

A RAPID APPRAISAL OF SWASTH PANCHAYAT SCHEME IN CHHATTISGARH

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PREFACE

Despite significant improvements made in the past few decades, the public health challenges in the country are huge, and these challenges are growing and shifting at an unprecedented rate. The concerns shown by the organisations 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 a better public health management approach. This urgency was realised and expressed in the public health conference expressed in the 'Calcutta Declaration', which calls for the creation of an appropriate structure for public health professionals and promoting reforms in the field of public health education and training.

The Department of Community Medicine at various medical colleges along with the nursing colleges, Health Training Institutions (SIHFW and HFWTC), Collaborating Training Institutions and Mother NGOs have been functioning for the promotion of public health either in small groups or totally in isolation. This may be one of the reasons for not achieving the desired objectives of the various health programmes. Therefore, an urgency being felt for joint collaborative efforts, through networking and partnership processes to pool all the available human resources from the above-mentioned institutions and also develop common strategies for the uplift of public health activities in the country.

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

Currently, under the NRHM many innovations have been introduced in the 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.

The 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 partnerships with different organisations working in the field of health and family welfare. The objective of the project is to accelerate programme implementation in the identified states by organising timely and appropriate research inputs for addressing priority implementation problems. The specific objectives of the 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 the RAHI project, the UNFPA India office supported 12 health system research projects. In this phase, five low performing states viz. Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh and Orissa were included. Initially, proposals were invited from medical colleges, NGOs and other health institutions. After a rigorous screening of the proposals by the Technical Advisory Committee (TAG) consisting of eminent public health experts, 12 projects were finalised in a national workshop conducted at the NIHF. The NIHF faculty provided technical support for finalisation of the tools, imparting training to investigators, planning and monitoring of the data collection process. A quality assurance mechanism was developed in consultation with members of TAG and experts from the UNFPA. The progress of the projects was reviewed by TAG from time to time. A draft report entitled **“A Rapid Appraisal of the Swasth Panchayat Scheme in the State of Chhattisgarh”** by the Department of Community Medicine, Chhattisgarh Institute of Medical Sciences, Bilaspur. The report has been finalised by the Institute in consultation with the UNFPA.

It is hoped that the present report will be useful to policymakers, health planners and health administrators in states/districts to undertake corrective decisions based on the findings of the report.

Prof. Deoki Nandan
Director, NIHF

ACKNOWLEDGEMENT

I wish to acknowledge the support that we received from the National Institute of Health and Family Welfare, New Delhi. Prof. (Dr.) Deoki Nandan, Director, NIHFWD deserves special mention. His quest for new horizons in public health has been a source of strength for the entire project staff.

I would like to express my sincere gratitude towards Dr. V.K. Tiwari, Associate Professor NIHFWD; Dr. Manoj Agarwal, Consultant, RAHI; and Dr. Kamlesh Jain, State Health Resource Centre, Raipur for their support in conducting this study.

I thankfully acknowledge the UNFPA for generously funding this project. We have made every effort to ensure that this fund is utilised in the interest of a healthy India. I am also thankful to all my departmental colleagues and research team members for having put in the maximum effort to complete the task within time.

I hope that this research will provide evidence based inputs to the state programme planners in bringing about necessary adjustments in the scheme for its better implementation.

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Abbreviations

ANC	Antenatal check-up
ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
BCG	Bacillus Calmette Guerin
FGD	Focus group discussion
IDI	In-depth interview
JSY	Janani Surakhya Yojana
NFHS-3	National Family Health Survey -3 (2005-06)
NHRM	National Rural Health Mission
NIHFW	National Institute of Health and Family Welfare
PHCs	Primary Health Centres
PNC	Postnatal check-up
PRI	Panchyati Raj Institution
RAHI	Rapid Assessment of Health Interventions
SPS	Swasth Panchayat Scheme
UNFPA	United Nations Population Fund

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EXECUTIVE SUMMARY

The National Rural Health Mission (NRHM) has been launched to provide integrated and comprehensive primary healthcare services, especially to the poor and vulnerable sections of the society. It aims at bridging the gaps in rural healthcare delivery systems through increased community ownership, decentralisation of the programmes to the district level, inter-sectoral convergence and improved primary healthcare delivery systems. 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 healthcare services.

The Government of Chhattisgarh has initiated the Swasth Panchayat Scheme (SPS) for capacity building of panchayats, village level institutions and individuals in health status assessment, health services monitoring and in local health planning to ensure community participation, understanding intra-panchayat and inter-panchayat variation and building inter-sectoral coordination at village level.

Capacities were built at the panchayat level to develop village health plans, implement them and monitor their activities. Now, health issues have become an area of important concern by the elected representatives too.

Under implementation in the state for the first time, it is essential to understand the functioning of the programme to know whether the programme is on track or we need to make any mid-term course corrections during its implementation phase. Since replicability of the programme is an important feature it is essential that a rapid appraisal of the SPS is carried out.

This study was carried out to understand the processes adopted during the implementation of the scheme. In this respect, data based on the designed 26 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 the reasons for the success and failures of the scheme and also to review the processes followed in its implementation.

Study Area: Chhattisgarh

Duration: 12 weeks (October 2007 to December 2007)

Sampling: Probability Proportional to Size Sampling (PPS)

Methodology

Thirty clusters were selected from villages. 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 to find 10 mothers who gave birth during the last one year and 10 mothers with children in the age group of 12 to 35 months. In these houses mothers, were interviewed and findings recorded in pre-tested and pre-designed schedules so as to get the current status of the indicators mentioned above. For each indicator, 300 respondents were interviewed .

In addition, three FGDs with Mitanins, three FGDs with ANMs and 15 in-depth interviews of the PRIs were conducted to understand the processes and the challenges faced in the implementation of the scheme.

Salient Findings

- Quantum leap in indicators in: institutional delivery (13.37 to 21.66 %), skilled delivery (26.74% to 36.11%), immunization coverage (81.05% to 92.59%), ANC coverage (82.70% to 94.44%) and recording of birth weight (57.39 -% to 67.77%).
- Increased community awareness of routine immunization and regular search for unimmunized children ensure 100% immunization
- Acceptance of ANC services is almost universal. Majority of pregnant women received three ANC visits and services provided by both ANMs and Mitanins.
- Lack of facilities at the sub-centres, e.g. blood pressure measuring instruments, lab facility for urine examination
- Lack of transport facilities for pregnant women in many villages leading to an increased number of home deliveries. In some villages it was observed that the panchayats arranged transport while in most cases it was the relatives.
- Community is well oriented towards institutional delivery, but non -availability of incentives under JSY a major concern
- Lack of participation in training programmes by ANMs is major concern
- Lack of community participation and interest is observed among the community members

Key Recommendations

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

- To increase levels of participation of ANMs during training programmes to ensure effective implementation of the programme
- To conduct training need assessments of PRIs and Mitans to bridge the gaps in training and actual implementation at the field level and ensure subject specific training

CHAPTER - 1

INTRODUCTION

The Panchayati Raj Institutions (PRIs) are the oldest institutions of governance in the country at the grassroots level. Under Article 243 G of the Constitution, panchayats have been assigned 29 rural development activities, including those related to health promotion and population stabilisation.

The National Rural Health Mission (NRHM) has been launched to provide integrated comprehensive primary healthcare services, especially to the poor and the vulnerable sections of the society. It not only aims at bridging the gaps in rural healthcare delivery but also integrates with the health and family welfare related interventions and addresses health from a holistic, preventive, promotive and curative viewpoint and to take a much more significant view of the PRI engagement.

The PRIs are seen critical to the planning, implementation, and monitoring of the NRH. Success of NRHM significantly depends on the well functioning Gram, Block and District level panchayats. A Village Health Committee is an integral part of every panchayat. The PRIs through Village Health Committees create 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 the planning and monitoring of the Village Health Plan enforces transparency and accountability within the programme.

This scheme has helped change perceptions of the panchayats in regards to health and related issues. Almost all the panchayats are now focusing on health planning and its outcomes. Many elected representatives are now prioritising healthcare issues and assisting in developing health plans.

The NRHM ensures that preventive and promotive interventions reach the vulnerable and marginalized sections of the society through expanding outreach and linking with local governance institutions and further ensuring sustainability of health programmes from the village to the state level.

Overall Objective

To conduct a rapid appraisal of the SPS: in terms of its functions and overall implementation in 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 outcomes for the indicators designed, and
- To review the processes followed for the implementation of this scheme.

CHAPTER-II

METHODOLOGY

Study Area: 27 villages of Chhattisgarh (geographically distributed).

Study Design

Type of study: A cross sectional descriptive design.

Study Subjects

- Women who gave birth in the last one year
- Mothers of the children aged between 12 months and 35 months
- Mitanins [ASHAs]
- ANMs
- PRIs

*For FGDs and IDIs, selection of participants was done on the basis of availability.

Sampling

The PPS or is it SPS selected villages in the first stage. Within the selected villages random sampling was used to select respondents (subjects). In three villages two samples were selected as the population of these villages was more than sample interval.

Table No. 1: List of villages selected for study

District	Block	Name of the Village
Kawardha	Sahpur	Dongariya
Kawardha	Sahpur	Navaghata
Korba	Kartala	Ghatdwari
Korba	Kartala	Kharwani
Bastar	Bastar	Mundagoan
Bastar	Bastar	Bringpal
Dhamtari	Kurud	Bagaond
Dhamtari	Kurud	Kulhadi
Janjgir	Jaijaipur	Kasigarh
Janjgir	Bamnidihi	Choriya
Janjgir	Bamnidihi	Kadri
Janjgir	Bamnidihi	Jhara

District	Block	Name of the Village
Janjgir	Bamnidi	Sanjaygram
Janjgir	Akaltara	Pondidalha
Bilaspur	Bilha	Lopahandi
Bilaspur	Bilha	Udantal
Bilaspur	Masturi	Kuli
Bilaspur	Masturi	Nargoda
Bilaspur	Masturi	Gidha
Koriya	Sonhat	Akalsarai
Koriya	Sonhat	Kachar
Koriya	Sonhat	Pondi
Koriya	Baikunthpur	Tendua
Koriya	Baikunthpur	Karji
Raigarh	Sarangarh	Bhedwan
Raipur	Bhatapara	Tonatar

Definitions used in the Study

Fully Immunized: A child who has received one dose of BCG, one dose of Measles, three doses of Polio and three doses of DPT is defined as fully immunized.

ANC Recipient: A pregnant women who has received TT injection, 100 tablets of iron folic acid and three visits by a health functionary during the antenatal period is defined as having availed of the service of the ANC.

Study Duration: 12 weeks (Oct 2007 to Dec 2007)

Data Collection Methods

Data collection was done with the help of focus group discussions (FGDs) and in -depth interviews. Primary data were collected from both the groups of mothers (300 women who gave birth in last 12 months and 300 mothers of the children aged between 12 and 35 months) using semi-structured schedules. Secondary data regarding village -wise status of various indicators were collected from the State Health Resource Centre, Raipur.

A total of six FGDs were conducted [3 with Mitanins and 3 with ANMs] and 15 in -depth interview were conducted with PRIs depending on their time and availability. The study maintained all research ethics throughout. All in-depth interviews and FGDs were recorded with the consent of the respondents and were transcribed. All the data collected were triangulated to have a clear idea of the findings at the time of analysis

The research team was given one-day training in the Department of Community Medicine. This was followed by pre-testing of all the tools developed for the research project.

A summary of the study subjects, sample size and data collection technique and tools is detailed in Table No.2.

Table no 2: Details on Sample Size and 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

*In addition, compilation of secondary data on the selected indicators was done from records.

Quality Assurance

The project was monitored and supervised by the principal investigator (PI). To ensure the desired quality of data, faculty members from the Department of Community Medicine accompanied researchers during the FGDs and IDIs in most of the villages. The PI monitored the quality of data collection in the field by cross-checking at least 10% of schedules collected by the field investigators. A central monitoring team from the NHIFW closely monitored the training, field activities, data analysis and report writing. The data collected in the form of recorded interviews were coded and each interview was transcribed on the same day. Each interview was given an ID number to eliminate bias. Data handling and data analysis was supervised by the PI and the Co-PI.

Data Analysis Plan

Quantitative Data was analysed by generating frequency tables. For qualitative data, semi quantification was done by coding the responses from different stakeholders and merging them into different headings using adjectives according to the NHIFW guidelines.

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

Ethical Clearance

The project structure was examined and cleared by the ethical committee of the institution review board at NIHFV for ethical considerations.

CHAPTER-III

FINDINGS AND DISCUSSIONS

Baseline Data

Data Variations

The baseline data collected before the implementation of the programme revealed that coverage of immunization and ANC in the villages under study was 81.50% and 82.7% respectively. Institutional deliveries and deliveries by trained/skilled birth attendants were 13.37% and 26.74% respectively. Slightly more than half of children (57.37%) were measured weight within three days of the birth.

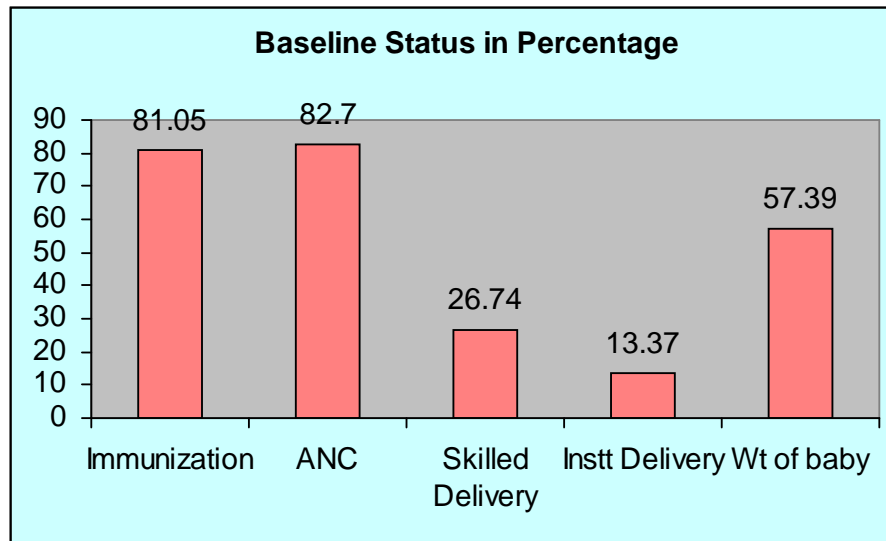
However we could observe large variations in meeting the indicators in various villages under the study. In immunization, it ranged from nearly 100% in Mundagaon to around 40% in Kargi. In ANC it ranged from 100% in Akhalsarai to 31% in Mundagaon. For deliveries attended by skilled birth attendants, it ranged from 0 in Ganiyari and Giddha to 69% in Bringpal. Institutional delivery ranged from 0 in Ganiyari and Giddha to 23% in Akhalsarai and for the measuring the weight of the baby within 3 days, it ranged from nearly 4% in Akhalsarai to 100% in Kulhadi, Navaghata and Tonatar.

The data above show large variations and interpretations. As an example in the case of Ghaniyari, immunization and ANC coverage are very high while skilled birth attendant and institutional deliveries is zero. In Kargi, the immunization coverage is the lowest while institutional deliveries are the highest.

This pattern has been observed throughout the study villages. It clearly reflects the existing mindsets, choices and priorities of the population and the need for development of village-specific action plans which focus on the poor/low indicators of that particular village. This also emphasises the need for reorienting the PRI members and peripheral health functionaries on the data based evidence to understand their situations and needs and work towards a more holistic planning for improvement of all health indicators .

Table 3: Baseline Status

Name of Village	Immunization	ANC	Skilled Del	Instt Del	Wt within 3 days
Akhalsarai	80.72	100	4.65	23.91	4.65
Bagaound	56.3	62.5	37.88	6.06	24.24
Bhedwan	86.89	70	60	40	70
Bringpal	80	90.91	69.23	10.26	69.23
Choriaya	87.7	91.15	11.11	14.81	79.63
Dongariya	94.44	94.12	34.21	10.53	81.58
Ganiyari	88	100	0	0	6.67
Ghatdwari	84.3	92.86	47.62	14.29	71.43
Giddha	58.33	100	0	0	100
Jhara	82.7	95	15.38	21.43	26.92
Kachnar	76.27	90.48	16.07	17.86	16.07
Kadari	72.65	94.44	15.63	15.63	71.88
Kargi	42.37	100	58.82	58.82	58.82
Kashigarh	85.65	54.76	57.14	3.06	17.35
Kharwani	86.26	92.31	13.04	4.35	69.57
Kulhadi	53	75	38.64	18.18	100
Kuli	100	100	15.63	15.63	62.5
Mundagaon	99.59	31.87	12.79	13.95	23.26
Nargoda	100	100	0	3.85	87.18
Navaghata	100	100	24.49	12.24	100
Pachauri	76.84	69.44	20	14.29	74.29
Podi	87.16	58.33	11.11	5.56	29.63
Pondidalha	75.58	87.93	14.63	10.98	21.95
Sanjaygram	86.4	70	21.88	6.25	71.88
Tendua	67.51	51.11	60.53	11.84	35.53
Tonatar	96.6	100	52.73	7.27	100
Udantal	83.33	60.87	8.77	0	75.44
Total %	81.05	82.7	26.74	13.37	57.39



Immunization Services

The study has found almost 100% coverage in the increase in receiving immunization services. However, there is a wide variation in coverage of immunization services among the sample villages. Coverage is as low as only 42 percent in Kargi, but it is 100 percent in Kuli and Mundagaon. Increase in coverage of immunization after implementation of SPS is not uniform throughout the villages under study. An increase in coverage of immunization has been observed as much as 57% and 41% in Kargi and Gidha village respectively, while there is a negative change in Mundagoan, Ganiya ri, Kuli and Udantal.

On exploring reasons for this discrepancy it has been found that the project was implemented more intensively in the first quarter of the year. Therefore, in Kulhadi immunization coverage was only 53% during baseline survey which did not increase to any significant level after implementation of the SPS programme. Thus it appears that villages where immunization coverage was low during baseline survey did not improve to any significant level barring a few exceptions.

The immunization programme is largely found to be acceptable, and migration during certain months of the year and illness (fever) are only reasons for not immunizing the children in these villages. However, the overall immunization coverage was a high 81% before SPS was started which could be considered satisfactory and therefore scope for major improvement is limited.

Table 4: Change in Quantity of Immunization Services

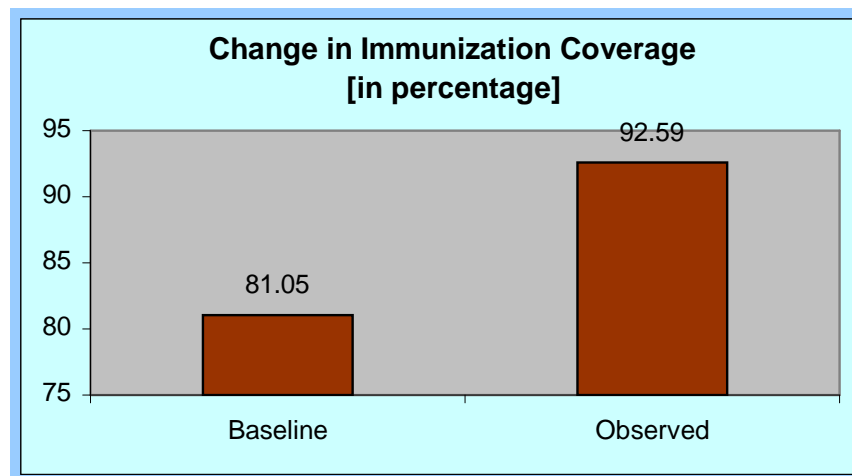
Name of village	Fully Immunized		Percentage Change
	Baseline [in percentage]	Observed [in percentage]	
Akhalsarai	80.72	100	19.28
Bagaound	56.30	95	38.70
Bhedwan	86.89	100	13.11
Bringpal	80.00	90	10.00
Choriaya	87.70	95	7.30
Dongariya	94.44	100	5.56
Ganiyari	88.00	70	-18.00
Ghatdwari	84.30	100	15.70
Giddha	58.33	100	41.67
Jhara	82.70	90	7.30
Kachnar	76.27	100	23.73
Kadari	72.65	100	27.35
Kargi	42.37	100	57.63
Kashigarh	85.65	100	14.35
Kharwani	86.26	100	13.74
Kulhadi	53.00	60	7.00
Kuli	100.00	90	-10.00
Mundagaon	99.59	50	-49.59
Nargoda	100.00	100	0.00
Navaghata	100.00	100	0.00
Pachauri	76.84	90	13.16
Podi	87.16	100	12.84
Pondidalha	75.58	90	14.42
Sanjaygram	86.40	100	13.60
Tendua	67.51	100	32.49
Tonatar	96.60	100	3.40
Udantal	83.33	80	-3.33
Total Percentage	81.05	92.59	11.53

According to the Mitanins and ANMs, there are only a very few non-immunized children in their villages and that the community thinks that immunization is necessary. All the

respondents agree on involvement/ participation during the immunization programme. In regards to the panchayats, it is observed that though they are instrumental in the management of local immunization programmes, they are not very active in planning and monitoring the same. It is gathered that limited follow -up action is the main reason for the delayed monthly rounds of immunization.

Capacity Building

The above-mentioned analysis shows the urgent need for capacity building, re-orientation of the panchayat members in health planning and monitoring processes not only to enhance coverage in the areas with negative or minimally positive trends under the SPS but also to systematically plan and increase efforts in regular monitoring and evaluation of the programme.



Provision of Antenatal Care Services

There has been increase in the utilisation of ANC services with all its consequential benefits in terms of reduction in morbidity and mortality. Utilisation of ANC services has been defined by the programme as those beneficiaries who are registered and receive TT injection and iron folic acid tablets. Maintaining the quality of services is the responsibility of the Mitans.

It is gathered from the study that very few Mitans have complete and correct knowledge about all the components of ANC. Ironically, they share the principal responsibility of providing ANC to the beneficiaries. However, 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, antenatal care is being provided in the village and pregnant women are getting at least three ANC visits. Majority of the beneficiary women are happy about this and report that all their

examinations and investigations are done during ANC visits. However, the Mitanins have not confirmed this information.

“Blood tests, urine examination and blood pressure measurement are practically not done in any antenatal case. ANC services provided at the health centre is limited to provision of iron folic acid tablets and TT injections,” said a Mitanin.

‘I have been given only iron folic acid tablets and injection for prevention of Tetanus. No other tests were done and examinations conducted,’ informs a mother.

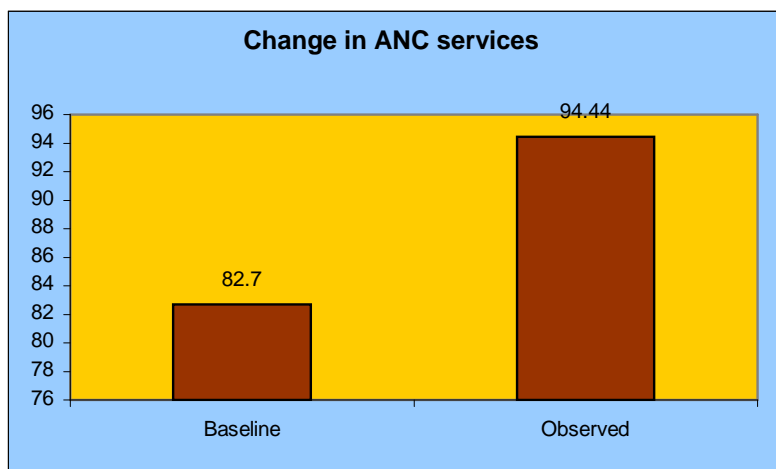
A few steps in the right direction can help in the provision of better quality ANC services, such as:

- Availability of the BP instrument and other basic yet essential equipments at the sub centre
- Provision of urine albumin services at the village level and adequate training to the Mitanins on it
- Ensuring regular monitoring of ANC days/check-ups by the Village Health Committee, and
- Providing regular updated knowledge about the JSY to the health workers, because the motivation for the patient to undergo an institutional delivery begins during the ANC and if not done well this may deprive the expectant mother of the benefits of the JSY.

Table-5 : Changes in Provision of Antenatal Care Services

Name of village	ANC coverage		Percentage Change
	Baseline [percentage]	Observed [Percentage]	
Akhalsarai	100.00	80	-20.00
Bagaound	62.50	100	37.50
Bhedwan	70.00	80	10.00
Bringpal	90.91	100	9.09
Choriaya	91.15	100	8.85
Dongariya	94.12	90	-4.12
Ganiyari	100.00	90	-10.00
Ghatdwari	92.86	90	-2.86
Giddha	100.00	100	0.00
Jhara	95.00	100	5.00

Name of village	ANC coverage		Percentage Change
	Baseline [percentage]	Observed [Percentage]	
Kachnar	90.48	90	-0.48
Kadari	94.44	100	5.56
Kargi	100.00	100	0.00
Kashigarh	54.76	100	45.24
Kharwani	92.31	100	7.69
Kulhadi	75.00	100	25.00
Kuli	100.00	100	0.00
Mundagaon	31.87	90	58.13
Nargoda	100.00	70	-30.00
Navaghata	100.00	100	0.00
Pachauri	69.44	100	30.56
Podi	58.33	100	41.67
Pondidalha	87.93	100	12.07
Sanjaygram	70.00	80	10.00
Tendua	51.11	90	38.89
Tonatar	100.00	100	0.00
Udantal	60.87	100	39.13
Total [%]	82.70	94.44	11.73



The ANC is considered important for the health of mothers and children, according to almost all the Mitans and ANMs. Acceptance of ANC by the community is almost

universal, according to the ANMs, but Mitanins report that they face problems while dealing with the families of Zamindars in the village.

According to the PRI members and the ANMs, it is found that the Village Health Committee monitors the implementation of ANC services, however, on detailed exploration it is observed that Mitanins are held responsible for this activity by the Village Health Committee.

“The Village Health Committee has entrusted all jobs related to health in the village to us and therefore we have to conduct all the activities with practically no participation of the committee,” complained a Mitanin.

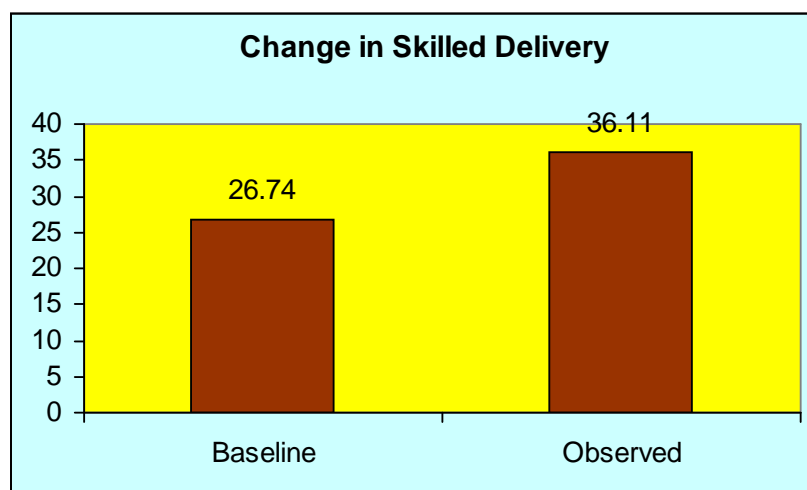
Overall, there has been an increase of 11.73 % in the provision of ANC services in the villages covered under the study. Despite the fact that the quality of ANC services remains disputed more pregnant women are now utilising it.

Delivery Services

The JSY has been launched to ensure effective healthcare to expectant mothers together with a provision of incentives for seeking healthcare during the antenatal period and delivery. But surprisingly, in a large number of villages, incentives are either not given at all or considerably delayed. This has adversely affected the provision of quality healthcare to the pregnant women.

Importance of institutional delivery is very well recognised by the villagers. Although there has been increase in institutional delivery after the implementation of the scheme, yet it is far below the expected level. Many women still prefer home deliveries by unskilled attendants to avoid expenses at hospitals. The Medical College Hospital at Jagdalpur is no exception.

“Many women prefer home delivery to institutional delivery because at the Maharani Hospital attached to the Government Medical College, Jagdalpur they have to pay for the services. Nurses and other staff demand money at the time of delivery. These expenses are much less when delivery is conducted at home,” informs a Mitanin from Mundagoan village in Bastar District.



Almost all the Mitanins, ANMs and PRIs state that institutional delivery is considered necessary by the community, but the acceptance of institutional delivery is not fully recognised.

Further, the ANMs inform that the provision of referrals to women during pregnancy and delivery exist even now but very few PRIs accept this view.

Majority of the respondents across three groups are of the opinion that the Village Health Committee plays a key role in the provision of referral services but it is limited to making transportation arrangements. No regular and available transportation is found in majority of villages at the time of emergency. In majority of such cases relatives make their own arrangement. Panchayats also sometimes provide help.

Therefore, it is desirable to strengthen the availability of effective transport facility at the village level to provide immediate assistance to pregnant women.

Table 6 : Change in Skilled Delivery

Name of village	Skilled Delivery		Percentage Change
	Baseline [percentage]	Observed [percentage]	
Akhalsarai	4.65	0	-4.65
Bagaound	37.88	85	47.12
Bhedwan	60.00	40	-20.00
Bringpal	69.23	40	-29.23
Choriaya	11.11	70	58.89
Dongariya	34.21	30	-4.21

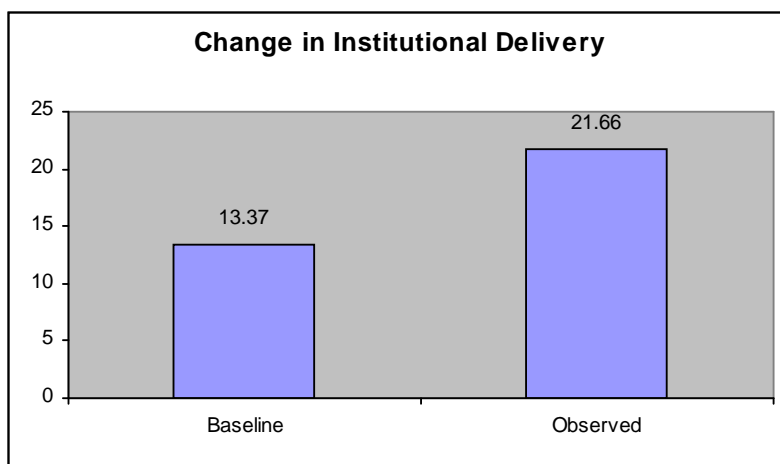
Name of village	Skilled Delivery		Percentage Change
	Baseline [percentage]	Observed [percentage]	
Ganiyari	0.00	0	0.00
Ghatdwari	47.62	20	-27.62
Giddha	0.00	30	30.00
Jhara	15.38	10	-5.38
Kachnar	16.07	60	43.93
Kadari	15.63	10	-5.63
Kargi	58.82	80	21.18
Kashigarh	57.14	40	-17.14
Kharwani	13.04	100	86.96
Kulhadi	38.64	30	-8.64
Kuli	15.63	20	4.38
Mundagaon	12.79	30	17.21
Nargoda	0.00	0	0.00
Navaghata	24.49	70	45.51
Pachauri	20.00	20	0.00
Podi	11.11	20	8.89
Pondidalha	14.63	40	25.37
Sanjaygram	21.88	10	-11.88
Tendua	60.53	90	29.47
Tonatar	52.73	20	-32.73
Udantal	8.77	10	1.23
TOTAL PERCENTAGE	26.74	36.11	9.37

Despite the problems of delayed/non-payment of incentives under the JSY, there is an increase of 9.37 percentage points of births attended by skilled personnel. However, in some villages there is no significant increase and in some villages there is even a decrease. In Nargoda and Ganiyari villages, no delivery is found to be conducted by skilled health personnel and a large number of deliveries are still being conducted by unskilled personnel, which reflects on the poor implementation of the JSY.

Table 7: Change in Institutional Delivery

Name of village	Institution Delivery		Percentage Change
	Baseline [Percentage]	Observed [Percentage]	
Akhalsarai	23.91	0	-23.91
Bagaound	6.06	70	63.94
Bhedwan	40.00	10	-30.00
Bringpal	10.26	40	29.74
Choriaya	14.81	15	0.19
Dongariya	10.53	30	19.47
Ganiyari	0.00	0	0.00
Ghatdwari	14.29	10	-4.29
Giddha	0.00	0	0.00
Jhara	21.43	10	-11.43
Kachnar	17.86	40	22.14
Kadari	15.63	10	-5.63
Kargi	58.82	50	-8.82
Kashigarh	3.06	30	26.94
Kharwani	4.35	40	35.65
Kulhadi	18.18	30	11.82
Kuli	15.63	20	4.38
Mundagaon	13.95	30	16.05
Nargoda	3.85	0	-3.85
Navaghata	12.24	50	37.76
Pachauri	14.29	10	-4.29
Podi	5.56	20	14.44
Pondidalha	10.98	10	-0.98
Sanjagram	6.25	10	3.75
Tendua	11.84	40	28.16
Tonatar	7.27	0	-7.27
Udantal	0.00	10	10.00
TOTAL PERCENTAGE	13.37	21.66	8.29

Apart from the deliveries being conducted by unskilled personnel, non -availability of transport and payment for services at health centres are among a few other reasons for poor percentage of institutional delivery as mentioned by majority of PRIs .



Postnatal Care Services

Postnatal Care Services (PNC) is found to be provided mainly by Mitanins [ASHA]. Their knowledge level on various components of the PNC are very low, though. Measurement of weight of the child is considered the main component of PNC services, but due to their lack of knowledge other PNC aspects are either overlooked or ignored.

Table 8: Measurement of Weight of Babies within 3 Days

Name of Village	% of Children whose Weight was Taken Within 3 Days		Percentage Change
	Baseline [Percentage]	Observed [Percentage]	
Akhalsarai	4.65	100	95.35
Bagaound	24.24	100	75.76
Bhedwan	70.00	80	10.00
Bringpal	69.23	50	-19.23
Choriaya	79.63	30	-49.63
Dongariya	81.58	90	8.42
Ganiyari	6.67	0	-6.67
Ghatdwari	71.43	30	-41.43
Giddha	100.00	50	-50.00
Jhara	26.92	50	23.08

Name of Village	% of Children whose Weight was Taken Within 3 Days		Percentage Change
Kachnar	16.07	80	63.93
Kadari	71.88	40	-31.88
Kargi	58.82	90	31.18
Kashigarh	17.35	60	42.65
Kharwani	69.57	100	30.43
Kulhadi	100.00	100	0.00
Kuli	62.50	70	7.50
Mundagaon	23.26	30	6.74
Nargoda	87.18	10	-77.18
Navaghata	100.00	100	0.00
Pachauri	74.29	50	-24.29
Podi	29.63	90	60.37
Pondidalha	21.95	90	68.05
Sanjaygram	71.88	60	-11.88
Tendua	35.53	100	64.47
Tonatar	100.00	100	0.00
Udantal	75.44	80	4.56
Total [percentage]	57.39	67.77	10.38

Increasing the knowledge and skills of Mitanins for providing PNC services is seen as a crucial aspect of the healthcare delivery system. Since ANMs are well trained for delivery of PNC services, improvement in the quality of services can be achieved by ensuring their frequent visits to villages and availability at sub-centres.

Drinking Water Supply

Main sources of drinking water in the villages are hand pumps and tap water. Majority of villagers are using these safe drinking water sources and, therefore, there is no water borne diseases in the last one year in almost all the study villages.

Awareness and Knowledge about the Swasth Panchayat Scheme

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

Almost all the PRIs and Mitanins think that the only strategy of the scheme is to make the community participate in the meetings and campaigns. Most of the ANMs also have

similar opinions. This is also confirmed by the fact that majority of pachayats are found to be involved in the implementation of the programme only. Although village plans are prepared with assistance of the panchayats, yet many are not aware of their role in preparation of the plan.

Thus it appears that although PRIs have been involved in the preparation of village health plan, yet they do not have conceptual clarity about their role in the SPS.

Training

Training sessions are organized under the scheme which is mainly attended by PRIs and Mitanins, who find the programme useful but there is a serious lack of participation by the ANMs. ANMs being the most important functionary at grassroots level, their involvement is seen as important.

Role of Village Health Committee

The Village Health Committee is in existence in almost all the villages. In majority of villages they have been there for more than a year. In many villages they existed even before the implementation of the SPS, but were largely non-functional. But since the launch of the SPS programme, they have become active and are involved in meetings and other activities. Almost all the PRIs and majority of ANMs know the composition of the Village Health Committees but majority of Mitanins do not know how they have been formed.

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

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

Majority of PRIs agree that Village Health Committee is responsible for monitoring of health programmes but no monitoring plans are prepared, also there is a lack of protocol and responsibility. As a result there is no effective monitoring by the Village Health Committee. Monitoring and evaluation are important components of SPS. Unless the Village Health Committee is actively involved in this process, effective implementation of SPS may not be possible.

CHAPTER IV

RECOMMENDATIONS

Policy issues	Recommendations
<ul style="list-style-type: none"> • Delay of distribution of incentives under JSY 	<p>This is adversely affecting the programme performance. Utilisation of banks available in rural areas can be made to facilitate timely payment.</p>
<ul style="list-style-type: none"> • Existing system of financial management which hinders regular flow of finances to the grass roots 	<p>Replacing the old system with new technology of telephones and the Internet. Computerisation of the financial system will effectively deal with this problem..</p>
<ul style="list-style-type: none"> • Lack of involvement by panchayats in delivering effective healthcare 	<ul style="list-style-type: none"> • Involvement of panchayats is crucial for effective implementation of the programme. A selected member from the panchayat need be trained and held responsible for this activity to ensure focus and continuity in the health care programme.
<ul style="list-style-type: none"> • Lack of transportation facilities 	<ul style="list-style-type: none"> • A mechanism to ensure committed availability of transportation in the villages should be planned
Programme Level Issues	
<ul style="list-style-type: none"> • Poor/limited knowledge on the various issues of programme among the PRIs, ANMs and Mitanins 	<ul style="list-style-type: none"> • To ensure a need-based training based on a rapid assessment done from the previous trainings to address the gaps directly
<ul style="list-style-type: none"> • Lack of participation in trainings by the ANMs 	<ul style="list-style-type: none"> • ANMs to be motivated to take part in the trainings to ensure better delivery of the healthcare programme
<ul style="list-style-type: none"> • Ensure delivery of quality of healthcare services 	<p>To provide ANMs with necessary equipments and basic instrument to ensure effective delivery of service. To set up a system wherein all the necessary investigations are done at the village level.</p>

Limitations of the Study

Study was conducted when programme was in operation for about one year only. This is too short a time for assessing the outcome. Therefore, findings related to outcome indicators may not be true in future. However, the study has been able to effectively find out strengths and weaknesses of the process adopted in the programme. Since study period was short, no control was used to measure the impact of the programme.

Future Directions of Research

Various other community-based organisations should be studied and their capacity to provide effective healthcare at grassroots level needs to be assessed. Capacities of panchayats to deliver healthcare services at village level should be studied to find out the strengths and weaknesses of panchayats. Accordingly, capacity of the panchayats can be augmented to make them more effective partners in the delivery of healthcare to the masses.

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