India’s country experience in addressing social exclusion in maternal and child health

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Executive Summary

In the Indian context, caste may be considered as the most important indicator of social exclusion and broadly as a proxy for socio-economic status and poverty. In the identification of the poor, Scheduled Caste and Scheduled Tribes and in some cases the Other Backward Castes are considered as socially disadvantaged groups and such groups have a higher probability of living under adverse conditions and poverty. The available data suggest that the marginalized sections such as Scheduled Castes/Scheduled Tribes and the other backward Castes who are also the poor in India suffer from a ‘social gap’ in terms of health status and health services. The Government of India and the state governments in India have undertaken specific measures to address the problem of exclusion and to overcome the problems of accessibility and availability of MCH care to the excluded populations. This paper present some of the key initiatives that have been undertaken and the potential implications of these measures for women and child health based on interviews with program managers and health workers as well as review of official documents, published papers, relevant content on official websites, and data sources mainly focusing on the States.

The integrated approach evolved by the Government of India combining infrastructural development with social sectoral development is very closer to the inter-sectoral vision propagated by the W.H.O in the early 1980s. It is evident that this is one of the largest integrated and joined-up package visualized in a country to achieve human development and is broadly akin to a governance model with Health in All perspective which realizes the inter-dependence of public policy. Health interventions and the specific measures to address the issue of exclusion have to be examined against this integrated scenario. The Government of India in 2005 initiated the National Rural Health Mission (NRHM) with a number of components for improving the state of rural health services. Some of the components were intended to achieve better MNCH outcomes keeping in mind the MDG goals 4 and 5. However, some of these interventions could help to reduce inequities in health by enhancing interactions between health services and the people. The Janani Suraksha Yojana (JSY) under NRHM is one such effort to bring the poor, excluded and marginalized women closer to the health services system through a facilitatory and participatory approach with the objective of
reducing maternal and neo-natal mortality. The Accredited Social Health Activists (ASHA) who are women from the same community under this program serve as the link to motivate and support the women. The JSY is a program which combines economic support and facilitatory approaches to enhance institutional deliveries in rural areas.

There are shifts in the way in which the health services are perceived by the people. Study findings indicate a huge increase in utilisation of the JSY scheme. In order to reach the stated goal of 80 per cent institutional deliveries, more capacity needs to be created in health systems to cater to this JSY-induced demand. It is necessary to state that the impact of the policy initiatives on addressing inclusion have to be seen in deductive terms. The measurable change is only in terms of health indices i.e. MMR and IMR. However, it is possible to assume that such changes are due to the policy and program shifts focusing on the women below the poverty line who by and large belong to the under-privileged castes in India. Moreover, the strong linkage between such focused action and the reduction in inequity is evident from a larger share of JSY beneficiaries among the women accessing facility-based care for deliveries. Preliminary analysis based on DLHS data shows that the JSY scheme has helped in the coverage of antenatal and intrapartum care and has also probably contributed to reductions in the numbers of perinatal and neonatal deaths although the effect on maternal mortality is not known. For the moment, it is a matter of deduction that since coverage has increased as evident from the data; the program could have led to some spin-offs on increasing access and acceptability of health services among the under-privileged sections in the country.

The review of state experiences revealed that most initiatives and innovations are focused on services which have indirect implications for social determinants. The available data and trends indicate that provision of care and availability services are important factors which influence outcomes both in reducing inequities as well as in improving health. However, this may not always lead to positive outcomes in care as evident from some states.

One of the corollaries of the emphasis on services is that the synergy and inter-sectoral coordination between health services and other sectors need to be considerably scaled up at the regional levels. In the Indian case, a positive policy orientation exists in terms of a comprehensive and joined-up vision which has not percolated into the implementation levels. Secondly, the net-effect of different policies and programs has to be conceptually and wherever possible empirically demonstrated. This
exercise is challenging and requires a multi-disciplinary approach. The experience of states such as Kerala where the women's self-help groups were utilized for convergent actions points to the need for forming Empowered Action Groups (EAG) of women who can guide the program for the focused actions on health promotion supervised by the health services with ASHA as a nodal person. Mobilization of women using the group approach as witnessed in Kerala could be an answer for promoting equity and further improvements in maternal health.

The Problem Space and the Context of Social Determinants in India

One of the important social determinants that needs to be addressed with respect to the Indian health service system is 'social exclusion'. Social exclusion mainly refers to the inability of our society to keep all groups and individuals within reach of what we expect as society to realize their full potential. Economic capability (poverty), gender, age, caste and religion, etc. are important variables which indicate exclusion from social and economic opportunities. In the Indian context, social organization on the basis of caste and other social groups such as tribes represent a form of social stratification. Such an organization may be considered as the most important indicator of social inclusion/exclusion and broadly as a proxy for socio-economic status. In the identification of the poor, Scheduled Caste (SC) and Scheduled Tribes (ST) and in some cases the Other Backward Classes (OBC) are considered as socially disadvantaged social groups and such groups have a higher probability of living under adverse conditions and poverty. The Indian government has specific programs for economically and socially uplifting the Scheduled Castes and Scheduled Tribes such as provision of development packages, reservation in educational institutions and employment etc. Such measures are intended to reduce the adverse conditions and social exclusion.

There are considerable variations with respect Infant and child mortality rates between different caste groups in India (Table 1) the health status and utilization patterns of such groups give an indication of their social exclusion as well as an idea of the linkages between poverty and health. Data on prevalence of anemia, treatment of Diarrhoea, Infant Mortality Rate, and utilization of maternal health care and childhood vaccinations among different caste groups in India based on the National Family Health Survey II highlight the caste differentials in health.
Table 1: Infant and Under 5 child mortality rate by Social groups in India

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<tr>
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<tbody>
<tr>
<td>Infant Mortality Rate</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>SC</td>
<td>107.3</td>
<td>83</td>
<td>71</td>
</tr>
<tr>
<td>ST</td>
<td>90.5</td>
<td>84.2</td>
<td>63.9</td>
</tr>
<tr>
<td>OBC</td>
<td>NA</td>
<td>76</td>
<td>61.1</td>
</tr>
<tr>
<td>Others</td>
<td>82.2</td>
<td>61.8</td>
<td>55.7</td>
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<tr>
<td>Under 5 mortality Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SC</td>
<td>149.1</td>
<td>119.3</td>
<td>94.7</td>
</tr>
<tr>
<td>ST</td>
<td>135.2</td>
<td>126.6</td>
<td>99.8</td>
</tr>
<tr>
<td>OBC</td>
<td>NA</td>
<td>103.1</td>
<td>78.7</td>
</tr>
<tr>
<td>Others</td>
<td>111.5</td>
<td>82.6</td>
<td>68.2</td>
</tr>
</tbody>
</table>

Source: IIPS, National Family and Health Survey-1, 2 and 3, NA: Not Available

Regarding accessibility variables, the upper castes are better-off regarding treatment of diarrhea while the proportions of scheduled castes, scheduled tribes and other backward castes not availing any treatment are considerably higher. The proportion of scheduled castes not availed any treatment for diarrhea stands out which clearly indicates problems of accessibility and availability for these sections which belong to the poorer sections. The same pattern is discernible in the case of maternity care as well. The proportion of scheduled caste and scheduled tribe women who have not availed any antenatal care is considerably higher compared to other castes. Institutional delivery is also comparatively lower among these sections (Table 2). Various rounds of NFHS also indicate that complete coverage of childhood vaccination is lowest among the scheduled castes followed by the Scheduled Tribes.
**Table 2** Utilization of Ante-natal care by Social groups in India

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<tbody>
<tr>
<td>ANC at home from health workers</td>
<td>SC</td>
<td>14.6</td>
<td>5.9</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>ST</td>
<td>18.5</td>
<td>10.0</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>OBC</td>
<td>NA</td>
<td>5.9</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>11.9</td>
<td>4.0</td>
<td>NA</td>
</tr>
<tr>
<td>Doctors</td>
<td>SC</td>
<td>29.4</td>
<td>41.7</td>
<td>42.0</td>
</tr>
<tr>
<td></td>
<td>ST</td>
<td>21.0</td>
<td>34.7</td>
<td>32.8</td>
</tr>
<tr>
<td></td>
<td>OBC</td>
<td>NA</td>
<td>48.9</td>
<td>48.4</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>44.0</td>
<td>56.5</td>
<td>63.6</td>
</tr>
<tr>
<td>Other Health professionals</td>
<td>SC</td>
<td>12.8</td>
<td>13.3</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>ST</td>
<td>7.1</td>
<td>11.5</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>OBC</td>
<td>NA</td>
<td>9.6</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>9.1</td>
<td>10.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Traditional Birth Attendants and Others</td>
<td>SC</td>
<td>0.2</td>
<td>0.2</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>ST</td>
<td>0.2</td>
<td>0.3</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>OBC</td>
<td>NA</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>0.3</td>
<td>0.2</td>
<td>1.1</td>
</tr>
<tr>
<td>No ANC</td>
<td>SC</td>
<td>42.2</td>
<td>38.2</td>
<td>25.9</td>
</tr>
<tr>
<td></td>
<td>ST</td>
<td>52.3</td>
<td>43.1</td>
<td>29.4</td>
</tr>
<tr>
<td></td>
<td>OBC</td>
<td>NA</td>
<td>34.8</td>
<td>25.5</td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td>34.0</td>
<td>27.9</td>
<td>15.2</td>
</tr>
</tbody>
</table>

Source: IIPS, National Family and Health Survey-1, 2 and 3

NA: Not Available
On the whole, available data suggest that the marginalized sections such as Scheduled Castes/Scheduled Tribes and the other backward Castes who are also the poor in India suffer from a ‘social gap’ in terms of health status and health services. Specific behavioral practices in child birth or early child development are closely linked to the social and cultural background of the population. There is enough evidence that behavioral practices including health actions are rooted in the social, political and cultural context. However, the specific pathways of such social variables and health are not well-researched which often results in half-baked and uni-focused actions such as behavioral change programs or educational activities. What is required is a more multi-focused action on vulnerable sections of the population which can not only take care of the specific social vulnerabilities such as unemployment, social exclusion etc. but can also enhance accessibility and availability of health services. Health service system should take into cognizance such issues to be able to achieve universal health care. The goals of achieving reductions in mortality rate under five and the maternal mortality rate by two-thirds (MDG Goals 4 and 5) are also contingent upon addressing some of these important social determinants.

**Objectives of the Paper**

Given the above scenario, this paper would attempt to document how social determinants especially the problem of social exclusion have been addressed with respect to mother and child health in India in various policies and programs.

**The objective of the paper is to document the policy formulation and intervention programs to address social determinants with respect to MCH care in India.**

The available studies would be documented and reviewed in order to evolve a broad picture of the country experiences. The paper would specifically focus on the two interventions such as JSY and the ASHA apart from documenting other salient trends if identified during the process of review.

**Methodology**

It needs to be mentioned that a country report for a country such as India is a challenging task given the huge variations between states and the problems of data availability with regard to health and
health services. A methodology which combines available documentation and some primary data collection using interviews with key informants is the most appropriate in such a situation.

The Government of India and the state governments in India have undertaken specific measures to address the problem of exclusion and to overcome the problems of accessibility and availability of MCH care to the excluded populations. This paper will present some of the key initiatives that have been undertaken and the potential implications of these measures for women and child health. The paper is based on:

1) Review of official documents, published papers, relevant content on official websites, and data sources. The review will be undertaken by systematic search through available search engines and existing data bases such as NFHS and DLHS and data available from UNICEF, WHO, UNFPA, etc. It also made use of available reports and documents of the Ministry of Health and Family Welfare. We also examined nation-wide data on how exclusion has been addressed at program and policy levels. Given the federal nature of the country and the fact that health is a state subject, the paper relied on various initiatives evolved by the state governments. Particularly, we were interested in finding out innovative schemes which fit into the framework of social determinants.

2) Interviews with government officials of the Ministry of Health, key program managers of National Rural Health Mission of some selected states, village health workers such as Auxiliary Nurse and Mid-wife (ANM) and Accredited Social Health Activist (ASHA) who are involved in the Janani Suraksha Yojana. The states - Kerala, West Bengal, Jharkhand, Maharashtra and Uttarakhand were purposively selected in which Kerala represents a best case scenario while Jharkhand represents a worst-case scenario. The paper has been organized to give a regional representation of the country and for this; the findings of review studies and respective state government reports were also used for other selected states.

**An Integrated approach to Human Development in India: The Policy and Planning framework in India**

The Bharat Nirman (Development of Bharat) and the flagship programs of the Government of India is an attempt to develop an integrated approach to human development which includes health. In
other words, it could be considered as an innovative approach to 'Health in All' policy. Many of these programs have direct and indirect implications for health. The following are some of the important components of the integrated package:

1. Rural Roads
2. Rural housing
3. Drinking water
4. Irrigation
5. Rural Telephony
6. Rural electrification
7. Rural employment Guarantee
8. Education for all
9. Mid Day Meal
10. Rural Health
11. Urban Renewal and Urban health
12. Total Sanitation

The integrated approach combining infrastructural development (the first six items under the program called Bharat Nirman) with social sectoral development is very closer to the inter-sectoral vision propagated by the W.H.O in the early 1980s (Gunatilleke, 1984). This is also a rejuvenated package of the earlier such approach evolved in the sixties known as the Minimum Needs Program. It is evident that this is one of the largest integrated and joined-up package visualized in a country to achieve human development and is broadly akin to a governance model with Health in All perspective which realizes the inter-dependence of public policy. Such joined-up actions will be “strongest, and outcomes are best, when the collaboration is both vertical and horizontal … weaving these elements together yields a resilient and durable end product, and provides a shield against inaction, flogging interest, or disintegration” (WHO and PHAC, 2008).

At the policy level, there exists a vision for convergence and intersectoral approach. This may not necessarily translate into convergence at the implementation level although some state
governments have evolved such a platform. However, it is evident from the list that there is a possibility of convergence between different programs such as Mid Day Meal, Education for all, Rural and Urban health, Sanitation, housing, roads and employment from the point of view of enhancing inclusion and improving women's health and accessibility to services. However, an intersectoral analysis in terms of impacts is too early at present. It is against this integrated policy scenario which assumes the importance of developing rural India in terms of infrastructure and social sectors for inclusive and equitable growth that the health interventions and the specific measures to address state of MCH care and the exclusion have to be examined.

The Policy of focused Action in Health: The Indian Innovation for addressing social determinants

The Government of India in 2005 initiated the National Rural Health Mission with a number of components for improving the state of rural health services. Some of the components were intended to achieve better MNCH outcomes keeping in mind the MDG goals 4 and 5. However, some of these interventions could help to reduce inequities in health by enhancing interactions between health services and the people.

From a policy perspective, considering the health inequality and social inequality inter-phase, the focus has to be on the poorer classes who have a higher risk for diseases as well as higher probability from being excluded from the health services. This is essential given the higher proportion of the poor as well as socially disadvantaged, the magnitude of health problems, the epidemiological profile in the society and the inequities with respect to health services as evident from the available data reported above.

Empowering the women by appropriate economic and social programs could be one of the ways to grapple with ‘inequity trap’ that the women face which may indirectly impact on MCH service utilization. Given the cultural and social norms attached pregnancy, child birth and child rearing, the best possible pathway for the health programs is through the women themselves. These could be through focused action with women's participation (as against targeted interventions imposed from above). This could be through a democratic participation in health programs through which ideals of Primary Health Care can be realized while we celebrate the 25 years of the Ottawa charter for health promotion (WHO, 1986). The Janani Suraksha Yojana (JSY) is one such effort to bring the poor,
excluded and marginalized women closer to the health services system through a facilitatory and participatory approach with the objective of reducing maternal and neo-natal mortality. The Accredited Social Health Activists (ASHA) who are women from the same community under this program serve as the link to motivate and support the women. The JSY is a program which combines economic support and facilitatory approaches to enhance institutional deliveries in rural areas. Public health scholars have raised a number of issues with regard to the JSY. One controversy is with regard to the over-emphasis on institutional deliveries given the long-term mistrust of government health services i.e. the credibility gap and the caste, class and gender bias when women access care (Jeffrey P and Jeffrey R, 2010). The other issue is with respect to the component of privatization which some public health scholars argue could lead to further weakening of public sector health services (Nayar, 1998). The third issue is with regard to the approach of conditional cash transfer and the argument that it is difficult to attribute cash transfer alone to positive outcomes (Lagarde, Haines and Palmer, 2009)). Despite such critiques, some states in India have introduced people-friendly and socially and culturally oriented innovations in the JSY program although these could be in the form of small steps.

**Some Case Studies: Implementation of policies and innovations**

A number of state governments in India have evolved innovative mechanisms under the JSY to address the issue of inequities in MCH care.

**Kerala** is one of the few states with almost 100 percent institutional deliveries, the highest maternal and child health outcomes as well as the first state to achieve MDG targets. The current thrust on institutional deliveries to achieve better maternal health is based on evidence from Kerala where it is assumed that the institutional deliveries have contributed to bringing down MMR. Despite the achievement of such high rates of institutional delivery and health outcomes, the state has evolved a number of innovations to bring the women closer to the health services. Some of the innovative approaches undertaken in Kerala are as follows. Kerala has evolved a State Women's Policy in 2009. The policy recognizes the multi-focused and multi-dimensional inputs and initiatives required for enabling women. There were initiatives to empower women's access to maternal and child care through directly enabling the ASHA workers who are also members of women's self-help groups.
known as *kudumbasree*. They have been successful in facilitating women's access right from the pre-natal stage including access to the entry point (reception) to the labour rooms as well as post-natal care. The self-help groups are also involved in preparing nutritious food packets for the anganwadi under Integrated Child Development Scheme (see box 1). Unlike many other states, even the comprehensive insurance scheme (CHIS/RSBY) implemented in Kerala resulted in strengthening public sector hospitals and the maternity care which is utilized by the poor. The insurance scheme incorporated maternity care for reimbursement of costs. Many initiatives have also been taken to improve the immunization status in the state. Immunization sessions are organised in the remote areas giving special attention to tribal, coastal and urban slums. In the low coverage areas, immunization activities are strengthened with the help of NGOs and private institutions.

**Box 1** Role of Women's Self-Help Groups in Nutrition of children and mothers

Though women self help groups are helping Local self government institutions as well as local level health service institutions like PHC’s in carrying out sanitation measures in the locality especially during the monsoon season like distribution of bleaching powder, finding out sources of mosquitoes, etc. But very interestingly one of the innovations in MCH programme in Kerala is the distribution of ‘AMRUTHAM’ (a powdered mix of Ragi, Wheat, Sugar and Soyabean) supplied by a unit of kudumbasree (Self Help Groups). The production of Amrutham is supported by ICDS to improve maternal and child health in Kerala and it is distributed to the beneficiaries through anganwadi workers and ASHA workers in the locality.

There are 28 such units working in Kannur district of Kerala. It is distributed in such a manner that each child will get 6 packets in a month (I packet contains 563 grams) from 6 months to 3 years. Our primary survey reveals that one such unit in Korom panchayath of Kannur district supplies this product in the above mentioned manner to 970 children in the Payyanur municipality, 300 children in the Kadannappilly panchayat, 500 children in Cheruthazham panchayath and 350 children in Karivellur panchayath. Thus altogether this single unit of Self Help Group produces 12,720 packets in a month for serving 2120 children in nearby areas of this panchayath.

As opposed to this best-case scenario, **Jharkhand** continues to share a number of characteristics with other backward states of India such as high infant mortality, low immunization of children and expectant mothers, high mortality due to infectious and contagious diseases, high maternal
mortality, and low institutional delivery. Reviews and studies of NRHM in Jharkhand have shown that the process of decentralization, responsiveness to local needs, paradigm shift in health system management and availability of untied funds have improved the facilities and their credibility among the people. Earlier, there existed ignorance, inhibitions and lack of awareness on issues of MCH, reproductive health and rights, adolescent reproductive and sexual health, abortion etc among the population. Gradually with intensive interventions adopting comprehensive IEC/ BCC strategies there is increased awareness and articulation on these issues. This has been facilitated through the concerted involvement of NGOs and Civil Society Organizations. Today there is a receptive community and a wider platform for dissemination on reproductive issues and beyond. Setting-up of Sahiya Resource centre is one innovation that has helped this process of community mobilization. It was evident from the fieldwork that the women activists can positively channelize the responses of the people (see box 2). Unfortunately, such activities have not resulted in an increase in institutional deliveries and the state continues to remain at the bottom of the ladder. In Uttarakhand, a hill state of India, interviews with ASHAs revealed that due to absence of roads in the higher altitudes, ambulances can not reach their villages. This disabled the pregnant woman to reach any hospital for delivery. Some success stories from districts like Barav saw the Village Health and Sanitation Committee (VHSC) making a palki (a stretcher like carrier) to enable the lady in labor to reach till the main road up till where the ambulance could travel. Such culturally appropriate innovations for transport are a small step towards developing a vibrant MCH care in rural areas.

Bringing the excluded tribal population is another major challenge for the JSY programmed. In the tribal dominated state of Odishsa, maternity waiting homes (MWH) are constructed in most remote tribal block of several districts. This has helped in developing positive attitudes to institutional deliveries. The MWH function like a platform for the expectant mothers to come before hand, which is to be established in the mid way to the institution. Due to extreme poverty, women can not afford
to stay outside before delivery and such homes provide a social support to them. The ASHAs have been able to also facilitate immunization among children. Similar to many other states such as Jharkhand and Uttarakhand, geographical accessibility is a major problem in Odisha.

In Rajasthan, the awareness levels of Janani Suraksha Yojana is as high as 95 percent (UNFPA, 2009). The state had evolved a program called ‘panchamrit’ in 2006 in which fixed day and fixed site outreach services to reach child and maternal care to families living below poverty line in each village of the state. The focus is also for covering far flung and tribal dominated districts by providing six components such as immunization, elimination of micro-nutrient deficiency, ensuring safe motherhood, and ensuring healthy new born. Such an innovation could have led to some positive impacts in terms reducing lack of accessibility to excluded and marginalized populations. Rajasthan also experimented with a program called “Parinche” under NRHM which aimed at empowering rural communities through provision of public health programs in sanitation, nutrition and communicable diseases through a female community health worker.

Madhya Pradesh is one of the states which has evolved a draft health policy which purports to reduce inequities in health care including gender inequities. The Janani Sehyogi Yojana in Madhya Pradesh is another innovation which is meant to improve neo-natal and maternal care in rural areas for the families living below poverty line by providing emergency care as well as qualitative curative support to new borne children and pre and post-natal care to women. The Janani Express Yojana provides transport facilities to pregnant women to the health facility. Apart from factors such as provision of transport to pregnant women, payment of cash incentives to mothers and ASHA, involvement of private sector etc., community mobilization has facilitated an increased awareness and an increase in institutional deliveries in Madhya Pradesh, Rajasthan and Odisha. More than three-fourths of the mothers in Madhya Pradesh, Rajasthan, Odisha and Bihar knew that the health facilities are open round the clock for delivery services (UNFPA, 2009). The state of West Bengal has initiated the 'ayushmati' scheme which engaged the private sector in providing essential and emergency obstetric care to the BPL and SC/ST families. The cost of this service would be borne by the government. Qualitative field work conducted in a district revealed that although the services
have improved tremendously, there are problems in disbursal of payment, lack of transportation, lack of proper SC/ST and BPL certificates etc. are some of the constraints in the program.

**Chattisgarh** is one of the states which initiated people-friendly health services even before the implementation of NRHM. The Mitanin program which is the pre-cursor of the ASHA program originated in this state. Evaluation of Mitanin program shows that the Mitanin program has been more effective compared to the ASHA in other states in terms of reaching the pregnant women, newborn and infants in aspects like newborn care, child feeding practices, diarrhea management etc. (European Union, 2011). This could be attributed, as evident from the evaluation, to their involvement in the community and their commitment to serve the people. The evaluation also shows that the Mitanins have been able to increase awareness, help in empowerment of women, facilitate institutional deliveries and increase the rates of immunization. The state also evolved a scheme to place health into Panchayats agenda named the Swasth Panchayat Scheme. This is a programme to support local health planning and to enhance PRI role in health. An indicator based health and human development index has been prepared for all Panchayats of the state that is hamlet-centred so as to capture the intra-panchayat variations. The panchayats are also encouraged to develop village health plans through people's participation ([http://health.cg.gov.in/ehealth/welcome.htm](http://health.cg.gov.in/ehealth/welcome.htm)).

In **Gujarat**, the State Policy for Gender Equity (GEP) is formulated with a vision to safeguard women and create awareness, fostering well being and security of women in the state. The Gujarat government has evolved a number of packages and schemes for the overall health and well-being female children and women. In health, the Chiranjeevi Yojana implemented by the Government of Gujarat is aimed to encourage the BPL families to improve access to Institutional delivery in partnership with the private sector. The scheme also provides for financial support to the accompanying person for loss of wages ([http://www.gujaratindia.com/](http://www.gujaratindia.com/)).

**Maharastra** is another state which is closer to achieving the MDG target. One of the salient initiatives to bring the tribal population closer to the health services was undertaken in the Amravati district of the state. This was to help the excluded tribal population of the district to access various services of
the public sector health services by providing a counselor who speaks the language of the tribals (see box 3).

**Box 2. Impressions of Sahiyas: The positive and negative feedback**

As first contact points of the community under the programme Sahiyas are faced with several challenges. Being part of the community themselves their views and concerns are also reflective of those of the community at large.

Some issues that emerged are enumerated as under-

<table>
<thead>
<tr>
<th>Physical access as a hindrance to seeking care in health institutions considering the remoteness of certain areas and forest cover</th>
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<tbody>
<tr>
<td>• Mostly non existent and non-functional health infrastructure deters people from approaching institutional care.</td>
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<tr>
<td>• Widespread ignorance and lack of awareness on health issues used to reinforce prevalent beliefs, myths and misconceptions. Earlier there was less of structured exposure and discussion on these issues and it was very difficult to convince and motivate people. Today with increasing knowledge and understanding through intensive facilitation and IEC/ BCC activities there is greater acceptance towards institutional care and services.</td>
</tr>
<tr>
<td>• The exclusion of tribal homogenous society is linked to their socio economic profiles and care seeking ability in monetary terms.</td>
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<td>• Sahiyas enjoy goodwill and rapport in the community and this works both ways to their advantage as well as disadvantage. The goodwill helps them to motivate people and convince them on certain issues. However, sometimes they are not valued as advisors, mentors, or facilitators especially by elders of the community on grounds of their age and experience. Sometimes confronting religious and political views/ beliefs of the community impedes their community mobilisation processes.</td>
</tr>
<tr>
<td>• Incentives under JSY are motivating factors for seeking institutional care but procedural hassles and delays discourage both the Sahiyas and women</td>
</tr>
</tbody>
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**Box 3. Facility based Counselors programme in Melghat, Maharastra**
Melghat region, consisting of blocks Dharni and Chikaldhara in Amravati district of Maharashtra is mostly inhabited by Korku tribes. The region has a tiger reserve and bird sanctuary and therefore all the reserve forest laws apply to the region. The tribal region has several context specific variables—such as wide geographical spread of the population, 3 lakhs population in 4500 square kilometer, poor educational opportunities and literacy rate, livelihood challenges and overall socio-economic backwardness, seasonality of under nutrition and child death. The region came in media focus in the year 1992-93 and since then is almost a synonym for Malnutrition and child deaths.

The region has a well networked public system with 6 Primary Health Centre in Dharni block and 5 in Chikaldhara block, 2 Rural Hospitals one at the block head quarters of Chikaldhara and other in remote village at Churni and 1 Sub District Hospital at the block head quarter of Dharni. The region has 395 Anganwadi Centres and 352 Primary schools and caters to almost all villages in the region. However despite all the infrastructure and resources, the Korku community has remained poor and vulnerable. The poor uptake of services from the public institutions including that of MCH services is because of several social and cultural factors. One of the foremost hindrances to low uptake of services from the public health system has been the inaccessibility of these institutions to the people. Besides physical barriers in terms of poor connectivity between villages to the facilities and the problem of absenteeism of staffs in the facilities, there exists a cultural barrier in terms of inability of the service providers at the health institutions to be able to communicate to the Korku patients coming to the hospitals. This has resulted in low patient turn out at the public facilities, less number of IPDs, referrals to higher centers.

Taking note of the above situation, local civil society groups led by MAHAN and KHOJ forged a partnership with the Zillaparishad, Amravati and started a pilot programme of placing one female counselor in day time and Male counselor for the night in all the 14 health institutions in Melghat. The counselors helped the patients to converse with the medical staffs, looked after the hygiene and sanitation in the hospitals and also reported the absenteeism, misconduct of service providers to the district administration. The programme had started in September 2007 and ended in November 2007. The programme helped in increasing OPD and IPD attendance, in improving quality of food served in the hospitals, in increasing number of hospitalization of severe malnourished children and in improving sanitary, lighting facilities etc.

The early positive signs of the pilot programme led to the programme being re-introduced in the Melghat hospitals in June 2008 and got integrated with the district program. Although in 2010, the program was arbitrarily withdrawn, interventions by the Mumbai Highcourt led to restoration of the counsellors program. The counselors programme has been an example of making health facilities more accessible to tribal people by decimating the cultural and social barriers.
Potential Impacts and Changes

The impacts of these initiatives are not measurable yet. But as evident from the responses of grass-root level workers, there are shifts in the way in which the health services are perceived by the people. Study findings indicate a huge increase in utilisation of the JSY scheme. In order to reach the stated goal of 80 per cent institutional deliveries, more capacity needs to be created in health systems to cater to this JSY-induced demand (Common Review Mission, 2010; UNICEF, 2009). Methodologically, it is necessary to state that the impact of the policy initiatives on addressing inclusion have to be seen in deductive terms. The measurable change is in terms of health indices i.e. MMR and IMR. However, it is possible to assume that such changes are due to the policy and program shifts focusing on the women below the poverty line who by and large belong to the under-privileged castes in India. Moreover, the strong linkage between such focused action and the reduction in inequity is evident from a larger share of JSY beneficiaries among the women accessing facility-based care for deliveries. This is found out both by the Common Review Mission as well as the UNFPA Concurrent Assessment.

The UNFPA evaluation conducted in five states revealed considerable improvement in institutional deliveries (Figure 1). Madhya Pradesh and Rajasthan which belong to the vulnerable states have recorded high institutional deliveries compared to the previous years. Although such a trend has not led to dramatic decline of MMR as reflected from the MMR figures released in 2011, the decline for the vulnerable states has been from 375 in 2004-06 to 308 in 2007-09, a decline of about 18 percent which can be called as significant (see also Figure 2). The all India figure shows that MMR declined from 254 in 2004-06 to 202 in 2007-09, a fall of about 17 percent. Apart from Kerala, Tamil Nadu and Maharashtra have also joined the states which achieved the MDG target (Sample Registration Scheme, 2011 and see Figure 2 for some selected states). However, the linkage between high rates of institutional deliveries and MMR reductions is yet to be demonstrated.
**Figure 1** Institutional deliveries in rural areas of selected states of India 1998-2008

[source: UNFPA (2009)]
MDG envisages reduction of IMR to 28 and U5MR to 42 by the year 2015. IMR for the country has registered a decline of 3 points to 50 in 2009 from 53 in 2008. The maximum IMR has been reported in case of Madhya Pradesh (67) and the minimum for Kerala (12) (see Table 6 and Figure 3). Neo-Natal Mortality Rate (<29 days) and Post Neo-Natal Mortality Rate (1 month to 11 months) has declined by 1 point and 2 points respectively. Kerala (12) and Tamil Nadu (28) have already achieved the MDG target while Andhra Pradesh, Gujarat, Haryana and West Bengal closer to achieving the target (Table 4 and Sample Registration System, 2011).
**Figure 3.** Infant Mortality in selected states in India 2005-2009


U5MR for the country has declined by 5 points over 2008 (64 in 2009 against 69 in 2008). A uniform decline of about 5 points is seen in male and female U5MRs. The Maximum U5MR has been reported in Madhya Pradesh (89) and the minimum U5MR in Kerala (14). As of now, five States/UTs viz. Kerala (14), Tamil Nadu (33), Maharashtra (36), Delhi (37) and West Bengal (40) have achieved the MDG target (Sample Registration System, 2011).

DLHS 2 and 3 data from 2002-04 and 2007-08 show that Orissa and West Bengal are the two states which have recorded considerable improvement with respect to ante-natal checkup across different caste groups. Not only there is improvement in the figures in these two states, the social gap between different caste groups has reduced. However, in most other states, the effect of antenatal
coverage was smaller. Other Analyses based on NFHS rounds and DLHS also show that the states have moved to higher equity with respect to institutional deliveries (Shekhar and Ram, 2011). The linkage between cash assistance and increase in institutional care is evident from the increase in institutional deliveries especially in high-focus states like Madhya Pradesh (see Table 3). Preliminary analysis based on DLHS data shows that the JSY scheme has helped in the coverage of antenatal and intrapartum care and has also probably contributed to reductions in the numbers of perinatal and neonatal deaths although the effect on maternal mortality is not known (Lim et al., 2010). The uptake of JSY among the poorest and least educated women has also not been high. The explanations for this trend are 1) the short duration of the JSY scheme 2) problems in the physical access and, 3) cultural barriers against institutional births among certain groups (Lim et al, 2010). DLHS data also show that with respect to immunization coverage, there is considerable improvement in states such as Orissa, West Bengal, Chhattisgarh and Uttarakhand especially among the SC/ST communities. The issue whether the JSY could reduce inequities in care is still an open question which needs further studies (Das et al., 2011). For the moment, it is a matter of deduction that since coverage has increased as evident from the data; the program could have led to some spin-offs on increasing access and acceptability of health services among the under-privileged sections in the country.

Lessons learned and recommendations

The review of state experiences revealed that most initiatives and innovations are focused on services and personnel which have indirect implications for social determinants. The available data and trends indicate that provision of care and availability services are important factors which influence outcomes both in reducing inequities and improving health. However, this may not always lead to positive outcomes in care and indicators as evident from some states. The program continues to be better in non-vulnerable states such as Kerala, Tamil Nadu, Maharashtra, West Bengal etc. Pro-poor affirmative policies and actions in several vulnerable (focused) states may not lead to immediate results but could function as facilitatory factors for future positive changes.
Recommendations and possibilities for action

a) Country level

- One of the corollaries of the emphasis on services is that the synergy and inter-sectoral coordination between health services and non-health sectors need to be scaled up. The flagship program in India is an example of joined-up approach although the coordination between different sectors is not evident. Feasibility of establishing state-level and district-level multi-sectoral coordination committees for monitoring the state of health could be explored.

- The net-effect of different policies and programs has to be conceptually and wherever possible empirically demonstrated. This exercise is challenging and requires a multi-disciplinary approach.

- Specifically, the review throws up a number of challenges especially from the experience of states such as Kerala where the women's self-help groups were utilized for convergence actions. The experience points to the need for forming Empowered Action Groups (EAG) of women who can guide the program for the focused actions supervised by the health services with ASHA as a nodal person. The composition of the group should be based on age, social background, leadership qualities etc. In other words, this could be the democratic component of the program through which ideals of Primary Health Care and the Ottawa Charter can be realized. This could be in addition to the Village Health and Sanitation Committee under the NRHM. Another option is to provide representation of women in this committee.

- Mobilization of women using the group approach as witnessed in Kerala could be an answer for promoting maternal health and consolidating existing gains. As mentioned earlier, the best possible pathway for achieving program objectives in MCH is through women themselves.
Culturally appropriate innovations such as in Orissa, Jharkhand, Maharashtra and Uttarakhand can also bring positive changes in the way in which women perceive health institutions. Some studies and reviews of JSY have pointed out the limitations of existing health promotion activities and the constraints of communication strategies dependent on literacy. The counselor program in the tribal belts of Maharashtra is an innovation which addresses the above issue.

There is a need to encourage context-specific and culturally and socially acceptable provisioning of care by states in order to facilitate better outcomes.

b) Regional Level

Regular exchange of innovative strategies adopted by member states could be useful for addressing social determinants in health including social exclusion. Publication of at least an annual social determinants regional trend report could help in achieving this objective and help in monitoring the progress.

A regional knowledge hub on social determinants which collects and disseminates literature and data could be useful. This analysis revealed the need to identify context-specific features of social determinants (for instance the role of caste within the broader concept of exclusion), processes and innovations. Similarly, the need to understand the factors which contribute to community organization and community mobilization was also highlighted in this paper. A knowledge hub can capture all these commonalities and variations.

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