Issues and Challenges in Maternal and Child Health Care

in Tribal Dominated Districts of Odisha

Perceptions from the Ground

Foreward

Maternal and Child Health (MCH) needs adequate attention in the whole arena of health care system. In recent years, a wide range of schemes and programmes have been launched in the state; still maternal and child health continues to be a key issue while considering the aspects of MMR and IMR.

The study is an attempt to understand the functioning of the existing schemes and programmes relating to MCH along with the issues and challenges associated with the food and nutritional status of women during antenatal, delivery and postpartum phase. Second in a series of perception studies it captures the perception of women beneficiaries, front line workers and other service providers on the persisting issue of poor MCH in selected districts. The findings of the report aspire to formulate a productive debate in the appropriate forums.

Jagadananda
Mentor & Co-founder

Contents

Abbreviation

ANC:	Ante Natal Check-ups
ANM:	Auxiliary Nurse Midwife
ASHA:	Accredited Social Health Activists
AWW:	Anganwadi Worker
BCG:	Bacillus Calmette-Guérin
BKKY:	Biju Krushak Kalyan Yojana
BPL:	Below Poverty Line
CHC:	Community Health centre
GKS:	Gaon Kalyan Samiti
ICDS:	Integrated Child Development Services
IFA:	Iron and Folic Acid
IHHL:	Individual Household Latrine
IMR:	Infant Mortality Rate
IYCF:	Infant and Young Child Feeding
JSSK:	Janani Shishu Suraksha Karyakaram
JSY:	Janani Suraksha Yojana
MCH:	Maternal and Child Health
MCPC:	Mother and Child Protection Card
MDG:	Millennium Development Goals
MMR:	Maternal Mortality Ratio
MO:	Medical Officer
NFHS:	National Family Health Survey
NFSA:	National Food Security Act
NHM:	National Health Mission
PDS:	Public Distribution System
PHC:	Primary Health Centre
PRI:	Panchayati Raj Institutions
SBM:	Swachh Bharat Mission
SDG:	Sustainable Development Goals
THR:	Take Home Ration
TT:	Tetanus Toxoid
VHND:	Village Health Nutrition Day

Chapter - 1

BACKDROP

1.1 Importance of Maternal and Child Health: The Macro Scenario

Maternal health includes the health of women during antenatal, delivery and post-natal phase which is an important period in a woman's life as it carries the family's offspring. While in developing countries, the mother and child constitute nearly 71.14% of the population (Park, 2017), as per World Health Organization (WHO), everyday, around 830 women die in pregnancy and child birth related health issues. Of them, 99% of the maternal deaths take place in developing countries (WHO, 2016). This aspect was included in the Sustainable Development Goals (SDGs) and a target was set up to decrease maternal death to less than 70 by 2030. Even during the MDG era (1990-2015), it was targeted to reduce IMR from 80 to 27 and MMR from 437 to 109 by 2015. The stated target was not achieved as the IMR and MMR were 39 and 140 respectively.

SDG Goal 3:
Ensure healthy lives and promote well-being for all at all ages

Target to address Maternal & Child Health

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

Again it was visualized that, the target can be fulfilled by providing proper health care, awareness and by appointing skilled health personnel. In India, the Ministry of Health and Family Welfare is continuously engaged in developing several schemes and programmes to address the issue. As per the report of World Health Organisation (WHO), during 2010 the MMR ratio of India was 215 per 100,000 live births but in 2015 the ratio reduced to 174 (Global Health Report, 2017). Similarly, in 2015-16, the infant mortality rate has declined to 41 in comparison to 2005-06 when the ratio was 57.

Park, K., Preventive Social Medicine, January, 2015.
World Health Organization, Accessed on 5.11.2017, http://www.who.int/maternal-health/en/
World Health Organization, Key Facts on Maternal Mortality, http://www.w-ho.int/en/ne-ws-room/fact-she-e-ts/d-etail/mat-ernal-m-or-tali-ty
Ministry of Statistics and Programme Implementation, Government of India, Milleniun Development Goals, India Country Report, 2015.

The Scenario of Odisha

In the context of Odisha, the MMR during 2005-06 was 303 and it came down to 222 in 2013 (SRS, 2013). Similarly, the IMR during 2005-06 was 65 and has come down to 40 during 2015-16 (NFHS-4, 2015-16). To achieve the stated SDG goal, the state has planned to reduce the MMR and IMR to 117 and 30 by 2020. The targeted aim cannot be fulfilled by only implementing the plans and programs; rather it necessitates a bird's eye view on the prevailing issues at the ground level. In addition to this, in Odisha 47.6% pregnant women in the age group of 15-49 years are anemic. Similarly, breast feeding of the newborns within an hour of birth is 68.6%.

Therefore, it is evident that, despite lots of efforts that have been made to address the issue in the most possible way, still there lies some serious setback in the remote rural regions in general and tribal dominated regions in particular. Further, the tribes have an entirely different lifestyle than the rural population. Mostly they live in the remote and hilly regions and consume seasonal forest products as their daily food. They neither have ample access nor are they aware about the food and nutritional practices during child bearing and post-partum phase.

1.2 Provisions for Maternal and Child Health

Maternal and child health is often associated with multifaceted issues. On one hand, the schematic approach and facilities are not reaching every beneficiary. On the other hand, the level of awareness is almost lacking among the rural outreach mass. Quite a lot of striking schemes and programmes like JSY, JSSK, BKKY and MAMATA have been designed and implemented not to address high IMR and MMR, but to ensure a healthy life for mother and child. Along with ante-natal, delivery and post-natal care, appropriate attention is needed towards food intake, nutritional status, sanitation practices, access and availability of drinking water for women as well. To develop the nutritional status of women, some provisions have been made in the National Food Security Act (NFSA). As per this act, ICDS, PDS and MAMATA schemes are facilitating to improve the nutritional status of pregnant women, lactating mothers together with children. Likewise, the intake of safe drinking water, adequate sanitation and good hygiene have a direct connection with maternal, new born and child health. Basically, the pregnant women and new born babies are at risk due to their fragile immune system.

1.2.1 Schematic Provisions on MCH

As discussed above, several schemes have been launched to improvise the situation of maternal and child death. A brief analysis of the schemes is as follows:

Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) was introduced by the Govt. of India under National Rural Health Mission (NRHM) by taking the objective of reducing maternal and neo-natal mortality. The primary aim of this scheme was to promote institutional delivery among the poor pregnant women. This scheme provides financial assistance (Rs 1400 for Rural and Rs 1000 for Urban) to women opting for institutional delivery. To implement the scheme ASHA/AWW and other link health workers are assigned definite roles i.e. identification of pregnant women as

[5] Department of Health and Family Welfare, Government of Odisha,
Odisha State Strategy for Accelerated Reduction of Maternal and Infant Mortality, Odisha 2020.

beneficiaries, facilitate registration for ANC, counseling about the benefits of institutional delivery, identification of a functional government health centre or an accredited private health institution for referral and delivery, accompanying the pregnant women at the time of delivery and staying with her till she is discharged, arranging immunization for the new born till 14 weeks of birth and paying post-natal home visits to monitor both mother and child's health and counsel on breast feeding etc.

As per JSY scheme, all pregnant women having genuine BPL cards or SC/ST Certificate are eligible to avail the prescribed benefits. As the scheme promotes safe institutional delivery, it facilitates the beneficiaries in coming to and delivering in Government health centres like Sub-centres, PHCs, CHCs/FRUs/General wards of Sub Divisional, Districts and State Hospitals and Govt. medical colleges. Even the beneficiaries can avail the facilities of Accredited Private Institutions by producing BPL cards or SC/ST certificate. The scheme also covers deliveries taking place in Municipal Hospitals.

The scheme also includes ASHA's incentives for each delivery (Rs 600 for Rural and Rs 200 for Urban). The incentive includes rural referral transport (Rs 250) and transactional costs (Rs 150) and for facilitating institutional delivery (Rs 200).

Janani Sishu Suraksha Karyakram (JSSK)

Janani Sishu Suraksha Karyakram (JSSK) is a centrally sponsored scheme that aims to bear all the expenses related to institutional delivery. Under this scheme, every beneficiary would avail benefits such as to and fro free transportation at the time of delivery, minimum 48 hours stay at the health institution after delivery, free drugs and consumables, free diagnosis (blood, urine tests and ultra-sonography), free blood as and when required, free diet during a woman's stay at the facility, free and cashless delivery including caesarean section, and free transportation between facilities during referral cases.

Mamata

MAMATA is a conditional cash transfer maternity benefit scheme. The scheme basically provides monetary support to the pregnant women and lactating mothers to improve their nutritional status during pregnancy and post partum phase.

A beneficiary is entitled to receive a total incentive of Rs. 5000 in four installments. The first three installments are given every three months after the completion of second trimester of pregnancy up to delivery. The fourth installment is given to ensure that every woman continues to breast feed their children while ensuring a balanced feeding and complete immunization of the child till 9-12 months of age.

However, in the year of 2018, the scheme has been modified and four installments have been revised into two. At the same time, the incentive is also increased to Rs. 6000. While the objective

Objectives

- To provide partial wage compensation to pregnant and nursing mothers so that they are able to rest adequately during their pregnancy and after delivery.
- To increase utilization of maternal and child health services, especially ante-natal care, post-natal care and immunization.
- To improve mother and child care practices, especially exclusive breast feeding and complementary feeding of infants.

and the targets are same, the conditionality of cash transfer has been revised. As per the revised norms, a beneficiary is able to avail the first installment only if she fulfills five specified conditionalities i.e. (a)pregnancy registered within six months; (b) received at least one ante-natal check-up; (c) received IFA tablets; (d) received at least one TT vaccination; (e) received at least one counseling session at the AWC/VHND/home visit. The second installment is released only if the beneficiary fulfills 6 specified conditions i.e.

(a) registration of child birth;
(b) Child received BCG vaccination;
(c) Child received Polio -1 and DPT-1 vaccination;
(d) Child received Polio-2 and DPT-2 vaccination;
(e) Child weighed at least two times after birth (out of optimal 4 times including weighing at birth);
(f) Mother attended at least two IYCF counseling sessions at the AWC/VHND/Home Visit after delivery (out of optimal 3 times).

1.2.2 Other Schemes to address MCH:

Besides the above mentioned MCH schemes, there are some other schemes that are also trying to address maternal and child health in the most possible way. They are as follows:

BKKY's Maternal Benefit Criteria

Biju Krushak Kalyan Yojana (BKKY) is a state sponsored health insurance scheme which covers the farmers and their families against out of pocket expenditure for their medical care. To avail the facilities of BKKY each beneficiary family needs to register by providing rupees 30 per year. As per the guidelines of this scheme, in a farmer's family five members can be included to get the benefit. As per the provisions, a farmer's family can avail up to Rs. 30,000 for maternity benefit and new born care purpose.

Objective

To improve access of identified farmer families to quality medical care for treatment of diseases involving hospitalization through an identified network of health care providers.

SBM's Special Component for MCH

Swachh Bharat Mission (SBM) is a centrally sponsored scheme which aims to bring an improvement in the sanitation aspect by promoting cleanliness, hygiene and eliminating open defecation. The scheme is designed for both rural and urban sectors of the country. As per the provisions, sanitation is one of the important criteria especially for the rural families. It also prioritizes families having pregnant women and lactating mothers.

Nutritional benefit under ICDS

Integrated Child Development Services (ICDS) was launched by Government of India with five objectives and six integrated services (supplementary nutrition, immunization, health

Objectives

- Improve the nutritional and health status of children in the age-group 0-6 years.
- Lay the foundation for proper psychological, physical and social development of the child.
- Reduce the incidence of mortality, morbidity and malnutrition.
- Achieve effective coordination of policy and implementation amongst the various departments to promote child development.
- Enhance the capability of the mother/care giver to look after the normal health and nutritional needs of the child through proper nutrition and health education.

check-up, referral services, pre-school education and nutrition and health education) to collide with the multi-dimensional and inter-related prerequisites of children.

Of them, four services were designed together for children below six years and pregnant and lactating women. As per the supplementary nutrition programme of ICDS, every state has the flexibility to introduce their Take Home Ration (THR) services by taking into consideration the cost, calorie and protein norms fixed by the union Govt. In Odisha, wheat based chhatua in the form of THR was introduced and every pregnant woman, lactating mother, all children between three months to six years of age are being provided with the same.

Key MCH Indicators

Indicators	India	Odisha	Kalahandi	Balangir
MMR	174.0	222.0	245.0	234.0
IMR	41.0	40.0	43.0	99.0
Pregnant women age 15-49 years who are anemic (%)	53.0	47.6	73.7	59.5
Institutional Births (%)	78.9	85.4	74.5	87.1
Institutional births in public facility (%)	52.1	75.9	65.2	84.9
Births assisted by doctor/nurse/LHV/ANM/ other health personnel (%)	81.4	86.6	76.9	91.4
Mothers who had antenatal check-up in the first trimester (%)	58.6	64.1	70.6	73.7
Mothers who had at least 4 antenatal care visits (%)	51.2	62.0	46.7	76.5
Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	30.3	36.5	33.2	49.1
Mothers who had full antenatal care (%)	21.0	23.1	13.7	34.4
Registered pregnancies for which the mother received Mother and Child Protection (MCP) card (%)	89.3	97.2	96.7	100.0
Mothers who received postnatal care from a doctor/nurse/LHV/ ANM/midwife/other health personnel within 2 days of delivery (%)	62.4	73.3	58.8	78.5
Average out of pocket expenditure per delivery in public health facility (Rs.)	3,198.0	4,225.0	5,133.0	4,989.0
Children who received a health check after birth from a doctor/ nurse/LHV/ANM/ midwife/other health personnel within 2 days of birth (%)	24.3	29.5	10.2	39.1
Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%)	62.0	78.6	88.2	93.0
Children age 12-23 months who have received BCG (%)	91.9	94.1	98.3	100.0
Children age 12-23 months who have received 3 doses of polio vaccine (%)	72.8	82.8	88.2	96.3
Children age 12-23 months who have received 3 doses of DPT vaccine (%)	78.4	89.2	94.8	98.1
Children age 12-23 months who have received measles vaccine (%)	81.1	87.9	98.3	96.7
Children age 12-23 months who received most of the vaccinations in public health facility (%)	90.7	98.3	98.7	100.0
Children under age 3 years breastfed within one hour of birth (%)	41.6	68.6	71.9	81.5
Children under age 6 months exclusively breastfed (%)	54.9	65.6	67.4	53.4
Households with an improved drinking-water source (%)	89.9	88.8	93.6	94.0
Households using improved sanitation facility (%)	48.4	29.4	14.9	14.1

Sources: NFHS-4, Annual Health Survey 2012-13, Global Health Report 2017.

Chapter - 2

Objectives and Methodology

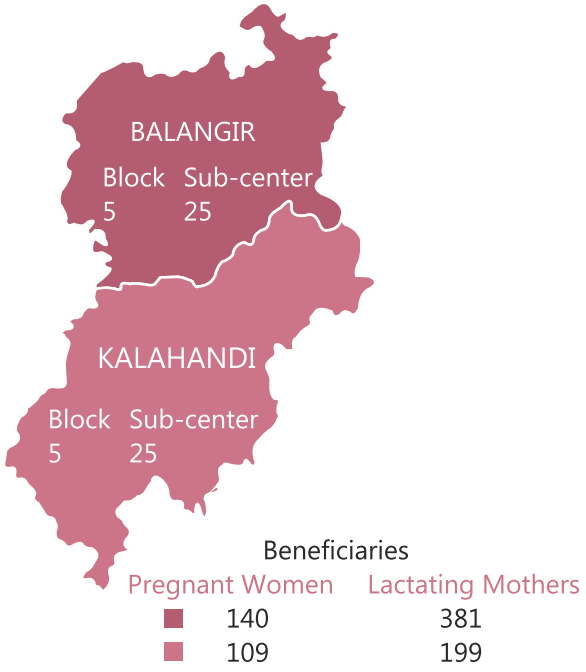
This section deals with the objectives and methodology that have been followed for the present study. Primarily, the study was undertaken by collecting the perceptions of beneficiaries and service providers. The study followed an intensive approach where beneficiaries' i.e. pregnant women and lactating mothers were meticulously interacted with. In addition to this, different agents of public health delivery mechanism such as Sub-Centers, PHCs and CHCs, community institutions i.e. members of panchayati raj institutions and Gaon Kalyan Samitis (GKS) were interacted with and a key programme i.e. Village Health Nutrition Day (VHND) was observed closely. As the front line health workers i.e. ASHAs, ANMs and AWWs are playing an important role in improving community health, they were also interviewed.

2.1 Objectives

- To understand the schemes and programmes on maternal and child health such as JSY, JSSK, BKKY and MAMATA and their coverage in the tribal pockets.
- To analyze the level of awareness and pertaining issues regarding nutrition, hygiene and sanitation in the context of safe motherhood.
- To examine the role of institutions i.e. Panchayati Raj Institutions, GKSs, and key programmes i.e., VHND and Prustikar Diwas in addressing MCH.

2.2 Methodology and Sampling

The study was undertaken in two tribal dominated districts i.e. Kalahandi and Balangir of Odisha. Further, from each district five blocks were selected randomly. The blocks that were selected in Kalahandi are M. Rampur, T. Rampur, Narla, Golamunda and Junagarh. Similarly, the blocks that were chosen in Balangir are Agalpur, Loisingha, Deogaon, Balangir and Gudvela. Further, from each block 5 sub-centers were chosen. By considering the time constraint, geographical locality and feasibility, 829 women beneficiaries i.e. 580 lactating mothers and 249 pregnant women were interviewed on the basis of random and purposive sampling. Of them, the lactating mothers were interviewed about their child's health.



2.3 Sources of Data

For the present study, data was collected from both primary and secondary sources. To obtain data from primary sources, tools like interview schedules, questionnaires, observations, case studies, focused group discussions, key informant's interviews were used. In the context of secondary sources, data were collected from NFHS-4, SRS, Census 2011 and WHO.

2.3.1 Data Collection Tools

Though the study relied basically on primary sources, different data collection tools were employed to get the data. They are:

- On the basis of objectives, at first interview schedules were developed for the beneficiaries. The schedules were semi-structured where both open ended and close ended questions were included;
- Besides this, some focused group discussions were also carried out with the local community in general and the women beneficiaries in particular;
- A set of interview schedules was also prepared for the ASHA, ANM and AWW regarding their involvement in MCH related issues and Govt. implemented programmes;
- A set of interview schedules was prepared for the PRI members such as the sarpanches, ward members, naib sarpanchs etc. including the members of GKS committee and Panchayat's Health standing committee members;
- A set of questionnaires was prepared for the medical officers and pharmacists;
- Along with this, some case studies were also collected where women beneficiaries expressed their perceptions on the existing grass roots issues and some corrective measures were also suggested by them;
- Non-participant observation method was also followed to observe the VHND, dietary practices of both pregnant women and lactating mothers, MCH cards, Red Cards etc.
- To ensure error free data collection, mobile based technology was adopted for primary data collection.

2.3.2 Time Frame of the Study

- The present study was completed within four months (December 2017 -March 2018).

2.3.3 Limitations of the Study

The present study has its own limitations too. As discussed above, the study was conducted within four months only. During the initial phase, it was targeted to cover 1000 women beneficiaries. However, due to time constraints, scattered geographical region, improper road connectivity and unavailability of beneficiaries, the study could only cover 829 beneficiaries into the sample frame.

Chapter - 3

Effectiveness of Schemes and Programs

3.1 Awareness and Access of MCH Schemes

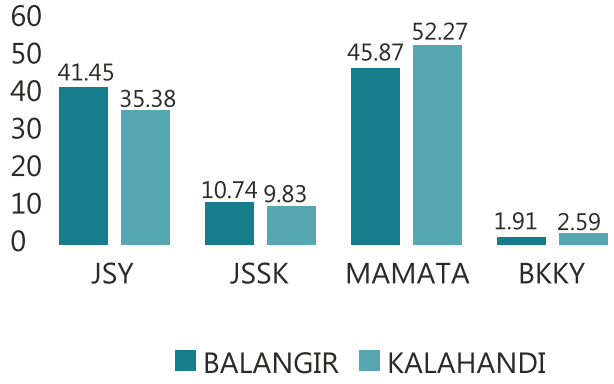
Taking note of the status of maternal and child health issues of the nation as a whole the Ministry of Health and Family Welfare has introduced several schemes and programmes on a regular basis. It was also felt that the degree of MMR and IMR could be contained within a specified time period by escalating accurate and healthier delivery care (Jahn and De Brouwere, 2001). Again, nine high focus states (i.e. Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand) with high fertility and mortality were also focussed upon to reduce the MMR and IMR by employing their own strategies. Several initiatives such as Janani Suraksha Jojana (JSY) and Janani Sishu Suraksha Karyakram (JSSK) were launched by the Government of India and the states are acting as implementing agencies. These schemes are being introduced under the National health Mission (NHM) by setting the goal to reduce MMR and IMR.

In the context of Odisha, the Dept. of Women and Child Development (WCD) is also trying to reduce the MMR and IMR. In addition to NHM's maternal benefit scheme, the department of WCD has also introduced MAMATA scheme for the pregnant women and lactating mothers of 19 and above age group. Even within the gamut of NHM, the state Govt. is running a health insurance scheme (i.e. BKKY) particularly meant for the farmer's community. As mentioned in chapter-1, the insurance scheme is providing maternity benefit and new born care to the farmer's family, where they can avail up to Rs. 30,000 in a year.

3.1.1 Level of Awareness about the Schemes

The ground reality is depicting an entirely different scenario. The present study shows that, the scheme-related awareness among the beneficiaries of both districts is not that widespread. Of all the schemes, around half of the beneficiaries of both districts are well aware about MAMATA scheme, followed by around only 40% awareness on JSY scheme. While awareness regarding the JSSK scheme is very poor, at the same time BKKY which is only meant for the farmers family is not so well-known among the communities.

Figure 3.1 : Level of Awareness



Inadequate awareness obstructs MCH schemes' functionality...

The basic objectives of the MCH schemes could be achieved if people are aware and have access to it. In the present study, it was observed that there is absolutely no awareness about BKKY scheme. On the contrary, schemes (JSY & MAMATA) that are providing monetary benefit are somehow recognized by the beneficiaries.

3.1.2 Registration of Beneficiaries

In both the districts almost all the women beneficiaries are accessing registration facility. In addition to this, majority (i.e. 59.42%) of the respondents have registered for pregnancy within two months of their pregnancy.

Table 3.1 Registration of Pregnancy

Particulars	Balangir	Kalahandi	Overall
Time period of Registration			
Within 2 months of pregnancy	61.66	55.59	59.42
Within 3 months of pregnancy	30.83	31.58	31.11
Within 6 months of pregnancy	7.51	12.83	9.48
Overall Registration for Pregnancy	99.62	98.7	99.28
Prevalence of Bribe	6.91	7.47	7.12

Source: Field Study

However, beneficiaries of Balangir district are accessing the registration process bit more in comparison to Kalahandi district. But the overall scenario of both districts is 99.28 percent which indicates a positive sign in terms of registration of pregnancy. Some beneficiaries (7.12 percent) reportedly have engaged in unethical practices either with the ASHAs or with the ANMs for registration.

3.1.3 Access and Outreach of JSY

As discussed in chapter-1, the objective of JSY is to promote institutional delivery by providing monetary assistance to the beneficiaries. In the present study, it is evident that 91.68 percent beneficiaries are having JSY-MCH Cards and 92.07 percent women have preferred institutional delivery. Only 7.93 percent women had their home deliveries owing to different circumstances, such as improper roadways, unavailability of vehicle at the time of delivery etc. Preference of public health institutions for delivery (92.88 percent) is playing a key role. But getting the cash assistance for institutional delivery is a serious matter to look into. Out of the 580 lactating mothers interviewed, only 47.41 percent women availed the cash assistance of JSY. As per the scheme, the money should be transferred to the beneficiaries' accounts within 7 days of delivery. But it was found that, the average time taken to release the assistance is 2 months and 11 days.

Particulars	Balangir	Kalahandi	Overall
JSY Card Holder	92.32	90.58	91.68
Place of delivery			
Institutional delivery	95.80	84.92	92.07
Public institution	92.88	92.9	92.88
Private institution	7.12	7.10	7.12
Home delivery	4.20	15.08	7.93
Cash Assistance			
Cash Assistance after delivery (Lactating mother)	48.82	44.72	47.41
Average time taken			
Average time taken to receive cash assistance after delivery	2 months 17 days	1 months 27 days	2 months 7 days

The situation is not the same for everyone. Even after 2 years of delivery some beneficiaries are still struggling to get the assistance. In this regard, the Medical Officer (MO) of a CHC was approached to find out the reason. As per the MO, the generation of MCTS/RCH number usually takes time and takes up to 3 months and in some cases this number is not generated even after the delivery. The sole reason responsible for this delay is the unavailability of identity cards such as Aadhar, Voter Id etc.

Voices from the ground:
Irregularity in getting JSY benefit

I have opened the bank account to get the monetary assistance. I had my delivery at Deogaon CHC. I received Rs. 5000 as a beneficiary of MAMATA scheme. Now my child is two and half years old and I am yet to receive Rs. 1400 from the JSY scheme which I am supposed to get within seven days of delivery. I asked ASHA Didi about this in-discrepancy but she is clueless.

Basanti Banchhor
Deogaon, Balangir

3.1.4 Access, Awareness and Outreach of JSSK

JSSK was introduced by the Govt. of India to pull out all kinds of user charges at the time of institutional delivery and also to end high out of pocket expenditure. The scheme has several dimensions (See Chapter-1, Page No. 3 & 4). In the present study, both access and outreach are not garnering much focus due to tiny information of the multifarious scheme.

Table 3.3 Access and Outreach of JSSK Scheme

Particulars	Balangir	Kalahandi	Overall
Free transportation during delivery	36	27	33
Free drop back after delivery	28	25	27
Free and cashless delivery	34	28	32
Delivery Performed by			
Doctor	24	21.92	23
Nurse	71.80	63	68
Others (Family member, ANM, ASHA)	4.72	16.08	8.62
Delivery Type			
Normal	82	92	85
C-section	18	8	15
Mean time Stayed at hospital after delivery			
Normal	5.30hr	4.30hr	5hr
C-section	5days 9hr	6days 19hr	5days 15 hr

As per the above table, in both districts the percentage of transportation during and after delivery is very low. However, transportation during delivery is a bit high in Balangir district i.e. 36 percent. But free drop back is very less in both the districts. In case of free and cashless delivery only 32 percent beneficiaries availed it. As per the opinion of other beneficiaries, at the time of delivery nurses are demanding money.

Unavailability of human resources is posing a major threat. As per the beneficiaries of both the districts around 68 percent of the deliveries have been conducted by the nurses and only 23 percent of the deliveries have been conducted by the doctors. Some even reportedly prefer home deliveries. It is mandatory for both the mother and child to stay at hospital for at least 48 hours in case of normal delivery and seven days in case of C-section. But this practice is almost nil in both the districts. On an average basis, after delivery the beneficiaries are not staying more than five hours at the delivery point. When inquired, the women beneficiaries started that they got discharged by doctors. In this regard, the following case study of a medical in charge is a value addition. Even in case of C-section, seven days stay is a nightmare.

Voices from the ground

At the time of delivery the doctor was not there and two nurses performed it. They demanded Rs. 1100 without which they said they would not help me out. I was in severe pain. My husband gave the demanded money to the nurses, and then only the nurses performed the delivery.

Janani Bariha,
Lousingha, Ba angir

Voices from the ground

As per JSSK Scheme, the budget for a beneficiary's per day diet is Rs. 50-55. It is tad difficult for us to provide entire day's diet including breakfast, lunch and dinner within this prescribed amount. Even the beneficiary's attendees are also demanding food for them. In this kind of situation we prefer to discharge the new born baby and mother within hours of delivery.

Said by
a Medical Officer of a CHC

3.1.5 Access and Outreach of Scheme MAMATA

Taking cognisance of the close knit connection between maternal nutrition and pregnancy outcomes, the scheme MAMATA was introduced by the state Govt. The primary objective of this scheme is to improve the poor nutritional status during pregnancy and help mothers not to resume work immediately after delivery which leads to neonatal morbidity along with neonatal and perinatal mortality. To address this objective, an amount of Rs. 5000 was set to release to each beneficiary in four installments. To receive the first installment, it is mandatory for each beneficiary to fulfill five criteria i.e. registration of pregnancy, at least one antenatal check up, receipt of IFA tablets, TT vaccination and receipt of at least one counseling session at AWC or on one of the Village Health and Nutrition Days (VHND).

In the present study, it is clearly evident that, out of 829 respondents, 498 (60%) registered under MAMATA scheme. Of the registered beneficiaries, 480 (57%) beneficiaries received antenatal checkups, 489 (58.9%) received IFA tablets, 490 (59.1%) received TT vaccination and 437 (52.7%) received counseling sessions.

Table 3.4 Criteria Followed for 1st Installments of MAMATA

Indicators	Balangir	Kalahandi	Grand Total
Registration under MAMATA Scheme	416	222	498
Received Antenatal check-up	301	179	480
Received IFA Tablets	308	181	489
Received TT Vaccination	311	188	490
Received Counseling Session	282	155	437
Place of Receiving Counseling Session			
AWC	146	93	239
Home	88	38	126
VHND	48	24	72

Counseling plays an important role in the context of maternal and child death. As per the guidelines, a mother should attend at least one counseling session either at the AWC/home/during VHND. In the present study it is clearly evident that, out of 498 MAMATA beneficiaries, 437 beneficiaries attended counseling sessions. In addition to this, majority (54.46%) respondents received counseling sessions at Anganwadi centers followed by 28.83 percent at home and 16.47 percent during the VHND. Likewise, there are certain rules to be followed to get the second installment of MAMATA scheme. As per the guidelines, a lactating mother is eligible to get the second installment after three months of delivery and only if she follows six prescribed conditions.

Objective of scheme MAMATA is at crossroads...

It was observed that, out of 580 lactating mothers interviewed, only 339 (58.44%) beneficiaries have done the birth registration of their children. Others are not aware about registration. At the same time, BCG vaccination, Polio-1 and Polio-2 vaccinations are also not very popular among the beneficiaries.

Table 3.4: Criteria Followed for 2nd Installment of MAMATA

Indicators	Balangir	Kalahandi	Grand Total
Registration_of-child_birth	219	120	339
Child_received_BCG_vaccination	242	141	383
Child_received_Polio1	239	133	372
Child_received_Polio2	232	121	353
Child_weighed	222	115	337
Mother_attended_IYCF_counseling	184	82	266

Infant and Young Child Feeding (IYCF) counseling sessions are very important for every lactating mother to get enough knowledge regarding nutrition for mother and child, exclusive and continuous breast feeding, complementary feeding etc. It was found that out of 580 lactating mothers, only 266 (45.86%) beneficiaries attended IYCF counseling. Of them, majority (24.82%) of the beneficiaries got the counseling from the ASHAs followed by 12.7 percent from ANM and 8.2 percent from their respective family members.

Table 3.5: IYCF Counseling of Beneficiaries

Counseling on Child/infant Health	Balangir	Kalahandi	Grand Total
ASHA	103	41	144
ANM	44	30	74
Elder_family_member	37	11	48
Total	184	82	266

The prevailing situation in both the districts clearly indicates that, there is a need of proper capacity building of the front line health workers to create awareness on the prescribed norms of IYCF.

3.2 Some other prevailing difficulties

Various difficulties such as (a) in accessing the cash assistance; (b) unavailability of ambulance; (c) prevalence of undue money during registration of pregnancy and delivery; (d) unavailability of mobile health units; (e) unavailability of maternity home; (f) unavailability of specialized doctors etc. have been faced by the beneficiaries during pregnancy and after delivery as well.

3.2.1 Difficulties in availing cash assistance is a persisting issue

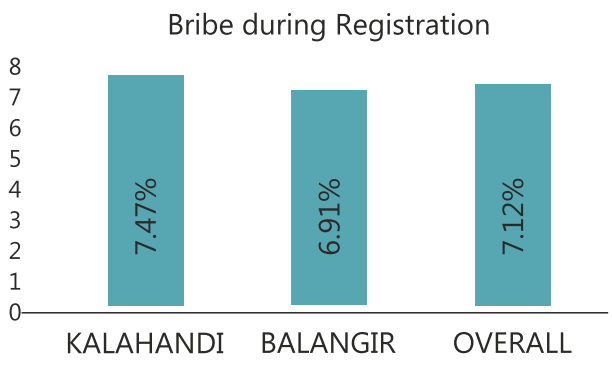
As per the opinion of some of the respondents, they are facing difficulties in getting the cash assistance of JSY and MAMATA. In this regard lack of awareness regarding the process of having bank account is a major issue. Even no one is accompanying a beneficiary during the process. One of the major issues associated is the unavailability of required documents such as Pan Card, Aadhar Card and Voter Id.

Table 3.6: Issues Associated with Bank Account

Particulars	Balangir	Kalahandi	Overall
Having bank account	91.17	88.64	90.23
Average No. of visit to bank to open account	2.32	2.94	2.54
Average distance of home to bank	8.52	8.75	8.60
Average cost involved to open a bank account	159.95	169.87	163.57

3.2.2 Prevalence of mal practice creates discontentment among the community

Prevalence of unauthorised money claims during registration of pregnancy and delivery is creating discontentment among the community people. Around 7.12 percent beneficiaries expressed that they were asked to pay such undue money during registration of pregnancy either by ASHAs or ANMs.



Chapter - 4

Nutritional Security and Sanitation Measures

It is being considered that, if women are not well nourished, they are more likely to give birth to weak babies resulting in high infant mortality rate. Hence nutrition needs a special focus all through the period of pregnancy and breastfeeding. But this aspect is often neglected. To address this issue, the Govt. of India has initiated Supplementary Nutrition Programme under ICDS. As per the said programme, Take Home Ration (THR) is provided to pregnant and lactating women and children from 6 months to 3 years. Even steps have been taken to counsel the pregnant women, lactating mothers and their respective family members to take care of the food habits.

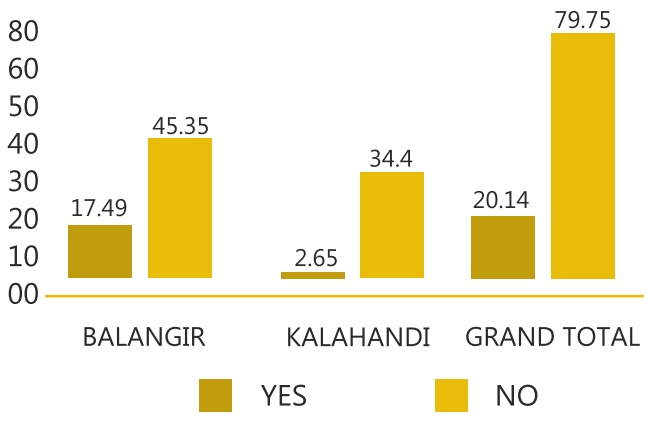
4.1 Take Home Ration (THR): Current Provision

As per THR per head ration cost is Rs. 7 for pregnant and lactating mothers, Rs. 3 is for normal children under 3 years of age and Rs. 9 is for severely malnourished children. In addition to this, the Govt. of Odisha has decided to give ready to eat i.e. wheat based chhatua in form of THR to the beneficiaries.

In the present study, the women beneficiaries were asked whether there is any change in food habits during pregnancy and dishearteningly majority of them didn't report any change in their food habits. They continued to take their usual food even at the crucial phase of their life. In total 79.75 percent beneficiaries did not change their food habits and only 20.14 percent beneficiaries have taken some healthy diets.

Of them, only 2.65 percent beneficiaries of Kalahandi district have adopted some change in their food habits and 34.4 percent beneficiaries have not gone through any dietary changes. However, in Balangir district 17.49 percent beneficiaries reportedly changed their food habits and added some healthy diets along with their daily diet. Majority of them i.e. 45.35 percent did not adopt any change in their dietary practices. The respondents who changed their dietary practices started taking leafy vegetables, milk, cereals, kandul dal, chicken, egg and meat

Figure 4.1: Change in Food Habit



along with their regular food. Of the 20.14 percent beneficiaries, 7.14 percent beneficiaries of Kalahandi district and 1 percent beneficiaries of Balangir district took *Mandia jau* (boiled Ragi) as their main food during pregnancy and lactating period.

In this context, they were asked about the consumption of *Chhatua* which is being provided to them through Anganwadi Centers. Around 47.40 percent beneficiaries are consuming Chhatua that is being provided by Anganwadi Centre.

Rest of the beneficiaries are not consuming chhatua though they are taking it to their home. Different reasons are cited as reasons for not consuming the same. In both the districts, poor quality of Chhatua is the main constraint followed by an irregular supply. As per the views expressed by beneficiaries of both the districts.

- The quality of chhatua is not at all good and many a time they got sand and small stones in it. As a result they stopped consuming.
- Irregular supply is the other reason behind the non-consumption of chhatua.

As discussed earlier the objective behind supplementary nutrition is to take care of the nutritional aspect especially during pregnancy and lactating phase but irregular supply of the same prevents the beneficiaries from fulfilling their nutritional aspect for which the scheme has been designed.

Figure 4.2: Consumption of Chhatua

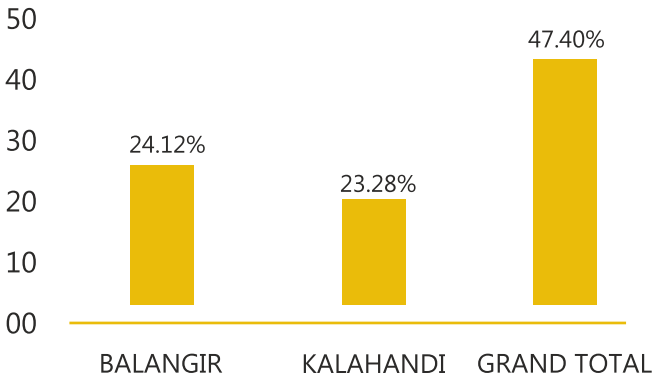
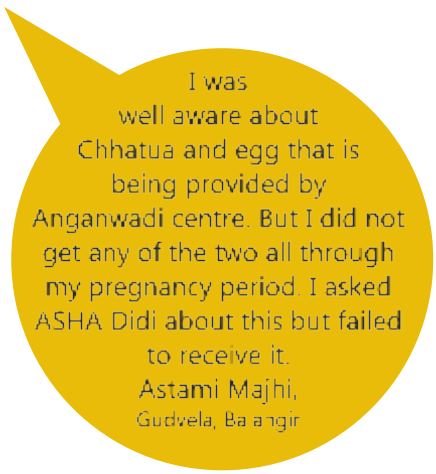


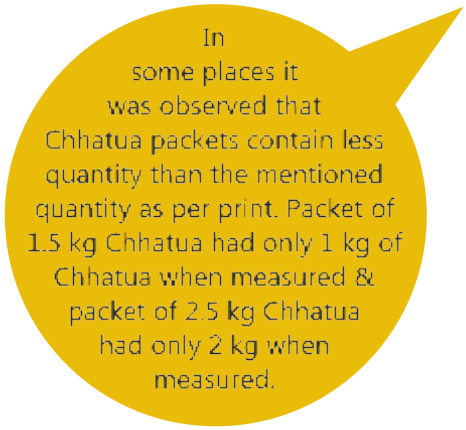
Table 4.1:
Reasons behind non-consumption of Chhatua

Particulars	Kalahandi	Balangir
Poor Quality	11.21	25.45
Irregular Supply	2.65	13.26
Total	13.86	38.71

Note: Figures are in percentage



Voices from the Ground:
Irregularity in supply of Chhatua continues



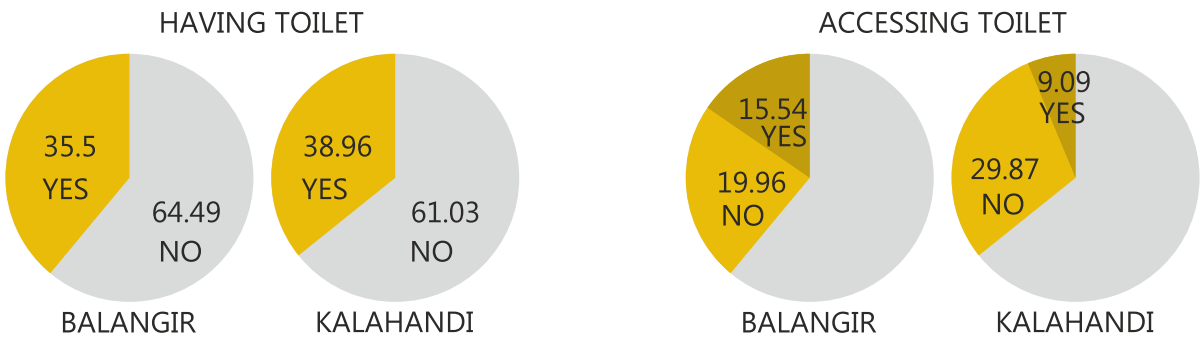
In-discrepancy in the quantity of Chhatua:

4.2 Water and Sanitation Measures

The intake of safe drinking water, adequate sanitation and good hygiene have a direct connection with maternal, new born and child health. Basically, the pregnant women and new born babies are at risk due to their fragile immune system. Some provisions have been made by the Govt. to give an end to the prevailing issues of water and sanitation.

Likewise, Swachh Bharat Mission (SBM) has a special focus on households having pregnant women and lactating mothers. As per the Guidelines, SBM places priority on pregnant women and lactating mothers who are covered by the state or central Govt. sponsored maternal health programmes under the National Rural Health Mission.

Figure 4.3: Availability & Access of IHHL

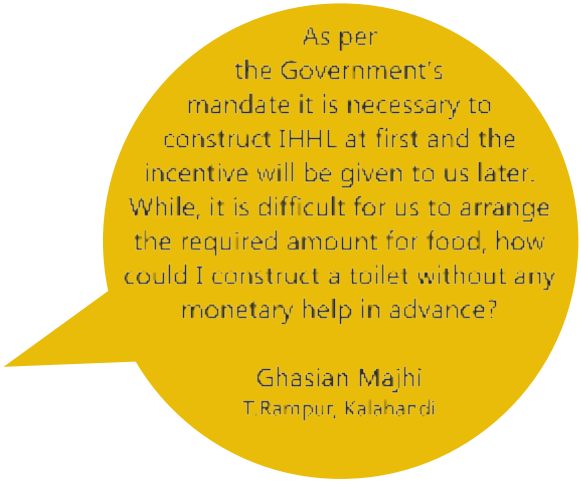


However, the present study depicts an entirely different scenario in both the districts. Both availability and access of Individual Household Toilets (IHHL) are serious issues. As per the findings of present study, only 39.96 percent households of Kalahandi and 35.5 percent households of Balangir district are having IHHLs. Of them, 9.09 percent households of Kalahandi district and 15.54 percent households of Balangir district are accessing their household toilets. Majority of the beneficiary households are yet to have their toilets.

The households who are having IHHLs and not using this have two issues.

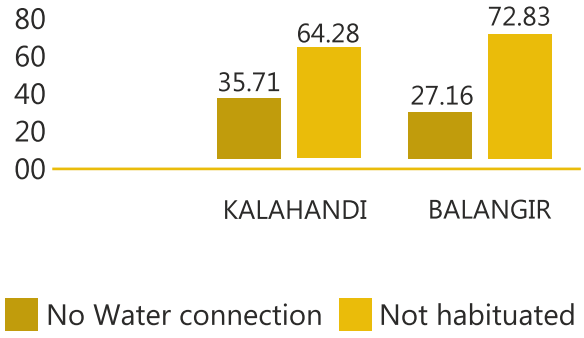
- First, they are not acquainted with the use of toilets and;
- Secondly the unavailability of water restricts them to make use of toilets.

As a result open defecation is very rampant in these districts. The age old practice of open defecation is the primary reason of not using IHHLs although they are having it. For them the unavailability of water within their household premises is also restricting them to use the toilets.



Voices from the Ground

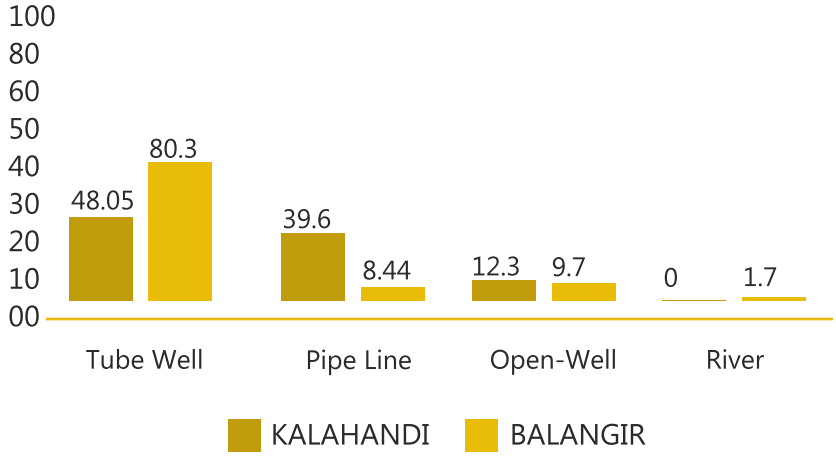
Figure 4.4: Reasons of not using IHHL



Sources of Drinking Water

Safe and clean drinking water is obviously essential for a healthy human being. The need for clean and safe drinking water is not only necessary for good health and sanitation, it also embraces an extensive economic impact on a community (Gerry, 2016). The present study shows that majority of beneficiaries from both the districts are taking drinking water from tube wells. Pipe line water connection has comparatively better coverage in Kalahandi district than Balangir. Around 1.7 percent in Balangir district have the practice of drinking river water as they do not have any other option.

Figure 4.5: Sources of Drinking Water



[1]Gerry, 2016, The Importance of Clean drinking Water, Norland International. Accessed from https://www.norlandintl.com/the-importance-of-clean-drinking-water/

Chapter - 5

Institutional Role and Social Accountability

Section-1: Institutional Role

Maternal and child health is one of the primary concerns in the Sustainable Development Goals (SDGs). India, taking cognizance of the SDGs, has redesigned various schemes and programmes and has also launched a few others. The success of these schemes and programmes depend entirely on the quality of services, of implementation strategies, of agents and infrastructure and of management as well as on proper coordination and planning among the implementing agencies.

This study closely examines the roles and functions of Sub-Centres, PHCs, and CHCs, in ensuring effective maternal and child healthcare. As per guidelines of the JSSK scheme, the primary delivery point for such health care, in rural areas, is the Sub-Centre. That is why the study involved close interactions with ANMs and AWWs at Sub-Centers chosen for field visits. Surprisingly, in both the districts, not a single Sub-Center is actually functioning as a delivery point for expecting mothers. Instead, all the beneficiaries contacted as part of the study said they prefer either the CHC or the District Headquarter Hospital (DHH) for their deliveries, preferring to avoid even use of PHCs.

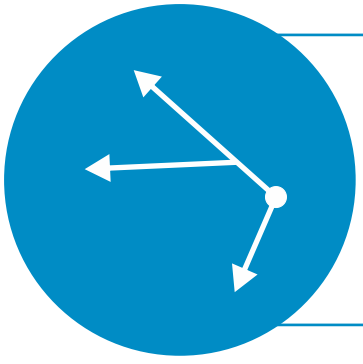
Unavailability of doctors along with facilities force beneficiaries to prefer PHC

Voices from the ground:

I delivered my babies in Loisingha CHC. All my neighbors and even ASHA Didi advised me to choose the CHC. A PHC is nearer to our village but no doctor is available all through the day. The PHC even lacks a labour room. So, not a single woman prefers to go there for delivery.

Lata Bariha,
Badibahal, Balangir

Absence of required infrastructure forces people to travel far to access proper medical care during child birth. That is why CHCs have become the grass root level delivery points.



In Arjunpur village of Degaon block, there is a PHC within the village but un-availability of electricity and water supply is restricting beneficiaries to make use of the facility. As a result, beneficiaries prefer to go either the DHH Balangir which is around 20 kms away from this village or Luisingha CHC which is again 12-15 kms away from this village.

Authorities at the DHHs or CHCs are finding it difficult to accommodate patients due to the following issues:

- Lack of human resources
- Lack of basic facilities within institutions
- Poor monitoring and supervision

5.1 Human Resource

For this study, to get a sense of the human resource situation, interactions were held with various staff members of chosen PHCs and CHCs. Emphasis was laid on meeting Medical Officers (MOs) of these institutions. The MOs and other staff members (in some CHCs) complained about inadequate human resources. They cited this as the main reason that prevents PHCs from becoming delivery points; despite increasing number of pregnant women seeking institutional delivery services; despite clear guidelines that PHCs should be focal points for these; and despite the availability of required facilities. Addressing this situation requires human resource inputs in form of medical specialists, gynecologists, pediatricians, paramedics, pharmacists, sanitation support workers, and managerial staffs.

In the absence of these health personnel, in actual practice, these PHCs are only providing treatment for minor illnesses. The study found not one delivery had been carried out in any PHC of Balangir district, while in Kalahandi district too, the same situation prevailed, except for Barabandha PHC (N), where the MO said some normal deliveries had taken place. All sampled CHCs were managed by a single MO, except Luisingha CHC, where a gynecologist is also posted. However, at the time of interaction with the MO, the gynecologist was on maternity leave. So, even Luisingha CHC was being managed by the MO.

Inadequate human resource is hindering quality delivery of services

Voices from the ground:

"Shortage of sanitation support staff, female attendants, and doctors, particularly a gynecologist, is the main reason for poor quality delivery of services of my CHC."

Said by a Medical-Officer
of a CHC, Balangir

The common human resource issues observed were as follows:

- A single medical officer was posted as against the sanctioned strength of three, thus leading to overburden of work and job responsibilities;
- Lack of adequate paramedical staffs is posing a major threat while conducting deliveries;
- The criteria for "cleaning staffs on call basis" are creating serious problems for cleanliness.

5.2 Basic Facilities within Institutions

Proper execution of maternal and child health programmes depend on adequate logistical support in the form of labour rooms, instruments for labour room, new born care corner, emergency delivery kit, essential medicines, beds in delivery wards etc. The study revealed that while all CHCs are equipped with a labour room, instruments for the labour room, new born care corner, separate toilets for males and females, essential medicines, and separate delivery ward, there are still matters of concern in form of the unit of labour room, where CHCs have a single labour room, with one or two tables only, and poor cleanliness. Hospital authorities find themselves inadequately equipped to handle emergency cases.

Shortage of bed creates challenge for delivery

Voices from the ground:

A minimum of 30 beds are necessary for our delivery ward. At present only 6 beds are there. This poses severe challenges on many occasions.

Said by a Pharmacist at a CHC

Unavailability of cleaning staff challenges cleanliness

Voices from the ground:

Toilets and labour rooms are not properly maintained. Basically two reasons are responsible for this i.e. (a) non-availability of cleaning staff and (b) inadequacy of water. Our CHC is having just one sanitation support staff. He comes for cleaning on call basis. Even water facility is not available round the clock.

Said by a Pharmacist of a CHC

5.3 Monitoring and Supervision

Monitoring and supervision are important aspects to check effectiveness of existing schemes and programmes. As per the JSY scheme, every CHC needs to display names and the date of disbursement of financial assistance on its notice board. Some CHCs of Balangir district i.e. Chudapalli and Luisingha are doing this. But other CHCs of Balangir and Kalahandi districts are not following this norm. Similarly, field visits by the MO, that is very important to supervise the effectiveness of, and discrepancies in, existing programmes are infrequently done.

Voices from the ground:

I rarely make visits for supervision of any MCH scheme. I am the only medical officer at the block CHC and there is always a patient overload.

Said by a Medical Officer of a CHC

Grievance redressal mechanism is a must for improvement of any scheme or programme. The beneficiaries are encountering several issues too. Yet, the absence of any grievance unit makes it difficult to put across any kind of grievance. However, the MOs of concerned CHCs often generously take up grievances themselves. The common grievances are those relating to:

- Lack of on-time availability of ambulance and Janani Express;
- Delay in getting the financial assistance of JSY and MAMATA and;
- Unhygienic condition of toilet.

Section-2: Social Accountability

Social accountability is an approach to ensure the accountability of stakeholders regarding emerging social concerns and priorities. In the context of maternal and child health the stakeholders include service providers, receivers, implementing agencies and the community. In rural areas, as per the 73rd Constitutional Amendment, functions related to the provision of primary health care, including maternal health and family welfare, is the responsibility of PRIs. The Reproductive Child Health (RCH) Policy, of Government of India, emphasizes greater accountability of PRIs at the grass root level. Even the 14th Finance Commission has provided flexibility to Gram Panchayats to include health issues in their Gram Panchayat Development Plan (GPDP).

In this study, the participation and accountability of stakeholders was closely observed, and some of them, from among the front line health workers, i.e. Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), and Anganwadi Workers (AWWs), PRI members, members of GKS, and members of health standing committee were interviewed. Based on the observations and interviews, this section assesses the extent to which the front line health workers, PRI members, health standing committee members, and GKS members are able to discharge their responsibility of reducing the incidence of maternal mortality and infant mortality.

5.4 Front Line Workers (FLWs)

Front Line Workers (FLWs) are the accountable Government personnel to implement manifold health activities at the grass root level. In order to reach the outreach mass, the FLWs such as the Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs) and Auxiliary Nurse Midwives (ANMs) are trained on different vertical health programmes of the state. Alongside, it is imperative to keep an eye on their activities at the community level which they are supposed to accomplish. In addressing the MCH programmes of the state, there is a specific role of these FLWs in every schematic guideline of the state and center.

- In the present study, it was found that all the FLWs are doing extremely well in identifying the beneficiaries and registration of pregnancy. In Chapter-3 (Table 3.1) it was clearly mentioned that, 99.28 percent beneficiaries have registered for pregnancy. At the same time, 7.12 percent beneficiaries reportedly have paid undue money for registration of pregnancy.

Money is unduly being demanded by some ASHA for registration of pregnancy

Voices from the ground:

ASHA Didi asked Rs. 50 for registration of my pregnancy. She said it is compulsory for all to provide this amount for registration.

Mamita Bag, Gudvela, Balangir

- Awareness about JSY and MAMATA provisions among the community is greater as they provide monetary assistance. On the contrary, awareness on JSSK is very poor among beneficiaries, as well as even among ASHAs. However, there is greater awareness about ambulances and about Janani Express service. The study found a little over 29.7 percent beneficiaries availed Ambulance/Janani Express at the time of delivery, all of whom gave the credit to ASHAs for helping avail these. However, the statistics also indicates that a majority of respondents are deprived of these services. The ASHAs cited two reasons for this; (a) shortage of ambulances to meet the peak need; and (b) poor road quality rendering some places unapproachable for ambulances.

Infant mortality is high due to LBW and septicemia

Voices from the ground:

Once I called the ambulance immediately after getting information about a woman experiencing labour pain.. But it reached late and the woman delivered her baby at her home. Some hours after delivery, the baby developed some unusual complications and we took her to hospital. The baby died the same day due to low birth weight (LBW) along with septicemia.

Lily Sahoo, ASHA, Deogaon, Balangir

These types of cases were also found in Kalahandi and other blocks of Balangir district. While the unavailability of ambulance compromises mothers' and new born babies' chances of survival, deaths are also a result of LBW and septicemia. One has to be circumspect about ascribing a cause-effect relationship to merely one factor.

- As per the JSSK scheme, there is a free drop back after delivery. But the study found only 27 percent beneficiaries availed free drop back. Others are not aware of this facility. Greater initiative by FLWs could have helped improve the situation.

5.5 PRI Members

PRI representatives such as Sarpanches, Naib Sarpanches, and Ward members were spoken to about their ongoing work and also their action plan for current financial year. Of the activities undertaken by their initiative, the common ones they cited are:

- Construction of bathing ghats and changing rooms near village ponds;
- Construction and maintenance of roadways;
- Supply of drinking water through pipe line connection;
- Cleanliness of village.

All these are welcoming steps by PRI representatives and will definitely help improve the health status of the villages. But in context of maternal and child health no specific agenda is prepared to address the issue. Even Health Standing Committees are non-functional at the Panchayat level.

Non-functional Health Standing Committees persist at the Panchayat level

Voices from the ground:

In our Panchayat, we have a Health standing Committee. In total, 11 members, 6 females and 5 males, are there in this committee. But the members do not come for any meeting nor are they undertaking any activity.

Bhagbati Nag, Sarpanch, Arjunpur Panchayat, Deogaon

Chapter - 6

Policy and Implementation Bottleneck

Implementation is a stage of policy making between the establishment of a policy and the outcome of the policy for the people whom it influences (Edwards, 1980). Associated with multifarious procedures such as accessibility, availability, outreach, awareness etc, it was observed that policy implementation is one of the major problems in both the districts. The maternal and child health policies have been designed well and with great care but activities that are needed to establish the policies are missing.

Primary Health Care Institutions Are Not Able to Impart Proper Health Care Services

- Lack of adequate number of cleaning staffs, female attendants and specialized doctors, especially gynecologists, is a major hurdle in ensuring good quality delivery services.

  In addition to this, insufficient labour rooms, ambulance services, and inadequate beds in maternity wards are posing serious challenges in implementing MCH programmes.

Low Awareness Hinders the Accessibility of MCH Schemes

- Schematic awareness is extremely responsible behind little access of MCH schemes. The beneficiaries of both the districts are having modest awareness regarding the benefits of MCH schemes which obstructs the outreach of the schemes. A fair awareness exists on JSY and MAMATA as they are providing cash benefits.

Front Line Workers (FLWs) Need to be More Strengthened

- The FLWs are trained on different vertical health programmes of the state. But it was found that, they are not able to impart the required service to beneficiaries who lack awareness regarding the government schemes, programmes, the facilities they should be providing, the nutritional aspect of mother and child and the need of sanitation measures etc.

Institutions are Obsolete in Addressing MCH Issues

- Panchayati Raj Institutions, Panchayat's Health Standing Committee and Village Health and Sanitation Committee/ Gaon Kalyan Samiti are not active agents in addressing the health issues of their concerned panchayats and/or villages.

Nutrition is Still A Matter of Concern

- Malnutrition is still a challenge in both the districts. High risk mothers are being identified by the front line health workers and yet situation is not getting under control. Even the supplementary nutrition programme is failing to improve the nutrition of the beneficiaries i.e. mother and child, due to poor quality and irregular supply of *Chhatua* and egg.

Poor Sanitation Practices Continues

- Both availability and access of Individual Household Toilet (IHHL) are serious issues. Majority of the beneficiary households are yet to have their household toilets. The beneficiaries say the reason behind the unavailability of IHHL is Government's mandate to construct IHHL at first and to provide incentive amount to them later. On the contrary, those who have their IHHL are not using it, as they not habituated to use this.

Low Quality Village Health Nutrition Day (VHND) Continues

- No proper health check up is done during the VHNDs.

Annexure

Indicators	Findings
No. of pregnant and lactating mothers	829
No. of lactating mothers	580 (70%)
No. of pregnant women	249 (30%)
Average age of the respondents	25
Literacy of Respondents	
Graduates	13 (2%)
Higher Secondary	68 (8%)
Matriculate	244 (29%)
Middle class	158 (19%)
Primary	133 (16%)
Literate	56 (7%)
Illiterate	158 (19%)
Reproductive health (Age at Marriage)	
Less than 18 years (<18 Years)	161 (19%)
More than or Equal to 18 Years (>=18 years)	668 (81%)
Average birth weight of child	2.68Kg
Average weight of mother during delivery	49.87Kg

Indicators	Balangir	Kalahandi	Overall
Average weight of mother during pregnancy (in Kg)	50.19	49.27	49.87
Average mother's weight below 50Kg during pregnancy(%)	44.62	49.75	46.38
Low weight birth babies (less than 3Kg) (%)	67.98	76.38	70.86
Changes in diet intake (%)	27.83	7.14	20.14
Use of alcohol (%)	1.54	4.89	2.78
Use of tobacco (%)	7.29	10.39	8.44
Use of mosquito net (%)	99.42	97.40	98.67
Households having ration card (%)	78.50	74.03	76.84
Households having toilet (%)	35.51	38.96	36.67
Household's accessing toilet (%)	15.54	9.09	12.51

ODISHA STATE TREATMENT FUND OSTF

POLICY BRIEF

ChALLENGES aND OpPORTUNITIES

This policy brief is an attempt to understand various types of challenges associated with effective implementation of Odisha State Treatment Fund (OSTF). Till date, there has been limited information available in the public domain on OSTF, which is considered as a successful health care financial protection scheme for the poor. The policy brief is an attempt to;

- Understand the financial protection health care schemes and programme in Odisha.
- Analyse the state assured financial protection health scheme – OSTF
- Identify the implementation challenges and provide suggestive measures for improvement of the scheme.

Despite of its well articulated nature, some setbacks are triggering in the process and approach of OSTF. The major issues and challenges have been identified and some mechanisms are suggested for wider and hassle free implementation of OSTF.

Introduction

Health is a fundamental human right and basic need for a better quality of life. It has been recognised by the government in several plans and policies. The 12th Five Year Plan targeted a long-term goal of Universal health coverage where "each individual would have assured access to a defined essential range of medicines and treatment

World Health Organisation (WHO), define Universal Health Coverage: "Ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services".

at an affordable price, which would be entirely free for a large percentage of the population. The National Health Policy 2017 which is in tuned with Sustainable Development Goal (SDG)-3 emphasises on universal access to good quality health care services without anyone facing financial hardship as a consequence.

Based on the NSSO's 60th round data, the Government of India has presented a set of estimates related to Out Of Pocket Spending (OOPS) in medical care for all Indian states in its report on National Health Accounts. The key estimates for Odisha and India (for 2004-05) are:

- Total estimated OOPS on all types of medical care in Odisha was ` 27.55 billion. This was roughly 80% of total health expenditure – much higher than national average of about 71%.
- Medicines account for the major share of OOPS in public hospitals (72.6% in rural and 77% in urban areas). This is also much higher than national average (66.5% and 62% respectively).
- About two-thirds (65.4%) of total OOPS in the state (i.e., ` 27.55 billion) was attributable for Outpatient care, followed by 27% to inpatient care, and about 3.4% to birth deliveries. The ratios were more or less the same for all states taken together.

A recent study by Technical Management Support Team (TMST), Odisha in the year 2011-12, showed that the OOPS for common ailments was Rs 2,041 and Rs 3,562 for trauma and other ailments. The share of drugs in total OOPS for inpatient care was 53%, whereas it was 48% for outpatient care in Odisha. It was also estimated that about 5% of all households in the state fell below

Issues and Challenges of Primary Health Care Facility

Perception of Service Providers and Beneficiaries in Balangir and Kalahandi Districts of Odisha

OBAC Odisha Budget and Accountability Centre

OBAC, working on budget research, budget literacy and its process, evidence based advocacy for pro-poor budgeting and policy practices, has been operating in the State since 2003 as a constituent unit of CYSD. The centre promotes accountability tools like Community Score Card, Citizen Report Card, Social Audit, Expenditure Tracking and community led monitoring for enhancing the effectiveness of public service delivery and encourages participation in decentralised planning and budgeting in Odisha. The centre has been holding Pre-Budget Consultation since 2007 on a sustained basis.

The key areas of the centre are:

- Macro State Budget Analysis
- Social Sector Budget Analysis (Health, Water & Sanitation, Food & Nutrition Security, Education, Social Security)
- Budget for Disadvantaged groups (Women, Children, STs & SCs)
- Agriculture and Livelihoods
- Decentralized Planning & Budgeting
- Citizen Led Accountability of basic services (PDS, ICDS, Maternal Health, Water & sanitation etc)

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