EDITORIAL

Despite significant improvements made in last few decades, India's public health challenges are huge and growing at an unprecedented rate. The concerns shown by the organizations at the global level indicate that, in view of the resurgence of various epidemics, both infectious and non-infectious, the situation can be handled only through the public health management approach. This urgency was realized and expressed in the public health conference in India expressed as 'Calcutta declaration', which called for the creation of appropriate structure for public health professionals and promoting the reforms for public health education and training.

The National Institute of Health and Family Welfare initiated a Public Health Education and Research Consortium (PHERC) with the objective of networking and partnership with public health institutions in the country to enhance their research capacity. As the nodal agency for imparting in-service training to the health personnel and conducting research under NRHM, the institute is an ideal partner to facilitate the mainstreaming of the Department of Community Medicine in Medical Colleges, Nursing Colleges and other public health education and training institutions in the health care delivery system of the country, and for providing a platform to build networks for capacity building of these institutions.

Currently, under the National Rural Health Mission many innovations have been introduced in states to deliver health services in an effective manner. State programme managers wish to know how well these innovations are performing so that in case of gaps, corrective measures can be taken to achieve the stated objectives. There has been an increasing recognition for incremental improvements in the programme delivery by undertaking quick and rapid health systems research and engineering the feedback into the processes. An impending need was discerned to develop a cluster of institutions and strengthen their capacities on rapid appraisal methodologies for generating programme relevant information at local and regional levels.

Rapid Assessment of Health Interventions (RAHI), a collaborative activity with the United Nations Population Fund (UNFPA), is a unique initiative taken under the wider umbrella of 'Public Health Education and Research Consortium (PHERC)' of the National Institute of Health and Family Welfare for developing partnership with different organizations working in the field of health and family welfare. The specific objectives of this initiative are to develop a network of state/regional institutions for conducting health systems research and to provide technical support for steering locally relevant research based on the specific issues identified by the state/district programme managers.

During the first phase of RAHI project, the UNFPA India office supported 12 health system research projects. In this phase, 5 low performing states of India viz. Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh and Orissa were included. Initially, proposals were invited from Medical Colleges, NGOs and other health institutions. After rigorous screening of the proposals by the Technical Advisory Group consisting of eminent public health experts, 12 projects were finalized in a national workshop conducted at NIHFW. The faculty of NIHFW provided technical support for finalization of tools, training to investigators, planning and monitoring of data collection. Data for the studies were collected during September, 2007 to November, 2007 by the partner institutions. Quality assurance mechanism was developed in consultation with members of Technical Advisory Group and experts from UNFPA. The progress of the projects were reviewed by Technical Advisory Group time to time. A draft model report was finalized by the institute in consultation with the UNFPA, so that all partner institutions would bring out their project reports in a uniform format.

During the second phase, another 12 health system research projects from 6 low performing States viz. Uttar Pradesh, Uttarakhand, Madhya Pradesh, Jharkhand, Bihar and Rajasthan are supported. In this phase, processes similar to the earlier phase were followed and all 12 projects are under completion. The current issue of the NIHFW journal 'Health and Population: Perspectives and Issues' brings out salient findings of twelve research projects undertaken in the first phase.

It is envisaged that findings and recommendations from these studies will trigger off series of follow up measures by concerned programme managers in the respective states. We also feel strongly about continued need for optimum engagement of available human resources in Community Medicine, Peadiatrics and Obstetrics/Gyneacology departments of the medical colleges in such assessments. Such initiatives by the programme managers will end current isolation of medical colleges and will be conducive for incorporating such public health interventions during undergraduate and post graduate training.

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A RAPID APPRAISAL OF FUNCTIONING OF ASHA UNDER NRHM IN ORISSA

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ABSTRACT

The realization of the goal of NRHM largely depends upon the functional efficacy of ASHA as the grassroot health activist. The paper an extract from a cross sectional, descriptive study with a blend of qualitative and quantitative techniques which was undertaken in two districts of Orissa: Jagatsinghpur and Mayurbhanj in September-December 2007. In-depth interview was conducted to the Panchayati Raj Institution (PRI) members, Self Help Group (SHG) members, members of Village Health and Sanitation Committee (VHSC), Accredited Social Health Activists (ASHAs), Auxiliary Nurse Nurse Midwives (ANMs), Anganwadi Workers (AWWs), Child Development Project Officer (CDPOs), Additional District Medical Officers (ADMOs), Medical Officers (MOs) and members of the community. The selection of the subject for the study, was through a multi-stage sampling. The study revealed that being young in age, ASHAs are amenable to motivation and capacity building for functional efficacy. All the ASHAs were the residents of the village and were selected by the community. This gives them the strength to perform better in the community. The health functionaries, the Panchayati Raj Institution (PRI) members and the community were by and large satisfied with the functioning of ASHA. Most respondents perceived ASHA as a potential link between the community and health sector. The study recommends that ASHA should be paid more compensation and a mobile phone. Refresher training at regular interval should be imparted at block and district level on specific topics.

Key Words: Accredited Social Health Activist, National Rural Health Mission and Village Health Committee.

National Rural Health Mission was launched in April, 2005 with a commitment to provide effective health care to the rural population throughout the country with special focus on 18 low performing States including Orissa. The goal of this mission is to create a village level social activist, designated as ASHA to provide primary medical care, advice on sanitation, hygiene, ante-natal and post-natal care, escorting expectant mothers to hospital for safe delivery at the village level etc.

In order to perform her activity in proper manner, NRHM envisaged the capacity building of ASHA through training and motivating them through a performance-based compensation.

To a large extent the actualization of the goal of NRHM depends on the functional efficacy of ASHA as the grassroot health activist. Her efficacy depends on several factors; her own cognitive competency (including capacity building), aptitude, and attitude, effective relationship with other key health

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functionaries (e.g., Anganwadi Worker (AWW), Auxiliary Nurse Midwife (ANM), PHC staff), dynamics between ASHA and Panchayati Raj Institutions (PRI)s (including selection, interface, coordination, supervision), and acceptance of ASHA by the community.

General Objective

This study was undertaken to understand the functioning of ASHA in the community, in order to suggest strategy for improvement.

Specific Objectives

- To understand the selection procedure of ASHA;
- To assess their sustenance and motivational issues;
- To understand the training process and its output;
- To explore the different aspects of functioning of ASHA; and
- To offer recommendations for improved functional efficacy of the ASHA.

The analysis and interpretations of data from different stakeholders have been summarized into many areas of strength and weakness, which are extremely useful to bring about improvement in the functioning of the ASHA.

METHODOLOGY

Sampling

The sample area selection comprised of selection of districts, blocks and villages with the above mentioned study subjects. Districts Jagatsingpur and Mayurbhanj were selected as per the sample selection scheme presented in Table 1.

Table 1
Scheme of Sample Selection

Sl. No.	Stage of selection	Method of selection	No of units	Remark
1	District	Purposive	2	1 tribal district with tribal population more than 50 per cent and another non-tribal rural district.
2	Block	Purposive	4	@ 2 from each district. One nearer and other far from the district headquarters
3	CDMO	Purposive	2	CDMOs of the respective sample districts
4	ADMO	Purposive	2	ADMOs of sample districts
5	MO	Purposive	4	MOs of respective block PHCs and CHCs
6	CDPO	Purposive	4	CDPOs of the respective sample blocks
7	ANM	Random	8	@ 2 from each PHC/CHC area
8	PRI/CBO	Random	8	@ 2 from each block
9	ASHA	Random	80	@ 20 from each sample block. A list of ASHAs having more than one year experience was collected and from among them 20 were selected randomly.
10	Village for FGD	Random	8	@ 2 from each sample block. 2 villages were selected in each block from among the 20 villages from where ASHAs were selected.
11.	FGDs with AWWs		4	10 AWWs were selected on the basis of availability in each block from among 20 villages where ASHAs were selected for the study.
12	FGD with community		8	Village leaders, school teachers, leaders of SHGs, elderly women, lactating mothers and JSY beneficiaries were included for FGD.

Data Collection

For data collection, in-depth interviews were conducted through pre-designed and pre-tested interview schedule with different stakeholders. Focus Group Discussions (FGDs) were conducted at village /community level for the study. NIHFW faculty visited the field to maintain quality assurance. The selection of data collection is presented in Table 2.

Table 2
Scheme of Data Collection

Sl. No.	Levels of data collection	Respondents	Methods of data collection	Instrument used
1	District	CDMO, ADMO	In-depth interview	Semi-structure interview Schedule
2	Block	MO, CDPO	In-depth interview	Semi-structure interview Schedule
3	Sub-center	ANM	In-depth interview	Semi-structure interview Schedule
4	Village	PRI/Community-based Organisation	In-depth interview	Semi-structure interview Schedule
5	Village	ASHA	-do-	-do-
6	Village	Community (SHG members, PRI members, beneficiaries, community leaders)	FGD	Guidelines
7	Village	AWW	FGD	- do -

Data Analysis

The information obtained from CDMOs, ADMOs, MOs, PRI members, CDPOs and ANMs were all tabulated. Data collected from IDI of ASHAs were analyzed using the SPSS software. For qualitative data, semi-quantification was done by coding the responses for different stakeholders and merging into different headings using adjectives. Ethical clearance for the project was given by Institutional Review Board of NIHFW.

FINDINGS AND DISCUSSION

Selection Process of ASHA

All the ASHAs were the residents of the village and were selected by the community. This gave them the strength to perform better in the community. Due to involvement of women, Self Help Groups (SHGs) in the selection process in Orissa, the selection process was more transparent and the selected ASHAs were more acceptable to the community.

Motivational and Sustenance Issues

The acceptance of ASHA in the community was better and the community perceived them as potential link between the community and health sector. The community expected more work from ASHAs for health and non-health sector activities like helping in getting old age pension, BPL card etc which indicate the confidence they have in ASHAs. According to the norm there should be one ASHA per 1000 population. But the majority of the ASHAs were catering to a population of more than 1000. Due to hilly geographical terrain ASHAs even failed to visit certain hamlets and certain section of the population remained un-served and un-reached. The distribution of

medicine is a key factor for addressing the common ailments at the community level and also a catalyst for community acceptance and participation. But about a quarter of the ASHAs interviewed had not even received medicine kits. Those who had received the kits were incomplete. Most of the ASHAs indicated that the non-availability of transportation to the pregnant mothers was a major problem. Lack of communication or unwillingness of the beneficiaries to inform her leads to loosing her incentive. Besides, she also loses the incentive if the client opted for the delivery in private hospital or nursing home. Majority of the ASHAs were not getting incentives in time. Even nearly a quarter of ASHAs had not received incentives for more than six months. There was a good supportive monitoring system to supervise and facilitate the work of ASHA.

Knowledge of ASHA

The knowledge of ASHA on the nature of the activities and job responsibility is the pre-requisite for effective service delivery. The ASHAs were interviewed to assess their knowledge about their job responsibilities. The data are presented in Table 3.

Activities undertaken by ASHA

They were asked about the activities they are actually undertaking in the field and the result is tabulated in Table 4.

Table 3
ASHA's Knowledge about Their Job Responsibility

Jobs supposed to be done by the ASHA	Name of the district				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
Create community awareness on determinants of health	15	37.5	24	60.0	39	48.8
Counsel community on safe delivery, ANC/PNC, breastfeeding, immunization, contraception and prevention of RTI and STI	32	80.0	33	82.5	65	81.3
Mobilize community to access health services at different facilities	8	20.0	26	65.0	34	42.5
Work with VHSC to develop a village health plan	3	7.5	7	17.5	10	12.5
Accompany pregnant mothers to hospitals	34	85.0	33	82.5	67	83.8
Depot holder of medicine and also Providing DOTs.	10	25.0	26	65.0	36	45.0
Motivate the community for construction of household toilet	15	37.5	24	60.0	39	48.8
Inform AWW/ANM about birth and deaths	3	7.5	6	15.0	9	11.3
Sample size	40		40		80	

Table -4
Activities Undertaken by ASHA

Activities under taken by ASHA	Name of the district				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
Registration of pregnant mother	21	52.5	34	85.0	55	68.8
Counselling on ANC, PNC, safe delivery	31	77.5	36	90.0	67	83.8
Accompany pregnant mother to hospital	37	92.5	37	92.5	74	92.5
Distribution of IFA, oral pills, ORS	35	87.5	35	87.5	70	87.5
Distribution of DOTS	5	12.5	26	65.0	31	38.8
Inform AWW/ANM on birth and death	3	7.5	4	10.0	7	8.8
Help AWW in supplementary nutrition feeding	11	27.5	18	45.0	29	36.3
Motivate for construction of latrines	17	42.5	17	42.5	34	42.5
Help ANM for immunization	33	82.5	31	77.5	64	80.0
Education to adolescents	1	2.5	6	15.0	7	8.8
Motivate the couple for family planning			6	15.0	6	7.5
Sample size	40		40		80	

The most important activities enumerated by the ASHAs were accompanying the pregnant women to the hospital (92.5%), counselling the mothers on AWC, PNC and safe delivery (84%), distribution of IFA and oral pills (87.5%), registration of pregnant mother (68.8%), mobilizing the mothers children for immunization and providing help to ANM on immunization day (80%). The activities like informing AWW/ANM on birth and death motivating community to construct household toilets, motivating the couple for family planning have assumed least priority among the ASHAs. Besides, ASHAs have indicated their involvement in certain activities like helping AWW in preparation of food, distribution of ration and weighing the babies at AWC. During our interaction with different ASHAs it was revealed that the AWWs were trying to take undue advantage from ASHAs in taking their assistance.

Social Acceptance and Community Support

The ASHA has to work in the community for the rural poor. She has to motivate every household and generate awareness in the community for ante-natal care, post-natal care, safe delivery practices, immunization, importance of breast-feeding, family planning and sanitation etc. Her work will be accomplished if she is well accepted and supported by the community. Eight FGDs that were conducted indicated that ASHAs were well accepted in the community and considered as a friend to the household especially for the pregnant and lactating mothers and children. The PRI members, SHG members, community leaders, and mothers who participated in the FGDs were very out spoken in their praise for ASHA. Some of their views are worth quoting.

'At the time of her need, we help ASHA from the SHG fund and co-operate with her to accompany the patient to health facility'.

The interview with ASHA's also captured certain points to probe into the acceptability of ASHA in the community *(Table 5)*.

It was revealed that all most all ASHAs (98.8%) paid visit to all household in the village, barring one exception who stated that 'she did not feel the necessity to visit rich household'. It was also revealed that most ASHAs (87.5%) indicated that they were called by all the families. However, a few indicated that rich families as well as upper caste families do not call them for services. It does not matter if rich families are not calling them but it matters when the needy families of the upper caste do not seek their help at the time of need on the pretext of caste only. The issue of high caste people ignoring the ASHAs if belonging to lower caste and high caste ASHAs ignoring lower caste clients need to be tackled. It is fortunate to find that majority, over half of ASHAs conducted meeting where they invite the pregnant and lactating mothers, adolescent girls, PRI members, SHG members to generate awareness in the community. The analysis

Table 5
Community Acceptance: Views of ASHA

Aspects of community acceptance	**Name of the district**				**Total**	
	Jagatsingpur		**Mayurbhanj**			
	No	**%**	**No**	**%**	**No**	**%**
Visit to households						
Yes	40	100.0	39	97.5	79	98.8
No	0	0	1	2.5	1	1.3
Total	40	100.0	40	100.0	80	100.0
Reasons for no visit						
Rich family don't accept services			1	2.5	1	1.3
Are you called by families						
Yes	34	85.0	36	90.0	70	87.5
No	5	12.5	2	5.0	7	8.8
Sometime	1	2.5	2	5.0	3	3.8
Total	40	100.0	40	100.0	80	100.0
Reason for not being called by all families (7)						
Rich family do not call	3	60.0	0	0	3	42.9
Upper caste people do not call	2	40.0	1	50.0	3	42.9
Not good terms with me	0	0	1	50.0	1	14.3
Total	5	100	2	100	7	100
Invitees to attend meetings convened by you						
Pregnant women	27	93.1	16	72.7	43	84.3
Lactating mother	14	48.3	6	27.3	20	39.2
Mother of children (0-6 yrs)	1	3.4	3	13.6	4	7.8
All mothers	9	31.0	4	18.2	13	25.5
Adolescent girls	3	10.3	1	4.5	4	7.8
PRI/MSS members	8	27.6	9	40.9	17	33.3
SHG members	19	65.5	10	45.5	29	56.9
ANM	14	48.3	18	81.8	32	62.7
AWW	20	69.0	15	68.2	35	68.6
School teachers	1	3.4			1	2.0

of the views that emerged in the FGD and the data from interview with ASHAs brought out that ASHA has got better acceptance in the community and they were also making effort to reach out to the community.

RECOMMENDATIONS

- The compensation to the ASHA should be suitably increased and the payment should be done at worksite without any payment delays.
- The transportation facility for the pregnant mother to the health institution should be streamlined by making available Janani Suraksha Van in the PHC/CHC area round the clock on call from the ASHA. Possibility of providing mobile phones to ASHAs could be considered so that they can have connectivity with the community and health facility, transport vehicles, without any hassles.
- VHSC should be made functional in every village and should be motivated through incentive to prepare a comprehensive health plan. PRIs should be involved in every stage of planning, implementation and monitoring of VHSC.
- A TOT for the ASHAs should be conducted. Refresher training at regular interval should be imparted at PHC block and district level on specific topics. It is suggested to publish a 'news letter' in local language on half-yearly or yearly basis for updating knowledge and skill for grassroot level functionaries especially for ASHAs.
- There is a need to strengthen the sub-centre by equipping them with infrastructure, logistics and instruments so that non-complicated normal delivery can be conducted by the trained staff at the sub-centre level in remote inaccessible areas.
- Irregularity i.e. in the area of supply of medicine kits should be investigated and appropriate action should be taken.
- Activities like formulation of village health plan through Village Health and Sanitation Committees (VHSCs), awareness and motivation for construction of household latrines, motivation for family planning and adolescent education by the ASHAs should be monitored by the health authorities.
- The PRI members and community leaders should be adequately oriented and sensitized so that community monitoring and social audit becomes effective. They should be sensitized to make use of the Right to Information Act which is extremely important to understand the situation and take appropriate corrective measures.

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A RAPID APPRAISAL OF SAHIYA (ASHA) IN JHARKHAND

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ABSTRACT

NRHM proposed to appoint a community level health worker named Accredited Social Health Activist (ASHA) acts as a first contact point of contact with health care facility to the community in her village/s. In Jharkhand, Sahiya is the term used in place of ASHA. Key Health Workers (Sahiya) are the central agents in the community health programmes. The Sahiya is nominated by Village Health Committee/Gram Sabha as outreach worker and selected by the community to support the service providers on health issues with focus on reproductive and child health needs and services. The study aimed to assess and evaluate the functioning of the Sahiya programme in 10 blocks across the State namely, Ormanjhi, Kanke, Mandu, Vishnugarh, Ichak, Sesai, Potka, Chandil, Jamtara and Narayanpur. This study involved health providers viz. ANMs, AWWs, MO/Ic, and district level health officers and the Sahiyas as stakeholders. The tools used were semi-structured questionnaires, checklist for in-depth interviews and focus group discussion. Nearly, 51 per cent of women informed that Sahiya visited them during pregnancy. Almost all ANMs received help from Sahiya in immunization activities. However, Sahiya's had limited linkage with AWW and members of Village Health Committee. The study recommends to provide proper incentives for Sahiya's work and their capacity building in the field of maternal and child health including basic health and hygiene and adolescent health.

Key Words: Sahiya, Key Health Workers, Community Health Programmes, Community.

The National Rural Health Mission (2005-12) seeks to provide effective health care to rural population throughout the country with special focus on States, which have weak public health indicators and/or weak health related infrastructure. It aims to undertake architectural correction in strengthening public health management and health care delivery system in the country for optimization of the benefits of various health initiatives to the rural masses.

It has as its key components, provision of a female health activist in each village; a village health plan prepared by a local team headed by the Health and Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of Health and Family Welfare Programmes for optimal utilization of funds, infrastructure and strengthening delivery of primary health care.

Sahiya is a volunteer who is supposed to assist villagers for their health needs and

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bridge the gap between health care system and community. She is also expected to motivate the community to avail the services that are available in Health Sub-Centre such as immunization, ante-natal care, post-natal care and consumption of iron and folic acid, etc. She should be skilled to identify the complicated and high risk cases thereby motivating villagers to avail proper services at Health Sub-Centre (HSC) or Primary Health Centre (PHC) and is also responsible for counseling the adolescent girls regarding their nutrition, personal hygiene and life skills as potential knowledgeable mothers.

General Objective

To review the implementation status of Sahiya programmes in Jharkhand and suggest suitable measure for its effective implementation.

Specific Objectives

- To study the functioning of Sahiya in Jharkhand;
- To assess the acceptability of Sahiya in the community; and
- To study the linkage between Sahiya and other health functionaries i.e. Auxiliary Nurse Midwife (ANM)/Anganwadi Worker (AWW).

METHODOLOGY

Sampling

The study was carried out in 10 blocks of Jharkhand located in six districts namely Ranchi, Hazaribagh, Jamtara, East Singhbhum, Gumla and Saraikela Kharswan where selection and training of Sahiya has been completed.

A Multi-staged stratified random sampling method was used. The list of blocks where Sahiya programme has been implemented during Phase-I was procured. These blocks were grouped in two categories: Category I - high performing blocks, and Category II: low performing blocks. A total of 10 blocks (five from each category) were selected and were located in six districts. Overall, two blocks of Ranchi district, three blocks of Hazaribag district, one block of Gumla district, one block of Saraikela Kharsawan, one block of East Singhbhum and two blocks of Jamtara district were included in the study.

In each block, two sub-centers were selected, one close to the block headquarter (within 10 kms.) and another distant one (>10 kms.). In each sub-centre, one randomly selected village was covered. If the required number of eligible women were not available there, another adjoining village was covered.

The following sample of respondents was selected from the identified districts, blocks and villages:

Health Care Providers: Civil Surgeon-cum CMO of the concerned districts (6) and Block Medical Officers (10) were respondents at planning and administration level. Ten (10) ANMs, Ten (10) AWWs and Ten (10) Sahiyas from each block were selected randomly. One group of village health committee members was also selected on the basis of their availability for Focus Group Discussion (FGD) in each block.

Women Beneficiary: A list of women who delivered in the last six months was procured from selected villages of each block. From each village, 18 women were randomly selected for the study. If sufficient number of respondents were not available in the village, then the nearby village (within the same sub-centre) was considered for the study to complete the sample.

Table 1
Sample Covered, Tools and Techniques Used for Data Collection

Stakeholder	Number	Data Collection method and Tools
Women who delivered within past six months	360 (36 per block)	Interview-Semi-structured schedule
Civil Surgeon-cum- CMO BMO Sahiya ANM AWW	6 (1 per district) 10 (1 per block) 60 (6 per block) 10 (1 per block) 10 (1 per block)	Interview-In-depth interview guidelines
Village Health Committee	1 per block	FGD -FGD guidelines

Data Collection

All the research staff was provided two days of hands-on training on research guidelines, tools and research issues including field training and pre-testing before commencement of the actual field work.

In order to ensure the quality of data, core team members conducted FGDs and in-depth interview of district authority. Principal Investigator/Co-investigator was supported by one field staff who was responsible for taking notes during focus group discussions (FGDs) and in-depth interviews. Ten (10) FGDs and 6 in-depth interviews of Chief Medical Officers were divided among Principal Investigator and Co-investigator.

Following techniques were used to collect data:

- Interview using semi-structured schedules
- In-depth interviews using guidelines
- FGDs using guidelines

The faculty from NIHFW visited field to maintain quality assurance. Details of sample covered, tools and techniques used for data collection is given in Table 1. Ethical clearance for the project was given by the Institutional Review Board of NIHFW.

FINDINGS AND DISCUSSION

The study revealed the following findings:

Around 24.2 per cent (87 women) women who were interviewed, had heard about Sahiya; 92.2 per cent (80 women) of those women who have heard of Sahhiya, would recognize Sahiya within the hamlet. Women were aware that Sahiya helps pregnant women for early registration with ANM, promotes community people to receive facility from health centre and advises on health matters as well as promotes community to receive ICDS services from Anganwari Centre (Table 2).

50.6 per cent women informed that Sahiya visited them during pregnancy (Table 3). Getting medicines, immunizations, assistance in procuring

Table 2
Services Provided by the Sahiya

Service *(n=87)*	**No.**	**Per cent**
Early registration of pregnant women with ANM	15	17.2
Promote community to receive health facility	37	42.5
Promote community to receive ICDS facilities from AWC	5	5.7
Advice on health related issues	14	16.1
Other	16	18.4

Table 3
Help Received from Sahiya During Pregnancy

Help *(n=87)*	**No.**	**Per cent**
Sahiya visited during pregnancy or later	44	50.6
Sahiya helped when it was needed during pregnancy	34	39.1

24.1 per cent of women who were aware about Sahiya and 16.8 per cent women who were not aware about Sahiya had institutional delivery. The difference was not significant (p = 0.1283). Overall institutional delivery was 18.6 per cent (Table 4).

immunization. In some areas, ANMs take assistance of Sahiya in home visits, health education and health programmes like catch-up round, malaria, pulse polio, etc.

Chief Medical Officers and Medical Officers I/Cs commented that the good coordination between ANM and Sahiya had not been observed. In their opinion, ANMs may not knew Sahiya even of of their respective villages.

Table 4
Distribution of Respondents by Place of Delivery and Their Awareness' About Sahiya

Place of delivery	**Those who heard about Sahiya (n=87)**	**Those who did not hear about Sahiya (n=273)**	**Total (n=360)**
	No. (%)	**No. (%)**	**No. (%)**
Home delivery	66 (75.9)	227 (83.2)	293 (81.4)
Institutional delivery	21 (24.1)	46 (16.8)	67 (18.6)

Post Natal Care

About 26.4 per cent of women who were aware about Sahiya received post-natal care whereas 15 per cent of those unaware had received post-natal care. The difference was significant (p=0.0153). Sahiya helped only 30.4 per cent women in post-natal care.

Linkages with ANM

Almost all the ANMs agreed that they got help from Sahiya in immunization. Some also take help in identifying pregnant women and give ANC. Almost all Sahiyas told that ANMs helped them in receiving drugs and they also seek help in

It appears that though Sahiya was doing some health related work in the village, especially in the field of immunization, she was neither recognized at PHC nor by district health functionaries.

Linkages with AWW

The linkage between AWW and Sahiya was low. More than half of interviewed AWWs did not receive any help from Sahiya. Those who received help was largely for conducting immunization. They also did not provide assistance to Sahiya. However, some worked together

Table 5
Availability of Sahiya and Their Work Performance within the Village

Performance(N=87)	**No.**	**Per cent**
Sahiya is easily available in the community	78	89.7
Women share health related problems with Sahiya	19	21.8
Sahiya of the Tola is knowledgable	83	95.4
Sahiya is doing her work sincerely	54	62.1
Women were satisfied with Sahiya's services	51	58.6

for immunization.
'Koi koi madad karti hai, koi kuchho nahi'.
'Some help, and some don't', *'AWW.*

Sahiyas also said that AWW do not ask them for help. In some places, they helped AWWs in collecting children for immunization and their distribution.

The cause for imperfect linkage may be that some AWWs perceive Sahiya as their competitor and also lack clarity about Sahiya's roles.

Linkages with CBOs and VHCs

The linkage of Sahiya and VHC was at low level. In almost all the blocks, some Sahiyas were already attched to some CBOs, mostly mahila mandals. But, so far their activities related to health were concerned, linkages were not observed.

'Hamin mahila mandal me paisa jama karai la. Aur kono madad nai milat hai'.

'We invest our money in Mahila Mandal, apart from that we got no help', Sahiya.

In most of the places, regular Village Health Committee (VHC) meetings do not take place. Places where meetings were held, maternal and child health and hygiene practices were discussed. Sahiyas were aware of VHC but, they did not know about meetings in most places.

RECOMMENDATIONS

- Proper incentives for Sahiya's work should be paid timely.
- Capacity building should be continued in the field of maternal and child health including basic health and hygiene and adolescent health.
- Sahiya should be linked with different health schemes of government to facilitate their motivation.
- At the district level convergence meeting should be organized at least once in a month at Civil Surgeon office in the presence of AWW, ANM, Sahiya and members of village health committees.
- A proactive attempt to continue training of Sahiyas to ensure that they approach the beneficiaries with full knowledge and confidence and provide right services to them.
- Communication on regular basis with all health functionaries could lead to effective decision-making. Modification in field strategies for home visits on regular basis for better utilization of services including JSY and involvement of Sahiya should be planned.
- Intensification of IEC activities in the community especially focussing at the maternal and child health from registration to post-natal care component.

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AN APPRAISAL OF JANANI SAHYOGI YOJANA IN THE STATE OF MADHYA PRADESH

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ABSTRACT

The Janani Sahyogi Yojana (JSY) in Madhya Pradesh has been in operation since 15 October 2006. Under this scheme, Private Service Providers (PSPs) are given benefits for providing JSY services to BPL families. The objective of this study was to give information to implementers, programme managers as well as the policy-makers on delivery of the programme, its effectiveness, quality of intervention as well as the gaps. The study covered districts of Bhopal, Indore, Jabalpur (with Katni) and Chhindwada (with Betul) in the State of Madhya Pradesh. Primary data collected from beneficiaries of Janani Sahyogi Yojana, PSPs' incharge and Chief Medical and Health Officers (CMHOs) and secondary data were collected from available reports and records at PSPs and CMHO office at district level. The study revealed that the PSPs who adopted multiple motivational strategies e.g. meetings with Accredited Social Health Activists (ASHAs)/Anganwadi Workers (AWWs), free out-patient services for Below Poverty Line (BPL) patients, publicity through media etc. were successful in getting more number of cases as compared to those who did not adopt such strategies. Motivational charges for institutional deliveries was very effective in increasing the institutional deliveries in private hospitals, thus meeting the objective of the scheme. Caesarian rate among BPL women were not higher than non-BPL women. The study recommends the need for continued dialogue/communications between CMHOs and PSPs to strengthen the partnership as well as help in identification and rectification of the problems faced by PSPs.

Key words: Institutional Delivery, Public Private Partnership, Private Service Providers.

In Madhya Pradesh, the 'Janani Sahyogi Yojana' has been under implementation since October 15, 2006 with the sole aim to increase availability of delivery and newborn care services through Private Service Providers (PSPs) for Below Poverty Line (BPL) families. The scheme has essential features for the private and non-government hospitals who are invited to render services in delivering safe motherhood and child health care to the BPL families under the Reproductive and Child Health Programme-II. The guideline provides the criteria (12 essential facilities are listed) to select the Private Service Providers (PSP). Initially the scheme was intended for BPL families through rural PSPs but due to being few in number or their complete absence or not fulfilling the criteria of accreditation, urban PSPs were included in the scheme. Monetary compensation was provided to the beneficiaries with changing rules at different times and modes of operation of funds. Initially, when the scheme was started, there was only provision for reimbursement for the services provided to BPL beneficiaries. Later, monetary

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compensation was also started for institutional deliveries in private sectors (as per Government guidelines). To improve participation of the private sectors in Bhopal and Indore, motivation charges were also given to Accredited Social Health Activists (ASHAs)/Anganwadi Workers (AWWs) for motivating BPL beneficiaries for institutional deliveries in PSPs.

This study was planned to assess the outcome of the JSY and to identify the operational bottlenecks in order to understand whether Public Private Partnership is a means to increase institutional deliveries and to decrease maternal rate. This study would enable timely modifications in the processes of this scheme.

General Objective

To assess the functioning of 'Janani Sahyogi Yojana' in four districts of Madhya Pradesh.

Specific Objectives

- To assess the proportion of Private Service Providers (PSPs), fulfilling the selection criteria;
- To assess the proportion of BPL families out of total deliveries conducted in the PSPs;
- To determine the Caesarian rate among BPL families and compare with non BPL families;
- To analyze adequate coverage of ANC and PNC care under the 'Janani Sahyogi Yojana';
- To understand mechanism of payment to PSPs as well to beneficiaries under this scheme; and
- To assess satisfaction level among BPL families under 'Janani Sahyogi Yojana' in PSPs.

METHODOLOGY

JSY was initiated in all 48 districts of Madhya Pradesh, but due to lack of sufficient accredited private hospitals under this scheme, only those were selected which had been functioning for at least six months i.e. Bhopal, Jabalpur (with Katni), Chhindwada (with Betul) and Indore. The study design was descriptive in nature.

Sampling

The following stakeholders were the subjects of this study in 4 districts: (a) 32 PSPs from 6 districts (2 neighbouring districts were added to complete the sample of 32 PSPs, 25-50% PSPs), and (b) 6 CMHOs, (c) 100 beneficiaries availed or availing services from PSPs (Table 1). (A district was characterized where at least 8 PSPs were functioning, in case of less than 8 functioning PSPs in the district, the adjoining district was included to complete 8 accredited PSPs).

Data Collection

Both primary (In-depth interviews) as well as secondary (records) sources were

Table 1
Sample Size, Tools and Techniques Used for Data Collection

Stakeholder	Number	Data Collection Method and Tools
Beneficiaries of Janani Sahyogi Yojana	100 (25 per districts)	Interview - structured schedule
CMO/District Nodal Officer	6 (1 per district)	In-depth interview checklist
PSP incharge	32 (8 per district)	In-depth interview checklist

used for data collection in the study area. Primary data were collected from beneficiaries of Janani Sahyogi Yojana, PSPs' incharge, and CMHOs and secondary data were collected from available reports and records at PSPs and CMHO office at district level regarding the operational mechanism and utilization of the scheme. All the data collected were triangulated to have a clear idea of the findings at the time of analysis. The data collected in the form of recorded interviews were coded and each interview was transcribed with the help of field notes and further translated by the supervisors and field assistants on the same day of the field study. Each interview was given an ID number to eliminate bias. The PI and the Co-PI supervised the data handling and data analysis. The faculty from NIHFW visited the field to maintain quality assurance.

Data Analysis

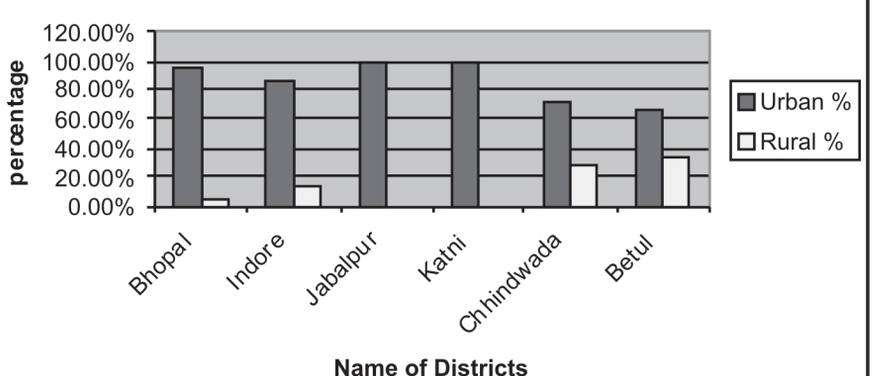
Quantitative data were analyzed by generating frequency tables which were generated using SPSS 13 software. For qualitative data, semi-quantification were done by coding the responses for different stakeholders and merging into different headings using adjectives as the guidelines provided by the NIHFW. Adjectives used in the study for qualitative data are (<10 %- Very few; 10-24%- Some; 25-49 %- Approximately; Half; 50-74 %- Majority/Over half; 75-89 %- Most ; > 90 %-Almost all). The ethical clearance for the project was given by Institutional Review Board of NIHFW.

FINDINGS AND DISCUSSION

Distribution of PSPs According to Urban/Rural Area

Figure 1 indicates that total number of PSPs in districts were 83. And out of this, 75 (90.36%) were urban and 8(9.63%) were rural. Though this scheme was intended to increase institutional deliveries among BPL population and majority of BPL population live in rural areas but there were very few number of rural PSPs. The reason may be that rural PSPs were not fulfilling the eligibility criteria of this scheme and some withdrew in between. For better participation of rural PSPs further relaxation in selection criteria may be required.

Figure 1
Distribution of PSPs according to Urban/Rural area



PSPs Fulfilling the Criteria for Mandatory Services

In all the PSPs, the delivery related services were found to be adequate, however the critical ANC services like pathological testing was absent in around 15 per cent of the PSPs. Routine immunization of the mother and children were not available in 28 per cent of the PSPs. Ready and available blood transfusion services which were required in majority of complicated deliveries and constitute a high percentage of maternal mortality were missing in 37.5 per cent of PSPs, whereas the safe abortion facilities were also missing in 15 per cent of the facilities. Absence of the services like IUD insertion, which is of national priority were missing in 46 per cent of the PSPs and RTI/STI treatment in around 46 per cent of the PSPs (Table 2).

PSPs Fulfilling the Criteria for Mandatory Infrastructure Facilities

The study also shows that most of the PSPs were fulfilling the several criteria for mandatory infrastructure requirements. However, availability of blood and absence of blood storage facilities in 50 per cent of the PSPs and lack of lists of the voluntary donors near the facility in 68 per cent of the units was very significant and needs urgent intervention by the planners.

Table 2
PSPs Fulfilling the Criteria for Mandatory Services

S.No.	Mandatory services under the Scheme	PSPs fulfilling the criteria		PSPs not fulfilling the criteria	
		No.	%age	No.	%age
1.	ANC/PNC care	32	100	0	0
2.	Routine immunization for pregnant women and children	23	71.87	9	28.12
3 a.	24 hours normal delivery services	32	100	0	0
3 b.	24 hours assisted delivery services	32	100	0	0
4 a.	Parenteral antibiotics for management of common obs. care	31	96.87	1	3.12
4 b.	Parenteral oxytocines	32	100	0	0
4 c.	Parenteral sedatives/anti-convulsants	32	100	0	0
4 d.	Manual removal of placenta	32	100	0	0
5.	Early and safe abortion services	27	84.37	5	15.62
6 a.	IUD insertion	17	53.12	15	46.87
6 b.	Provision of OCP, condom, Emergency Pill	30	93.75	2	6.25
6 c.	T.T	27	84.37	5	15.62
6 d.	V.T.	29	90.62	3	9.37
6 e.	T/t of RTI/STI	19	59.37	13	40.62
7.	New born care	32	100	0	0
8.	Emergency care of sick children	26	81.25	6	18.75
9 a.	Hb Estimation	27	84.37	5	15.62
9 b.	Blood grouping and testing	27	84.37	5	15.62
9 c.	BT, Ct	27	84.37	5	15.62
9 d.	Urine albumin and sugar	27	84.37	5	15.62
10.	Caesarian section and laprotomy	31	96.87	1	3.12
11.	Blood transfusion services	20	62.5	12	37.5

PSPs Fulfilling the Criteria for Mandatory Supplies and Equipments

The mandatory requirement for cold chain equipment was a fridge. It was required for proper maintenance of vaccines and short storage of blood. This was found missing in 21 per cent of the facilities. Also the reagents and equipment for pathological testing were not present in 15 per cent of the PSPs. Another important observation was that though IV fluid and transfusion sets were included in the essential supplies criteria, blood transfusion sets were missing from this list. This brings the focus back on reassessment of the strategy of assuring blood transfusion services in the accredited PSPs.

PSPs Fulfilling the Criteria for Mandatory Manpower

All PSPs had Gynaecologists and Pediatricians and only in one hospital Anaesthetist and Surgeon were not available. Complete paramedical support staff was also not there in all hospitals though more than 80 per cent PSPs were fulfilling the criteria. If on call doctors are available then an attempt to relax norms of accreditation should be made, to incorporate larger number of PSPs into the scheme.

Data show that majority of PSPs fulfilled the accreditation criteria under Janani Sahyogi Yojana. However in some PSPs particularly in rural areas, some relaxation was given for laboratory services, blood bank and emergency care for sick children. The specialists were not full time in PSPs but their services were utilized by PSPs as and when required.

Socio-demographic Characteristics of Beneficiaries

The maximum number of beneficiaries were in 21-25 years of age group i.e. (54%) followed by in 26-30 years i.e. (22%) and in 15-20 years age group i.e.(16%). The study indicates that almost half of the beneficiaries' education was primary (24%) and middle (24%) followed by illiterate i.e. 19 per cent.

Figure 2
Socio-economic Status of Beneficiaries

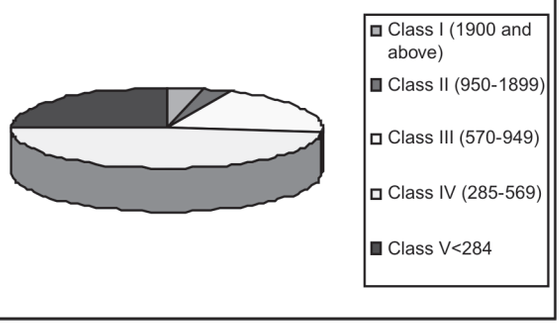


Table 3
Socio Economic Status of Beneficiaries as per Modified Prasad Classification

Social Class Based on per month	No. of Beneficiaries	%age of Beneficiaries
Class I (1900 and above)	4	4
Class II (950-1899)	3	3
Class III (570-949)	20	20
Class IV (285-569)	48	48
Class V<284	25	25
Total	**100**	**100**

According to the above table maximum beneficiaries' socio-economic status was in class IV (48%) followed by class V (25%) and class III (20%), which also indicates the BPL status of beneficiaries (Table 3).

As per NFHS III, institutional deliveries in urban area was 60 per cent, rural area was 20 per cent and total institutional deliveries were 30 per cent in MP. In the present study the overall percentage of BPL deliveries in 32 PSPs of six districts was 41.5 per cent (Table 4). It ranges from 11.75 per cent in Indore to 52.09 per cent in Bhopal. Before implementation of Janani Sahyogi Yojana there were hardly any BPL beneficiaries as per statement of PSPs' incharges. Increase in BPL deliveries to >1/3 of total institutional deliveries within one year of implementation of this innovative public private partnership scheme clearly indicates that private sectors can be very well involved for the benefits of BPL section.

A majority (64%) of beneficiaries were informed about the scheme by local health workers and 56 per cent of the beneficiaries were accompanied by ASHA/AWW workers to PSPs. It indicates that ASHA/AWW were the key players in client mobilization. Majority of PSPs had developed some strategies for target group management. Over half of these PSPs had meetings with local health workers to inform the beneficiaries regarding Janai Sahyogi Yojana, which is evident from the findings of the beneficiaries, majority of whom were informed by the local health workers about this scheme.

Table 4
Proportion of Deliveries Among BPL Out of Total Deliveries in PSPs (October 2006September 2007)

Districts	Deliveries among BPL group		Deliveries among non BPL groups		Total Deliveries	
	No.	%age	No.	%age	No.	%age
Bhopal	1640	52.09	1508	47.90	3148	100
Indore	69	11.75	518	88.24	587	100
Jabalpur (with Katni)	40	14.13	243	85.86	283	100
Chhindwada (with Betul)	146	26.59	403	73.4	549	100
Total	**1895**	**41.49**	**2672**	**58.50**	**4567**	**100**

Figure 3
Caesarian Rate among BPL and non BPL in PSPs

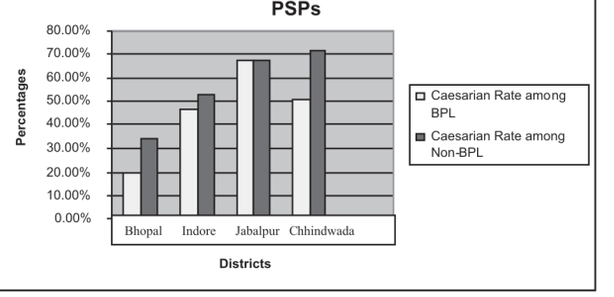


Table 5
Distribution of Beneficiaries According to Nature of Deliveries

Districts	Normal Delivery		Caesarian Section		Spontan. Abortion		Total
	No.	%	No.	%	No.	%	
Bhopal	15	60	10	40	0	0	25
Indore	14	56	7	28	4	16	25
Jabalpur (with Katni)	11	44	14	56	0	0	25
Chhindwada (with Betul)	11	44	10	40	4	16	25
Total	**51**	**51**	**41**	**41**	**8**	**8**	**100**

Table 6
Reasons for Not Taking Advance Money

S.No.	Reasons	PSPs who opted reimbursement (multiple answers were accepted) N = 32	
		No.	Percentage
1.	Finding problem in giving bank guarantee	11	34.37
2.	No delay in getting reimbursement money	3	9.37
3.	Few no. of BPL cases so advance not needed	6	18.75

Overall percentages of caesarian deliveries in BPL group was not higher than percentages of caesarian deliveries in non-BPL group, which indicates that BPL group was not being unnecessarily forced for caesarian deliveries for monetary benefit (Table 5). However the percentage of caesarians in most of the districts was higher than the accepted average of 8 per cent. This may be indicative either of a high percentage of the patients opting for elected caesarian sections or a very high percentage of complicated deliveries due to poor ANC coverage or this high percentage is driven by bigger monetary benefits to PSPs.

Payment Mechanism for PSPs and Beneficiaries under This Scheme

Maximum number of PSPs received payment through cheque i.e. 84.4 per cent followed by cash (3.1%). Since cash as a mode of financial transactions was strongly discouraged in the Government, it should be ensured that such practices should be discouraged in future.

Fund Availability to PSP from CMHO

About 72 per cent PSP-in-charges informed that monthly verification by record check was done by CMHO office. And for reimbursement of claim 18.75 per cent PSP in- charges told it was done whenever they submitted their claim on monthly basis, 50 per cent PSP in charges told the same with the advance money as they got it whenever they required it. It indicates that reimbursement of the claim is being done timely and there was no delay from the CMHO office.

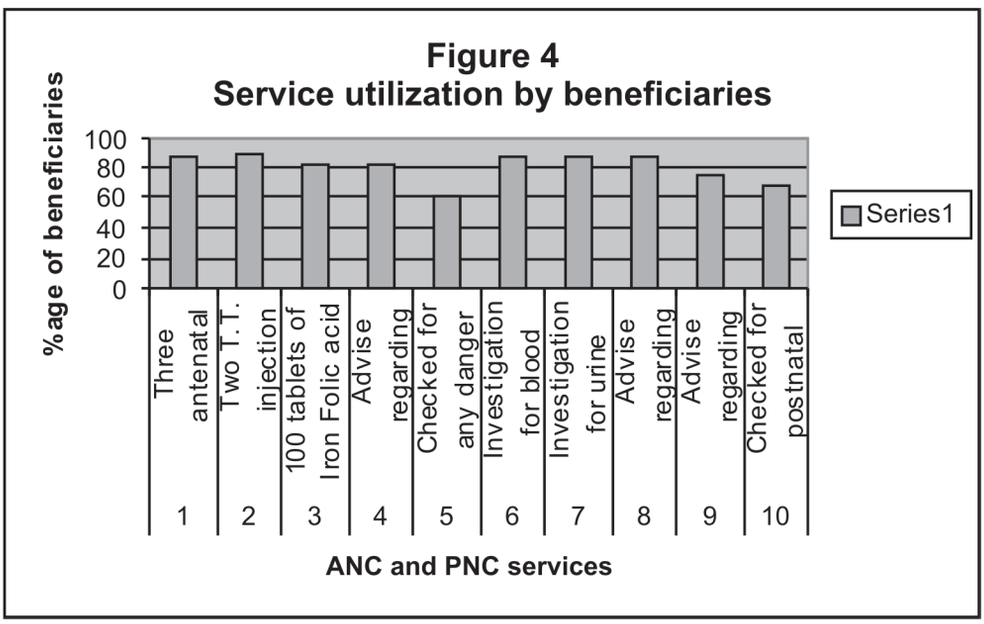
As per the original guideline by Public Health and Family Welfare Department of Madhya Pradesh, all the claims should be submitted to CMHO office before 5th of every month. After the verification of claim and services provided by PSPs, reimbursement would be done within a week. But later guidelines were changed where advance money was being provided against the bank guarantee. Reasons for not taking advance money is given in Table 6.

Coverage of ANC and PNC Care in Janani Sahyogi Yojana

During ante-natal period beneficiaries availed three ante-natal check-ups (88%), two doses of tetanus toxoids (89%), IFA tablets (82%). 61 per cent beneficiaries were checked for danger signs of pregnancies. Family planning counseling services availed by the beneficiaries was 74 per cent and post-natal check-ups were conducted in 68 per cent cases (Table 7).

Table 7
ANC and PNC Service Utilization Amongst Beneficiaries

S.No.	ANC and PNC services utilized by BPL beneficiaries	No. of beneficiaries	%age of beneficiaries
1.	Three ante-natal visits	88	88
2.	Two T.T. injection	89	89
3.	100 tablets of Iron Folic acid	82	82
4.	Advise regarding nutrition	81	81
5.	Checked for any danger sign for pregnancy	61	61
6.	Investigation for blood	87	87
7.	Investigation for urine	88	88
	3PNC visits		
8.	Advise regarding breastfeeding	88	88
9.	Advise regarding family planning	74	74
10.	Checked for post-natal complication	68	68



The present study indicates clear picture of improved utilization of ANC/PNC services by beneficiaries after involvement of private service providers (Table 7, Figure 4). Whereas as per NFHS-II, (PIP-NRHM) in Madhya Pradesh women receiving three ante-natal visits was 28.1 per cent, two T.T. Doses 55 per cent and 100 tablets of iron and folic acids was 78.4 per cent.

Extent of Satisfaction among BPL Families

Quality and ready availability of services were the features which attract the patients more in PSPs. However, there were hidden out of pocket expenses by the beneficiaries under the scheme. Overall, most of the beneficiaries were satisfied with services offered by PSPs under this scheme. Only three per cent beneficiaries were not satisfied with the services.

Negative Aspect of the Scheme as Felt by CMHOs and PSPs' In-charges

Approximately half of the CMHOs and PSPs' in-charges strongly felt that under the scheme, the selection criteria of BPL was not clear and the high risk cases were not included in the package. Some of the

CMHOs and approximately half of the PSPs' in-charges felt that charge are very less and some of the PSPs in-charge told that there was no allocation of money for PNC services. It was observed that around 45 per cent of the PSPs were also charging money in lieu of various services offered to the beneficiaries. However, this important observation is suggestive of required enhancement in the quality of monitoring especially in the patients' follow-up.

Service Providers' Perspective Towards Service Charges

Data show that approximately half of PSPs' in-charges were satisfied with the charges being offered for blood charges, baby warmer, phototherapy and care for immature babies followed by some PSP in-charges who were dissatisfied with other charges too. Almost all told that service charges for pediatrician was not sufficient followed by other charges for other services being offered. It indicates that there was a need for reasonable increase in present charges. Majority recommended Rs. 2000 for normal delivery in place of Rs.1200, Rs. 750 for spontaneous abortion, Rs. 8000 for caesarian section in place of Rs.5500, Rs.1000 for blood charges in place of Rs.750, Rs. 100 for bay warmer in place of Rs.50, Rs. 50 for phototherapy, Rs. 150 for visit by paediatrician in place of Rs. 50 and Rs. 250 for care of immature baby.

RECOMMENDATIONS

- More effort should be made to encourage private sectors for participation in the scheme in order to increase institutional deliveries and decrease maternal mortality.
- Provision for motivation benefit to motivators (ASHA/Anganwadi Worker), establishment of call centres including ambulance services to maternity emergency services, relaxation in criteria to select rural PSPs in order to cater to the needs of the rural population.
- Improve dialogue/communications between CMHO and PSPs to strengthen the partnership as well as help in identification and rectification of the problems faced by PSPs.
- Efforts should be made to increase awareness of the scheme among beneficiaries by the Government as well as by the PSPs through appropriate IEC strategies.

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A STUDY ON UTILIZATION OF UNTIED FUNDS IN SUB-CENTRES IN INDORE DIVISION UNDER NATIONAL RURAL HEALTH MISSION

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ABSTRACT

The study intended to analyze utilization of untied funds and understand problems faced by the sub-health centres in receiving and utilizing the untied funds. The study was conducted in three districts i.e. Dhar, Indore and Khandwa of Indore division in Madhya Pradesh. A sample of 27 sub-health centres were selected from each district totaling to 81 sub-health centres. Health functionaries and officials at different levels (ANM, Medical Officer, BMO, CMHO, DPM, Regional Director and DHS) were interviewed. The records related to untied funds maintained at SHC level were studied. The study suggested regular monitoring of utilization of untied funds and a transparent system of signing cheques by the signatories. There is a need to have proper printed guidelines on utilization of untied funds in local language and distributed to individuals concerned.

Key words: Untied Funds, Sub-Health Centres, Village Health Committee.

The goal of the National Rural Health Mission is to improve the availability of and access to quality of health care especially for the poor, women and children, residing in rural areas. Strengthening the health infrastructure, decentralization of health services, community participation and autonomy in functioning are a few of the many strategies that are adopted under NRHM.

The National Rural Health Mission proposes to provide funds to health centres to manage urgent and important activities that need relatively small amount of money, as against the allocated planned funds. There is a need to have funds for unforeseen expenditures that cannot be anticipated in advance. This innovative approach provides funds for undertaking centre-specific need- based activities.

The untied fund is an innovative approach for provision of autonomy to the health centres. This fund is spent based on the local felt needs and is not bound to be spent for pre-defined purposes given by higher authorities. Provision of these funds is made in NRHM to facilitate meeting urgent yet discrete activities that need relatively small amount of money This fund can also be used for meeting the unforeseen expenditures that are not defined. Under the UF, each sub-centre is being given Rs. 10,000 per annum as untied grant for local health action and every PHC an annual maintenance grant of Rs. 50,000/- for infrastructure.

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The untied fund money is given to the BMO as part of NRHM fund and she/he issues a cheque of Rs 10,000 to ANM (except where MPW male is the signatory instead of ANM). The cheque is then deposited into the joint account of the ANM and Sarpanch.

NRHM attempts to strengthen the existing structures by infusing additional human resources at state, district and block level. Similarly, establish programme management structures/bodies at different levels starting from Village Health Committee at most peripheral level to Mission Steering Group at the national level.

It is in this context and emerging programme environment that there is an increasing recognition of organizing collateral inputs for incremental improvements in the programme delivery. Hence, undertaking such quick and rapid health system research using appropriate information such as on untied funds will enable provision of feedback and suggestions.

General Objective

To study the availability, disbursement and utilization of untied fund at sub-centres and to identify problems and constraints, if any, in the implementation of the scheme.

Specific Objectives

- To study the availability of guidelines for utilization of the untied funds;
- To assess the awareness regarding implementation of the guidelines among ANMs;
- To study the funds flow in terms of its availability and utilization at the sub-centre;
- To analyze the decision-making process for utilization and expenditure of untied fund;
- To review problems and constraint, if any, in utilization of untied funds; and
- To recommend measures for better utilization of untied funds at sub-health centres.

METHODOLOGY

Three districts *Dhar, Indore and Khandwa of Indore Division in Madhya Pradesh* were selected to conduct the study. From each district three block PHCs were selected. Circular Systematic Sampling was used to select SHCs in each district. From each block PHCs/CHCs, three PHCs were selected and finally from each PHC three sub-health centers were selected. The total sample size was 81 SHCs. Only those sub-health centres were taken up where the untied fund was disbursed in the current financial year. Following were interviewed to collect the needed information:

(a) ANM and members of Village Health Committee
(b) Medical Officer and BMO [within the universe]
(c) Chief Medical and Health Officer (CMHO), District Programme Manager (DPM), Regional Director/Director Health Services (DHS) (Outside the universe)

In order to collect the data, following tools and techniques were used:

- **Semi-structured Interviews:** The research team visited the block level CHC on the day of the monthly meeting. The ANMs of the identified SHCs were interviewed using the semi-structured interviews.
- **Focus Group Discussion:** ANMs other than those who were interviewed were taken as respondents for the FGD. This was done with the view to have a larger

representation of the study population. Focus Group Discussions were also conducted with members of Village Health Committee, which were organized with the help of the ANMs. All FGDs were conducted as per established norms.

- **Review of the Records at Sub-centre** (Financial Records bank passbook, bills of expenditure, account register): A pre-designed checklist was used to collect the information. Photocopies of passbook, account register and meeting register were taken.
- **In-depth Interviews:** One Medical Officer and BMO were interviewed using a pre-designed in-depth interview schedule. Thus, 9 MOs and 9 BMOs were interviewed in the study. Also CMHO and DPM (one each from three districts) and Regional Director and DHS too were interviewed with the help of an in-depth interview guide. The faculty from NIHFW visited the field to maintain quality assurance. The ethical clearance was given by the Institutional Review Board of the NIHFW.

FINDINGS AND DISCUSSION

In most of SHCs more than 90 per cent of the untied funds were spent. There was no significant difference in the percentage utilization of untied funds in places where SHC building was present and at places where it was not. At places where SHC building was not present, about one-fourth of the untied fund amount was shown to be spent on repair works as against 60 per cent at places where building was present. The money was spent on repair of toilets, water tank and water pipeline fittings and electrical fittings. The second major expenditure was on furniture. At places where there was no government SHC building, one-fourth of the untied funds was spent for paying the rent of the SHC building. In one of the SHC over half of the untied funds was paid as rent.

The other main areas where untied fund was utilized were stationary, purchase of health related articles [medicines, bandages, ointment] and cleaning of SHCs.

At some of the SHCs, 10 per cent to 50 per cent of the untied funds was left unspent for two main reasons. Firstly, the money was only for emergency purposes (46%) and secondly, the other works required large amount of money (38%).

Almost all the ANMs were aware of the areas where the untied funds could be utilized. But in many FGDs with VHC members, most of the sarpanchs were not aware about the use of untied fund. Guidelines on the use of untied fund were explained only to the ANM in the block meetings by the Block Medical Officer.

Majority of the ANMs perceived that the untied fund was inadequate. The suggested amount according to most of the ANMs should be in the range of Rs. 15,000 to Rs. 20,000. The members in all the FGDs with VHCs perceived that the untied funds was inadequate. The main reason for this was poor physical condition of the SHCs as mentioned by the ANMs. Most of the SHCs required large amount of money for upgradation. Some members felt that the untied funds amount was insufficient for maintenance of SHC building. BMOs and MOs also mentioned that the amount was insufficient but the CMHOs, DPM, Regional Director, Health and the Directorate Health Services considered that the amount was adequate. The DGHS stressed that there was a need for

strict monitoring of the utilization of untied fund as per the guidelines. The money provided should be used to meet the needs of the poor than spending on rent, etc.

Mismanagement of untied funds was observed at various levels for example, in some cases the BMO took a major portion of the amount from the ANMs for carrying out minor jobs at the SHCs which probably required smaller sums of amount.

Another problem encountered by the ANMs was bringing the VHC members together for meetings on untied funds. Distance of the bank from the SHC was also mentioned as a problem by some of the ANMs. But in eight (10%), SHCs the signatory of the untied funds account was only the ANM. In majority of the cases, the decision regarding the utilization of untied funds was taken in the VHC meeting. But in some of the SHCs the decision was taken jointly by the ANM and sarpanch alone and at very few places ANM decides alone (where the ANM was the only signatory). It was observed in majority of FGDs that VHC members were not aware of the untied funds.

KEY RECOMMENDATIONS

1. Untied fund should be used in upgrading the sub-health centre to a functional level rather than paying rent.
2. It should not be mandatory to have sarpanch as the signatory of the untied funds account. The expenditure should be decided in the meeting by consensus and decisions to be documented properly.
3. Regular monitoring of utilization of untied funds should be done to ensure no mismanagement or pilferage. A transparent system of signing cheques by the signatories in the presence of some VHC members should be initiated. A register should be maintained to monitor the expenses and spending through the untied funds. Effective involvement of the Janpad Panchayat should be ensured in overall monitoring.
4. Printed guidelines on utilization of untied funds in local language should be prepared and distributed to individuals concerned.
5. Orientation on the untied funds should be provided by the Medical Officer to the VHC members and the Panchas and Sarpanchas by the Janpad Panchyat.
6. The untied funds amount should be released timely to the ANM/VHC i.e. at the beginning of the financial year.

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AN ASSESSMENT OF PROCESS AND PERFORMANCE OF VIJAYA RAJE JANANI KALYAN BIMA YOJANA IN MADHYA PRADESH

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ABSTRACT

The State of Madhya Pradesh designed an innovative strategy to supplement the Janani Suraksha Yojana (JSY) known as Vijaya Raje Janani Kalyan Bima Yojana (VRJKBY), which covers Below Poverty Line (BPL) families and has a provision of delivery in private institutions; partially compensate the cost on caesarean delivery, abortion along with insurance in case of death following the causes related to the delivery. The scheme provides an insurance of Rs. 50,000/- for ante-natal mothers in case of death during delivery or during post-puerperal period related to the pregnancy related causes with provision of additional cash incentives of Rs. 1000/- for institutional delivery to all BPL families. The study was conducted in three rural blocks and one urban area in the district of Gwalior and Guna with the objective to assess the process and performance of VRJKBY and understand the perception of the clients and their satisfaction. Data were collected by in-depth interviews and Focus Group Discussion. The analysis of secondary data available from block and district levels were also used to reach the reasonable conclusions. The study revealed that Anganwadi Workers (AWWs) and Auxiliary Nurse Midwives (ANMs) were the main source of information for the beneficiaries. Nearly 50 per cent of staff were not fully aware about the benefits and provisions under this scheme resulting into their poor convincing powers with the prospective clients. There was major lack of knowledge about this scheme amongst PRI members and community leaders. As the scheme did not bring any significant change, the scheme has been discontinued by the State government.

Key Words: Vijaya Raje Janani Kalyan Bima Yojana, JSY and MMR.

Janani Suraksha Yojana (JSY) is a safe motherhood intervention initiative implemented with objectives of reducing maternal mortality and neonatal mortality. This is to be achieved by promoting institutional deliveries and ensuring the ante-natal, natal and post-natal services under National Rural Health Mission (NRHM). This scheme was implemented in all the States and Union Territories (UT) with special focus on low performing States. The scheme had the flexibility to allow the implementing States to innovate within the principles of the JSY.

General Objective

To assess the process and performance of VRJKBY on institutional deliveries and understand the perception of the clients and their satisfaction.

Specific Objectives

- To assess the implementation of the

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scheme against the laid down guidelines;
- To identify the challenges faced under VRJKBY;
- To assess the stakeholder's perception towards the scheme;
- To assess the trends in institutional deliveries over last three years to capture the performance of the scheme; and
- To document the good practices, if any under this scheme.

METHODOLOGY

Sampling

A rapid appraisal of the scheme was carried out in the Gwalior and Guna districts of the State of Madhya Pradesh with both rural and urban strata from October 2007 to January 2008. Purposive sampling technique was used.

Study Subjects

- Planners, (State officer-in-charge);
- Policy makers and implementers - District Chief Medical and Health Officers (CMHOs), Block Medical Officer (BMO), Medical Officer (MO) of a Primary Health Centre, ANMs and AWWs.
- Community and PRI members; and
- Beneficiaries and non-beneficiaries.

The beneficiaries considered were all those Below Poverty Line (BPL) women, who had delivered during the implementation of the VRJKBY and had utilized any of the benefits provided under this scheme. The non-beneficiaries were all those BPL women, who were otherwise eligible for the scheme but did not utilize the benefits under this scheme, due to some reason.

Data Collection

Quantitative: A pre-tested semi-structured interview schedule was designed for in-depth interviews. There were separate sets of proformae for beneficiaries, non-beneficiaries, planners, policy-makers, implementers and for the community leaders. The FGD guidelines were also prepared for smooth and organized functioning of the FGDs.

(i) Desk review of the State and district specific indicators institutional deliveries, ANC, etc.

Table 1
Detailed Break-up of IDIs and FGDs

Method	Target Population					
		Single District				
		Block 1	Block 2	Block 3	Urban	Total
In-depth Interviews	BMO/Health facility in-charge	1	1	1	1	4
	ANM	2	2	2	-	6
	AWW	2	2	2	-	6
	Beneficiaries	25	25	25	25	100
	Community leaders	-	-	-	2	2
	Non-beneficiaries	25	25	25	25	100
	Total	55	55	55	53	218
FGD	PRI members	1	1	1	-	3

(ii) Detailed study of the VRJKBY followed by the review of the policy framework for maternal health care and health care delivery in the State.

The NIHFW team visited the field area to maintain quality assurance. The ethical clearance of the project was earlier obtained from the Institutional Review Board of NIHFW. The detailed break-up of interviews and FGDs for a CHC in rural area is given in Table 1.

Data Analysis

The data were collated and analyzed in the following steps:

In the first step, the responses to a particular question were listed to obtain a range of responses for all open-ended questions in the schedules. The process was followed for each categories. In the second step, a specific code was given to every response. The code was given upon the basis of type of response and under which category of question, it was falling. In the third step, all entry responses were regrouped to the code allotted of a response. There were a few responses not related to any study objective, such responses were rejected and not included in the trial analysis. In the fourth step, the quotes were included as general/ common comments as and where appropriate.

FINDINGS AND DISCUSSION

Utilization of Services

The study reported that the VRJKBY was well received by the eligible population. There was a significant increase in the institutional deliveries during the implementation period. A large proportion of BPL population was not aware about the scheme, non-availability of BPL card proved to be one hurdle in getting the benefits under this scheme.

The study helped in the review of the performance of this scheme in the two districts of M.P. Although, the scheme was time bound in the design, the process also helped in understanding of the problems and constraints in this scheme. The majority of the non-beneficiaries of the scheme could not utilize because the possible beneficiaries were not aware about this scheme. Other common reason was non-availability of the BPL card with the beneficiaries. The third reason was that although the mother was registered at the health facility, the delivery happened at home, during the night or when there was no body to accompany her to the health facility. Details are highlighted in Table 2.

Awareness About the Scheme

It was found during the study that almost half of the beneficiaries had never heard about this scheme and among non-beneficiaries almost none had heard about the scheme. Besides, half of the Auxiliary Nurse Midwives (ANMs) and Anganwadi Workers (AWWs) also did not know about the scheme. However, all medical officers know about the scheme (Table 3).

Table 2
Reasons for Non-utilization of Services

Reason	Gwalior (n=100)	Guna (n=100)	Total (N = 200)
No information about scheme	82%	68%	74%
Deliveries are conducted at home	15%	9%	12%
BPL card was not available	34%	44%	39%
Hospital is far away	15%	21%	18%
Delivery in private hospital	08%	03%	10.5%
The doctor was not available at PHC	02%	04%	03%

*Multiple responses.

Table 3
Awareness About the Scheme Amongst the Study Participants

	Beneficiaries (25)	Non-Beneficiaries (25)	AWW/ANM (4)	MO (1)	Total (55)
Gwalior					
Mihona	14 (56)	02 (8)	3 (75)	1 (100)	20 (36.4)
Bhitarwar	17 (68)	00	2 (50)	1 (100)	20 (36.4)
Dabra	16 (64)	00	2 (50)	1 (100)	19 (34.5)
Urban	11 (44)	01 (4)	-	1 (100)	13 (34.5)
Guna					
Bamhori	11 (44)	02 (8)	3 (75)	1 (100)	17 (31)
Badhera	09 (36)	04 (16)	4 (100)	1 (100)	18 (32.7)
Aron	14 (56)	02 (8)	2 (50)	1 (100)	19 (34.5)
Urban	15 (60)	02 (8)	-	1 (100)	19 (34.5)

Source of Information

Regarding source of information, AWW and ANM were the main source of information for the beneficiaries. However, a limited number of people got information from doctors, newspapers and TV etc. It was because of the incentives given to the AWWs/ANMs that they used to contact the expectant mothers early in the pregnancy. Other major informants of the scheme were the health staff at PHCs and CHCs. However, there was very poor dissemination through PRI members which shows that either they were not oriented about the scheme in a systematic and comprehensive manner or the scheme was operational in the State for a very short period resulting in limitations (Table 4 and 5).

Table 4
Source of Information for the Beneficiaries in the District Gwalior

District	Gwalior				
Block	**Mihona (25)**	**Bhitarwar (25)**	**Dabra (25)**	**Urban (25)**	**Total (100)**
AWW/ANM	22 (88)	20 (80)	23 (92)	14 (56)	79
PHC/Health Facility	11 (44)	15 (60)	12 (48)	19 (76)	57
Neighbours	5 (20)	3 (12)	4 (16)	2 (8)	14
PRI/Community Members	2 (8)	4 (16)	6 (24)	4 (16)	16
Media	7 (28)	2 (8)	3 (12)	8 (32)	20
Others	12 (48)	5 (20)	11 (94)	15 (60)	43

Table 5
Source of Information for the Beneficiaries in the District Guna

District	Guna				
Block	**Bamhori (25)**	**Badhera (25)**	**Aron (25)**	**Urban (25)**	**Total (100)**
AWW/ANM	22 (88)	24 (96)	21 (84)	17 (68)	84
PHC/Health Facility	08 (32)	11 (44)	12 (48)	15 (60)	46
Neighbours	5 (20)	02 (8)	06 (24)	02 (8)	15
PRI/Community Members	3 (12)	4 (16)	8 (32)	4 (16)	19
Media	3 (12)	5 (20)	5 (20)	11 (44)	24
Others	14 (56)	12 (48)	16 (64)	15 (60)	57

* Multiple responses.

Human Resources and Training

The implementers informed that there was sufficient manpower available. However, the training component in this scheme was grossly missing. Even the health staff was not fully aware about the benefits and provisions under this scheme resulting into their poor convincing powers with the prospective clients. There was major lack of knowledge about this scheme amongst PRI members and community leaders. All of them were getting confused with this scheme and JSY. The implementation guidelines were made available at all the health facilities. However, none of the ANM or AWW interviewed had ever seen such documents.

Target Groups and their Management

There were a lot of difficulties in the identification and mobilization of the beneficiaries for this scheme. Almost all of the health staff at each level felt that a number of pregnant mothers in the community, who were actually very poor could not be given benefits under this scheme, as they did not have a BPL card or were either not issued or were in the process of making. Almost all community leaders stated that BPL card were not being issued to the people who were actually poor.

Coordination

Due to provision of cash incentives to the promoter under the JSY scheme, there were some incidences/reports of quarrel between ASHAs/AWWs because both of them claimed to have worked as promoter for single beneficiary. The coordination at village level was missing and this reflected in their VRJKBY also. However, there was smooth facilitation of the deliveries under the scheme at the health facility level.

Inter-sectoral Coordination

The health staff at the facilities were often overwhelmed by the number of ANC clinic attendees and deliveries at the health facility. There was often no separate discussion about this scheme as this was considered to be a part of JSY only by way. Some beneficiaries also complained that health staff demanded money before release of the cash incentives under this scheme.

Social Mobilization and Communication Efforts

The awareness in the society about this scheme was missing. Even AWWs in some areas were not aware about the scheme. No special efforts were made to do the IEC campaigns for the promotion of VRJKBY. Community members (both beneficiaries and non-beneficiaries) felt that there should be better information dissemination to the community so more number of people could utilize this scheme.

Community Participation

The Panchayati Raj Institution members were largely not aware of this scheme. Their participations were limited or almost nil in the scheme. There was no involvement of NGOs or any other SHG/CBO was their in the study districts. Community members, whosoever were aware about the scheme promoted the beneficiaries to go for institutional delivery.

Client Perspective

The majority of the clients got the full information about the scheme only when they reached the health facilities. Occasional contacts were made by AWW, however, even during their visits, the major emphasis was upon the institutional deliveries. The clients were

not also aware about the other benefits/facilities provided under VRJKBY. A few of the mothers complained that health facility where delivery facility was available were far away from their home. However, they also mentioned that availability of Janani Express Yojana vehicle had simplified the issue. Number of times the clients reported that a lot of money was spent on various transport related and health issues related expenditure on the mother.

Amount of Money Disbursed in this Scheme

The beneficiaries reported to have received cash or cheque payment in the range of Rs. 1000-2400. The VRJKBY was in addition to the JSY going on in the area. The whole amount was given in one go.

Therefore, it could not be clarified under what head this money was given. However, simple variation in the amount of money distribution (as different people received dissimilar amount of money i.e. Rs. 1000, Rs. 1100, Rs. 1300, Rs. 1400, Rs. 1700, Rs. 2000 and Rs. 2400) reflects that there was problem or discrepancy in the distribution of money.

The mode of distribution was either cash or cheque. The cheque used to be issued by the MO and which were encashable at specified nationalized bank. There was no need of having an account in the bank as cheques were not account payee. The time period for the distribution of money was at the time of discharge to one month. The median time in the process was one week.

Funds Flow

The money used to be sent to the person concerned from the office of the State Directorate of Health Services. The CM&HO used to allocate these funds to a CHC and then to a PHC.

The performance of the scheme was dependent upon the funds availability. At one PHC in Gwalior, Rs. 30,000 only was allocated under this scheme. Therefore, the benefits of the scheme were given to first 30 eligible women till mid September, 2006. Even though, the scheme was running in the State, the beneficiaries could not be enrolled from that PHC after that period as there were no funds available.

Similarly at another PHC, where the scheme was running, the MO I/c distributed the fund from 'flexi pool' available expecting that government would repay the amount. However, the funds were not reimbursed by the government and he had to run for the explanation on why money was spent in this scheme, when funds were not available.

Utilization of Money

The beneficiaries had reported of having this money spent on the medicines and treatment of common illnesses for both beneficiary mothers and the newborn. Only few of beneficiaries had utilized the money for family purposes or had saved the money for the future. The most common utilization of the money was cited to be medicines and on the treatment followed by the diet and nutrition of the mothers.

Reasons for Non-utilization

The majority of the non-beneficiaries of the scheme could not utilize it because the possible beneficiaries were not aware about this scheme. Other common reason was non-availability of the BPL card with the beneficiaries. The third reason was that although the mother was registered at the health facility, the delivery happened at home, during the

night or when there was no body to accompany her to the health facility (Table 6).

Implementer Perspective

The AWW/ANM was supposed to have played key role in the implementation of this scheme. However, only a limited were aware about the VRJKBY. And those who knew about the scheme, their knowledge was restricted to the cash incentives and the insurance plan in the scheme. Nearly all of them were confused regarding the JSY and VRJBY. Though they mentioned about insurance however could not provide any information about this component of the scheme. This lack of information about the scheme prevented them from giving any useful suggestions for the improvement in the scheme.

Monitoring and Supervision

The monitoring of the programme was integrated with other health programmes. There were no separate efforts to ensure to record the programme performance.

Programme Performance

The information about the total number of ANC registration, institutional deliveries and total beneficiaries under VRJKBY was also collected for the preceding year and in the year which the scheme was implemented in the State. The information was collected in the monthly format. It was noticed that there was only slight increase in the number of total registrations and institutional deliveries in all the four study sites in both the districts. However, this difference was not found to be statistical significant. It might have happened as JSY was already going on prior to the start of VRJKBY and the most of the eligible beneficiaries were already included under JSY. The overall institutional delivery rate had already increased by ongoing JSY and VRJKBY did not bring any significant change.

Policy Implications

The following are the policy related issues of the study;

- The stake-holders like community leaders and PRIs were not involved in planning and awareness generation about the scheme.
- There was insufficient budgetary allocation for the IEC activities under the scheme.
- Monitoring and evaluation components were not inbuilt in the scheme for implementation.
- Continous review of the scheme was not taken place for taking any remedial measures.

Table 6
Reasons for Non-utilization

Reason	Gwalior (n=100)	Guna (n=100)	Total (N = 200)
No information about scheme	82%	68%	74%
Deliveries are conducted at home	15%	9%	12%
BPL card was not available	34%	44%	39%
Hospital is far away	15%	21%	18%
Delivery in private hospital	08%	03%	10.5%
The doctor was not available at PHC	02%	04%	03%

*Multiple responses.

- BPL card as eligibility criterion was a big hurdle in the implementation of the scheme. The criterion should either be made according to socio-economic conditions irrespective of the BPL card.

As the Scheme did not bring any significant change, the State government has discontinued the scheme.

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A RAPID APPRAISAL OF THE SWASTH PANCHAYAT SCHEME IN THE STATE OF CHHATTISGARH

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ABSTRACT

The present study has been carried out to understand the processes adopted during the implementation of the Swasth Panchayat Scheme in Chhattisgarh. In this respect, data based on the designed twenty six indicators were collected for each village and hamlets. A set of quantitative (Routine Immunization, ANC, PNC, delivery care and safe drinking water) and qualitative indicators were designed to know reasons for success and failures and to review the processes followed for the implementation of this scheme. The study suggests Training Need Assessments of PRIs and Mitanins to bridge the gaps in training and actual implementation at the field level.

Key Words: Primary Health Care, Swasth Panchayat Scheme, Capacity Building.

National Rural Health Mission (NRHM) has been launched in India for providing integrated comprehensive primary health care services, especially to the poor and vulnerable sections of the society. It aims at bridging the gaps in rural health care through increased community ownership, decentralization of the programmes to the district level, inter-sectoral convergence and improved primary health care. The fulcrum of the NRHM programme is an accredited social health activist at the village level, who will work with the village level resource team in providing preventive and promotive health care services. The NRHM ensures that preventive and promotive interventions reach the vulnerable and marginalized through expanding outreach and linking with local governance institutions.

The Government of Chhattisgarh initiated the Swasth Panchayat Scheme for capacity building of Panchayats, village level institutions and individual's health status assessment, health services monitoring and active involvement in local health planning to ensure community participation, understanding intra-panchayat and inter-panchayat variation and building inter-sectoral coordination at village level. The best two Panchayats are selected based on their performance in respect to selected health indicators and awarded by the Chief Minister of the State. As a result of this scheme, capacities were built at the Panchayat level to develop village health plans, implement them and monitor the activities.

PRIs are instrumental for planning, implementation, and monitoring of the NRHM. The success of NRHM significantly depends on the well functioning of gram, block and district level panchayats. A Village Health

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Committee is an integral part of every Panchayat. PRI through Village Health Committees creates a link between the Gram Panchayat and the community. The Village Health Committee is expected to prepare a village health plan and maintain village level data supervised by the Gram Panchayat. Engaging the Gram Panchayat and other smaller groups in planning and monitoring of the Village Health Plan enforces transparency and accountability within the programme.

This scheme has helped to change perceptions of the Panchayats in regard to health and related issues. Almost all the Panchayats are now focusing towards health planning and its outcomes. Many elected representatives are now prioritizing health and assisting in developing health plans.

Being implemented in the State for the first time, it was essential to understand the functioning of the programme and further to make any mid-term corrections during its implementation phase. Replicability of the programme being an important feature, hence, it was essential that a rapid appraisal of the Swasth Panchayat Scheme was carried out. The study has been done with the following objectives:

General Objective

To conduct a Rapid Appraisal of the Swasth Panchyat Scheme in terms of its functions and overall implementation in the State of Chhattisgarh.

Specific Objectives

- To assess the present status of five selected indicators (routine immunization, ANC, PNC, delivery care and safe drinking water) and compare with the baseline data;
- To analyse the reasons of success and failure in achieving the desired outcome for the indicators designed; and
- To review the processes followed for the implementation of this scheme.

METHODOLOGY

Data collection were done with the help of Focus Group Discussions (FGDs) and in-depth Interviews (IDIs). Primary data were collected from two groups of mothers (300 women who gave birth in last one year and 300 mothers of the children aged between 12 months and 35 months) using semi-structured schedules. Secondary data regarding village-wise status of various indicators were collected from State Health Resource Centre, Raipur.

A total of six FGDs were conducted (3 with Mitanins and 3 with ANMs) and 15 IDIs were conducted with PRIs depending on their convenience and availability to understand the processes and the challenges faced in the implementation of this scheme.

The ethical clearance was given by the Institutional Review Board of the NIHFW. The study maintained all research ethics throughout. The faculty from NIHFW visited the field to maintain quality assurance. All in-depth Interviews and FGDs were recorded after taking prior consent from the respondents and were transcribed. Triangulation of results was made using all the data collected to have a clear idea of the findings at the time of analysis.

Thirty clusters were selected from villages and Probability Proportional to Size Sampling (PPS) was utilised. A village was made a unit for selection of clusters. In three villages, two clusters were selected

as population of these villages was more than cluster interval. In each selected village, houses were selected randomly so as to find 10 mothers who had given birth in last one year and 10 mothers with children in the age group of 12 to 35 months. In these houses mothers were interviewed and recorded in pre-tested and pre-designed schedules so as to get current status of the indicators mentioned above. For each indicator, 300 respondents were interviewed (Table 1).

attendants, it ranged from 0 in Ganiyari and Giddha to 69 per cent in Bringpal, while in case of institutional delivery, it ranged from 0 in Ganiyari and Giddha to 23 per cent in Akhalsarai and for measurement of weight of infants within 3 days of birth, it ranged from nearly 4 per cent in Akhalsarai to 100 per cent in Kulhadi, Navaghata and Tonatar.

The data mentioned above reflects large variations. As an example in Ganiyari, the

Table 1
Scheme of Data Collection

Stakeholder	Number	Data Collection Method and Tools
Mothers who gave birth in last one year	300- 10 per sample village	Interview: Semi structured schedule
Mothers of the children aged between 12 to 35 months	300- 10 per sample village	Interview: Semi structured schedule
Mitanins (ASHA)	3 sessions	FGDs: FGD Discussion Guide
PRIs	15 sessions	Interview: In-depth Interview checklist
ANMs	3 sessions	FGDs – FGDs Discussion Guide

FINDINGS AND DISCUSSION

Baseline data collected before implementation of the programme, revealed that coverage of immunization and ANC in villages under study was 81.50 per cent and 82.7 per cent respectively. Institutional deliveries and deliveries attended by trained attendants were 13.37 per cent and 26.74 per cent respectively. Slightly more than half of the infants (57.37%) were measured weight within 3 days of birth (Table 2).

However, there were large variations in indicators observed in various villages under the study. For instance, in immunization, it ranged from nearly 100% in Mundagaon to a low level of around 40 per cent in Kargi. In ANC it ranged from 100 per cent in Akhalsarai to 31 per cent in Mundagaon. Among the deliveries attended by skilled birth

coverage of immunization and ANC was very high while deliveries attended by skilled birth attendant and institutional deliveries were zero. In Kargi, immunization coverage was the lowest while institutional deliveries were the highest. This pattern has been observed throughout the study villages.

It clearly reflects existing mindsets, choices and priorities of the population and the need of development of village specific action plans which focus on the poor/low indicators of that particular village. This also emphasizes the need for reorienting the PRI members and peripheral health functionaries based on the evidences to understand their situations and needs and work towards a more holistic planning for improvement of all health indicators. The observed findings emerging from the Table 2 is also given below.

Table 2

Baseline and Observed Status After Introduction of Swasth Panchayat Scheme

Name of Village	Immunization		ANC		Deliveries Attended by Skilled Birth Attendants		Institutional Deliveries		Weight Measured within 3 days	
	Base-line	Observed	Baseline	Observed	Baseline	Observed	Baseline	Observed	Baseline	Observed
Akhalsarai	80.72	100.00	100.00	80.00	4.65	0.00	23.91	0.00	4.65	100.00
Bagaound	56.30	95.00	62.50	100.00	37.88	85.00	6.06	70.00	24.24	100.00
Bhedwan	86.89	100.00	70.00	80.00	60.00	40.00	40.00	10.00	70.00	80.00
Bringpal	80.00	90.00	90.91	100.00	69.23	40.00	10.26	40.00	69.23	50.00
Choriaya	87.70	95.00	91.15	100.00	11.11	70.00	14.81	15.00	79.63	30.00
Dongariya	94.44	100.00	94.12	90.00	34.21	30.00	10.53	30.00	81.58	90.00
Ganiyari	88.00	70.00	100.00	90.00	0.00	0.00	0.00	0.00	6.67	0.00
Ghatdwari	84.30	100.00	92.86	90.00	47.62	20.00	14.29	10.00	71.43	30.00
Giddha	58.33	100.00	100.00	100.00	0.00	30.00	0.00	0.00	100.00	50.00
Jhara	82.70	90.00	95.00	100.00	15.38	10.00	21.43	10.00	26.92	50.00
Kachnar	76.27	100.00	90.48	90.00	16.07	60.00	17.86	40.00	16.07	80.00
Kadari	72.65	100.00	94.44	100.00	15.63	10.00	15.63	10.00	71.88	40.00
Kargi	42.37	100.00	100.00	100.00	58.82	80.00	58.82	50.00	58.82	90.00
Kashigarh	85.65	100.00	54.76	100.00	57.14	40.00	3.06	30.00	17.35	60.00
Kharwani	86.26	100.00	92.31	100.00	13.04	100.00	4.35	40.00	69.57	100.00
Kulhadi	53.00	60.00	75.00	100.00	38.64	30.00	18.18	30.00	100.00	100.00
Kuli	100.00	90.00	100.00	100.00	15.63	20.00	15.63	20.00	62.50	70.00
Mundagaon	99.59	50.00	31.87	90.00	12.79	30.00	13.95	30.00	23.26	30.00
Nargoda	100.00	100.00	100.00	70.00	0.00	0.00	3.85	0.00	87.18	10.00
Navaghata	100.00	100.00	100.00	100.00	24.49	70.00	12.24	50.00	100.00	100.00
Pachauri	76.84	90.00	69.44	100.00	20.00	20.00	14.29	10.00	74.29	50.00
Podi	87.16	100.00	58.33	100.00	11.11	20.00	5.56	20.00	29.63	90.00
Pondidalha	75.58	90.00	87.93	100.00	14.63	40.00	10.98	10.00	21.95	90.00
Sanjaygram	86.40	100.00	70.00	80.00	21.88	10.00	6.25	10.00	71.88	60.00
Tendua	67.51	100.00	51.11	90.00	60.53	90.00	11.84	40.00	35.53	100.00
Tonatar	96.60	100.00	100.00	100.00	52.73	20.00	7.27	0.00	100.00	100.00
Udantal	83.33	80.00	60.87	100.00	8.77	10.00	0.00	10.00	75.44	80.00
Total	**81.05**	**92.59**	**82.70**	**94.44**	**26.74**	**36.11**	**13.37**	**21.66**	**57.39**	**67.77**

Baseline data - obtained from the Directorate of Health Services.
Observed status - based on the information provided by the respondents.

Immunization Services

Increase in immunization services with almost 100 per cent coverage was observed in some of the villages. However, wide variation in coverage of immunization services was observed among the sample villages. Coverage was as low as only 42 per cent in Kargi while 100 per cent in Kuli and Mundagaon. Increase in coverage of immunization after implementation of Swasthya Panchayat Scheme was not uniform throughout the villages under study. There was an increase of as much as 57 per cent and 41 per cent in Kargi and Gidha village respectively while there was a decline in Udantal, Kuli and more substantially in Mundagoan followed by Ganiyari. On exploring reasons for this discrepancy, it was found that implementation of Swasthya Panchayat Scheme (SPS) was more intensive in the first quarter of the year. In Kulhadi immunization coverage was slightly improved with a change from 53 per cent during baseline to 60 per cent after implementation of SPS programme. Thus, it appears that villages where immunization coverage was low during baseline survey did not improve to any significant level barring few exceptions.

Immunization programme was by and large found to be acceptable but migration during certain months of the year and illness (fever) were the main reasons for not immunizing children in the villages. However, overall immunization coverage was as high as 81 per cent before Swasthya Panchayat Scheme (SPS) was introduced which could be considered satisfactory and therefore scope for improvement became limited.[9,10]

Provision of Ante-natal Care Services

There has been increase in utilization of ANC services with all its consequential benefits in terms of reduction in maternal morbidity and mortality. Utilization of ANC services has been defined by the programme as those beneficiaries whose pregnancies were registered and who received TT injection with iron and folic acid tablets. Maintaining the quality of care of services is the responsibility of the Mitanins.

The study reveals that very few Mitanins had complete and adequate knowledge about all the components of ANC. Ironically, they also share the principal responsibility of providing ANC to the beneficiaries. Therefore, it becomes pertinent to update their knowledge, provide them with refresher training courses to maintain the quality of care services to women. According to the ANMs, ante-natal care was being provided in the village and pregnant women were getting at least 3 ANC visits and majority of them also informed that all the necessary examinations and investigations had been done during ANC visits. However, this information was not corroborated by the Mitanins.

Awareness and Knowledge about the Swasth Panchayat Scheme

Almost all the respondents belonging to the three groups were aware of existence of Swasth Panchayat Scheme. In some villages, the scheme was started just within one year but in majority of villages it was introduced more than a year back.

Almost all the PRIs and Mitanins thought that the strategy of the scheme is to make community participate in the meetings and campaigns related to health. Most of

the ANMs also had similar opinion. This is also confirmed by the fact that majority of Pachayats were found to be involved in implementation of the programme only. Although village plans were prepared with the assistance of the Panchayats, yet many were not aware of their role in preparation of the plan.

Thus it appears that although PRIs have been involved in preparation of village health plan yet they do not have conceptual clarity about their role in Swasth Panchayat Scheme (SPS).

Training

Training sessions were organized under this scheme and were mainly attended by PRIs and Mitanins. It was informed that they found the training programme useful but they also observed lack of participation by the ANMs in these trainings. ANMs were the most important functionary at grass-roots level.

Role of Village Health Committee

Village Health Committee was found to be in existence in almost all the sample villages. In majority of villages they have been there for more than a year. In many villages they existed even before implementation of SPS, but were largely non-functional. After Swasth Panchayat Scheme (SPS) programme was launched all the Village Health Committees became active and involved in meetings and other activities. Almost all the PRIs and majority of ANMs knew the composition of Village Health Committee but majority of Mitanins did not know how the Village Health Committee was formed.

Almost all the PRIs and ANMs were of the opinion that providing assistance in implementation of health programmes is the only function of Village Health Committee.

Village health plans were prepared by involving PRIs and Village Health Committee but they were not aware of the details of the plan prepared for their village. Community was informed about various strategies of Swasth Panchayat Scheme (SPS) and their role in implementation of the programme, yet their role was a limited only to providing assistance in implementation of various health programmes like immunization campaigns etc.

Majority of PRIs agreed that Village Health Committee was responsible for monitoring of health programmes in the village but no monitoring plans were prepared. Lack of guidelines for monitoring and responsibility were observed. As a result no effective monitoring by Village Health Committee had been done in the villages. Monitoring and evaluation are important components of Swasth Panchayat Scheme (SPS). Unless the Village Health Committee is actively involved in this process, effective implementation of Swasth Panchayat Scheme (SPS) might not be possible.

RECOMMENDATIONS

- Develop an efficient system for fund flow under JSY to ensure that the benefits reach the pregnant women on time.
- Regularize/reduce the number of home deliveries and deliveries conducted by unskilled attendants.
- Ensure regular transport facilities available at the village level for the

pregnant women.

- Increase levels of participation of ANMs during training programmes to ensure effective implementation of the programme.
- Conduct Training Need Assessments of PRIs and Mitanins to bridge the gaps in training and actual implementation at the field level and ensure subject specific training.

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FUNCTIONING OF VILLAGE HEALTH AND SANITATION COMMITTEES (VHSCs) IN ORISSA STATE

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ABSTRACT

Village Health and Sanitation Committees (VHSCs) represent the lowest level management structures as per the implementation framework of National Rural Health Mission. The present study was undertaken to review the current status of formation, empowerment, functioning and capacity of VHSCs in Orissa to address the health needs of the people. The study area included six blocks, two in each district of Bolangir, Kendrapada and Nabarangpur. The stakeholders in the study were ASHAs, AWWs, ANMs, PRIs and SHG members alongwith block and district level officials. Record review, semi-structured interview schedules and key informant interviews and guideline for conducting focus group discussions were used as tools. The study revealed that the awareness about VHSCs was highest among ANMs followed by ASHA and CDMO/MOs, PRI, SHG. None of the PRIs and SHG members had received any training/orientation on NRHM and VHSC. Non-availability of information about the funds has affected the VHSC functioning. Institutional setup at the village level to undertake village level planning and inter-sectoral co-ordination, convergence and involvement of PRIs were found lacking. Support mechanisms need to be strengthened in all these areas for improving not only the formation and spread of VHSCs across villages but also their effective functioning.

Key Words: NRHM, Village Health and Sanitation Committees and Village Health Plan.

Village Health and Sanitation Committees (VHSCs) are the ground level management set-ups for the speedy and effective implementation of the National Rural Health Mission (NRHM) objectives. The committee is supposed to facilitate village level development programmes and reflect the health needs of the people.

The section on 'strategies for institutionalizing community level action for health' clearly indicates that VHSC will be formed in each village within the overall framework of gram sabha in which proportionate representation from all hamlets would be ensured. The VHSCs will be responsible for preparation of a village health plan and are expected to play a leading role in the health matters of the village. The village health plans will form the basis for a district health plan. It is expected that by the year 2009 all the district health plans will be prepared. The functioning of VHSCs is, therefore, critical in the context of decentralized health planning and preparation of district health plan.

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The NRHM has already completed two years of its implementation in the State of Orissa. The present study was undertaken during the period August 2007 to December 2007 to assess the status of VHSC formation and critically look into its operational aspects in the State under Rapid Appraisal of Health Interventions (RAHI) project funded by United Nations Population Fund (UNFPA).

General Objective

To examine the current status of formation, empowerment, functioning and capacity of VHSCs to address the health needs of the people in the context of NRHM.

Specific Objectives

- To examine the process of formation/composition of VHSC and find out the deviations if any from the prescribed framework of guidelines;
- To review the process of empowering the VHSC for the tasks expected - assess the orientation/capacity building initiatives undertaken so far by the district or State health mission;
- To assess the functioning of VHSCs i.e. frequencies of meeting, agenda and issues;
- To review the process of fund flow to the VHSCs; and
- To assess the skill set/resources available with the VHSCs to formulate village health plan and support required for this.

METHODOLOGY

The rapid appraisal of VHSCs is done in six blocks (two blocks in each district) and three districts of Orissa namely Bolangir, Kendrapada and Nabarangpur through a descriptive design adopting both qualitative and quantitative techniques.

Sampling

The study covered three (10%) districts out of 30 districts of Orissa selected purposively on the basis of low and better health indicators, tribal concentration and non-tribal area. The districts covered belong to tribal concentrated areas of the State and one of them (Kendrapada) belongs to a non-tribal area. In each district 2 blocks were purposively selected for primary study where community-monitoring activity was started. A total of 6 blocks were covered under the study. The names of the 3 districts and 6 blocks covered under the study are given below (Table 1).

From each selected blocks, 10 villages where the village health and sanitation committees have been formed were covered based on the availability. The selections of villages were done randomly.

Table 1
Districts and Blocks Covered under the Study

District	Blocks
Bolangir	Loisingha
	Patnagarh
Kendrapada	Derabisi
	Patamundai
Nawarangapur	Nabarangpur
	Tentulikhunti

Data Collection

The primary data collected were through FGDs, In-depth Interviews and Key Informant Interviews. The secondary data were collected through review of records. The data collection followed a stepwise procedure. The key informant interviews were conducted at the district and block level, the FGDs at block/CHC level and In-Depth Interviews and review of records at village level. Guidelines for conducting FGDs were strictly followed. Semi-structured interview schedules for In-Depth Interviews and Key Informant Interviews were used to collect information from different types of respondents. Besides, a checklist was used to review the records of VHSCs.

As per the design records of 60 village health and sanitation committees, 18 Focus Group Discussions (FGDs), 18 In-depth Interviews (IDIs), 6 Key Informant Interviews (KIIs) planned to be conducted during the study. However, only 25 reviews of records instead of 60 planned reviews could be conducted as the VHSCs in four blocks out of six blocks covered under the study were not available during the study period. Twenty four in-depth interviews were conducted instead of 18 planned to maintain a uniformity of sample covered from ex-officio categories such as Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) during the study. The details of interviews/ reviews conducted during the study are shown below in Table 2.

Out of six FGDs under Self Help Groups/Panchayat Raj Institution members' category, 3 FGDs were conducted with women Self Help Groups (SHGs) members and 9 in-depth interviews out of 12 members interviewed from SHG/PRI members were women.

Table 2
Details of Interviews/Reviews Conducted under the Study

	Interviews/Reviews Conducted			
	Village	**Block**	**District**	**Total**
Review of VHSC records	**25**			**25**
Focus Group Discussions		**18**		**18**
ANMs		6		6
AWWs		6		6
SHG/PRI members		6		6
In-depth Interviews				**24**
ANM/ASHA	12			12
SHG/PRI members	12			12
Key Informant Interviews				**12**
CMO/District Nodal Officer			3	3
District Panchayati Raj Officer			3	3
Block MOIC		3		3
Block Panchayati Raj Officer		3		3

The ethical clearance for the project was earlier obtained from the Institutional Review Board (IRB) of NIHFW.

Data Analysis

Two-tailed t-test and analysis of variance (ANOVA) was used to find out whether the differences of mean value of parameters between groups are significant using statistical programme SPSS. $p<0.05$ was considered statistically significant.

FINDINGS AND DISCUSSION

The awareness about VHSCs was highest among ANMs followed by ASHA and Chief District Medical Officer (CDMO)/Medical Officers (MOs), Panchayati Raj Institution (PRI), Self Help Group (SHG). The awareness was least for the panchayat officials among all stakeholders. With respect to involvement in VHSC formation it was highest among ASHA, ANM and SHG followed by CDMO and PRI members (Table 3). The panchayat officials were found not involved in the process. The knowledge on objectives of VHSC was highest among ASHA, ANM, SHG and least among the PRIs. Lack of clear guidelines and instructions from State level has affected the VHSC formation process.

It was found that the awareness on NRHM as well as on VHSCs was poor among the community-based organizations and PRIs. More IEC activities on information relating to various components of NRHM and VHSCs should be undertaken in order to create an enabling environment for the uptake of the VHSC activities at the community level.

The results of the record review of VHSCs in Loisingha and Patnagarh block of Bolangir district indicate that almost all committees (95%) were formed within six months prior to the study. Majority of members were found to be women (82%) and belong to OBC category (69%) followed by SC and ST (24%). The general category members were found to be least (6%) in these committees. Although PRI members were within the 95 per cent committees' more than 60 per cent of VHSC did not have the office bearers.

Orientation training was received by CDMO/MO followed by ASHA, ANM

Table 3
Knowledge and Awareness About VHSC Among Different Stakeholders

	ASHA (N = 6)	ANM (N = 6)	PRI (N = 6)	SHG (N = 6)	DPO/GPEO (N = 6)	CDMO/MO (N = 6)
Know about NRHM	5	6	3	4	3	6
Know about VHSC	5	6	3	4	2*	5
Belong to Village having VHSC	3	2*	2*	3	Nil	Nil
Member of VHSC	3	2*	2*	3	Nil	Nil
Know about VHSC Objectives	3	3	1*	3	Nil	Nil
Knows the office bearers of VHSC	1*	3	1*	1*	Nil	2*

*P<0.001

and District Panchayati Raj Officer (DPROs)/Gram Panchayat Extension Officer (GPEO). None of the PRIs and SHG members had received any training/orientation on NRHM and VHSC (Table 4). Almost all ASHA, ANM, PRI members and SHG members, those interviewed, were of opinion that there is a need of detailed training on VHSC irrespective of the fact whether anybody has received any training or not.

meeting was found decreasing and lack of proper follow-up on the planned activity due to unavailability of funds resulted in poor functioning of VHSCs. None of the VHSCs had received any fund.

There was also lack of clarity about the village health committee (VHC) functioning at sub-centre level and VHSCs at the village level.

With respect to skill set available with

Table 4
Perception of Capacity Building on VHSC among Different Stakeholders

	ASHA (N = 6)	ANM (N = 6)	PRI (N = 6)	SHG (N = 6)	DPO/GPEO (N = 6)	CDMO/MO (N = 6)
Received any training or orientation on NRHM	6	6	Nil	Nil	2*	4
Received specific training or orientation on VHSC	4	3	Nil	Nil	2*	5
Remembers training/orientation contents on VHSC	4	3	Nil	Nil	2*	5
Perception about the usefulness of training	3	2*	Nil	Nil	1*	5
Think that detail training is needed	6	6	6	6	2*	Nil

Non-availability of information about the VHSC funds affected its functioning (Table 5). The average number of members participating in VHSCs

VHSC to formulate village health plan (VHP) it was observed that almost all CDMO/MOs are aware about the VHP but none had received training as to how

Table 5
Perception on Functioning of VHSC among Different Stakeholders

	ASHA (N = 6)	ANM (N = 6)	PRI (N = 6)	SHG (N = 6)	DPO/GPEO (N = 6)	CDMO/MO (N = 6)
Know about the role of VHSC	4	3	1*	3	Nil	4
Able to tell about the frequency of meeting	3	3	1*	3	Nil	3
Opine meeting held regularly	2	3	1*	2*	Nil	2*
Opine proceedings are recorded	3	3	1*	Nil	Nil	3
Monitoring system is in place	3	3	Nil	Nil	Nil	6
Activities monitored by seniors	2	3	Nil	Nil	Nil	4
Confirms initiatives taken by the VHSC	1*	2*	Nil	Nil	Nil	2*
Village health plan prepared	1*	1*	Nil	Nil	Nil	1*

*P<0.001

to prepare a VHP and no guidelines were received by them in this regard (Table 6).

IEC/wall painting activities in villages (Table 7).

Table 6
Opinion on Skill Set/Resources Available with VHSC to Formulate Village Health Plan among Different Stakeholders

	ASHA (N = 6)	ANM (N = 6)	PRI (N = 6)	SHG (N = 6)	DPO/GPEO (N = 6)	CDMO/MO (N = 6)
Aware about Village Health Plan	1	2	Nil	Nil	Nil	6
VHP made in their locality/area of operation	1	1	Nil	Nil	Nil	Nil
No training on VHP has been organized	6	6	6	6	6	6
No guideline on VHP	6	6	6	6	6	6
No VHSC is formed	3	3	3	3	6	3
No idea whether to take up VHP in the current year	6	6	6	6	6	2

Table 7
Activities Undertaken by the VHSCs

Activities Undertaken	Number	Percentage
Created awareness about health programmes	6	30.0
Undertaken village survey	5	25.0
Participated in cleaning of drain and tubewell surroundings	4	20.0
Helped during immunization	2*	10.0
Use of sub-centre untied fund	1*	5.0
Oversee the IEC activity/wall painting	1*	5.0
Total villages	20	100.0

*P<0.001

Lack of institutional set-up at the village level to undertake village level planning and inter-sectoral co-ordination, convergence and involvement of Panchayati Raj Department indicate that in spite of appropriate plans, ownership by the community is still a matter of concern.

As per the records of VHSCs, the committees undertook awareness activity on health programmes, village survey, participated in cleaning of drain and tubewell surroundings, helped the immunization of children, oversaw utilization of sub-centre fund and

RECOMMENDATIONS

Based on the above findings, the following recommendations were suggested to improve the functioning of VHSCs:

- Issue detailed instructions specifying membership of VHSC, process of constitution, its integration with PRIs, funds flow mechanism, with clear roles and responsibilities of different office bearers. Support mechanisms at the district and block level are to be established to ensure the convergence, merger or re-designation of earlier health and

allied committees at the village level.

- Financial information should be made available to each block PHCs and below. If required e-financial information systems can be established to ensure quick flow of information. Attempt has to be made to involve each concerned departments at all levels.
- Programme guidelines should be clearly explained to the implementors and other providers.
- Steps should be taken to avoid confusion relating to Village Health Committee at sub-centre level and Village Health and Sanitation Committee at the village level. The purpose of both the funds and function of both the committees are to be clearly explained to providers as well as the people. Efforts should be made to involve the NGOs in facilitating formation process of VHSCs.
- IEC activities need to be intensified in the community particularly on the provisions and entitlements under NRHM. Social mobilization activities around general health issues and health as a right of people need to take place for positioning of ASHA and VHSC.
- Training on VHSC and its functioning should be imparted to ASHAs, AWWs and ANMs so that they can approach the community with full knowledge and confidence. Further, the quality of the training is to be enhanced and refresher training on village health plan and other functional aspects of VHSC should be provided based on the need assessment. Attempt has to be made to establish linkage between the standing sub-committee on health and sanitation committee of the panchayat and VHSC.

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AN ASSESSMENT OF THE FUNCTIONING AND IMPACT OF JANANI SURAKSHA YOJANA IN ORISSA

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ABSTRACT

Since the inception of the National Rural Health Mission (NRHM) on 17th July 2005 in the State of Orissa, a large number of health programmes have been implemented to address various health related concerns and needs to improve the efficiency and effectiveness of the health system. This study was conducted in the three districts i.e. Balasore, Jagatsinghpur and Nayagarh of Orissa selected on the basis of high, middle and low percentage of institutional deliveries respectively. The overall objective was to review the implementation process of JSY in the State and to provide inputs for any corrective action. The study was a typically cross-sectional design with a mix of both qualitative (FGDs) and quantitative techniques. The study revealed that at the district, block and sub centre level there was a shortage of medical and para-medical staff, inadequate facilities for institutional delivery. However, available staff was well trained on various implementation procedures under JSY. IEC activities were also being implemented efficiently. Beneficiaries revealed that HW (F) and ASHAs were playing the key roles in generating awareness regarding JSY. Still many non-beneficiaries were not aware about the JSY. Study concludes with two major recommendations: (i) Strengthening of infrastructure, supplies and human resources at all levels under the JSY, and (ii) Streamlining the fund flow mechanism at two levels: immediate compensation to the beneficiary after the delivery and regular payments/ salaries to the ASHA.

Key Words: Janani Suraksha Yojana, ASHA, Institutional Delivery.

Since the inception of the National Rural Health Mission (NRHM) a large number of health programmes have been implemented to address various health related concerns and needs to improve the efficiency and effectiveness of the health system. NRHM was launched in the State of Orissa on 17th July 2005, with an aim to provide accessible, affordable and quality health services to the rural and underserved populations of the State.

National Rural Health Mission aims at reducing maternal and childhood morbidity and mortality through timely interventions like engagement of Accredited Social Health Activist (ASHA) at village level, RKS, JSY are some of them. The figures State that every five minutes one woman dies somewhere in India from pregnancy related complications amounting to one lakh maternal deaths and 10 lakh newborn deaths each year. NRHM launched its JSY scheme as one of its most important key interventions to reduce maternal mortality.

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Janani Suraksha Yojana (JSY) is an incentive-based programme for the promotion of institutional deliveries. The main objective under this programme is to ensure that each delivery is conducted in an institution and is attended to by a Skilled Birth Attendant (SBA) to minimize/prevent maternal deaths and pregnancy complications in women and at the same time ensure maternal and newborn well-being. Under JSY, cash assistance to mothers and ASHAs is provided for institutional deliveries. Recruitment and training of ASHA in each village has given further impetus to the efforts of preventing maternal deaths.

JSY was implemented in Orissa in June 2006. Under this scheme, a selected number of ASHAs have been identified at the village level to facilitate early registration of ante-natal women to provide ante-natal care and ensure timely transport for women for institutional delivery. Both the woman and the ASHA are given cash assistance for ensuring a safe institutional delivery.

General Objective

To review the implementation process of JSY in the State of Orissa and provide inputs for any corrective actions.

Specific Objectives

- To review the mechanism in place for implementation of JSY;
- To study the processes and procedures of ensuring financial benefit or cash assistance to the beneficiaries;
- To probe the acceptance of the JSY programme in the community; and
- To identify the problems/barriers (if any) faced during the implementation of JSY.

METHODOLOGY

The study was a typically cross-sectional design with a mix of both qualitative (FGDs) and quantitative techniques. (In-depth interview, Record analysis).

Sampling

Three districts viz. Balasore, Nayagarh and Jagatsinghpur were identified based on the performance (High, Medium and Low) according to the maternal health indicators. (e.g. Institutional delivery in 2006-07- 43 per cent in Balasore, 18 per cent in Nayagarh and 10 per cent in Jagatsinghpur). Two blocks (one nearest and the other farthest) were identified from each sample district. From each block one sub-centre was randomly selected. Further, from each sub-centre two villages were selected randomly. In total, 6 sub health centres and 12 villages were selected.

The Study Respondents

- District level: Additional District Medical OfficerFW (ADMO) FW and District Programme Manager (DPM);
- Block level: Medical Officer In-Charge (MO I/c.) of Primary Health Centre (PHC)/UGPHC/ Community Health Centre (CHC);
- Sub-center level: Health Worker (Female);
- Village level ASHAs, beneficiaries and non-beneficiaries. From each Block 15 beneficiaries and 15 non-beneficiaries were selected at random.

A total of 210 respondents were contacted during the entire duration of the study.

Data Collection

Data were collected using semi structured schedules, In-Depth Interviews (IDI) and Focus Group Discussion (FGD). Primary and secondary data sources were used for data collection. Primary data were collected from the beneficiaries and non-beneficiaries in each village by using semi-structured interview schedules. The NIHFW team visited the field area to maintain quality assurance.

Secondary data were collected from the available reports and the records available at district, block and sub-centre levels regarding the operational mechanism and utilization of the services under JSY. All the data collected were triangulated to have more clarity on the findings at the time of analysis.

The study maintained all research ethics throughout. All In-Depth Interviews and FGDs were recorded after taking prior consent from the respondents and were transcribed. One FGD was conducted in each block with the available PRI members, SHGs and school teachers to know about their perception and bottlenecks in the implementation of the programme at the community level. Data collected were from each block were 1 FGD, 4 In-depth Interviews (IDI), 30 interviews of beneficiaries and non-beneficiaries.

Data Analysis

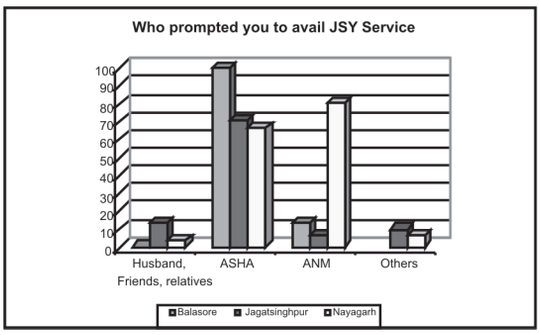
Qualitative data was analyzed using SPSS-II software. For qualitative data semi-quantification was done by coding the responses for different stakeholders and merging into different headings using adjectives. The ethical clearance of the project was given by the Institutional Review Board of NIHFW.

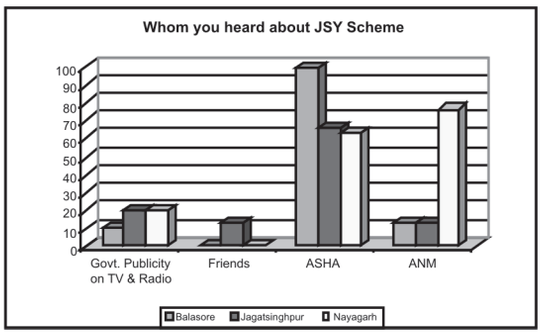
Table 1

District-Wise Source of Information for Beneficiaries for Availing JSY Service

	Name of the district						Total	
	Balasore		Jagatsinghpur		Nayagarh			
Who prompted you to avail JSY service	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Husband, Friends and relatives	0	0	4	13.3	1	3.3	5	5.6
ASHA	30	100.0	21	70.0	20	66.7	71	78.9
ANM	4	13.3	2	6.7	24	80.0	30	33.3
Others	0	0	3	10.0	2	6.7	5	5.6
From whom you heard about JSY scheme								
Government publicity on TV, Radio	3	10.0	6	20.0	6	20.0	15	16.7
Friend	0	0	4	13.3	0	0	4	4.4
ASHA	30	100.0	20	66.7	19	63.3	71	78.9
ANM	4	13.3	4	13.3	23	76.7	33	36.7

• Multiple sources possible





FINDINGS AND DISCUSSION

Human Resource

It was revealed from the study that at the district, block and sub-centre level there was a shortage of medical and para-medical staff posing a major hindrance for the programme.

Logistics

Inadequate facilities for institutional delivery was observed at all levels. Delivery tables, instruments and equipments were not adequate to meet the increased delivery load. 50 per cent SCs had no building of their own.

Training, Capacity Building and Sensitisation

It is encouraging to note that 92 per cent of ASHAs in the study district had received modular training on JSY. 84 per cent of HW (F) was trained on maintenance of account related to JSY and imprest money.

At some places sensitization of MOs has been undertaken. The district and block health authorities have indicated some gaps in the sensitization programme. So far as sensitization of the community members is concerned, wall paintings, leaflets, local dailies and local TV and Radio were utilized as the means of IEC. Janamancha in the DHH Nayagarh was organized to generate awareness among the community members. Beneficiaries revealed that HW (F) and ASHAs were playing the key roles in generating awareness regarding JSY. Still many non-beneficiaries were not aware about the JSY (Table 1).

Knowledge of Service Providers

The level of knowledge of service providers is of paramount importance in

Table 2

Level of Knowledge of Service Providers on Various Components of JSY

Component of Scheme	Balasore		Jagatsinghpur		Nayagarh	
	ADMO	DPM	ADMO	DPM	ADMO	DPM
Eligibility	2	3	1	2	1	2
Incentives	1	2	1	2	1	2
Accredited institutes	1	2	1	0	1	2
Roles and responsibilities of service providers	2	2	2	2	2	3
Average Score	0.5	0.75	0.4	0.5	0.4	0.75

the successful implementation of JSY in the community.

The levels of knowledge of ADMO (FW), DPM (Ref. Table 3.1) at the district level, MOI/C of CHC/PHC at the block level HW(F) and ASHA at the village level was assessed with the help of structured schedule for in-depth interviews incorporating key components of the JSY programme. The overall score of > 0.5 was considered to indicate poor knowledge, 0.5 to 0.7 as an indicator of average knowledge and 0.7 < as good knowledge (Table 2).

Monitoring and Supervision

With regard to monitoring and supervision of JSY non-availability of required number of staff was a major hindrance in the monitoring of JSY programme. Mostly during monthly review meeting, the JSY activities were reviewed. HW (F) was mostly supervising the JSY activities in the field. MOs were not able to go for field level supervision and monitoring due to extra workload.
Study in the six PHCs/CHCs revealed that there was significant and sudden spurt in the percentage of institutional deliveries during 2005-2006 to 20062007 due to introduction of JSY.

Cash Incentives

ASHAs were receiving the incentives from Health Worker (F) in the form of cash for facilitating institutional deliveries in her area with regard to receipt of incentives, out of 12 ASHAs interviewed, 9 were in receipt of Rs. 600/- each for promoting early registration, ante-natal care and institutional deliveries, one had not received her incentives as yet and two of them had received only Rs. 350/- and Rs. 150/- respectively. 50 per cent of Health Workers (F) and 80 per cent ASHAs expressed that fund flow is irregular and delayed. As a result, disbursement of money to the beneficiaries in both institutional and home deliveries was delayed.

RECOMMENDATIONS

Based on the study findings a set of suggestions have been formulated for efficient delivery of services under JSY:

- Ongoing and regular updates and orientation to the service providers about the JSY and their roles and responsibilities within it.
- Utilizing the GRAMSAT network for cost effective and timely orientation for service providers.
- Strengthening IEC Activities: developing effective messages, using the Janmancha, banners and slogans and putting an effective communication strategy in place for effective monitoring of JSY.
- Streamlining the fund flow mechanism at two levels: Immediate compensation to the beneficiary after the delivery and regular payments/salaries to the ASHA.
- Strengthening of infrastructure, supplies and human resources at all levels under the JSY.

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A RAPID APPRAISAL ON FUNCTIONING OF JANANI SURAKSHA YOJANA IN SOUTH ORISSA

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ABSTRACT

The JSY scheme was implemented in the State of Orissa since April 2006 and the cash assistance was provided to the utilizers with changing rules at different times and mode of disbursement of funds. Issues related with procedural constraints in JSY implementation and inadequate feedback from the community were the primary concerns, which necessitated this study in Orissa. The study endeavours to assess and evaluate the operational mechanism and utilization of Janani Suraksha Yojana, reasons for non-utilization, perception and awareness of utilizer and non-utilizer mothers and the involvement of ASHAs, ANMs alongwith district and block officers in two blocks each from districts of Ganjam, Gajapati and Kandhamal of South Orissa. Different stakeholders in this study were both utilizers and non-utilizer mothers, health providers such as ASHAs, ANMs, PRI members alongwith block level and district level health officers. The study revealed that there was a lack of orientation of the health staff other than ASHA on JSY. ASHA played a major role in motivation for institutional deliveries in two-thirds of the utilizers. Most of the utilisers expressed problems of communication and transport. Further non-availability of 24x7 facilities and lack of staff were major deterrents for prospective mothers in accessing JSY services. The study recommends for streamlining of funds flow, accreditation of private hospitals, intensification of IEC activities and increased involvement of PRIs and community leaders and women groups.

Key Words: Janani Suraksha Yojana, Utilizer and ASHA.

The JSY scheme was implemented in the State of Orissa since April 2006 and the cash assistance was provided to the utilizers with changing rules at different times and mode of operation of funds. Total number of JSY utilizers in the State of Orissa till December 2007 were 36, 2087. The total number of ASHAs appointed were 34,178 out of which 30,992 (90.6%) were trained.

Initially, only BPL families were entitled for JSY assistance. Likewise, assistance was granted to mothers upto two children. However, several problems such as delayed release of funds, poor management of funds, poor maintenance of accounts and non-involvement of PRI members were reported as barriers in effective implementation. Inadequate awareness on part of different stakeholders, including community representatives, also acted as a hindrance to proper implementation.

General Objective

To assess the functioning of Janani Suraksha Yojana (JSY) in South Orissa.

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Specific Objectives

- To review the operational mechanism of JSY;
- To review the utilization status of JSY and reasons for non-utilization in the districts;
- To assess the perception and awareness of utilizer/non-utilizer mothers regarding Janani Suraksha Yojana;
- To assess the involvement of ASHA/ANM and district/block officers in implementation of Janani Suraksha Yojana; and
- To make recommendations in light of study findings.

METHODOLOGY

Sampling

Two blocks from each district, one close to the district headquarter and one remotely located from district headquarter were chosen for the study. Thus, six blocks from three districts were selected for the study. From each block, five or more villages were selected randomly. The lists of districts, blocks and villages in the study are given in Table 1.

The following sample of respondents were selected from the identified districts, blocks and villages:

Programme Implementers: Chief Medical Officers/ADMO of the

Table 1

Selected Districts, Blocks and Villages under Study

District	Block and Villages	
	Proximal	**Remote**
Ganjam	Kukudakhandi • Ratanpur • Anksushpur • Krupasindhipur • Balipada • Sihala	Khallikote • Kanka • Bikrampur • Manikpur • Birnarasinghpur • Khajapalli
Gajapati	Mohana • Jodamaba • Dhadiamba • Nuasahi • Kidasingi • Gabariguda	Gosani • Labanyagada • Sariapalli • Garabandha • Gurandi • Rautpur
Kandhamal	Tikabali • Totagudu • Barapalli • Pasara • Raipada • Gurusahi • Mundagoan	Chakapada • AMCS colony • Chatijhar • Kaltimendi • Kedarsahi • Gumalmendi • **Tiparigoan**

concerned districts (3) and Block Medical Officers (6) qualified as respondents. One ASHA from each block (6) and one ANM from each block (6) were selected randomly. One group of PRI members and ASHAs were also selected on the basis of their availablilty for FGDs in each block. This constituted the sample respondents on the implementers' side.

Utilizers and Non-Utilizers: A list of utilizers who underwent institutional deliveries and availed services under JSY in the last six months was procured from five selected villages under each block. Also, through feedback from key informants, a list of non-utilizers was prepared who had given birth to a child in the last six months but did not utilize services under the JSY. From each village, four utilizers and four non-utilizers of JSY scheme were randomly selected for the study. If sufficient number of respondents were not available in the village, then the nearby village was considered for the study to complete the sample. The total number of respondents included in the study from the beneficiary side were 120 utilizers and 120 non-utilizers (Table 2).

Primary data were collected from utilizer mothers and non-utilizer mothers and other stakeholders of Janani Suraksha Scheme. Secondary data were collected from available reports and records at district and block level regarding the operational mechanism and utilization of the scheme. Data were collected from various respondents using semi-structured schedules, In Depth Interviews and Focus Group Discussions. All IDIs and FGDs were recorded after consent of respondents and were transcribed. One FGD for ASHA and PRI in each block were included in the study sample. The NIHFW team visited the field area to maintain quality assurance. All the data collected were triangulated to have a clear idea of the findings at the time of analysis. The ethical clearance of the project was given by the Institutional Review Board of NIHFW. Details of sample covered and techniques used are shown in Table 2.

FINDINGS AND DISCUSSION

The knowledge imparted in the ASHA training provided by the government was considered useful by most. But majority felt that further training was required for resolving practical problems they face in the field. However, the lack of orientation of the health staff other than ASHA on

Table 2
Sample Covered and Techniques used for Data Collection

Stakeholder	Number	Data Collection Method and Tools
JSY Utilizer mothers JSY Non-utilizer mothers	120 (4 Utilizers from each of 5 villages per block from 6 blocks i .e. 4 Utilizers X 5 villages X 6 blocks) 120(4 Utilizers from each of 5 villages per block from 6 blocks i .e. 4 Utilizers X 5 villages X 6 blocks))	Interview-Semi Structured schedule
CMO/District nodal officer BMO ASHA ANM	3 (1 per district) 6 (1 per block) 6 (1 per block) 6(1 per block)	Interview: In-depth interview checklist
ASHA PRI/Community leaders	1 per block 1 per block	FGDs: FGD Checklist

JSY is a significant finding emerging out of this study.

Less than half of utilizers and non-utilizers were having knowledge on various aspects of the JSY scheme like provision for escort by ASHA, stay during hospital delivery and cash assistance. In approximately three-fourth of the utilizers, 1st contact of ASHA with the mother was for ANC in 3-6 months of pregnancy. ASHAs also played a major role in motivation for institutional deliveries in two thirds of the utilizers (Table 3).

Table 3
Programme Utilization by Utilizer Mothers

Performance Indicators	Values
Ist contact/ANC	12-24 wks in 70%
Motivation for ANC by ASHA	65%
ANC done by Medical Officer	49.2%
Motivation for institutional delivery by ASHA	62%
Time of getting JSY card	<3 months in 3.3% 3-6 months in 48.3% 6-9 months in 39.1% > 9 months in 9.1%

JSY scheme has a continuum of services to be utilized by the mothers. Services like three ANCs were perceived as useful by majority of utilizers but some of non-utilizers did not perceive receiving three ANC as useful. Essentiality of 100 IFA tablets figured low in the perception of all respondent categories.

Majority of the stakeholders perceived monetary assistance as a big advantage for the mothers and perceived that the JSY scheme had made the health staff more helpful and friendly towards the utilizers such as making frequent contacts, issue of JSY cards and motivating prospective mothers to avail JSY benefits.

Most of the utilizers expressed that there were lack of transparency in money distribution and they had to use inducement for either getting JSY card or getting the cash assistance. Nearly all except the district officials felt that the JSY assistance was received late and it was delayed due to complicated procedure of filling and sending of forms or due to interruption of money flow to the PHC.

Most of the respondents felt that there were problems of communication and transport. Hiring transport at odd hours, high cost of transportation and denial by transporters to carry patients from distant locations, was a barriers in availing JSY services. Non-availability of 24x7 health centres and lack of staff were major deterrents for prospective mothers in accessing JSY services.

There were very little or no involvement of PRI members in the scheme. So was the case with community leaders, women groups and local NGOs.

About 36.7 per cent of the utilizers in the study area got payments within one week. 40 per cent of the utilizers of the scheme

Table 4

Time Taken in Receipt of JSY Payment by the Utilizers

Time Taken	Ganjam(n=40) number/(%)		Gajapati(n=40) number/(%)		Kandhamal(n=40) number/(%)		Total (120) number/(%)
	Khall	Kukud	Mohan	Guran	Tikab	Chakap	
<7 days	4(20)	10(50)	5(25)	9(15)	8(40)	4(20)	40(33.3)
7 days to 1 month	2(10)	9(45)	9(45)	8(40)	8(40)	9(45)	45(37.6)
>1 month	10(50)	1(5)	4(20)	3(15)	3(15)	7(35)	28(23.3)
Not received yet	4(20)	0	2(10)	0(0)	1(5)	0	7(5.8)
Total	20(100)	20(100)	20(100)	20(100)	20(100)	20(100)	120(100)

To enable local availability of money, ANM was given advance money which was kept in a joint account with sarpanch. This money was replenished on time-to-time basis on submission of bills and vouchers of the last round of disbursements. Two out of Three CDMOs and four out of six BMOs told that most of the times the funds flow at various levels (from State to district and below) were interrupted because of delayed submission of bills and vouchers. This delay resulted in lack of money at operational levels, affecting its release eventually to the utilizers. All the money required should be planned in advance depending upon the expected number of deliveries at each level of institutions and necessary amounts should be earmarked in the budget for them in one go so that the operationalizing the scheme does not get blocked due to lack of money at the ANM level.

RECOMMENDATIONS

- The process of making JSY card should be made simpler and should be issued as soon as possible. The JSY card issued in one State should be accepted in other States as JSY is a centrally sponsored scheme.
- There is a need to accredit more private and charitable hospitals under the JSY scheme at block level on the pattern of Chiranjeeve Scheme. Due to higher out-of-pocket expenditure in case of caesarian section more assistance should be considered in the scheme.
- Intensification of IEC activities focussing on benefits of JSY with special attention to clearing the myths and misconceptions about the scheme.
- All recruited ASHAs should be trained well within a time frame and post training field appraisal should be done and thereafter refresher trainings should be given in a planned manner. Training to other categories of health staff on JSY should be planned so that the services to expecting mothers are more user friendly.
- Service centres should be provided with better infrastructure and supplies to provide round the clock services and to avoid unnecessary referrals and out of pocket expenses.
- Increase involvement of PRIs, community leaders, women groups and local NGOs for enhancing coverage of the scheme.
- Villagers should be informed through ASHAs about 24x7 services available nearest to the village.

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ASSESSMENT OF FUNCTIONING OF ASHA UNDER NRHM IN UTTAR PRADESH

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ABSTRACT

In the State of Uttar Pradesh, induction of Accredited Social Health Activist (ASHA) under National Rural Health Mission (NRHM) was initiated in the year 2006. A rapid appraisal research study was undertaken in four districts of Uttar Pradesh to understand the operationalization of ASHA scheme. This study included one district from each region. Cross-sectional evaluation design, blending both quantitative and qualitative data was followed. Sample included were 4 DNOs, 12 BNOs, 23 Training Facilitators, 43 ANMs, 43 AWWs, 60 ASHAs, PRI representatives, and 360 beneficiaries i.e. pregnant and lactating mothers. They were selected using simple random technique. The study revealed that all the stakeholders and facilitators were aware of steps of recruiting ASHAs. All the DNOs, BNOs and ASHAs found the training useful; however 37 per cent of ANMs did not express any opinion. The need of training to ASHA was expressed by almost all the DNOs, BNOs including ASHAs. The involvement of the community, PRIs, NGOs, and AWW etc was limited and poor. The ASHA's support in ANC services and immunization was significantly high in comparison to other services. The role of ASHA in institutional deliveries was appreciable. The majority of ASHAs and ANMs had incomplete knowledge about the compensation provisions made available under the scheme. There were some constraints in making timely payments i.e. non-submission of adjustment vouchers and utilization certificate followed by non/late availability of relevant guidelines/norms. The key recommendations include design of a communication strategy to create awareness among PRI members and community on ASHA scheme, making available financial guidelines at all levels, provide complete knowledge and skills to the trainees in the stipulated time and making available the medicine kit to ASHA on time.

The Government of India launched National Rural Health Mission to address the health needs of rural population, especially the vulnerable section of the society. Under NRHM, ASHA is proposed to take up the responsibility of a change agent on health in a village. It is the first port of call for any health related demand of the depressed section of the population, especially women and children, who find it difficult to access health services.

Framework of NRHM underlines ASHA as a health activist in the community. One of the main tenets of the programme is to identify one ASHA (Accredited Social Health Activist) per 1000 population in the rural areas to facilitate community to access the public health services.

ASHA is expected to create awareness on health and its determinants, mobilize the community towards local health planning, and increase the utilization of

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the existing health services, Government of India issued certain guidelines to all the States to ensure that women with required capacity may only take the assignment of ASHA. A twenty-three days training in four phases was proposed to enhance the knowledge and skill of ladies identified as ASHA. To make her functional in an appropriate manner, she is trained for 7 day in the first instance on a set curriculum developed by the Government of India. Since ASHA receive a fixed honorarium as compensation money in lieu of each activity performed, the timely flow of this money is of paramount importance for her commitment and motivation.

The role and responsibilities of ASHA indicate that she plays a significant role in the achievement of the objectives of the Mission. In view of the guidelines issued by the Government of India on selection, training and provision of payments to ASHAs on the one hand and their success in mobilizing the community to access the quality health care on the other, it was thought to undertake a rapid appraisal of ASHAs at the very outset. Since no specific effort have been made to know the actual status of the selection and training of ASHA, her acceptance by the community and the system of compensation payments after this programme was implemented in Uttar Pradesh.

General Objective

To undertake rapid appraisal of functioning of ASHA and evolve the suggestions for its improvement.

Specific Objectives

- To assess implementation of the guidelines of recruiting and training of ASHA;
- To ascertain the acceptability of the ASHA by the community;
- To study the appropriateness and timeliness of payment of compensation money during training and performance based incentives to be paid subsequently; and
- To suggest on how ASHA can be made more effective.

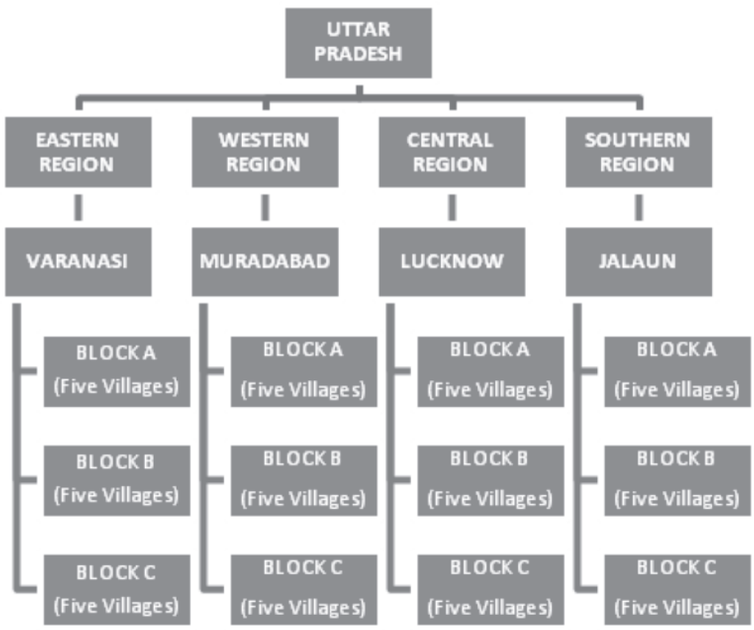
METHODOLOGY

The study was cross-sectional evaluation study, blending both quantitative and qualitative data.

Sampling

The study was conducted in four districts. Multi-stage random sampling design was used in the study. From each district three blocks and from each block 5 villages were selected randomly.

Keeping in view the different geographical regions of the Uttar Pradesh State i.e. Eastern, Central, and Western and Bundelkhand, one district from each region was selected. Thus Varanasi from Eastern, Moradabad from Western, Jalaun from Bundelkhand and Lakhimpur-Khiri from central region were selected. Three blocks from each district - two close to the district headquarter and one remotely located from the district headquarter were selected for the study. Thus 12 blocks from four districts were chosen for the study. From each block 5 villages were selected randomly. The list of selected districts, blocks and villages under study are shown in Table 1. The study included 4 District Nodal Officers (DNOs), 12 Block Nodal Officers (BNOs), 23 Training Facilitators, 43 Auxiliary Nurse Midwives (ANMs), 43 Anganwadi Workers (AWWs), 60 ASHAs, Panchayati Raj Institution representatives, 360 beneficiaries. Selection of the subjects was based on simple random technique.



Data Collection

Both qualitative and quantitative data collection techniques were used. Data collection tools were developed, pre-tested and administered to the subjects. Qualitative methods included checklist and in-depth interview comprised of variables like process of selection, training and compensation payments to ASHA, PRI's opinion on the programme and provider's view about actual status of implementation of scheme. It also included Focus Group Discussion (FGD). Data collection work were completed in December 2007.The NIHFW team visited the field area to maintain quality assurance.

Data Analysis

The data collected in the form of recorded interviews were coded and each interview was transcribed with the help of field notes and further translated by the hired field investigators on the same day of the field study.

Quantification was done for qualitative data by coding the responses of different stakeholders and merging into different headings using adjectives as per guidelines for qualitative data entry interpretation and report writing format provided by NIHFW. The ethical clearance of the project was given by the Institutional Review Board of NIHFW.

FINDINGS AND DISCUSSION

Background of ASHA

The study showed that 5 per cent ASHA were yet to be selected. The backlog was relatively more in Varanasi (5%), Lakhimpur (6%) and just one per cent less in Jalaun. Moradabad completed selection of ASHA. Only 3.3 per cent ASHA were more than prescribed the age of 40 years in the guideline of selection of ASHA. 35 per cent ASHA came from general category (which contains possibility of higher caste more than any). 40 per cent of ASHAs were Backward Class and 25 per cent from Scheduled Castes (23%) and Scheduled Tribes (2%). This classification needs to be addressed in terms of caste composition in each district. The guideline accord emphasis

of education up to junior high school. Only 53.3 per cent of ASHAs were up to Junior High School, 31.7 per cent High School and 5 per cent intermediate, 10 per cent were graduates. The study also revealed that 91.7 per cent of ASHAs were married.

Analysis of the information revealed that 74 per cent of the stakeholders knew and followed the steps proposed for recruitment. However, 26 per cent of facilitators did not conduct FGDs for short-listing the name of ASHA (Table 1). This was strengthened from 88.3 per cent of ASHAs who were also unaware about the FGDs happening in their villages. The facilitators responsible to short-list ASHA had not carried out full procedure in the selection of ASHA. Majority of facilitator stated that there was heavy pressure from gram sabha for a particular candidate. All the nominated facilitators belonged to health department while it was directed that facilitators must come from across the departments and also from NGOs, which shows that representation of other departments was missing in the selection process.

Training

Training of Trainers (TOT) was organized for imparting training to ASHAs. Through in-depth interviews with DNO and BNO, it was tried to ascertain whether the guidelines issued by the government were followed. Finding revealed that the constitution of district training team, block training team and their training was conducted as per State Government guidelines. Facilitator guide for trainers, teaching aids and reading materials for ASHA was also provided to them.

Status of Training of ASHA by District and Block

Several components of training were asked to ascertain the extent, these ASHA had retained the knowledge about different contents taught to them. Extent of retentions of the subject matter were taken confirmed 'without probe' and recall laps in the form of 'with probe'. The topic wise analysis of the responses showed that knowledge of ASHA about the eleven listed contents 'without probe' ranged from 10 per cent to 85 per cent, while in case of 'with probe' it ranged from 45 to 100 per cent (Table 2).

Table 1
Steps Taken During Recruitment

Recruitment steps	Facilitator	DNO	BNO	ASHA
	N=23	N=4	N=12	N=60
Whether facilitator was in the village for short-listing	23 (100.0)	4 (100.0)	12 (100.0)	13 (21.7)
Whether FGD wer e conducted for short - listing	17 (74.0)	4 (100.0)	12 (100.0)	7 (11.7)
Filling of FGD forms and their submission to BMOs	No	No	No	No

Another interesting trend observed is that a number of ASHA recalling the topics covered under training after telling them about the list of contents increased considerably in most of the topics, which showed that after a lapse of time, ASHA have been unable to retain all the functions and responsibilities to be undertaken by them. ASHA were found to be more aware on the subjects related to delivery where recall-laps was found minimum ranging from 13 per cent in case of antenatal care and natal services and 23 per cent in immunization services as against 55 per cent of the ASHA, who could not recall whether something about NRHM was taught to them or not?

useful, 37 per cent of ANMs did not express any opinion on this issue. 16 per cent of the ANMs said that recurrent trainings to ASHAs affects their routine work. Further need of training to ASHA was considered necessary by all the DNOs, BNOs and ASHAs. About 12 per cent of ASHAs also informed that the duration of training was less than seven days.

Knowledge on Compensation Money

Awareness of BNOs, ASHAs and ANMs about the different amount of compensation moneys to be paid to ASHAs for carrying out different

Table 2
Contents of ASHA Training (N=60)

Contents	Without Probe	With Probe	Increment	Don't Remember
Orientation Aspects				
• About NRHM	9(15%)	27(45%)	30%	33(55%)
• Role & responsibility of ASHA	41(68%)	56(93%)	25%	4(7%)
Clinical Aspects				
• About ANC & Natal	51(85%)	59(98%)	13%	1(2%)
• About PNC	12(20%)	51(85%)	65%	9(15%)
• Breast-feeding	46(77%)	60(100%)	23%	0
• Supplementary food	14(23%)	42(70%)	47%	18(30%)
• Child & Mother Immunization	46(77%)	60(100%)	23%	0
Management Aspect				
• Co-operation & co-ordination with block & village level members	33(55%)	51(85%)	30%	9(15%)
• Counseling & community participation	6(10%)	34(57%)	47%	26(43%)
• Team work & meeting	13(22%)	36(60%)	38%	24(40%)
• Co-operation & Co-ordination with ANM & other sectors	27(45%)	58(97%)	52%	2(3%)

Training related issues like contents, place and duration of training, it's usefulness, need for further training and the honorarium received by ASHA during the course of training were also assessed across PRIs, BNOs, and ANMs. All the DNOs and BNOs found the training as

activities was ascertained. It was observed that while BNOs had more or less complete knowledge of the provisions, only 57 per cent of ASHAs and 70 per cent of ANMs had the knowledge of the various compensatory provisions under the scheme (Table 3).

Table 3
Knowledge About Compensation Money

Compensation money	BNO N=12	ASHA N=60	ANM N=43
Knowledge on compensation money for different activities for ASHA	12 (100%)	34 (57%)	30 (70%)

Availability of Budget

Frequent shortfalls of budget was also observed in the study districts against the requirement in different programme heads creating pending liabilities and resulting in delayed payments to ASHAs . It was also observed that whenever budget is allocated to the district, the effort is to immediately transfer it to the sub-district level through e-banking. This system was introduced in the state in March 2007. Funds were not utilized in stipulated time due to non-orientation of staff on e-banking transactions and transfer of money from the districts without any accompanying directives.

Difficulties in Fund Flow

There were several hindering factors which delayed the disbursement of claims due to ASHAs. Most of the DNOs and BNOs admitted that unavailability of funds at operational level was due to non-submission of adjustment vouchers and utilization certificate. Non-availability of relevant guidelines also contributed to this lethargy. It was also observed that non-operation of imprest money account and requirement exceeding the available funds was also responsible for delay in funds release. Most of the officials said that late transfer of money under the head 'Additionalities under NRHM' account as the main source of payments to ASHA has been the foremost obstacle in timely payments. This problem is compounded by apathatic attitude of staff at district and sub-district hospitals. One of the CMO was pointing out the problem of non-submission of required financial formalities at district from PHC.

Acceptability of ASHA- A Client Perspective

Acceptability of the ASHA and activities performed by her was assessed by administering a questionnaire to the lactating mothers. The analysis revealed that out of 360 lactating mothers, 90 per cent were registered for ANC services and about 63 per cent got their registration through ASHA. Of the total number of ANC registration , a little more than two-third (67%) of the expectant mothers got their check-up during pregnancy period through ASHA which shows a high degree of involvement of ASHAs in this area. 65 per cent of the ANC cases received T.T. doses through ASHAs. 41 per cent and 12 per cent mothers received IFA tablets and supplementary food respectively through ASHA.14 per cent of the pregnant mother had one or the other form of complication during pregnancy, out of which 35 per cent were facilitated by ASHAs in getting the treatment which is again an indication of helping the beneficiaries in access to the health delivery services.

Promotion of Institutional Delivery

The analysis of the quantum of work being done by ASHA under JSY scheme showed that half of the total deliveries took place at home, while 42 per cent at public health service units and the rest at

private nursing homes. Out of total institutional deliveries, around three fourth (70%) were motivated and facilitated by ASHAs. Arrangement of and payment for transport was made by ASHA for 22 per cent of the deliveries conducted at public institutions. It was also observed that in 6 per cent of the home deliveries, ASHA arranged trained dai/ANM at home.

Out of 83 per cent newborns that were administered BCG vaccination, 59 per cent were facilitated by ASHA in getting the immunization.

40 per cent were counseled for acceptance of any method of family planning by ASHA, out of whom 6 per cent turned up as acceptor of tubectomy, 26 per cent as condom users, less than 2 per cent got IUD inserted, and 3 per cent started the use of either oral pills or some other traditional method. It looks encouraging that within a very short period of time, ASHAs were able to motivate 37 per cent to accept one or other method of family planning.

The acceptability of ASHA by community can be gauged through their level of effective involvement in various activities for facilitating the community to access public health delivery services. As ASHAs are providing the services voluntarily to the community and are not paid workers, their involvement in facilitating community in the access of health delivery services to such a high extent implies that they are well accepted by the community. However more than three-fourth of the beneficiaries were found satisfied with the ASHA's activities.

Findings Based on Qualitative Techniques

When ASHA training was evaluated with PRI members, it was found that though, they knew a bit with respect to place, duration and conduction of training but the awareness about training content was almost nil. PRI members were also not correctly aware about the steps of selection. The analysis regarding the procedure of recruitment of ASHAs indicates that only facilitators, DNOs and BNOs had the correct knowledge about the selection procedure. Knowledge and participation of community, PRIs, other sectors like NGOs needs enhancement for advancement equate community ownership in further selecting and owning this important human asset under NRHM.

In brief, all the stakeholders i.e. DNOs, BNOs and facilitators were aware of steps of recruiting ASHAs however one-fourth of the facilitators did not carry out the FGDs/GDs activity in the villages. All the DNOs, BNOs and ASHAs found the training useful; however, 37 per cent of ANMs did not express any opinion. The need of training to ASHA was expressed by almost all the DNOs, BNOs including ASHAs. 16 per cent of the ANMs did not support recurrent trainings to ASHAs because it affects their routine works and it is not necessary. The involvement of the community, PRIs, NGOs and AWWs, etc. was limited and poor. The ASHA's support in ANC services and immunization was significantly high in comparison to other services. The role of ASHA in institutional deliveries was appreciable. More than three-fourth of the beneficiaries were found satisfied with the ASHA. PRI members too were

appreciative of ASHA's presence in the village indicating acceptance of ASHAs in the community. Non-availability of funds at district was not found to be a problem. Funds were being transferred to sub-district level through e-banking. Almost all the BNOs had complete knowledge of the provisions of compensation money for ASHA. The majority of ASHAs and ANMs had incomplete knowledge about the compensation provisions made available under the scheme. There were some constraints in making timely payments i.e. non-submission of adjustment vouchers and utilization certificate followed by non/late availability of relevant guidelines /norms.

Proposed cascade model of training to ASHA not paying dividends as the inter-phase duration of training is becoming too long, which is adversely affecting the knowledge and confidence of ASHAs.

Following are major policy issues:

- Delay in selection: backlog in ASHA is retarding the rapid scale-up of the programme.
- Low level of awareness about the components of ASHA scheme amongst the PRIs members/ community leaders.
- Sometime interrupted fund flow from top to bottom leads to low morale of functionaries and adversely affect the programme.
- The provision of distance-wise payments of transportation charges to ASHA (In case she accompanies the beneficiaries of JSY) without directives from the state is creating confusion.
- Although it has been two years since the start of the programme in the State, selection of ASHA is still not complete. This impact the overall implementation of the programme,

RECOMMENDATIONS

A strategy should be in place to recruit the remaining ASHAs as early as possible to make the programme effective and efficient. Communication strategy needs to be designed to create awareness on ASHA scheme for PRI members and at community level for better acceptance of ASHAs. To avoid the delays in compensation money, mechanism developed by the State must be strictly followed. Self-explanatory, specific financial guidelines should be made available within time to the programme managers. A district-wise distribution of transportation amount be fixed and communicated to the district and sub-district level managers. Under the cascade model of training to ASHA, trainings should provide complete knowledge and skills to the trainees in the stipulated time. Quality of training should be enhanced and refresher training should be planned regularly. In specific to improving programme a medicine kit to ASHA must be provided at the earliest to help the community-serve better and readily. A process of community level monitoring, regular problem solving and skill upgradation should also be developed as early as possible.

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A RAPID APPRAISAL OF ORGANIZATION AND INFLUENCE OF RCH CAMPS IN SELECTED DISTRICTS OF UTTAR PRADESH

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ABSTRACT

The key objective of the study was to assess whether RCH camps are being organized as per the set guidelines, the referral mechanism, follow-up activities and client satisfaction. It was an observational type of study in which the organizational activities of RCH camps were assessed through direct observation, in-depth interviews and exit-interviews of the beneficiaries in eight districts of Uttar Pradesh in the year 2007-2008. The study found that most of the CMOs/Dy. CMOs (87.5%) received guidelines from State but approximately half (37.5%) participated in State level training and organized district level training (25%). 75 per cent of Block Medical Officers I/c told that they had received guidelines and training to conduct RCH camps, and among para-medical service providers most (88.24%) received training to organize RCH camps. In majority of the places problem faced by para-medical workers was work overload (50%) and approximately half of the places lack of staff (33.33%) was the main problem. Approximately half of the places of CMO/Dy. CMO (37.5%) suggested that increase in manpower (medical and para-medical) especially surgeons is a must to improve quality of RCH camps. Increase in budget (25%) and re-orientation training of ANM, ASHA and other para-medical staff (25%) were other suggestions.

Key words: NRHM, RCH Camps, Maternal and Child Health and RCH.

The National Rural Health Mission (NRHM) was launched in April 2005 with a view to bring about improvement in the health system and consequently in the health status of the people, especially those who live in the rural areas. The mission seeks 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.

Reproductive and Child Health Programme (RCH-II), flagship programme of NRHM, is the principal vehicle for reducing IMR, MMR and TFR. RCH-II encompasses a number of innovations and reforms. Its development objective is to bring about improved and equitable child health, maternal health and population stabilization through assured, responsive, quality health services, especially in States with low human development indicators.

RCH camps in Uttar Pradesh are being organized at block level. For every block, 18 RCH camps are proposed in one year. In Uttar Pradesh there are total 854 blocks. So a total of 15,372 camps are

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planned in the state for this year. The services to be provided in these camps are gynaecological check-up, paediatrics check-up, immunization and family planning services including counselling and transportation of clients for sterilization. Though sterilization camps have been part of the family planning programme for many years, these RCH camps are different in the manner that they provide assured services as per predetermined calendar and combine benefits of rural outreach and high quality services and also provide an array of maternal, child health and family planning services under one roof.

Each RCH camp is scheduled in advance and organization of these camps needs detailed planning relating to publicity, manpower deployment, camp arrangement, and post camp services including transport, availability of consumables and medical equipments. RCH camps provide an opportunity to integrate the efforts of providers and increase access to RCH services for women and children. These camps should also provide assured high quality services as per predetermined timeline. Hence, it is essential to assess the quality of organization and usefulness of these camps.

Thus, this study was carried out in total 16 blocks of 8 districts of Uttar Pradesh, and it is assumed that all the camps in one block will be same, so one camp from each block was observed. Thus, a total 16 RCH camps in 8 districts were assessed.

Research Question

Are RCH camps in Uttar Pradesh being organized as per laid down norms and able to fulfil expectation of the community?

General Objective

To undertake a rapid appraisal of organization and influence of RCH camps in selected districts of Uttar Pradesh.

Specific Objectives

1. To assess whether RCH camps were being organized as per guidelines including financial norms;
2. To estimate the number and characteristics of the service providers and beneficiaries;
3. To assess the referral mechanism and follow-up activities;
4. To assess the client satisfaction and usefulness of RCH camps; and
5. To find out organizational challenges and how they were addressed.

METHODOLOGY

Sampling

The study was done in 8 districts of Uttar Pradesh, two each from Eastern, Western, Central and Bundelkhand region (Jhansi, Banda, Allahabad, Jaunpur, Rampur, Moradabad, Khiri and Sitapur). The study was carried out in total 16 blocks of 8 districts of Uttar Pradesh. A total 16 RCH camps in 8 districts (2 in each district) were assessed. Out of 2 districts in each region one was randomly selected from good performing districts and another from poor performing districts based on their performance in achieving family planning targets in the previous year. From each district, two blocks were selected purposively one close to district headquarter and the other from remote area.

This was an observational study, comprising of two teams, each

Table 1
Adjectives Used in the Study for Qualitative Data

Proportion of respondents	Adjectives used
<10 %	Very few
10-24 %	Some
25-49 %	Approximately half
50-74 %	Majority/over half
75-89 %	Most
>90 %	Almost all

comprising of one supervisor and two investigators. Data were collected in two steps by making two visits to the selected districts. Reports and records of RCH camps held in previous years (total attendance, expenditure, and types of services etc.) were collected from respective CMOs and critical reviews were also conducted. The NIHFW team visited the field area to maintain quality assurance.

In-depth interview of CMO, Dy. CMO (RCH/NRHM), MO in-charge of CHC/PHC, doctors and other staff offering services in the camp, direct observation at camp-site and exit interviews of beneficiaries were conducted. Focus Group Discussion of beneficiaries and non-beneficiaries of the previous camp.

Following research instruments were used for data collection:

- Guidelines for in-depth interview
- Guidelines for FGDs
- Checklist for direct observation
- Schedule for exit interview
- Checklist for review of secondary data.

The ethical clearance of the project was earlier obtained from the Institutional Review Board of NIHFW.

FINDINGS AND DISCUSSION

Table 2 shows that demand of family planning method for spacing is more than terminating method. It also shows that tubectomy is the main sterilization operation performed in the RCH camp.

Table 2
RCH Camps Beneficiaries in the Eight Sample Districts During March 2006-April 2007

Name of District	V.O	T.O	IUCD	OCP Users	Condoms Users	ANC	Immunization to Children	Counselling Beneficiaries
Jhansi	19	15149	25192	10355	22065	50306	54961	NA
Banda	06	4779	19330	135702	1536788	NA	NA	NA
Allahabad	117	21005	74794	32296	65199	151889	NA	162096
Jaunpur	16	15882	46067	338870	281952	153013	92224	NA
Rampur	03	1821	16312	75820	1202525	37196	53571	NA
Moradabad	00	2533	1726	5652	7656	2368	1970	5541
Khiri	08	8710	18598	215673	1890411	NA	NA	NA
Sitapur	76	9994	29236	247408	2379734	137798	118925	NA*

Activities Carried out in RCH Camps

Maternal Health Services
- ANC
- MTP

Child Health Services
- Vaccination
- Vitamin A Supplementation
- ARI, Diarrhoea Treatment

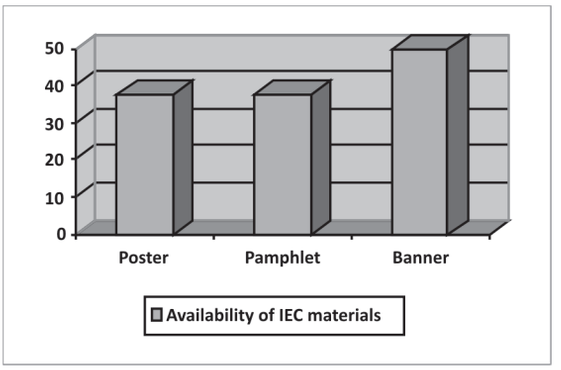
RTI/STI Treatment

Family Planning Services
- Tubectomy, Vasectomy, Cu-T Insertion, Oral Pills and Condoms Distribution

Family Planning Services

Other Diseases Management
- Malaria, TB, Leprosy, Eye Disease, etc.

Case Referral



Guidelines and Training to Organize RCH Camp

The study found that most (87.5%) of the CMOs/Dy. CMOs received guidelines from State, out of which, however, approximately half (37.5%) of them participated in State level training, whereas district level training was organized only in 25 per cent of the districts.

Most of the block MO I/cs (75%) told that they had received guidelines and training to conduct RCH camps and among medical service providers majority of the doctors (60%) and most of the para-medical (88.24%) received training to organize RCH camps. As far as the medicines and consumables are concerned, most of the medicines (including for RTI/STI, gynaecological diseases, sterilization, antibiotics, pain killers) were available in sufficient amount in most of the camps except for the iron and folic acid tablets were available in approximately half (43.75%) of places which needs special attention and concern. It is also found that needles and syringes were available in most of the places, but in the places where there was shortage the same syringe and needle was being used for blood testing of two or more persons. It increase the risk of transmission of diseases like HIV/AIDS, hepatitis-B. So this need to be immediately addressed.

Majority over half of the CMOs/Dy. CMOs received IEC material (posters and pamphlets) from State level.

In camp observation, it was seen that registration table with the five table concept was present in all camps (100%) but tables for ANC, immunization and counselling for FP/HIV/AIDS were present in majority over half of the places and examination table was seen in some (12.5%) of the RCH camps.

Table 3
Observation by RCH Five Columns Concept

Counter	Bundelkhand (%) n=4	Central UP (%) n=4	Eastern UP (%) n=4	Western UP (%) n=4	TOTAL (%) n=16
Registration	4 (100)	4 (100)	4 (100)	4 (100)	16 (100)
Counselling for FP/HIV/AIDS	2 (50)	3 (75)	2 (50)	2 (50)	9 (56.25)
ANC	2 (50)	2 (50)	0 (0)	2 (50)	6 (37.5)
Immunization	2 (50)	2 (50)	0 (0)	2 (50)	6 (37.5)
Gynaecological problems	1 (25)	0 (0)	0 (0)	1 (25)	2 (12.5)

Table 4
Problems Faced by Medical Personnel in Providing Services to Beneficiaries (No. of Respondents = 15)

S. No.	Response	No. of Respondents (%)
1.	Workload is too much in one camp, so quality services are difficult to provide	5 (33.33)
2.	Inadequate medical/para-medical staff	2 (13.33)
3.	OT capacities/OT facilities is less	7 (46.67)
4.	Non-cooperative staff	1 (6.67)
5.	Some surgeons do not take interest in RCH Camps	1 (6.67)
6.	Problem of transportation	1 (6.67)

At some places it was very disappointing that surgical gloves were being reused after they were washed. When MO I/c was asked about this, most of them told that they have to work in limited budget. Problem faced by medical personnel in providing service to beneficiaries in approximately half of the places was poor facilities in OT (46.67%) and high workload in one camp (33.33%). Test for RTI/STI was available at a few places. At most of the places it was found that there is a deficiency of medical and para-medical personnel in respect to the strength of clients per camp.

About half of the CMOs/Dy. CMOs and MO I/cs complained about the deficiency of surgeons. Lady doctor was present at only 50 per cent of camps and paediatrician at some places only. Thus camps are being organized in the absence of these two main service providers (Table 4).

Approximately half of MO I/cs (43.75%) told that there is no provision of transport to and fro for beneficiaries and all of them suggested that funds should be increased and vehicles should be provided by CMO's office.

After exit interview of beneficiaries, it was found that money was paid in very few places (1.4%) for any service. *49% of beneficiaries accepted that services being provided in the camp were better than routine. In FGD with beneficiaries, most of them told that they got information about camps from *behanji* (AWW, ASHA). Most of the campsites were clean (81.25%) and facility of drinking water (86.5%), urinal/lavatory (65.30%) was present. As per guidelines, sitting facility for clients should be available in the form of dari//chair, and it was available in majority of places (71%) (Table 5).

Table 5
Client Satisfactions Regarding Various Facilities

S. NO.	Observation	Yes (%)	No (%)
1.	Given advice on follow-up services	144 (96)	6(4)
2.	Services provided in this camp are better than routine services*	74 (49)	34 (22.6)
3.	Paid money for any service	2 (1.4)	148 (98.6)
4.	Proper sitting arrangement	107 (71)	43 (29)
5.	Availability of safe drinking water	130 (86.6)	20 (13.4)
6.	Facility for toilet	98 (65.3)	51 (34)

Table 6
Suggestions of Clients for Betterment of RCH Camps
(Total Respondents=150)

S. No.	Response	No. of Respondents (%)
1.	Transport facility	25 (16.67)
2.	Toilet facility	16 (10.67)
3.	Sitting facility	26 (17.33)
4.	Reimbursement should be increased	2 (1.33)
5.	Reimbursement should be provided	3 (2)
6.	Lack of doctor and staff	1 (.67)
7.	Camp must be started at correct time	3 (2)
8.	No comments	11 (7.33)
9.	Drinking water	19 (12.67)
10.	Cleanliness at camp-site	1 (.67)
11.	Stretcher/bed	9 (6)

Approximately at half of the places of CMOs/ Dy. CMOs (37.5%) suggested that increase in manpower (medical and para-medical) especially surgeons is must to improve quality of the RCH camps, whereas increase in budget and re-orientation training of ANM, ASHA and other para-medical staff was suggested at 25 per cent of places (Table 6).

Approximately half of the (40%) medical service providers suggested for improved OT condition to make RCH camps better and the permanent posting of surgeon at PHC level (33.33%). In approximately half of the places most common suggestions of para-medical personnel for betterment of RCH camps were - number of medical/para-medical personnel should be increased (29.41%) and medicines and consumables should be in sufficient amount (29.41%). According to some clients in various places main improvement were required in sitting and transport facilities, followed by drinking water and toilet facilities.

RECOMMENDATIONS

- Staff for providing the medical services should be increased at block and peripheral level. The vacancies at all levels need to be filled up immediately.
- Display of list of beneficiaries must be made mandatory at district and block level.
- The inadequacy of equipments and infrastructure should be assessed through facility surveys and the deficits are to be filled up urgently to meet increased demand on operation rooms.
- The IFA tablets should be made available on regular basis. The inadequacy of specialists (pediatrician, gynaecologist, surgeon) hampers the quality of services provided at camp-site. So they should be hired on contract basis and remuneration should be provided in proper amount.
- Proper transport facility should also be made available for them.
- There is a need for clear policy on

monitoring and supervision. The monitoring and supervision diary at district and block level must be made mandatory.

- Delay in disbursement of fund at district and block level need to be addressed appropriately. Discrepancies in the amount of compensation received by beneficiary need to be seriously viewed.
- Transport facilities must be made available at the camp-site and block level. Sensitization of district and block level Programme Managers need to be stepped up. Any modification in the programme needs to percolate down the hierarchy in time. Feedbacks from top to bottom need to be streamlined.
- Awareness generation activities in the community need to be strengthened. There is a need for repeated training and sensitization of MOs, service providers (medical and para-medical) and ASHA/AWW.
- Availability of other services should be made wide-based. So that beneficiaries could utilize more services under one roof.

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A RAPID APPRAISAL OF ORGANIZATION AND UTILITY OF HEALTH MELAS IN UTTAR PRADESH

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ABSTRACT

Health Melas provide an avenue for curative services and instant and massive awareness information on public health services rendered by Government and Non-Government Institutions on various diseases. Thousands of people availed various health services offered at the mela site.This study was undertaken in nine districts of Uttar Pradesh: Banda, Jalaun, Unnao, Hardoi, Aligarh, Moradabad, Azamgarh, Basti and Sonbhadra districts. The number of persons who visited the mela site during the study period in 9 districts were 103009 of which 91066 had received curative treatment and 1008 had undergone surgeries. The perception of the beneficiaries was that these camps were useful because specialists were available, staff was courteous and also free medicines were provided. About 43.3 per cent of beneficiaries opined that quality of services provided at Health Mela was good. The sites and dates for Health Melas should be fixed for each year in advance by the Government of India and should not be changed every year. Utilization rates can be increased with more publicity and intensive IEC activities about the mela.

Key Words: Health Melas, NGOs, Medical Services.

Popularly known as 'Parivar Kalyan Avam Swasthya Mela', these Health Melas provide instant and massive awareness on public health services rendered by Government and Non-Government Institutions; disseminate information on prevention of various diseases. The uniqueness of Health Mela as an approach was to provide composite health facilities such as laboratory services, consultation, medicine and treatment under one roof, done with the help of specialized doctors and other health professionals who came forward from various reputed medical colleges/institutions from different parts of the country for the purpose.

The Health Melas had been organized in various parts of Uttar Pradesh as one of the RCHII activities under NRHM. In order to provide opportunity to disseminate current ideas on health issues to the communities. Usually the melas were of 3 days duration and organized in Constituency of the Member of Parliament in their respective areas.

General Objective

To study the organization, functioning and utilization of Health Melas organized in selected districts of Uttar Pradesh.

Specific Objectives

i. To study whether these Health Melas are being organized as per guidelines,
ii. To study the socio-demographic characteristics of the beneficiaries

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and other details,

iii. To study the type of services available in Health Melas,

iv. To assess the satisfaction level of Health Mela beneficiaries,

v. To study the referral mechanism and follow-up activities of the patients attending in the Health Mela,

vi. To identify the problems and challenges in the organization of Health Mela,

vii. To assess the role of Health Mela in creating health awareness in the community, and

viii. To suggest measures in organization of successful Health Melas, in future.

METHODOLOGY

Study Area

Nine districts in Uttar Pradesh namely Banda, Jalaun, Unnao, Hardoi, Aligarh, Moradabad, Azamgarh, Basti and Sonbhadra districts of Uttar Pradesh.

Study Design

The rapid analysis of Health Mela was conducted by a team which underwent vigorous training for the purpose of collecting qualitative and quantitative information about the melas. Cross-sectional design was adopted for the study.

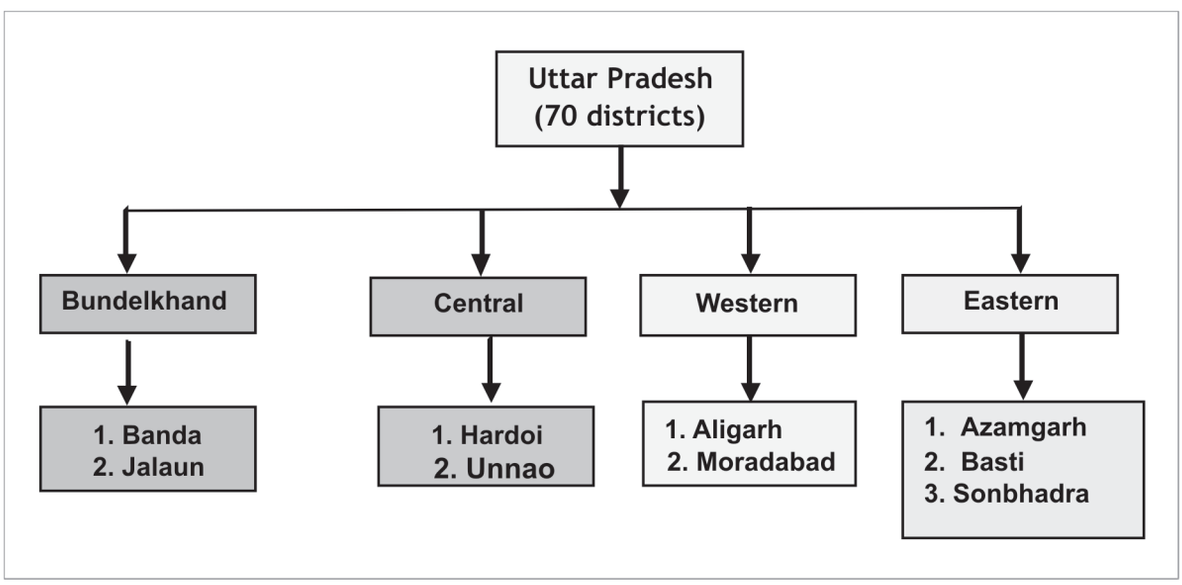
Study Subjects

- Chief Medical Officers,
- Mela Health Officers,
- Health Care Providers at Health Mela,
- Patients Availing Services, and
- Local leaders/PRI/Members/ NGOs in the area.

Sampling

In order to capture the variability amongst districts in the State, two districts each from four geographical regions viz. Eastern, Central, Western and Bundelkhand and one district from tribal area were selected randomly. A total of nine Health Melas were studied in the State in about 2 months duration.

The State of UP is distinctly divided into four zones viz. Bundelkhand, Central, Western and Eastern. While Eastern UP is thickly populated, the Bundelkhand is sparse and has scarcity of water. Also



there are certain districts of the State viz. Sonbhadra which is tribal area.

At each mela site, exit interview of beneficiaries and in-depth interview of mela in-charges were conducted. In addition, in-depth interviews of CMO/District Nodal Officer, health care providers at mela site and of local leaders/PRI members/NGO/CBO was taken. Records of Health Melas organized in the district in the previous one year were also analyzed.

Data Collection

Data was collected through:

- Exit interviews of beneficiaries.
- Desk review of data from office of CMO of the districts. Data were also collected using a checklist developed for the purpose.
- In-depth interviews were conducted in respect of CMOs/Nodal Mela Officers of district as well as other functionaries deployed for the mela work, and also PRIs/NGOs/local leaders.

Secondary data (total attendance, expenditure, type of services etc) regarding Health Melas held in previous years were also collected from the office of CMOs. The Health Mela dates were obtained from the office of Chief Medical Officers and accordingly team visited different districts selected randomly from every region. The activities of the Melas were recorded and records were obtained in respect of quantity of services delivered during 3 days of the Health Mela period. The data were collected by a team of two investigators (Social Scientists) and one Supervisor under the overall supervision of the Principal Investigators.

Exit Interviews of Mela Beneficiaries

A schedule was used for the patients who were coming out after utilizing the services of Health Mela. The cases were interviewed at the gate of Mela after making them sit on a chair and feeling comfortable. The consent was taken prior to the interview conducted. A total of 50 beneficiaries were interviewed from each Health Mela thus comprising of a total of 450 beneficiaries in whole of the study.

Five consultants/specialists/health care providers from each Health Mela were interviewed to understand the type of services for which their services are required/rendered at Health Melas as well as type of services for which cases were referred.

A team from NIHFW, New Delhi facilitated development of study tools and its pretesting, training of investigators, supervision of data collection, and data analysis and interpretation. The ethical clearance of the project was earlier obtained from the Institutional Review Board of NIHFW.

All the health melas were visited by all the senior investigators. They checked 10 per cent of the interview schedules and data collected.

FINDINGS AND DISCUSSION

A total of 9 Health Melas were studied in 9 districts from different regions/areas of Uttar Pradesh. The findings of the study are presented below:

Availability of AYUSH Specialists

A minimum of 2 Ayurvedic doctors were available at each district with a maximum of 8 of them available at two districts i.e. Moradabad and Sonbhadra. In four out

of the nine districts, viz. Banda, Jalaun, Unnao and Sonbhadra, none of the Unani Doctors were available. The Siddha doctor was available in only one district, viz. Moradabad. Homoeopathic doctors were available in all the districts (Table-1).

Table 1
Availability of AYUSH Practitioners in Health Mela Districts

Districts	Ayurvedic	Unani	Siddha	Homoeopathy	Total
Banda	2	0	0	4	6
Jalaun	3	0	0	1	4
Unnao	6	0	0	6	12
Hardoi	2	1	0	3	6
Aligarh	3	3	0	3	9
Moradabad	8	1	3	5	17
Azamgarh	5	3	0	3	11
Basti	5	3	0	5	13
Sonbhadra	8	0	0	4	12
Total	**42**	**11**	**3**	**34**	**90**

Availability of Allopathic Doctors

Allopathic specialists of different disciplines were available in all the districts. Maximum (11) number of surgeons were available in Azamgarh, and a minimum of only two surgeons, each were available in Jalaun and Moradabad. As far as availability of physicians was concerned, there were maximum 13 each in Banda and Azamgarh district. Only one physician was available in Moradabad district. Specialist of Obstetrics and Gynaecology were maximum (10) in Moradabad and minimum of 2 each were in Jalaun and Sonbhadra district. A maximum of 6 pediatricians were available in Azamgarh district. General Duty Medical Officers were present in plenty in almost all the districts (Table 2).

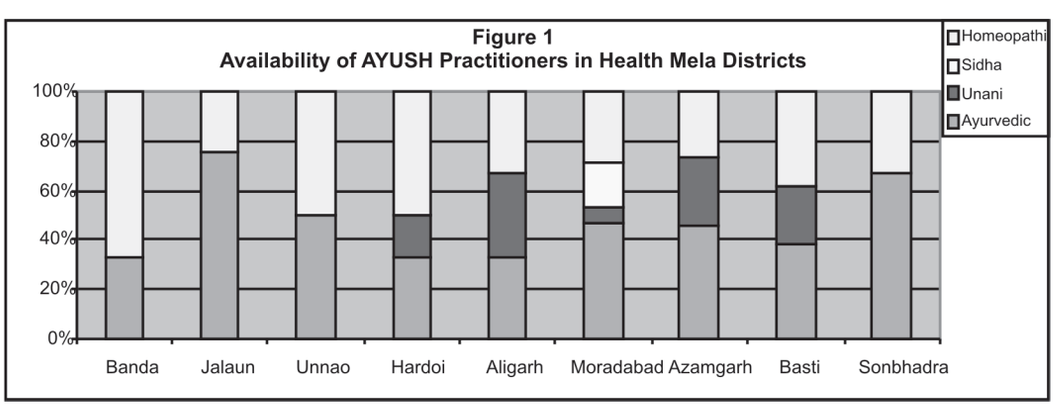


Table 2
Availability of Allopathic Specialists in Health Mela Districts

Districts	Surgeon	Paediatrician	Obs & Gynae	Physician	Radiology	GDMO	Total
Banda	10	4	8	13	1	8	44
Jalaun	2	2	2	4	1	9	20
Unnao	4	2	4	6	2	3	21
Hardoi	8	2	4	5	1	28	48
Aligarh	5	3	5	4	2	12	31
Moradabad	2	3	10	1	3	14	33
Azamgarh	11	6	6	13	3	4	43
Basti	10	3	3	7	1	30	54
Sonbhadra	7	4	2	5	2	16	36
Total	**59**	**29**	**44**	**58**	**16**	**124**	**330**

Availability of Paramedical Staff

A maximum of (28) of staff nurses were at Health Mela to take the care of patients in Moradabad and in Aligarh, only 5 were available. An exceptionally high number (168) of Paramedics were in Aligarh district with none of paramedicals in Jalaun district. A maximum number of (30) of pharmacists were available in Unnao and only 7 were in Moradabad district. A good number of volunteers were available in almost all the districts.

Beneficiaries Visited and Received Treatment

A total of 1,03,009 beneficiaries visited the Health Mela sites out of which 52,599 were males, 40,965 were females and 9,445 children also availed the services. Out of the visited beneficiaries 91,066 received one or the other treatment. In Banda, maximum number of beneficiaries (13,163) visited the Mela site and in Unnao district maximum beneficiaries (12,219) received one or the other treatment. A total of 1008

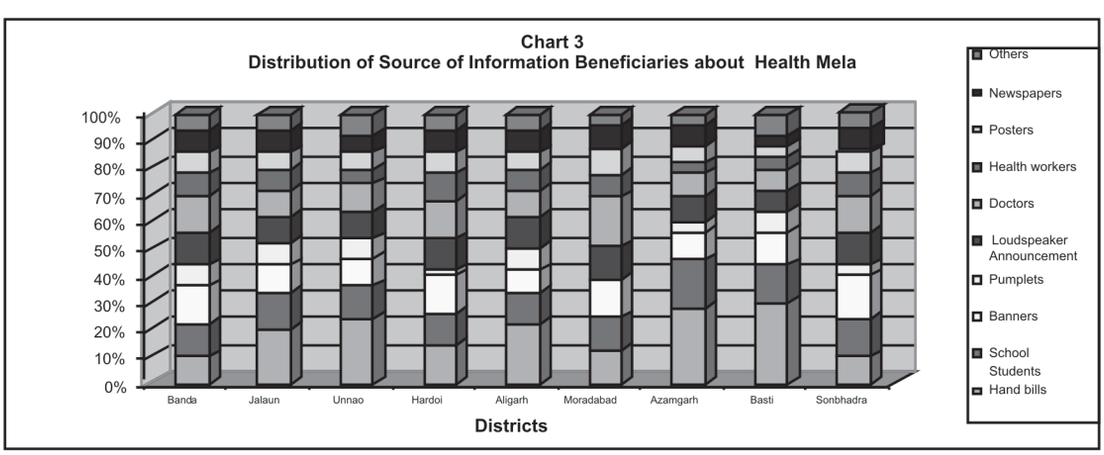
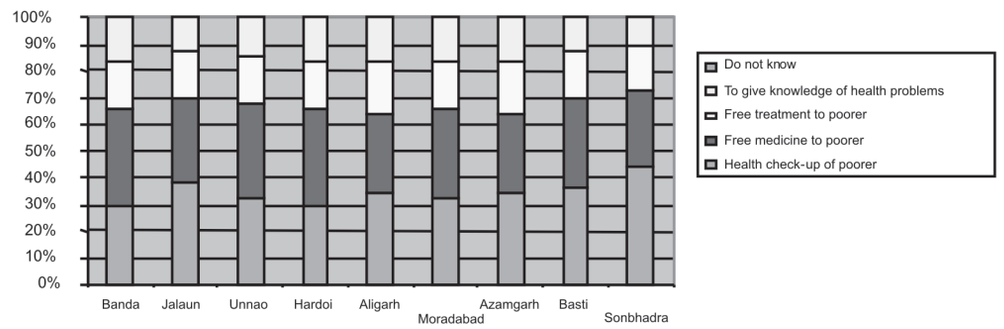


Chart 4

Perception about Purpose of Health Mela amongst Beneficiaries



operations were also performed with a maximum number of operations (219) performed at Hardoi. At Aligarh, only 6,997 beneficiaries visited, which is the lowest of all the Health Melas.

Source of Information about Health Mela to Beneficiaries

Overall, out of all the sources of information about Health Mela to the beneficiaries, maximum was through hand bill (18.9%) and least with pamphlets (5.8%). It was found that information to beneficiaries from all the other sources was almost similar.

Satisfaction about Services

Overall, about 72.2 per cent and 76.2 per cent beneficiaries were satisfied with the services rendered and behaviour of the staff employed at Health Mela respectively. Satisfaction about services provided was highest (84.0%) at Banda and it was lowest (58.0%) at Azamgarh.

Service Available in Health Melas

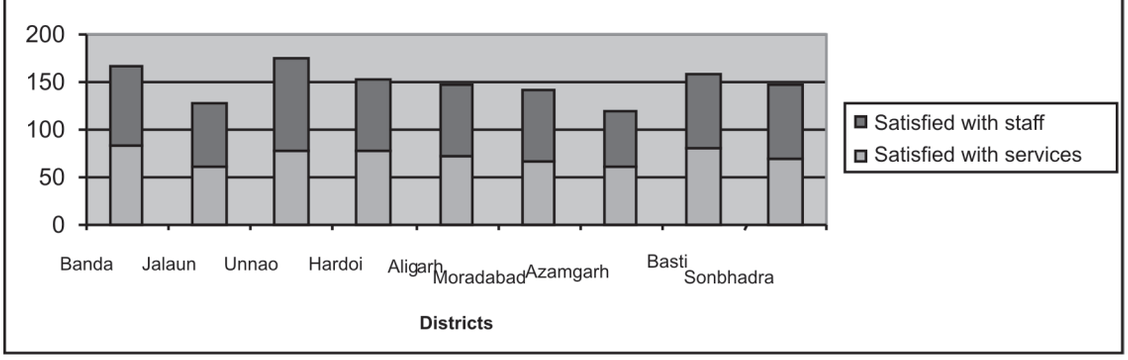
- Preventive, curative and rehabilitative health care
- National Programmes for control of cancer, HIV/AIDS, tuberculosis, blindness, malaria, leprosy
- Physical Check-up - eye, ENT, dental, etc.
- Investigations - urine, sugar, blood sugar, Hb, ECG, sputum test, PAP smear
- Referral services to higher institutions
- Health promotion and health education campaigns
- Counselling - immunization, contraceptive services, RTI/STI, prevention of blindness, rehabilitation of the disabled, nutrition, bad effects of smoking, hygiene, ill effects of alcohol.

Opinion about Quality of Services at Health Mela

Out of all the beneficiaries interviewed, 43.3 per cent were of the opinion that

Chart 5

Satisfaction of Beneficiaries by Services provided at Health Mela



quality of services provided at Health Mela was good and the rest (56.7%) were of opinion that the quality of services were either average, bad or worst. Almost the same type of opinion was found about quality of services provided at Health Mela in all the districts except in Aligarh district where a maximum of 62 per cent respondents, were of opinion that the quality of services provided were of good quality (Table 3).

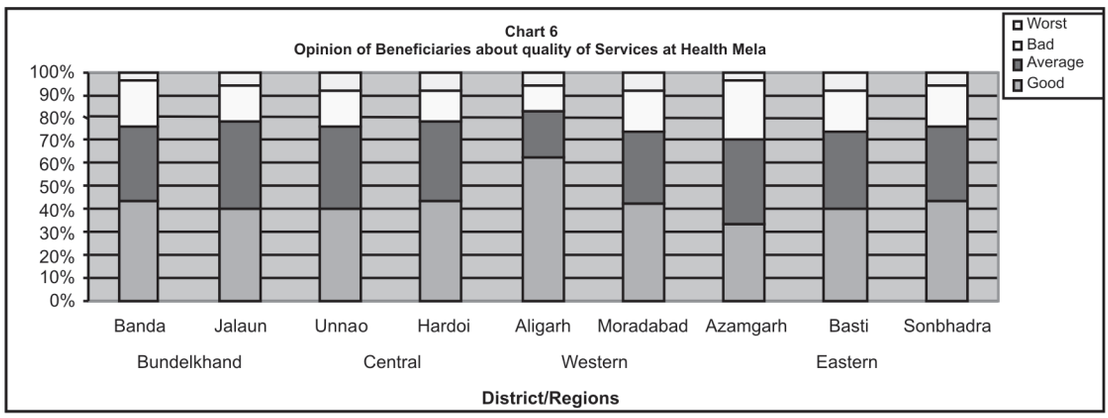


Table 3
Opinion of Beneficiaries about Quality of Services at Health Mela

Opinion about quality of services	District/Regions									Total %
	Bundelkhand		Central		Western		Eastern			
	Banda (%)	Jalaun (%)	Unnao (%)	Hardoi (%)	Aligarh (%)	Moradabad (%)	Azamgarh (%)	Basti (%)	Sonbhadra (%)	
Good	44.0	40.0	40.0	44.0	62.0	42.0	34.0	40.0	44.0	43.3
Average	32.0	38.0	36.0	34.0	20.0	32.0	36.0	34.0	32.0	32.8
Bad	20.0	16.0	16.0	14.0	12.0	18.0	26.0	18.0	18.0	17.5
Worst	4.0	6.0	8.0	8.0	6.0	8.0	4.0	8.0	6.0	6.5
Total Interviewed (No.)	50	50	50	50	50	50	50	50	50	450

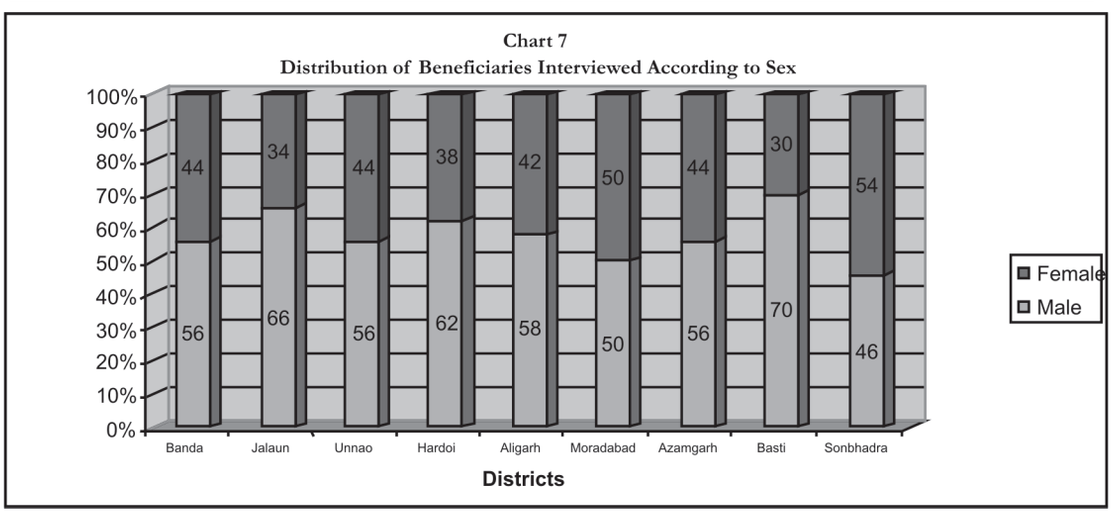


Table 4
Distribution of Beneficiaries Interviewed According to Sex

Sex of Beneficiaries	Regions/Districts									Total %
	Bundelkhand		Central		Western		Eastern			
	Banda (%)	Jalaun (%)	Unnao (%)	Hardoi (%)	Aligarh (%)	Moradabad (%)	Azamgarh (%)	Basti (%)	Sonbhadra (%)	
Male	56.0	66.0	56.0	62.0	58.0	50.0	56.0	70.0	46.0	57.8
Female	44.0	34.0	44.0	38.0	42.0	50.0	44.0	30.0	54.0	42.2
Total Interviewed (No.)	50	50	50	50	50	50	50	50	50	450

Sex of the Interviewed Beneficiaries

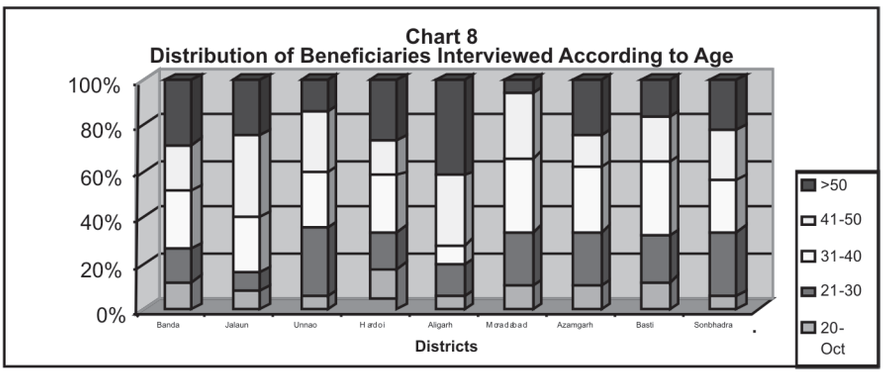
Overall 57.8 per cent of male and 42.2 per cent of female beneficiaries were interviewed in 9 districts. In 7 out of 9 districts more number of males were interviewed than females. Only in Sonbhadra district more number of females were interviewed. However, in Moradabad the equal number of males and females were interviewed (Table 4).

Age of Beneficiaries Interviewed

In almost all the district of the four regions, the beneficiaries who were interviewed were mostly (70.4%) more than 31 years of age. Overall 29.6 per cent of interviewed beneficiaries were in the age group of 10-30 years (Table 5).

Table 5
Distribution of Beneficiaries Interviewed According to Age

Age group of Beneficiaries (Years)	Regions/ District									Total %
	Bundelkhand		Central		Western		Eastern			
	Banda (%)	Jalaun (%)	Unnao (%)	Hardoi (%)	Aligarh (%)	Moradabad (%)	Azamgarh (%)	Basti (%)	Sonbhadra (%)	
10-20	12.0	8.0	6.0	18.0	6.0	10.0	10.0	12.0	6.0	9.8
21-30	14.0	8.0	30.0	16.0	14.0	24.0	24.0	20.0	28.0	19.8
31-40	26.0	24.0	24.0	24.0	8.0	32.0	28.0	32.0	22.0	24.4
41-50	20.0	36.0	26.0	16.0	30.0	28.0	14.0	20.0	22.0	23.6
>50	28.0	24.0	14.0	26.0	42.0	6.0	24.0	16.0	22.0	22.4
Total Interviewed (No.)	50	50	50	50	50	50	50	50	50	450



Recommendations

The study brought out many positive and negative perceptions of the community and providers regarding the Health Melas. It also provides an insight into the functioning of the melas, readiness of the system and scope for improvement.

The following recommendations are made:

- The Health Melas should preferably be organized in every quarter, especially in remote areas where accessibility to health services is difficult or is not available.
- The sites and dates for health melas should be fixed for each year in advance by Government of India and should not be changed every year.
- The referral services should be strengthened further to utilize the opportunity of medical care to the optimum.
- Care should be taken for follow-up of cases especially after surgery or treatment.
- A strong communication strategy should be followed to motivate community to utilise the services at the health melas. Utilization rates could be increased with more publicity and focussed IEC activities about the health mela.
- The facilities and specialists to be made uniform and as per the population and morbidity load of the district and not restricted to available resources.

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