Understanding

# Health and Nutrition Realities

of

Six Blocks of Four Districts in Madhya Pradesh

A Report By

CHETNA

For Women Young people Children

# Understanding Health and Nutrition Realities of Six Blocks of Four Districts in Madhya Pradesh

A Report
on
**Community Needs Assessment and Public System Gap Analysis**

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# List of Abbreviations

**ASHA**-Accredited Social Health Activist

**ANM**-Auxiliary Nurse Midwife

**ANC**-Ante Natal Care/Checkup

**AWW**-Anganwadi Worker

**AWC** - Anganwadi Centre

**CHC**-Community Health Centre

**CHETNA**-Centre for Health, Education, Training and Nutrition Awareness

**CLF**-Cluster Level Federation

**CNA**–Community Needs Assessment

**DH**-District Hospital

**DOT**-Directly Observed Therapy

**EDL**-Essential Drug List

**GAK**- Gram Arogya Kendra

**GOI** - Government of India

**GSST**- Gram Sabha Swasth Gram Tadarth Samiti

**Hb**: Haemoglobin

**HRP**-High Risk Pregnancy

**ICDS**-Integrated Child Development Scheme

**INC**-Intra Natal Care/Checkup

**IUCD**-Intra Uterine Contraceptive Device

**IV**-Intra Venous

**IYCF**- Infant and Young Child Feeding

**JSY**-Janani Suraksha Yojana

**LTT**– Laparoscopy Tubectomy

**MNREGA**-Mahatma Gandhi National Rural Employment Guarantee Act

**MTP**- Medical Termination of Pregnancy

**MUAC**-Mid Upper Arm Circumference

**NRC**-Nutrition Rehabilitation Centre

**NITI**- National Institution for Transforming India

**OBC**-Other Backward Classes

**ORS**- Oral Rehydration Solution

**PDS**-Public Distribution System

**PHC**- Primary Health Centre

**PNC**-Post Natal Care/Checkups

**PSGA** - Public System Gap Analysis

**RTI**- Reproductive Tract Infection

**SAM**-Severe Acute Malnutrition

**STI**-Sexually Transmitted Infections

**SHC** - Sub Health Centre

**SBA**-Skilled Birth Attendance

**SC**-Schedule Caste

**SNCU**- Sick New-born Care Unit

**ST**- Scheduled Tribe

**THR**-Take Home Ration

**TRI**- Transform Rural India

**VHND**- Village Health and Nutrition Day

**VHSNC**-Village Health Sanitation and Nutrition Committee

**WASH**- Water and Sanitation

# Introduction

The Government of Madhya Pradesh is committed to improve the health and nutrition status of women and children. The Healthy States Progressive India -2019 report has ranked Madhya Pradesh at number 18 of the 21 states.

The Transform Rural India (TRI) is an initiative of Tata Trusts to transform villages, village life and society, especially the bottom 100,000 villages. TRI looks at initiating ground-pilots in selected blocks in endemic poverty regions in central and eastern states. The pilots are aimed at developing process protocols for triggering multidimensional transformation of villages in endemic poverty regions.

Mission Antyodaya is a convergence framework for measurable effective outcomes on parameters that transform lives and livelihoods.As envisaged by the Ministry of Rural Development, Government of India, it is an effort to address the multidimensionality of poverty in a time-bound manner through a convergence of resources, both financial and human, to provide an opportunity for transformational changes.

CHETNA has joined hands with this initiative in the capacity of thematic expert NGO (T- NGO) to strengthen the Health and Nutrition Component of the programme. The project is being implemented in 420 selected Mission Antyodaya villages of six blocks@ 70 villages per block. The intervention blocks are Amarpur, Samnapur, Thandla, Petlawad, Manawar and Sondwa of four districts Dindori, Jhabua, Dhar and Alirajpur of Madhya Pradesh.

**Purpose of the Assessment:** With the view to understand the local health and nutritional realities and design effective interventions by which the standard of health and nutrition improves among women and children in the poverty hit regions of Madhya Pradesh, CHETNA conducted Community Needs Assessment (CNA) and Public System Gap Analysis (PSGA) in the sampled villages of the six blocks of four districts namely, Jhabua, Alirajpur, Dhar and Dindori.

**Methodology:** The qualitative research methodology has been used where in Group Discussions (GD), Key Informant Interviews (KII) and Observations were used for data collection.

For understanding the community needs, group discussions were facilitated with women of villages who were either the members of self-help groups, or hailed from different communities in the village. The GDs were conducted on the topics such as food security, gender, women's health, child health, contraception, access to health services, and entitlements. Most discussions were conducted in the afternoon. Since women in Samnapur were busy during the day time due to harvesting season, the GDs were conducted with them in the night time. On an average, the duration of the GDs was between two to two-and-half hours.

For understanding the gaps in the public system, visits were made to observe the functioning of Gram Arogya Kendras (GAKs), Anganwadi Centres (AWCs), Sub Health Centre (SHCs), Primary Health Centres (PHCs), as well as Village Health and Nutrition Days (VHNDs). (For details on the schedule of the visits to these public facilities please refer Annexure-I)

**Tools:** Data collection tools were developed in English language by the Health and Nutrition Sector Council of the TRIF. Separate tools were designed to collect information regarding Community Needs Assessment (CNA) and Public System Gap Analysis (PSGA). After finalising the tools, the data collection team was oriented on the use of these tools in the field. The sampled villages were selected by the Block Engagement Manager, TRIF. The sampling was purposive as it was based on the set criteria which included:

- Sardar Sarovar Dam linked areas
- Difficult to reach, hilly terrain, forest areas
- Functional Self Help Group (SHG)/Village Organisations
- Socio-economic condition of the population
- Proximity to the main road
- Ethnic composition of the village population

**Sample:** The data was collected from the six blocks-- Sondwa, Thandla, Petlawad, Manawar, Samnapur and Amarpur across four districts, namely, Alirajpur, Jhabua, Dhar and Dindori. A sample size of 10% of the total 70 selected programme intervention villages was considered for the assessment. Thus, around 6 villages were chosen to represent a block. Data was collected

from a total of 36 villages. Of these, two of the six villages of Samnapur-Gora kanhari and Pondi were forest villages, and one village, Padariya, was a Riyayat village. (For the name of villages and Cluster Level Federation (CLF) please refer Table 1).

**Table 1: Detail of Villages and Cluster Level Federation (CLF)**

| | Manawar | | Samnapur | | Amarpur | | Thandla | | Petlawad | | Sondwa | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. | Village | CLF | Village | CLF | Village | CLF | Village | CLF | Village | CLF | Village | CLF |
| 1 | Mohali | Manawar 1 | Gora kanhari | Bahnmi | Muhari | Bhanpur | Angliyapada | Thandla | Piplipada | Karwad | Badi Sirkhedi | Sondwa |
| 2 | Birpura | | Pondi | | Junwani | | Sujapura | | Polarunda | | Walpur | |
| 3 | Panchkheda | Manawar 2 | Padariya | Samnapur | Bodhgundi | | Sutreti | | Parewa | Raipuriya | Ojhad | |
| 4 | Sarikpura | | Singwara | | Khairda | Amarpur | Makodiya | Khawasa | Raliyawan | | Kakrana | |
| 5 | Karoli | Singhana | Kukarramath | Manikpur | Aloni | Amarpur | Bhamal | | Chandragarh | Jhaknavda | Moraaji | Chaktala |
| 6 | Sirsi | | Budrukhi Mal. | | Jaldamudiya | | Sujapura | | Kardawad | Barvet | Mathwaad | |

- One Group Discussion (GD) was conducted in each village. A total of 36 GDs were held in all the36 villages. Around 440 women participated in these discussions.
- Around 50% of ASHAs, Anganwadi Workers (AWWs) and all Auxiliary Nurse Midwives (ANMs) were interviewed. A total of 39 ASHAs, 78 AWWs and 31 ANMs were interviewed.
- All the Gram Arogya Kendras (GAKs), Sub Health Centres (SHCs) and Primary Health Centres (PHCs) expected to serve the sample villages were observed to learn about their functioning mechanism. A total of 29 GAKs, 29 SHCs and 13 PHCs were visited to collect data.
- About half the number of Anganwadi Centres (AWCs) and all the Village Health and Nutrition Days (VHNDs) organised during the field visit were

also observed. Data from 73 AWCs and 14 VHNDs was collected. (For the block-wise details of the activities please refer Table 2).

**Table 2: Block-wise details of Activites with the public system**

| Activity | Amarpur | Samanpur | Thandla | Petlawad | Manawar | Sondwa | Total |
|---|---|---|---|---|---|---|---|
| ASHA Interviews | 6 | 7 | 7 | 6 | 6 | 7 | 39 |
| AWW Interviews | 10 | 9 | 16 | 12 | 11 | 20 | 78 |
| ANM Interviews | 4 | 4 | 6 | 6 | 5 | 6 | 31 |
| VHND Observations | 0 | 4 | 4 | 4 | 1 | 1 | 14 |
| PHC Observations | 1 | 2 | 2 | 4 | 1 | 3 | 13 |
| SHC Observations | 5 | 4 | 6 | 6 | 2 | 6 | 29 |
| AWC Observations | 8 | 9 | 16 | 12 | 8 | 20 | 73 |
| GAK Observations | 4 | 6 | 5 | 5 | 3 | 6 | 29 |

**About the villages:** The total population of these 36 villages is around 64, 964, with the total number of households being 12,647. Of these 36 villages, 11 villages have predominantly Scheduled Tribe (ST) communities such as Gond, Baiga, etc. Scheduled Caste (SC) and Other Backward Classes (OBCs) were the predominant communities in remaining 25 villages. Ten out of 36 villages were not linked with pucca roads. In more than three-fourth of the sampled villages (31/37), transport facility was readily available during emergencies. In all the 36 villages, clean drinking water was available through hand pumps or by piped water sources.

However, women from 36 villages mentioned that they faced severe water scarcity in summers. A total of 146 Anganwadi Centres, including Mini Anganwadi Centres were found in these 36 sample villages. Around half the number of sampled villages (17/36) had Sub Health Centre (SHC) in the village, and the distance of the SHC ranged between one to seven kms from the remaining villages. The average distance of PHC/CHC from the villages was noted to be 10-25kilometres.

**About the women:** 440 women participated in the group discussions. They were either members of Self Help Groups or were independent, without any group association. They were between 18to 50 years of age. Majority of the women were in their reproductive age, with their ages ranging from 25 to 40 years. More than half of the sampled women participants (201/325) were not literate. Of the 124 women who were literate, very few of them had studied till higher secondary level and above. The number of illiterate women was greater in Sondwa, Petlawad and Thandla blocks. Majority of women from the 36 villages worked in their own farms, as labourers, and in their homes.

The nutritional status (height and weight) of a total of 417 women was measured and Body Mass Index (BMI) was calculated.213 out of 417 women (51%of total sample size) were found to have a normal BMI, and 152 out of 417 women (36%) were found to be underweight. 45/417 women were found to be overweight, and only eight women were found to be in the category of obese. (Please refer Table 3 for block-wise details of womens' nutritional status.)

**Table 3: Nutritional Status of Women (in numbers)**

| Blocks | Underweight | Normal | Overweight | Obese | Total |
|---|---|---|---|---|---|
| Samnapur | 22 | 29 | 2 | 0 | 53 |
| Amarpur | 15 | 32 | 4 | 7 | 58 |
| Sondwa | 34 | 22 | 2 | 0 | 58 |
| Thandla | 26 | 32 | 5 | 1 | 64 |
| Petlawad | 26 | 38 | 7 | 0 | 71 |
| Manawar | 28 | 60 | 25 | 0 | 113 |
| Total | 151 | 213 | 45 | 08 | 417 |

# What Women Say

## A: Food and Nutrition Securit

**Inadequate food consumption:** A total of 310 /440 women shared information about their eating patterns. Discussions with women indicated that their overall food consumption is inadequate as compared to their laborious work in the house as well as in the fields. They eat foods that are available in their areas, and those which they can afford.

The usual pattern noted about food intake was that they take two meals a day. This was mentioned by most of the women in five blocks--Amarpur, Samnapur, Petlawad, Manawar and Sondwa. The women in Thandla block said that they eat three meals in a day. Children eat several times in a day, as per the women from Manawar. Most women said that they eat before going to work in the fields, and then, in the evening, after returning from work. The afternoon meal consists mainly of food that was left over from the morning meal. This food is eaten at home and/or is carried to work place. Women from Sondwa said that their day begins with intake of black tea. In other five blocks women did not mention drinking tea in the morning.

*"We eat two meals in a day. First is between eight to ten o'clock in the morning, and the second between seven in the evening to nine at night. If we are hungry in the afternoon, and if there is some food left from the morning meal, we eat that in the noon. If there is no food left, we do not eat in the noon, even if hungry. We do not cook again in the afternoon," said a woman from Amarpur Block.*

A few women said that vegetables and fruits are eaten once in a day and some said that they eat them two to three times in a week. Usually in most households either vegetables or dal (pulses) are cooked with roti or chawal. When vegetables are not available, they cook dal. In three of the six villages in Petlawad, women also shared information about some families in their village who go hungry, indicating the need to ensure food availability.

**Limited food basket:** A majority of women from all the six blocks said that their meals comprised of roti or chawal (rice- cereals) accompanied by dal (pulses) or sabzi (vegetables). Usually, they eat only two food groups in one meal. It is only in Manawar that almost half (52/115) of the women participants said that they eat meals comprised of roti (made from a cereal) accompanied by both dal (pulses) and sabzi (vegetables). Women from Petlawad said that if vegetables or pulses are not available, they ate only roti (cereal) or else roti (cereal) with mirchi (chillies). Some quotes from the discussions are given below:

*"We eat sabzi-roti, roti-chutney, roti-dal, roti-besan and dal -chawal. Only two foods are eaten. We do not cook roti, sabzi, dal and chawal in one meal," said a woman from Amarpur.*

*"In our villages, rice is the staple food. We grow rice and so we eat it. Wheat roti is rarely eaten. We eat rice with dal or with sabzi," said a woman from Samnapur.*

*"We cook dal often as it grows in our fields and is easier to cook,"* said a woman from Sondwa.

Women conveyed that they eat foods that they grow in their fields or those purchased from the market. These are their only two sources to obtain their food. Only one woman mentioned getting food from the Public Distribution System (PDS or ration shop). No one mentioned receiving any food (THR--Take Home Ration) from the Anganwadi Centre.

Women in four blocks also listed foods that are eaten by the households. While wheat and maize are the main cereals eaten in four blocks--Thandla, Petlawad, Amarpur and Manawar, bajri (pearl millet) is the main cereal eaten in Sondwa, and rice is the main cereal eaten in Samnapur block. Here, a variation in the main cereal was seen in the sampled blocks.

Most of the foods listed by women were those available in the market or grown in their farms. Only in one block Samnapur they shared information about local cereals--kutki, kodon which are grown and sold outside the village, but are usually not eaten by them.

**Cereals:** Makai (corn, maize), bajri (pearl millet), chawal (rice) and gehun (wheat) are the commonly eaten cereals in these six blocks. Women from Manawar, Thandla and Petlawad said that they eat mainly corn and wheat. Corn and rice are primarily eaten in Amarpur, and rice is the main cereal eaten in Samnapur. Women in Sondwa mentioned bajri as the main cereal eaten and they eat wheat and jowar (millet) if available.

**Pulses:** Udad (black gram), chana (brown gram), tuver (pigeon pea) and major (lentils) are the most commonly eaten pulses mentioned by women from all the six blocks. In Samnapur block, women also mentioned eating matri (yellow peas) dal, and in Sondwa, they mentioned eating chaula (beans).

**Vegetables:** Majority of the women participants (310/440) did not talk about eating vegetables and green leafy vegetables. It appears, from their discussion that eating vegetables and fruits depends on the money available with the households, availability of vegetables in the particular season, cost, weather and distance to the market.

*"When we get work (labour) only then we cook vegetables. We do not have money to buy clothes so how can we eat vegetables and fruits?" said a woman participant in a group discussion.*

*"If there is heavy rainfall, we cannot go out to buy vegetables and often we do not eat vegetables in monsoon," said a woman from Amarpur block.*

Vegetables are available during winterand they grow in monsoon and so they are eaten quite often. Some even said that they eat vegetables daily. Women from a couple of villages of Thandla said that vegetables are grown in the village and so they eat vegetables three to four times in a week.

*"Vegetables are scarce in summer. Some families, who have water, cultivate vegetables and others depend on market. There are 20 households in our village who grow vegetables even in summer. So we take from them," said a woman from Thandla.*

In summer or when there is heavy rain, when vegetables are not available, they eat pulses or cook dried vegetables which are preserved during the season. Women, particularly from Samnapur mentioned drying and storing of vegetables for use in summer and monsoon.

*"We purchase gilki (sweet gourd); Vaal (beans), mirchi (green chillies) and baingan (eggplant, brinjal) from the market; and moong (green gram), mungfali (ground nut), soyabean grows in our field. Vegetables are available in our fields till Diwali only," said a woman from Sondwa.*

Market emerged as one of the key sources of purchasing vegetables, if they could not grow in their fields. Most women said that they purchase vegetables from the market but purchasing capacity is also a constraint for some women.

*"There is no income in our house so we do not go to the market. When we have money in our hand only then we cook vegetables," said a woman from Amarpur.*

Some commonly eaten vegetables mentioned by women are as follows:

**Amarpur:** Sarson (mustard), lauki (sweet gourd), bhindi (lady's finger) and aaloo (potatoes).

**Samnapur:** Lauki (sweet gourd), gobhi (cabbage), gobhi (cauliflower), baingan (brinjal), tamatar (tomatoes), aaloo (potatoes), methi (fenugreek leaves), chana bhaji (brown gram leaves), paalak (spinach), muli (radish leaves) etc. Some local vegetables such as chakoda, lal bhaji, chench, kundri were mentioned by women in a village of Samnapur.

**Manawar:** Bhindi (lady's finger, okra), gilka (gourd), karela (bitter gourd), lauki (sweet gourd) and tamatar (tomatoes) were the commonly listed vegetables. Green leafy vegetables were not listed.

**Petlawad:** Pyaaz (onion), aaloo (potatoes), gilka, turiya, lauki, karela (different types of gourds), tamatar (tomatoes) were listed by most women. Paalak (spinach) and methi (fenugreek) were listed by a few women.

**Thandla:** Aaloo (potatoes), bhindi (lady's finger), ilka (gourd), methi (fenugreek), gobhi (cauliflower), chana bhaji (brown gram leaves), tamatar (tomatoes), paalak (spinach), mooli (radish) leaves were listed by most women.

**Sondwa:** Tamatar (tomatoes) and baingan (brinjal, egg plant).

Most women said that since these vegetables are grown at their homes, they eat them frequently. Otherwise, they purchase whatever is available in the market.

**Fruits:** Fruits are rarely eaten as shared by almost all the women of the sampled 36 villages. None of the women from the six sample villages of Samnapur block mentioned eating fruits. Most of the women said that they eat fruits that grow in their homes or in their farms and in the forest. Some also said that sometimes they purchase fruits from the market, particularly when they have young children at home.

*"We never buy fruits. In the season, we eat half a kilogram of mangoes. We do not eat fruits since we do not have money to buy them. Fruits are sold at 100-150 rupees per kilogram so we do not buy them from market," said a woman from Sondwa.*

Mango, banana, guava, pomegranate, apple, papaya, custard apple, berries, palm, watermelon, grapes and java plum (jamun) were some of the fruits listed by women.

**Milk and milk products:** Consumption of milk and its products is a rare event as shared by women from all the 36 sample villages of the six blocks. Only in one village of Petlawad block, women said that children are given milk to drink. They also said that all the households in their village had goats, and so are able to drink milk. Almost all women in Thandla, Sondwa and Samnapur said that they do not consume milk and its products. Only those who have cattle consume milk.

*"In our village, only five households have cows and only one cow gives milk. So members from that household drink milk. Those who do not have any cows (cattle) do not drink milk, "said a woman.*

Ghee is not eaten. It is used for worship or to prepare sweets. Milk is not added to tea as generally black tea is drunk, and is also served to the guests. Some times jaggery is added to the black tea.

Cost is one of the factors affecting milk intake. In one of the six villages of Amarpur, all the ten women said, "Tea is not prepared in any house. Only when a guest comes, black tea is prepared. We do not buy milk because of its cost. It is sold at 50 rupees a litre, we cannot buy it."

**Animal-based foods:** Chicken, eggs, fish and mutton are some animal-based foods which are consumed by households as mentioned by women from all the 36 villages. Some women from Samnapur mentioned that people eat any meat that is available--goat meat, pork, rats, except beef.

The proportion of population eating animal-based food varies from village to village but all the 36 villages had a mix of people who ate animal and plant-based foods. Eating animal-based foods is not a daily practice. Animal-based foods are eaten either once or twice in a month, or once in a week. This is also related to availability of money for some. Availability is the prime factor in eating animal-based foods as some foods such as eggs and chicken are easily available in the village and hence, eaten more often. Fish has to be bought from the market or caught when there is water in the river.

*"When we have money, we cook it four times in a month otherwise we don't. We have money on hand when there is work in the farms. We do not get work in summer," said a woman.*

Women also said that children and pregnant women are not supposed to eat animal-based foods but if a pregnant woman wishes to eat, there are no restrictions. She can eat whatever she wishes. Women also said that in schools and hostels, children are discouraged from eating animal-based foods and so they do not eat these, even if it is cooked at home. Animal-based foods are not eaten during fasting by certain sects, or during shraavan (monsoon) month which is considered auspicious time. Children are introduced to animal-based foods in very small quantities, later. A woman from Manawar said that *"We give eggs and chicken to the children after they are two years of age."*

Some women from Manawar also spoke about the challenges faced in eating animal-based foods. Availability and cost seems to be a common concern. *"We eat chicken once in 15 days but mutton is costly, so we eat it only sometimes, when we have earned enough in that month,* "said a woman. Another woman said that *"In summer and monsoon seasons, we do not get enough vegetables so we eat more of eggs and chicken." "We eat less of chicken in summer as it leads to increase in body heat,"* said one of them.

**Other foods eaten:** Women from Samnapur said that they purchase snacks and sweets from the local market particularly for children as they like to eat them. Jalebi, samosa, namkeen and Kurkure are the most commonly-purchased snacks, they said. In one village, a woman said that *"We do not purchase vegetables but buy snacks from the little money that we have, as our children like to eat them."* Women from three of the six villages of Petlawad said that they eat sweets and special foods like puri, kheer, halwa, rice, bhajiya during festivals. In one village, a woman said that she prepared halwa (a preparation made from roasted flour, ghee and sugar) daily for her child who is fond of it and so they all eat it daily.

**Food Insecurity during lean season:** Women spoke about lean season and their coping methods. Monsoon and summer are the lean seasons when there is no earning from farm labour so it is difficult to purchase foods, said women from all the 36 sample villages. In these seasons, crops do not grow in their farms nor do they earn from farm labour. Several families migrate to Chattisgarh, Karnataka, and Kerala, Gujarat or Rajasthan states, in search of livelihood. Usually, the entire family migrates and if there are grandparents at home, young children are left behind in their care.

Women also shared information about households in the villages that do not have enough food to eat. But they do not go hungry, they said. They either borrow food from neighbours and family or buy from the market, on credit. Most households work and are able to take care of their food requirements, they said. One woman said that *"Due to addiction, their income is spent on liquor or other substances and so the family does not have enough food to eat."*

Vegetables are scarce during summerand there is no money with the families. A few women said that they dry vegetables and store them to be used in the lean season. By and large households save grains for the lean season. Those who do not have land or could not get adequate field produce borrow from those who have surplus. Only couple of women said that they obtain wheat from the ration shop just before starting of summer, so that food is available throughout the season.

*"When food is scarce we only eat pej,"* said women from Amarpur. Pej is a preparation made from corn flour and water.

Women from Manawar said that vegetables and fruits are scarce during summer so most people eat pulses and cereals. Those who can afford, buy vegetables and fruits from the market. No one in the village goes hungry. For households in these villages, it is normal to help and they happily share flour, corn and vegetables.

In one of the six villages of Samnapur, women spoke about several households who do not have enough to eat. They go from house to house in search of food and cook food from what they receive.

*"There are several households in our village who eat one meal a day. If they eat in the morning they miss the evening meal and if they eat in the evening they miss the morning meal. There is a house in our village with five members. With great difficulty, they manage their meals and eat only khichadi,"* said a woman from Samnapur.

Women from Padariya village of Samanapur block deserve special mention as they have developed a mechanism to meet food shortage. *"We meet every week and contribute half a kilogram of rice. If some member conveys that there is no rice in her home or if any member has a function in her house, we provide 50 kilograms of rice and also a thousand rupees,"* said one woman, and the others affirmed this.

Another woman said that *"We provide rice to non-members also. Shantididi is not a member of our group but when she informed us about the condition in her house, we gave her the rice."* Several women echoed *"No one sleeps hungry now-a-days. Earlier we have slept hungry. Those who did not eat beef ate it to*

*satisfy their hunger. But now no one needs to be hungry. All of us do farming and those who do not have their own farms, work in other's fields. In this way we share and move ahead."*

A woman from Sondwa said that *"In the lean season, when there is no wage, we pawn our jewellery and survive. We have to return the money at the interest rate of 25%. So after monsoon, we get wages and we return the loan."*

*" There are 10-15 households in our village who are farm labourers. They live on daily wages and when there is heavy or incessant rainfall, they do not get work. During this period they do not get to eat some times. When this happens, they borrow food from neighbours. We get to know about it during our meetings,"* said a couple of women from Sondwa.

**Cultural practices impacting nutritious food consumption:** Fasting continues to be a woman's domain. In all the 36 selected villages, women said that they fast on two or three specific days of the week, and at times for several days at a stretch during particular festivals such as Navaratri, Dasha Ma, Teej, Mahalaxmi puja etc. The eating practices during fasting days vary as for some it is complete fasting with only intake of tea, for some it means having one meal in a day, or some special foods to be eaten during fasts.

**Diet restrictions:** Baingan (brinjal), kumhda (pumpkin), tuver dal (pigeon pea), masoor dal (lentils) and whole pulses are generally not eaten by women as they are considered heat-producing pulses. Children are not given certain foods like banana, particularly during winter as it is considered cold food and may lead to cough and cold.

**Pregnancy:** During pregnancy, women are asked to eat less or avoid eating certain foods. This is done to avoid large babies, so that they are easily delivered. Moong dal (green gram) and wadi (green or black gram dal chunks) are eaten. Sour and cold foods are to be avoided during pregnancy. Buttermilk, curd, wheat roti, spicy food, onion, lady's finger, potato, brinjal, papaya and ground nuts are foods to be avoided during pregnancy, said women from Manawar. Udad (black gram), masoor (lentils), matar (peas), baingan (brinjal) and kumhda (pumpkin) are not to be eaten during pregnancy, and hence women can eat these foods after childbirth. Women from Thandla said that rice, oil, groundnut, buttermilk, ghee, curd, milk and cold foods are not to be eaten during pregnancy as they are considered harmful for the baby's health. Most of these foods are in any case not part of their daily diet.

**After childbirth:** In most households, restrictions are followed for a month after delivery. Mother and the baby are kept in a separate room or section of the room. Emphasis is laid on eating more energy-giving foods. For the first two to three months after child birth, the woman is given thuli or Dalia (broken wheat) and milk, khichadi (rice and dal cooked together), halwa (wheat flour roasted with ghee and sugar or jaggery), old rice, lauki (sweet gourd), aaloo (potato), dried coconut, jaggery, masoor (lentils) and arhar (yellow peas) dal. Women also mentioned that some herbs are collected from the forest and given to the woman after childbirth but they were not aware of the names of these herbs.

The decision to continue a specific diet is also based on sex of the new-born child. A woman said, *"If a girl is born, the special diet is continued for a month and if a boy is born, it is continued for two months. This is because new-born boys are considered to be weaker than new-born girls and so the mother needs extra care."*

According to what most women said oily, sour, cold and spicy foods, pigeon peas, lentils, black gram, ghee (clarified butter), salt, banana, rice, berries, guava, buttermilk, green chilies,brinjal , pumpkin, green peas, tomatoes , lemon, mangoes are not eaten after childbirth.

**Back to work:** Women from all the 36 36 villages said that getting back to work after delivery depends on one's personal situation. If there is no one else at home, women start working within a week. For those who have family to take care of the little one, they leave the baby with the elders and go to work in the fields. And for those who have no one at home, they tie their baby on their backs and go to work. If the family has money, women return to work after two to three months otherwise they return immediately after childbirth.

## B: Gender Issues

**Gender discrimination in education:** Women in the 36 villages said that both boys and girls are sent to school. Most of them said that the children are allowed to study as much as they want. Parents do not discourage them from studying further. The challenge comes when the school is outside the village; then only a few girls get to study further. For example, a school in a village of Amarpur has classes up to third grade. The high school is 15 kms away from the village. Most boys manage to attend the high school but more than half of the girls do not continue with their education.

Economic condition of the household also affects girls' education. A woman said that *"Girls study up to eighth grade in the school which is in our village. Then, the girls from poor families are pulled out and sent for labour work."*

Several women in Thandla, Manawar and Petlawad and Samnapur blocks said that girls are encouraged to study as long as they want. But the decision to send the girls for their higher education depends on financial resources. If resources are scarce, girl's education is often compromised. Once out of school they are sent to cities in Gujarat and Rajasthan, for work.

*"Girls get to study to a lesser grade than boys. When there is no money in the house, girls are first to be taken out from schools. Because boys will feed us after they complete their studies."*

Women also said that those who have money send mostly boys to private schools. Poor people send their children to government schools in the village.

In response to the issue of children commuting to the schools, a woman said that they accompany their children till they are five years of age. Other women said that there is a cycle which is given to commute to the school. However, the girls did not use the cycles to go school. Women also spoke about the challenges of being educated.

*"There is no benefit in being educated. The educated people of our village have no jobs. A boy and a girl in our village have studied up to graduation but they do not have jobs. Another boy has studied till 12$^{th}$ grade but he has got a job and works as a computer operator."*

**Age at marriage:** Almost all women in the 36 sample villages were aware of the legal age required for marriage of boys and girls which is 18 years for girls and 21 years for boys. They unanimously agreed that this is the appropriate age for marriage. Marriage at an earlier age had affected their own lives and they would not let that happen to t heir children, they said. Usually, if the girls and boys want to study further, they are married after the legal age. In one village Sarikhpura, of Manawa block, women said that the SHG members file a police complaint if anyone in their village gets their children married before legal age. Therefore, most households marry their children as per legal age bar. If girls do not wish to study further then they are married at an earlier age. The age at marriage, in their villages, is in between 15-17 years for the girls and for the boys it is 20 years of age, they said. However, in cases where the boy and the girl are found to be in love with each other, then they get them married without worrying about the legal age. The age is usually ignored in such cases as there is a fear of elopement. Elopement is considered as a negative mark on the honour of the family.

**Women eat last:** It is found that cooking and serving is still women's responsibility. *"Since we cook the food, we eat last,"* said a woman. Almost all said that most women eat the last. Men or elders eat first, followed by children and then, they themselves eat. At times, if both of husband and wife have to go out for work, they eat together. In some households, there is no such sequence followed; they eat as and when they are hungry. Women also said that if there is no food left, they do not cook for themselves, and remain hungry. *"It is alright if we do not eat at night but we have to go to work so we have to eat in the morning, "* said a woman.

**Work and employment:** Most women said that farming and labour were the two common works outside their homes. Men and women both worked in the fields, but only men go outside the village, to work, said a couple of them. So it would depend on the household whether women would work in the village or go out of the village.

*"Women and girls are allowed to work outside villages nowadays. Women go with their husband to Gujarat or bigger cities to work. Cost of living is rising day by day. It is good to have a good inflow of money when both husband and wife work,"* said a woman.

Gender division of work was obvious. *"Women do housework, farm work and labour work but men work only in farms or work as laborer."* said a woman. Most women shared information about their daily routine saying that they wake up early at four or five in the morning and continue to work till ten o'clock at night. They get only one or two hours rest, sometimes, in between from their work.

Some women also shared their concern over lack of livelihood opportunities. One said that there are not enough jobs, and another said that when children do not get jobs despite higher education, they work as laborers.

**Mobility of women and girls:** Most women said that they do not have free time to go anywhere. For almost all of them the day begins very early, at four or five in the morning and after doing their household work, they set off to work in the fields. If their houses are located near to the fields, they return in the afternoon to eat or complete the unfinished chores and go back to work. They return to their home in the evening and again get busy in house work, cattle work, cooking and then go off to sleep. They hardly get free time from their busy work schedule. If at all they get time they take some rest.

For most women an outing is when they visit their natal homes or when there is a mela (local fair). That too they are not allowed to go alone. Women unanimously said that besides going to school, girls are not allowed to go out alone. When asked why, they spoke about fear of abduction and rape as a reason for restricting girl's mobility.

**Menstrual practices:** Most women said that menarche is at the age of 12 to 13 years and menopause is at the age of 45 years. Most women conveyed that they use cotton cloth to soak the menstrual blood. The cloth is washed with detergent and dried under a sari or in such a way that it is not visible to anyone. Some women also said that for soaking menstrual blood, they buy the cloth (known as menstrual piece which made from flannel material and is red in colour) from the market. Few women spoke about using pads which are purchased from the market or from the Self Help Group. The used pads are burnt or buried in the ground. Girls who study in school also use pads. These are available at the Anganwadi Centers of some villages.

**Cultural practices during menstruation:** Women from all the 36 villages said that menstruation is considered impure and therefore, women are isolated and discriminated. Women do not cook during menstruation. Men or other family members cook food during those days. As a consequence women and girls have no say in what is given to them to eat, and when it is given to them. A woman also talked about the plight of young girls. *"Young brides are shy to ask for food. So they do not ask for food, even if they are hungry. They eat whatever is given to them."* During menstruation, women are asked not to enter places such as kitchen, prayer place, temple and fields where certain crops are grown. But this break does not give them any respite as during these days they have to do all the other work, including pending tasks.

## C: Women's Health

**Seeking treatment:** In almost all the 36 sampled villages, when sick, women seek care in public as well as private health care facilities. In Samnapur, they said that if they do not get cured from these two sectors, they also go to a local healer. A couple of women said that women often delay seeking treatment. They wait till they are unable to get up from the bed. A woman also said that *"If a boy is sick they take him to the doctor for treatment but ask the girls to take rest at home."*

*"When we go to public health facility, they simply give us tablets and do not give us injections and the job is done. When we go to private clinic, we pay them five hundred to two thousand rupees and they give us good treatment. If it is just fever, the treatment costs us up to two hundred rupees,"* said a woman.

*"In Government facility, they take blood from our fingers and check it, give us tablets and send us away. When we do not get cured, we go to Bhanpur or Samnapur at any clinic or hospital wherever we feel like going,"* said another woman.

*"When we go to public facilities, they admit us for two to four days or else refer us to Dindori or Mandla or Jabalpur. If we go to Jabalpur, we get lost in the city,"* said a woman from Amarpur.

*"We do not go to government hospitals because they get us admitted, and then who will take care of our homes when we are away? The private doctor treats us and sends us home."* said another woman.

A woman from Amarpur said that *"When the ANM comes, we go to the Sub Health Center and take medicines but on other days, the centre remains closed."*

Usually women go to the ANM if she is present or to a private practitioner in the village. Then they go to the Government Primary Health Centre for treatment. They visit the public health facility primarily because it is near, services are free and they get money for delivery. Most women said that they go to public facilities for delivery and find those services good.

Some women also said that they preferred private facilities as the services are better and faster. They would like to get free services from the public health facilities but are willing to spend money for want of better and quick treatment.

**Common illnesses:** Aches and pains, coughs and colds, diarrhea and vomiting, seasonal illnesses, malaria, are some of the common illnesses found in these villages. Weakness , swelling during pregnancy, fatigue, aches and pains after delivery, white discharge, painful periods--particularly among girls, heavy bleeding, prolonged menstrual bleeding are some of the health problems women face in these villages. Some women also spoke about seasonal illnesses which are as listed below:

- During monsoon eye infections, diarrhea, vomiting, fever and malaria are common.
- During summer and Harvest heatstroke, headache, diarrhea and fever are common.
- During winter fever, vomiting, cough and cold, malaria, body ache and skin problems like scabies are common.

## D: Infant and Young Child Feeding Practices

Initiation of breast feeding: Most women said they feed the baby immediately after birth, within one to two hours. There had been a change in the practice of initiating breast feeding since past few years. Since women deliver at the hospitals, the nurse asks them to put the child to breastfeed, as soon as the baby is born. However, some also said that breastfeeding is initiated six to seven hours later, or on the next day after the delivery. Most of the women said that breast feeding is initiated after giving the baby a bath. One of them said that they do not throw away the colostrum and feed it to the baby.

**Exclusive breast feeding:** As per their respective cultures, women practice prolonged breast feeding to infants. Breast feeding is continued till the baby starts eating on its own or till the age of one and half years or till the mother conceives again. However, the child is also given water, top milk and foods, randomly. Women also said that *"If the breast milk does not flow, the baby is fed cow's milk."*

**Initiation of complementary feeding:** A few women spoke about initiation of complementary feeding. The age at introduction of complementary feeding to the baby was four to five months, according to most women. A few women also said that they start giving food when the babies are nine months of age. Some said that foods are given even later when the baby is eighteen months old. Some said that they wait for the child to eat on its own. There was a difference in initiating complementary feeding to girls and boys as mentioned by women in some of the sample villages. Girls are fed at the age of four months and boys at five months. There was no specific reason given for this practice. *"It is custom and we follow the same,"* said a couple of them.

The most common food mentioned to be given as complementary food was biscuits followed by kheer (milk porridge) and foods cooked at home. No one talked about any ritual (annaprashan) for initiation of complementary feeding. Only a couple of women mentioned giving complementary food from the Anganwadi Centres.

Almost all women said that the mother decides about feeding the child. Some also said that the person who stays back and cares for the baby decides, and sometimes the in-laws decide about feeding the child. A woman highlighted the issue of food availability in the household. *"If there is food in the house, it will be fed to the baby. The question of who decides does not arise then,"*-she said. The father is hardly involved in

## E: Access to Entitlements

**Information about immunization services:** Women said that Anganwadi Centre and Sub Health Centre are the two places where immunization services are provided, on Tuesdays. A few women were able to list the first three doses of immunization. A couple of them said that the ANM or ASHA comes to call them for immunization and shots are given to children as well as to pregnant women. Women spoke about children getting fever afterwards and the injection site being painful and infected. Most women did not speak about the importance of immunization, the diseases that were prevented, the names of the vaccines and the immunization schedule.

**Information about growth monitoring:** Most women were aware that children are weighed at the Anganwadi Centres and that the child's mid-upper arm circumference is also measured. Most said that the AWW and ASHA tell them about the weight of the children. A few women said that they are informed whether their children are in red, yellow or green category but most of them said that they did not know about their child's nutrition status. Some of them also mentioned irregularities in weighing their children. In Manawar, women also discussed challenges in referral of Severely Acute Malnourished (SAM) children.

*"We can't take children to Manawar and stay there for so long as we are needed at home to work and take care of the home and other children,"* said one of them.

A woman from another village said that *"ASH asked a mother to take her child to Manawar for treatment. But her family members did not let her go."*

Another woman pitched in saying *"She (a woman) wants to take her child to Manawar, all mothers want to see their children in good health, but we can't go against them (family members)."*

**Contraception:** Most women were aware about spacing and permanent methods of contraception. They mentioned oral pills, condoms, copper- T and women's sterilization as the prevalent contraceptive methods. Majority of women said that sterilization of women was the most preferred contraceptive method. Usually they wait till the desired number of children, including the desired number of boy and girl is born, and then they opt for woman's sterilization. The desire for son does affect their decision to adopt contraception.

*"In our village, after two children--a boy and a girl are born, they go for sterilization. Some even go after the birth of a third child. They wait for the birth of a son."* said a woman

*"There is nothing like family planning. We wait for two children and then go for sterilization,"* said a woman. Another woman said *"We prefer sterilization as it is in the hands of the women to limit the number of children." "Usually after two children, women go for sterilization. But if both the children are girls, they wait for the birth of a son. The wait for a son continues till the birth of four daughters and then, if the son is not born they go for sterilization,"* said another woman.

The reason for men not getting sterilized as given by a couple of women was that *"Earlier women used to be scared of operation-sterilization, so men adopted contraception but now women are not scared and they opt for operation so men do not get operated."* Another reason mentioned by them was that "Men have to do heavy work and so they do not adopt sterilization."

The question as to whether contraception is discussed with their spouses evoked giggles from women and there was some hesitation to speak. By and large women said that there is no such discussion with spouse. But when it comes to taking decision about sterilization, they discuss with their spouse. The role of ASHA in family planning was limited as almost all women said that ASHA does not counsel newly-married couples.

**Access to services at the Anganwadi Centre (AWC):** When discussed about services from the AWC, a few women spoke and the responses were mixed.

Most women said that the AWC operates regularly- opens and closes on fixed time; a few women said that it opens only once a week. Some also said that they do not keep track of the AWC as their children have grown up.

Most women mentioned immunization, disbursement of food packets and hot cooked meals for children as the most common services of the AWC. A few also mentioned weighing of children, organizing games for children, and providing education to children were the services provided at the AWC. Regarding Take Home Ration (THR), it appears that there is lack of clarity regarding what is provided, to whom, the quantity and the day for dissemination. None of the women could list all the six services of the Integrated Child Development Scheme which are expected to be provided at the AWC.

A majority of women said that they did not know about the services provided to adolescent girls or they said that girls did not receive anything from the AWC. A few said that girls are provided Iron Folic Acid (IFA) tablets and some said that sanitary pads were provided.


When discussing about food provided by the AWC, the response was mixed. For example, in Amarpur, women in three villages said that food is not provided, and in three other villages they said, food is provided at the AWC but they are unaware of the menu. In Sondwa, most women said that the food is not provided, nor hot meals are served. Few women said that in some AWC dalia khichadi is given.

The discussion on services to pregnant women revolved around receiving THR packets. Most women said that pregnant women are not given THR but lactating women are given those packets. There was no discussion on the number of packets given, the disbursement schedule or its importance and use. Women also mentioned about irregularity in receiving THR as well as hot cooked meals.

*"Women get packets (-THR) two times during the nine months of pregnancy. There are two Anganwadi in our village. All women in Narmada tola get the packets but not in Sadak tola,"* said a woman from Amarpur.

In one village, women said that the *"Women's group provide cooked food to the AWC but it is not as per the menu. They do not get supplies on time and so they provide whatever is available with them."*

Regarding hot cooked meals, most women were aware that hot cooked meals-khichadi or dalia is given to children. In Sondwa, they said it is usually given on Tuesday when the centre is open and food packets are also given on the same day.

Several women also said that AWC does not open daily and so children do not go there. *"On Tuesday, at the AWC, children are given small quantities of food in their hands. By the time children reach their homes, the food gets spilled. Nothing else is given."* A woman from Sondwa also said that children are not taught at the AWC.

Some of the challenges in receiving the services from the AWC were also mentioned. These included lack of information regarding services available at the AWC; irregularity in functioning of AWC and poor quality of services.

Women said that they do want better services from the AWC. *"If the centre opens daily, if services and food are provided, the children will go to the AWC."*

**Access to public health services:** Discussions were held around access to services during pregnancy, childbirth, contraception, and child health. Women shared that they accessed health services from the public system, particularly immunization, pregnancy and childbirth related services.

Women said that they were aware that food and tablets (Iron Folic Acid) should be provided to women during pregnancy. Almost all women who spoke about the experience with 108-emergency transport service said that when they dial for the ambulance it usually arrives at the location. Most said that the ASHA helps them to call the ambulance and accompanies them to the hospital.

Most women were aware that they are supposed to get money if they go for delivery in public hospitals and the majority said that 1400 rupees are to be provided. While getting all the necessary documents was a challenge, some women also said that that despite submitting all the documents, they do not get the money. There was confusion regarding the amount received through Janani Suraksha Yojna (JSY) and the Shubh Lakshmi Scheme (to promote the birth of girl children) which provides cash benefits. They mentioned receiving the amount ranging from rupees Rs. 1200 to Rs. 1600. Some of the concerns shared by them included delay in receiving benefits, demand for informal payments, need for extensive documents and identity verification. These are tedious as at times, as the documentation and identity proofs are not available with families.

Most women said that they do not have to pay for delivery services at public health facilities. Women from Samnapur and Amarpur said that they did not incur any expense for delivery at the public health facility.49 women from Petlawad, Thandla, Manawar and Sondwa said that they incur expenses, even if the services are free. They said they had paid for delivery services, medicines, beds, documentation, etc. at the public health facilities. The amount ranged from Rs.300 toRs.1000. Two women said that their families spent around Rs.12, 000 and Rs.25, 000 respectively for Cesarean section delivery in the private sector.

**Inadequate food from Public Distribution System (PDS):** Regarding access to PDS, women from 36 villages said that almost all of them have ration cards. They do get ration such as wheat/corn, rice, salt and kerosene. However in a few of the villages, the women said that the quantity of grains received was not enough. Some also complained about the quality of grains. They also said that the salt is full of "black pebbles "so they discard it or wash it properly. Perhaps they were not aware that the salt is double fortified salt, which is provided by the Government of Madhya Pradesh.

**Poor access to MNREGA entitlements:** Women in all the 36 villages unanimously said that they and most people in the villages have job cards. Most women said that they have not received any work since last few years. Some of them also said that they have not received payments for the work done. A woman articulated the reason for no jobs as: *"Now a day's work is mechanized so one does not need people to do labour, and so we do not get work."*

**Inadequacy of Mid-Day Meal scheme:** Most women were aware that children get food in the Government schools. They were also aware of the menu and they said that the children liked the food. A few women said that the food was inadequate, the dal was watery and children remained hungry. Women in two villages spoke about the strike by women's groups who cooked the mid day meals and so the food supply was interrupted.

**Low awareness on VHSNCs and Gram Panchayat:** In all the 36 sampled villages, women said that they did not know about the VHSNCs or the role of Panchayat in promoting health.

**Inadequate water sources:** Bore well and hand pump were the sources of water were mentioned by women. In a couple of villages, women mentioned that they get piped water and were happy about it. However, most women said that in summer, there is scarcity of water and they have to draw water from the hand pump which is usually far from their homes.

**Sanitation facilities inadequate:** Most women said that in their villages, some households have toilets and some do not have them. Some households cannot use their toilets as the construction is poor or incomplete. In several villages, women said that almost half of the household members defecate in the open grounds. They also said that the Government's share of the cost for construction of the toilets has not reached to the people or to the builders who build their toilets.

# Gaps in Public System

## A. About Village Health and Nutrition Day (VHND)

Of the 14 VHND sessions that were observed by CHETNA team, 6 sessions were held at Anganwadi Centre, two each at Sub Health Centre and Public School and one session was held at ASHAs' home. All the three provider-- AWW, ASHA and ANM were present in 13 sessions, and a Multi Purpose Worker (MPW) was present in one session. Doctor was not present at any of the fourteen sessions, and the Panchayat members were present at two VHND sessions. UIP master register, and mother and child health master register was available at all the sessions. However, there were gaps in availability of basic amenities, equipment, supplies and drugs. Most of the essential medicines were not available at these sessions.

Counselling on household purification of water was done in 4/14sessions; that for a household toilet was done in 3/14 sessions and WASH practices like hand washing was demonstrated in two sessions only. (For block- wise details, please refer Table5).

**Table 4: Equipment and Supplies at VHND**

| No. | Aspect | Number (n=14) |
|---|---|---|
| Equipment1 | | |
| 1 | Apparatus to measure blood pressure | 13 |
| 2 | Adult weighing scale | 13 |
| 3 | Weighing scale for babies | 12 |
| 4 | Stethoscope | 09 |
| Medicines and Supplies | | |
| 5 | Tetanus Toxoid vaccine | 14 |
| 6 | Vitamin A Solution | 14 |
| 7 | Iron Folic Acid tablets | 10 |
| 8 | Oral contraceptive Pills/Condoms | 11 |
| Services | | |
| 9 | Motivation for conraception | 05 |
| 10 | Counselling on use of contraceptives | 3 |
| 11 | Ante Natal Check-ups | 11 |
| 12 | Counselling to pregnant women | 08 |

| Table 5: Block-wise Details of Supplies and Services at VHNDs | | | | | | | |
|---|---|---|---|---|---|---|---|
| No. | Particulars | Manawar (N=1) | Thandla (N=4) | Petlawad (N=4) | Samnapur (N=4) | Sondwa (N=1) | TOTAL (N=14) |
| 1 | Banner and poster displayed | 0 | 3 | 0 | 2 | 0 | 5 |
| 2 | Drinking water available | 1 | 3 | 3 | 3 | 1 | 11 |
| 3 | Toilet facility available | 1 | 1 | 2 | 1 | 1 | 6 |
| 4 | Immunisation card available | 1 | 3 | 4 | 3 | 1 | 12 |
| 5 | OPV given | 1 | 4 | 4 | 3 | 1 | 13 |
| 6 | Children weighing done | 1 | 4 | 2 | 4 | 0 | 11 |
| 7 | Nutritional advice to mother | 0 | 3 | 3 | 2 | 0 | 8 |
| 8 | Vaccines available | 1 | 4 | 4 | 3 | 1 | 13 |
| 9 | Vitamin A available | 1 | 4 | 4 | 4 | 1 | 14 |
| 10 | Tab Albendazole available | 1 | 4 | 2 | 4 | 1 | 12 |
| 11 | ORS available | 1 | 3 | 3 | 4 | 1 | 12 |
| 12 | Zinc tablets available | 1 | 2 | 1 | 4 | 1 | 9 |
| 13 | Cotrimoxazole(pediatric) available | 0 | 2 | 2 | 2 | 1 | 7 |
| 14 | Drugs for minor illness available | 1 | 2 | 1 | 4 | 1 | 9 |
| 15 | Emergency contraceptive pills available | 0 | 0 | 3 | 4 | 0 | 7 |
| 16 | Drug for malaria available | 1 | 3 | 3 | 3 | 0 | 10 |

## B. About Gram Arogya Kendras (GAK)

A total of 29GAKs were visited by CHETNA team to understand their functioning. The following are some observations:

Signage and Basic Infrastructure at GAKs:

- Sign board for GAK and AWC was displayed at 10/29 GAKs
- Village health plan was displayed at 3/29 GAKs
- Chair was available at 26/29GAKs
- Table was available at 23/29 GAKs
- ANC table was available at 22/29 GAKs but foot-step was available only at 16/29 GAKs.
- Availability of Information at GAKs:
- Basic information about the village was available at 14/29 GAKs
- Details of SHGs, mothers support group was available at 12/29 GAKs.
- Information about the SHG providing Midday Meals was available at 15/29 GAKs
- Information about target couples, pregnant women, new-borns, under five children, malnourished children, children registered in AWC and Birth, Death &Marriage registration details were available at (27/29 GAKs.
- Details and lists of immunization; list of people suffering from tuberculosis, leprosy, diarrhoea, and malaria were available at 20/29GAKs. List of temporary methods of FP was available at thirteen13/29GAKs.
- 16/29GAKshad the names of, and services provided by, ASHA, AWW and helper, and 15/29 had the information of health services provided by ANM and MPW and their visits.
- Contact details of officials and Janani Express was displayed at 11/29 GAKs. Information about village health sanitation and nutrition committee was available at 18/29centres but the detail of untied fund was available at fourteen GAKs.
- Register for village health meeting was available at 24/29 centres and register for other activities were available at7/29GAKs.

Availability of Instruments and Equipment: None of the GAKs had all the mandatory/necessary equipment available at the centre. (Please refer Table 6 for block-wise availability of instruments and equipment at GAKs.)

**Table 6:Availability of Instruments and Equipment at GAKs**

| No. | Particular | Manawar (n=3) | Thandla (n=5) | Petlawad (n=5) | Sondwa (n=6) | Amarpur (n=4) | Samnapur (n=6) | Total |
|---|---|---|---|---|---|---|---|---|
| 1 | Baby weighing machine | 1 | 2 | 3 | 3 | 3 | 6 | 18 |
| 2 | Infantometer | 2 | 4 | 2 | 1 | 1 | 3 | 13 |
| 3 | Children weighing scale | 2 | 5 | 5 | 3 | 1 | 6 | 22 |
| 4 | Adult weighing scale | 2 | 5 | 5 | 1 | 4 | 6 | 23 |
| 5 | Haemoglobin meter | 2 | 3 | 3 | 3 | 3 | 1 | 15 |
| 6 | Stethoscope | 2 | 0 | 3 | 0 | 1 | 4 | 10 |
| 7 | Curtains | 1 | 4 | 2 | 0 | 3 | 3 | 13 |
| 8 | Functional BP instrument | 2 | 4 | 3 | 0 | 2 | 6 | 17 |
| 9 | Thermometer | 2 | 5 | 4 | 1 | 3 | 6 | 21 |
| 10 | Slides | 2 | 5 | 4 | 5 | 4 | 5 | 25 |
| 11 | Almirah | 2 | 3 | 3 | 3 | 4 | 6 | 21 |
| 12 | Water tank | 3 | 4 | 4 | 2 | 4 | 0 | 17 |

**Availability of Medicines:** A huge gap was observed in availability of medicines at GAK. When compared with the Essential Drug List (EDL) meant for GAKs, none of the 29 GAKs visited by CHETNA team had all the drugs available. (Please refer Table 7 for medicines available at GAKs).

**Table 7: Availability of Medicines at GAKs**

| No. | Particular | Manawar (n=3) | Thandla (n=5) | Petlawad (n=5) | Sondwa (n=6) | Amarpur (n=4) | Samnapur (n=6) | Tota N=29l |
|---|---|---|---|---|---|---|---|---|
| 1 | Oral Rehydration Salt | 1 | 4 | 5 | 5 | 3 | 6 | 24 |
| 2 | IFA tablets- small and large | 1 | 5 | 4 | 5 | 3 | 6 | 24 |
| 3 | Cotrimoxazole tablets | 1 | 2 | 2 | 2 | 1 | 1 | 9 |
| 4 | Zinc sulphate dispersible tablets | 1 | 3 | 3 | 4 | 3 | 4 | 18 |
| 5 | Paracetamol tablet (500mg) | 1 | 2 | 3 | 5 | 4 | 6 | 21 |
| 6 | Albendazole tlblets (400mg) | 1 | 5 | 3 | 3 | 4 | 5 | 21 |
| 7 | Dicyclomine tablets (10mg) | 1 | 1 | 2 | 1 | 3 | 5 | 13 |
| 8 | Povidon Iodine ointment | 1 | 4 | 3 | 3 | 2 | 1 | 14 |
| 9 | Cotton bandage | 1 | 5 | 5 | 5 | 3 | 2 | 21 |
| 10 | Absorbent cotton | 1 | 5 | 4 | 2 | 2 | 1 | 15 |

**Scoring of GAKs:** A score card was developed by the TRIF Health and Nutrition Sector Council for assessment of GAKs which is based on the facilities and services available at the GAKs. There are a total of 57 indicators and each indicator in the checklist is allotted one mark. The maximum score is 57. On the basis of this, the scoring of GAKs was done and grades were given accordingly. As per the scoring system more than half of the GAKs get a 'C' grade and are in the red zone. The minimum score was14% and the maximum was 89%. (Please refer Table 8 for grades)


**Table 8: Grading of GAKs**

| Percentage Range | Grades | Manawar | Thandla | Petlawad | Sondwa | Amarpur | Samnapur | Total |
|---|---|---|---|---|---|---|---|---|
| Above 80% | A | 0 | 2 | 1 | 0 | 0 | 0 | 3 |
| Between 61% to 80% | B | 1 | 1 | 1 | 1 | 1 | 2 | 7 |
| Below 61% | C | 2 | 2 | 3 | 5 | 3 | 4 | 19 |
| Total | | 3 | 5 | 5 | 6 | 4 | 6 | 29 |

## About the Accredited Social Health Activists (ASHAs)

A total of 39/54 ASHAs accredited in the 36 sample villages were interviewed. A majority of ASHAs (20/39) were in the age group of 20-30 years and were from Scheduled Tribe (ST) caste category. Their education ranged from second standard to graduation, with majority of ASHAs (16/39) educated between sixth and eighth standards. Their work experience ranged from a year to eleven years, with most ASHAs (18/39) having experience within the range of six to ten years. Please refer Table 9 for profile of ASHAs). Each ASHA is expected to cover a population of approximately 1372 people.36/39 ASHAs said that all the communities in their area can access their services. Almost all (38/39) ASHAs said that they had received training on their roles and responsibilities when they first joined the work. Their training included technical aspects of maternal and child health, nutrition, contraception and counselling. Almost all of them listed their key tasks as: providing maternal and new-born care; counselling; community awareness and mobilisation; survey and documentation; home visits; accompanying for delivery; schemes linkages; immunisation; Direct Observation Treatment (DOT) for tuberculosis; taking blood smear for malaria and referral; weighing; convening GSSGT meeting;, dispensing medicine, participation in VHND, etc.

**Some of the concerns are as follows:**

- **Availability of drug kit:** 5/39 ASHAs did not have the drug kit.
- **Supply of contraceptives:** 3/39 ASHAs said that the supply was irregular.
- **Maintaining records:** 21/39 ASHAs said that they have to maintain too many records.
- **Difficulty in performing tasks:** ASHAs also mentioned that they face difficulty in performing some of their tasks. These are:
  - Counselling of family members to take the child to NRC, women for LTT, and on family planning services, counselling of pregnant women.
  - Accompanying pregnant women for delivery mainly in night
  - home visit to poor and remote homes
  - conducting surveys and maintaining records
  - writing slogans
  - campaign target accomplishment
  - ensuring patients consume medicines
  - Haemoglobin testing.
- **Attesting their activities:** 6/39 ASHAs said that they face difficulties in getting their activities attested.
- **Support from VHNSNCs:** 19/39ASHAs said that they did not receive any support Work load: 28/39 ASHAs said that they were overburdened with the department work.
- **Incentives:** All the ASHAs said that their incentives were delayed at times.
- **Grievance Redressal:** Only 7/39ASHAs were aware about ASHA grievance redress mechanism.

### Suggestions made by ASHAs

**Suggestions for themselves** Ensure provision of fixed salary to ASHAs; increase salary; reduce work load (especially survey);ensure they get support from PRIs; change in the schedule of home visit during immunisation; provide video clips for use in awareness campaigns; provide due list for immunisation in advance and not on the day of immunisation; provide accommodation for ASHA when they accompany women at CHC; nominate ASHA according to hamlets, create community awareness about the role of ASHA.

**Suggestions for improvement in services:** Timely disbursement of JSY and other payment to women; improve 108 accessibility; increase in the number of 108/JSY vehicles, ensure 108/ Janani ambulance reaches on time during emergency; reduction in the documentation for beneficiaries to avail the scheme benefits.

**Table 9: Basic Profile of ASHAs(Age range-wise table)**

| No. | Age | No. of ASHAs | Category | Education Qualification | | | | Work Experience (in years) | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Up to 5 Std. | 6 to 8 Std. | 9-10 Std. | 10th grade and above | Up to 5 | 6 to 10 | Above 10 |
| 1 | 20-30 years | 20 | ST-18 OBC-2 | 2 | 7 | 7 | 4 | 8 | 11 | 1 |
| 2 | 31-40 years | 18 | ST-15 OBC-3 | 1 | 9 | 5 | 3 | 1 | 6 | 11 |
| 3 | 41-50 years | 1 | ST | 0 | 0 | 1 | 0 | 0 | 1 | 0 |
| | | 39 | ST-34, OBC-5 | 3 | 16 | 13 | 7 | 9 | 18 | 12 |

## C. About the Anganwadi Centers (AWCs)

A total of 73 centres were visited to understand their functioning. Please refer Table 10 for basic details. The following are some observations:

- More than half of the centres (48/73) operated from their own buildings.
- The rest (25/73) operated from schools, Panchayat building, or the worker's home.
- More than half (43/73) of the centres needed repair.
- More than two third (56/73) of the centres needed water proofing.
- More than half of the centres (45/73) were not having boundary wall.
- 11/73centres were not easily accessible to the community as they were far from the hamlets.
- Most of the centres had baby weighing scale (66/73) and adult weighing scale (67/73).
- More than three fourth of the centres (61/73) had growth chart available.
- Most of the centres (68/73) had vessel for storing drinking water.
- Indoor play equipment and mats for children to sit were available at more than three fourth centres (61/73 and 57/73 respectively).
- IEC material was displayed in three fourth centres (55/73).
- THR stock was also available at more than three fourth centres (57/73) at the time of visit.
- More than half of the centres (42/73) did not have medicine kit.
- More than three fourth of the centres did not have medicines such as IFA tablets, Tab. Punarnava Mandur, Tab. Chloroquine, ORS packets, Tab. Paracetamol, Dicyclomine, Anti-septic ointment, cotton, bandage and thermometer.

### About the Anganwadi Workers (AWW)

Discussions were held with 78/146 AWWs that were expected to operate the AWCs. Majority were in the age group of 31-40 years, stayed in the village, were educated up to 10$^{th}$standard and above and were working since 10 years and more. Educational qualification and experience detail of one worker was not available at the time of the visit (Please refer Table 10 for the profile of AWW workers).

**Table 10: Basic details of the AWCs**

| No. | Particular | AWC status (N=73) |
|---|---|---|
| 1 | Designated building available for AWC | 48 |
| 2 | Location and easy accessibility | 62 |
| 3 | Availability of electricity | 11 |
| 4 | Clean drinking water available | 50 |
| 5 | Toilet available | 39 |
| 6 | Indoor activity space available | 47 |
| 7 | Storage facilities for food available | 41 |
| 8 | Storage facilities for equipment available | 35 |

Almost all the workers (74/78) said that they received training when they first joined and were able to list the major topics covered in the trainings which included pre-school education, health and nutrition topics, and that of their roles and responsibilities as AWW.

**Table 11: Basic Profile of AWW Workers (n=78)**

| No. | Age | No. of AWW | Caste | Education Qualification | | | | Work Experience (in years) | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 1 - 5 | 6 - 8 | 9-10 | 10 above | Up to 5 | 6 to 10 | Above 10 |
| 1 | 20-30 | 15 | ST-14, OBC-1 | 0 | 3 | 1 | 11 | 8 | 4 | 3 |
| 2 | 31-40 | 35 | ST-30, SC-2 OBC-3 | 6 | 10 | 2 | 17 | 3 | 7 | 25 |
| 3 | 41-50 | 18 | ST-9, SC-2, OBC-7 | 5 | 3 | 3 | 6 | 0 | 0 | 17 |
| 4 | 50 above | 10 | ST-5, OBC-5, Gen-3 | 3 | 4 | 1 | 2 | 0 | 0 | 10 |
| | | 78 | ST-58, SC-4, OBC-13, Gen-3 | 14 | 20 | 7 | 36 | 11 | 11 | 45 (1-NA) |

**Almost all the AWW listed their key tasks as:**
Providing pre-school education; THR distribution; immunisation; adolescent meetings; home visits; counselling; documentation; nutrition education; referral; mangal diwas (Tuesday) celebration; growth chart plotting and assessing nutrition status of children; collecting data for survey; counselling to pregnant and lactating women; providing IFA supplementation, participation in VHND and regular functioning of AWCs.

Almost all the workers (77/78) said that they undertake home visits, and homes were selected on the basis of children not coming to AWC, pregnant and lactating women, need-based malnourished children and children suffering from diarrhoea.

**Some of the concerns:-**

- Some of the AWW said that they found it difficult to regularly conduct growth monitoring, including growth chart plotting and counselling.
- Ten AWW said that it was difficult to keep the AWC open every day due to vacant post of helper, and absence of AWC building. Also that number of children enrolled was more than expected; delay in release of rent; pressure of frequent participation in meetings, and AWC being located far from their own homes.
- There was a gap in daily attendance of children as compared to enrolment. The reason given was high rate of migration, children going to private schools, self-exclusion by some households, and distance of the centre from the homes of young children.
- More than half of the workers (44/78) had concerns regarding hot cooked meals; these included insufficient quantity of food, poor quality of food, delay in providing food, and irregularity.
- Around one fourth (14/78) of the workers said that they did not receive support from other functionaries in the village.
- Around three fourth (55/78) AWWs said that they had to maintain too many records, and more than half of them (44/78) said that they were overburdened by work, and one fourth (27/78) said that they did not have enough time to perform their duties.
- More than half of the workers (44/78) said that the funds were not enough to operate the AWC. They said that they had to spend money from their own pocket for mangal diwas celebration, stationary, etc. otherwise they have to compromise on the activities.

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## Achievements and Suggestions shared by AWWs

**Major achievements:** The attendance of children has increased; improved linkages with other schemes; increased immunisation coverage; increase in mainstreaming of children in schools; increase in institutional deliveries, and community awareness. They said that now SAM children are referred to NRC and the number of malnourished children has decreased, women have started to work and earn; toilets are being constructed and there is awareness about sanitation. The VHNDs are regularised. There is an increase in women undergoing sterilisation operations. They themselves are respected in the community and there is a reduction in maternal and infant mortality. One worker said that there was no achievement and the community was not interested in availing the services.

**Some suggestions:**

**Infrastructure:** Toilets should be constructed in all the AWCs; new AWCs should be constructed, and every AWC should operate from its own building; all AWCS should have a boundary wall; chair and table should be provided for children; children attending AWCs should be provided with uniform; more toys and adequate utensils should be made available at AWC to serve meals to children, increase the maintenance and repair fund for AWC, provide adequate equipment at AWC.

**Linkages:** Ensure enrolment of AWC children in schools; locate delivery point nearby so that women are able to access institutions for deliveries (mathwad).

**Better execution:** Provide due list a week before the VHND; include summer vacation at AWC as children do not come at AWC due to heat; reduce routine and scheme documentation; workers should not be involved in other department works; training of workers and awareness through video on child marriage.

**THR and food:** THR should be provided based on economic condition in Sukanya Yojana Card, and written approval should be given; quality of food must be improved; regular supply of hot cooked meals as per menu in sufficient quantity; provide variety of meals; provide THR up to six years of age, hot meal should be cooked at AWC.

## D. About the Sub Health Centres (SHC)

A total of 30 Sub Health Centres (SHCs) were visited by CHETNA team to understand their functioning. The SHC at Chandragarh of Petlawad block did not have any building and so physical assessment regarding the same was not done. Please refer Table 12 for the basic information on the centres visited.

**Table 12: Profile of Sub Health Centres (n=30)**

| No. | Particular | Manawar | Sondwa | Petlawad | Thandla | Amarpur | Samnapur | Total |
|---|---|---|---|---|---|---|---|---|
| 1 | SHC Name | Sarikpura, Pachkheda Karoli, Mohali | Kakrana, Walpur, Mathwad, Atta, Ojhar, Lodni | Mandan, Jhavliya, Kadwali, Kardawad, Mathmath, Chandragarh | Machlaimata, Sujapura, Anglliyapada, Devka, Makodiya, Bhamal | Jhurma, Junwani, Bodhgundi, Kherda | Kukarramath, Jadasurang, Padariya, Majhgaon | 30 |
| 2 | No. of Health workers posted | 4 | 6 | 6 | 6 | 4 | 4 | 30 |
| 3 | Total population covered | 13484 | 33269 | 27907 | 31271 | 10745 | 14796 | 131472 |
| 4 | Distance of remote village in km | 5 to 15 | 2 to 10 | 2 to 14 | 2 to 20 | 4 to 8 | 4 to 7 | - |

**Infrastructure and Display:** A total of 29/30 SHCs operated from a building. Infrastructure of more than half of the centres (18/29) was in good/fair condition20/30 centres were found to clean. Around one fifth of the centres had a garbage dump (5/29), cattle shed (6/29), and stagnant pool (5/29) close to it. Separate toilets for men and women were available at one third (11/29) SHCs. Less than half (13/29) of the centres had clean water supply. Around three fourth (21/29) SHCs had a separate clinic room.
Less than half (13/29) of the SHCs had electricity connection and supply was regular only at one third (10/29) centres. None of the centres had telephone connection and transport facility was available at four centres only. More than half of the centres (16/29) did not have staff quarters. Referral transport for pregnancy and delivery was available at less than half (13/29) centres. None of the centres had a suggestion box.

Only half (14/29) of the centres had displayed board in local language. Except two, none of the centre had Citizen's Charter, and more than half of the centres did not have the screen to maintain the privacy at the centre. Village health plan was not available in almost half (13/30) of the SHCs.

**Medicines and Supplies:** More than half of the centres (16/29) did not have drugs as per Essential Drug List for SHCs. More than half (18/29) of the centres had medicine/chest available. Labour table and wooden screen were available at twelve and three centres respectively

**Human Resources:** The post of Health Worker (female) was filled in all the thirty SHCs visited. Four SHCs each also had a Male Health Worker posted. At one third of the centres (11/29) a worker was available for the cleaning of centre, which was paid from the contingency fund of the SHC.

**Services:** Maternal and Child Health Services- Ante Natal Care, Intra Natal Care, Post Natal Care, new born care, immunisation, contraception were provided. The centres also provided services related to adolescent health, school health and treatment of minor illness. More than one third (13/29) of the centres had labour room but the deliveries services were not provided at any SHC. The reasons for the same were poor condition of labour room; permission not granted; lack of staff; PHC being nearby, so no need for providing delivery services at SHC. Immunization at one SHC was not done as it did not have a proper building.

### About the Auxiliary Nurse Midwives (ANM)

Discussions were held with 30 Auxiliary Nurse Midwives (ANMs)/Health Worker (Female). Almost half of the ANMs were in the age group of 31-40 years (15/30) and majority belonged to Scheduled Tribe Category. Their education ranged from10$^{th}$standardto

**Table 13: Basic Profile of ANM Workers (n=30)**

| No. | Age | No. of ANM | Caste | Education Qualification | | | Work Experience (in years) | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 10th - 12th | Graduate | Post Grad | Up to 5 | 6 to 10 | Above 10 |
| 1 | 20-30 | 6 | ST-6 | 3 | 3 | 0 | 2 | 4 | 0 |
| 2 | 31-40 | 15 | ST-13, SC-1 OBC-1 | 5 | 4 | 6 | 0 | 4 | 11 |
| 3 | 41-50 | 7 | ST-7 | 5 | 2 | 0 | 0 | 0 | 7 |
| 4 | 50 above | 2 | ST-2 | 2 | 0 | 0 | 0 | 0 | 2 |
| | | 30 | ST-28, SC-1, OBC-1 | 15 | 9 | 6 | 2 | 8 | 20 |

post graduation. Most had the experience of working for more than 10 years. Please refer to Table13 for the basic profile of ANMs.

- Almost all the ANMs (28/30) said that all the communities in their area access their services. OneANM said that in her villages, the rich communities like Patidars did not access their services, and another said that people on the other side of the river were not able to access the health services.
- All the 30 ANMs said that they were trained when first joined. The major topics covered were health schemes; their roles and responsibilities; treating minor illnesses; immunisation; contraception; maternal and child health; nutrition; assessing nutrition status through Mid Upper Arm Circumference(MUAC); WASH (Water Sanitation and Hygiene);new-born care; Sick New Born Care Unit (SNCU);Skilled Birth Attendance(SBA; work at delivery point; hygiene; community health; giving injections and using Intra Venous(IV); Infant and Young Child Feeding( IYCF); malaria; polio diseases and their prevention.
- More than half (19/30) of the ANMs shared that they received training of (skilled) birth attendance and more than three fourth (26/30) had received training on Intra Uterine Contraceptive Device (IUCD) insertion.
- All the ANMs said that they observe VHNDs regularly and provide the services such as immunisation; Ante Natal and HB check-up; registration; sputum collection; blood smear for malaria slides; Post Natal Check Ups; counselling; family planning, and providing medicines.
- Most of the ANMs said that they coordinated with AWWs, ASHA, GSSGTS (VHSNC), PRIs (28/30)); coordination and supervision of activities of ASHA (27/30), and proper maintenance of stock and registers (27/30).
- All of them (30/30) said that they keep the records of births and deaths; register pregnant women, and record maternal and child deaths. They refer people to higher levels. Most said that they were satisfied, but few also said that the referred people were not treated well at the Primary Health Centre (PHC), there was a demand for informal payment. Proper information and guidance was also not provided at the PHC.

### Some of their concerns

- More than half of the ANMs (17/30) said that they did not have adequate equipment at SHCs such gloves, forceps, child weight machine, apparatus to measure blood pressure, etc.
- Only one fourth (7/30) of the centres were Directly Observed Therapy (DOT) centres.
- More than three fourth (25/30) ANMs shared that they have to maintain too many records and are overburdened with the work.
- Lack of time, funds and transportation, poor support from community, inadequate salaries were other concerns. One of them shared that she did not have ASHA in half of the villages where she functions.

## Achievements and Suggestions shared by the ANMs

**Major achievements:** Increase in immunisation coverage; 100% achievement in Tubectomy, improved IUCD and LTT services; building trust among community; increase in the ANC and PNC services; increase in institutional deliveries; compliance to IFA consumption; increased community awareness for health and sanitation; medicines of general illness available in sufficient quantity; increased community access to benefits of all the schemes; changes in food habits; and control of epidemics.

ANM of Lodni SHC has received a cash prize of Rs. 20,000.00 from the department for good work in immunisation.

### Some suggestions:

**Improvement in infrastructure and amenities:** Provision of piped water; electricity and gas connection at centre; Sub centre building in Petlawad. In Sondwa, one additional PHC is needed at Walpur to reduce the incidence of home deliveries.

**Better execution of programmes:** Amalgamation of schemes as due to new schemes old schemes are affected; timely release of Janani Suraksha Yojana payment; uninterrupted medicine supply from PHC to SHC; reduction in documentation; timely transportation facility; increase in the amount of benefits for acceptance of permanent contraceptive methods; appoint male health worker at SHC; ratio of sub centre and population should be according to the standard; additional Janine vehicle deputed to the areas where the network connectivity was poor, and untied fund amount should be raised to Rs.30,000from the current amount of Rs.10,000.

**Human resources:** Appropriate salary for contractual staff; filling up of the vacant post of Medical Officers of the PHCs.

**Community awareness:** Facilitate community awareness and support of community; linkages of panchayat and community on immunisation (VHND).

## E. About the Primary Health Centres (PHC)

A total of 13 Primary Health Centres (PHCs) were visited by the CHETNA team and discussions were held with the PHC in- charge or the staff present there. Some of the observations are as follows:

**Infrastructure:** All the 13 PHCs were located in government buildings, and the condition of the building was good. 10/13 PHCs were easily accessible. One PHC in Sondwa was 60kilometresaway from assessment village which was located across the river Narmada.

There was a garbage dump near three PHCs. A cattle shed and a stagnant pool of water was found near one PHC.12/13centres had facility for clean drinking water. Telephone and computer were available at 4/13PHCs only; out of which internet was available at 3 PHCs. 12/13PHCs had beds as per norm. Less than half (6/13) centres had a ramp for differently-abled individuals. Screen to maintain the privacy was available at 9/13centres. Only 8/13 PHCs had drugs available as per the EDL. Citizen's Charter was displayed at 4 of the 13 PHCs.

**Human Resources:** The post of Medical Officer was vacant in 5/13PHCs. 10/13centres had the nurse-midwife posted. Pharmacist was posted at 4/13centres only, and lab technician was posted at 5/13centres. Support staff was available at all the 13 centres. (Please refer to Table14 for profile of the PHCs.)

### Services Provided at the PHCs

- Primary management of wounds was provided at all the 13 centres; minor surgeries at six centres; poisoning/ snake/insect bite at seven centres; burn management at nine centres, and fracture management services were provided at two centres.
- 12/13 PHC's provided ANC, INC, PNC and family planning services. Six PHC's organised antenatal clinics.
- Immunisation day was fixed BCG and measles vaccine given regularly at nine PHC's.
- 13/13 PHC's provided treatment for anaemia; treatment of severe diarrhoea was available at eleven centres, and treatment of pneumonia was provided at six centres only.
- School Health programme and promotion of safe water supply and sanitation was provided in 10 centres.

**Table 14: Basic Profile of the PHCs (n=13)**

| Blocks | PHC Name | Population | 24x7 PHC | Daily OPD (M) | Daily OPD (F) |
|---|---|---|---|---|---|
| Manawar | Karauli | 42000 | yes | 10 | 10 |
| Sondwa | Umrali | 52500 | Yes | 10 | 20 |
| | Bakhatgarh | 72137 | yes | 10 | 10 |
| Samnapur | Guneri | 31365 | Yes | 8 | 12 |
| | Bahmni | 10000 | yes | 8 | 14 |
| | Gaura Kanhari | 13000 | yes | 7 | 13 |
| Amarpur | Kamako Mohaniya | 21191 | yes | NA | NA |
| | Karwad | 33000 | yes | 20 | 12 |
| Petlawad | Raipuriya | 312500 | yes | 200 | 300 |
| | Karnawad | NA | No | 15 | 05 |
| | Jhaknavad | 31000 | yes | 35 | 40 |
| Thandla | Khawasa | 52226 | yes | 20 | 40 |
| | kakanwani | 61219 | yes | 20 | 30 |
| | 13 | 450967 | 12 | 363 | 506 |

- Medical Officers at 6/13 PHCs conducted monthly visit to all the SHCs.
- Surgery for cataract was not available at any centre.
- Medical Termination of Pregnancy (MTP) and RTI/STI (Reproductive Tract Infection/Sexually Transmitted Infection) management services were available at 6 PHCs.
- Tubectomy and vasectomy services were available at 3 facilities.
- None of the thirteen PHCs had all the mandated laboratory testing facilities. Blood smear examination for malaria parasite was available at 12 centres. Routine urine and blood grouping was available at 6 centres. Bleeding time, clotting time and Sputum test for TB was available at 4 centres. Rapid test for HIV was available at 7 centres, and RPR test for Syphilis was available at 2 centres.

**Some observations during CHETNA teams visit:**

- ***PHC Umrali:*** *TB and leprosy cases are high in the area as shared by MO, Umrali. Due to lack of staff, the centre stopped conducting deliveries at the time when the team had visited. Subsequently, after staff has been posted and delivery services have been resumed in January 2019. The new PHC building is away from the main village due to which OPD has reduced from 60-70 patients per day to 20-30 patients. Laboratory facility is not available due to which test cannot be done. There is a tube well but the water table was low therefore sufficient potable water was not available.*
- ***PHC Bakhatgarh:*** *This is one of the remotest PHC in Sondwa block of Alirajpur. A section of the area to be covered by the PHC falls across the river Narmada, and therefore mobile connectivity and communication is an issue in the area. The PHC covers a population of more than 70,000.*
- ***PHC Guneri:*** *The ANM is irregular, and comes, if called, when a woman comes for delivery. When CHETNA team visited a woman had come for delivery to the PHC. Since the ANM was not present at the centre, the support staff referred the woman to the CHC. Vaccination was done on previous day i.e. 19/12/18 but the vaccine carrier was kept outside the cold chain room for more than 24 hours, as observed when CHETNA team visited on 20/12/18.*

# Annexure-I Block-wise Schedule of Activities

## Table 1: Schedule of Activities in Amarpur Block

| No. | Date | Village | Activity |
|---|---|---|---|
| 1 | 24/9/18 | Junwani | ANM Interview |
| 2 | 25/9/18 | Mohari | ASHA Interview(1) AWW Interview (2) GAK Observation (1) Discussion with Self Help Group(10 members) |
| | | Junwani | GAK Observation (1) ASHA interview (1) AWC observation (2) AWW interview(2) ANM interview(1) Discussion with Self Help Group(8 members) |
| 3 | 26/9/18 | Bodh gundi | Village Profile, AWW Interview (2) ASHA Interview(1) ANM interview (1) AWC observation(2) GAK Observation (1) Discussion with Self Help Group(8 members) |
| | | Kherda | Village Profile AWW Interview (1) ANM interview (1)GAK Observation (1) ASHA Interview(1) AWC Observation(1) Discussion with Self Help Group(12 members) |
| | | JaldaMundiya | Village Profile |
| 4 | 27/9/18 | Alauni | Village Profile, AWC Observation (1) AWW Interview (1) ASHA interview(1)(Discussion with Self Help Group (12 members) |
| | | Jalda Mundhiya | ASHA Interview(1) GAK Observation(1) AWC Observation (2) Discussion with Self Help Group (9 members) |
| | | Jhurma | ANM Interview |
| 5 | 29/9/18 | Jalda Mundhiya | AWW Interview(1) |
| 6 | 12/11/19 | Kherda | GAK Observation |
| 7 | 29/11/19 | Junwani | SHC Observation |
| 8 | 1/12/19 | Kamko Mohaniya | KamkoMohaniya PHC Observation |
| | | Alauni | GAK Observation |
| 9 | 11/12/19 | Jharna Ghughri | SHC Observation |
| 10 | 13-12-18 | Kherda | SHC Observation |
| 11 | 19-12-18 | Jalda Mundhiya | SHC Observation |
| 12 | 30-12-18 | Bodhgundi | SHC Observation |

## Table2: Schedule of Activities in Samnapur

| No. | Date | Village | Name of Activity |
|---|---|---|---|
| 1 | 06/11/2018 | Majhgaon | SHC Observation |
| 2 | 06/11/2018 | Padariya | ANM Interview, GAK Observation, ASHA Interview, SHC Observation |
| 3 | 19/11/2018 | Sighwara | ASHA Interview, AWC Observation, GAK Observation, VHND Observation, AWW Interview, Village Profile ; Group Discussion(11) |
| 4 | 19/11/201 | Padariya | AWC Observation, AWW Interview; Group Discussion(9) |
| 5 | 20/11/2018 | Kukarramath | ASHA Interview, 3 AWC,1GAK Observation, Village Profile,3 AWW Interview |
| 6 | 21/11/2018 | Kukarramath | ANM Interview, SHC Observation, ASHA Interview |
| 7 | 22/11/2018 | Kukarramath | Group Discussion(10) |
| 8 | 22/11/2018 | Budrukhi | ASHA Interview, 2 AWC Observation, VHND Observation, GAK Observation, 2 AWW Interview ; Group Discussion(6) |
| 9 | 23/11/2018 | Gaura Kanhari | AWC Observation, Village Profile, ASHA, AWW ANM Interview, PHC GAK Observation, VHND Observation, Group Discussion(10) |
| 10 | 24/11/2018 | Bamhani | PHC Observation |
| 11 | 24/11/2018 | Pondi | ASHA Interview, ANM Interview, AWC Observation, VHND Observation, GAK Observation, AWW Interview; Group Discussion(7) |
| 12 | 07/12/2018 | Jada surang | SHC Observation |

## Table 3: Schedule of Activities in Manawar

| No. | Date | Village | Activity |
|---|---|---|---|
| 1 | 10/09/2018 | Birpura | ASHA Interview(1) AWW Interview (2) Discussion with women (17) |
| 2 | | Mohali | GAK Observation(1) ASHA interview (1)<br>AWW interview(2) ANM interview(1) Discussion with women (19) |
| 3 | 11/09/2018 | Sarikhpura | AWW Interview (3) ASHA Interview(1) MPW interview (1) AWC observation(2) SHC Observation(1) Discussion with women(23 members) |
| 4 | | Panchkheda | AWW Interview (4); MPW interview (1)<br>GAK Observation (1) VHND Observation (1) ANM interview (1)<br>ASHA Interview(1) AWC Observation(2) Discussion with women (17 members) |
| 5 | 12/09/2018 | Karoli | AWC Observation (3) AWW Interview (3) GAK Observation (1)<br>ASHA interview(2) PHC Observation(1) ANM Interview(1)<br>Discussion with Self Help Group(18 members) |
| 6 | | Sisri | ASHA Interview(1) SHC Observation (1)<br>AWC Observation (2) AWW interview(2) Discussion with Self Help Group(20 members) |
| | | | VHND observation at Kudar mana |

## Table 4: Schedule of activities in Petlawad

| No. | Date | Village | Activity |
|---|---|---|---|
| 1 | 20-08-2018 | Piplipada | Group Discussion with 20 women |
| | | Kardawad | Group Discussion with 11 women |
| 2 | 21-08-2018 | Polarunda | Group Discussion with 17 women |
| 3 | 22-08-2018 | Raliyawan | Group Discussion with 12 women |
| | | Parewa | Group Discussion with 13 women |
| 4 | 23-08-2018 | Chandragarh | Group Discussion with 12 women |
| 5 | 29-11-2018 | Kardawad | SHC,PHC,GAK,VHND, 2 AWC observation, village profile |
| | | Chandragarh | ASHA interview, village profile |
| 6 | 30-11-2018 | Pareva | 2 AWC,VHND,GAK observation, 2AWW,ASHA,ANM interview |
| | | Piplipada | AWC observation, AWW interview, ANM interview, Village profile |
| | | Mandan | VHND observation |
| | | Chandragarh | 2 AWC Observation 1SHC observation, ASHA, ANM interview, village profile |
| | | Kardawad | 2 AWW interview, ASHA interview, ANM interview |
| | | Raipuriya | PHC observation |
| 7 | 01-12-2018 | Piplipada | GAK observation, SHC observation, ASHA interview |
| | | Raliyawan | GAK observation |
| | | Polarunda | ASHA interview, Village profile, |
| | | Chandragarh | GAK observation |
| | | Karwad | PHC observation |
| 8 | 03-12-2018 | Polarunda | 2 AWC observation, 2 AWW interview |
| | | Chandragarh | 3AWC observation, AWW interview |
| | | Chandragarh | 2AWW interview, ANM interview |
| 9 | 04-12-2018 | Jhavliya | VHND observation |
| | | Polarunda | ANM interview, SHC observation |
| | | Jhaknawda | PHC Observation |
| | | Parewa | SHC observation |

## Table5: Schedule of Activities in Thandla Block

| NO. | Date | Village | Activity |
|---|---|---|---|
| 1. | 01-11- 2018 | Sutreti | Group Discussion with 11women |
| | | Sujapura | Group Discussion with 11 women |
| 2. | 02-11- 2018 | Bhamal | Group Discussion with 12 women |
| | | Makodiya | Group Discussion with 8 women |
| 3. | 03-11- 2018 | Sagwani | Group Discussion with 9 women |
| | | Angliyapada | Group Discussion with 15 women |
| 4. | 16-11-2018 | Sutreti | AWC observation; AWW interview |
| 5. | 17-11-2018 | Sutreti | ASHA,AWW interview; GAK/AWC observation |
| 6. | 19-11-2018 | Machhlaimata | ANM interview |
| | | | SHC observation |
| 7. | 20-11-2018 | Sujapura | ASHA and2 AWW interview; GAK/2 AWC observation |
| 8. | 21-11-2018 | Sujapura | SHC observation |
| 9. | 22-11-2018 | Aangaliyapada | 2 AWW interview; 2 AWC observation, ASHA interview |
| 10. | 23-11-2018 | Sagwani | 2 AWC/GAK observation; 2 AWW interview |
| | | Makodiya | ANM interview; 3 AWC observation; 3 AWW interview |
| | | SHC Bhamal | ANM interview |
| 11. | 26-11-2018 | Aangaliya pada | SHC observation |
| | | Makhodiya | ASHA interview; GAK observation |
| | | Bhamal | 2 ASHA,4 AWW,ANM interview, GAK and 4 AWC observation |
| 12. | 27-11-2018 | SHC Sujapura | ANM interview |
| | | Bhimpura | VHND observation |
| | | Devaka (Sagwani) | SHC observation |
| | | Guvalrundi (Sujapura) | VHND observation |
| | | PadaDhamjar | VHND observation |
| 13. | 29-11-2018 | SHC Aangliyapada | ANM interview |
| | | Bhamal | SHC, VHND observation |
| 14. | 30-11-2018 | PHC Kakanvani | PHC observation |
| | | Sujapura | AWC observation; AWW interview |
| 15. | 01-12-2018 | PHC Khawasa | PHC observation |

## Table6: Schedule of Activities in Sondwa Block

| No. | Date | Village | Activity |
|---|---|---|---|
| 1. | 29-10-2018 | Ojhad | Group Discussion with 8 women |
| | | Moraji | Group Discussion with 13 women |
| 2. | 30-10-2018 | Badi Sirkhedi | Group Discussion with 8 women |
| | | Mathvad | Group Discussion with 12 women |
| 3. | 31-10-2018 | Kakrana | Group Discussion with 11 women |
| | | Walpur | Group Discussion with 10 women |
| 4. | 19-12-2018 | Walpur | ASHA, 3AWW,ANM interview, 3 AWC VHND, SHC,GAK observation |
| 5. | 20-12-2018 | Kakrana | ASHA interview, Village profile, 2 AWW interview, ANM interview, SHC, GAK observation?? |
| | | Guneri | PHCobservation |
| | | Badi sirkhedi | ASHA interview, 2 AWW interview, GAK observation |
| | | Umrali | PHC observation |
| | | Bakhatgarh | PHC observation |
| 6. | 21-12-2018 | Badi sirkhedi | Village profile , AWC checklist |
| 7. | 22-12-2018 | Moraji | Village profile, 3 AWW interview, 3 AWC checklist, GAK observation, ASHA interview |
| 8. | 23-12-2018 | Mathwad | ANM interview |
| | | Atta | ANM interview |
| 9. | 26-12-2018 | Ojhad | SHC ,3 AWC observation, ANM, ASHA 2 AWW interview, |
| | | Lodni | SHC observation, ANM interview |
| | | Kakrana | 2 AWC checklist |
| 10. | 28-12-2018 | Ojhad | Village profile, 2 AWC checklist, 2 AWW interview |
| | | Mathwad | SHC Observation, village profile, GAK observation, 2 AWW interview, 2 AWC checklist |
| | | Atta | SHC observation |
| 11. | 31-12-2018 | Mathwad | ASHA interview, 4 AWW interview, 4 AWC checklist |
| 12. | 10-01-2019 | Ojhad | GAK observation |

# A Report on Community Needs Assessment and Public System Gap Analysis

## Amarpur Block, Dindori, Madhya Pradesh

**Data Collection Period:**

September 24–December 30, 2018

**Data Collection CHETNA Team:**

Anurag Dubey, Preetibala Sharma, Bhanu Makwana, Nidhi Devani and Sushil Sharma

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## Samnapur Block, Dindori, Madhya Pradesh

**Data Collection Period:**

November 6– December 7, 2018

**Data collection CHETNA Team:**

Gaurav Verma, Abdul Jakir Khan, Shivlal Sonwani, Ashrita Marawi, Rakesh Thakur and Vandana Varkade.

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## Manawar Block, Dhar, Madhya Pradesh

**Data Collection Period:**

9-12 September, 2018

**Data collection CHETNA Team:**

Sushil Sharma, Ranu Sharma, Nidhi Devani, Mukta Chakma, Tarnishta Ray

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## Petlawad Block, Jhabua, Madhya Pradesh

**Data Collection Period:**

20August-4December, 2018

**Data collection CHETNA Team:**

Vinod Kamre, Devkanya, Dilip Chourdiya, Anju Sawale, Yogesh Solanki, Bhanu Makwana.

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## Thandla Block, Jhabua, Madhya Pradesh

**Data Collection Period:**

1st November-1st December, 2018

**Data collection CHETNA Team:**

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**PSGA Data Analysis:** Gaurav Verma, State Coordinator, CHETNA
**Final Report:** Vd. Smita Bajpai, Project Director, CHETNA

# Amarpur Block, Dindori, Madhya Pradesh

## Introduction:

The Government of Madhya Pradesh is committed to improve the health and nutrition status of women and children. The recently released Healthy States Progressive India -2019 report has ranked Madhya Pradesh at number 18 of the 21 states.

The Transform Rural India (TRI) Project is an initiative of Tata Trusts to transform villages, village life and society, especially the bottom 100,000 villages. TRI looks at initiating ground level pilots in selected blocks in endemic poverty regions in central and eastern states. The pilots are aimed at developing process protocols for triggering multidimensional transformation of villages in endemic poverty regions.

Mission Antyodaya is a convergence framework for measurable effective outcomes on parameters that transform lives and livelihoods.As envisaged by the national Ministry of Rural Development, it is an effort to address the multidimensionality of poverty in a time-bound manner through a convergence of resources, both financial and human, to provide an opportunity for transformational changes.

CHETNA has joined hands with this initiative in the capacity of thematic expert NGO (T- NGO) to strengthen the Health and Nutrition Component of the programme. The project is being implemented in 70 selected Mission Antyodaya villages of six blocks-Amarpur, Samnapur, Thandla, Petlawad, Manawar and Sondwa, of four districts Dindori, Jhabua, Dhar and Alirajpur of Madhya Pradesh.

This is a report on the assessment done in Amarpur block of Dindori district.

About Dindori district: Dindori is situated in the eastern part of Madhya Pradesh, bordering the state of Chhattisgarh. It is surrounded by Shahdol, Mandla and Umaria districts. It is divided into seven blocks namely Dindori, Shahpura, Mehendwani, Amarpur, Bajag, Kanranjiya and Samnapur. The population of the district was 704,524, of which male and female population was 351,913 and 352,611 respectively. The district has a sex ratio of 1002 females per 1000 males. The literacy rate of the district was 63.90 percent. The literacy rate of men

Amarpur block encircled in Dindori District

was 75.47 and that of women was 52.41 per cent. (Census 2011).

Health and Nutrition Status of Women and Children: According to the National Family Health Survey (NFHS-4, 2015-16) report of Dindori district, around 37% girls marry before the age of 18 years. The percentage of use of any kind of family planning method was 66.8 %. The acceptance of Male and female sterilisation was 0.9% and 61.2% respectively. Regarding access to Maternal and Child Health (MCH) services, 44.9% mothers had antenatal check-up in the first trimester, and 23.5% mothers had received four antenatal visits. But only 5.1% women had full antenatal care. The survey reports around 59.3% of pregnant women aged 15-49 years as being anaemic, and the percentage of pregnant women who consumed 100 Iron Folic Acid tablets (IFA) during their pregnancy was 18.9% only.

A total of 66.5% women of ages 15-49 years are anaemic as per the survey. Around 56% women delivered in institutions, and 36.8% of children aged below 3 years were breastfed within one hour of birth.

Regarding nutrition, the survey indicates that 35.5% children under 6 months of age were exclusively breastfed; and only 1.9% of the breastfeeding children aged 6-23 months received an adequate diet. Only 49.4% of children aged 12-23 months were fully immunised. Malnutrition status of children was also very severe; 45.8% of children below 5 years were stunted, 27.4% were wasted, and 10.5% were underweight. Similarly 66.5% children aged 6-59 monthswereanaemic.

The Health Management Information System (HMIS) of Dindori District and Amarpur Block shows significant improvement in access to maternal and child health services since the survey. (Please refer Table 1 for details.)

**Table 1 : Maternal and Child Health status of Dindori and Amarpur**

| No. | Indicator | Dindori (%) | Amarpur (%) |
|---|---|---|---|
| 1 | ANC registration | 81.18 | 75.88 |
| 2 | ANC reg. in 1st Trimester | 86.17 | 82.11 |
| 3 | Pregnant women given 180 IFA tab. | 83.59 | 76.44 |
| 4 | ANC with 4 Check-ups | 66.81 | 64.04 |
| 5 | Institutional delivery | 92.20 | 96.37 |
| 6 | Pre-term newborns Stillbirth | 7.05 | 0.00 |
| 7 | BCG Against live birth | 2.22 | 1.03 |
| 8 | Measles | 95.97 | 100 |
| 9 | Full immunization | 78.99 | 75.12 |
| 10 | | 86.97 | 82.63 |

Source: State HMIS unit, MP; April 2018 to February 2019.
Full immunization data is up to Jan 2019.

**Purpose of the Assessment:** With a view to understand the local health and nutrition realities and design interventions accordingly, CHETNA conducted Community Needs Assessment (CNA) and Public Health System Gap Analysis (PSGA) in sample villages of Amarpur Block of Dindori District, Madhya Pradesh.
Methodology: Qualitative research methodology was used in which Group Discussions (GD), Key Informant Interviews (KII), and facility-level observations were done (please refer to Table2 for schedule). Discussions were held on topics such as food security, gender, women's health, child health, contraception, access to services and entitlements. On an average the discussions continued for about two-and-half hours. Visits were made to observe Gram Arogya Kendras (GAKs), Anganwadi Centres (AWCs), Sub Centre (SHCs); Primary Health Centres (PHCs), and Village Health and Nutrition Day.

Sample: A 10% sample of the intervention villages @ six per block was taken for the assessment. Based on the following criteria, a total of six villages were selected.

- Functionality of Village Organisation(whether VO was functional till 2015 and whether any meeting took place in last one year)
- Poor connectivity and infrastructure
- Good connectivity -on-road village
- Functional Self Help Groups (SHGs) and Village Organisations(VOs)

A total of six group discussions were held with 59 members of Self Help Groups (SHGs) in each of the six villages during 25-27September 2018. The group discussions with women were held on topics such as food security, gender, women's health, child health, contraception, access to services and entitlements. On an average the discussions continued for about two-and-half hours. Five Sub Health Centres (SCs), eight Anganwadi Centres (AWCs) six Gram Arogya Kendras (GAK), and one Primary Health Centre (PHC) were visited. Since it was not held, Village Health and Nutrition Day could not be observed during the visit. Interviews were held with 50% of the ASHAs of the village, 50% of the Anganwadi

Workers, ANMs and Medical Officers. A total of six ASHAs, nine AWWs and four ANMs were interviewed by CHETNA team. (Please refer Table 2 for schedule).

**Table 2: Schedule of Activities in Amarpur Block**

| No. | Date | Village name | Activity |
|---|---|---|---|
| 1 | 24/9/18 | Junwani | ANM Interview |
| 2 | 25/9/18 | Mohari Junwani | ASHA Interview(1) AWW Interview (2) GAK Observation (1) Discussion with Self Help Group(10 members) |
| | | | GAK Observation (1) ASHA interview (1) AWC observation (2) AWW interview(2) ANM interview(1) Discussion with Self Help Group(8 members) |
| 3 | 26/9/18 | Bodh gundi | Village Profile, AWW Interview (2) ASHA Interview(1) ANM interview (1) AWC observation(2) GAK Observation (1) Discussion with Self Help Group(8 members) |
| | | Kherda | Village Profile AWW Interview (1); ANM interview (1)GAK Observation (1) ASHA Interview(1) AWC Observation(1) Discussion with Self Help Group(12 members) |
| | | Jalda Mundiya | Village Profile |
| 4 | 27/9/18 | Alauni | Village Profile, AWC Observation (1) AWW Interview (1) ASHA interview(1)(Discussion with Self Help Group (12 members) |
| | | Jalda Mundhiya | ASHA Interview(1) GAK Observation(1) AWC Observation (2)) Discussion with Self Help Group (9 members) |
| | | Jhurma | ANM Interview |
| 5 | 29/9/18 | Jalda Mundiya | AWW Interview(1) |
| 6 | 12/11/19 | Kherda | GAK Observation |
| 7 | 29/11/19 | Junwani | SHC Observation |
| 8 | 1/12/19 | Kamko Mohaniya | Kamko Mohaniya PHC Observation |
| | | Alauni | GAK Observation |
| 9 | 11/12/19 | Jharna Ghughri | SHC Observation |
| 10 | 13-12-18 | Kherda | SHC Observation |
| 11 | 19-12-18 | Jalda Mundiya | SHC Observation |
| 12 | 30-12-18 | Bodhgundi | SHC Observation |

Data Collection Tools: Separate tools were developed for CNA and PSGA.Ten checklists were developed in English by the Health and Nutrition Sector council team-TRIF. CHETNA survey team members were oriented on the data collection tools.

About the Villages: The total households of the six villages number 1481, and the total population is 6279. The villages are at an average distance of 3.2 km (2.5 to 10 km) from the main road. Half (3/6) of the villages did not have a pucca road. Transport was not readily available for medical emergencies in two of the six villages (2/6) viz. Mohari and Bodhgundi. Out of the other four, in Jaldamuniya village, there was no access to any other four-wheeler except 108 ambulances. Clean drinking water was available, and hand pumps were the source of water in all the villages. The Gond was the most powerful community in four villages, whereas Jaiswal and Yadav were the most powerful communities in one village.

These villages are expected to be served by 17 Anganwadi Centres and one mini Anganwadi Centre. The average population to be served, per centre, comes to 330; which shows a good population and centre ratio. Three of the six villages were sub centre villages, while the other three were at a distance of three kilo meters from the sub centre. Four of the six villages (4/6) were at a distance of three to eight kilometres from the sub centre while remaining two (2/6) were at a distance of 12 to 18 km from the Primary Health Centre at Kamko Mohaniya.

**About the Women:** A total of59 women from Self Help Groups and other women from the village participated in the discussions. They were from the age group of 18 to 50 years. Of these 18 women were not literate, and the education levels of the other 41 women ranged from 8$^{th}$standard to graduation. Most of the women worked in farms. The nutrition status (height and weight) of 58 women was measured and their Body Mass Index-BMI calculated. More than half (32/59) were found to be having a normal BMI; about one fourth (15) women were found to be underweight with BMI less than 18.5; 4women were found to be overweight and 7 were obese.

# What Women Say

## A: Food and Nutrition Security

Inadequate food consumption: Discussions with women indicated that their overall food consumption is inadequate as compared to the laborious work they do in the house and in the fields. 30/59 women shared information on their eating patterns. The usual pattern is to eat two meals a day. Afternoon meals are eaten only if there is some food left over from the morning.

*"We eat two meals in a day. Once around 8 to 10 in the morning, and then between7 and9 in the evening. If we are hungry in the noon, and if there are leftovers from the morning meal, we eat in the noon. If there are no leftovers, we do not eat in the noon, even if hungry. We do not cook again in the afternoon."*

**Limited food basket:** A total of 29/ 59 women said that they eat meals comprised of chawal (rice) or roti (cereal—corn or wheat) accompanied by dal (pulses) or sabzi (vegetables). Usually they eat only two food groups in one meal so either it would be roti-sabzi or roti-dal in the morning, and then dal-chawal or roti-chutney in the evening.

*"We eat Sabzi-roti, roti-chutney, roti-dal, roti-besan, and dal-chawal. Only two foods are eaten. We do not cook roti, sabzi, dal and chawal in one meal."*

When it comes to vegetables, these are eaten rarely. Availability is an issue as most women said that they purchase vegetables from the market. Purchasing capacity is also a constraint. The quotes below indicate their purchasing power.

*"We go to the market once in a month where we buy vegetables, and cook these for two or three days."*

*"There is no income in our house so we do not go to the market. When we have money in our hands only then the vegetables are bought and cooked."*

*"We never buy fruits. In the mango season we eat half a kilogram of mangoes. And we have banana, guava and mango trees at home so we eat them in season and do not purchase from the market. "*

*"We do not eat fruits since we do not have money to buy them. Fruits are sold at 100-150 rupees a kilo so we do not buy them from market."*

Milk and milk products are rarely consumed. Families who have cattle at home do consume milk. Usually black tea is given, even to the guests. Jaggery is added to the black tea. *Ghee* (clarified butter) is not eaten. It is used for worship or to prepare sweets.

In one of the six villages, all the ten women said that: *"Tea is not prepared in any house. Only when a guest comes, black tea is prepared. We do not buy milk because of its cost, it is sold at 50 rupees a litre and so we cannot buy it."*

*Makka* (corn) and *chawal* (rice) are the most commonly eaten cereals. As regards pulses, women said that they mainly eat *chana* (brown gram) and *udad* (black gram).

Green leafy vegetables were mentioned by a couple of women only, and a local vegetable *"chakoda"* was mentioned. *Lauki* (sweet gourd), *bhindi* (ladies finger, okra) and *aloo* (potatoes) were the commonly named vegetables. *Kela* (banana), *aam* (mango), *anaar* (pomegranate), *amrood* (guava) and *seb* (apple) were some fruits mentioned by women.

A total of 13/59 women spoke about animal-based foods. Chicken, eggs, fish and mutton are some of the foods eaten. The frequency of eating these ranged from eating these foods once or twice in a month to eating them once in a week. This was related to availability of money for some, and when guests arrive at home, for others. Availability is also a concern; some products such as eggs and chicken are available in the village, whereas fish has to be bought from the market, or they catch fish when there is water in the river.

*"When we have money, we cook animal based foods four times in a month otherwise we don't. We have money on hand when there is work in the farms. We do not have farm work in summer (so we do not eat these foods in summer)."*

Women also said that not everyone eats animal-based foods; children and pregnant women are not supposed to eat animal-based foods. But if a pregnant woman wishes to, she can eat animal products as per her wish. Women also shared that in schools, children are discouraged from eating animal-based foods, and so they do not like eating them, even at home.

Of the twenty two women who spoke, twenty said that foods/vegetables/fruits are purchased from market. Three women said that *sarson* (mustard), *lauki*(sweet gourd) are grown in their farms or homes. They go to the market sometimes, and those who can afford go daily. Usually they buy groceries, utilities and foods from the market. A total of 18/22 women said that they purchased snacks and sweets from the market particularly for children as they like to eat them. *Jalebi, samosa, namkeen* and kurkure are the most commonly purchased snacks. In one village, a woman said that *"we do not purchase vegetables but buy snacks as our children like to eat them."*

**Food insecurity during lean season:** Women from all the six villages spoke about lean season and coping methods. Summer is the lean season when there is no earning from farm labour, so most people go to Chhattisgarh,

Karnataka or Kerala to seek work. Usually the entire family migrates; if there are grandparents at home, young children are left behind in their care. Vegetables are scarce during summerand there is no money. Men migrate in search of work so most people survive on *"pej"*-a preparation made with maize flour and water.

**Cultural practices affect intake of nutritious food:** Fasting continues to be a woman's domain. In all the six villages, women said that they fast on Mondays, or during particular festivals such as *Navratri, Teej,* and *Mahalaxmi puja*. The eating practices during fasts varied. For some it was total fasting, with tea as the only intake, whereas for some it was only dinner, and some ate special foods meant to be eaten while fasting.

Women shared information about diet restrictions. In one of the villages, women said that *baingan* (brinjal), *kumhda* (pumpkin), *tuver* (pigeon pea) *dal, masoor* (lentils) dal and whole pulses are not eaten frequently as they are considered heat producing.

**Pregnancy:** Sour and cold foods are to be avoided during pregnancy according to all the eight women from a village. *Moong dal* (green gram) and *wadi* (chunks made from ground pulses) are eaten. *Udad* (black gram), *masoor* (lentils), *matar* (green peas), *baingan* (brinjal) and *kumhda* (pumpkin) are not to be eaten during pregnancy, and are eaten after childbirth. Herbs are collected from the forest and they are given to the woman during pregnancy. Names of these herbs were not known.

**After childbirth:** Women are given dried coconut and jaggery to eat. In another village, a woman said that *masoor dal* (lentils), *kumhda* (pumpkin), *kela* (banana), *baingan* (brinjal), *matar* (peas) and *sour foods, tamatar* (tomatoes), *aam* (mangoes) are not eaten after childbirth. During lactation foods such as old rice, lauki (sweet gourd) and potato are eaten. *Tuver dal* and sour foods such as *tamatar* (tomatoes) and *neebu* (lemon) are not eaten.

**Back to work:** Women from all the six villages said that getting back to work after delivery depends on the situation of the household. If there is no one else at home, women start working after a week. For those who have family to take care of the little one, they leave the baby in care of the elders. For those who have no one at home, they tie the baby on their back and work in the field. If financial resources are available at home, women return to work after two to three months.

## B: Gender Issues

Gender discrimination in higher education: Of the twenty women who spoke, almost all said that both boys and girls are sent to school. Most said that children are allowed to study as per their wish. Parents do not discourage them from studying further. The challenge comes when the school is outside the village or at a distant place. Then only few girls study further. For example the village has a school up to third or eighth grade; the high school is five to fifteen kilometres away from the six villages. Mostly boys study there, but half of the girls discontinue their studies. One woman said: *"Girls study up to eighth grade in the school which is in our village. Then girls from poor families are pulled out and sent for labour work."* Women also said that those who have money send their children, mostly boys to private schools. Poor people send their children to government schools in the village. In response to the question about how the children commute, in one village women said that they have to accompany their children till five years of age as they have to cross a river on the way. A few said that there is a cycle given to go to school, and when asked, they said that girls do not use it.

Women also spoke about the challenges when their children study up to higher grades and do not get jobs. A woman said: *"There is no benefit in education. For educated people of our village, there are no jobs. A boy and a girl here have studied up to graduation but they do not have jobs. Another boy has studied till 12$^{th}$ grade but he works as a computer operator."*

**Girls get married before the legal age:** Most women were aware of the legal age of marriage for boys and girls. If the girls and boys continue their studies, they are married after 18 and 21 years, but if not, then the girls are married between 15-17 years, and boys before 20 years of age. However, in case the boy and girl are in love, the families agree, and the age is overlooked for the fear of them running away from home, which is a social shame for the family. A woman also said that *"earlier boys and girls were married off at a young age, but now they are married after 18 years of age."*

**Women eat last:** A few women spoke about eating patterns. Almost all said that women eat last. Men or elders eat, first followed by children, and then the women themselves eat. At times, if both have to go out for work, they eat together. Women also said that if at times there is no food left, they do not cook for themselves and remain hungry. *"It is alright if we do not eat at night but since we have to go to work, we have to eat in the morning,"* said one of the twelve women who spoke.

**Work and employment:** A few women spoke about work and employment. For most, labour work was the only employment available. They spoke about migrating to different places-towns/cities and states for work. Sometimes the entire household migrates and at times it is only the men and boys who go out for work. Women do not go out alone to seek work, nor do girls. They work mainly in the village.

**Restricted mobility of women:** Women from all the six villages said that they do not have free time to go anywhere. They hardly get time from their busy work schedule at home and in the field. If at all they get some time they take some rest. For most women an outing is when they visit their natal homes or when there is a fair; then too they are not allowed to go alone. Besides going to school, girls are not allowed to move alone. Fear of abduction was mentioned as the reason for restricting girls' mobility.

## C: Infant and Young Child Feeding Practices

**Delayed initiation of breast feeding:** A total of 16/59 women spoke about initiation of breast feeding. Almost half of the women who spoke (7/16) said that they now feed the baby immediately after birth, within one to two hours. Eight of them said that breast feeding is initiated six to seven hours after birth, and one woman said that it is initiated the next day. All the sixteen said that breast feeding is initiated after giving the baby a bath. So it appears that most babies in this area are given bath on the first day itself. One of them said that they do not throw away the colostrum and feed it to the baby.

**Breast feeding is prolonged:** From all the six villages, women said that breast feeding is prolonged. The baby is fed either till it starts eating on its own, or till it is one-and-half to two years old, or till the mother conceives again. One woman said that *"If breast milk does not flow the baby is fed cow's milk".*

**Gender discrimination in initiation of complementary feeding:** A few women spoke about initiation of complementary feeding. The age of introduction of complementary feeding was four to five months, said women from all the six villages. A couple of them also said that children are started to be fed any time from nine to eighteen months of age. There was a difference in initiating complementary foods to girls and boys. Girls are fed at 4 months, and boys at five months. There was no specific reason given for this practice. *"It is customary and we follow the same"* according to a couple of women. Biscuit was the most common food given as complementary food to children, followed by *kheer,* and foods cooked at home. No one talked about any ritual (annaprashan) for initiation of complementary feeding or giving complementary food from the Anganwadi Centre.

**Mothers decide about feeding the child:** When asked about who decides about feeding the child, almost all shared that it was the mother who decides. Sometimes the person who stays back and cares for the baby also decides. At times the in-laws decide about feeding the child. One woman highlighted the issue of food availability in the household. *"If there is food in the house, it will be fed to the baby. The question of who decides does not arise".* The father is hardly involved in complimentary feeding.

## D: Women's Health

**Seeking treatment:** Women shared information regarding their visit to a doctor. In all the six villages women usually go to the Auxiliary Nurse Midwife (ANM) who comes to their village, or go to the PHC to seek treatment. A couple of women said that women often delay seeking treatment. They wait till they are unable to get up from bed. One woman also shared that if a boy is sick they take him to the doctor for treatment, but ask the girls to take rest. *"Girls often eat sour and spicy foods and so they fall sick,"* said one of them.

**Common ailments:** Women and children fall sick more often, said most of the women. Aches and pains, seasonal illnesses, malaria, swelling during pregnancy, fatigue and weakness are some of the common ailments faced by women in these villages. Weakness, aches and pains after delivery, white discharge, painful periods--particularly among girls, heavy bleeding, prolonged menstrual bleeding are some of the health problems women face in these villages.

**Menstrual practices:** Women from all the six villages spoke about menarche, menstrual practices, and the material for soaking menstrual blood. Most women said that menarche is at the age of 12-13 years and menopause is at the age of 45 years. Most women said that they use cotton cloth to soak blood. This is washed with detergent and dried under a sari or in a way that people do not see it. In one village women said that they buy the red colored cloth *"menstrual piece"* from the market. A few women spoke about using pads which are purchased from the market or Self Help Group. After use, pads are burnt or buried in the ground. *"Menstruation is considered a period of pollution. We are not allowed to cook or go to the temple or worship,"* said several of them. But women are asked, and allowed, to work in the field.

Women do not cook during menstruation. Men or other members of the family cook, so women and girls depend on what is given to them. One woman also talked about the plight of young girls: *"Young brides are shy to ask for food. So they do not ask even if they are hungry. They eat whatever is given to them."*

**Seasonal illnesses in the village:** Very few women spoke about seasonal illnesses and patterns. The most common seasonal illnesses as shared by them were diarrhea during summer; cough and cold, fever and pneumonia during winter.

- **During Monsoon:** Eye infections, diarrhea, vomiting, fever and malaria are common.

- **During summer and Harvest:** Headache and diarrhea and fever are common.
- **During winter:** Fever, vomiting, malaria, body ache and skin problems are common.

## E: Women's Work and Child Care

**Women's hectic schedule:** Discussions were held around women's daily schedule and 22/59 women spoke. They shared that usually they wake up early, at around four or five in the morning, complete the household chores, child care, cook food, eat and they go to the field; they return by 5 or 6 in the evening. From what most women shared, it appears that women spent almost 14-16 hours working, with approximately 6-7 hours working at home and 8-9 hours working in fields. Men do not work in the house, said most of them.

**Child care:** Most women said that if there is someone at home, the child is left home and the elders or in-laws look after it. If there is no one at home, the child is taken along at the work place too.

## F: Child's Immunization and Growth Monitoring

**Lack of information on immunization:** Women from all the six villages spoke on immunization services. Anganwadi Centre and sub centre were the places where immunization services were provided on fixed Tuesdays, said most of them. A few women were able to list the first three doses of immunization. In one village, Mohari, nine of the ten women who participated had no information on immunization and services available. However, no one spoke about all the vaccines and their benefits, immunization schedule, or preventable diseases.

## G: Contraception/ Family Planning

**Women bear the responsibility of contraception:** With regards to knowledge, most women were aware about spacing and permanent methods of contraception. They mentioned Oral pills, Condoms, Copper- T and Sterilization (female) as methods to space or limit children. But most women said that they opt for sterilization once the desired number of children and the child of desired sex is obtained. *"There is nothing like family planning. We wait for two children and then go for sterilization,"* said a woman. Another woman said "We prefer sterilization as it is in the hands of the women to limit the number of children. Another said, *"Usually after two children, women go for sterilization. But if both the children are girls, they wait for the birth of a son. The wait for a son continues till the birth of four daughters and then, if the son is not born they go for sterilization."*

Whether contraception is discussed with their spouses invoked much giggling and hesitation. Women from four villages said that there is no such discussion with spouse, and in two villages, women said that they discuss regarding sterilization with their spouse. The role of ASHA in family planning was limited as 34/59 women said that ASHA does not counsel newly-married couples.

## H: Access to Entitlements

**Access to Anganwadi services:** When discussing about services from the Anganwadi Centers, few women spoke. In two villages women said that they were not aware of the services by AWC to adolescent girls. In two villages they said that girls are given Iron Folic Acid (IFA) tablets, and in two villages they said that adolescent girls do not get anything from the AWC. There was inadequate information regarding Take Home Ration (THR). In two villages women said that they were not aware of services provided by the Anganwadi Centre. In four villages they said that THR is provided to pregnant women and lactating women. From what women said, it appears that there was lack of clarity regarding what is provided to whom, the quantity and the day for dissemination.

*"Women get packets (THR) two times during the nine months of pregnancy. There are two Anganwadi Centers in our village, all women in Narmada tola get the packets but not in Sadak tola,"* said a woman from Kherda village.

Regarding hot cooked meals, in three of the six villages, women said that hot cooked meals are provided to children at the Anganwadi Centre. Of the rest three villages, in one village women said that this is not provided, in another they said it is provided but once a week, in one they said they only know that the AWC opens, but nothing else.

**Poor access to public health services:** Discussion was held around pregnancy, childbirth, contraception and child health services and very few women spoke. In one village none of them discussed the issue. Women from four of the five villages said that for delivery they go to public health facilities in Amrapur and if there is a need for cesarean they are referred to Dindori. Delivery services, even caesarean, is provided free of cost, said almost all women.

For treatment they said that if the Sub Center does not open, they purchase medicines from the shop. One woman shared that: *"Treatment from public facility takes time. So we have to go to private practitioner, which costs a thousand rupees or so."*

Women from four of the six villages said that the transport facility- Janani Express or 108 ambulance services is good, and the ambulance comes when dialed. They appreciated the support and said that the ASHA

calls the ambulance. They said that the ambulance services are provided free of cost.

As regards financial incentives under JSY, women were aware that incentives are provided when they deliver in public facilities. When they shared information about the amount, it ranged from 500 to 1200 rupees. None of the women spoke about the name of the scheme. While several women said that they received the incentives, in one village they said that despite submitting all the documents, a woman did not receive the incentive. The reasons for the same were not known.

Women in five of the six villages spoke about the role of ASHA and they said that the ASHA visits them; accompanies them for delivery; provides treatment for minor ailments; visits homes of pregnant women and young children, and provides them information; takes children to the Anganwadi Centre and also accompanies people suffering from Tuberculosis. In one village, women said that ASHA does not provide any information.

With regards to out-of-pocket expenses, women from five of the six villages said that they do not have to pay for the services. *"We do not have to pay even the nurses at Amarpur"* said one woman. In one village, Jalda Mundhiya, women said that they have to pay 5 rupees for case paper and 30 rupees for 'bottle' (saline) in Kushipura PHC; injections are free of cost.

**Limited information about public services:** In five of the six villages, women spoke about the number of Anganwadi and mini AWCs in their village. In one village they said that they are not aware about the AWC, but expressed that young women with young children may know about the Centre.

The most common service as shared by women was food provided at the AWC, followed by immunization. Only one woman shared about weighing of children. In one village almost all women said that they are not aware about the daily opening of the Centre.

**Inadequate food from Public Distribution System (PDS):** Regarding access to PDS, women from five of the six villages said that almost all have ration cards. They do get ration such as wheat, rice, salt and kerosene. However in a couple of villages women said that the food given was not enough and that the quality of food grains has improved.

**Poor access to MNREGA entitlements:** Women in all the six villages unanimously said that they and most people in the villages do have job cards. Most said that they have not received any works since past couple of years. A couple of them also said that they have not received payments for the work done.

**Inadequacy of Mid-Day Meal scheme:** Women from all the six villages were aware that children get food at the schools. Most were also aware of the foods provided and said that the children liked the food. In one village women said that the dal was watery and children remained hungry. Women in two villages spoke about the strike by the groups who cooked the meals, and so the food was not supplied.

**Low awareness on VHSNCs and Gram Panchayats:** In all the six villages, women said that they did not know about the VHSNCs.

**Inadequate water sources:** Bore well and hand pump were the sources of water, mentioned by women from all the six villages. In summer, there is scarcity and they draw water from hand pump which may be located away from their homes.

**Sanitation facilities inadequate:** Women in all the six villages said that some have toilets in the village and almost half of the households defecate in the open. They also spoke about the incentives not being provided to the people, or to the builders who built them.

# Gaps in Public System

## A. About Gram Arogya Kendras (GAKs)

A total of six Gram Arogya Kendras (GAKs) of all the six villages were observed. A score card was developed by TRIF's Health and Nutrition Sector Council, on the basis of facilities and services available at the centre. Each question in the checklist consists of one mark and the maximum mark was 57. Three of the GAKs fall in green zone (above 80%) two were in red zone (below61%) and one in yellow zone (61-80%). As per the GAKs score analysis the minimum score was 38% and the maximum was 89%. The lowest was the GAK Bodhgundi and highest was GAK Aloni. (Please refer Table 3 for grades).

**Table 3: Grading of GAKs as per scoring**

| Percentage Range | Grades | No. of GAKs (N=6) |
|---|---|---|
| above 80% | A | 3 |
| between 61% to 80% | B | 1 |
| below 61% | C | 2 |

The infrastructure and display, information and records, instruments, equipment, medicines and supplies were also observed. (Please refer Table 4 for details). Some observations are given below:

**Infrastructure and display:** Only half (3/6) of the GAKs had signage displayed. An Information Board was available outside, at two GAKs. All the six GAKs had requisite furniture like tables and chairs. Five of the six centres had the ANC table, but foot step/stool was available at three centres only.

### Availability of information

- Basic information about the village was available at one centre only; village health plan was available at two centres.
- Half of the centres (3/6) had displayed the contact details of department officials and Janani Express, outside the centre.
- Birth, death and marriage registration details were available at four (4/6) centres. Information about SHGs, Mothers' Committee and MDM scheme was available at half (3/6) of the centres.
- Information about married and target couples, pregnant women, newborns, under-five children, malnourished children, children registered in AWC was available at all the six centres.
- Due list for immunization; list of people suffering from tuberculosis, leprosy, diarrhoea, and malaria was available at four centres; and list of temporary methods of family planning was available at three centres.
- Information about village health committee and detail of funds was available at three centres only.
- Details of services provided by ANM & MPW, ASHA, AWW, and Helper along with their names were available at two centres.
- Village health register, death related information, and register for village health committee meetings was available at all the centres. Register for other activities at the centre was also available at three centres.

**Availability of instruments and equipment:** Adult weighing machine and hub cutter were available at all the centres. Apart from these, no equipment was available at all the centres.

**Availability of medicines at GAK:** None of the six GAKs had all the sixteen medicines as per the Essential Drug List (EDL) for GAKs. Only Paracetamol and Albendazole tablets were available at all the centres.

**Table 4: Availability of Instruments and Equipment at GAK**

| No. | Particular | Availability (N=6) |
|---|---|---|
| 1 | Weighing machine for baby | 5 |
| 2 | Infantometer for newborn | 3 |
| 3 | Weight machine for children | 3 |
| 4 | Haemoglobin meter | 5 |
| 5 | Stethoscope | 2 |
| 6 | Curtains | 5 |
| 7 | Functional BP instrument | 2 |
| 8 | Thermometer | 5 |
| 9 | Slides | 6 |
| 10 | AlmirahWater tank | 6 |
| 11 | Paracetamol tablets | 6 |
| 12 | Albendazole tablets | 6 |
| 13 | ORS availability | 6 |
| 14 | IFA tablets-small and large | 5 |
| 15 | Cotrimoxazole tablets | 5 |
| 16 | Zinc sulphate dispersible tablets | 2 |
| 17 | Dicyclomine tablets (10mg) | 5 |
| 18 | Povidon | 5 |
| 19 | Iodine ointment | 2 |
| 20 | Cotton bandage | 5 |
| 21 | Absorbent cotton | 2 |

## B. About the ASHAs

Of the total seven ASHAs who were in the village, six were interviewed. All the six ASHAs belonged to Scheduled Tribes. Their age group ranged from 33-40 years and their educational qualification ranged from 8th to 10th standards, and work experience as ASHA ranged from 4-11 years. Each ASHA was expected to serve a population of about 947. The average time spent per day to do their work was two to three hours. All the ASHAs said that no community was left behind in accessing services. All the ASHAs said that they received training on joining, on all the subjects related to their roles and responsibilities.

When asked about their key tasks, they listed the following: Registration of pregnant women, Ante Natal Care, information on Institutional Deliveries, accompanying them for delivery, immunization, counselling, survey, newbirths,looking after general diseases, awareness on health, follow up of children, counselling on weight and diet, and reducing maternal and child deaths. All the ASHAs (6/6) said that they undertake home visits which were prioritised on the basis of pregnant and lactating women in the household, when pregnant women fall sick, and malnourished children.

All the ASHAs said that they provided services to the pregnant women, lactating women, children and married couples. All the six ASHAs said that they worked in coordination and received support from the higher levels. All said that they participated in observing the Village Health and Nutrition Days.

Some of the concerns expressed by them included difficulty in conducting surveys, calling parents for pulse polio immunisation; maintaining numerous records; getting their activities attested by supervisor. A majority (5/6) ASHAs said that they were overburdened with the work. Only one (1/6) ASHA was aware about the grievance mechanism, the rest were not aware of it. For most (5/6) ASHAs, lack of funds, and for one of them, lack of time were constraints. One of them said “We receive less salary “and another said “We have no money for photocopy and travel.”

Delayed payments were a concern of almost all the ASHAs, as all the six ASHAs had not received their incentives since June 2018. The reason for the delay was given to them as scarcity of funds. When they enquired at the higher levels, they were assured that the process had been initiated. “I have not received the incentives since last five six months,” and “I have not received it since three months,” and “ I have received incentive after five months,” were the problems expressed by them.

Their major achievements, according to them were increase in institutional deliveries, immunization coverage, birth spacing by couples, and patients becoming TB free. They suggested that their salaries should be fixed and increased.

## C. About the Anganwadi Centres (AWCs)

Eight Anganwadi centres from five villages were visited. Anganwadi worker was present in six of the eight AWCs visited. No one was present in Anganwadi at Bodh Gundi even at 11 am, and the helper at AWC Jalda Mundiya said that the Anganwadi Worker (AWW) had gone for a meeting. (Please Table 5 for details)

**Table 5: Basic Profile of the Anganwadi Centre**

| No. | Particular | AWC status (N=8) |
|---|---|---|
| 1 | Designated building available for AWC | 7 |
| 2 | Location and accessibility | 7 |
| 3 | Availability of electricity | 1 |
| 4 | Clean drinking water | 3 |
| 5 | Toilet availability | 4 |
| 6 | Indoor activity space | 7 |
| 7 | Storage facilities for food | 7 |
| 8 | Storage facilities for equipment | 7 |
| 9 | Sufficient space for VHND | 8 |
| 10 | Baby weighing machine | 8 |
| 11 | Adult weighing machine | 8 |
| 12 | Indoor play equipment in good condition | 7 |
| 13 | Vessel for storing water in good condition | 6 |
| 14 | Mats | 8 |
| 15 | Growth charts and IEC materials | 8 |
| 16 | Take-Home Ration (THR) | 6 |
| 17 | Records and registers | 5 |
| 18 | Iron Folic Acid Tablets | 2 |

Of the eight, seven centres were operating from their own building, and one operated from panchayat building. Majority of the centres were located inside the village; they were adequately ventilated and had adequate light. None of the centres had a boundary wall.

**Equipment and Supplies:** All the eight centres that were visited were well equipped with supplies and equipment. However, there was a major gap in availability of basic drugs, even iron folic acid. Only two centres (2/8) were having IFA tablet, Dicyclomine and Tab. Chloroquine. Tablet Punarva Mandur and antiseptic ointment was available at only one centre. Three centres had stock of ORS packets, Tab. Paracetamol and Cotton/ Bandage. None of the centres reported to have thermometer.

## D. About Anganwadi Workers (AWWs)

A total of 9/10 AWWs from the 18 centres of all the six villages were interviewed. Their age ranged from 32 years to 50 years; their education levels ranged from 8$^{th}$grade to graduation; six belonged to Scheduled Tribes and their experience ranged from two to 15 years. Majority (8/9) were living near the AWC and could reach the centre within half an hour. One worker stayed at a distance of three kilometres and took at least an hour to reach the centre. On an average the centres remained open daily for six hours, with only one of them open for three hours.

All the nine workers said that the number of children present at the centres was less than the enrolment; and they cited two reasons for the same--migration, and the distance to the centre which was far from the hamlets.

All the nine AWW said that they received training on joining, and the content was as per their roles and responsibilities. All the nine workers could list the key tasks expected from them. All the workers (9/9) said that they weighed the children and plotted the growth chart, and counselled the mother on growth monitoring. All the workers (9/9) said that they conducted various activities, played with children and provided pre-school education. One of the nine workers said that since the ANM does not come to AWC, VHND is not observed at the Anganwadi but at the Sub Centre. Four workers (4/9) said that they organised sessions on health and nutrition at regular intervals

Some of the concerns expressed were inadequate quantity and poor taste of the hot cooked food provided at the centre, and irregular supply of THR as mentioned by 5/9AWW. Two of them found conducting surveys and maintaining registers as challenging; Six (6/9) workers shared that they felt that they have to maintain too many records. They also reported that they were overburdened by ICDS work. Four workers said lack of funds was a main constraint, while two felt it was lack of time. Less than half (4/9) workers said they had adequate equipment at the centre. Six workers (6/9) said that they do not have adequate funds to operate the Anganwadi centre.

The main achievements as shared by seven workers included increased immunization, registration, institutional deliveries, non-formal education, and reduction in maternal and infant mortality, and increase in attendance of children at AWC.

## E. About the Sub Health Centre (SHC)

Four sub centres expected to serve the six identified villages were visited by CHETNA team. The total population to be served by these Sub Centers is 12988, and they were located at a distance of 4 to 8 km from the villages. (Please refer Table 6 for centre-wise information).

**Table 6: SHCs Coverage and Distance**

| No. | Particular | Amarpur | | | | Total |
|---|---|---|---|---|---|---|
| 1 | SHC Name | Jhurma | Junwani | Bodh Gundi | Kherda | 4 |
| 2 | Population covered | 3500 | 4610 | 2635 | 2243 | 12988 |
| 3 | Distance of remote village in km | 8 | 8 | 4 | 8 | - |

The services were provided by ANM in four, and by Multi-Purpose worker in one centre. Four centres had a worker to keep the premises clean, who was paid from the contingency fund.

All the four centres were operating from their own building while one operated from a rented building. The construction of two centres (2/5) was in good condition. Cleanliness at one centre (1/5) was good. There was no cattle shed and industry pollution near to any centre. There was a pool of stagnant water close to one, and garbage dumps near three (3/5) centres. Residential facility for the staff (quarters) was available at three centres. Separate toilets for men and women, and clinic room was available at four (4/5) centres. Examination room was available at three centres. Supply of clean water was available at one centre only. Three centres (3/4) had hand pump as a source of water. Regular electricity supply was available at four centres (4/5). Screen to maintain privacy was available at three centres (3/5). Drugs as per EDL were available at all five (5/5) centres.

Medicine chest was available at all the centres, but labour table was only available at two centres. None of the centres had a telephone for communication. Transport facility was also not available at any facility. Suggestion/complaint box was not available at any centre. Citizen's Charter in local language was not available at any centre.

## F. About the Auxiliary Nurse Midwives (ANMs)

Discussions were held with all the four ANMs. All belonged to Scheduled Tribes; they were in the age group of 33 to 62 years; their educational qualifications ranged from 10$^{th}$grade to 12$^{th}$grade, and work experience was from 12 to 21 years. All the ANMs shared that all the communities in their area access their services but one also said that there are some communities who do not wish to access the services of the centre. All the ANMs said that they received training on joining, and this was on Maternal and Child Health (MCH), primary care, and their roles and responsibilities. All the ANMs (4/4) said they had received training on Intra Uterine Contraceptive Device (IUCD) insertion, while three ANMs (3/4) received the training for birth attendance. The key tasks of the ANM were reported as ANC, PNC, and immunization, care of newborns, counselling on breastfeeding, surveys, records and administrative work.

Three ANMs shared that the services available at the centre were immunisation, peripheral blood smear, contraceptive services, antenatal care services, and treatment for minor illnesses like fever, cough, cold, worm disinfection, etc. All the ANMs (4/4) said that they coordinated services with AWWs, ASHA, VHSNC, PRIs. They supervised the activities of ASHA, and also had developed a health plan or a sub centre plan.

They all mentioned that they provide services to the pregnant women, children, and married couple. The tasks related to communicable diseases were mentioned as cleaning, giving advice and medicines, said two of the four ANMs interviewed. Three ANMs (3/4) mentioned that they refer the person in case of non- communicable diseases.

Some of the concerns expressed included non-availability of amenities and equipment at one centre making it difficult to provide services; ensuring that patients complete the course of medicines prescribed for treatment of malaria was a challenge for one; and for one surveys were difficult as the houses in her villages were scattered.

Only two ANMs (2/4) said that they receive support from functionaries and groups in the village; they also receive support from member of panchayat, SHGs and youth groups.

All of them (4/4) shared that they have to maintain too many records, and three ANMs also said that they were overburdened with the work. Lack of time was a major constraint shared by all.

### Achievements and Suggestions

The major achievements were that the community was taking benefit of all the schemes; increased immunization coverage; community is now more aware about their disease; increased awareness for immunization; changes in food habits; people have started coming for immunization and check-up, and there was increase in institutional delivery, and control of epidemics.

Some of the suggestions for improving the schemes were that the sub centre should be properly constructed and fully equipped, village allocation for ANM should be less so that she is able to reach all the households; greater support of community.

## G. About the Primary Health Centre (PHC)

PHC Kamko Mohaniya was visited by CHETNA team and information was solicited from the in-charge Dr. Khushram. The PHC offers services 24x7, and the total population covered by the PHC is 21191.The PHC was located in a government building and was easily accessible; the distance of farthest village was 5 km only. Distance from Primary Health Centre(PHC) to Community Health Centre(CHC) was 30 km, and from PHC to District Hospital (DH) was 48 km. Facility of clean water was available at the centre. There were no cattle shed, stagnant pools, and pollution from industry close to the facility, but garbage dump was seen near the centre. Beds were available as per the norms for PHC. Citizen's Charter was displayed at the facility. Grievance redressal mechanism, screen to maintain privacy, and ramp for differently-able individuals was available.

Medical officer, nurse midwife, health worker (female), health assistant, lab technician and support staff was available at the facility. Pharmacist was not available.

**Services provided at the PHC**

- Primary wound treatment and management was provided at the centre.
- Ante Natal, Intra Natal care, Post-Natal care, new-born care, management of Sexually Transmitted Infections and Reproductive Tract Infections (STIs/RTIs), and delivery services under Janani Suraksha Yojana (JSY) were available at the centre.
- Immunisation day was fixed at the centre, and BCG and measles vaccine were given regularly.
- Services for treatment for anaemia, treatment of children with pneumonia, and management of children with severe diarrhoea/dehydration were available at the PHC.
- Other services and functions performed included school health programme; promotion of safe water supply and sanitation; prevention of locally endemic diseases; disease surveillance and control of epidemics; collection and reporting of vital statistics; education about healthy behaviour and National Health Programmes was provided by the facility.
- Monitoring services such as monitoring of National Health Programmes, monitoring activities of ASHA, monthly visits of Medical Officer to all sub centres were done by the PHC.
- Lab testing facilities were available at the PHC and tests such as routine urine, stool and blood tests, blood grouping, bleeding time, clotting time, diagnosis of RTI/STIs, sputum testing for Tuberculosis; blood smear examination for malaria parasite; rapid tests for pregnancy and rapid tests for HIV were available.
- Drugs were available as per the Essential Drug List (EDL) and the availability of drug was monthly.

**Some of the concerns were:**

- Services such as surgery for cataract, burn cases, primary management of fracture, and treatment for poisoning/snake bite were not available.
- MTP service was not provided at the centre; ANC clinic was not organised.
- Services of vasectomy and tubectomy were not provided at the PHC.
- Lab test for syphilis was not available.
- Low-birth babies were not managed.

# Samnapur Block, Dindori, Madhya Pradesh

## Introduction:

The Government of Madhya Pradesh is committed to improve the health and nutrition status of women and children. The recently released Healthy States Progressive India -2019report has ranked Madhya Pradesh at number 18 of the 21 states.

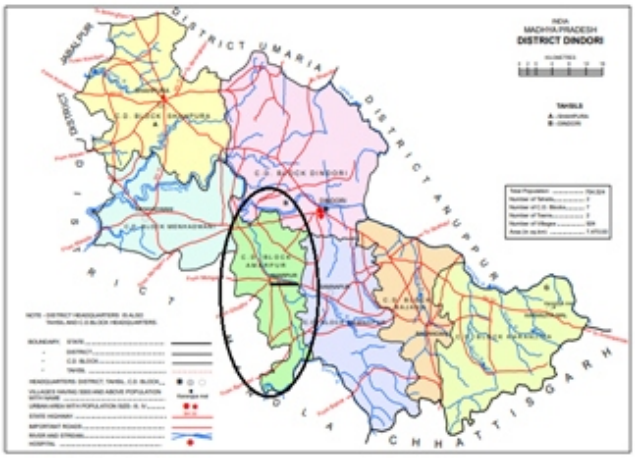
The Transform Rural India (TRI) Project is an initiative of Tata Trusts to transform villages, village life and society, especially the bottom 100,000 villages. TRI looks at initiating ground-level pilots in selected blocks in endemic poverty regions in central and eastern states. The pilots are aimed at developing process protocols for triggering multidimensional transformation of villages in endemic poverty regions.

Mission Antyodaya is a convergence framework for measurable effective outcomes on parameters that transform lives and livelihoods.As envisaged by the l Ministry of Rural Development, Government of India, is an effort to address the multidimensionality of poverty in a time-bound manner through a convergence of resources, both financial and human, to provide an opportunity for transformational changes.

CHETNA has joined hands with this initiative in the capacity of thematic expert NGO (T- NGO) to strengthen the Health and Nutrition Component of the programme. The project is being implemented in total 420 selected villages, 70 villages in each of the six d Mission Antyodaya blocks--Amarpur, Samnapur, Thandla, Petlawad, Manawar and Sondwa of four districts Indore, Habra, Dear and Alirajpur of Madhya Pradesh.

This is a report on the assessment done in Samnapur block of Dindori district.

**About Dindori district:** Dindori is situated in the eastern part of Madhya Pradesh, bordering the state of Chhattisgarh. It is surrounded by Shahdol, Mandla and Umaria districts. It is divided into seven blocks namely Dindori, Shahpura, Mehendwani, Amarpur, Bajag, Kanranjiya and Samnapur. The population of the district as per the 2011 census was 704,524 of which male and female population was 351,913 and 352,611 respectively. The district has a sex ratio of 1002 females per 1000 males. The literacy rate of the district was 63.90 per cent. The literacy rates for men and women are 75.47 and 52.41 per cent respectively.



Samnapur block encircled in Dindori District

**Health and nutrition status of women and children:** According to the National Family Health Survey (NFHS-4; 2015-16), in Dindori, around 37% girls marry before the age of 18 years. The percentage of use of any kind of family planning method was 66.8 %. Male and female sterilisation was 0.9% and 61.2% respectively.

Regarding access to Maternal and Child Health (MCH) services, 44.9% mothers had antenatal check-up in the first trimester and 23.5% mothers had received four antenatal visits. But only 5.1% women had full antenatal care. The survey reports around 59.3% of pregnant women aged 15-49 years as anaemic, and the percentage of pregnant woman who consumed 100 Iron Folic Acid (IFA) tablets during their pregnancy was 18.9% only. 66.5% women between ages 15-49 years are anaemic, as per the survey. Around 56% women delivered in institutions, and36.8%. of children aged below 3 years breastfed within one hour of birth.

35.5% children under 6 months of age were exclusively breastfed; and the breastfeeding children between ages 6-23 month who received an adequate diet was 1.9% only. Only 49.4% of children aged 12-23 months were fully immunised. Malnutrition status of children was also very severe, 45.8% of children below 5 years were stunted, 27.4% were wasted, and 10.5% were underweight. Similarly 66.5% children aged 6-59 months were anaemic. The Health Management Information System (HMIS) of Dindori District and Samnapur block shows significant improvement in access to maternal and child health services since the survey. (Please refer Table 1 for details)

**Table 1:MCH status of Dindori and Samnapur**

| No. | Indicator | Dindori (%) | Samnapur (%) |
|---|---|---|---|
| 1 | ANC registration | 81.18 | 94.22 |
| 2 | ANC Reg. in 1st trimester | 86.17 | 82.75 |
| 3 | Pregnant women given 180 IFA tab. | 83.59 | 80.51 |
| 4 | ANC with 4 check-ups | 66.81 | 64.35 |
| 5 | Institutional delivery | 92.20 | 92.28 |
| 6 | Pre-term newborns | 7.05 | 3.65 |
| 7 | Still birth | 2.22 | 2.23 |
| 8 | BCG against live birth | 95.97 | 92.33 |
| 9 | Measles | 78.99 | 74.46 |
| 10 | Full immunization | 86.97 | 82.22 |

Source: State HMIS unit, MP; April 2018 to February 2019. Full immunization data is up to Jan 2019.

**Purpose of the assessment:** With a view to understand the local health and nutrition realities and design interventions accordingly, CHETNA conducted Community Need Assessment (CNA) and Public Health System Gap Analysis (PSGA) in sample villages of Samnapur block of Dindori district, Madhya Pradesh.

Methodology: Qualitative research methodology was used in which Group Discussions (GD), Key Informant Interviews(KII) and facility-level observations were don e(Discussions were held on topics such as food security, gender, women's health, child health, contraception, access to services and entitlements. On an average the discussions continued for about two-and-half hours. Visits were made to observe Gram Arogya Kendras (GAKs), Anganwadi Centres (AWCs), Sub Health Centre (SHCs); Primary Health Centres (PHCs) and Village Health and Nutrition Day.

**Sample:** A 10% sample of the intervention villages @ six per block was taken for the assessment. Based on the following criteria, a total of six villages were selected. (Please refer Table2 for list of villages).

**Table 2: List of Selected Villages and Clusters**

| S.No. | Village Name | Name of CLF |
|---|---|---|
| 1 | Gora kanhari (Forest village) | Bahnmi |
| 2 | Pondi (Forest village) | Bahnmi |
| 3 | Padariya | Samnapur |
| 4 | Singwara | Samnapur |
| 5 | Kukarramath | Manikpur |
| 6 | Budrukhi | Manikpur |

- Difficult to reach, hilly terrain, forest village
- Functional SHG
- Economic conditions
- Road connectivity
- Caste concentration

A total of six group discussions were held with 53members of Self Help Groups (SHGs), one in each of the six villages during 19-24th November 2018. Group discussions with women were held on topics such as food security, gender, women's health, child health,

contraception, access to services and entitlements. On an average the discussions continued for about two-and-half hours.

Four Sub Health Centres (SCs), nine Anganwadi Centres (AWCs); six Gram Arogya Kendras (GAK), two Primary Health Centres (PHC) were visited. Four Village Health and Nutrition Days were observed during the visit. Interviews were held with 50% of ASHAs of the village, 50% of the Anganwadi Workers, ANMs, and Medical Officers. A total of seven ASHAs, nine AWWs and four ANMs were interviewed by CHETNA team. (Please refer Table 3 for schedule of activities).

**Table3: Schedule of Activities in Samnapur**

| No. | Date | Village | Name of Activity |
|---|---|---|---|
| 1. | 06.11.2018 | Majh gaon | SHC Observation |
| 2. | 06.11.2018 | Padariya | ANM Interview, GAK Observation, ASHA Interview, SHC Observation |
| 3. | 19.11.2018 | Sighwara | ASHA Interview, AWC Observation, GAK Observation, VHND Observation, AWW Interview, Village Profile ; Group Discussion(11) |
| 4. | 19.11.2018 | Padariya | AWC Observation, AWW Interview; Group Discussion(9) |
| 5. | 20.11.2018 | Kukarramath | ASHA Interview, 3 AWC Observation, GAK Observation, Village Profile,3 AWW Interview |
| 6. | 21.11.2018 | Kukarramath | ANM Interview, SHC Observation, ASHA Interview |
| 7. | 22.11.18 | Kukarramath | Group Discussion(10) |
| 8. | 22.11.2018 | Budrukkhi | ASHA Interview, 2 AWC Observation, VHND Observation, GAK Observation, 2 AWW Interview ; Group Discussion(6) |
| 9. | 23.11.2018 | Gaura Kanhari | ASHA Interview, AWC Observation, Village Profile, AWW Interview, PHC Observation, GAK Observation, VHND Observation, ANM Interview; Group Discussion(10) |
| 10. | 24.11.2018 | Bamhani | PHC Observation |
| 11. | 24.11.2018 | Pondi | ASHA Interview, ANM Interview, AWC Observation, VHND Observation, GAK Observation, AWW Interview; Group Discussion(07) |
| 12. | 07.12.2018 | Jada surang | SHC Observation |

**Data collection tools:** Separate tools for CNA and PSGA were developed by the Health and Nutrition Sector Council of the Transform Rural India Initiative. Ten checklists were developed in English by the Health and Nutrition Sector Council team-TRIF.CHETNA survey team members were oriented on the data collection tools.

**About the villages:** The total number of households in these six villages is 1641, and the population is 6386. The people belong mainly to Scheduled Tribes and Other Backward Classes (OBC). OBC was the powerful category in five of the six villages.

The six sampled villages were expected to be served by 15 Anganwadi centres, and the average population to be covered was 426 per centre. Three of the six villages were sub centre villages and the remaining three were located at a distance of 1 to 7 kilometres from the sub centre.

Five of the six villages had transport readily available for medical emergencies. In two of the six villages there is a delay in timely arrival of the ambulance as they are not connected by pucca road.

**About the women who participated:** 53 women from Self Help Groups and other women from the village participated in the group discussions. They were from the age group of 26 to 50 years. Sixteen women (16/53) were not literate, and the education levels of the rest 43 women ranged from 2$^{nd}$ to 12$^{th}$grade. Most women worked in farms. The nutrition status (height and weight) of the 53 women was measured and BMI calculated. More than half (29/53)of the women were found to be having a normal BMI ; almost half of the women (22/53) women were found to be underweight with BMI less than 18.5, and two women were found to be overweight.

# What Women Say

## A: Food and Nutrition Security

**Inadequate food consumption:** Discussions with women indicated that their overall food consumption is inadequate as compared to the laborious work they do in the house and in the fields. 35/53women shared information on their eating patterns. They usually eat two meals a day, and those who work in the fields, eat three meals one meal in the fields. Four women said that there is no fixed routine; they eat whenever they are hungry.

**Limited food basket:** Most women said that they eat rice accompanied by either dal (pulses) or subzi vegetables. None of the women mentioned of eating foods from all the food groups in a meal. No one mentioned milk and milk products or fruits in their daily food intake.

Of the 35 women who spoke, 16 said that the main cereal eaten is rice. Nine women said that they eat maize, and a couple of women said that they eat wheat-*roti or dalia (broken wheat)*.13/35 women said that they ate dal along with rice. *Masoor* (lentils) and *matri* (yellow pea) were the two types of *dals* listed.

*"In our villages rice is the staple food. We grow rice so we eat it. Wheat roti is rarely eaten. We eat rice with dal or with sabzi"* said a woman.

Women listed several vegetables that are eaten, including green leafy vegetables such as fenugreek leaves, gram leaves, spinach, radish leaves, etc.; as well as gourd, cabbage, cauliflower, brinjal, tomatoes, and potatoes.

Women also shared information about locally available leafy vegetables such as lal bhaji, chench and kundri. Chech bhaji is available in monsoon, which is dried, stored and eaten in winters. Similarly kundri is available in summer. Some of the local food grains like kodon, kutki were also mentioned, but they are not eaten nor easily available now, they said.

Women also said that the vegetables are available easily in winter season and it is difficult to get them in summer and monsoon season. So vegetables are eaten more in winter, and in summer or /monsoon they eat dal. Women also said that most women grow vegetables near their homes for their consumption. Those who do not grow, buy vegetables from the local market.

Women listed four fruits-papaya, guava, custard apple and banana which are eaten sometimes. Those who have planted fruits at their homes eat them. Women also said that foods/vegetables/fruits are purchased from market. Most said that they go to the market sometimes, and some said they go frequently.

Women from the entire six villages spoke about eating animal based f foods. Most said that more than half of the people in the village eat animal based foods. The most commonly eaten foods are chicken, eggs and fish. Some women also mentioned that people eat whatever is available--goat, meat, pork, rats; everything except beef. But this is part of the daily fare; the frequency of eating these foods ranged from once a week to once a month. For some this was eaten when there was a feast or when guests arrived at home. These foods are not eaten during fasting by certain sects, or during Shravan month which is considered a holy month.

**Food insecurity during lean season:** Women from all the six villages spoke about lean season and coping methods. Monsoon and summer are the lean seasons when there is no earning from farm labour and foods are not available in their farms. So to earn money, several families migrate to Gujarat or Rajasthan. Most households save grains for the lean season. Those who do not have land, or where the produce is not adequate, borrow from those who have surplus food. In one village, women spoke about several households who do not have enough. They go from house to house in search of food and cook that food that they get.

*"There are several households who eat one meal a day. If they eat in the morning they miss the evening meal and if they eat in the evening they miss eating the morning meal. There is a house in our village with five members. With great difficulty they manage their meals and eat only khichadi,"* said a woman.

What women said in village Padariya is worth applauding. *"We meet every week and contribute half a kilogram of rice to the collective kitty. If some member says that there is no rice in her home or if any member has a function, we provide 50 kilograms of rice, and also a thousand rupees"* said a woman.

Another woman said that *"Now groups have been formed in several places but our group functions in a different way. We provide to non-members also. Shanti didi is not a member of our group but when she informed us about the condition in her house we gave her the rice."*

Several women echoed *"No one sleeps hungry nowadays. Earlier we have slept hungry. Those who did not eat beef ate it to satisfy their hunger. But now no one needs to be hungry. All of us do farming and those who do not have land, work in other's fields. In this way we share and continue."*

**Cultural practices affect intake of nutritious food:** Fasting continues to be a woman's domain. In all the six villages, women shared that they fast on specific days; two to three days in a week, and during particular

festivals such as Navaratri. The eating practices during fasts varied--for some it was total fasting with tea as the only intake, whereas for some it was only dinner, while some ate special foods meant to be eaten while fasting.

**Pregnancy:** Diet restrictions are not to be followed during pregnancy, said women from six villages. Women like to eat sour foods and should eat what they wish. Heat producing foods are to be avoided.

**After childbirth:** Women are given masoor (lentils) and arhar (pegion peas) dal only. Matar dal, udad (black gram) dal, sour foods, cold foods, green chillies and brinjal are not to be eaten.

**Back to work:** Women from all the six villages said that getting back to work after delivery depends on the situation of the household. If there is no one else at home, women start working after a week. For those who have family to take care of the little one, they leave the baby in care of the elders. For those who have no one at home, they tie the baby on their back and work in the fields. If the financial resources are available, women said that they return to work after two to three months of childbirth.

## B: Gender Issues

**Gender parity in education:** Women from five of the six villages said that both boys and girls are sent to school. A woman said *"Earlier, people used to say that they did not have enough money so they did not send girls to school. The mindset was that the daughter will go to other household so why to invest. But now both boys and girls are sent to school and for higher education."* This was echoed by several women. In one village a couple of women said that girls are allowed to study less than the boys or boys are sent to private schools and girls are not because they have to pay fees in private schools.

**Girls get married at the legal age:** Most women were aware of the legal age at marriage for boys and girls. Women said that the times have changed and girls are not married at an early age, now. Preparations are started when the girl completes 10$^{th}$ grade, and then when she completes 12$^{th}$ grade, she is married off. If the girls continue their studies, they are married after 18 to-21 years of age but if not, they are married between 15-17 years, and boys before 20 years of age. However, in case the boy and girl are in love the parents agree and the age is overlooked for the fear of elopement which is a prestige issue for the family. A couple of women did say that their daughters were married at 16-17 years of age and it has impacted their health and they have become weak.

**Women eat last:** A few women spoke about eating patterns. Cooking continues to be women's responsibility. *"Since we cook the food, we eat first,"* said a woman. There was a mixed response to the question about when the women eat. Most said that women eat last. Men or elders eat first, followed by children, and then they themselves eat. But if a woman is hungry she does not wait and eats by herself. Most women also said that if at all there is no food left they do not cook for themselves, and remain hungry. *"It is alright if we do not eat at night, we have to sleep (do not need food) but we have to go to work so we have to eat in the morning"* said a woman.

**Work and employment:** A few women spoke about work and employment. For most, there was no discrimination in terms of getting employment, both boys and girls can get jobs and go where ever their jobs take them. In the village, farm work was the only employment

available. Women in all the six villages spoke about migrating to different places--towns/cities and states for work. Usually men and boys go out in search of work. They go in summer and after a couple of months return in monsoon for farm work.

**Mobility of women:** Women from all the six villages said that they do not have free time to go anywhere. They hardly get time from their busy work schedule at home and in the fields. If at all they get some time they spend it to chat with other women from their hamlets. Girls and boys are free to move about and play in the village and there are no restrictions if they want to go out of the village. A couple of women did say that girls are not allowed to go outside the village alone.

## C: Infant and Young Child Feeding Practices

**Early initiation of breastfeeding:** 16/53women spoke about initiation of breast feeding. All of them said that they feed the baby immediately after birth, within one to two hours. They also said that the *"yellow milk"* (colostrum) is fed and it makes the baby strong. A couple of them said that if the mother's milk does not flow, the baby is fed cow's milk.

**Exclusive breast feeding is practiced:** From all the six villages, women said that child is breast fed till six months of age. Then they take it to the Anganwadi Centre and start giving food. A couple of women said that food is started after six months of age for boys and after four months of age for girls. Another woman said that this is not done nowadays. One woman also said that that *"if breast milk does not flow the baby is fed goat's milk".*

**Initiation of complementary feeding:** A few women spoke about initiation of complementary feeding. The age at introduction of complementary feeding was six months said women from all the six villages. There was a difference in initiating complementary foods to girls and boys. Girls are fed at 4 months and boys after six months. Most of the women also said that the child is fed at the age of one year, when she demands or starts eating on its own. The most common food given as complementary food was biscuits, followed by kheer (porridge made with rice and milk) and foods cooked at home. Foods from animal sources are given when the child is older, or if it is cooked when guests come. A couple of women talked about annaprashan and giving complementary food from the Anganwadi Centre.

**Mothers decide about feeding the child:** When asked about who decides about feeding the child, almost all said that the mother, or the parents, and also the person who stays back and cares for the baby decides.

## D: Women's Health

**Seeking treatment:** 30/53 women shared their views about visit to a doctor. Of these, 18 said that they visit a doctor when they fall sick. 15 women said that they go to hospital for their delivery. Women go to public as well as private facilities and if they do not get cured they also go to local healer. 22 women said that they visit public health facility primarily because it is near, services are free, and they get money for delivery. Most women said that they go to public facilities for delivery, and find the services good. 11women said that they go to private facilities as the services are better. From what women said it appears that they want quick relief; they would like free services, but are ready to pay for better care.

*"People go to public hospitals more often as they do not have money. Even those who have money come to the public facility."* said a woman.

*"We go to public hospital and if we do not get cured, we have to arrange for money and then go to private facility."* said another

*"We go to the doctor (private) at Dindori, Samnapur, Bhanpur, and Majhgaon and take injections. Some also go to the local healer. First they go to the doctor and if they do not get well then they go the health facility-clinic or hospital. People go the private more often, and many people do not go to public facility."*

*"When we go to public facility, they simply give us tablets and do not give us injections, and the job is done. When we go to private, we pay them Rs500-2000 and they give good treatment. If it is just fever, the treatment costs us Rs 100-200. In government hospital they check blood from our fingers, give us tablets and send us away and we do not get cured, so we go to private afterwards either in Bhanpur or Samnapur, where ever we feel like"* said another woman.

*"When we go to public facilities, they admit us for 2-4 days or else refer us to Dindori or Mandla or Jabalpur. If we go to Jabalpur, we get lost."* said a woman.

**Common illnesses:** 22/52 women shared information regarding when they fall sick. They discussed about the stages of life, the physical conditions, the illnesses and the seasons for falling sick. Adulthood, childhood and adolescence were the life stages where women fall more sick, said four of them. Pregnancy and menstruation are the physical conditions where most women fall sick, said ten of them. Some of the common illnesses mentioned were malaria, anemia, weakness, coughs and colds, aches and fevers, menstrual pain, heavy menstrual bleeding, and premature delivery. Three women said that they fall sick all through the year, four said during monsoon, and one said during winter. Weakness/anemia and menstrual pains were the two common ailments found in girls,

women said. Diarrhea and vomiting, coughs and colds, aches and pains, malaria, measles, typhoid were some of the common illnesses observed in the villages.(Please refer Table 4 for details)

**Table 4: Common Illnesses**

| S.No. | Illnesses | women(n=30) |
|---|---|---|
| 1 | Weakness | 6 |
| 2 | Anemia | 10 |
| 3 | Stomachache | 2 |
| 4 | Menstrual problems | 3 |
| 5 | White discharge | 1 |
| 6 | Body ache | 3 |
| 7 | Problems during pregnancy | 2 |
| 8 | Skin problems-scabies | 1 |
| 9 | Diarrhea and vomiting | 1 |

**Menstrual Practices:** Women from all the six villages spoke about menstrual practices and the material for soaking menstrual blood. Most women said that they use cotton cloth to soak blood. This is washed with detergent and dried under a sari, or in a way that most people do not see it. Women also said that they buy the red menstrual piece from the market. Few women spoke about using pads.

## E. Women's Work and Child Care

**Women's hectic Schedule:** Discussions were held around women's daily schedule and in all the six villages women spoke about their daily schedule, the excessive workload and fatigue. They said that usually they wake up early at four or five in the morning. In all the six villages, women said that they defecate in the open, in the wee hours of the morning. After returning, they complete the household chores, tend to cattle child care, cook food, eat and they go to the field and return by five or six in the evening. From what most women shared, it appears that women spent almost 14-16 hours working, with approximately six to seven hours working at home, and eight to nine hours working in fields. Men do not work in the house said most of them.

**Child care:** The usual practice is that women who have small babies do not go to work outside. If they go, they work for fewer hours. For women who have to work in the fields and do not have anyone to look after their children at home, they take them to the work place. If the child is young, they tie it on their back and work. Most women said that if there is someone at home, usually the in-laws, or the elderly, the child is left at home and the elders look after.

## F: Child's immunization and growth monitoring

**Lack of information on immunization:** Women from all the six villages spoke on immunization services. Anganwadi Centre was the place where immunization services were provided on fixed Tuesdays, said most of them. A couple of them said that the ANM comes to call them for immunization. Shots are given to children as well as pregnant women they said. In all the six villages the women spoke about children getting fever and the local site being painful and infected. Few women said that they did not know about immunization. A few women were able to list the first three doses of immunization. However no one could tell about all the vaccines, its schedule, the preventable diseases etc.

**Information about child's weight:** Most women were aware that children are weighed in the Anganwadi Centre and their mid-arm circumference is also measured. Most said that the AWW and ASHA tell them about the weight of the children. A couple of women from three villages had young children at home and they were aware of the weight of their children. A couple of women also said that as their children had grown up, they did not know. One of them also said that they are informed whether the children are in red, yellow or green category.

**Maternal and child deaths:** Women from five of the six villages said that there were one or two child deaths in their village. The reasons for the same were not known

## G: Contraception/ Family Planning

**Women bear the responsibility of contraception:** With regards to knowledge about contraceptive methods, of the twenty women who spoke, ten said that they were not aware; four said that they were aware of sterilization, and two were aware of emergency contraceptive pills. Most said that it is the woman who adopts contraception, and that sterilization is the most common method adopted.

*"Women adopt sterilization but none of the men go. We do not know why men do not adopt sterilization. Women have to bear all the brunt as if they have asked God to give them this gift."* said women from one village.

*"Women adopt sterilization; men have to do heavy labour work, do not get ready themselves, who will earn for the family if they undergo sterilization,"* said a woman.

The role of ASHA in family planning was limited as half of the twenty women who spoke said that ASHA does not inform them about contraception.

Women said they opt for sterilization once the desired sex of the children is obtained. *"If the first two children are boys then we wait for a girl, and if the first two are girls we wait for a boy. If the two children are a boy and a girl we get operated after two children,"* said a woman.

The question whether contraception is discussed with their spouses invoked silence. A couple of women said that they do not know, or nor have they used any form of contraceptives, so the question of discussion with the spouse does not arise.

## H: Access to Entitlements

**Access to Anganwadi Services:** When discussing about services from the Anganwadi Centers (AWC), few women spoke. With regards to services to adolescent girls, a couple of women from two of the six villages said that girls are provided pads and Iron Folic Acid (IFA) tablets. Registration, Take Home Ration (THR), and IFA tablets were the three services provided at the AWC as mentioned by a couple of women from all the six villages. Lactating women are given food packets. With regards to services to children, a couple of women said registration, weighing, immunization, food and food packets were the services provided at the AWC.

With regards to hot cooked food 15/53 women shared their views. From what they said, it appears that women are aware that hot cooked food is provided to children at the AWC and that it is cooked by women's' group and should be as per menu.

In one village women said that the *"women's group provides food to the AWC but it is not as per the menu. They do not get supplies on time and so they provide whatever is available with them."*

**Poor access to public health services:** Discussions were held around pregnancy, childbirth, contraception, and child health services and very few women spoke. Women from four of the six villages said that for delivery they go to public health facilities. The ASHA helps them in dialing for ambulance 108 and everyone has a mobile so they access ambulance services. However women from two villages wanted delivery services near their homes as they have to travel around 15-20 km for delivery.

*"We need a hospital in the other village so that we can easily access the services and we need a vehicle in the village. We do not know when the doctor comes at Majh gaon hospital so we do not get services."* said one woman.

Another said: *"There is no health center in the village and it should be there. Kukurrmath does not open. The ANM does not stay there. It operates from Panchayat building. Samnapur is 25 kms and Dindori is 15 kms away from our village."*

Women from four of the six villages said that the transport facility-Janani Express or 108 ambulance services is good and it comes when called. They said that ASHA supports them and calls the ambulance. Ambulance services are provided free of cost, they said. A couple of women also said that sometimes there is a delay in the ambulance reaching the village. If the woman delivers at home, the ambulance takes them to the hospital later on.

As regards to financial incentives under Janani Suraksha Yojana (JSY ) most women were aware that incentives are provided when women deliver in public facilities. A couple of women said that they did not know about this. When they shared information about the amount, it ranged from Rs.1200 to 16000. None of the women spoke about the name of the scheme. Several women said that they received the incentives. They also said about the delay in receiving the incentive. A couple of women also shared that the requirement of several documents was a constraint in receiving the benefits.

Women in five of the six villages spoke about the role of ASHA and they said that the ASHA visits them, accompanies them for delivery, provides treatment for minor ailments, and visits houses where pregnant women and young children are there, and provides information; takes children to the Anganwadi Centre.

With regards to out-of-pocket expenses, women from five of six villages said that they do not have to pay for the services. In two villages women said that they have to pay Rs.5 for case paper and in one they said the driver asks for 100 rupees.

**Limited information about public services:** When discussing about services provided at the Anganwadi Centres women from all the six villages spoke. They said that the AWC opens daily. A couple of women said that they were not aware. One woman said that children do not get any service except food.

The most common service as shared by women was food provided at the AWC, followed by immunization, check-ups, treatment for minor ailments, referral services, health education and some activity with the children. One woman said that children are safe at the AWC.

**Access to entitlements from public distribution system (PDS):** Regarding access to PDS, women from the entire six village said that most households have ration cards. A couple of women from two village said that they do not have ration card so they do not get ration. They do get ration such as wheat, rice, salt and kerosene. However in a couple of villages women said that kerosene was costly.

**Poor access to MNREGA entitlements:** Women in all the six villages unanimously said that they and most people in the villages do have job cards. Most said that they have not received any work since past couple of years.

**Midday Meal Scheme:** Women from five of the six villages were aware that children get food at the schools. Most were also aware of the food provided and they said that the children liked the food. In two villages women said that the food was adequate and of good quality. In three, they said it was inadequate and children remained hungry.

**Low awareness on VHSNCs and Gram Panchayats:** In all the six villages, women said that they did not know about the VHSNCs.

**Inadequate water sources:** Bore well and hand pump were the sources of water, mentioned by women from five villages. In one village women said that they get tap water. For most, hand pumps are far off and women have to walk long distances to fetch water. In summer, there is scarcity and they draw water from hand pump which may be away from their homes.

**Sanitation facilities inadequate:** Women in all the six villages said that some have toilets in the village and almost half of the households do not have toilets. Some have toilets but do not use it due to water scarcity or incomplete construction.

# Gaps in Public System

## A. About Village Health and Nutrition Days

A total of four VHND sessions were observed by CHETNA team. Three of the four sessions were held at Anganwadi Centres (Pondi, Gaura Kanhari and Singharwa) and one was observed at ASHA's home (Badrukhi). This was due to conflict between ASHA and the Anganwadi Worker. UIP master register and mother and child health master register was available at all the sessions.

**Human resource:** ANM and ASHA were present in all the four VHNDs; AWW was present in three of the four VHNDs and MPW was present in one VHND. Medical Officer from PHC, community representatives and PRI members were not present at any of the sessions

**Equipment and amenities:** BP instrument, baby weighing scale and adult weighing scale were available at all the sessions. At three sessions (3/4) stethoscope was not available. Toilet facility and examination with screen was not available at three sessions. (Please refer Table 5 for details)

**Table 5: Availability of Supplies and Amenities at VHND**

| No. | Particular | Availability (N=4) |
|---|---|---|
| 1 | Banner and poster is displayed | 2 |
| 2 | Iron Folic Acid Tablets | 4 |
| 3 | Vitamin A | 4 |
| 4 | Tab Albendazole | 4 |
| 5 | ORS | 4 |
| 6 | Zinc tablets | 4 |
| 7 | Cotrimoxazole (pediatric) | 2 |
| 8 | Chloroquine phosphate tablet | 3 |
| 9 | Oral contraceptive Pills | 4 |
| 10 | Condom | 3 |
| 11 | Vaccines | 3 |
| 12 | Clean drinking water | 3 |
| 13 | Toilet | 1 |
| 14 | Clean venue | 3 |
| 15 | Immunisation card | 4 |

**Services provided on VHND:** Polio vaccine (OPV) was given to children; Ante Natal Checkups (ANC) was provided by ANMs; pregnant women were counselled; motivation for sterilization and IUD was done at three sessions. Two ASHAs at the session site said that they counselled couples during home visits. Children were weighed and nutritional advice given. WASH related activity was not conducted at any sessions.

### Discussion with ASHAs

7/13 ASHAs from the six villages were interviewed. Of the seven, four belonged to Scheduled Tribes and the rest belonged to Other Backward Classes. Their age group ranged from 28 to 42 years, and their work experience ranged from 6 to 12 years. The average population covered by each ASHA was 491. Five of the seven ASHAs said that they worked for 2-4 hours a day; one said that they work full day on VHND and another said their time depends on need.

All ASHAs said that they were trained when they first joined. More than half (4/7) of the ASHAs had not received the complete induction training (modules 1 to 5). All the ASHAs said that they have undergone refresher training. The major task of ASHAs, they said were: home visits, support in immunisation, accompanying women for delivery, community mobilisation, and awareness and counselling. All ASHAs had drug kits with them, and one mentioned irregular supply of drugs, mainly that of ORS and Paracetamol tablets.

**Some of their concerns are:**

- Mobilising women and families to take SAM children to NRC during the VHND was difficult for three fourth (5/7) of the ASHAs.
- While all said that they accompany women for delivery, it was difficult to go with them at night said two of the seven ASHAs interviewed.
- All the ASHAs mentioned lack of support from the VHSNCs, and lack of participation from the PRIs, teachers and VHSNCs members in VHND.
- Overburden of work, participation in too many meetings, lack of funds, maintaining too many records, and delay in payment was reported as major constraints.

### Achievements of ASHAs and their suggestion for scheme improvements

Some of the achievements mentioned by ASHAs were increase in immunisation and institutional delivery; benefits of schemes reaching women; women are now availing antenatal checkups services, they consume IFA and take the immunisation shots; reduction in maternal deaths, and people have become more informed, One ASHA mentioned that she saved a high-risk pregnant woman who was identified as severely anemic by ensuring that she completes the iron sucrose.

Some of the suggestions from them were there is a need for support and involvement of Sarpanch and Panchayat members; create awareness about ASHA; reduce the over burden; timely disbursement of incentives and fixing salary of workers.

## B. About Gram Arogya Kendras

Gram Arogya Kendras of all the six villages were observed by CHETNA team. The following are some of the observations:

- Sign board of GAK cum AWC, notice board and health plans were not displayed at any of the six centres. Notice board was not displayed outside any of the six centres.
- Furniture such as chair was available at all the centres, while table and ANC table was available at five centres.

**Information availability at GAK**

- Village health plan was available at one of the six GAKs.
- Contact detail of service providers and Janani Express was not displayed outside any GAK.
- Information about the birth, death, marriage registration, pregnant women, new born, SAM child under five children were available at all the GAKs.
- Information about the VHSNCs was available at four GAKs; register for village health committee was available at all the six GAKs, but information about untied funds detail was available at only one GAK.
- Details of SHGs, Mothers Help Committee and MDM Scheme Group were available at four GAKs.
- Details of immunization, TB and leprosy patients, diarrhoea, malaria patients were available at four GAKs.

**Availability of instruments and equipment:**
None of the six GAKs were equipped with all the necessary equipment. None of the six GAKs had all the drugs as per Essential Drug List. This will be challenging to provide the treatment for minor illness at village level. (Please refer Table 6 for the list).

**Table 6 : Availability of Instruments, Equipment and Drugs at GAK**

| No. | Particular | Availability (N=6) |
|---|---|---|
| 1 | Baby weighing scale | 6 |
| 2 | Infantometer for newborn | 3 |
| 3 | Weighing scale children | 6 |
| 4 | Weighing scale for adults | 6 |
| 5 | Haemoglobin meter | 1 |
| 6 | Stethoscope | 4 |
| 7 | Curtains | 3 |
| 8 | Functional BP instrument | 6 |
| 9 | Thermometer | 6 |
| 10 | Slides | 5 |
| 11 | Almirah | 6 |
| 12 | Water tank | 0 |
| 13 | ORS available | 6 |
| 14 | IFA tablets- small and large | 6 |
| 15 | Co-trimoxazole tablets | 1 |
| 16 | Zinc sulphate dispersible tablets | 4 |
| 17 | Paracetamol tablet (500gm) | 6 |
| 18 | Albendazole tablets (400mg) | 5 |
| 19 | Dicyclomine tablets (10mg) | 5 |
| 20 | Povidon Iodine ointment | 1 |
| 21 | Cotton bandage | 2 |
| 22 | Absorbent cotton | 1 |

A score card was developed on the basic of facilities and services available at the centre. Each question in the checklist consisted of one mark and the maximum mark was 57. On the basis of this GAKs were scored and grades were given. Accordingly, none of the GAKs were in the A category. The minimum score was 47% and the maximum was 68 %. More than half of the GAKs were in grade C. (Please refer Table 7 for grades)

**Table 7: Grading of GAKs as per scoring**

| Range | Grades | No. |
|---|---|---|
| above 80% | A | 0 |
| between 61% to 80% | B | 2 |
| below 61% | C | 4 |

## C: About the Anganwadi Centres (AWC)

Nine out of the total 15 Anganwadi centres (7 main and 2 mini) of the six sampled villages were visited.

### The following are some observations:

**Infrastructure and amenities:** Eight of the nine AWC operated from government building. One AWC operated from a rented room. None of the nine AWCs had electricity. Only two centres (2/9) had toilets. All the nine AWCs were in need of repairs. Five of the nine centres needed a boundary wall. Four of the nine centres did not have sufficient space to organise VHND. Only two centres had a medicine kit available.

Seven of the nine AWCs were accessible to the communities. Clean drinking water was available at all the centres. All the nine AWCs had space for indoor activity, but it was not sufficient at three AWCs. Seven of the nine AWCs had storage for food. Three of the nine centres did not have space to store equipment.

**Equipment and supplies:** Functional baby and adult weighing scales were available at all the nine AWCs. While toys were available at all the nine centres, they were in poor condition in six of them centres.

- All the facilities had utensils to serve the hot cooked meal; mats were found to be in good condition in eight of the nine AWCs.
- Only one of the nine AWCs had growth chart in good condition.
- IEC material was available at eight AWCs but it was not in good condition.

**Human resource:** The post of AWW and helper were filled at all the nine AWCs. A total of nine AWW were interviewed. Four AWW belonged to Scheduled Tribes and five belonged to Other Backward Class category. They were in the age group of 26 to 52 years; educational qualifications ranged from 8$^{th}$ grade to post graduation, and their work experience ranged from four to twenty two years.

All of them stayed in the same village at a distance up to one km from the AWC. They said that the AWC opened daily, and the timings were from 9AM to 4PM. The number of children coming to the Anganwadi was comparatively less than the enrolment. The reason given by eight of them was that parents take their child along with them to the fields. One said that irregular supply of THR was the reason.

All the workers said that they have received training at the time of joining and relevant topics were discussed which included pre-school education, counselling, health and nutrition, basic requirement of AWC and its functioning, services of AWC and THR.

**Services of the AWC:** They listed the key tasks performed by them as per their roles--services to children, pregnant women, lactating women and adolescents. All the workers said they conducted 15-16 home visits monthly. All the nine mentioned regular distribution of THR. At the time of the visit, eight of the nine AWCs had the stock of THR as well as record registers. Hot cooked meal was not provided at one centre, and three workers (3/9) shared that meals were not provided as per menu. Only three workers shared that they provided extra ration or food to malnourished children. One worker shared that there was complaint from the community regarding the taste of THR Khichadi. All the AWCs had on an average 2-3 Severe Acute Malnourished (SAM) children and around 8-9 Moderate Acute Malnourished children, but in last six months only two workers (2/9) referred SAM to Nutrition Rehabilitation Centre.

### Some of the concerns were:

- More than half (5/9) AWW said that they have to maintain too many registers.
- Two workers (2/9) shared that they were overburdened with the work.
- Eight of the nine AWW said that they did not have sufficient to funds to operate the Anganwadi centre. In this case either they have to bear from their pocket or avoid the activity. One AWW also said that they have to bear the THR transportation charges from their own pocket as it does not get reimbursed.
- One centre was in a rented building and the worker said that she was not getting the rent of the AWC.

### Achievements and their suggestions

**Some of the achievements mentioned were:**
community access to the schemes has increased; improvement in education levels of community; reduction in maternal and child deaths and increase in community awareness.
Some changes suggested were construction of boundary wall around the centre for protection of children; providing chairs and tables for children to sit; providing uniform s for children, more toys and quality food.

## D. About the Sub Health Centres

A total of four Sub Health Centres (SCs) providing services to the selected six villages were visited. These were SC Kukarramath, Majhgaon, Jada surang and Padariya. oint. Gaura Kanhari SC was closed since past six months and hence was not visited. Discussions were held with the ANMs posted in the four SCs.

Out of four, three centres (3/4) operated from their own building and were clean. Kukarramath SC operated from the panchayat building. There was a garbage dump and pollution from brick kiln near Jada Surang SC. A pool of stagnant water was near Majhgaon. The average distance to the PHC and CHC was 12 and 21 km respectively. The average distance to the farthest village was 5.5 km. One hamlet of Kukkurmath SC was unable to access services of the SC as it is cut off during rainy season. (Please refer Table 8 for profile of Scs)

**Human Resource:** A total of 5 ANMs were posted at the four sub centres. One ANM was posted at each of the three e sub centres Pardariya, Kukarrmath and Jada Surang; whereas two ANMs were posted at Majhgaon SC as it was a designated Delivery Point. The post of MPW was vacant in all the sub centres, and two of the four SCs had a worker to keep the SC clean. Two of the five ANMs stayed near the SC--one at SC and one in the SC village. Others travelled 2-8 km to reach the SCs.

**Facilities and infrastructure at SCs**

- None of the four SCs displayed sign board.
- Citizen's Charter was not displayed at any of the four SCs.
- Separate toilets for men and women were at Padariya SC only.
- Three centres did not have electricity.
- None of the four SCs had facilities for clean drinking water.
- There was no transport and communication facility for the staff at any centre.
- Staff quarters were available at only one-Majhgaon SC.
- Labour room was available at two SCs, but deliveries were conducted at one SC--Majhgaon.
- Complaint box was not available at any sub centre.
- Two SCs--Padariya and Kukarramth did not have drugs as per the Essential Drug List.
- Newborn corner was not available at Majhgaon SC where deliveries were conducted.

### About the ANMs

Discussions were held with four of the five ANMs. All the four belonged to Scheduled Tribes category. They were in the age group of 38-47 years; their educational qualifications ranged from 12$^{th}$ grade to Masters in Commerce, and their work experience ranged from 12-18 years.

**Table 8: Profile of SCs**

| No | Particular | Samnapur | | | | Total |
|---|---|---|---|---|---|---|
| | SHC Name | Kukarramath | Padariya | Majhgaon | Jadasurang | 4 |
| 1 | Population covered | 3335 | 4268 | 3643 | 3550 | 14796 |
| 2 | Distance of remote village in km | 4 | 6 | 5 | 7 | - |
| 3 | Health worker female | 1 | 1 | 2 | 1 | 5 |
| 4 | Health worker male/MPW | 0 | 0 | 0 | 0 | 0 |
| 5 | Voluntary worker to keep the Sub Centre clean | 0 | 1 | 1 | 0 | 2 |

All the four mentioned that they received training when first joined their job. All the ANMs shared that they have received training for IUCD insertion and only one (1/4) received training on birth attendance.

**Services provided at the centres:**

- All the ANMs said that they provided immunisation services, contraceptives, Ante Natal Care/Checkups.
- All the ANMs mentioned that they coordinated with AWW, ASHA, VHSNCs and PRIs. They also mentioned supervision of activities of ASHA as their role.
- One of the four ANMs said that when they refer people to CHC Samnapur, they were not treated appropriately; the staff did not provide proper counselling to them.
- None of the ANMs had the village health plan.

**Some of the concerns were:**

- rregular visits of Male Health Worker or Lady Health Visitor to the SC.
- Inadequate equipment and basic amenities like ANC table at SCs.
- All the ANMs said that they have to maintain too many records and three fourth mentioned that they are overburdened.
- Half of them shared that not receiving support from the community was the major constraint.

## Achievements and Suggestions:

**Some of the achievements were increase in institutional deliveries; sufficient quantities of medicines were available; people are aware about their health. Suggestions were: MPW should be posted at SHC; timely release of Janani Suraksha Yojana incentives, filling the positions of medical officers, and regular supply medicines at SC.**

## E. About the Primary Health Centres

CHETNA team visited two PHCs-Bahmani and Gaura Kanhari and discussed with the staff nurses posted at the PHC. The following are some of the observations:

**Location and access:** Both the PHCs operated from a government building. Gaura Kanhari PHC was located on the outskirts of the village and connected by kuccha road making it difficult to access. The farthest village was at a distance of 15 km. from the PHC. Average distance of both the Centres to CHC-Amarpur and District Hospital Dindori was 25 and 52 km respectively. There was a garbage dump near Bahmni PHC. Citizen's Charter was not displayed at one facility and there was no grievance redressal at the two PHCs. (Pease refer Table 9 for PHC profile).

**Human Resource:** The post of Medical Officer was vacant in both the PHCs. Staff nurse, Health Worker-Male, laboratory technician, and support staff were available at both the PHCs. Pharmacist was available at Bahmni PHC only. Post of Health Worker-Female and Health Educator was vacant.

**Facility and services provided at the centres:**

- Ante Natal Check-ups, Intra-natal care, Post-natal Care, newborn care, and family planning services were provided at both the PHCs. Labour room was available at both the PHCs and delivery services were provided .In Brahmin, the Operation Theatre was used as labour room.
- Treatment of anaemia and management of children with severe diarrhoea/dehydration was provided at both the PHCs.
- Both the PHCs worked for prevention of locally endemic diseases and collection and reporting of vital statistics on monthly or weekly basis. Services for management of snake bite/ poisoning and management of burn were provided at Bahmni PHC only.

**Some of the concerns were:**

- Staff nurses of both the PHCs expressed delay in supply of drugs as per Essential Drug List.
- Screen to maintain privacy was not available at one facility; lack of privacy was observed by the team when male health worker provided injection to a woman.
- Both PHCs are not involved in the monitoring of SHCs; it was directly done by the BMO.
- Operation theatre was at one facility, but surgeries were not done.
- Drinking water was not available at Bahmni PHC.
- Communication facilities like telephone, computer internet were not available at both the PHCs.
- Minor surgeries, management of fracture, cataract surgery was not provided at both the PHCs.
- Immunisation services were was not provided at both the PHCs centres.
- None of the two PHCs provided pneumonia management; MTP, tubectomy, vasectomy and management of RTI/STI.

**Table 9: Basic Profile of PHCs**

| No | Particular | Samnapur | | Total |
|---|---|---|---|---|
| 1 | PHC Name | Bahmni | Gaura Kanhari | 2 |
| 2 | Population covered | 1000 | 13000 | 23000 |
| 3 | PHC providing 24x7 delivery facilities | Yes | Yes | 2 |
| 4 | Daily OPD-Male | 8 | 7 | 15 |
| 5 | Daily OPD-Female | 14 | 13 | 27 |
| 6 | No. of beds | 6 | 6 | 12 |

# Manawar Block, Dhar, Madhya Pradesh

## Introduction:

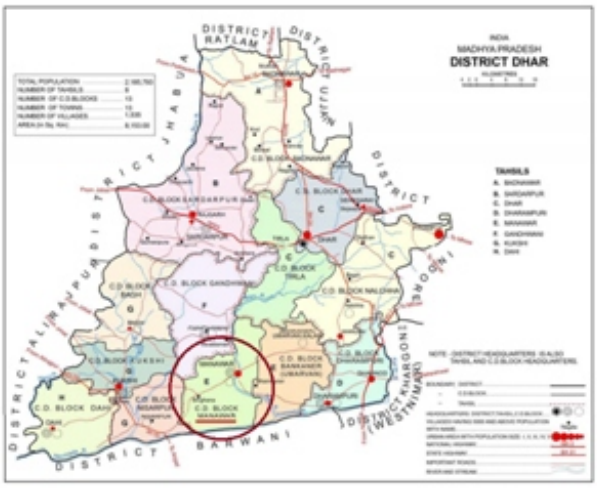
The Government of Madhya Pradesh is committed to improve the health and nutrition status of women and children. The Healthy States Progressive India -2019 report has ranked Madhya Pradesh at number 18 of the 21 states.

The Transform Rural India (TRI) Project is an initiative of Tata Trusts to transform villages, village life and society, especially the bottom 100,000 villages. TRI looks at initiating ground-pilots in selected blocks in endemic poverty regions in central and eastern states. The pilots are aimed at developing process protocols for triggering multidimensional transformation of villages in endemic poverty regions.

Mission Antyodaya is a convergence framework for measurable effective outcomes on parameters that transform lives and livelihoods. As envisaged by the Ministry of Rural Development, Government of India it is an effort to address the multidimensionality of poverty in a time-bound manner through a convergence of resources, both financial and human, to provide an opportunity for transformational changes.

CHETNA has joined hands with this initiative in the capacity of thematic expert NGO (T- NGO) to strengthen the Health and Nutrition Component of the programme. The project is being implemented in 420 selected Mission Antyodaya villages of six blocks@ 70 villages per block. The intervention blocks are --Amarpur, Samnapur, Thandla, Petlawad, Manawar, and Sondwa of four districts Dindori, Jhabua, Dhar and Alirajpur of Madhya Pradesh. This is a report on the assessment done in Manawar block of Dhar district.

**About Dhar district:** Dhar is a tribal and high-priority district in the context of health and nutrition indicators. It is comprises of thirteen blocks. Bhils and Bhelala are the major tribes. Around 55.94% population belongs to Scheduled Tribes, and 6.65% belongs to Scheduled Castes. Dhar district has a population of 2,185,793, of which 1,112,725 are men, and 1,073,068 are women; and the sex ratio is 964 females per 1000 males. The total literacy rate is 59.00%, and literacy rate of men is 68.95% and that of women is 48.77%. Agriculture and daily-wage labour are the main sources of livelihood. In the lean season, people migrate to adjoining states for employment.(Census 2011).



Dhar district encircled in red

**Health and Nutrition Status in Dhar:** According to the National Family Health Survey4(2015-16), 32.4% women of ages 22-24 years married before the age of 18 years, and 9.9 % women aged 15-19 years were pregnant/mothers at the time of survey. A total of 61.7 %women received antenatal check-up in the first trimester; only 29.6% women received four antenatal visits, and only 4.1% women received full antenatal care. 78 %women delivered in institutions, and 86% births of children under the age of five were registered. Only 65.6% children aged 12-23 months were fully immunised.

21% children aged below 3 years were breastfed within one hour of birth, and 72 % children under six months of age were exclusively breastfed. Of the children aged 6-8 months, those receiving solid and semi-solid food and breast milk were 17.8 %. Only 14.6% of breastfeeding children aged 6-23 months were receiving an adequate diet.42.6 % of children less than 5 years were stunted, 31.4 % were wasted, and 47.9% were underweight. Similarly 75.3% children aged 6-59 months, and 56.2% women aged 15-49 years were anaemic. 63.7% of pregnant women aged between 15-49 years were anaemic, and the percentage of women who consumed 100 IFA tablets during their pregnancy was 14.1% only. 30.4% women had BMI below normal (18.5Kg/$m^2$)

**About Manawar Block:** Manawar block of Dhar district of Madhya Pradesh has a population of 3, 08,188, with 1, 52,519 women and 1, 55,669 men. 13.5% of the population is under 6 years of age. Average literacy rate is 63%; male literacy is 68%, and female literacy is 58.7%. People are mainly dependent on agriculture. Most cultivated crops are soybean, cotton, wheat, and red chillies.

Maternal and Child Health indicators of Manawar indicate the need to make efforts for universal access to health services. While 93.3 % children receive BCG vaccination, 81.12 % children receive full immunization. The total registration of pregnancy is 80.7 %,but 78.1% women register in the first trimester; 96% receive three Ante Natal Care, whereas only 4.1% women receive full Ante Natal Care. The percentage of women delivering in institutions is 69 %. (Please refer to Table 1 for details).

**Table- 1. District and Block wise MCH Status of Dhar and Manawar**

| No. | Indicator | Dhar* (%) | Manawar** (%) |
|---|---|---|---|
| 1 | Full Immunisation | 65.6 | 81.12 |
| 2 | Measles | 85.7 | 81.12 |
| 3 | BCG | 94.8 | 93.3 |
| 4 | Total Registration | - | 80.7 |
| 5 | Early(1st trimester) Registration/1stCheck-up | 61.7 | 78.1 |
| 6 | 3/4 ANC | 29.6 | 95.9 |
| 7 | Institutional Delivery | 78% | 69.2 |
| | Home delivery | - | 139 |

Source: *NFHS-4(2015-16)
** Block Wise Health Bulletin; April 2018-March 2019; State HMIS Unit, MP

**Purpose of the assessment:** With a view to understand the local health and nutrition realities and design interventions to address the needs and the gaps, CHETNA conducted Community Need Assessment (CNA) and Public Health System Gap Analysis (PSGA) in sample villages of Manawar block of Dhar district, Madhya Pradesh.

**Methodology:** Qualitative research methodology was used in which Group Discussions (GD), Key Informant Interviews (KII) and facility-level observations were done. Discussions were held on topics such as food security, gender, women's health, child health, contraception, access to services and entitlements. On an average the discussions continued for about two-and-half hours. Visits were made to observe Gram Arogya Kendra s (GAKs), Anganwadi Centres (AWCs), Sub Centre (SCs); Primary Health Centres (PHCs) and Village Health and Nutrition Day.

**Sample:** A 10% sample of the intervention villages @ six per block was taken for the assessment. The following was the selection criteria:

- Remoteness, ethnic composition (Majority Bhil community)
- Prosperous village/mixed community; nearness to the approach road
- Linked area in Sardar Sarovar Dam
- Active village organisation(VO) and Self Help Group(SHG); financial status of VO

A total of six group discussions were held with 115 members of SHGs in each of the six villages during 9-12 September 2018. Group discussions with women were held on topics such as food security, gender, women's health, child health, contraception, access to services and entitlements. The discussions continued for about two and half hours.

Two Sub Health Centres (SCs), seven Anganwadi Centres (AWCs), three Gram Arogya Kendras (GAK), one Primary Health Centre (PHC) were visited, and one Village Health and Nutrition Day was observed. Interviews were held with 50% of ASHAs of the village, 50% of the Anganwadi Workers, ANMs and Medical Officers. A total of six ASHAs, 11 AWWs, four ANMs and one Multi Purpose Worker (MPW) were interviewed by the CHETNA team. (Please refer Table 2 for schedule).

**Table 2: Schedule of Activities in Manawar**

| Sr. No. | Date | Village | Name of Activity |
|---|---|---|---|
| 1. | 10/9/18 | Birpura | ASHA Interview(1) AWW Interview (2) Discussion with Self Help Group (17) |
| 2. | | Mohali | GAK Observation91) ASHA interview (1) AWW interview(2) ANM interview(1) Discussion with Self Help Group(19) |
| 3. | 11/9/18 | Sarikhpura | AWW Interview (3) ASHA Interview(1) MPW interview (1) AWC observation(2) SC Observation(1) Discussion with Self Help Group(23) |
| 4. | | Panchkheda | AWW Interview (4); MPW interview (1) GAK Observation (1) VHND Observation (1) ANM interview (1) ASHA Interview(1) AWC Observation(2) Discussion with Self Help Group(17) AWC Observation (3) AWW Interview (3) GAK Observation (1) |
| 5. | 12/9/18 | Karoli | ASHA interview(2) PHC Observation(1) ANM Interview(10) Discussion with Self Help Group(18) |
| 6. | | Sisri | ASHA Interview(1) SC Observation (1) AWC Observation (2) AWW interview(2) Discussion with Self Help Group(20) |
| | | | VHND observation at Kudarmana |

**Data collection tools:** Separate tools for CNA and PSGA were developed. A total often checklists were developed in English by the Health and Nutrition Sector council team-TRIF. CHETNA data collection team members were oriented on data collection tools.

**About the villages:** The six selected villages are Pachkheda, Sirsi, Karoli, Birpura, Sharikpura and Mohali. The total number of households in the is 2732 and the population is 8876. The prominent caste categories in these villages are Scheduled Tribes and Scheduled Caste. The dominant communities are Patidars, Rajputs, Bhils and Bhilalas. All the six villages were connected with pucca roads and had clean drinking water source through hand pumps and tube wells. Two villages (2/6) were on the main road while the remaining four (4/6) were at a distance of 2 to 20 kms from the highway. Three (3/6) of the villages were Sub Centre villages; one village was at a distance of 1km, while remaining two (2/6) were at the distance of 4 and 7 km respectively from the Sub Centre. The average distance of PHC/CHC from the villages was 5 km.

**About the Women:** A total of 115women from Self Help Groups-leaders, secretaries, and members participated in the discussions. Most of the women worked in farms. The nutrition status (height and weight) of 113 women was measured and their Body Mass Index (BMI) calculated. About half (60/113) were found to be having a normal BMI; about one fourth (28) women were found to be underweight with BMI less than 18.5, and 25 women were found to be overweight.

# What Women Say

## A: Food and Nutrition Security

Inadequate food consumption: Discussions with women indicated that their overall food consumption is inadequate as compared to the laborious work in house and in the fields. 42/114 women shared information about their eating patterns. The usual pattern is to eat two or three meals a day according to 29/42 women. Children eat frequently said a couple of them. Vegetables and fruits are eaten once in a day, said a couple of women; or are eaten two to three times in a week, said a few of them. Usually either vegetables or dal are cooked, and when vegetables are not available, they cook dal.

"We eat vegetables in winter as they are cheap and we also grow them," said a woman.

**Limited food basket:** 52/115women said that they eat meals comprised of roti made from a cereal accompanied by dal (pulses) and sabji (vegetables). Only two women spoke of consuming milk, but that was for children, and in houses that had a goat or a cow.

The commonly eaten cereals are maize (26/52) and wheat (25/52). As regards pulses, women said that mostly tuver (pegion pea), chana (bengal gram), udad (black gram) and moong (green gram) dal are eaten.

**Table 3: List of Cereals and Pulses Eaten**

| Cereals and Pulses | Number of women(n=52) |
|---|---|
| Maize | 26 |
| Wheat | 25 |
| Rice | 1 (rarely) |
| Tuvar dal | 14 |
| Chana dal | 14 |
| Moong dal | 14 |
| Milk | 2 |

Green leafy vegetables were not listed by the women. Bhindi (Ladys finger), gilka (gourd), kareli (bitter gourd), lauki (sweet gourd) and tomatoes were the commonly listed vegetables. Ber (berries), papaya, mango, palm, banana, custard apple were some fruits listed by women.

Availability of diverse foods appears to be a challenge. The following quotes highlight the challenges faced by women and families in eating diverse foods.

*"We do not buy fruits from market as we cannot afford them." "We have papaya and custard apples, but children do not like them; they like apples and grapes. These are expensive so we rarely buy them."*

*"Those who have a cow or a goat have milk in their homes, but it is not enough."*

32/52 women spoke about eating foods from animal source. While a couple of them said that there was no fixed schedule, for some (13/32) the schedule ranged from once or twice in a month to once or twice in a week, which was the maximum. With regards to starting giving animal based foods to children, a woman said that *"we give eggs and chicken to the child after the age of two years."* Chicken (7), mutton (5), fish (2), eggs (2) and milk were the animal based foods listed. Women also mentioned the challenges faced:

*"We eat chicken once in 15 days but mutton is costly so we eat it only sometimes, when we have earned enough in that month"* said a woman. Another said that *"in summer and monsoon we do not get enough vegetables so we eat more of eggs and chicken." "We eat less of chicken in summer as it leads to increased heat in the body,"* said one of them.

From what women said, it appears that there are no religious or cultural restrictions regarding eating of animal based foods. However availability and cost seems to be a concern in eating these foods. Giving these foods to children has been mentioned by only one and that too after the age of two years. This delays children learning to eat animal based foods.

**Limited availability of diverse foods:** Women mentioned that they eat what is grown in their fields' o what they purchase from the market. These are the only two sources to obtain foods as mentioned by women. Only one woman mentioned getting food from the public distribution system (PDS). Anganwadi centre was not mentioned as a source to obtain food.

Market emerged as one of the key sources of purchasing vegetables, if not grown in their fields. Vegetables are cooked daily when they are available, which is usually in winter and monsoon. Availability of vegetables seemed to be a major concern during summers so they eat dal (pulses).

**Food insecurity during lean season:** Around forty women spoke about the lean season and coping methods. Women in all the six villages mentioned that during summer, which is the lean season there, is no earning from farm labour so most people go to Gujarat to seek work; usually the entire family migrates. Vegetables and fruits are scarce during summer so most people eat pulses and cereals. Those who can afford to, buy vegetables and fruits from the market. Those who cannot, eat available vegetables. Women mentioned that no one in the village goes hungry. For households, it is normal to help each other and they happily share flour, maize and vegetables. A couple of women mentioned that they obtain wheat from the ration shop, just before summer.

**Cultural practices affect intake of nutritious food:** Fasting continues to be a woman's domain. In all the six villages, women mentioned that they fast two or three days in a week, or during particular festivals such as Navratri, Sharvan maas, Dashamata. They mentioned that during fasts they eat special foods such as sweets ago, ground nuts, potato and chips, or eat fruits and drink tea. In some fasts they eat only one meal a day. They do not eat tomatoes, Tata salt, garlic, and turmeric when fasting.

**Women mentioned about diet restrictions:** Fruits are to be avoided for children during winters to prevent coughs and colds; banana and curds are to be avoided during winter.

**Foods restricted during pregnancy:** During pregnancy, women are asked to eat less, or avoid eating certain foods to avoid large babies and for easy birth. Buttermilk, curd, wheat roti, spicy food, onion, lady's finger, potato, brinjal, papaya and ground nuts are foods to be avoided.

Foods restricted during lactation: Restrictions are followed for a month after delivery. Mother and the baby are kept in a separate room. Oily and spicy foods are restricted during lactation. Usually khichdi *(Rice and pulses cooked together)*, halwa *(floor roasted in ghee with sugar or jaggery added)*, or dalia *(broken wheat)* is given.

Women also mentioned about getting back to work after delivery. Usually for a month or two they do not go out to work, but for the poor, getting back to work is immediate-say within 15 days of childbirth.

*"The poor have to work more. A poor mother starts working within few days, and those who are better off are allowed to take one to two months rest at home,"* said one of them.

## B: Gender Issues

**Gender discrimination in higher education:** In five of the six villages women said that both boys and girls are sent to school, usually when the school is in the village. Some mentioned that they send both boys and girls for higher studies to cities. In one village-Sarikhpura, women mentioned that girls are sent to study in the village school only, which is up to 5$^{th}$ grade. Most parents are scared as there are limited transport facilities and a girl was raped in the nearby village.

**Girls get married before the legal age:** Most women were aware of the legal age at marriage, the age ranged from 16-21 years. In one village Sarikhpura women said that the SHG members file a police complaint if the marriage is before legal age, so most girls are married late. However, in case the girl falls in love or wants to get married, they agree and the age is overlooked, said several of them. Bride price was also mentioned by a couple of women in form of cash, goat and alcohol. Strict norms for girls are to marry within the caste, but these norms are relaxed when a boy wants to bring a bride from another caste.

**Women eat last:** Women in all the six villages talked about eating patterns. Most mentioned that there is no fixed pattern, whoever is hungry eats. Several of them also said that usually children and men eat first, and women eat last. And some women mentioned that the family eats together, at least for one meal, particularly when all the members have to go to the fields for work.

**Work and employment:** 30/115women spoke about their work and employment. Most women said that farming and labour were the two common works outside their homes. Men and women both worked in the field, but only men go to work outside the village, said a couple of them. So it would depend on the household whether women would work in the village or go out.

*"Women and girls are allowed to work outside villages now days. Women go out with their husbands to Gujarat or bigger cities to work. Cost of living is rising day by day. It is good to have a good inflow of money when both husband and wife work,"* said a woman.

Gender division of work was obvious: A woman said *"Women work in house, farm, and also work as labourers but men work only in farms or as labourers."* Most women mentioned that they wake up early, at 4 or 5 in the morning and continue working till 10 at night. Sometimes they get one or two hours of rest from their work.

Women also expressed concern over lack of livelihood opportunities. One said that there are not enough jobs, and another said that when children do not get jobs despite higher education, they work as laborers. A couple of them also mentioned that in free time they watch television, or sleep.

**Restricted mobility of women:** Women mentioned that they are free to go anywhere on their own during the day, especially on the haat (market) days. However, going out at night is restricted. In one of the six villages, women said that if at all they have to go out at night, they usually go in groups. Most of them said that they usually do not go out as they have too much work and no free time. They do meet at gatherings and religious events, but that is occasional.

## C: Infant and Young Child Feeding Practices

**Delayed initiation of breast feeding:** 27 women spoke about initiation of breast feeding. Most mentioned that there was a change from earlier practice as they now feed the baby immediately after birth. Almost three fourths (18/27) women said that the baby is breastfed immediately after birth. One of them said that they are scared that the nurse will scold them so they feed the baby immediately. A couple of them said that they initiate breast feeding after two or three days. One of them said that the ASHA comes and squeezes the colostrums out and then it is fed to the baby.

**Need to ensure excusive breast feeding:** From all the six villages, women mentioned that the child is exclusively breast fed for six months. Some also mentioned that they give water, milk and pre-lacteal feeds besides breast milk, particularly in the first couple of months. Most women mentioned that the baby is breastfed on crying. When they go to the field, and the baby stays in the hammock, it is fed on demand.

**Delayed initiation of complementary feeding:** A few women spoke about initiation of complementary feeding. The age at introduction of complementary foods ranged from 7 months to 2 years, when the child starts eating by it or starts walking. The most common food given was biscuits, followed by fried snacks, kurkure and milk. Dal water, rice water is also fed to the baby said a couple of women. With regards to giving animal based foods, one woman shared that these are introduced after the baby is twelve months of age. No one spoke about any ritual (annaprashan) for initiation of complementary feeding or giving complementary food from the Anganwadi Centre. A woman also mentioned the constraints of giving nutritive foods to children.

*"We are aware that chips are not good for health but children like these, they are available and we can afford."*

*"Everyone knows children should be given milk, curds, fruits but we are not rich so we cannot give these foods to our children."*

**Mothers-in-law decide about feeding the child:** When asked about who decides about feeding the child, almost all mentioned that the person who stays back and cares for the baby decides. Usually the mother-in-–law, and if she is not there, the mother stays back to care for the baby. So mother-in-law or the mother decides about the baby's food. The father is hardly involved or aware.

## D: Women's Health

**Seeking treatment:** A few women shared their views about visit to a doctor. In all the six villages women talked of going to the public health facilities and private facilities. Usually women go to ASHA to seek treatment or they go to compounder/medical store to buy medicines. If they do not find relief, then they go to Manawar CHC. Some women talked of seeking treatment from private facilities which are 2-3 km away from their village, and spending up to 1000 rupees.

**Illnesses faced by women:** Menstrual pain, aches and pains after childbirth, dizziness, vomiting, swelling during pregnancy, and weakness are some of the common illnesses faced by women in these villages.

*"Average number of children in our village is four to five. Repeated deliveries make women weak, but what to do?"* said a woman.

Women also spoke about a host of health problems they face--chickenguniya, diarrohea, vomiting, skin problems, and infections and so on. But the most common illnesses mentioned by women from all the six villages were weakness/fatigue/anemia. Most women associated weakness/anemia with multiple pregnancies and childbirth.

*"There are more problems with the women who do not have a son. They have to undergo repeated pregnancies," said one of them."*

Some also spoke about excessive workload and responsibilities which provide no space for respite.

*"We feel weak but what to do; we have to work for the family,"* said one of them.

A few women shared information on common health problems of adolescent girls. Of these, the most common problems were body ache, problems related to menstruation such as abdominal pain, irregular periods, bleeding, and weakness/anemia.

**Menstrual practices:** 50/115womenspoke about menarche, menstrual practices and the material for soaking menstrual blood. Only five women spoke about using pads which are purchased from market. One of them also said that VO/SHGs sell pads which costRs20 for a packet. Women use this for four days and then burn it. The rest said that an old cloth or menstrual piece-red flannel is purchased from the market. Most said that they wash it, and if men are not around dry it in sun. If they are around, any other garment is spread on it or the cloth is dried in the bathroom. Women in all the six villages said that they are considered polluted during menstruation and not allowed to cook or work in the kitchen. Men or any other member of the family cook for

four days. But women are asked and allowed to do outside work in the field. Some also said that they are not allowed to work in the fields growing green vegetables, chilies and ginger. A couple of them also spoke about early onset of menarche and the fact that some women take pills to prolong the date of menstruation.

**Seasonal Illnesses in the village:** Very few women spoke about seasonal illnesses and patterns. The most common seasonal illnesses mentioned by them were fever and malaria, diarrhea and vomiting, body ache and headaches. They said that:

- During monsoon, eye infections, diarrhea, vomiting, fever and malaria are common.
- During summer and harvest, headache and diarrhea and fever are common.
- During winter, fever, vomiting, malaria, body ache and skin problems are common.

## E: Women's Work and Child Care

**Women' hectic schedule:** Discussions were held around women's daily schedule and 28/115 women spoke. They mentioned that usually they wake up early in the morning at 5 or 6 am, complete the household chores, child care, cook food, eat and then go to the field. If the field is nearby some return home at noon, do some work in the house, and again go back to the field to return by 5 or 6 pm. Women spend almost 14-16 hours working, with approximately 6-7 hours working at home and 8-9 hours working in field. Most women mentioned that their work increases during festivals, monsoon and harvest.

**Child care:** 31/115 women spoke about child care facilities. Almost all said that the child is left at home and the elders or in laws look after it. If there is no one at home, the child is taken along to the work place, or the older siblings take care of the young ones. No one mentioned leaving the child at the Anganwadi Center, when they go to work.

## F: Child's Immunization and Growth Monitoring

**Greater awareness on immunization services:** 21/ 66 women spoke on immunization services and almost all said that they get their child immunized. However none spoke about the types of vaccines, its schedule or its benefits. Most women mentioned that immunization services are provided at the Anganwadi Center; a couple of women said that it is provided on Tuesdays, once a month and ASHA comes to call them. Fever and swelling were the most common after effects mentioned.

**Maternal and child deaths:** When discussing on recent child deaths, a woman mentioned about death of a newborn that was born very weak by cesarean and admitted to the ICU but did not survive. Other than that, no other deaths were mentioned by the women.

**Lack of information on childs'nutrition status:** Of the 21women who discussed about their child's weight, only two said that almost all were aware that child is to be weighed at the Anganwadi centres. Six to seven women said that they knew of their child's weight, but none was aware about the nutrition status of their child.

Four women also discussed challenges in referral of SAM children. A woman was told by ASHA and Anganwadi worker that her baby is severely undernourished and she should go to Manawar. But she returned after one week.

*"We can't take children to Manawar and stay there for so long. Mother-in-aw says who will work and take care of the home and other children if you stay out of home for long?"* said one of them.

A woman from another village said that *"ASHA told a mother that they should take the child to Manawar for treatment. ASHA takes malnourished children to Manawar for treatment for two/three weeks. But the mother- in-law and her husband did not let her take the child with ASHA to Manawar."*

Another woman pitched in saying *"She wants to take her child, all mothers want to see their child in good health but we can't go against them."*

## G: Contraception/ Family Planning

**Gender division of responsibility of contraception:** With regards to knowledge about contraceptive methods, 44 women spoke, and of them, most women (37/44) were aware about sterilization (female). Only five women spoke about oral pills and Copper-T (IUCD) as a contraceptive method. Almost all women said that female sterilization is the most commonly adopted method of contraception. Several of them said that because they get incentive ofRs1400, women go for sterilization.

*"Men are not prepared to accept male sterilization but in our village two men have undergone sterilization,"* said one of them.

Discussion with their spouses on contraception was missing, as only 36 women responded and all of them said that contraception is not discussed. The role of ASHA in family planning was limited, as almost all said that ASHA does not counsel newly married couples.

## H: Access to Entitlements

**Access to Anganwadi services:** When discussed about services from the Anganwadi centers, few women spoke and they said that take-home ration is provided to adolescent girls, pregnant women and lactating women. They said that there are no issues; they get food once a month on fixed day and children get food at the anganwadis as per schedule. However none spoke about other services to be provided by the Anganwadi Centre.

**Poor access to public health services:** Discussions were held around pregnancy, childbirth, contraception and child health services and very few women spoke. Women said that for delivery they go to public health facilities in a PHC in their village or Manawar. If complication arises, they go to Badwani.

For treatment they said that if the Sub Center does not open, they purchase medicines from the shop. A woman shared that treatment from public facility takes time, so they have to go to a private practitioner which costs them a thousand rupees or so.

Women from four of the six villages mentioned that the transport facility - Janani Express or 108 ambulance services is good and it comes when called. They appreciated the support and said that the ASHA calls the ambulance. One of them said that the driver asks for baksheesh and they have to pay them Rs. 100-200. Most women were aware that money is provided if they go for delivery in public hospitals. As regards financial incentives under JSY, women mentioned that the money is received. However there is a mix up between the scheme to promote the birth of the girl child and JSY. For women, it is the amount they receive that matters. But there are challenges:

*"It is not easy to get the money. One has to have bank account and they ask for all sort of documents,"* said a couple of them.

Women in all the six villages spoke about the role of ASHA and they said that the ASHA visits them, accompanies them for delivery, provides treatment for minor ailments, visits houses where pregnant women and young children are there, and provides information; she takes children to the Anganwadi Centre and also accompanies people suffering from Tuberculosis.

With regards to out-of-pocket expenses, women from three of the six villages mentioned that they usually do not have to pay for the services. But they have to pay baksheesh of 100 to 200 rupees to the ward boys and support staff. One of them mentioned that they have to purchase medicines from outside.

**Limited information about Anganwadi services:** When discussing about services provided at the Anganwadi Centers, women from four villages spoke. The most common service was food distribution and registration. A couple of women spoke about weighing of children, pre-school education, and immunization services provided at the AWC. In one village almost all women said that they are not aware whether the AWC opens daily or not r. Most mentioned that the food provided was good and that children liked it. A couple of women also said that given their multiple works it is difficult to take their children daily to the AWC. As regards the take-home ration (THR), women mentioned that this was available but at times there are gaps; they also said that it is not enough. Overall there was lack of information regarding entitlements for THR.

**Limited access to entitlements from Public Distribution System (PDS):** Regarding access to PDS, women from five of the six village said that almost all households have ration cards. They do get ration such as wheat, rice, salt and kerosene. Two women mentioned that the ration shop is far and they have to walk two to three kilometers to get the supplies.

**Poor access to MNREGA entitlements:** Women in all the six villages unanimously said that they and most people in the villages do have job cards. Most said that they have not received any works since past couple of years. Articulating the reason for the same, a woman said that *"Now a day's most of the works is done by machines so we do not get work."* A couple of them also said that they have not received payments for the work done.

**Inadequacy of Mid Day Meal Scheme:** A few women from five of the six villages spoke about the Mid Day Meal. Most said that they were aware that meals are provided in Government schools. In two villages women mentioned that the quantity is inadequate and the quality is poor. "Children do not like to eat the food; quantity provided is not sufficient; children are usually hungry when they get back home. Children eat at home in the morning and go to school "said one of them. "The consistency of dal is very watery. The contract has been given to a SHG since last 15 years and the same person cooks the meal. It should be changed now," said a woman.

**Low awareness on VHSNCs and Gram Panchayats:** In all the six villages, women said that they did not know about the VHSNCs.

**Inadequate water sources:** Piped water bore well and hand pump were the sources of water mentioned by women from all the six villages. In four villages, women mentioned that all households have pipelines and they get water three times in a week, which was convenient to them. They usually store it and use for drinking as it is safe. In summer, there is scarcity and they draw water from hand pump.

**Sanitation facilities inadequate:** Women in three of the six villages said that all have toilets in the village. In two of the six villages women said that almost half of the households defecate in the open. Most said that they received twelve thousand rupees for construction of toilets. Some also said that they had to make cash payment of 2000 rupees to the panchayat, and some mentioned they did not receive the money.

# Gaps in Public System

## A. About Village Health and Nutrition Day (VHND)

One VHND was observed in Kurdmana village. The session was conducted at sub centre. Venue of session was clean. The following are some of the observations from the visit:

**Presence of human resource:** MPW, AWW and Sarpanch were present on the VHND. ASHA/ ANM and other members of the community were not present.

**Equipment and amenities:** Apparatus to measure blood pressure, stethoscope, adult and baby weighing machine were available at the VHND. Clean drinking water and toilet facility was available at the session sites. UIP master register, and mother and child health register was available.

**Drugs:** Vaccines were available and OPV was given. Vitamin A, Albendazole, ORS, zinc and drug for minor illness was available at the session but paediatric co-trimoxazole was not available. Iron Folic Acid Tablets and contraceptives like oral pills and condoms were available. Emergency contraceptive pills were not available at the session. Drug for malaria was available, and blood slide was taken for malaria. WASH practices like hand washing were not demonstrated; counselling for household latrines was also not done. Only counselling was given on household purification of water

**Services provided:** ANC was performed but the counselling to pregnant women was not done. Blood pressure was measured and record was maintained. Couples were not counselled on use of contraceptives, nor motivated for permanent methods of contraception including IUD. Children were weighed on VHND; nutritional advice was not given to the mothers. None of the children were identified in last four sessions, and no children were referred to NRC in the day. Blood slide was taken for malaria detection. Banner poster was not displayed at the session.

## B. About Gram Arogya Kendras(GAK)

Three Gram Arogya Kendras were observed at Karoli, Mohali and Panchkheda villages. Some of the observations are mentioned below:

**Information:** None of the three centres were having the basic information about the village. Contact information of District Collector, Chief Medical and Health Officer, District Programme Manager, Block Medical Officer, Chief District Project Officer, Janani Express, etc. was available at one (1/3) centre. Birth, death & marriage registration details were available at two (2/3) centres. Details of SHGs, Mothers' Help Committee were available at three, and information about MDM scheme group was not available at any of the three centres. Information about married and target couples, pregnant women, newborns, under-five children, malnourished children, children registered in AWC was available at two (2/3) centres. Details and lists of immunization, TB, leprosy, diarrhoea, malaria patients, and list of temporary methods of contraception were only available at one of the three centres. Two (2/3) centres had the names and services provided by ASHA, AWW and Sahayika, but none of them had information on health services provided by ANM and MPW and their visits. Information about village health committee was available at one centre only, but the detail of untied funds was not available.

**Furniture and equipment:** Basic furniture like chair was available at all three facilities, but table and bench were available at two (2/3) centres only. Infantometer for newborn, weighing scale for children, weighing scale for adults, haemoglobinometer, stethoscope, foetoscope, spirit lamp, functional BP instrument were available at two (2/3) centres. Weighing scale for infants was available at only one centre. Hub cutter, test tubes, thermometer and slides were available at two centres only. These were not available at Mohali centre.

All the centres were having ANC table but foot step was only available at one centre, which means that the use of ANC table would be difficult at the remaining two centres. One centre also did not have an almirah to store medicines and other equipment safely. Water tank was available at all the facilities. Karoli GAK also had a mike, height machine and loud speaker in addition to the other equipment.

**Drugs and supplies:** Oral Rehydration Salt, Iron Folic Acid tablets, Co-trimoxazole tablet, Zinc sulphate tablet, Paracetamol tablet (500gm), Albendazole tablets (400mg), Dicyclomine tablets (10mg), Povidon Iodine ointment, cotton bandage and absorbent cotton were available at one (1/3) centre only. Gentian violet and Methyl Ergometrine tablets were not available at any centre.

Village health register was available at only one centre. Registers for village health committee meeting were available at two centres. One centre also had the register for other activities being conducted at the centre. Sign board for GAK and AWC was only available at one (1/3) centre. Notice board for displaying information outside the centre and village health plan was not available at any GAK.

Based on a scoring pattern developed by TRIF Health and Nutrition Sector Council, the GAKS were graded according to a checklist based on 57 indicators. Two of the three GAKs visited were in red zone (i.e. score below 61%, and 35/57 marks). Only one GAK scored 74% and was in yellow zone. None of the GAKs were in the green zone i.e. above 80% score. The range of percentages was between 14 to 74 percent. The lowest was the GAK Mohali and highest was GAK Karoli.

## C. About the ASHAs

Six of the eight ASHAs working in five villages were interviewed. On an average, one ASHA was expected to serve a population of 991, which was according to the norm. They were in the age group of 26 to 40 years; their education ranged from 8th to 12th grade; four (4/6) were from Scheduled Tribes and two (2/6) were from Other Backward Class category. Two were nominated as ASHA since last two years, and the other four had been working since last six-twelve years. Their work as ASHA ranged from two to five hours per day. Two ASHAs said that one community in her area, and those who work as daily labourers were unable to access because they had to go for work daily.

All the six ASHAs said that they had received training when they first joined the work. All said that they had received refresher training. All the six ASHA were able to list the key tasks they have to perform including home visits. The visits were prioritised on the basis of providing Home Based New Born Care (HBNC), high risk pregnancy, malnourished children, newly-married couples, adolescent girls, and seriously ill people. The number of households visited per month ranged from four to 120 households per ASHA.

All of them expressed that it was difficult to counsel family members of under-nourished children, particularly for referral to NRC; accompanying women for their delivery, particularly at night; home visit to poor and remote homes; conducting survey and maintaining records, and writing slogans.

All the six ASHAs said that they have to maintain 4-7 registers and they found it cumbersome some to maintain too many records. All of them said that they were involved in VHNDs. Major Constraints expressed were: Lack of funds; maintaining too many records; less and delayed payments, and no payment for many surveys conducted. Some of the achievements mentioned by ASHAs include increased immunisation coverage; increased institutional deliveries; identification and treatment of high-risk pregnancy by ensuring iron sucrose dosage. They said that women are now prepared for check-ups, and people have become more informed.

**Table:4 Physical Condition of AWC**

| No. | Particular | Number of AWCs(n=08) |
|---|---|---|
| 1 | Building | |
| | Own building | 08 |
| 2 | Building need repairs | 06 |
| 3 | No boundary wall | 07 |
| 4 | Clean drinking water | 03 |
| 5 | Food storage facility | 04 |
| 6 | Toilet in usable condition | 01 |
| 7 | Electric connection with power supply | 02 |
| 8 | Space for indoor activities | 04 |
| 9 | Toys | 08 |
| 10 | Space for VHNDs | 13 |
| 11 | Utensils for cooking | 02 |
| 12 | Mats | 07 |
| 13 | Poster and banners | 08 |
| 14 | Records and registers in fair condition | 08 |
| 15 | Medicine kit | 07 |
| 16 | IFA/ORS packets | 03 |
| 17 | Vitamin A solution available | 07 |
| 18 | Growth chart available | 08 |
| 19 | THR stock available | 08 |

## D. About the Anganwadi Centres

Eight centres were visited to observe their functioning. Some of the observations are:

**Infrastructure and display:** All the eight centres were operating from their own building. Seven of the eight centres were located in the village. Only one AWC had a telephone, and it was in good condition. Only two of the eight centres (2/8) were in good condition with five of them having a leaking roof. Only five centres (5/8) were adequately ventilated, and four AWCs had adequate light. Kitchen space was available at four centres (4/8), with storage facility for food.

Medicine kit was in good condition at six (6/7) centres. All the centres were having the vessels for storage of water in good condition. Utensils for serving the meal were in good condition in seven (7/8). Only three centres (3/8) had the stock of Iron Folic Acid tablets and thermometer; Tab. Punarva Mandur and Tablet Chloroquine was available at four centres (4/8). ORS packets, Tablet. Paracetamol, Tablet Dicyclomine, Antiseptic ointment and cotton/bandage were available at five (5/8) centres. Sanitary pads were available at one centre only. Overall there was a need to strengthen infrastructure and supplies at the AWCs.

## E.About the Sub Health Centres

CHETNA team visited two sub centres at Sirsi and Sarikpura villages. SC Sirsi was constructed a year ago and the ANM joined six months ago. Some of the observations are:

**Human resource:** Both the sub centres had the requisite staff posted. One of the two had a male worker posted. Support staff was not posted and so the sahyogni and anganwadi sahayika volunteered to keep the centre clean.

**Infrastructure and display:** Both the Sub Centres were in their own Government building, were clean and in good condition. Examination room, clinic room, and clean water were available at both the facilities.

There was industry garbage near one centre, and a cattle shed as well as a pool of stagnant water was seen near the other. A board in local language was displayed prominently at both centres. Separate toilets for men and women were available at one of the two centres. Suggestion box was not available at any centre. Only one (1/2) facility had electricity connection and supply was regular. Communication and transport facility were not available at the centres. Only one centre had staff quarters.

**Drugs:** Drugs as per Essential Drug List were available at one (1/2) facility only, and Amoxycillin, Chloroquine and condoms were out of stock in the other. Medicine/chest was available at both the centres, but labour table and stool as well as screen was available at one centre only. Citizen's Charter in local language, and screen to maintain privacy was also available at one centre only.

Peripheral blood smear facility was available at two (2/3) centres. Referral transport was available at all the three (3/3) centres, and two (2/3) ANMs mentioned that they or a trained personnel accompanies the woman in labour when referred l. Two centres (2/3) provided contraceptive services such as insertion of copper T, oral contraceptive pills, and condoms, but IUDs/ Copper- T was not available in one of the centres. Labour room was available at two centres (2/3) but deliveries were conducted at one centre, and it had a newborn corner.

## F. About the ANMs

Interviews of three ANMs posted in four SCs of the six sample villages were conducted.

**Profile of the ANMs:** Their age group was between 28 to 42 years. All the three were graduates; belonged to Scheduled Tribe category, and their experience ranged from 7-16 years.

**Population and area:** The total population covered by the ANMs was 13,484, and the average population to be served by one ANM is 3371, which is as per the norm. The distance to their homes from SC was six to 14 km and it would take 15 to 30 minutes for them to reach the centre. One village was having the PHC within the village, while the remaining were at the distance of 5 km, 6 km and 12-15 km away from the PHC. The distance of one SC from CHC was six km, while the remaining three (3/4) were between 10 to 20 km.

**Services provided:** The following services were provided by the Sub-Centre: Ante Natal Care, Intra-Natal Care, Post Natal Care, newborn care, immunisation, family planning and contraception, adolescent health care, services under JSY, and treatment of minor illness. Immunisation was done by all the three (3/3) ANMs. Treatments for minor illnesses were readily available at all the centres.

All the three ANMs said that they monitored water quality in the village and maintained proper records and registers. Only two ANMs (2/3) said that they havehad a village health plan.

The ANMs mentioned that they did not have adequate equipment at sub centre. Gloves, forceps, child weighing scale, and fibre water tank were additional requirements at sub centres. All the ANMs mentioned that they conducted disease surveillance, kept an eye on local endemic diseases, promoted sanitation, conducted field visits and home visits, and implemented National health programmes and HIV. The reasons given for not conducting deliveries were that: staffs is not staying at the centre, poor condition of labour room, regular power supply and water not being available.

All the ANMs said that most communities in their area access their services. But some well-to-do communities like Patidars did not access their services. All the ANMs had received trainings including those on PPIUCD, Counselling, and providing injectable contraceptives- Antara and Chaya.

**Achievements:** The major achievements mentioned by them were: increase in immunisation, 100% achievement in LTT, improved IUCD and LTT services, immunisation in sub centre, better cleanliness at the sub centre.

**Suggestions:** Some of the suggestions to improve the schemes were to ensure piped water,, electricity and gas connection at the centres; increase in salary for contractual staff; support in terms of MO posting; ensuring use of family planning to reduce maternal and child deaths; ensuring exclusive breast feeding for 6 months, complementary feeding, and timely referral of SAM child to NRC.

## G. About the Primary Health Centre

CHETNA team visited PHC Karoli and had a discussion with medical officer in-charge Dr.Prakash Rao. Based on the visits the following were the observations:

The centre was providing services 24x 7. The number of women and men per day in the OPD was mentioned as 10 each. The population coverage of the PHC was around 42000.

**Human resources:** The position of medical officer was vacant y; a doctor from CHC visited for camps and emergency. Pharmacist, laboratory technician, ANM and support staff total four personnel were available at the centre. None of the staff had been trained in the past one year.

**Infrastructure:** The centre was located in government building. There were no garbage dumps and cattle sheds close to the facility. The PHC was easily accessible and the distance of farthest village was 4 km. Distance of PHC to CHC was 15 km, but PHC to District Hospital was 100 km. Operation theatre was available at the facility but the operations were not conducted. There was not enough space in the OT, and it was also not used for gynaecological purpose. Labour room was constructed at the PHC.

Tap water was available at the centre. There was no communication facility including computer and email available at the PHC. Staff used their personal phones for communication.

Citizen's Charter was not displayed at the facility. Grievance redressal was available and ANM was in charge of it. Screen to maintain the privacy was available. There was no ramp in the PHC for differently abled individuals. There were two beds available, but in-patient service was not available.

**Services:** OPD, referral and emergency services were provided by the centre. Facility for primary wound management, minor surgeries, and burn cases was available at the centre. Ante natal care, intra-natal care, post-natal care, newborn care, and child care during immunisation, family planning services and services under JSY were available at the centre. Antenatal clinics were also organised at facility, and normal delivery services were available for 24 hours even days of the week.

Treatment for anaemia was available at the centre. Newborn corner was available at the facility but they referred the low birth weight babies to higher facilities l. Immunisation day was fixed at the centre and BCG and measles vaccine given regularly. The vaccines reached twice a month to the centre from district headquarter. Treatment of pneumonia was available at the centre but those with severe diarrhoea were referred to CHC Manawar.

Laboratory testing facilities were available at the PHC and tests such as routine urine, stool and blood tests, blood grouping, bleeding time, clotting time, diagnosis of RTI/STIs;sputum testing for TB, blood smear examination for malaria parasite, rapid tests for pregnancy, test for syphilis and rapid tests for HIV were offered.

Tubectomy and vasectomy were not done at the PHC. MTP and RTI/STI management services were also not available at the PHC. Surgery for cataract, and poisoning/snake, insect bite treatment was not available.

Drugs were also not available as per the EDL, out of 72 only 50 drugs were available.

# Petlawad Block, Jhabua, Madhya Pradesh

## Introduction:

The Government of Madhya Pradesh is committed to improve the health and nutrition status of women and children. The recently released Healthy States Progressive India -2019 report has ranked Madhya Pradesh at number 18 of the 21 states.

The Transform Rural India (TRI) Project is an initiative of Tata Trusts to transform our villages, village life and society, especially in the bottom 100,000 villages. TRI looks at initiating ground pilots in selected blocks in endemic poverty regions in central and eastern states. The pilots are aimed at developing process protocols for triggering multidimensional transformation of villages in endemic poverty regions.

Mission Antyodaya is a convergence framework for measurable effective outcomes on parameters that transform lives and livelihoods.As envisaged by the national Ministry of Rural Development, it is an effort to address the multidimensionality of poverty in a time-bound manner through a convergence of resources, both financial and human to provide an opportunity for transformational changes.

CHETNA has joined hands with this initiative in a capacity of the thematic expert NGO (T- NGO) to strengthen the Health and Nutrition Component of the programme. The project is being implemented in 420 @70 per block, selected Mission Antyodaya villages of each of the six blocks--Amarpur, Samnapur, Thandla, Petlawad, Manawar and Sondwa, of four districts Dindori, Jhabua, Dhar and Alirajpur of Madhya Pradesh. This is a report on the assessment done in Petlawad block of Jhabua district.

**About Jhabua district:** Jhabua is a tribal district, identified as high priority district under the National Health Mission. Jhabua has 813 villages and a population of 1,025,048.The percentage of Scheduled Tribes is 87.0. The major tribes are Bhils and Bhilalas. The sex ratio of the district is 990 women per 1000 men. The average literacy rate is 43.30 % with male and female literacy rates being 52.85% and 33.77% respectively. (Census 2011).


Jhabua district encircled in red

Agricultural productivity is low, and there is high migration to Gujarat. The district consists of six blocks: Jhabua, Meghnagar, Thandla, Petlawad, Rama and Ranapur.

**Health and Nutrition of women and children:** The Health and Nutrition status of Jhabua district requires substantial efforts as per the National Family Health Survey (2015-16). Early age at marriage is a reality; with 54.5% women aged 22-24 years marrying before the age of 18 years, and 24% women becoming mothers at the age of 15-19 years. Access to maternal health services is poor, with 29.3% mothers receiving antenatal check-up in the first trimester. Only 20.8 % mothers received four antenatal checkups and five percent women received full antenatal care. The percentage of women who delivered in institutions was 74.2% and 60.5% births of children under the age of five years were registered. Only 25% children aged 12-23 months were fully immunised.

21% children aged below 3 years were breastfed within one hour of birth, and 55.8% children aged six months

are exclusively breastfed. Of the children aged 6-8 months, those receiving solid and semi-solid food and breast milk were 26.8%. Only 4.8% of breastfeeding children aged 6-23 months received an adequate diet.

Malnutrition status of women and children is of concern as 45.5% of children under 5 years were stunted; 24.4 were wasted, and 43.6 were underweight. Similarly 72.4% children aged 6-59 months, and 58.8% women aged 15-49 year were anaemic. Around 74.3% of pregnant women aged between 15-49 years were anaemic, and the percentage of pregnant women who consumed 100 IFA tablets during their pregnancy was 19.4% only. The percentage use of any family planning method was 10.4 %, and male and female sterilisation was 0.2% and 8.2% respectively.

**Health and Nutrition Status in Petlawad:** Petlawad block of Jhabua district of Madhya Pradesh has a population of 2, 32,800 people. There are 46,446 households in the sub-district. There are about 214 villages in Petlawad block, and 77 Gram Panchayats. The population of children between ages 0-6 years is 43,185, which is 18.55% of the total population. The sex-ratio is 995 females per 1000 men. The literacy rate is 39.45%; out of which 48.33% men are literate and 30.53% women are literate.

Maternal and Child Health indicators of Petlawad indicate the need to make efforts for universal access to health services. While 72% children receive full immunization, 72% receive measles and 139% receive BCG vaccination. The total registration of pregnancy is 82% but 52% women register in first trimester and 71% receive three ANC. The percentage of women delivering in institution is 54% and 2.5% are still births. (Please refer to Table 1 for MCH status).

**Table 1 MCH Status of Jhabua and Petlawad**

| No. | Indicator | Jhabua (%) | Petlawad (%) |
|---|---|---|---|
| 1 | Full Immunisation | 73 | 72 |
| 2 | Measles | 73 | 72 |
| 3 | BCG | 108 | 139 |
| 4 | Total Registration | 96 | 82 |
| 5 | Early(1st trimester) Registration | 49 | 52 |
| 6 | 3 ANC | 78 | 84 |
| 7 | Institutional Delivery | 92 | 96 |
| 8 | Still Births | 2.4 | 3.5 |

Source: Block Wise Health Bulletin; April-December 2017; State HMIS Unit, MP

**Purpose of the assessment:** With a view to understand the local health and nutrition realities and design interventions to address the needs and the gaps, CHETNA conducted Community Needs Assessment (CNA) and Public Health System Gap Analysis (PSGA) in sample villages of Petlawad block of Jhabua district, Madhya Pradesh.

**Methodology:** Qualitative research methodology was used in which group discussions with women, key informant interviews with front line workers and service providers, and facility-level observations were done.

Group discussions were held with women-leaders/members of self-help groups, and other women of the six villages. Most women were in the reproductive age group. The discussion focussed on food security, gender, women's health, child health, contraception, access to services and entitlements. On an average the discussions continued for about two-and-half hours.

**Sample:** A10% sample of the intervention villages@ six per block was taken for the assessment. The following selection criterion was followed:

- Remoteness, ethnic composition (majority Bhilala community)
- Economic conditions/ethnic composition/nearness to the approach road
- linked area in Sardar Sarovar Dam
- Active village Organisation (VO) and SHG; financial status of VO

A total of six group discussions were held with 85 members of SHGs and women from the villages in each of the six villages during 20-23 August 2018 and public facilities were visited between 29th November and 4th December 2018. Interviews were held with 50% of ASHAs (6); 50% of the Anganwadi Workers (12); all ANMs (6) and all Medical Officers/In charges (4). Visits were made to observe the status of Gram Arogya Kendras(5),Anganwadi Centres(12), all Sub Centres(6) ; all Primary Health Centres (4), and Village Health and Nutrition Days(4). (Please refer to Table 2 for schedule).

**Table2:Schedule of Activities- Petlawad Block**

| Date | Village name | Activity |
|---|---|---|
| 20-08-2018 | Piplipada | Group Discussion with 20 women |
| | Kardawad | Group Discussion with 11 women |
| 21-08-2018 | Polarunda | Group Discussion with 17 women |
| 22-08-2018 | Raliyawan | Group Discussion with 12 women |
| | Parewa | Group Discussion with 13 women |
| 23-08-2018 | Chandragarh | Group Discussion with 12 women |
| 29-11-2018 | Kardawad | SHC observation, VHND observation, GAK observation, 2 AWC observation, PHC observation, Village profile |
| | Chandragarh | ASHA interview, village profile |
| 30-11-2018 | Pareva | 2 AWC observation, 2AWW interview, VHND observation, GAK observation, village profile, ASHA interview, ANM interview |
| | Piplipada | AWC observation, AWW interview, ANM interview, Village profile, |
| | Mandan | VHND observation |
| | Chandragarh | 2AWC observation, ASHA interview, 2 AWC observation, ANM interview, SHC observation, village profile |
| | Kardawad | 2 AWW interview, ASHA interview, ANM interview, |
| | Raipuriya | PHC observation |
| 01-12-2018 | Piplipada | GAK observation, SHC observation, ASHA interview |
| | Raliyawan | GAK observation |
| | Polarunda | ASHA interview, Village profile, |
| | Chandragarh | GAK observation |
| | Karwad | PHC observation |
| 03-12-2018 | Polarunda | 2 AWC observation, 2 AWW interview |
| | Chandragarh | 3AWC observation, AWW interview |
| 04-12-2018 | Chnadragarh | 2AWW interview, ANM interview |
| | Jhavliya | VHND observation |
| | Polarunda | ANM interview, SHC observation |
| | Jhaknawda | PHC Observation |
| | Parewa | SHC observation |

**Data collection tools:** Separate tools for CNA and PSGA were developed. A total of ten checklists were developed in English by the sector council team-TRIF.CHETNA survey team members were oriented on data collection tools.

**About the Villages:** The total population of the six identified villages was 13697, and there were 2043 households. All the villages had tribal population, and more than three fourth (5/6) villages had a majority of tribal population. There were 23 Anganwadi and Mini Anganwadi centres in the villages. One third (2/6) of villages were sub centre villages, one village was a primary health centre village. Five of the six villages had transport facilities readily available in case of medical emergencies.

**About the Women:** A total of 85 women from Self Help Groups- Leaders, Secretaries and members participated in the discussions. Of the 85 women who participated, 74 members worked in farms, four were potters, two were also Anganwadi Workers, and one each worked as ASHA and Community Resource Person. Three women said that they did not work outside their houses and fields.

Their age group ranged from 20-50 years with69/85 women in the age group of 20-40 years.22/85 women were literate, and their education ranged from third grade to tenth grade. The nutrition status (height and weight) of 71/85 women from five villages was measured and BMI calculated. More than half (38/71) were found to be healthy, having a normal BMI; 26/71 women were underweight, and seven were overweight. Nutrition assessment of women from one village could not be done as the weighing scale of the Anganwadi Centre was not in working condition.

# What Women Say

## A: Food and Nutrition Security

**Inadequate food consumption:** Discussions with women indicated that there overall food consumption is inadequate as compared to the laborious work in house and in the fields. In three of the six villages, women also talked about families which go hungry, indicating the need to ensure food availability.78/85 women shared information on their eating patterns.

**Limited food basket:** 50/78 women said that they eat meals comprised of roti made from a cereal, accompanied by either dal (pulses) or sabji (vegetables). When vegetables or dal are not available, women said that they ate only roti or roti with chillies. For most women, easy availability determines what they eat. Only one woman said that they eat two cereals - roti and chawal - along with dal in a meal. The usual pattern is to eat two meals a day. A few (nine) women said that they eat three meals a day; they eat in the morning and take the same food along with them to the work place and eat it at noon. The last meal is usually early in the evening.

The commonly eaten cereals are maize and wheat. As regards pulses, mostly tuver (yellow lentil), chana (bengal gram), udad (black gram) and moong (green gram) dal is eaten. Usually they eat what is grown in their fields. In two villages women said that they ate chowla and masoor dal which is purchased from the market. Rest is usually grown in their fields. Onions, potatoes, gourds (gilka, turiya, lauki, karela), and tomatoes were the commonly listed vegetables. Palak and methi (fenugreek) were listed by a few women from one of the six villages. (Please refer Table 3 for the list).

**Table 3: Foods Listed by women from Petlawad**

| No. | Foods | Number of women (n=78) |
|---|---|---|
| 1 | Dal (pulses) | 40 |
| 2 | Fruits | 26 |
| 3 | Roti | 60 |
| 4 | Vegetables | 40 |
| 5 | Animal Sources | 2 |
| 6 | Rice | 5 |
| 7 | Milk / ghee | 3 |
| 8 | Do not take milk /milk products | 5 |
| 9 | Jaggery | 4 |

*One woman may have mentioned more than one food item

Milk and its products are rarely taken. Only in one village women said that they consumed milk, and mostly children are given this, and they also said that all families in that village had goats.

Animal based foods are eaten by few, only in one of the six villages women said that they eat animal based foods. However these are not eaten routinely, and eaten usually in festivals. Eggs, chicken and meat are eaten. In other villages women did not share about eating animal based foods.

Women from three of the six villages also said that they eat sweets and special foods like puri, kheer, halwa, chawal, bhajiya during festivals. In one village, a woman said that she prepared halwa (a preparation made from flour, ghee and sugar) daily for her child who is fond of it, and so they all eat it daily.

**Limited availability of diverse foods:** Women said that they eat what is grown in their field, or whatever is available in the market. These are the only two sources to obtain foods. None of them mentioned public distribution system or Anganwadi Centres, or any other place as sources to obtain food. Vegetables are cooked daily when they are available. Availability of vegetables seemed to be a major concern in consumption. The market emerged as one of the key source of purchasing vegetables, if not grown in their fields. However for most women, purchasing foods from market is not a daily affair. A woman said: *"We go to market once in a month and purchase fruits and vegetables from the market."* Around sixteen women said that in summer vegetables are scarce so they cook them once or twice in a week, and frequently eat dal and roti. 14/17 women from Polarunda village said that *"Vegetables are available throughout the year and we all eat them.*

In Piplavad village, all the 21 women who participated in the discussion said that *"We purchase vegetables from the market which is in another town, but we do not go there daily."*

**Poor intake due to poverty and cultural practices:** Women spoke openly about lack of money. 12/13 women from Parewa village said that they prepared halwa only when they have money. In another village Pipalpada, a woman said that *"When we do not have money we take loan to purchase food items and cook them."* Some women also said that if they do not have the food items, how will they cook food?

In all the six villages women talked about eating foods from animal sources. They said that some people eat these foods and some people do not. 21/78 women said that they do not eat animal based foods as they follow the bhagat sect, also when they are fasting. Children do not eat these foods.

Fasting continues to be a woman's domain with no reduction in their physical, social and reproductive

workload. In all the six villages, women said that they fast two or three days in a week, or during particular festivals, or season such as Shravan month.

**Food insecurity during lean season:** Women in all the six villages said that summer is the lean season. During the lean season there is no earning from farm labour so most go to Mumbai, Gujarat or Rajasthan to seek work, said 35/78 women. However most of them (44/78) said that they have not seen any food inadequacy during the lean season. In one village, three women said that families with more members do not cook two or three days in a month during summer due to shortage of food grains. In another village six women said that due to addiction, the income is spent on liquor or other substances. In absence of money the family does not have food to eat. A woman said that when there is no food, families borrow money at the interest rate of 10%.

## B: Gender Issues

Women continue to eat last, and leftovers: Women did not share a lot on gender discrimination in food intake. A total of ten women spoke about the eating norms. Gender stereotypes were evident from what they said. If the family is small, and they are eating early, then the family sits together and eats. Otherwise it is the men, children and elders who eat first, and women eat last.

**Girls drop out from schools:** 70/85 women spoke on different aspects of girls' education. When the schools are located in the village, girls and boys both are sent to schools said 30/70 women.21/70 women said that usually boys and girls both study till 10$^{th}$ or 12$^{th}$ standard. (Please refer to Table 4 for details).

**Table 4: Reasons for School Dropout**

| No. | Reason for drop out | Women n=70 |
|---|---|---|
| 1 | Girls like staying at home and doing housework | 12 |
| 2 | Girls get married and go away | 12 |
| 3 | Teachers hit children | 05 |
| 4 | It is the norm that people do not study much | 05 |
| 5 | Girls do not have to do jobs so they are not sent | 01 |
| 6 | Girls are not interested in studies | 02 |
| 7 | Boys do not like to go to school | 13 |
| 8 | Quality of education given is poor | 05 |

Note: Not all women spoke about the reasons for dropout

*"The school in our village is up to eighth standard where both boys and girls go. After that they go to a school in the village nearby on a bicycle, or use bus or tempo. That school is till tenth standard. After that they go to Petlawad or Rajpuriya, stay in a hostel and pursue further studies. Girls also go and study outside the village".* (16/30 women from two villages).

None of them said that their daughters were studying outside the village. Overall the situation of boys and girls pursuing higher education is low. All the 21 women from one village Piplipada said that till date no one from their village has studied in a college. The reasons for low levels of education and gender biases are several, compounded by the quality of education. A couple of women spoke about their concerns,-*"There is no guarantee of jobs even if children study till 12$^{th}$ standard. Several people are jobless even though they have completed higher studies."* 13/70 women said that even boys drop out as they do not like going to school.

19 women spoke about work and employment. Twelve of them said that there are no classes in the village where girls can learn about tailoring, computers, etc. They have to go to Petlawad and join such classes and spend the whole day. Such classes should be opened at the village level. Nine of them said that girls who do not study are sent for labour work.

**Girls get married before the legal age:** 44/83 women shared their views on marriage. Women said that there was a change in the trend. *"Earlier girls did not study and so were married off early. Now they study and so their marriage is delayed."* A total of thirteen women said that girls are married at the legal age of marriage, and fourteen said that they are married earlier, at 15-18 years of age. Boys are married at 18-20 years of age, according to six of them.

*"If the girls do not study then they are married early,"* said seven women. Another four said that if they find a suitable groom, the girl is married off, and age is not considered. A woman said that poor families organise marriages of four or five couples together, and so young girls aged 10-13 years are also married off, but they are sent to their marital homes later, when they grow up. Women also shared their concern regarding children eloping. Five of them said that if parents do not agree, then the young couple, which creates more problems.

**Restricted mobility of women:** 70/83 women spoke on the issue of mobility. Of these, a majority(29/70) said that they usually do not go out as they have too much work and no free time, except for monsoon and summer seasons. Eighteen of them said that girls are not allowed to go alone, and one said that they do go alone. *"For girls who do not go to school, they do household chores but they do not go out, and boys go out,"* said four women. Women from all the six villages said that there was no adolescent or youth group in their villages. Girls meet each other at school, work place or when they fetch water, said nine of them. Boys and men meet at the chowk (square) but do not disclose what they discuss, said three of them. Eight women said that girls ride bicycles, and those who go to school, play and dance. Eight of them said that girls do not have time to play.

## C: Infant and Young Child Feeding Practices

**Delayed initiation of breast feeding:** A total of 36/85 women spoke about initiation of breast feeding. The time of initiation as mentioned by them, ranged from immediately after birth to 5 days, with about half of them saying that the baby is breastfed within six hours of birth.

A total of eight women said that colostrum is not fed to the baby. Only one woman said that colostrum is fed to the baby. Pre-lacteal feeds such as jaggery water are fed to the baby.22/40 women said that exclusive breastfeeding is practiced. Goat's milk or cow's milk is given to the baby if there is no breast milk said 12/40 women. Nine of them said that the baby is fed when it cries.

**Delayed initiation of complementary feeding:** A total of 56 women spoke about complementary feeding. The age at introduction of complementary feeding ranged from 6 months to 3 years of age, when the child starts eating by itself. A couple of women said that there is no fixed age as complementary foods are introduced once the mother becomes pregnant again, or when the baby starts eating by itself. (Please refer Table 5 for details)

**Table 5: Age at Introduction of Complementary Foods**

| No. | Age at Introduction of Complementary Foods | No. of Women (n=56) |
|---|---|---|
| 1 | After six months of age | 07 |
| 2 | After 12-18 months of age | 21 |
| 3 | After 24 months of age | 17 |
| 4 | Before 24 months of age | 9 |
| 5 | No fixed age | 02 |
| | Total | 56 |

26/56 women said that the baby is given whatever is cooked at home, and they also said that eggs and meat are given to the child when cooked at home, which is once a month or when there are guests at home. Roti, khichadi, moong water with rice, dalia (broken wheat), dal, fruits, cow or goat's milk are some of the foods given to the baby. Three women said that the baby is given Cerelac at the age of six months, and two said that the baby is given biscuits. No one talked about any ritual (annaprashan) for initiation of complementary feeding.

When discussed about who decides about feeding the child, 72/80 women said that the mother decides. The rest said that there is no formal decision making for feeding the child.

## D: Women's Health

**Delay in seeking treatment:** A total of 62/85 women spoke about seeking treatment. They said that they visit the doctor when sick (38), and for delivery (28). However, they did talk about delay in seeking treatment.

*"We do not seek treatment for minor illness and go to take treatment when we suffer more."* (6/62 women)

26/62 women said that they go to Government hospitals (Rajpuriya, Petlawad and Sarangi) and 10/62 said that they go to private facilities.

One woman said that *"We do not have money so we go to government hospital. The Government ambulance is called."*

Nine of them said that the government gives money for delivery and so they go there. A couple of women did mention that medicines are prescribed from outside when they go to public hospitals.

*"Those who have phones dial for 108 ambulance. Others go on their own vehicles (bikes) or jeep. The way to the main road is not good so we have to walk till the road. Villagers do not want to give their agriculture land for building road, and so a road is not built here,"* said a woman from Parewa.

**Table 6: Common Illnesses of Women**

| No. | Illness | Women (n=50) |
|---|---|---|
| 1 | Fatigue /weakness | 23 |
| 2 | Not able to see at night | 22 |
| 3 | Swelling on feet | 22 |
| 4 | Vomiting | 21 |
| 5 | Weakness and problems after delivery | 06 |
| 6 | Other(menstrual issues, fever, loss of appetite, gynecological problems, deafness, body ache, abdominal pain) | 12 |

Note: A woman may have said about more than one illness

Few women said that children fall sick more, often followed by women and the elderly. A couple of them said that all fall sick frequently. Diarrhea, malaria and skin diseases were the common ailments listed by women. Of the 44 women who spoke, 19 said that women fall sick during adolescence, during pregnancy (25), and after child birth (27). (Please refer table 6 for a list of some of the common illnesses)

Pregnancy and childbirth are treated as natural events and therefore the need for medications or examinations is undermined.

“Iron tablets are given during pregnancy but we do not take them. If there is no problem then why should we take any medicine?”said one woman.

Of the twelve women who said that they received iron folic acid tablets, eleven of them said that they had eaten them but they were not informed regarding its benefit, etc. One woman said that she discontinued taking them as it caused vomiting.

For some families, childbirth leads to indebtedness. “Delivery is usually by operation and the expenses range from 20,000 to 40,000 rupees. The family has to give this amount if they want to save their lives. The money is usually arranged by pawning two yields/crops to the lender,” said one woman.

Menstrual practices: Menstruation continues to be a topic of silence and something to hide. Mother, a friend in school, brother's wife, Anganwadi worker or ASHA were mentioned as sources of imparting information, by very few women. The discussion on who explains about menstruation to adolescent girls revealed the need for imparting information to women and girls.

Most women said that a cloth is used to soak menstrual blood. Some purchase it from market. The cloth is changed 3 times in a day or more if the flow is heavy. A few women (8) that the cloth is dried in sun, and same number of women (7) said that the cloth is hung to dry where no one can see it (away from the eyes of mother-in-law, husband, children), and is covered by another cloth. The cloth is wrapped in an aluminum foil (namkeen wrapper) and stored. Very few (3) mentioned using pads.

## E: Women's Work and Child Care

Discussions were held around women's daily schedule, and a total of 62/85 women spoke. They said that usually they wake up early in the morning at 5 or 6 am, complete the household chores, child care, adult care, etc and they go to the field and work. Eleven of them that they spend 7-8 hours outside their homes, working. When they return they have to do household chores and take care of children. Five women also said that they took care of elders of the house. 15/62 women said that their work increases during monsoon. Five of them said that men work only in the field whereas they work at homes and in the fields too.

A total of 77 /85 women spoke about child care facilities. 51/77 women said that no arrangements are made for child care. The child is left at home and the elders, children or neighbours take care of children, said 33/77 women. For those who do not have anybody at home the child is taken along at the work place, or left at home in a cradle, said five women. A couple of women also said that if the baby is small women stay at home, and do not go to work.

## F: Child's Immunization and Growth Monitoring

Inadequate information on child's health and nutrition: A total of 38/77 women spoke on immunization services. Women from all the six villages said that immunization services are provided at the Anganwadi Centre and usually the mother or grandparents take the child to the centre. Only a couple of women were able to list the names of the vaccine and key vaccines to be given. Most women remembered the sequence, but not the name nor schedule or benefits of the vaccine. 19 women said that the service is irregular, and often, they do not come to know about the nurse's visit. Five of them specially mentioned that the card is given to them. Of the 85 women who participated, 74 said that they did not know about their child's weight.

## G: Contraception/ Family Planning

Women bear the responsibility of contraception: A total of 61/85 women shared their views regarding contraception. With regards to knowledge about contraceptive methods, most (45) women were aware about sterilization (female). Only four women spoke about oral pills, and two spoke about Copper-T (IUCD) as a contraceptive method. Ten women were aware about temporary methods but said that no one in their village uses them and a similar number of women said that they were not aware of the services.

46/61 women said that women undergo sterilization after birth of two children. Son preference was evident as mentioned by a few: *“In our village, if a boy and a girl are born then the couple (woman) goes for sterilization. But if both the children are girls, they wait for the birth of son.”*

The role of ASHA in family planning was limited as most of them (40/61) said that ASHA does not counsel newly-married couples. 45/61 women said that women use contraceptive methods, and usually it is sterilization. The reason for men not getting sterilized as given by a couple of women was that *“Men have to do labour work, heavy work, so they do not adopt sterilization; men do not come forward; men have to work and if they get sterilized who will earn?”* Spousal discussion on spacing was almost absent as none of the women said that they discuss about spacing with their spouses. Some said that the discussion with spouse happens when they have to decide for sterilization.

## H: Access to Entitlements

**Limited access to Anganwadi services:** A total of 55/84 women in five of the six villages said that the Anganwadi does not open regularly. It is only when the madam is expected to come and immunization is to be done, that the Anganwadi is opened, and the mini Anganwadi opens once week, on Tuesdays, when the ration has to be distributed. In one village Polarunda, women said that there was no building and services were provided under the shade of a tree, or at someone's house in monsoon. Only in one village, all 12 women that the Anganwadi Centre opens regularly. When asked about regularity of THR, 64/85 women said that they get THR sometimes.

Of the eleven who spoke about services provided by the Anganwadi Centres, five said that packets are given to adolescent girls, and six said that tablets are given. 15/23 women spoke regarding services to pregnant women. They said that registration, distribution of nutrition packets, and Iron folic acid tablets are the services given to pregnant women. There was no discussion about services to women with infants, or regarding quality of food.

**Poor access to public health services:** Discussions were held around pregnancy, childbirth, contraception, and child health. A total of 83 /85 women from all the six villages spoke on these issues. Women said that they access health services from the public system, primarily immunization, pregnancy and childbirth-related services. Delay in receipt of benefits, demand for informal payments, need for extensive documents and identity which are at times not available with families, and lack of attention were some of the constraints mentioned by women.

Health facilities were outside all the six villages, at a distance of 3-10kms. The PHC at Raipuriya remains open 24 hours, they said. For major illness or complications they go to Petlawad (CHC) or Sarangi (PHC).

A total of 66/83 women said that they were aware that extra food and tablets (IFA) should be provided to women during pregnancy. Of the 38 women who spoke about their experience with 108 emergency transport services, all said that it comes when dialed. A few said that the ASHA also comes with them to the hospital. Most women were aware that money is provided if they deliver in public hospitals. Two women said that that they received 1400 rupees, and one said that she had received 1600 rupees. In three villages women said that despite submitting documents, women do not get the money. Regarding out-of-pocket expenses, of the 49 women who spoke, forty eight said that they incurred expenses at the public facility which were for delivery services, medicines, documentation, beds, etc. The amount ranged from 300 to 1000 rupees. Two women said that the families spent Rs.12, 000 and 25,000 respectively for cesarean section in private facilities.

**Limited access to entitlements from Public Distribution System:** Regarding access to PDS, a total of 72/85 women said that all have ration cards in their village, called “coupon” locally. Of these, 44 said that they get wheat/maize, rice, salt and kerosene. 17 women said that they get the commodities, some times. Four of them also mentioned receiving gas connections/ cylinders from the PDS.

**Poor access to MNREGA entitlements:** With regards to having job cards, a total of 72 women spoke. All the 72 women said that they, as well as most people in the village, have job cards. However most shared that they do not get work. Only in one village, four women said that they got some work, a year ago. “When we work in the Panchayat, we do not get money; even after two or three years they do not give money and say that government has not sent money.”

**Low information about Mid Day Meal scheme:** Regarding Mid Day Meal, eight women in two villages said that they were aware that one meal is given in school. In rest of the four villages women did not know of the scheme, and they were not aware that a meal is given in school.

**Low awareness on VHSNCs and Gram Panchayat:** Women from all the six villages did not share any information about Village Health Sanitation and Nutrition Committees, or the Gram Panchayat.

**Inadequate water and sanitation facilities:** Women said that around 50-70% houses in villages have toilets. Some use it and some don't. A total of 61/85 women spoke; 33/85 women said that they had toilets in their homes, and 28/33 said that they are using it. Women also spoke about some constraints such as the small size of the toilet, poor quality of construction, broken doors, etc. In all the six villages, women said that there were households without toilets and women had to go far as they need to find a secluded place, for privacy, and in such places there is a danger of animals. Women from five of the six villages said that there was no public toilet in their villages.

Open well (15), bore well (13) and hand pump (24) are the sources of water. In one village Kardawad, women said that taps are the common source of water. In the period of 2000-2005, the woman sarpanch of the village ensured that roads were built and that every house has tap water. Here women said that they were relieved and relaxed. In the other five villages, women said that the drudgery of fetching water remains a woman's domain, and that the sources of water are far.

*“We have to walk long distances to fetch water. There is a well in one hamlet and women from other hamlet have to walk four to five times a day. Women fetch water, men do not”.*

*“For drinking water there is a hand pump which is 2-3 kilometers away, and it takes 2-3 hours to fetch water.”*

# Gaps in Public System

## A. About the Village Health and Nutrition Day

Village Health and Nutrition Days (VHND) were observed in Jhavaliya, Parewa, Kardawad and Mandan (Piplipada) villages. The observations revealed the scope for strengthening the VHNDs in terms of supplies, package of services, community participation, and health communication.

- **Place of VHND:** Of the four VHNDs observed, two were held at a school, one at Sub Centre, and one at Anganwadi Centre.
- **Presence of human resource:** ASHA and ANM were present at all the four sessions. The Anganwadi worker was not present in one of the sessions held at school. Participation of Male Health Worker, Panchayat member, and other members of the community was limited to only one of the four VHNDs observed.
- **Communication materials:** At none of the four VHNDs, posters were displayed nor was any material available for counselling.
- **Equipment:** The equipment at VHND was inadequate. BP instrument was not available in 1/4 VHNDs, stethoscope was not available at 2/4 and 2/4VHNDs baby weighing scale was not available.
- **Privacy:** private space (bed with screen) for check-ups as not available in more than half (3/4) VHNDs.
- **Supplies:** Immunisation card was not available at 2/4 VHNDs.
- **Contraceptives:** Condom and emergency pill were available at three, and oral contraceptive pills were available at one of the four VHNDs.
- **Drugs:** Oral Rehydration Salt was available at three, and zinc and drugs to treat minor illness were available at one VHND only.
- **Services provided:** At three VHNDs, antenatal check-ups were done, children were weighed, and mothers were counselled. Pregnant women were counselled, and IFA was provided at two centres.
- **WASH:** Demonstration of hand washing was done at one, and counselling on WASH was done at two VHNDS.

## B. About the Gram Arogya Kendras (GAK)

**Five Gram Arogya Kendras:** Piplipada (Mandan), Parewa, Kardawad, Raliyawan, Chandragarh and Polarunda were visited. There was no GAK in one village--Polarunda.

In order to assess the status of the Gram Arogya Kendras, a scoring system was used, based on various parameters such as display, furniture, medicines, supplies etc. According to this scoring, more than half (3/5) of the GAKs were in red zone (i.e. percentage below 61% and marks below 35 out of 57). Only one GAK--Chandragarh scored 89% and was in green zone, and one in Kardawad scored 75% and was in yellow zone.

- In all the five GAKS, information about the village was available; basic information and Janani Express number was displayed; registration details were available; information about village health sanitation and nutrition committee and untied funds was available; basic furniture (chair, table, and ANC table) was available; adult weighing scales were available; ORS and cotton bandages were available.
- Signboard of AWC and GAK was at 3/5 centres.
- Notice board outside the centre was at 4/5 centres.
- Village Health Plan was available and displayed at 4/5 centres.
- Information about SHG and MDM groups was displayed at 3/5 centres.
- Baby weighing scale was available at 2/5 centres.
- BP instrument was available at 3/5 centres.
- Medicines esp. Zinc, Paracetamol, Albendazole, Iron Folic Acid tablets and Povidon Iodine ointment were available at 2/5 centres.
- Most of the medicines were not available at Parewa GAK.

**Some pertinent issues**

- ASHA of Raliyawan Gram Arogya Kendra kept all the supplies and medicines of GAK at her home as the Sahayika of the AWC had retired five years ago, and she does not allow newly appointed Sahayika or any other person to enter the centre.
- All the PHCs had sufficient medicines as mentioned by the staff of PHC, but at GAK the medicines were not regularly supplied. There seems to be a gap in the supply chain.

## C. About the ASHAs

All the six ASHAs of the identified villages were interviewed. They were in the age group of 24- 36 years, and their education ranged from 8th to 12thstandard. Their experience as ASHAs ranged from 3 to 12 years. Three of them were also involved in agriculture work. All ASHAs were from tribal community. They mentioned spending an average 4.5 hours per day for their work as ASHA.

The average population covered by the ASHAs was 2283, creating a challenge for outreach. All the ASHAs said that they had received training.

**Some of the constraints were:** Not having the medicine kit; irregular supply of oral contraceptive pills; irregular supply of basic medicines at SHC; lack of time, and low and delayed incentives both for them and for the communities.

**Most difficult task:** ASHAs said that counselling on family planning services; counselling of pregnant women; use and understanding about the new medicines where the label is in English language was difficult.

**Some achievements:** Increase in institutional deliveries; improved reach of services/schemes; medicines available within village, and reduction in illness caused by diseases. Their suggestions included timely reimbursement of JSY benefits to women; change in the process of home visit during immunisation; use of video clips in awareness campaigns, and improving 108 accessibility facilities.

## D: About the Anganwadi Centres

Twelve centres from six villages were visited and interviews were held with Anganwadi Workers. This indicated the need to strengthen the Anganwadi Centres in terms of infrastructure, supplies, and skills of the workers.

**Opening of Centre:** In their interviews, all the twelve anganwadi workers said that they open the Centre at 9am and close it at 4pm. 3/4workers found it difficult to open the centre daily due to their personal reasons. 4/12 of the workers said that in the last one year the centre was closed for one week due to festivals.

VHND was not organised at two centres; the centres were in hamlets and the immunisation of that centre was conducted at other centre. 2/12 centres had stock of Paracetamol tablets.

3/12 of the centres did not have adult or baby weighing scale.

Information regarding enrolment could be obtained from 8/12 AWCs. Workers said that almost all the children aged 6 months to 3 years (297) and 3 to6 years (223) were registered at 8/12 Anganwadi centres. 4/12 of the workers were not aware about the number of children enrolled at Anganwadi centre. Workers from 7/12 centres said that the average attendance is 17 children per day.

**Table 7: Physical Condition of AWC**

| No. | Parameters | Nnumber of AWCs(n=12) |
|---|---|---|
| 1 | Own building | 04 |
| 2 | Building need repairs | 06 |
| 3 | No boundary wall | 06 |
| 4 | Clean drinking water | 08 |
| 5 | Food storage facility | 02 |
| 6 | Toilet in usable condition | 00 |
| 7 | Electric connection with power supply | 01 |
| 8 | Space for indoor activities | 07 |
| 9 | Toys | 08 |
| 10 | Utensils for serving meals | 09 |
| 11 | Mats | 05 |
| 12 | Poster and banners | 04 |
| 13 | Records and Registers in fair condition | 08 |
| 14 | Medicine kit | 07 |
| 15 | IFA/ORS packets | 04 |
| 16 | Growth Chart available | 10 |
| 17 | THR stock available | 08 |

*The number of children coming to the centre was less than enrolled due to migration. One worker said that a hamlet was unable to access the service of centre since it was located far from the hamlet. Discussions with women indicated that if the centre opens regularly and quality food and services are provided they would be happy to send their children to the Anganwadi centre.*

**Services provided:** When asked, all the 12 workers said that they weighed the children and plotted the growth chart. Two workers said that they sought support from the family member to plot the chart. All of them said that they undertake home visits on the basis of ANC, PNC and SAM children. The average home visit was 12 households per month.

Take Home Ration (THR) was distributed to pregnant women, lactating women, children aged 6 months to 3 years, and 5/12 also said that they distribute THR to adolescent girls. 7/12 of them said that they provide extra meal to SAM children. One third of the workers said that the children do not like the food, and 6/12 of the workers said that the quantity served was not sufficient.

Two workers said that the quality of food was not good; the food is cooked in morning and served at noon. Another said the quality of food was not good, some children eat and some don't eat it. One fourth of the workers said that there is a complaint for THR; half of the children do not like the taste of khichadi.

7/12 of the workers said that they hold nutrition and health meetings at times. The main topics covered were ANC, malnutrition, hygiene and adolescent health.

**Human resource:** There was no vacancy in all the 12 Centres. The age group of 12/23 workers was between 22 to 58 years, and education from 5$^{th}$standard to Bachelor of Arts. All were from tribal community. Their experience ranged from one year to 30 years. All the workers stayed in the same village.

10/12 workers said that they have received training of minimum 3 days to maximum 3 months. They could list the key tasks such as playing with children, pre-school education, regular functioning of anganwadi centres, THR distribution, record keeping, and IFA supplementation.

**Some of the constraints:** Almost all said that they had inadequate funds for functioning of AnganwadiCentres. 5/12of the workers said that they have to bear the additional expenses from their own pockets. Overburden with the department work (4/12); not having own building (8/12); frequent meetings of department (2/12).

**Some Challenges:** 3/7workerssaid that they faced challenges in ensuring that people participate in village meetings. 6/12 said that it was difficult to provide counselling on family planning and THR, and ensuring children's attendance at Anganwadi Centre.

**Major Achievements:** Increase in immunisation coverage; mainstreaming of children in schools; reduce in malnutrition among children; institutional deliveries, and community awareness were some achievements listed.

One worker said that there was no achievement in the area served by the AWC and the community did not have interest in availing the ICDS services.

**Suggestions for improvement:** Having own building of Anganwadi; adequate toys for the children for learning; awareness through video on child marriage; sufficient funds for normal functioning, and less documentation were some suggestions made.

## E: About the Sub Health Centres

Visits were made to six sub centres--Mathmath, Jhawaliya, Piplipadi (Mandan), Karnawad, Kadwaliya, and Chandragarh, which were expected to provide services to the selected villages.

- Three centres--Mathmath, Mandan and Karnawad, were in Government buildings with good condition and cleanliness. SC Jhavliya operated from ANM's home, SC Kadwaliya operated from Anganwadi centre, and SC Chandragarh did not have any physical infrastructure.
- Male health workers were also posted in Karnawad and Mandan SC.
- Two of the three centres had toilets, but none of them were in functional condition. Suggestion and complaint box was not available at any of the centres.
- Clean water was available at three centres (3/6); electricity was available at only one centre. ANMs used their own personal mobile phone for communication, as the centre did not have any facility.
- More than half of the centres did not have the essential medicines available.
- Only one centre displayed the Citizen's Charter in local language.
- One third (2/6) centres had privacy for patient check-ups.

**Discussion with ANMs:** The six ANMs interviewed were in the age group of 27 to 40 years, and education was 12$^{th}$standard to post graduation. Five were from tribal community and one was from scheduled caste. Their experience ranged from 6 to 18 years. The average population covered by each ANM was 4651. Mathmath and Mandan sub centres had a population of 6500.

Only one ANM stayed at the centre and the rest commuted from a distance of 2 to 30 km. The average distance to the farthest village from SC was 6 km, and it would take around 30-45 minutes to reach those villages. Half of them said that the Lady Health Visitors visited the centre once a week.

All the six ANMs said that they provided ANC services; family planning services like condom and oral pills; four of them shared that they conducted disease surveillance, field visits and implemented National health programmes and HIV. Five of the ANMs said that they coordinate and supervise the activities of ASHA, and also coordinate with the AWWs, ASHA, VHSNC and PRIs.

All the six ANMs said that they have received training upon joining, and five of them mentioned that they received training on SBA and IUCD insertion.

**Constraints:** Some of the difficult tasks they mentioned were counselling to men; home visits in some areas; promoting institutional deliveries, and treatment of major illnesses. All the six said that they have to maintain too many records, and that they were overburdened with the work; not receiving proper support from the community, lack of funds, and transportation facility were some other constraints.

**Some suggestions:** There is a need to provide government building for SC Jhavliya SC Kadwaliya and SC Chandragarh; disbursement of benefits to women must be done on time, reduction in documentation, and timely transportation.

## F. About the Primary Health Centres

Visits were made by CHETNA team to the four Primary Health Centres--Karwad, Raipuriya, Kardawad and Jhaknawda, which are expected to serve the identified six villages. The average population covered by three of the four PHCs was 31752. Three of the four PHCs were in the category of 24x7 PHCs. Discussion was held with the PHC In charge.

All the four PHCs were located in government building, and area near the centre was clean. The farthest villages from the centres were at a distance of 15 to 22 kms. The average distance of PHCs from the CHC and District Hospital was 13 and 37 km respectively. Labour room was available at all the four PHCs, but deliveries were conducted in three PHCs.

Communication facility like telephone and computer was available at one PHC only. Clean water facility was available at all the facilities. Medicine stock was mostly available at all the facilities. Citizen's Charter and ramp for differently-abled individuals was available at three PHCs only.

Emergency services, referral services and in-patient services were available at three of the four of the centres. The centres had average 6 bed facilities. The average per day OPDs for male and female were 68 and 89 respectively. The primary management of wounds was available at all the facilities. Treatments for snake bite/poisoning, and management of burns was available at three of the four facilities. ANC, INC, PNC, newborn, childcare facility was available at three of the four centres. MTP services and management of STI/RTI was available at two of the four PHCs.

Delivery services were available at three PHCs. Newborn corner was available at only one of the three PHCs where delivery services were provided. All Low Birth Weight babies were referred. All the PHCs worked for the promotion of safe water supply and sanitation, prevention of locally endemic diseases, disease surveillance and control of epidemics, and collection and reporting of vital statistics. Three of the four facilities were monitoring of SCs and NHPs. Only half of the PHCs said that Medical Officer conducts monthly visits to all SCs.

Medical Officer was posted in all four centres. In one PHC, the medical officer and other staff were found to be irregular. The average staffs were of five persons. At two of the four facilities MO had received the training, while the data of one facility was not available. At one facility MO said that the last training was attended in 2007. At one facility the health worker has received the training on ANC care. Kits for pregnancy test were not available in two centres, and Laboratory Technician was available at only one facility, so at that centre basic lab test facility was available.

# Thandla Block, Jhabua, Madhya Pradesh

## Introduction:

The Government of Madhya Pradesh is committed to improve the health and nutrition status of women and children. The report Healthy States, Progressive India 2019has ranked Madhya Pradesh at number 18out of the 21 states of India.

The Transform Rural India (TRI) Project is an initiative of Tata Trusts to transform villages, village life and society, especially the bottom 100,000 villages.TRI looks at initiating ground pilots in selected blocks in endemic poverty regions in central and eastern states. The pilots are aimed at developing Mission Antyodaya is a convergence framework for measurable effective outcomes on parameters that transform lives and livelihoods.As envisaged by the national Ministry of Rural Development,it is an effort to address the multidimensionality of poverty in a time-bound manner through a convergence of resources, both financial and human, to provide an opportunity for transformational changes.

CHETNA has joined hands with this initiative in the capacity of thematic expert NGO (T- NGO) to strengthen the Health and Nutrition Component of the programme. The project is being implemented in 70 selected Mission Antyodaya villages of six blocks--Amarpur, Samnapur, Thandla, Petlawad, Manawar and Sondwa, of four districts Dindori, Jhabua, Dhar and Alirajpur of Madhya Pradesh. This is the report on the assessment done in Thandla Block of Jhabua district.

**About Jhabua district:** Jhabua is a tribal district, identified as a high priority district under the National Health Mission. Jhabua has 813 villages, and a population of 1,025,048.The percentage of Scheduled Tribes is 87.0.% The major tribes are Bhils and Bhilalas. The sex ratio of the district is 990 women per 1000 men, and the average literacy rate is 43.30% male and female literacy rate is 52.85% and 33.77%respectively (Census 2011). The agricultural productivity is low, and there is high migration to Gujarat. The district consist of six blocks--Jhabua, Meghnagar,Thandla, Petlawad, Rama, and Ranapur.

Jhabua district encircled in red

**Health and Nutrition of Women and Children:** The Health and Nutrition status of Jhabua district requires substantial efforts as per the National Family Health Survey-4 (2015-16). More than half (54.5%) women aged 22-24 years marry before the age of 18 years, and 24 % women become mothers at the age of 15-19 years. Access to maternal health services is poor, with 29.3% mothers receiving antenatal check-up in the first trimester; only 20.8 % mothers receiving four antenatal visits, and five% women receiving full antenatal care. The percentage of women who delivered in institutions was 74.2 %, and 60.5% births of children under the age of five years were registered. Only 25% children aged 12-23 months were fully immunised.

A total of 21% children aged below 3 years were breastfed within one hour of birth, and 55.8% children aged six months were exclusively breastfed. Of the children aged 6-8 months, those receiving solid and semi-solid food and breast milk were 26.8%. The percentage of breastfeeding children aged 6-23 months receiving an adequate diet was 4.8% only. Nutrition

status of women and children is of concern as 45.5% of children under 5 years are stunted; 24.4 are wasted, and 43.6 are underweight. Similarly 72.4% children aged 6-59 months and 58.8% woman aged 15-49 years are anaemic. Around 74.3% of pregnant women between 15-49 years of age are anaemic, and the percentage of pregnant women who consumed 100 IFA tablets during their pregnancy was 19.4% only. The percentage of use of any family planning method was 10.4 %, and male and female sterilisation was 0.2% and 8.2% respectively.

**Health and Nutrition status in Thandla:** Thandla block of Jhabua district of Madhya Pradesh has a population of1,82,362 people. The population of children of ages 0-6 years is 37840, which is 21% of the total population. The total number of families residing in Thandla block is 34,456. The total literacy rate of Thandla is 41.9%. The male literacy rate is 39.85%, and the female literacy rate is 26.46%.The total sex ratio is 987 women per 1000 men.(Census 2011)

Maternal and child health indicators of Thandla indicate the need to make efforts for universal access to health services. 87% children received full immunization. 53% women register in first trimester and 82% receive three ANC. The percentage of women delivering in institution is 88%, and 1.7 % are still births. (Please refer to Table 1 for MCH status)

**Table 1: MCH Status of Jhabua and Thandla**

| No. | Indicator | Jhabua (%) | Thandla (%) |
|---|---|---|---|
| 1 | Full Immunisation | 73 | 87 |
| 2 | Measles | 73 | 87 |
| 3 | BCG | 108 | 114 |
| 4 | Total Registration | 96 | 106 |
| 5 | Early(1st trimester) Registration | 49 | 53 |
| 6 | 3 ANC | 78 | 82 |
| 7 | Institutional Delivery | 92 | 88 |
| 8 | Still Births | 2.4 | 1.7 |

Source: Block Wise Health Bulletin; April-December 2017; State HMIS Unit, MP

**Purpose of the assessment:** With a view to understand the local health and nutrition realities and develop need-based interventions, CHETNA conducted Community Need Assessment (CNA) and Public Health System Gap Analysis (PSGA) in sample villages of Thandla block of Jhabua district, Madhya Pradesh.

Methodology: Qualitative research methodology was used in which group discussions (GDs),Key Informant Interviews(KII), and facility-level observations were done.(Please refer Table 2 for schedule)

**Table2:Schedule of Activities**

| Date | Village name | Name of Activity |
|---|---|---|
| 01-11- 2018 | Sutreti | Group Discussion with Women(11) |
| | Sujapura | Group Discussion with Women(11) |
| 02-11- 2018 | Bhamal | Group Discussion with Women(12) |
| | Makodiya | Group Discussion with Women(08) |
| 03-11- 2018 | Sagwani | Group Discussion with Women(09) |
| | Angliyapada | Group Discussion with Women(15) |
| 16-11-18 | Sutreti | AWC Observation; AWW Interview |
| 17-11-18 | Sutreti | ASHA,AWW Interview; GAK /AWC Observation |
| 19-11-18 | SC-Machhlaimaata | ANM Interview |
| | Machhalai Mata | SC Observation |
| 20-11-18 | Sujapura | ASHA & 2 AWW Interview ; GAK/ 2 AWC Observation |
| 21-11-18 | Sujapura | SC Observation |
| 22-11-18 | Aangaliyapada | 2 AWW Interview; 2 AWC Observation, ASHA Interview |
| 23-11-18 | Sagwani | 2 AWC/GAK Observation; 2 AWW Interview |
| | Makodiya | ANM Interview; 3 AWC Observation; 3 AWW Interview |
| | SC Bhamal | ANM Interview |
| 26-11-18 | Aangalipada | SC Observation |
| | Makhodiya | ASHA Interview; GAK Observation |
| | Bhamal | 2 ASHA,4 AWW,ANM Interview GAK and 4AWC Observation |
| 27-11-18 | SC Sujapura | ANM Interview |
| | Bhimpura | VHND Observation |
| | Devaka (Sagwani) | SC Observation |
| | Guvalrundi (Sujapura) | VHND Observation |
| | PadaDhamjar | VHND Observation |
| 29-11-18 | SC Aangliyapada | ANM Interview |
| | Bhamal | SC ,VHND Observation |
| 30-11-18 | PHC Kakanvani | PHC Observation |
| | Sujapura | AWC Observation; AWW Interview |
| 01-12-18 | PHC Khawasa | PHC Observation |

**Sample:** A10% sample of the intervention villages@ six per block was taken for the assessment. The following selection criteria was followed to select the villages:

- Remoteness,ethnic composition (majority Bhilcommunity)
- Prosperous village/mixed community; Nearness to the approach road
- Linked area in SardarSarovar Dam; Active village and SHG;Financial status of VO

A total of six group discussions were held with 66 members of different SHGs in each of the six villages during November 1st -3rd 2018, and public health and nutrition facilities were visited between November 16th and December 1st 2018.

Group discussions with women of reproductive age group in the six villages focussed on food security, gender, women's health, child health, contraception, access to services and entitlements. On an average the discussions continued for about two-and-half hours.

To understand the gaps in service delivery, public health facilities were visited, and services providers were interviewed. Interviews were held with 50% of ASHAs of the village, 50% of the Anganwadi Workers, ANMs and

Medical Officers. Visits were made to observe the status of Gram Arogya Kendra, Anganwadi Centre, Sub Centre, Primary Health Centre, and Village Health and Nutrition Day.

A total of 22 Anganwadi Centres were expected to provide health and nutrition services, out of which services from 16 Anganwadi Centres were assessed. Services of two PHCs, six SCs, 16 AWCs and six GAKs were observed. A total of seven ASHAs, 16 AWWs, six ANMs were interviewed, four VHND sessions were observed. (Please refer Table 2 for a schedule of activities).

**Data collection tools:** Separate tools for CNA and PSGA were developed. A total of ten checklists were developed in English by the Health and Nutrition sector council-TRIF.CHETNA survey team members were oriented on data collection tools.

**About the villages:** The total population of these villages was 12586,and there were 2007 households. The predominant tribe residing in these villages is Bhils. The villages were located at the distance of 2-12km from the highway, and all had vehicles available in case of emergencies. All the six had sources of clean drinking water which was bore well and hand pump. Of the six, four were sub center villages, and the two were at a distance of 1.5 to 2 km from the sub centre. The average distance of Health facility(PHC/CHC) from these villages was approximately 5 km from the PHC, the nearest village was 2.5 km,and the farthest was 17 km away from the PHC.

**About the Women:** A total of 66women from Self Help Groups- leaders, secretaries and members participated in the discussions. More than half (43/66) of the women were not literate; Around one fourth (23/66) of the women who were literate, their education ranged from 5$^{th}$standard to graduation. Most women worked in farms. Their age group ranged from 19- 48 years, with 24/66 women in the age group of 19-30 years, and 33/66 women in the age group of 31-40 years.

The nutrition status (height and weight) of 64 women was measured, and BMI calculated. About half (32/64) were found to be having a normal BMI between 18.5-24.9; 26/64 women were found to be undernourished with BMI less than 18.5. Five women were found to be overweight and onewas obese with BMI more than 30.

# What Women Say

## A: Food and Nutrition Security

**Inadequate food consumption:** Discussions with women indicated that their overall food consumption is inadequate as compared to the laborious work in their house and the fields. 65/66women shared information on their eating patterns; they usually eat three meals a day.

**Limited food basket:** 34/65 women said that they eat meals comprised of roti (made from cereal like wheat or maize) accompanied by either dal (pulses) or sabji (vegetables).None of the women talked about eating more than two food groups in one meal.

The commonly eaten cereals are maize (22/34) and wheat (9/34). As regards pulses, they said that mostly tuver (yellow lentil),masoor(lentil), chaula(kidney bean), udad(black gram) and moong(green gram)dal is eaten.

In one village,Sutreti, women said that vegetables are grown in plenty in the villages and so they eat vegetables three to four times in a week.

*Aloo* (potatoes), *bhindi* (ladiesfinger or okra), *gilka* (gourd),*methi* (fenugreek); *gobhi* (Cauliflower) *chana* bhaji (leaves of bengal gram)and tomatoes were the commonly listed vegetables. Women in three villages also said that they grow *methi*(fenugreek), *palak* (spinach), *mula* (radish) in their fields. Vegetables are scarce in summer. Some families who have water, cultivate vegetables, and others depend on market in summer.

*"There are 20 households in our village who grow vegetables even in summer. So we take from them,"* said a woman in Sujanpura.

Women listed eating 10-12 fruits such as banana, papaya, guava, watermelon, pomegranate, grapes, mango, apple, water melon, custard apples, and jamun. For some, tomatoes were also considered as fruits. However they said that they eat fruits occasionally, and this is usually eaten in households that have young children. Often fruits are bought when they go to the market. A few women said that they have planted a guava tree in their yard.

In none of the six villages, women talked about consuming milk or milk products, but in one village a woman said that they used milk powder instead of milk.

In four of the six villages women said that animal sources of food are eaten by some families. In one village, women said that there are few families who eat this, and in another many families ate foods from animal sources. However, these are not eaten daily, but eaten on a weekly or fortnightly basis. Some said that they eat food from animal sources during festivals, or once in 15 days, or when there are guests. Eggs, chicken, fish and mutton are usually eaten, they said.

**Limited availability of diverse foods:** Women said that they eat what is grown in their fields or they purchase from the market. These are the only two sources to obtain foods. Only one woman mentioned getting food from the public distribution system. Anganwadi Centre was not considered as a source to obtain food.

Market emerged as one of the key sources of purchasing vegetables, if not grown in their fields. Vegetables are cooked daily when they are available, which is usually in winter and monsoon. Availability of vegetables seemed to be a major concern during summers so they eat dal instead.

**Food insecurity during lean season:** Women from all the six villages said that during summer, which is the lean season, there is no earning from farm labour so most go to Gujarat or Rajasthan to seek work. In three villages women said that there are some households who do not have food. But they do not go hungry, they either borrow food from other households or purchase on credit. Most households, they said, work and are able to take care of their food requirements. In one of the six villages, women said that *"due to addiction, the income is spent on liquor or other substances and so the family does not have food to eat".*

**Cultural practices affect intake of nutritious food:** Fasting continues to be a woman's domain with no reduction in their workload. In all the six villages, women said that they fast two or three days in a week, or during particular festivalssuch as *Navratri, Sharvan maas, Dashamata.* During fasts they eat special foods such as sago, groundnuts, potato and chips, or eat fruits and drink tea. In some fasts they eat only one meal a day.

Women talked about diet restrictions during pregnancy and lactation in three villages, and in one village they said that there are no restrictions, all foods are eaten. A woman said that during pregnancy, there should be no restrictions and a woman should eat what she likes. Another woman said that those who can afford eat cashew and almonds during lactation.

**Foods restricted during pregnancy:** Rice, oil, groundnut, buttermilk, ghee, curds, milk, buttermilk and cold foods are not eaten during pregnancy as they are considered harmful for the baby's health. Most of these foods are, anyway, not part of their daily diet.

**Foods restricted during lactation:** Sour foods, ghee, salt, cold foods, banana, rice, berries, guava, buttermilk, brinjal (eggplant),and spicy foods are restricted during lactation.

Emphasis is laid on eating more energy-giving foods after child birth. For the first two-three months after childbirth

the woman is given thuli (broken wheat) and milk to eat. But the decision to continue is also based on sex of the child. One woman said, *"If a girl is born this diet is continued for a month, and if a son is born, it is continued for two months since boys are considered to be weak."*

## B: Gender Issues

**Women continue to eat last, and leftovers:** 41/66 women shared their views regarding the eating norms. Gender stereotypes were evident from what they said. Cooking is solely a woman's domain, said 10/41 women. Men help or cook when women are in periods, said two of them. Very few women said that the whole family eats together. Fifteen of them said that they eat leftovers, as a result they get to eat only certain foods, and the quantity is also less. Only a couple of women said that they cook for themselves if there is no food left. When they realize that the quantity of food is less, they serve men first, and take less for themselves. *"If we serve less food to men, we may get beaten up,"* said a woman.

**Gender discrimination in higher education:** 30/66 women spoke on the education of girls. When the schools are located in the village, which is usually till 5 or 8standard, girls and boys both are sent to schools,said most of them. When asked to share about their own children, of the 25 children between them, 10 boys and 15 girls are sent to schools and colleges outside the village. Only one woman said that she did not send her daughter to study, but sent her son.

In one village, women said that more girls go out of the village to study. They shared information about their daughters doing graduation, nursing at neighbouring cities such as Indore and Ujjain. However the decision to send girls for higher education depends on financial resources. If resources are scarce, girls' education is often compromised. Once out of school they are sent to cities in Gujarat and Rajasthan for work.

*"When there is no money girls are first to be taken out from schools. Because boys will feed us after they complete their studies,"* said a woman. *"Girls are educated up to a lesser grade than boys,"* said another woman.

Several women had something to say about the quality of education. Most women said that they send their children to private schools."The teachers are inadequate in villages and so more children are sent to private schools," said a woman.

**Girls get married before the legal age:** 19/38 women from three villages talked about age at marriage. Almost all women agreed that the legal age at marriage-18 for girls and 21 for boys is the right age for marriage. But marriages take place between 12-17years of age, said five of them.

The common reason for early age at marriage, given in all the three villages, was the fear of elopement of young couples. If one girl elopes, then other households in the villages get their children married at an early age. Another reason cited was the need for a helping hand so even boys are married off at an early age.

The women enumerated the ill effects of early age at marriage such as birth of weak children, complications during childbirth, immaturity which affects relationships, etc.

**Work and employment:** 21/66 women spoke about their work and employment. Farming and labour were the two common works mentioned by women. Women and men both go for labour work or farming. Children are also engaged in plucking and weeding during their school vacations, or if they discontinue schooling. Most people in the villages, particularly during summer, migrate to Surat, Rajkot, Ahmedabad, Kota and Bhopal cities of Gujarat, Rajasthan and Madhya Pradesh in search of work. They usually go after Diwali (October-November) and return for Holi (March),and then again go during summer(April-May),and return in monsoon(June-July). At times the entire household, except the elderly, migrates. Gender division of work was obvious; *"Women do housework, farmwork and labour work, but men work only in farms or as labourers,"* said a woman.

**Restricted mobility of women:** 40/66 women spoke on the issue of mobility. Of these, almost all said that they usually do not go out as they have too much work and no free time. Three of them said that they have some free time in summer season. Only one woman said that some households do go out together.

## C: Infant and Young ChildFeeding Practices

**Delayed initiation of breast feeding:** 43/66women spoke about initiation of breast feeding. The time of initiation ranged from immediately after birth to four days later. Almost half (21/43) of them said that the baby is breastfed immediately after birth. 7/43 women said that colostrums is fed to the baby. Pre-lacteal feeds such as jaggery water, goat's milk are also fed to the baby.

*"The sister at the hospital tells us not to give anything else to the baby but people do not listen. Breast milk does not come and the baby keeps on crying so they give top milk,"* said one woman.

**Need to ensure excusive breast feeding:** From all the six villages, most women said that the child is breastfed exclusively for six months. But they also said that in case breast milk does not flow, goat's milk is fed. A few also said that jaggery water is fed to the baby.

Most women said that the baby is breastfed on demand-crying, and the frequency ranged from four to nine times. When they go to the field and the baby stays at home, the baby is breastfed less frequently--before going and on returning. *"If the baby sleeps the whole day, we do not wake her up for breast feeding,"* said a woman.

**Delayed initiation of complementary feeding:** 34/66 women spoke about complementary feeding. The age at introduction of complementary feeding ranged from 6 months to 2 years, when the child starts eating by itself. A couple of women said that there is no fixed age for introducing complementary feeding. Food is given if the woman becomes pregnant again, or when the baby starts eating by itself.(Please refer Table 3 for details)

**Table 3: Age at Introduction of Complementary Foods**

| No. | Age of the child | Number of women (n=22) |
|---|---|---|
| 1 | After six months of age | 06 |
| 2 | After 12 months of age | 11 |
| 3 | After 24 months of age | 1 |
| 4 | When child starts eating by itself /sits | 4 |
| | Total | 22 |

The most common food given as complementary food was biscuit followed by roti, fruits, thuli, dalia (broken wheat),fruits, cow or goat's milk. Rice, dal water, rice water is also fed to the baby, said a couple of women. Five women said that some households feed chicken, eggs, or meat when the child is 2-3 years of age. No one talked about any ritual (annaprashan) for initiation of complementary feeding, or giving complementary food from the Anganwadi Centre.

**Mothers decide about feeding the child:** When asked about who decides about feeding the child, almost all said that the mother decides. The father is hardly involved or aware. Only in two villages a couple of women said that the members/elders of the family decide on the food to be given to the child.

## D: Women's Health

**Seeking treatment:** 40/66 women spoke about visit to a doctor. In all the six villages women talked of going to the public health facilities( 12), private facilities(11), and a mission hospital at Thandla. Two women said that they seek services such as immunization from the AWC, and one said that there was a private facility in their village and so they go there.

Seven of them said that they go to public facility for delivery and two of them said they go there as the government gives money. A couple of women did mention that medicines are prescribed from outside when they go to public hospitals and they have to spend at least 200-300 rupees to purchase them.

The reason for going to private facilities as given by a couple of women was mainly lack of time, distance to the public facility, and effective treatment, including quick recovery. About five of them said that a one-time cost of treatment at a private facility is minimum five hundred rupees. Women also narrated their experience of multiple referrals.

*"If there are complications then the government facility asks us to go to mission hospital. And if the complication is greater, they send us to Jhabua or even Dahod in Gujarat,"* said a woman.

15/66 women talked about women's illnesses, with most (7/15) saying that it is during pregnancy, childbirth, and after childbirth that women fall sick or become weak. Two of them said that after marriage a woman falls sick often, and three said that during adolescence, girls fall sick/become weak. One woman said that it is after 'operation' (sterilization?) that a woman falls sick often. For some of the common illnesses mentioned by women, please refer Table4.

**Table 4: Common Illnesses of Women**

| No. | Illness-Pregnancy and childbirth related | No of women(n=15) |
|---|---|---|
| 1 | Vertigo/weakness | 2 |
| 2 | Anemia | 3 |
| 3 | Swelling on limbs | 1 |
| 4 | Vomiting | 1 |
| 5 | Bleeding | 1 |
| 6 | Other(chakkar-vertigo, bodyache, white discharge, | 07 |
| Note: One woman may have listed more than one problem | | |

*"My daughter falls sick when she goes to school. Her shoulders ache as she has to walk a kilometer to reach the school,"* (A woman in Sagwani).

29/66 women talked about common health problems of adolescent girls. Of these the most common problems mentioned were body ache (11/29) and menstrual problems such as abdominal pain and weakness (6/29). Some other problems mentioned were anemia and weakness(6/29) and white discharge(1/29).

Menstrual practices: Of the 29 women who spoke on this issue, most women said that a cloth is used to soak menstrual blood. Girls go to school and stay in hostels so they use sanitary napkins/pads. The cloth or pad is changed 2-3 times in a day. The cloth or pad is burnt after use, said most of them.

Seasonal illnesses in the village: 25/66 women discussed about seasonal illnesses and patterns. The most common seasonal illnesses mentioned by them were fever, malaria, diarrhoea and vomiting, body ache, and headaches.

- During monsoon: Diarrohea, vomiting,fever, malaria, itching.
- During summer and harvest: Heat stroke and fever
- During winter and autumn: Fever, vomiting, malaria, body ache and scabies.

## E: Women's Work and Child Care

Discussions were held around women's daily schedule and 61/66 women spoke. They said that usually they wake up at 5 or 6 am in the morning, complete household chores, child care, cook food, and they go to work in the field at around 8-9 am. Some return home in the noon, do some work in the house and again go back to the field to return by 5 or 6 pm. From what most the women said, it appears that women spent almost 14-16 hours working, with approximately. 6-7 hours working at home, and 8-9 hours working in fields.

Most women said that their work increases during monsoon and harvest, and they have less work during summer. 28/66 women spoke about child-care facilities. 16/28said that the child is left at home and the elders- in-laws/parents look after the child. 7/28 said that if there is no one at home, the child is taken along to the work place. Work is resumed soon after child birth, and the period ranges from 15 days to 2 months, depending on the family.

## F: Child's Immunization and Growth Monitoring

**Greater awareness on immunization services:** 41/66 women spoke on immunization services, and almost all were aware of immunization and its benefits. More than half (29/41) of the women said that immunization services are provided at the Anganwadi Centre. A couple of women said that it is provided on Tuesdays, once a month, and ASHA comes to call them. Fever and swelling were the most common after effects mentioned by six to eight women. Two of them said that tablets are given after the child is immunized to provide relief.

Lack of information on the vaccines: Only one woman was able to tell the name of measles vaccine in local language, saying it was for *"mataji."* No one could tell about the details of the vaccines, their names, the schedule, or the diseases against which it gives protection. One woman expressed her concern that children of families who migrate are often left out from the immunization.

**Maternal and child deaths:** When discussing on recent child deaths, women from five villages mentioned about five child deaths, and one maternal death. The age of four children who died ranged from 2 days to 2 year, and one died in the womb. Of these, one baby girl died within 15 days of birth, and the reason was not known. The causes of death of two children were mentioned as jaundice and diarrhea-vomiting.

Lack of information on child's nutrition status: Of the 39/66 women who discussed about their child's weight, almost all were aware that the child is to be weighed at the Anganwadi Centre. Six to seven women said that they knew their child's weight, and three said that they did not know it. However no one was aware about the nutrition status of their child. Only one woman said that her child was admitted to NRC and was alright after that. 11/39 women said that the child is not weighed every month. In two of the six villages, women spoke about irregularity of weighing and excluding children. Two women from the group said that their children aged three and four years were weighed about two years ago.

## G: Contraception/Family Planning

**Gender division of responsibility of contraception:** With regards to knowledge about contraceptive methods, a few women spoke, and of them most women were aware about sterilization (female). Only four or five women spoke about oral pills and Copper-T(IUCD) as a contraceptive method. Almost all women said that female sterilization is the most commonly adopted method of contraception. Of the six women who spoke, all of them said that they discussed with their spouses, and decision was taken jointly. The role of ASHA in family planning was limited as 17/17 said that ASHA does not counsel newly married couples.

## H: Access to Entitlements

**Limited access to Anganwadi services:** When discussing about services from the Anganwadi Centres,in five villages women said that the centre opens regularly, though they did not speak about its timings. According to most of them, the centres remained open for three to four hours in a day. In three of the six villages, women also said that the centre does not open regularly.

Of the ten who spoke, women said that "packets"(Take Home Ration- THR), tablets are given to adolescent girls from the Anganwadi Centre. One of them said that, neither tablets nor packets are given.

Regarding services to pregnant women, most women spoke about the THR packets being given to pregnant women, children and adolescent girls. One woman said that that maize and rice are given but she did not like the quality as it appeared to be old and was bitter in taste. In one of the six villages, women mentioned that registration of pregnancy is done at the AWC. Only one woman talked about nutrition supplement(dalia) being given to women during lactation. Regarding hot cooked meals, women in five of the six villages said that hot cooked food is given to children. They had concerns

related to quality and quantity of meals provided. In three villages women said that meals are given to children who stay near the AWC, and the rest are excluded.

Poor access to public health services: Discussions were held around pregnancy, childbirth, contraception and child health services, and very few women spoke. For all the six villages, health facilities were outside their villages at a distance of 3-10 km at Thandla, Khawasa and Bedla.

14/66 women spoke on availability of Janani Express or 108 ambulance services, and eleven of them said that it comes to pick up when dialed. In two villages women said that the ambulance comes to the village. Two women said that the ambulance does not come for sick children but one said that it does come. One woman said that there is no road to their hamlet and so they have to walk for some distance to reach the ambulance. Women in four of the six villages spoke about the role of ASHA and they said that the ASHA visits them, accompanies them for delivery, and also accompanies people suffering from Tuberculosis.

Most women were aware that they get money if they deliver in public hospitals. Of the eleven women who spoke of receiving 1400 rupees, seven said they received it and four said they did not receive this. One was aware that she did not receive money due to incomplete papers; one said that despite submitting all the papers and proofs she did not receive the JSY money. Two were not aware of the reasons for not receiving the money. With regards to out-of-pocket expenses, women from all the six villages said that they have to pay for services at public health facilities starting from the ambulance to the staff at the facility. Of the 13 women who spoke, most said that they incurred expenses at public facility which were for ambulance, delivery, cleaning, signing of forms, and documentation etc. The amount ranged from 300 to 500 rupees. Eight women that they have to pay for ambulance services and the amount ranged from 100 to 250 rupees. Five of them said that they have to pay for drop back services also.

Limited information about public services: Few women (14/66) discussed about services provided at the Anganwadi Centres. None of them could list all the services provided at the centres, and most barely listed two to four services. The most common services listed were immunization and pre-school education (4 each), followed by check-ups and treatment/medicines including Iron Folic Acid tablets. None of them mentioned health and nutrition education, health check-up, referral, growth monitoring or weighing as a service provided by the Anganwadi Centre.

Limited access to entitlements from Public Distribution System: Regarding access to PDS, a total of 64/66 women discussed and almost all (55/64) said that they have ration cards called “coupon” locally. Women said that they do get ration such as wheat (23/55), rice (22/55), salt(13/55)and kerosene (12/55). Two women said that they have not received ration since 2-3 months.

Women also spoke about challenges in receiving their entitlements from PDS such as irregularity, exclusion, and behavior of the provider. A couple of them said that the behavior of the shop owner was disrespectful. Some women complained about the quality of foods provided, particularly salt. The Government of MP provides double fortified salt through the PDS. But there is hardly any effort to educate and inform communities about the fortified salt. Some of their challenges are quoted below:

“Earlier it was easy for us to get ration. Since the new system of verifying thumb impression has come, if the thumb print does not match, we do not get ration,” said two women.

“The salt provided in the ration shop is not good in taste, it also has small stones,” said a couple of them.

“The ration is given in two to three months, but the quantity is enough for a month only,” said a woman.

*“The grain from the shop is sold. The doors are closed on us and we are shooed away,”* said two of them.

*“There is only one shop in our village and if we reach at the end, we are refused ration,”* said a woman.

Poor access to MNREGA entitlements: Women from all the six villages unanimously said that they and most people in the villages have job cards. From five villages women said that they did not get any work since last two to five years. In one village, women said that that summer (2018) there was work in the village. Some said that they worked, but did not receive any payment, and some said that they received half of the amount. One woman also mentioned about her experience with KIOSK,*“We face problems in receiving money in our account. People at the kiosk do not inform and when we ask they say that they do not have money.”*

Inadequacy of Mid-Day Meal scheme: Regarding Mid Day Meal, few women from all the six villages spoke about the foods given and their quantity. In one village, a woman appreciated the quality of food given, and in rest of the five villages, women said that the quantity was inadequate and children often went hungry. One woman said that when an inspection team visits, the children are served kheer (a sweet preparation made from milk and rice).

Low awareness on VHSNCs and Gram Panchayats: In all the six villages, women said that they did not know about the committees-Gram Sabha Swasthy Gram Tadarth Samiti(GSSGTS or VHSNCs). One woman said that women do not participate in the Gram Sabha.

Inadequate water sources: Open well, bore well and handpump were the sources of water, mentioned by

women from all the six villages. A woman said that tap water supply is not available in their village. In all the six villages, women spoke about the drudgery of fetching water several times a day, the sources of water are far, and it remains a woman's domain. Water scarcity peaks in summer.

“We face severe scarcity of water in summer. When there is no electricity we draw water from the well. We fetch water from one to two kilometers and it takes about an hour.”

Sanitation facilities inadequate: Women agreed that there should be a toilet and it is good to use it, but only few households (10-15%)have toilets. Some use it and some don't, they said. Women also mentioned about the constraints such as small size, poor quality of construction, broken doors, etc. In three villages women said that there is a community toilet but these were not in use due to poor quality. A woman said,“We do not have enough water to drink so how can we use it for toilets?”

# Gaps in Public Health and Nutrition Services

## A. Village Health and Nutrition Day (VHND)

A total of four VHNDs held in Guvalrundi, Bhimpura, Bhamal and PadaDhamjarvillages were observed. The following are some of the observations from the visits:

**Presence of human resource:** ASHA,AWW and ANM were present at all the four sessions. Male Health Worker, Panchayat member, and community members were not present.

**Equipment and amenities:** Apparatus to measure blood pressure, stethoscope, adult and baby weighing scale were available at all four VHNDs. Clean drinking water was available in three, and toilet was available at one of the four centres.

**Privacy:** Space for antenatal check-ups (bed with screen) was not available at any of the four VHNDS.

**Supplies:** UIP master register and mother and child health register was available with all the ANMs. At three VHDNs, MCP cards were not available and photocopy of cards were used. Condom and oral contraceptive pills were available at three of the four centres.

**Drugs:** Vitamin A solution and Tablet Albendozole was available at all the four VHNDs. IFA tablets, ORS,Chloroquine tablets were available at 3/4VHNDs; Zinc tablets, drugs for minor illness were available at 2/4 VHNDs.

**Services provided:** Antenatal check-up was done by all the ANMs, but pregnant women were counselled at three centres only. IFA was also provided at three VHNDs. OPV was given on all the four VHNDs. Motivation for family planning was done at only one VHND. Nutrition advice was given at three of the four VHNDs observed. Counselling on household toilets and purification of water was done at one, and demonstration on hand washing was done at one of the four VHNDs.

## B: About Gram Arogya Kendras (GAK)

A total five GAKs of Sureti, Sujapura, Bhamal, Makodiya and Sagwani were visited. Angaliya Pada village did not have a GAK. In order to assess the status of the Gram Arogya Kendra, a scoring system was used which is based on various parameters such as display, furniture, medicines, supplies etc. As per the GAKs score analysis, the minimum score was 49% and the maximum was 88%. (Please refer Table 5 for grades).

**Table 5: Grading of GAKs**

| Percentage Range | Grades | No. of GAKs |
|---|---|---|
| above 80% | A | 2 |
| between 61% to 80% | B | 1 |
| below 61% | C | 2 |
| TOTAL | | 5 |

Display and furniture: Four of the five centres had the sign board of AWC and GAK. Village health plan was displayed outside the three centres. Table, chair and examination table were available at all the centres but foot step/ stool was only available at two (2/5) centres.

**Availability of Information: Of the five GAKs visited:**

- Basic information of villages was available in 3/5 GAKs.
- Contact detail of service providers, officials and Janani Express were displayed at three centres.
- Village health register and death related information was available at all the five centres.
- Information about married and target couples, pregnant women, newborns, under five children, malnourished children, and children registered in AWC was available at all the centres.
- Birth, death and marriage registration was available at four of the five centres.

- Information about the village health sanitation and nutrition committee and untied fundwas available at four of the five centres visited.

Availability of instruments and equipment: None of the GAKs had all the instruments and equipment available, as per norms. (Please refer Table 6 for details).

**Table 6 : Availability of Instruments and Equipment at GAK**

| No. | Particular | Number of AWCs(n=08) |
|---|---|---|
| 1 | Weighing machine for baby | 2 |
| 2 | Infantometer for newborn | 4 |
| 3 | Haemoglobinometer | 3 |
| 4 | Stethoscope | 0 |
| 5 | Curtains | 4 |
| 6 | Fuctional BP instrument | 4 |
| 7 | Slides | 5 |
| 8 | Almirah | 3 |
| 9 | Water tank | 4 |

**Availability of medicines**

- All the five centres had stock of Iron FolicAacid, Albendazole, cotton bandage and absorbent cotton.
- Four of the five centres had the ORS sachet available at the centre, but only three centres had stock of zinc tablets.
- Providon ointment was available in four of the five centres.
- Paracetamol and Cotrimoxazole tablets were available in two of the five centres

Dicyclomine tablets (10mg) were available at only one of the five centers.

## C. About the ASHAs

Interviews were held with 7/9 ASHAs of the six villages. All belonged to ST category. Their education ranged from 5-12$^{th}$standardand their work experience ranged from 6-12 years. The average population covered by each ASHA was 1398. More than half (5/7) were also engaged in other work for income. Six of the seven had received training on their roles and responsibilities, health and nutrition issues. Major achievements mentioned by ASHAs were decrease in home deliveries; increase in immunisation and institutional deliveries;regular immunisation and Ante Natal Check-ups, improved family planning services and use of contraceptives. One ASHA said that she hadadmitted one SAM child in NRC from her own expenses..

**Some suggestions were:** Reduction in the documentation for beneficiaries to avail the scheme benefits;, timely disbursement of beneficiary's payment, and increase in the incentives of ASHAs.They were able to list their role in ensuring health and nutrition services to pregnant and lactating women, young children, accompany women for delivery, support in VHNDs, take slides for malaria, care of TB and leprosy patients, counselling, home visits and referral. ASHA of Bhamal village said that Bhil community of Maalphaliya chose not access her services.

**Some of the concerns mentioned were:**

- Two ASHAs said that they had not received drug kit.
- Three talkedabout irregular supply of paracetamol and iron folic acid tablets from PHC/SC.
- Difficulty in conducting survey; accompany woman for delivery at night as there was no facility for ASHA to stay; accomplishing campaign target; ensuringthat TB patients consume medicines, and Hb testing.
- Delayed and non receipt of incentives was cited by five of them.
- Four ASHAs said that they did not receive any support from VHSNCs and PRIs

Major achievements mentioned by ASHAs were decrease in home deliveries; increase in immunisation and institutional deliveries;regular immunisation and Ante Natal Check-ups, improved family planning services and use of contraceptives. One ASHA said that she hadadmitted one SAM child in NRC from her own expenses..

Some suggestions were: Reduction in the documentation for beneficiaries to avail the scheme benefits;, timely disbursement of beneficiary's payment, and increase in the incentives of ASHAs.

## D: About the Anganwadi Centre (AWC)

A total of 16/22 AWC centres from six villages were visited. Of these, fifteen were main AWCs and one

was a mini Anganwadi Centre. None of the fifteen AWCs were fully equipped and there were gaps in infrastructure, basic amenities and space. (Please refer Table 7 for details)

**Table 7: Physical Condition of AWC**

| No. | Parameters | Nnumber of AWCs(n=16) |
|---|---|---|
| 1 | Building | |
| | Own building | 11 |
| | Rented building | 02 |
| | Helpers home | 01 |
| | Government school | 01 |
| | Somebody's home | 01 |
| 2 | Building need repairs | 09 |
| 3 | No boundary wall | 08 |
| 4 | Clean drinking water | 11 |
| 5 | Food storage facility | 11 |
| 6 | Toilet in usable condition | 07 |
| 7 | Electric connection with power supply | 00 |
| 8 | Space for indoor activities | 15 |
| 9 | Toys | 13 |
| 10 | Space for VHNDs | 13 |
| 11 | Vessels for cooking | 06 |
| 12 | Mats | 12 |
| 13 | Poster and banners | 12 |
| 14 | Records and registers in fair condition | 15 |
| 15 | Medicine kit | 00 |
| 16 | IFA/ORS packets by ASHA | 06 |
| 17 | Vitamin A solution available | 07 |
| 18 | Growth chart available | 08 |
| 19 | THR stock available | 10 |

Interviews were held with 16 Anganwadi Workers (AWW). Their age ranged from 21-50 years with maximum AWWs (9/16) in the age group of 32-42 years, and two at the age of 45 and 50 years respectively.

Half of the AWWs(8/16) had studied between 10-12$^{th}$ standardand four each had studied up to 5$^{th}$ - 8$^{th}$ standard,and Bachelor of Arts respectively.

Majority(14/16) of the AWWsbelonged to Scheduled Tribe(ST) category. One was aMuslim and another belonged to Other Backward Class(OBC) category.

Their experience of working as AWW ranged from 1-29 years, with five workers having experience between 1-10 and 11-20 years, and experience of six workers ranged from 21-29 years.

**Enrolment of children:** Almost all the expected children in the villages were enrolled but the attendance of children was less compared to the enrolment. Of the total 651 children enrolled in the age group of 3-6 years, a total of 291 children (45%) attended the AWC.

In the interviews, half (8/16) of the Anganwadi workers cited migration, 6/16 cited distance of anganwadi from the childrens' own homes, and3/16said admission in private school as reason for poor attendance of children at the AWC. Every centre had an average 11-12 underweight children identified in last six months.

### Achievements and suggestions by the AWWs

**Major achievements:** Increase in linkages of people with schemes,immunisation coverage, institutional deliveries, awareness level of community, SAM referral to NRC, child education and enrolment in school, and decrease in malnutrition.

**Suggestions:** Worker should not be involved in other department works, reduction in routine and scheme documentation, hot cooked meal should be prepared at AWC, more training of workers, ade quate equipment at centre, quantity of ration/food should be increased.

### Services Provided:

Pre-school education to children, games and hand washing.

- Weighing and identification of malnourished children.
- Health check-up of children. Referral of SAM children to NRC.
- Distribution of THR to pregnant, lactating women, children aged 6 months to 3 years, and adolescent girls. Extra ration/food to malnourished children.
- Registration of pregnant women, IFA distribution, counselling on food intake and immunisation.

### Some of the concerns were:

- Meals were not provided as per menu at most of the centres.
- Quantity of ration served to the children was not sufficient (11/16).

- THR provided was not sufficient (3/16).
- Difficulty in documentation work related to survey, schemes, and record maintenance(7/16).
- Overburden with the department work. Workers said to maintain around 11 -13 registers(13/16).
- Lack of time was major constraint(4/16), while 12/16said that lack of fundswas a major constraint. For proper functioning they have to bear expenses from their own pockets, or they have to stop that activity.
- Inadequate toys for children, IEC material, water storage vessel, utensils, table chair and mats. Half of the centres were also not having the storage facility for equipment.

## E: About the Sub Health Centres

Visits were made to six sub centres-Machlaimata, Sujapura, Devaka.Mkodiya and Bhamal, which were expected to provide services to the selected villages. All the centres were located at government buildings. The average distance of sub centre from primary health centre and community health centre was 7 and 17 km respectively. Display board in local language was not available at half (3/6) of the centres. Citizen's Charter in local language was not displayed at any centre. Cleanliness at three (3/6) centres was good, at two centres (2/6) it was fair, and at one centre (1/6) it was in poor. Half (3/6) of the centres werebuilt near cattle shed,and one had garbage dump and stagnant water pool close to the centre. (Please refer Table 8 for SC coverage and human resource detail)

### Services provided:

ANC, PNC, immunisation, adolescent health, school health services.

- TT, IFA provided; weight and BP measured during ANC. Table 9 : Facilities and Infrastructure at SCNo.Amenities, Infrastructure, EquipmentNo of SC(n=6)1.Staff Quarters52.Availability of Labour Room53.Delivery services14.Examination Room45.Medicine Chest36.Screen to maintain privacy27.Electricity Connection with regular supply28.No medicines29.Separate toilets for men and women210.Facility of clean water211.Adequate equipment212.Furniture(table chair)213.Complaint box114.Drugs as per EDL in required quantity0

**Table 9 : Facilities and Infrastructure at SC**

| No. | Amenities, Infrastructure, Equipment | No of SC (n=6) |
|---|---|---|
| 1 | Staff Quarters | 5 |
| 2 | Availability of Labour Room | 5 |
| 3 | Delivery services | 1 |
| 4 | Examination Room | 4 |
| 5 | Medicine Chest | 3 |
| 6 | Screen to maintain privacy | 2 |
| 7 | Electricity Connection with regular supply | 2 |
| 8 | No medicines | 2 |
| 9 | Separate toilets for men and women | 2 |
| 10 | Facility of clean water | 2 |
| 11 | Adequate equipment | 2 |
| 12 | Furniture(table chair) | 2 |
| 13 | Complaint box | 1 |
| 14 | Drugs as per EDL in required quantity | 0 |

**Table 8: SCs Coverage and Human Resources Availability**

| No. | Particular | Particulars | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| 1 | SC Name | Machlaimata | Sujapur | Angliapada | Devaka | Makodiy | Bhamal | 6 |
| 2 | Population covered | 6562 | 6841 | 4727 | 5000 | 3895 | 4246 | 31271 |
| 3 | Distance of remote village in km | 6 | 2.5 | 5 | 5 | 20 | 4 | - |
| 4 | Health worker female | 1 | 1 | 1 | 1 | 1 | 1 | 6 |

- Oral contraceptives and condom; IUD insertion in 2/6 SCs.
- Sanitation, national health programs and home care promotion.
- Treatment for minor illness was readily available at all the centres.
- Coordination with AWWs, ASHA, VHSNC, PRIs and supervision of the activities of ASHA and proper maintain the records and registers.
- Observe VHNDs and provide ANC,PNC, immunisation and general medical aid.

### Documentation and support:

- Four ANMs (4/6)said that they had village health plan. They all said that they kept the records of registration, birth, death, new couple, family planning, maternal and child death record and ANC registration.
- Only two ANMs (2/6) said that they received support from panchayat members, out of this one also said that she received support from teacher and SHGs.
- One third of the ANMssaid the Male Health Assistant or the LHV visit sub centre once a week, but doctors did not visit the SC.

The most difficult tasks as mentioned by four ANMs (4/6) were information collection and ensuring participation of women and children on VHND. All the six ANMs said that they were overburdened with the work, and the major constraint was lack of time. Some of the achievements of the ANMs were increase in the ANC and PNC services, immunisation coverage, institutional deliveries, IFA consumption, contraceptive usage (permanent), and community had started to come forward for treatment during general illness like fever.

Suggestions by the ANMs were to reduce the operational area (4/6); increase the incentives for contraceptive methods(3/6);provide additional male health worker at the centre(1/6). Another suggested for linkages of panchayat and society with immunisation (VHND).

### Some Observations

- Machlai mata:SC had only labour table.One room of the centre was utilised by anganwadi centre.
- Sujapura SC:The building was old, doors and windows were broken and the Sub Center. The materials get stolen if stored at the centre.
- Angliyapada SC: Building was newly constructed but due to lack of transportation ANM was not staying at the centre.
- Makodiya: New building was constructed but there was no facility.
- Bhamal: This was the delivery point centre and ANM stayed at the same centre. Medicines were not available at sufficient quantity. There was only one ANM at the centre and it is a

## E: About the Primary Health Centre (PHC)

CHETNA team members visited Khawasa and Kakanwani PHCs and held interviews with facility in charge. Both the facilities were located in government building within the village and were easily accessible to the community. The average distance of the PHC from CHC and DH was 21 km and 47 km respectively. Facility of clean drinking water was available at both the centres. (Please refer table 10 for PHC profile)

**Table 10: Basic Profile of PHCs**

| No. | Particular | Thandla | | Total |
|---|---|---|---|---|
| 1 | PHC Name | Khawasa | Kakanwani | |
| 2 | Population covered | 52226 | 61291 | 113517 |
| 3 | PHC providing 24x7 delivery facilities | Yes | Yes | 2 |
| 4 | Daily OPD load Male | 20 | 20 | 40 |
| 5 | Daily OPD load Female | 40 | 30 | 70 |

The post of Medical officer, ANM was filled, and a counsellor was posted at one PHC. The position of lab technician and pharmacist was vacant at both the facilities. Tests were conducted through strips at one facility. A technician came twice a week from other centre in one PHC. Only one PHC had support staff and both centres did not have clerks. The population load was high at both the facilities. During the last full year only medical officers of both the facilities had received training.

Citizen's Charter was not displayed at any facility and there was no grievance redressal mechanism. Ramp for differently-abled individuals was also not available at both the PHCs.

Services provided and facility available at the centres:

- Services like primary management of wounds, poisoning/snake bite, management of burns and minor surgeries were available at both the centres. One centre also provided the services of primary management of fracture.
- Both the PHCs provided ANC, INC,PNC, child care including immunization, family planning, MTP, facilities under JSY and new born care.
- Management of pneumonia and severe diarrhoea/dehydration was available at both the facilities. Immunisation day was fixed at both the PHCs and both were the cold chain point.
- Promotion of safe water, sanitation, prevention of locally endemic diseases, disease surveillance, collection and reporting of vital statistics was done at both the PHCs.
- Diagnosis of STI/RTI, blood smear examination for malaria parasite, pregnancy test and test for HIV was available at both the facilities. Majority tests were conducted using rapid diagnostic kits.
- Computer was available and email facility was being operated at the centres using mobile internet connectivity.
- All the drugs were available as per EDL, but regular supply was a concern.
- Both the centres had labour room and provided 24 hour delivery services, and anaemia treatment through iron sucrose.

Some of the gaps that emerged:

- Cataract surgeries were not performed at any facility.
- Only one facility provided STI/RTI management services, services on nutrition, school health and health education.
- The services like tubectomy and vasectomy were not provided at any facility.
- Laboratory facilities were not available at both the centres.
- Facility for sputum testing for TB and RPR test for syphilis was not available at any facility. Test facility of routine urine, blood grouping and clotting time was available at one (1/2) facility.

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