice available to women to select most comfortable delivery position, maternity waiting room, sensitisation/skill-based training of health staff.
- Remove restriction on sterilisation, recognise autonomy of Baigas to take decision about own family & body.
- Intersectoral action on health- PHE, School, Food & Civil Supplies, ICDS, Forest, Roads & highways, Mining departments.
- Introduction of eggs and other local grains & vegetables in Anganwadis Mid Day meals.

Study on retaining rural health personnel

A Paper on "Is the Chhattisgarh Rural Medical Corps able to attract & retain health personnel for rural and remote areas? A qualitative study of health personnel's perspectives in Kanker District" has been published in the Medico Friend Circle Bulletin for February 2018 on the theme Health Workforce in India: facing the crisis in public health for its 44th Annual Meet of the MFC. This study was undertaken with the support of two second year students pursuing their Masters in Health Administration from Tata Institute of Social Sciences during their internship in PHRN Chhattisgarh"

Campaign for patients' rights presented at South Asia Learning Exchange Workshop

Deepika Joshi from PHRN presented learning and experiences from the Campaign on Patients' Rights in Chhattisgarh, at the two days South Asia Learning Exchange Workshop on Patient's Rights from 23rd to 24th January 2018 organized by Support for Advocacy and Training to Health Initiatives (SATHI) and Centre for Health and Social Justice at Mumbai.

COPASAH - Community of Practitioners on Accountability and Social Action in Health - is a global network of community of practitioners who share a community –centric vision and human rights based approach to health, health care and human dignity.

Other activities

- Sulakshana was invited as a Plenary speaker at 'Clairvoyance', the Annual Health Conference of the School of Health System Studies, TISS Mumbai, on 25th November 2017. The plenary was on '21st century leaders in Health Sector.. Paragons of inspiration'.
- Paper titled 'Hospital utilization and out of pocket expenditure in public and private sectors under the universal government health insurance scheme in Chhattisgarh State, India: Lessons for universal health coverage' by Sulakshana Nandi along with Helen Schneider (School of Public Health, University of the Western Cape, South Africa) and Priyanka Dixit (School of Health Systems Studies, TISS Mumbai) published in PLOS ONE, on 17th November 2017. The study finds that despite insurance coverage, the majority still incurred OOP expenditure. The public sector was nevertheless less expensive, and catered to the more vulnerable groups. It suggests the need to further examine the roles of public and private sectors in financial risk protection through government health insurance.

Link to the article- http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0187904

NEWS FROM ODISHA

Status of the project "Mainstreaming of Crèches to Reduce Malnutrition in Odisha"

Satya Patnaik and Shahnawaz

PHRN and Azim Premji Philanthropic Initiative launched the project "Mainstreaming of Crèches to Reduce Malnutrition in Odisha" in the latter half of 2017. The project is supported by the State Government.

The project aims to set up 10 crèches each in three blocks of Rayagada and Kalahandi districts. Three models of creches are being set up:

- Anganwadi cum crèche
- Crèches in villages with PVTG community
- Crèches in villages with non-PVTG communities in remote locations.

Creche sites are chosen on the basis of the availability of adequate space, nutritional status of the children, community interest in the program, and number of mothers going for wage work..

Each creche has 10-15 children and 2 creche workers who are local women selected by the community, and are given residential training Eligible children are screened with the help of the creche workers, ASHA and AWW.

Till date, a total of 15 crèches in Rayagada and 14 crèches in Kalahandi district are functioning on trial mode. A total of 378 and 429 children aged under three were identified in Kalahandi and Rayagada districts respectively, out of which around 235 (Kalahandi) and 347 (Rayagada) children have enrolled themselves to avail the services of the crèches. The process for setting up of another 15 crèches has also been initiated as per phase 2 in both the districts, and it is expected that they will be opened by end of April 2018.

A model creche

As the project is in trial mode, continuous handholding support is being provided to the crèche workers by the PHRS team and quarterly block level review and experience sharing meetings have also been planned.

All the crèches are functional for 7-8 hours a day, and for 6 days/week. The children are fed three times a day. In addition to this, children are being provided eggs twice a week. The feeding programme in the crèches aims to take care of 60-70% of daily calorie requirement and 75-100% of daily protein requirement of a child.

The children are being weighed every month and the heights are scheduled to be measured every 4 months. Out of the total children whose weight measurement were taken in Rayagada and Kalahandi districts, 44.3% are underweight. Again, out of the total children, 14.2% children were found to be severely underweight. In terms of weight for height, 16.5% children were found to be wasted. The proportion of SAM children is 3%. The proportion of stunted children is found to be 50.5% while out of the total children whose height measurement was taken, 20.5% were found to be severely stunted. 2 SAM children in Rayagada have been referred to NRC while information on health complications of 2 children in Kalahandi has been communicated to the concerned MO/IC(s). Home visits have been conducted for all the SAM children and their respective families have been counselled.

There is a strong focus on promotion of proper hygiene not only in the crèches, but also in the homes of all the children. Handwashing with soap and water is part of the daily curriculum and is a strong component of the training.

The crèches have been provided with toys for early childhood care and development. Apart from this, formal training of the crèche workers on ECCD activities has also been planned.

Mothers of all the eligible children in the villages are being encouraged to form a creche and take responsibility for better and smooth management of crèches.

There are several challenges facing the project. These include lack of telephones and road connectivity, toilet facilities and safe drinking water.

A new 'basant" for this Majhi

Satya Prakash and Shahnawaz

Basanta Majhi is a 37-month old child from Badatikaraguda village in Thuamul Rampur block of Kalahandi district. The village Badatikarguda is proximal to the Karlapat Wild Life Sanctuary and is composed of mainly Scheduled Tribe (ST) population. His father's name is Suna Majhi and mother's name is Moti Majhi . When the first creche in Kalahandi under PI project was opened on 27th October 2017 Basanta Majhi was severely underweight and severely wasted and not very active.

Though at the time of creche opening he had already completed 35 months, keeping in mind the critical situation of the child, nevertheless, he was admitted to the crèche by PHRN team in the district.

On having a detailed conversation with his mother (she is also a crèche worker) it was found that even at the age of 35 months Basanta's diet mainly depended on breastfeeding. However, she mentioned that after receiving training from PHRN, where information was disseminated on importance of complimentary feeding after 6 months, she had started focusing on complementary feeding. Gradually. Basanta Majhi became used to eating rice, dal, etc. His family mentions that the creche programme has helped Basanta Majhi (and many others) in changing his feeding habits and there has been a slight, although gradual, increase in his weight.

The family members also mention that the feeding programme as well as play activities introduced in the creche has enabled him to be more active, and as he is with children of his same age group in a safe environment (creche), he is better able to socialize.

Though the child has over 36 months of age and should graduate from the programme, he is coming to the creche; keeping in mind the vulnerable condition of the child, and with the AWC merely providing basic services, PHRN has accommodated him in the programme. Now he seems to be the most physically active child in the crèche.

NUTRITION NEWS

Reproduced from Urban HUNGaMA, 2014

The objective of the URBAN HUNGaMA Survey 2014 was to assess the nutrition status of children aged 0-59 months living in the 10 most populous cities of India, namely: Mumbai, Delhi, Bengaluru, Hyderabad, Ahmedabad, Chennai, Kolkata, Surat, Pune and Jaipur. The survey was implemented between April and July 2014.

The proportion of children born with low birth weight (i.e. less than 2.5 kg) was 15.7%, ranging from 13.5% in Hyderabad to 25.1% in Kolkata. In all, 22.3% of children under five years of age were stunted (chronic undernutrition) and 7.6% were severely stunted. The prevalence of stunting ranged from 14.8% in Chennai to 30.6% in Delhi and was significantly higher among children whose mothers had five years of schooling or less (35.3% compared to 16.7% among children whose mothers had 10 or more years of schooling) and children from households in the lowest wealth quintile (29.3% compared to 15.0% among children from households in the highest wealth quintile). Overall, 13.9% of children were wasted (acute undernutrition) and 3.2% were severely wasted.

The prevalence of wasting ranged from 10.8% in Jaipur to 19.0% in Mumbai. As in the case of stunting, the prevalence of wasting was signifi cantly higher among children whose mothers had five years of schooling or less (17.6% compared to 12.2% among children of mothers with 10 or more years of schooling) and children from households in the lowest wealth quintile (16.7% compared to 10.5% among children from households in the highest wealth quintile).

The prevalence of overweight in children was 2.4%, ranging from 0.7% in Hyderabad to 3.7% in Chennai. The prevalence of overweight was significantly higher among children from the highest wealth quintile (3.6% compared to 1.8% among children from households in the lowest wealth quintile).

The survey revealed sub-optimal compliance with those recommendations: 37.7% of children aged 0-23 months were breastfed within one hour of birth (ranging from 13.3% in Jaipur to 66.8% in Chennai); 30.47% of children aged 0-5 months were exclusively breastfed (ranging from 12.0% in Chennai to 38.7% in Kolkata); 45.2% of children aged 6-8 months were fed complementary foods (ranging from 29.1% in Jaipur to 70.5% in Chennai); 47.2% of children aged 6-23 months met the standard of minimum meal frequency (ranging from 21.8% in Delhi to 88.8% in Mumbai); and 37.8% of children aged 6-23 months received at least a minimum number of food groups (dietary diversity) (ranging from 22.7% in Ahmedabad to 59.4% in Kolkata). On indicators of minimum dietary requirements (breastmilk/ milk, minimum meal frequency, and minimum dietary diversity) 22.5% of children aged 6-23 months were fed in accordance with all three (ranging from 9.7% in Surat to 47.3% in Kolkata).

The findings of the URBAN HUNGaMA Survey 2014 indicate that in the 10 most populous cities of India, one in four children has stunted growth and development due to chronic nutrition deprivation. Poor infant and young child feeding practices, compounded by the poor status of women, the prevalence of household poverty and lack of government service delivery centre seem to be three major drivers of stunting among urban children. Less than one in four children (22.5%) were fed a diet that meets the minimum requirements for healthy growth and development.

MATERNITY BENEFITS AND BUDGET 2018-19

On 31st December 2016, Prime Minister Modi, in his address to the nation, announced the expansion of the Indira Gandhi Matritva Sahyog Yojana (IGMSY) to cover all births across the country. The IGMSY was based on the National Food Security Act (NFSA), which entitles all pregnant and lactating mothers to a cash incentive of Rs 6,000 for the first two live births, if they meet several conditionalities, as compensation for wage loss, provide them adequate nutrition and rest before and after delivery to enable them to exclusively breastfeed the newborn for the first six months. .

The 2017-18 budget allocation of Rs. 2700 crores for the maternity entitlement scheme, now called the Prime Minister Matru Vandana Yojana (PMMVY) reduced the benefit to only the first living child, violating not just the law of the land, but also withholding the entitlement of women who have had an earlier child. The amount per beneficiary was also reduced to Rs. 5000. According to the ministry, the reduction in number of beneficiaries and their entitlement was done as the allocated budget was wholly insufficient to meet the requirements of NFSA. In spite of the reduced number of beneficiaries, according to the ministry, women who received maternity benefit, numbered barely 1% of the IGMSY coverage.

The budget for 2018-19 has further reduced the allocation to Rs. 2400 crores. The decision to merge the implementation of PMMVY and Janani Suraksha Yojana (JSY) means that women will get Rs. 1000 less if they do not have institutional delivery. The JSY scheme is a separate scheme altogether, meant to encourage institutional delivery. The merger, thus, appears to meet the requirements of NFSA, while it actually changes the nature of the entitlement, putting the onus on the woman to "earn" the entitlement.

Besides diluting the entitlement by offering wage compensation only for the first living child, the new scheme and the budget for 2018-19 further deepens inequity and discrimination, as the amended Maternity Benefit Act provides women working in the formal sector with 26 weeks maternity leave on full pay, and with no conditionalities. Further, unlike for the formal sector, the payment is linked to Aadhaar, causing severe problems for the beneficiaries. Not just this, even the husband's Aadhaar card has to be shown, thus further discriminating against unmarried mothers.

When combined with the reduction in the allocation for the Reproductive and Child Health component of the National Health Mission by 33% in the 2018-19 budget, there is little hope of India reducing its high figures of maternal and infant mortality.

Currently there are two cases in Supreme Court seeking to expand the coverage under the NFSA. On domestic workers, there is an ongoing case (Shramjeevi) before Justice Kurian Joseph's bench which covers aspects of defining domestic work, registering employment, maintaining records of employment, etc. It was decided that an impleadment application will be filed in this ongoing case on issue of applicability and implementation of Maternity Benefits Act to domestic workers. On construction workers, there was a case before Justice Lokur's bench for which the judgment would be out in a month or so. A fresh writ petition may be filed using this judgement.

Excerpt from the reply by CIC, in reply to Second Appeal by Dr. Vandana Prasad on maternity benefit scheme and domestic and construction workers

Hundreds and thousands of women leave their domicile and their nearest and dearest for a better life, better career opportunities and in quest of ending all their melancholies, but do they in fact get those better career opportunities? Do they really get what they have been searching for? Does providence take them to a different world altogether? To make a slightest effort to know where those dejected people have headed to, we must have to digest this atrocious and appalling truth. The stakeholders conjure up people by narrating fancy stories of imaginary persons, but alas, people accustomed to peasant culture and bucolic lifestyle who are so naïve are entrapped to their sugar-coated words and succumb to each and every dictum. Paradoxically they are given away to an unusual form of life which is far from reality and strained to carry on for survival with what has been offered to them. To put it in simple words, those guiltless people who have not even attained the age of majority are sold to work at factories, industries as forced/bonded labours; women who are capable and are aspiring to become big in life are auctioned off as domestic workers.

At present, domestic workers often given very low wages, made to work for excessively long hours, have no guaranteed weekly day of rest and at times are vulnerable to physical, mental and sexual abuse or restrictions on freedom of movement. Exploitation of domestic workers can partly be attributed to gaps in national labour and employment legislation, and often reflects discrimination along the lines of sex, race and caste. The growing impact of domestic work in paid employment in India makes it more crucial to ensure that such work is given dignity and occurs under decent conditions with adequate pay. Appointment is done off the record and usually by word of mouth and workers rarely get benefits like insurance, paid leave, compensatory leave, gratuity, provident fund or pensions. Official figures in India suggest there are more than four million domestic workers in the country, but the real figures are almost certainly much higher. It is unfortunate to note that as

long as overall productive employment generation remains slothful, the ongoing pressures will be on both male and female workers forcing to accept working conditions that are degrading.

There have been many attempts to regulate this sector since independence. Most of these have failed due to governmental resistance-active or through neglect.

Enhancing shared parental pay - Ali v Capita Customer Management Ltd (employment tribunal)

Since shared parental leave (SPL) was introduced in 2015, the issue of whether or not employers need to enhance shared parental pay if they already enhance maternity pay has been controversial. The recent employment tribunal decision in Ali v Capita Customer Management Ltd has generated further uncertainty.

The claimant issued a claim in the employment tribunal following his employer's refusal to enhance his pay during a period of SPL. He complained that this amounted to direct sex discrimination given his employer's policy to enhance maternity pay.

The employment tribunal upheld his claim, commenting that the role of primary carer is a matter of choice for the parents, but that the choice should be free of "generalised assumptions" that the mother is always best placed to undertake the primary role and should get full pay.

As the case is a first-instance decision and therefore not binding, employers will have to wait for an appeal court decision before greater certainty is provided.

It has been reported that the claimant's employer, Capita, will appeal the decision.

The introduction of SPL has largely been a positive move to better flexible arrangements for working parents. However, the revised provisions have also given rise to discrimination claims in relation to pay disparity between men and women.

In the case of Ali v Capita Management Ltd, a father successfully argued that his employer's failure to match enhanced rates of pay when taking SPL amounted to direct discrimination. The Tribunal ruled that not offering enhanced pay to a Mr Ali who took ShPL after his wife was diagnosed with postnatal depression amounted to direct discrimination. Mr Ali's employer offered 2 weeks full pay for paternity leave, whist providing 14 weeks full pay for mothers on maternity leave.

PUBLIC HEALTH RESOURCE NETWORK (PHRN)

PHRN is a growing network of individuals and organizations with the perspective of strengthening technical and management capacities to take action towards the common goal of 'Health for All'. Its 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. PHRN is currently working directly in the states of the states of Chhattisgarh, Jharkhand and Odisha and has contributed to the on-going work of strengthening public health systems in other states through its partnerships with other institutions.

Whereas PHRN is a voluntary network of many hundred concerned public health practitioners who are willing to intervene towards 'Health for All', **Public Health Resource Society (PHRS)** is the core group that has initiated the network. PHRS is a national level organization that is registered in Delhi under Societies Registration Act 1860 (Act XXI). It comprises of a small group of members and full timers that provides leadership to the network as well as functions as its secretariat.

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