Listening to the Voices from the Field

Mid Term Appraisal of the Eleventh Five Year Plan (2007-2012)

(Health, Women and Child Development, Minorities, Handicraft and Handlooms)

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FOREWORD

The Eleventh Five Year Plan was instrumental in establishing a perspective on growth which is truly inclusive, for instance; it reprioritized policies in a gender sensitive manner through gender budgeting and by designing integrated schemes in the Minorities sector. I believe institutional reforms work best in a setting where there is a constant redesigning of policies and a scope for the regular assessment. The Mid-Term Appraisal (MTA) of the Eleventh Five Year Plan provided us with an opportunity to not only engage with existing ground realities but to extensively review our current schemes and programmes. Besides, it provided perceptive solutions and good practices from across the country.

Five regional consultations were held at; Chandigarh (North Consultation), Bubhaneshwar (East Consultation), Jaipur (West Consultation), Bangalore (South Consultation) and Guwahati (North East Consultation), in collaboration with UNIFEM, UNFPA and UNICEF. The process also involved national level NGO's, Voluntary Health Association of India (VHAI) and National Alliance of Women (NAWO) who were instrumental in conducting these state level consultations. Through these consultations we analysed the interplay of schematic implementation and feedback on policy corrections from all quarters.

In this Report, VHAI is presenting the findings from the consultations as the MTA of Eleventh Five Year Plan.

I end with a few lines by the great Sufi poet Jalaluddin Rumi in celebration of hope and possibility for the balance of the plan period and all our future endeavors.

Constant, slow movement teaches us to keep working
Like a small creek that stays clear
That doesn't stagnate but finds a way
Through numerous details, deliberately
This is what gives us hope.

Syeda Hameed

(Syeda Hameed)

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Preface

The Eleventh Five Year Plan envisages "faster and inclusive growth." There is a clear acknowledgement that inspite of an improved economic performance, there has not been the desired dent on the poverty front. This situation is further complicated by slow progress in the Social Sector, namely Health, Women & Children, Handloom & Handicrafts and Minorities. The 11th Plan proposes to address this critical concern by ensuring a significant focus on these unmet development challenges. Significant number of programmes and schemes have been launched with matching budget to address this gap.

As a part of Mid-Term Appraisal of the 11th Five Year Plan, it was felt that it is critical that we get feedback on the schemes and programmes of the Ministries of Health, Women and Children, Handlooms & Handicrafts and Minority Affairs, from their intended beneficiaries. In twenty seven States of the country, State level Consultations were followed by five Regional level Consultations. These Consultations aiming at capturing the 'voices from the field' were supported by the UNFPA, UNIFEM and UNICEF and coordinated ably by the Voluntary Health Association of India (VHAI) and National Alliance for Women (NAWO). This rigorous exercise was carried out across the country in one month duration by these two national level NGOs, each having a large network of organizations. This process created unique opportunities to hear from the people on the ground from diverse settings and background, on these programmes and more importantly their recommendations on how to improve their effectiveness and outreach in the future. The report tries to capture the essence of these deliberations.

Dr. Syeda Hameed, Member Planning Commission of India addressing the participants during the Eastern Region Consultation

Participants while appreciating, the government's focus and attention to meet the gaps of the Social Sector expeditiously, had a broad consensus that these programmes need to have more evidence based outcome. They felt this will necessitate a more decentralized need based people centered approach. Better governance and greater accountability of the implementing agencies was an all-round concern. The importance of convergence of the Social Sector programmes was a highlight of all the discussions. Participants strongly felt that there is a need for a more effective dissemination of detailed information regarding the schemes amongst the beneficiaries in every corner of the country.

The participants strongly felt that the unique opportunity of making a paradigm shift in the Social Sector should not be lost. Need of the hour is to ensure that during the remaining part of the 11th Plan, the above recommendations are proactively implemented. We also create a synergy between implementing agencies, beneficiaries, PRIs and non-government agencies for an effective implementation of the Social Sector Programmes.

The state wide Consultations resulted in generating considerable enthusiasm and awareness among the participants to play an active role in the process of implementation of the Social Sector Programmes. They felt, "Paths are made by walking....."

Overview

'Towards Faster and More Inclusive Growth' is the central theme of the country's Eleventh Five-Year Plan (2007-2012). With a substantial increase in the allocation of resources, the chief thrust of India's Rs 36.44 trillion (US$ 910 billion) Eleventh Plan (2007-2012) is agriculture, along with education and infrastructure, which constitute the basic premise of economic growth. The Eleventh Five-Year Plan confirms the UPA Government's commitment to making growth *inclusive* by ensuring that the benefits of economic growth accelerate the pace of both industralisation and employment-generation, reduce the rural-urban divide and bring immeasurable benefits to the SC/STs, minorities and other backward groups.

With three years gone, it becomes pertinent to review the performance and make some evidence-based assessment of the impact made on the social sector. With the mid-term appraisal of the plan scheduled for this year, it is considered important to obtain feedback from the poor and marginalised social groups regarding delivery of different schemes, which are specifically targeted to improve the quality of life. It is perhaps with this objective that the Planning Commission of India recently took the initiative to bring together the civil society organisations so as to ensue a realistic appraisal of the Eleventh Plan. The UNFPA, UNIFEM and UNICEF supported the regional and state-level consultations across the country to capture "*the voices from the fields*". The consultations aimed to reach and engage the intended beneficiaries at the grassroots, the civil society organisations and key groups from the Planning Commission, state governments and the UN agencies in judging the performance of the social sector during this period. NGOs, having a wide presence and acceptability

Left to right. Dr. N.K. Sethi (Planning Commission), Mr. Alok Mukhopadhyay (VHAI), Dr. Syeda Hameed (Planning Commission), Dr. Venkatesh Srinivasan (UNFPA) and Mr. Satyen Chaturvedi (Rajasthan VHA)

at the Central, state and local levels were chosen for this mammoth task. Voluntary Heath Association of India (VHAI) and National Alliance for Women (NAWO), each with a large network of organisations, were given this stupendous task of organising and conducting state- and regional-level consultations across the country. As many as 27 state-level consultations involving community members were preceded by five regional-level consultations. These consultations provided a platform for a direct interface between the community members belonging to the Scheduled Castes, Scheduled Tribes, minorities, artisans, weavers, women and representatives from the Planning Commission, UN agencies and civil society organisations to discuss for two days the gaps, challenges and scope at the community level in meeting the objectives of various schemes in sectors like health, women and child development, minorities, handicrafts and handlooms.

Objectives:-

- To review the performance of the Eleventh Five-Year Plan through the eyes of the public and make evidence-based assessment of the impact on the social sector (health, women and child development, minorities, handicrafts and handlooms)
- To facilitate a dialogue on the gaps, challenges and opportunities at the community level in meeting the objectives of the Eleventh Five-Year Plan among the relevant representatives of the Planning Commission, collaborating UN agencies, voluntary organisations and the actual beneficiaries, i.e. the community members from various marginalised sections of the society (SC/ST, OBCs, women and children)
- To assess the level of knowledge of the community members on various components of the national-level schemes designed for them
- To assess the actual benefits accruing to the genuine beneficiaries
- To discuss specific issues relating to the minority community in accessing benefits under different schemes and the challenges faced by them
- To assess the community-level participation in the Central Government programmes
- To understand the community perspectives on gender responsiveness of programmes/schemes.
- To synthesise community feedback and recommendations to feed into national-level Eleventh Plan Mid-term Review (MTR) processes

Methodology:-

'*Voices from the Fields*' is a unique kind of initiative to help the people at the grassroots to share their feedback on various social development schemes and programmes while suggesting ways to strengthen them. At the helm of 'inclusive growth' is the overall objective of the Eleventh Five-Year Plan that involves a participatory approach in the mid-term appraisal. '*Voices from the Field*' is a

Community members inaugarating Western Region Consultation organised at Jaipur

genuine attempt of the Planning Commission, supported by the UN Interagency, to heed the perception of the actual beneficiaries comprising women, the aged, SC/ST, OBCs and rural artisans regarding the various initiatives taken up by the Government of India during the Eleventh Plan period.

The state- and regional-level consultations were conducted in a tight time-frame of one month across the country. It comprised of five regional consultations preceded by 27 state-level consultations in the east, north-east and west organised by the VHAI and in the north and south regions by the NAWO.

Schema of Consultations and Briefings:

1. Briefings for facilitators
   - ✦ One national-level briefing (organised by VHAI)
   - ✦ Five regional-level briefings (three of them organised by VHAI and two by NAWO)
2. Consultations with stakeholders
   - ✦ Twenty-seven state-level consultations (17 of them organised by VHAI and 10 by NAWO)
   - ✦ Five regional-level consultations (three organised by VHAI and two by NAWO)

A national-level orientation programme was organised right in the beginning to share the concept, purpose and idea of the initiative with the representatives of regional units of both VHAI and NAWO. The purpose of this programme was to equip the beneficiaries with necessary tools and ideas to carry out the process at the state as well as regional levels in order to achieve the maximum results

MR. K. Chris Hirabayushi, UNICEF Representative addressing the participants at the National level Briefing at VHAI, New Delhi

Duration:

The project began on 20 August 2009 to continue till 25 September 2009. Various state-level consultations were held simultaneously with an adequate participation from the VHAI network to facilitate the process in the required direction.

Key Observations

The overall objective of the Eleventh Five-Year Plan (2007-2012) is to ensure a faster and inclusive growth in agriculture, the social sector (health, women and child development, minorities, handicrafts and handlooms) and the infrastructure which are the basic premises of economic growth. There has been a substantial increase in the allocation of resources guided by the noble intention of ensuring that benefits of economic growth reach all sections of the society. Considering the Eleventh Five-Year Plan focus on inclusive growth, it is important to find out how these social sector schemes are impacting the lives of SC/ST/minorities, women, artisans belonging to the marginalised sections of the society. Some grassroot-NGOs working directly with the poor also participated and helped in articulating the views of the marginalised groups.

The following section shares significant observations made during these deliberations that reflect the situation in general. Some common observations across all sections (health, women, child, minorities, handloom and handicrafts) of the social sector were as follows:

*Centralisation of planning***:** Against the common rhetoric, planning has continued to be done in a top-down manner with a minimal or no involvement of the community members who are supposed to be the actual beneficiaries. As a result, most of the developmental programmes and schemes have drawbacks in their designing. These programmes are designed on the basis of general observations and statistical figures without taking into account the critical ground realities. Hardly any thought is given to the geographical diversity or remoteness of the area, cultural differences, religion-specific issues, availability of expert services, etc.

Information dissemination: Once the programme has been conceptualised and is ready for implementation, the next immediate step should be to disseminate the information about its objectives and operational mechanisms. But, in the absence of this happening, the community members in most settings are not aware of the various schemes and programmes entitling them to the benefits. Ignorance about the developmental programmes was noticed at block and district levels.

Mismatch between the funding and programme objectives: The development programmes must take into consideration the ground realities during their conceptualisation stage. Irregularity in fund flow is another issue which needs immediate appraisal. Most of the schemes and programmes, especially those implemented by the NGOs, receive the funding postdate. This affects the performance and dampens the NGO's spirit in undertaking government projects.

Lack of innovation and restructure: Once a scheme is made, very few innovations go into it to improve its impact. There is a need to undertake on a regular basis a performance-review activity for the various developmental schemes and programmes. This effort should be followed by a careful revision of the existing programmes in the light of the shortcomings and new developments.

Special package for programmes and schemes for hilly and inaccessible regions: It was clear from the state- and regional-level deliberations that the hilly regions have

Mohd. Sayed raising the concerns on minority issues

a separate set of problems, which have not yet been addressed adequately in any of the health programmes. Financial provisions, standard population size as per the service coverage of health workers or health centres, etc. need to be taken into account while keeping the geographic variations in view. There should be separate packages designed for these areas.

Governance of the developmental programmes: Poor governance of developmental programmes has left many questions unanswered. Lack of transparency in programme implementation with little or no follow-up action has led to corruption, leakage of funds and subsequent exploitation of the beneficiaries. The report, based on the deliberations, discusses in detail the concerns raised by community members regarding the schemes and programmes designed by the Government of India and its impact at the grassroot level.

The next section details the area-specific observations followed by the recommendations, while capturing the community perspectives shared during the series of consultations across the country and attended by representatives from the women groups, minority groups, artisans and NGOs providing services to the marginalised sections of the society.

Health Issues : The overall health condition of the mother and child, communicable and non-communicable diseases and health delivery system were the key focus areas of the discussion under the health section.

The National Rural Health Mission is an important health policy initiative in recent times with a clear objective to improve the availability of and access to quality health care, especially to the poor, women and children across the country. Most of the health schemes and programmes, such as reproductive and child health, vector-borne disease control, tuberculosis control, blindness control, leprosy eradication, iodine deficiency control and integrated disease surveillance have merged into the overarching umbrella of NRHM. The NRHM is intended to take a holistic approach of programme implementation as per the needs of the community. The provision of flexible financing is included to support the state initiatives in addressing the gaps in the health schemes. The deliberations reflected on the outreach of these programmes and the existing gaps in the performance.

- *Functioning of committees under NRHM* at the state/district and village levels has been generally ineffective with no involvement of the community members.
- *Janani Suraksha Yojana* has found wide acceptance in the community, leading to substantial improvement in maternal and child health while promoting institutional delivery. The discussions further revealed that poor women from the remote districts of Bihar and Orissa have taken to availing the benefits of the JSY services. However, the scheme is facing some *operational*

problems in the reimbursement of incentives to the beneficiaries as well as the health workers. ASHAs are not trained enough to handle critical cases or even manage a delivery in an emergency situation. Some other impeding factors included that most of the health centres are not well equipped for conducting delivery at the community or the block level and these include unavailability of doctors, uninterrupted electricity supply, proper equipment, infrastructure, etc.

- *Variations in geographic diversity* as seen between the hilly regions and the plain areas, or cultural diversity, different social practices and economic condition of the people were not taken into account when formulating and implementing most of the programmes.
- Despite all good intention of *improving the health infrastructure*, especially at the primary level, many gaps need to be filled in the available health services in terms of infrastructure, manpower, drugs and equipments. Such limitations compel the local inhabitants to spend a fortune in travelling miles for obtaining the basic health services.
- Health Days focusing on nutrition, family planning and safe abortion are not given due importance through special attention in most settings. During the discussions at state- and regional-level consultations, it was discovered that the Village Health and Nutrition Day is not a commonly known concept in rural areas except for few pockets in some states like Tamil Nadu and Andhra Pradesh or in the southern region and Assam in north-east of the country.
- Despite the country's commitment to *stabilising the population growth* by 2010 and reaching a total fertility rate of 2.1, the current state of family planning services with its limitations leaves much to desire. There is no assured availability of reversible contraceptives at the village level. Lack of follow-up action after sterilisation, especially in case of complications is another concern.
- *Provision of safe abortion facilities* is missing and even the ASHAs are reported to be unaware of such facilities reaching the poor rural communities.
- Diseases, like tuberculosis, receive more emphasis than others, like malaria which affects the rural community more. Medicine supply is also not regular and people have to buy medicines from the market at a high price.
- Though the *immunisation campaign* has proved a success, some of the roadblocks reported were absence of facilities like proper electricity supply, insufficient health equipment, especially the pre-requisites for maintaining the cold chain.
- Technically, HIV/AIDS control is not an integral component of the NRHM, but is preventable. Its spread in increasing day by day, affecting more and more of the human population. There is an urgent need for creating more intensive awareness and providing testing/counselling services at the block/community level.

Women Issues: In the current scheme of things, several legislations and programmes in the women's section provide health benefits and reduce their social and economic vulnerability.

- As expected, *lack of awareness* about various legislations is seen amongst the women participants. The legislations aim at providing them protection against various atrocities, like violence at home or dowry harassment. The local village resident in most settings is not aware of whom to approach in case of any such situation.

- One of the factors responsible for poor performance of some of the health programmes involving the NGO sector is the *irregular release of funds*. Homes for women and other integrated programmes are clear examples of such a case.
- *Gender budgeting* is yet a new concept for the community groups comprising the minority section, women's groups, handloom artisans and the NGO fraternity. No successful inclusion of gender budgeting is made in the functional programmes.
- The *Rashtriya Mahila Kosh (RMK),* a micro credit-promoting programme has not been able to reach the common people due to bottlenecks in operation and lack of clarity in its objectives. In states like Jharkhand, Orissa, Madhya Pradesh, Uttar Pradesh and Rajasthan, the nodal agencies are not transparent in their operation and money is given to NGOs at a higher rate of interest than that permissible under the scheme. This scheme ran effectively some five to six years ago. It made a good beginning in Orissa some 16 years ago, but the number of defaulter cases is so high that now applications from Orissa are kept in abeyance.

Sita Devi, community health worker representing the concerns of the tribal community

- *Revision of the guidelines* for providing vocational training programmes for women has been a cause for concern. Most of the existing programme guidelines need to be updated with a market-driven approach, so as to economically empower them better.
- *Popularising the Prevention of Violence against Women Act*: District- and block- level task forces need to be built for a strict enforcement of the Act. Proper communication at the community level regarding the laws, roles and responsibilities of the service providers and protection officers under the Act is essential so as to help them achieve greater powers to discharge their duties effectively. There should be more than one service provider and protection officer in every district.
- A *regular monitoring system* has to be in place along with a follow-up mechanism for better implementation of the schemes.
- *Women in difficult psychological and social conditions* are provided services of government-run Short Stay Homes (SSH). Lack or absence of basic facilities, like food, clothing, and psychological guidance are a common phenomenon. The women beneficiaries, who raised their concerns along with the representatives of the organisations running such centres are of the view that budget allocation for running such homes are inadequate and the release of funds is often irregular. This is one of the reasons for faulty services in the Short Stay Homes.

Child Issues: Programmes and schemes meant for a holistic development of children have not proved effective due to lack of community participation and ownership. Also the legal, welfare, non-government entities involved in implementation of such programmes work in isolation with minimal or no coordination.

- The *ICDS programme*, one of the biggest initiatives of the government in operation in almost all states of the country for over more than three decades, has virtually failed in meeting its overall goal of improving the health and development status of children below the age group of five years. The basic facilities available in ICDS centres, like the play/ educational material or health equipments for children, are inadequate. The quality of food provided to children in the age group of 0-6 years is questionable in most settings. There is no system of regular training of the ICDS workers/teachers for providing quality teaching and care. Neither is there any linkage between the primary school and pre-school teachers and education institutions. The monitoring and supervision mechanism is not effective. Guided by a non-transparent governance system with poor inter-sectoral coordination-and-monitoring mechanism and lack of skills and commitment among the frontline health workers, it is practically impossible to realise the goals of ICDS.
- *Lack of awareness* is apparent amongst the local voluntary organisations and the community members regarding several promising schemes and programmes.
- Community members do not have any clue about the various *protective legislations* for children, like the Shishu Griha Scheme, Integrated Scheme for street children, scheme for the welfare of working children and children in need of care and protection.
- No effort has been made to involve the community in the implementation of schemes like the ICDS, Juvenile Justice Act.
- *Inter-sectoral convergence* is missing in the implementation of most of the programmes. Despite a progressive amendment of legislations like the Juvenile Justice Act, Childline (a helpline for children in distress) in place, the various departments involved, like the police, JJ Homes, Childline staff or the NGOs do not operate in coordination, resulting in children being deprived of a holistic support. Nutrition is not a subject to be dealt in isolation. The primary reasons

A women participant sharing the gaps in the implementation of women and child schems

for nutritional deficiencies are lack of inputs from the health care centres and departments of social justice, social welfare, women and child development, finance, rural development, education, water and sanitation, Panchayati Raj, etc.

***Minority Issues*:** The minority section comprising nearly one-fifth of the total population has been taken care of very well by the government in terms of formulation of specific programmes and schemes. Their implementation however is tardy, thus hindering realisation of the achievements and the challenges. State- and regional-level consultations attracted a fair participation from the minority community and this helped in receiving feedback on actual implementation of these programmes.

- There is a general *lack of awareness about the schemes*. Even those who had benefited from some of the schemes said that the process of availing the benefits is very cumbersome and the benefit received eventually often amounts to less than the cost incurred during the process, like the pre-matric, post-matric and vocational scholarships. With a limited number of scholarships available, the processing of applications for scholarship is cumbersome and time-consuming as it involves a lot of paper work. Also, at the time of selection, favouritism is shown to affluent and influential persons at the government level.
- The *educational programmes* meant for this section of the population are not integrated with the mainstream education programme and have a very limited coverage as a result of which the benefits reach a very few people.
- The uniforms provided to the minority girl students are not culture sensitive. This is becoming one of the major reasons for the increase in the dropout rate amongst the girls.
- *The National Minority Development Finance Corporation (NMDFC)* schemes offer interest as low as 1% and the rules for applying are difficult. As a result, awareness and outreach of the NMDFC amongst the minority group is low. Other limitations are lack of funds -- only Rs 5 to 10 lakh per NGO. Since RMK charges 8%, while NMDFC charges 1%, it leads to a conflict among the communities. The loan is paid randomly without assessing or building up the capacity of the beneficiary. The repayment period is very short -- only two years and does not look after the business or enterprise till it gets its return. The NMDFC does not respond to enquiries and shows no transparency in its dealings. The official website of NMDFC fails to provide information regarding the programme and its various components. Christians and linguistic minorities get ignored and are thus deprived of this facility.

Handicrafts and Handloom Issues: Handloom and handicrafts are the second largest source of income for the people of India. There is a general agreement that the existing programmes are sufficient to meet the critical needs of the artisans but the intended benefits are often not reaching them.

- There is a general awareness and acceptance of the *Ambedkar Hastashilpa Vikas Yojana* (*AHVY*), but most of the other schemes, like the Integrated Handloom Development Scheme and the Mill Gate Scheme, are very new to the participants. Not only the intended beneficiaries, that is the artisans, but even the NGOs engaged in the field of handicraft and handloom are not aware about them. The handloom sector is much neglected as the schemes are not implemented properly.

- AHVY is the only programme in the handicraft and handloom sector which is well known as it has a wide coverage and is implemented in most parts of the country.
- Some of the *operational problems in AHVY implementation* include the few number of market-support programmes which cause artisans to lose interest in the programme. With global competition, it is necessary for the handloom and handicrafts sector to be further strengthened so as to fill in the critical gaps. The monitoring mechanism in the AHVY is also a cause for concern. With provisions for the artisans to attend exhibitions outside the state, they are often not provided any TA/DA. Very few common facility centres have been established under the scheme. The scope for integrated development of the artisans is limited as most of the programmes are run independently.
- Apart from AHVY, there is no other scheme envisaging partnership with the local NGOs. It has however been agreed that the NGO sector with a better presence at the grassroots can increase awareness about the various government schemes and programmes, besides identifying potential beneficiaries and effectively implementing the programme in collaboration with the government.
- Since there is no baseline data available to analyse the changes in the income pattern, social condition or cultural changes among the artisans on implementation of the programmes, it becomes difficult to assess the effectiveness of any programme.

Recommendations

The mid-term appraisal of the Eleventh Five-Year Plan of the Government of India by 'listening to voices from the field', provided a realistic assessment of various developmental schemes and programmes for the uplift of the social sector (health, women and child development, minorities and handicraft and handlooms). The 35 state- and regional-level

Participants raising voice for an effective implementation of the Govt. Schemes

consultations organised across the country in a month's period were successful in enlightening the community folk about the gaps in the performance of various Central and state government programmes as also schemes in the social sector.

Some of the key suggestions that emerged during the deliberations were:

Health

- It was strongly felt that there is lack of stress on preventive and promotional aspects of health care in the NRHM. Further tobacco control-related activities have not received due importance and need to be taken up more proactively in the remaining part of the Eleventh Five-Year Plan.
- *Building awareness about government schemes and programmes* is necessary through better information dissemination at the community level, IEC activities, mass media, and increased involvement of NGOs.
- *Capacity building of ASHAs, ANMs* and other frontline health workers must be done through their skill development as per the roles assigned to them.
- *Strengthening of health committees under the NRHM* by formalising the role of the members and arranging orientation programmes for them are called for.
- *Promoting inter-sectoral coordination among different departments* for building the community health and health of the mother and children cannot be dealt in isolation by directing efforts at improvement of health alone. A coordinated approach between different sectors is the need of the hour.
- *Special packages for programmes and schemes* should be provided in hilly and difficult regions.
- *Strengthening of the health infrastructure with adequate manpower* is necessary.
- *Morbidity mapping* needs to be done scientifically as per the prevalence of different diseases. Climatic issues and geographic location have to be considered during the mapping exercise. Serious health problems which have state- or region-specific concerns, such as HIV/AIDS, malaria, chikungunya**,** kalazaar, etc. call for improved surveillance, monitoring, prevention and treatment procedures in accordance with the seriousness and prevalence in the affected areas.
- *Enhanced honorarium/incentives* should be provided to the ASHAs on a regular basis. They should be given specific roles and responsibilities to perform.
- *Regular joint monitoring* of programmes and government schemes is essential on a regular basis with a joint representation from the government and non-government agencies. Monitoring should have a component of follow-up or else the entire exercise would be futile.
- *Revising of the family planning programme* can be done through better dissemination of information about the various family planning measures, their usage and the compensation in case of any mishap.
- *JSY should include complete ANC and PNC*. The Janani Suraksha Yojana (JSY) has proved worthwhile with one of the reasons being the variability of incentives. The scheme could be made more comprehensive by including complete ante-natal care and post-natal care. Involvement of the ASHAs in PNC could also ensure better family planning, advantages of breast feeding, etc.
- *HIV/AIDS awareness, care and support* can best be built by propagation of relevant information and removal of myths and social stigma. Provision of better care and treatment services at the block level, increase in the number of mobile Integrated Counselling and Testing Centres (ICTCs) and more serious prevention

and treatment facilities in the north-eastern states of the country are some other steps to be taken.

- *Public-private partnership* is necessary for implementation of different programmes, like, PHC management, malaria control, immunisation campaign, HIV/AIDS programme, etc. Clear guidelines covering all aspects, like careful selection of the NGOs, regular and timely release of funds, periodic monitoring, etc. should be provided.

Child

- *Service coverage of ICDS centres and other programmes* is necessary while keeping in mind the geography of the state (hilly/plain/desert), caste and ethnicity of the functionaries and the beneficiary group. The services of the ICDS programme and also the Rajiv Gandhi Creche Scheme should be extended to include juvenile homes and red light areas in urban settings and mining areas.

- *Better infrastructure and services* are needed for the ICDS Centre which should function as an independent structure, having its own boundary. The layout of the building should provide for adequate space and ventilation, proper segregation of playing space, kitchen, store room and toilets. There should be a boundary wall to protect the children against outside elements. A garden, overhead water-tank and regular water supply are some other critical features of an ICDS Centre with its mandate of encouraging a holistic development of children.

  The ICDS Centre should be adequately supplied with all the necessary requirements, i.e. play and study material, furniture items, health equipments, like the height and weight measurement devices, amongst others.

- *Human resource development* should be emphasised and proper selection and training of the ICDS workers made mandatory. They should be equipped with knowledge on child growth and development and also on various social determinants governing that. The training at the ICDS Centres may be organised at the block or district level. To facilitate a more coordinated working of the various health functionaries at the primary level, joint/combined orientation programmes for ICDS workers, ASHAs and ANMs can be organised.

- *Monitoring of programmes* like the ICDS, Early Childhood Education, Rajiv Gandhi Creche, Childline, etc. is essential by setting up proper guidelines and well-defined roles and responsibilities for the workers. To ensure effective functioning, these programmes must be monitored on a regular basis by a committee having representatives from both the government and the NGO sector.

- *Childline* service needs to be made fully functional in each district of the states and if possible, at the block level. It should operate 24x7 and better awareness about the scheme created through the website of Childline, which provides information on missing children, trafficked children, child labour, substance-abused children, etc.

- *Financial resources* through a flexi pool can be created to muster the creativity of the workers at the district, block and community levels. This should support financial inputs and innovative ideas on generation of mass awareness regarding nutrition, hygiene and other health issues.

- *Inter-sectoral convergence* is necessary to check nutritional imbalance. Inputs from all sectors like health, social justice, social welfare, Panchayati Raj, women and child development, finance, rural

development, education, water and sanitation, etc. should be gathered to bring about the desired change in the health and development status of children.

- *Life cycle approach* is necessary at all ICDS Centres, so as to provide for a more holistic growth and development of children. Beyond the provision of food services, this comprises exchange of information about personal hygiene and adolescents' education with a participatory approach involving the womenfolk.
- *Community participation and ownership* can be encouraged by involving the PRIs, women self-help groups, adolescents, etc. for the implementation of ICDS activities.
- *The ICDS must orientate adolescent girls* on nutrition, low-cost nutrition, complementary feeding which in turn would then help to carry forward the ICDS agenda in the community as an agent of change.
- *Women SHGs* (self-help groups) should be identified and promoted by ICDS with their subsequent involvement in the implementation of ICDS activities, like supply of food materials and cooking. This approach will not only provide employment to the SHG members but also equip them to ultimately take over responsibility of such centres.
- There should be regular meetings amongst the PRI members, ICDS workers, pregnant and lactating women, mothers and SHG members to discuss the functioning of *anganwadi* centres and the gaps and challenges faced in the effort to improve the functioning of these centres.
- *Sustainability of the efforts of ICDS and other programmes* must be ensured with the community actively participating in owning up the responsibility of the children. Rigorous involvement of the Panchayat Raj institutions and women's self-help groups are pertinent to pursue this effort with a long-term development agenda.
- All existing schemes and programmes designed for the children should create better *awareness through the mass media and IEC activities* about the various schemes and programmes dealing with children's issues and their development.

Women

- *Budget allocation and release of fund* are an essential prerequisite for a smooth functioning of the Short Stay Homes for women in distress. The budget allocation must be streamlined and improved to meet adequately the basic facilities, psychological, mental, medical, legal and other requirements. The fund release process should be simplified.
- *Awareness about programmes and protective legislations* must be put into force through well-designed and comprehensive IEC activities and media campaigns involving NGOs. Government website on these schemes must be updated on a regular basis.
- *Restructuring of the vocational training programme* can be done by involving a component of prior market mapping of products and skills. With such skills the person can start some work which helps in becoming self-sufficient. The trainer hired for these programmes must possess adequate skills and his honorarium must be as per the market rates. The duration of vocational training may be increased to a minimum of six months to one year.
- *Monitoring of the schemes and performance* should be done on a regular basis. Improvement in the budget allocation and awareness about the programmes should be done by a committee comprising representatives from the government as well as the non-government

sector. This committee must regulate the budgeting and functioning of various homes and schemes for women in distress.

- *Coverage of the programme* should be increased so as to include more than one district. The same holds good for the number of SSH in districts and blocks along with family counselling centres and other programmes.
- *Selection of NGOs* for the implementation of different programmes should be transparent. The criteria for selection and the process must be shared through the government-specific website. Pending applications should be shown on the website. Every five years the schemes should be revised. Licences of all NGOs should be renewed every three years instead of annually in order to reduce the paperwork and other formalities.
- *Public-private partnership* can be put in place. Industries can come up to join the partnership as part of the corporate social responsibility and create a stronger finance base to improve the quality of services provided.
- *Inter-sectoral convergence* in the functioning of health, women and child development, social justice, human rights, rural development, Panchayati Raj, should be facilitated with particular reference to women.
- *Effective implementation of RMK* should be encouraged at all levels regarding micro credit. A complete overhauling of the RMK scheme is required in terms of increase in the loan amount; simplification of the application procedure along with an effective monitoring system in place. A state office can help in looking after the administration and functioning of the scheme in that particular state. Selection of the NGO selection in the scheme implementation must be rigorous and based on long-term partnerships with the selected agencies.
- *Laws for prevention of violence against women* should be strictly enforced at various levels. Better awareness should be generated at the community level regarding the Act and its provisions. The law should be translated into vernacular languages and a district- and block-level task force should assist in enforcement of the Act. The protection officer under the programme should be better trained and vested with more powers for a proper discharge of duties. The office of the District Collector and family counselling centre should work in coordination for a better implementation of the provisions. Follow-up action on provision of monetary relief should be taken, so that the victim gets it well in time. The other agencies like the police and the lawyers should be better motivated for a sensitive handling of cases of domestic violence. Legal cases should not take more than 60 days in court settlement.
- For the generation of better awareness amongst the public, a display board in public buildings mentioning the name and telephone number of the protection officer, service provider, etc. should be put up. The 'bell *bajao*' campaign should be broadcast in regional languages and redesigned so that the meaning and objective of the advertisement reach the people successfully.

Minorities

- *Building awareness about government schemes and programmes* can be done by printing the guidelines in local languages and made available at different, convenient points, i.e. education institutes, religious centres, *madarsas*, Panchayats, etc. The information can be telecast in a campaign mode on the electronic

media. Awareness should be generated amongst both the minority section as well as the general public. Possibilities of National Minority Development Finance Corporation (NMDFC) and state based funding arm to hold scheme-related publicity in minority-concentrated districts of the country should be explored to ensure better reach of the schemes.

- Members of the Minority Commissions at the state and district levels should galvanise the NGOs so that messages on the schemes reach the minority community.
- The possibility of earmarking a certain percentage of the funds in the schemes for the purpose of local publicity should be explored, for example, printed posters on the schemes must be displayed at prominent locations, such as minority schools, religious places, NGO offices, Panchayat Bhawans, etc.
- *Simplification of the application process and transparency in selection* should be brought to the notice of the applicants. To rationalise the processes of applications received from students, a fixed cut-off percentage should be specified in advance in the advertisement so that students with low scores do not spend funds to apply for scholarships where they do not stand a chance of receiving it. This will improve the scheme implementation; reduce the processing time while sparing the poor students from bearing unnecessary efforts and expenditures.
- *Increased fund allocation* should be made for the existing schemes and programmes meant for the minority section. The schemes must be revised with an increase in the funds provided.
- *Education schemes*, where scholarships are integrated and distributed through the Sarva Shiksha Abhiyan and increase in scholarship funds, provision of free coaching facilities, etc. should be given preference.
- *National Minority Development Finance Corporation* should revise the amount of finance provided and increase the repayment duration from the current two years to three to five years.

Handicrafts and Handloom

- *Awareness and information dissemination* about the available schemes and programmes through the mass media should be put to use by involving the NGOs and ensuring that the beneficiaries become better aware.
- *Partnerships with NGOs* have proved successful programme.
- *Monitoring of schemes and programmes* through a system of regular feedback from the artisans and the implementing agencies must be put in place. To bring in more transparency, NGOs can be involved in the monitoring exercise.

  Export promotion can be given a fillip by streamlining and developing the skills of the artisans, particularly in context of the high value accorded to handicrafts and handlooms of India.
- *Market orientation and promotion* of local artisans will help in building market linkages at different levels.
- *Integrated development through cluster development* and systematic mapping of artisans depending on the crafts practiced should be done at both the state and district levels to improve the handloom and handicraft sector.
- *Integration of programmes and schemes* can improve the outcome and smoothen out the process of implementation, monitoring, follow-up and linkages of various schemes and programmes under a single umbrella. These programmes should further be converged with different sectors.

Chapter: 1

Health Issues

The National Rural Health Mission, launched in the year 2005 and framed initially for seven years, from 2005 to 2012, aims at the architectural correction of the public health system in order to provide accessible and affordable health services to the poorest households in the most remote parts of rural India. The implementation framework of NRHM and thereby its design stand on four pillars of community involvement -- flexible financing, improved management, innovation in human resource management and monitoring progress against standards. The NRHM is an attempt to craft credible public health systems so that specific health programmes, such as reproductive and child health, vector-borne disease control, tuberculosis control, blindness control, leprosy eradication, iodine deficiency control and integrated disease surveillance programmes achieve their stated objectives. The NRHM is firmly entrenched in the sprit of decentralisation. The provision of flexi financing is included to largely support the state initiatives to address the gaps in the health systems.

The mid-term appraisal of the Eleventh Five-Year Plan carefully assessed the implementation of various health sector schemes and programmes through the eyes of the people in the state-level consultations organised nation-wide. These deliberations aimed at getting feedback from the community on the manner in which GoI programmes in the health sector influence the life of the common people. Some of the overarching principles adhered during facilitation of discussions were:

a. Equity in access to health services (SC/ST/minorities/ landless labourers/ other marginalised population groups)

b. Access to health services (geographical and social)

c. Quality (availability of drugs, privacy, providers' behaviour/attitude)

d. Cost of services, direct or indirect, incurred by patients and their families in seeking care from public facilities

e. Cash benefits realised in different schemes

The following sections are the outcome of deliberations held nation-wide and share the concerns and recommendations of the participants. They share the community perspectives with a special reference to the delivery of services and their utilisation by the poor and vulnerable sections of the population.

Section – 1

The health schemes and programmes broadly covered under the review process have been those related to RCH as well as other health issues impacting the health of women. It also includes health issues, such as communicable diseases and interaction with health systems in the larger context of primary health care/NRHM.

The concerns of the participants were put across scheme-wise to highlight the specific scheme-related gaps and success factors more blatantly.

A. National Rural Health Mission – Reproductive Health including Child Health

i) Maternal Health: The RCH programme is a flagship programme within the NRHM. The annual programme implementation plans, formulated by the states, spell out interventions to increase access to quality package of RCH services, including maternal health. The technical interventions in maternal health aim at a universal coverage with focused ANC, skilled attendance at birth, access to emergency obstetric care for management of common obstetric complications and access to early and safe abortion services. Grassroot volunteers, such as ASHAs, have an important role to play in mobilising women for intuitional deliveries.

ii) Village Health and Nutrition Day is a community-based initiative which serves as the first point of service for poor women and children. NRHM guarantees once a month availability of a package of RCH services in the village. As per the NRHM guidelines, the Village Health and Nutrition Day should be observed in every village every month. This provides a platform to encourage interface between the community and the health system. This combined effort at the community level has to be carried out by the frontline health workers, i.e. ANMs, ICDS workers and ASHAs.

Participants interacting during the state level Consultation in Orissa

Views of the Participants

Success

- ❖ Generally speaking, there is awareness in the community about the VHND in the villages. However, these days ICDS Centres are still identified with immunisation services.

Concerns

- Awareness level has been found low with respect to the complete package of services and also the specific nutrition days. Similarly, there is very little engagement of the PRI or VHSC members in the organisation of the Village Health and Nutrition Days.
- ❖ Village Health and Nutrition Day per se was not a commonly known concept in the rural areas, barring a few pockets in states like Tamil Nadu and Andhra Pradesh in the south and Assam in the north-eastern region.
- ❖ There are days fixed for immunisation whereby the community members interact with the ANMs, ICDS workers and ASHAs, who work together to provide their services.
- ❖ Geographic variations act as a hindrance in the provision of services. In the hilly and remote pockets of the country, the immunisation days are neither regular nor uninterrupted. In most places in the north and north-eastern region, immunisation is done at the health centre (mostly at the block or district level) and the local beneficiaries are compelled to travel long distances in order to get their children immunised. This happens as the houses are sparsely located and the health workers avoid traveling door to door for immunisation. In the accessible and plain lands, where there is good road connectivity and the block and district level infrastructure is adequate, the immunisation programme is adhered to as far as possible. .
- ❖ Absence of complete coverage of maternal and child health services is a common phenomenon. Even on immunisation days, the ANC-related awareness is lacking. Health workers leave soon after completion of the immunisation task.
- ❖ ANC services to pregnant women are not adequate. Distribution of IFA tablets and TT as part of the ANC are not regular and sufficient.
- ❖ Patient's privacy during ANC services is not ensured, especially during abdominal examination and other checkups. Health workers do not carry sufficient supplies of testing strips for urine checkup or pregnancy test kits, etc.
- ❖ The ANC sessions do not cover the family planning services and services for adolescents.
- ❖ Geographic variations are not taken into account during the appointment of health workers (ANMs, ASHAs, ICDS workers). The national standard of appointment of one ANM per 5,000 population, one ICDS worker per 1,000 population and one ASHA per 1,000 population is not suitable for all regions, especially in the hilly regions where 1,000 population is spread across a larger geographic area. This makes it difficult for the health worker to cover this population and provide them the required health services.

iii) Janani Suraksha Yojana (JSY) is an integral component of RCH-2/NRHM to promote institutional delivery. The JSY scheme is a conditional cash transfer scheme to encourage pregnant women to deliver in the institutions. The ASHAs in the villages are expected to identify pregnant women, get them registered for ANC, help develop micro-

plans and accompany them to the nearby health centre to facilitate institutional deliveries. It also involves ante-natal and post-natal care and follow-up of pregnant women. There is provision of cash assistance for both ASHAs and pregnant women for transportation and other expenses to mobilise and ensure institutionalised delivery.

Views of the Participants

Success

- Awareness and usage about JSY has been impressive in most states as evident from the rise in institutional deliveries.

  During our deliberations this was confirmed, as poor women from the remote districts of Bihar and Orissa were found visiting health care centres to avail the services.

Concerns

- Though the programme has been well received at the community level, there are still several gaps in terms of awareness at the community level regarding their entitlements.
- Delay in the release of financial provisions, both for the ASHA and the pregnant woman, is a common occurrence. It also breeds many corrupt practices.
- Absence of support after delivery has been cited a major reason for compelling a pregnant woman's family to incur a lot of informal expenditure in the institutions after delivery. This turns out to be much more than the amount that they receive.
- The health centres, as revealed during the deliberations, are not fully geared up to cope with the increase in demand, thus affecting the quality of services.
- Geographical variations (plain/hilly regions) were not considered when formulating the scheme of plan under NRHM services. Participants pointed out that the government had not taken into consideration the inaccessibility of certain areas in the hilly regions.

People's Voice

West Bengal

Success Stories

Saraswati Mandia, a member of a self-help group in *Bankura district* of West Bengal participated in the consultations and said that her community members were aware of the Janani Suraksha Yojana. She was aware that the mother would receive Rs 500/- after delivery but no arrangement was forthcoming for meeting the expenses incurred in commutation. Support groups were present in Bankura and they do discuss birth preparedness and how to save money and grain as an act of delivery preparedness. What is more, not only the members of the women support groups were oriented; even the male members of the community participated in the discussions. Some cases of delivery are still handled at home but mothers in Bankura district do not receive and money if the delivery is conducted at home.

Sounak Basu from *Jalpaiguri district* informed that the government hospital provided additional support and incentive in the form of clothes besides giving Rs 500/- to pregnant woman. This has prompted a greater number of expectant mothers availing the service.

Limitations: In *Purulia district,* due to bad roads, vehicles cannot move smoothly. Women in advanced state of pregnancy or on the verge of delivery are not able to reach the hospital. What is more, the *ASHAs are neither skilled nor willing to help them in case of an emergency*.

- ❖ In the absence of any provisions for accommodation near the health institutions or related expenses, pregnant women even in their third trimester are compelled to travel on hilly roads in order to avail the institutional services.
- ❖ The frontline health workers, especially the ASHAs, are not well trained to handle critical cases or even manage delivery cases in an emergency situation.
- ❖ Health institutions are not well equipped for conducting delivery at the village or at the block level due to unavailability of doctor or uninterrupted electricity supply, equipments, infrastructure, etc.

iv) Family Planning: The family planning strategy in RCH-2 under the NRHM focuses on meeting the unmet demands for family planning by creating awareness about the method choices and contraceptive use, counselling and services available to the community. Male participation and services for adolescents show an increase as the programme provides for wage compensation to sterilisation acceptors. Additionally an Indemnity Insurance Scheme has been launched to cover empanelled providers as well as acceptors who report failure, any major complication or death following sterilisation. The programme also aims to involve the private sector in delivery of services. ASHAs are expected to serve as depot holders for non-clinical contraceptives, such as condoms and oral contraceptive pills.

Views of the Participants

Concerns:

- ❖ Unavailability of contraceptives: There is no regular supply of condoms/oral pill/emergency contraception pills at the community level. Assured availability of reversible contraceptives at the village level is rather limited. VHNDs are neither popularised as a source of providing family planning services and nor are these services available. Some participants complained that at the village level, even when contraceptives were available with the ANM, their quantity was either insufficient or their supply irregular.
- ❖ People are of the view that the condoms available in health centres are of inferior quality. In most areas, people are either unaware about the depot holders or social marketing outlets or such depots do not exist at all in many places.
- ❖ People don't have access to *emergency contraceptive pills* which are not provided through the government health system.
- ❖ IUD insertion is a commonly adopted measure for practicing family planning among women. The men-folk were found reluctant to accept vasectomy due to the prevalence of myths and misconceptions which need to be addressed in order to promote male participation.
- ❖ Lack of follow-up after sterilisation, even to manage cases of minor complications, was cited as one of the concerns. It was clear from the discussions that at the community level, there was no awareness about the provision of compensation in cases of failure or some major complications. *However, a case was cited where it was informed by the doctors that no provision for compensation had been made in such cases.* Though private providers are providing sterilisation services, wage compensation to the acceptors is not forthcoming and this deprives them of their legitimate right.

v) Safe Abortion: Complications due to unsafe abortions contribute significantly to maternal morbidity and

People's Voice

From the discussions in the ***Western Regional Consultation,*** it became evident that abortion faces a lot of social stigma. For various reasons, people avoid visiting a government hospital for Medical Termination of Pregnancy. Privacy and confidentiality are not maintained in health centres. Functionaries at the government health centre ask embarrassing questions, making the patient feel uncomfortable. There are even complaints of mental harassment.

Rajasthan: A participant from Rajasthan said that most women preferred to go to an untrained health worker or a *dai* for abortion, instead of visiting a government health centre. In case the patients are financially better-off, then they prefer to go to a private practitioner. A participant from Madhya Pradesh revealed that private practitioners surreptitiously conduct sex-selective abortion in the second trimester knowing well enough that it is not safe for the mother. There were many instances where providers seek unauthorized payments taking advantage of situation where woman is desperate to get rid of an unwanted pregnancy.

mortality. Though India is one of the few countries to have progressive laws for increasing access to safe abortion services, a large majority of women avail of unsafe abortion services from unqualified and unregistered providers. The government-run programme aims at introduction of safer and non-invasive methods along with training of service providers who can provide services at 24x7 PHCs and CHCs, including FRUs.

Views of the Participants

Concerns:

- Discussions and regional consultations in the state on this issue revealed that abortion is still considered a taboo as it is not accepted as a woman's right to freely access the services for termination of pregnancy under the clearly spelled out conditions in the MTP Act.
- In government health centres, the woman patient and her caregiver have to confront stress and unpleasant enquiries while going in for an abortion. Expert doctors for medical termination of pregnancy are not easily available at the PHC level, as result of which it is not feasible to opt for an abortion in these centres.
- Private doctors, in their bid to seek quick monetary benefits, often tend to ignore the specifications for conducting a legal abortion as laid out in the MTP Act and carry out abortions even in the second trimester of pregnancy. What is worse, pregnant women often tend to visit traditional practitioners and untrained birth attendants for abortion, which is very dangerous for their life
- IEC activities related to safe abortion services are not seen in the field. ASHAs themselves are not aware of the places where safe abortion services are

available, then how can they guide a poor woman who requires such services.

***vi. Child Health*:** Under the NRHM, specific evidence-based technical strategies are designed to reduce infant/child mortality and morbidity. Immunisation against contagious diseases is one such intervention that is visible on the ground. There is provision of treatment of sick and malnourished children in the nearest health centre. Management of diarrhoea by providing sufficient ORS and case management of ARI is also included in this programme. Promotion of breast feeding is also an important component of the service delivery package.

Views of the Participants

Concerns:

❖ *Immunisation of children* is commonly resorted to in most villages. However, regular and uninterrupted immunisation is possible in areas which are well connected to PHCs/ CHCs/ district health centres where the necessary infrastructure is well in place and the cold chain is maintained.

✦ In the hilly regions, due to lack of transportation and difficult access, the health facilities are irregular. In these places immunisation is not done at the village level and is organised at the block-level health centres. All states with hilly and remote geographic spread, such as Arunachal Pradesh, Assam, Sikkim, Meghalaya, Mizoram, Manipur, Tripura, Orissa, Jharkhand, Chhattisgarh, Uttaranchal, Himachal Pradesh, Madhya Pradesh and Uttar Pradesh share drawbacks which pose a major challenge to health care providers. It is difficult for the mother to travel such long distances to get their children immunised. Information regarding immunisation does not reach them in time and it is difficult for the ANMs to travel with immunisation vaccines from one corner of the village to another due to the difficult and hazardous hilly terrain.

Mr. Mihir, Programme Officer at Gujarat VHA sharing the ground realities of the implementation of various Govt. Schemes

- ✦ In the plains also the immunisation services are not regular. In certain months in a year when there is a flood or any other disaster, the immunisation service gets disrupted. In many areas, due to unavailability of electric supply, insufficient health equipment and infrastructure the cold chain cannot be maintained, leading to irregularity in the immunisation programme.

❖ One of the objectives of ASHAs is to spread awareness about breastfeeding. The work is incentive based but since these incentives are negligible, the ASHAs prefer to work where they get better honorarium. However, some ASHAs are doing their bit by taking proactive initiatives to create awareness on breastfeeding.

- ✦ Post-natal care is almost absent in most areas. Workers at the ICDS Centres can do this work but their focus remains more on the supply of food and dry ration to children and pregnant women. Neither the ANMs nor ASHAs pay regular visits to the residences of pregnant women or lactating mothers for creating awareness and to follow up the cases.
- ✦ It has been accepted that the ASHAs are not competent enough to spread awareness as their own knowledge level is not adequate. Unfortunately not much effort has been put in at capacity building of the ASHAs. In many cases, mothers start giving supplementary food at a very early stage as they often complain of not getting adequate breast-milk. In such cases, it is the duty of the ASHAs to check whether the nutritional status of the mother is adequate, whether the child has any other health problems or whether the method of breast feeding is proper. But there is no scope or skill available to address these issues.

❖ *Oral rehydration solution* sachets are not adequately available in villages with ASHAs or even in the health centres. Usually doctors or health workers advise the patients to buy it from outside. In case of diarrhoea outbreak, emergency care services are not available as doctors are not available in the centres. One can find doctors only at the district-level health centres and in some places at the block- level health centres.

❖ *Inadequate staffing of PHCs and sub-centres* is a common phenomenon. Either doctors are not regularly available or are not posted. It becomes difficult to address the cases of ARI without a doctor. Thus ARI cases remain unattended as the villagers find it difficult to take the child to the district health centres in case of an emergency.

People's Voice

In the ***north-eastern states,*** especially in the hilly regions, immunisation services are not regular and children do not get complete immunisation services. Health workers do not go from village to village for immunisation due to difficult geographic accessibility. Immunisation is done at the block level where there is adequate infrastructure to maintain the cold chain. But for mothers to travel such a long distance to get their children immunised is not easy, resulting in limited use of such services and the children fail to receive regular and complete immunisation.

Similar cases were reported from the hilly and tribal pockets of other regions too.

People's Voice

Jharkhand*:** Ms Priti Sworen Kujur, a resident of Jharkhand state, revealed the story of a case where a community member was diagnosed with HIV in the village some five to six years ago. The health centre doctor, who had diagnosed him with HIV/AIDS, shared this piece of information with some of the employees in the health centre from where it spread all over the village. The patient was then ostracised and alienated by the villagers. This is an example of ***lack of confidentiality followed in the government-run health centres in HIV cases. People thus usually avoid going to the nearest centre to get tested for fear of the social stigma attached in case the news were to spread in their localities, since they have already seen its repercussions.

B: Other Health Issues

***i) HIV/AIDS*:** Technically speaking, HIV/AIDS control is not an integral component of the NRHM. The National AIDS Control Programme-3 (NACP-3) was launched in the year 2006 as a programmatic response to reverse the epidemic.

Views of the Participants
Concerns represent both challenges and work at the grassroots:

- Participants felt an increased need for creating intensive awareness, testing and counselling services at the block and community level.
- The treatment for ART and ST is available at the district health centres. However, these services are not available at the peripheral level, thus compelling the patient to travel long distances to obtain medicines. This limitation either makes them discontinue the treatment or opt for high-priced private treatment.

***ii) Malaria*:** The National Vector-Borne Disease Control Programme is implemented across the country to reduce the incidence of malaria and prevent its spread, morbidity and mortality, as an integral component of NRHM. Rapid Diagnostic Kits (RDKs) are provided in the identified endemic districts so as to ensure early detection, and timely treatment of the disease. Similarly bed nets and more effective drugs are being made available. In some states, ASHAs are being trained in conducting blood tests using RDKs.

Views of the Participants
Concerns:

- *Awareness about the programme activities* is not good. Wherever there is involvement of NGOs the awareness and implementation status is noticeably better.
- *Facilities are not adequate.* The RDK supply is not at all adequate in many endemic districts in the eastern states of the country.
  - In some of the endemic areas, people informed that the RDKs available had crossed the expiry period. The medicine supply is also not regular and people have to buy medicines themselves. There are no trained persons to collect the slides.
  - The bed nets supply is also not sufficient. The participants also said that the system of distribution of bed nets is faulty as the whole family cannot sleep in one net.

- ❖ Spray of insecticides in the village is not done regularly. The participants informed that they did not even remember the day when the team had last visited their area.

***iii) Tuberculosis*:** The National Tuberculosis Control Programme aims at reducing the incidence of tuberculosis through early diagnosis and prompt treatment made possible by its network of Directly Observed Treatment Short-course (DOTS) centres and providers. The patient is to receive treatment until he/she is cured.

Views of the Participants
Success:

- ❖ Some success was reported in achieving the target of the programme through better services at the grassroots, with rigorous efforts to ensure patients' regularity in availing the treatment at government health centres.

Undoubtedly the deliberations were successful in bringing together the concerns of the participants regarding the RNTCP implementation.

Concerns:

- ❖ Quite often diagnostic services such as sputum examination are not available at the local facilities.
- ❖ The people who are migrating to other areas for work find it difficult to get DOTS at their work site due to the absence of permanent address proof in that area.
- ❖ Sometimes the supply of DOTS drugs is interrupted, forcing the patients to wait till the supply come.

People's Voice

Orissa - Kandhamal is a declared malaria endemic area in Orissa. But adequate services are not available.

"The home visits of ANMs are sporadic and if by chance they come across any case during their irregular visits, they suggest the patient should visit the sub-centre for blood test. Only in case of frequent and repeated incidences of malaria, a team from PHC visits the cases and collects slides for blood test. In other districts the situation is more or less the same." This is the level of operation in the malaria-endemic areas in Orissa as per Mr Rabindra Singh from Kandhamal district.

Sikkim – As per Dr B.B. Rai from Sikkim, the situation is no different is Sikkim, "*The ANMs do not go for regular home visits or check-ups. If they come across any suspected case, they suggest the patient to go to the ANM for blood test. If they find that the patient is suffering from fever for three or four days, then they refer him to PHC/CHC for blood test and treatment. After having information from AWWs, ANM visits the malaria patient but not regularly."*

West Bengal - "*The PHC in the Canning Block in S-24 Parganas of West Bengal is staffed with both doctors and nurses and the hospital is well equipped. But when it comes to service provision at the community level, there is a huge gap. The malaria cases are not identified or referred regularly by the ANMs."*

Section – 2

Recommendations

After a detailed discussion on the government health programmes under the umbrella of NRHM as well as other significant ones like RNTCP, NACP-3 and National Vector-Borne Disease Control Programme, different regions/states based on their experience came up with

some definitive suggestions towards an improvement in the current state of affairs. These suggestions are aimed at improving the implementation and outreach of these programmes.

- *Building awareness about government schemes and programmes:* From the discussion in various settings, one of the common findings was that there is inadequate information at the community level regarding various schemes and programmes of the health sector. The community does not have adequate knowledge about the programme and thus does not demand its entitlements. Through community-level IEC activities, awareness programmes through NGOs, information dissemination through mass media, the schemes can be made popular and known amongst the common people.
- *Capacity building of ASHAs and other frontline health workers:* ASHAs, ICDS workers and ANMs are involved in the implementation of different health programmes at the community level. They are the nodal point of contact between the community and primary health care services. It is thereby vital to build the capacity of ASHAs to better address the primary health care issues, of ICDS workers who deal with children, pregnant women and lactating mothers on a regular basis and of the ANMs responsible for mobilising different health programmes at the community level. There should be skill building of this cadre of health functionaries as per the roles assigned to them.
- *Strengthening the health committees:* The health committees formed at different levels should be formalised and their roles and responsibilities finalised in consultation with them. They should be empowered to take decisions and follow up the actions. The health committee members are generally from different fields such as tfhe health system, PRI, general administration, civil society organisations, etc. Thus they may not possess adequate knowledge about the schemes and programmes they are supposed to deal with. Hence, there is a need to orient them on the programmes, its components and the related issues.
- *Intersectoral coordination among different departments***:** Community health and health of mother and children cannot be dealt in isolation and only with the efforts of one sector, i.e. health. In fact there is a need for a coordinated approach involving different sectors. The departments for Women and Child, Water and Sanitation, PRI, Social Justice, Labour, Law, Rural Development, etc., should have a coherent approach developed through mutual understanding to address various critical issues influencing health at the community level. This coordination should be extended much further and should work effectively at the community level.
- *Special package for programmes and schemes for hilly and difficult regions:*
  - It was clear from the state- and regional-level deliberations that the hilly regions face a separate set of problems, which have not yet been addressed adequately in any of the health programmes. The financial provisions, standard population size as per the service coverage of health workers or health centres, etc., are some of the provisions to be decided, keeping the geographic variations in view. There should be separate packages designed for these areas.
  - The otherwise successful programmes, like the JSY, should have the special component designed for regions (hilly/desert/plains, etc.) having geographic limitations.

- ✦ Pregnant women, especially those in hilly locales, cannot travel in the advance stage of pregnancy. Hence, there should be provision for two to three months' accommodation expenses near a well-equipped health centre, apart from transportation arrangements to be provided by the government health system at the community level. The sub-centres should be equipped to handle critical childbirth cases as travel in such conditions is risky in hilly areas.
- ✦ In order to attract a skilled workforce (doctors/ paramedics) and ensure their stay in the government health centres located in such difficult regions, their salary structure should be improved.

❖ *Strengthening the health infrastructure and institution*: A lot of commitment has been made under the Eleventh Five-Year Plan which needs strong infrastructure support. There is a need to ensure proper health infrastructure with sufficiently equipped infrastructure and adequately staffed institution. The commitment of 24 X7, institutionalised delivery, family planning interventions, ARI, treatment for diarrhoea, malaria, TB, etc. needs a lot more effort than what exists. Medicines, ORS, etc. should be adequately and regularly available in the health centres at different levels.

❖ *Morbidity mapping*: There should be scientific mapping of areas as per prevalence of different diseases. Climatic issues and geographic location should also be considered while doing the mapping exercise. There are some serious health problems which have state- or region-specific concerns, such as HIV/AIDS, malaria, chikungunya, kalaazar, etc. Improved surveillance, monitoring and prevention and treatment procedures should be planned separately in accordance to the seriousness and prevalence in the areas.

❖ *Enhanced honorarium/incentives to the ASHAs:* The incentives to ASHAs are activity based and release of this incentive is not as streamlined as visualised.

- ✦ As shared by the participants, the ASHAs are required to give a lot of time, effort and sometimes money in order to get their due. With these constraints, it is coming to notice that the ASHAs are focusing more on incentive-based health activities.
- ✦ To ensure a better functioning of this sector and to ensure that the workforce shoulders maximum responsibilities at the grassroots, it is important to increase their payment with some system of regularisation in the release. They should be given specific roles and responsibilities to perform.

❖ *HIV/ AIDS awareness, care and support:* HIV/AIDS is an alarming health issue in our country.

- ✦ This is more serious in the north-eastern states, regions from or to where migration happens frequently and hilly areas. In these areas and beyond, awareness of preventive measures and treatment aspects should be massive. The social stigma attached to HIV/AIDS needs to be reduced.
- ✦ Participants from the difficult pockets, the hilly regions, suggested that care and support along with treatment should be available at the block level. Due to difficulty in travel, the patient cannot come to the district health centre to avail the treatment.

- ✦ There were also proposals for *increase in the number of mobile ICTCs* so that a large area of difficult access can be covered.

❖ *Public private partnership***:** The health programmes with a PPP approach have by far delivered good results. This approach must be then introduced for a better implementation of various other health programmes, like PHC management, malaria control, immunisation campaign, HIV/AIDS programme, etc.

- ✦ With an involvement of the non-government organisations having community presence, the awareness generation about government schemes can be more effectively done and people's participation can also be ensured.
- ✦ Under PPP there should be equal stake of both the government and non- government sectors. The fund release should be timely and regular. There should be official guidelines for NGO selection and further work.
- ✦ Budget-head for the health programmes should be planned specifically. It is observed that the flexi funds which are meant for the mother NGO programme are diverted towards other expenses, such as payment of salary to the staff, thus delaying release of fund for the said purpose.

❖ *Regular joint monitoring of the programmes***:** The health programmes implemented across the country should be monitored regularly and there should be a joint representation of government and non-government agencies in the monitoring committee. Following the careful identification of the gaps, rectification measures should be planned and implemented.

❖ *Revisiting the family planning programme***:** Education and awareness about the reproductive health issues should be initiated with the adolescents.

- ✦ There should be wide information sharing on various contraceptive choices available and the venue.
- ✦ Compensation in case of any mishap should be shared with the community and action should be taken to help the victim in getting the compensation.
- ✦ Depots should have a regular supply of contraceptives.
- ✦ Contraceptives such as condoms, oral pills and emergency contraceptives should be made available adequately.

❖ *JSY should include complete ANC and PNC:* The Janani Suraksha Yojana is a very fruitful effort and is working well on the basis of incentives.

- ✦ *Building on its success:* It was recommended that the JSY should cover the entire ANC phase and the ASHAs should be involved from the very beginning of pregnancy and should also help in birth preparedness.
- ✦ There should be incentives at different levels.
- ✦ The JSY should also have provisions for accommodation of the ASHA while she is staying near the health centre at the time of delivery.
- ✦ Involvement of ASHA in PNC can also ensure mobilising of awareness about family planning, exclusive breast feeding, etc.

Chapter-2:

Women Issues

Despite getting suitably politically empowered, the Indian woman continues to lag behind on almost all crucial developmental parameters like education, health and economic participation. They constitute half the country's 1.2 billion population and make up a whopping 340 million voters out of a total electorate of 710 million.

There have been efforts to address the gender-related issues concerning women and their development through the country's Five-Year Plans, assuring more resources to their welfare and development. The Eleventh Five-Year Plan has assured some important commitment for the uplift of women's population and their overall development for establishing an equal society. Stress has been given on gender issues and budgeting, along with schematic approaches to address different social and economic issues and challenges faced by women. The Eleventh Five-Year Plan has committed for some important achievements by 2012, such as:

- ❖ Sex ratio for age group 0–6 to be raised to 935 by 2011-12 and to 950 by 2016-17.
- ❖ Ensuring that at least 33 per cent of the direct and indirect beneficiaries of all government schemes are women and girl children.
- ❖ Ensuring that all children enjoy a safe childhood, without any compulsion to work.

During the mid-term appraisal of the Eleventh Five-Year Plan, the participants comprising representatives from SHGs, PRIs, NGOs, community members, Central and state governments from across the country articulated the impact of various schemes and the effectiveness of the acts passed for the protection of women. The following sections have captured the voices of the participants sharing the community perspectives with a special reference to the delivery of services and their utilisation by the intended beneficiaries. It also sheds light on the recommendations by the community stakeholders to improve the modalities of implementation of these various women's welfare-oriented schemes.

Participants of the Regional Consultation for the Southern Region

Section – 1

The concerns of the participants have been put across scheme-wise to bring forth the specific scheme-related gaps clearly.

i) Short Stay Homes

The purpose for the establishment and development of Short Stay Homes (SSH) has been to address the critical needs of women and girls in the most distressed and difficult situations. These are institutional arrangements with counselling, guidance, medical check-up, psychiatric treatment and skill development facilities, in order to help women in distress to rehabilitate themselves within a short period of time. These centres are to be established and run by voluntary organisations.

People's Concerns:

- *Quality of services*: It was a common concern shared in most of the state deliberations that the facilities provided at Short Stay Homes are inadequate to provide physical or mental solace to any woman in distress. Even the basic requirements such as food, clothing, sanitary conditions, etc., are barely met.
- *Poor counselling facilities*: With the entitled budget it is difficult to hire services of qualified and experienced counselors, thereby causing poor mental health support to the inmates.
- *Insufficient budget allocation*: As per the representatives of the organisations running such centres and inmates, the budgetary provisions to run such homes does not provide any scope for improvement in the quality of services. Even such limited funds are often not released in time.
- There is a provision of Rs 500/- per inmate per month for the expenses towards food, clothing, medical and any other specific requirement. With such a small amount available per inmate, despite the provisions for recreational and cultural activities, they are often difficult to promote.
- There is a provision in each of the SSH for the stay of 30 women and seven children for a minimum period of three months to maximum three years. But in reality much more than the strength of the centre actually stay in most of the SSHs and for a longer period. The amount of funds available for the stay of children is also very minimal to address their critical needs.
- *Lack of medical support:* As per the provisions of the scheme, the inmates of SSHs should be given free

People's Voice

Sanu Tamang, an inmate in the N 24 Praganas of ***West Bengal*** shared her experience in the Short Stay Home-

"Our home is in Jalpaiguri. The name of the SSH is Khanikalaya, a Central Social Welfare Board supported programme. It was started in 2005 with a capacity of 30, though there are 77 inmates staying there currently. Medical camps are organised twice in a month. However, there is no provision for medicines or further treatment.

There are several other problems in the home, like if somebody falls sick and needs hospitalisation, she is not actually hospitalised due to the paucity of funds.

When a woman comes with children, then it becomes even more difficult and other basic facilities are also compromised, which are already of very inferior quality. We understand that these homes do not get money in time. There are no adequate provisions to meet different expenses. These homes are not in a position to fulfil even our basic needs. In a situation of distress, these homes do provide an option but the associated difficulties cannot be ignored."

medical treatment facility in the government medical centres. But this is not happening in reality. There is no support from government health system.

- *Non- availability of updated vocational training*: The vocational training provided to the women is insufficient, stereotypical and very traditional. Skills such as tailoring, coir-rope making and basket weaving have very limited market scope. Most of the skills are not market oriented, thus limiting the chances of inmates becoming capable of having a self-sustainable livelihood. Also, the training duration of three months is too short to train the inmates adequately.

ii) Family Counselling Centre:

The family counselling centre is set up with the objective to address and solve issues relating to dowry-related harassment, domestic quarrels, alcoholism, domestic violence, divorce and other such incidents. Through face-to-face interaction with a counsellor, it helps the individual to come out of the problems.

People's Concerns:

- *Lack of infrastructure*: The family counselling centres are not effective for proper counselling in the absence of a helpful, personalised environment.
- *Insufficient fund allocation and irregular release*: The budget allocated towards meeting various components of the scheme is too little to provide appropriate services to the clientele. Irregular release of the limited funds further deteriorates the quality of services.
- *Lack of convergence*: Despite the convergence of objectives, the functioning of the family Counselling centres and short stay homes is not aligned, making it difficult to establish further linkages. The family counselling centres are also not linked with various other government and non-government agencies which can extend further support.

People's Voice

North-eastern States: The existence, functioning and awareness about the family counselling centres in the north-eastern states is almost negligible. Very few people know about them and often mix them up with the short stay homes, which are also very few in the north-east.

Bihar: Participants from Bihar had many concerns as well as suggestions for an improvement in the functioning of the family counselling centres. Mrs Devika Biswas mentioned that the *honourarium* of the counsellors of these centres is very low and since their salary is disbursed by the government department, the counsellors have the notion that they are government employees. Despite the centres being managed by the NGO, they gradually feel less accountable to the NGO.

There is no system of referral and rehabilitation of the clients who come for counselling. Provisions of legal aid, police support and medical assistance cannot be given to them. There is no linkage between family counselling centres and short stay homes. The fund allocation for the centre is very minimal and the fund flow is irregular.

iii) Support for Training and Employment Programme for Women (STEP):

STEP is a programme designed for women from the section of daily-wage earners, unpaid daily workers, female-headed households, migrant labourers, tribal and other backward groups such as Scheduled Castes and Scheduled Tribes, and families in the category of BPL. STEP aims to mobilise women in small viable groups and make the facilities available through access to credit. It is also meant to provide training for the skill upgradation of these women with support for employment opportunities. The scheme covers 10 traditional sectors of employment such as agriculture, animal husbandry, dairy farm, fishery, handlooms, handicrafts, *khadi* and village industries, sericulture, social forestry and wasteland development.

People's Concerns:

- *Lack of awareness*: There is very less awareness among the participants regarding the STEP programme. Very few people were aware but none have seen the actual implementation of the scheme.
- *Rigidity of the guidelines*: Amongst the participants, a minimal ratio is aware of the programme. They shared the fact that the guidelines of the programme are very rigid, with practically no flexibility to change them as per local needs.
- *Lack of allied support*: Though the programme encourages mass production, no steps have been taken for a market linkage of these products. Other related components, i.e. the scope for design development, market study, promotion, etc., are not an integral component of the programme.

iv) Rashtriya Mahila Kosh (RMK)

RMK was set up in March 1993 as an independent registered society by the Department of Women & Child Development in the Government of India's Ministry of Human Resource Development. The RMK is constituted to offer certain services and facilities to the poor women of the country. It aims to provide or promote the provision of micro-credit to poor women for income generation activities or for asset creation. The RMK sets its guidelines to adopt a quasi-informal delivery system, which is client-friendly, uses simple and minimal procedures, disburses quickly and repeatedly, has flexibility of approach, links thrift and savings with credit and has low transaction costs, both for the borrower and for the lender.

People's Concerns:

- *Low awareness level*: The awareness level about the programme is very low among the community members.
- *Lack of transparency*: In the states of Jharkhand, Orissa, Madhya Pradesh, Uttar Pradesh and Rajasthan, the nodal agencies are not transparent. They are giving money to the NGOs at a very high rate of interest, which is much higher than the rates of RMK. Money is not reaching the actual needy women. In most of the states the scheme is not successful.
- *Lack of human resource base*: The offices managing RMK are overburdened and staffed inadequately. One office is coordinating five to six states, affecting the efficiency of the limited staff.
- *Varying rate of interest*: In many places NGOs are taking money at less interest, but they are giving it to the people at a higher rate of interest. The correct rate of interest charged by RMK is not clear to the actual beneficiaries.
- *Lengthy processing period*: The processing of the applications is lengthy and people have to go to Delhi for signing the agreement. It takes around one year

People's Voice

Orissa: *"It was very difficult for an NGO, like Durbar Sahitya Sansad, a grass root level organization, to implement the scheme. Since RMK's office is situated in Delhi, one has to travel to Delhi to sign MOU if the application is selected under the scheme. It's difficult for the grassroot level NGOs to go there. After submission of the project proposal, we got the feedback after two years. We received 50 per cent in advance before pre-monitoring and the remaining 50 per cent was received post-monitoring. The amount is not sufficient and there are very few staff members to manage the affairs of the entire country. One does not get any response over the phone or reply to the letters sent. We have mobilised more than 400 SHGs. But we get fund for 20 groups,"* says Kedar Choudhry, Secretary, DSS in Orissa.

In ***Chhattisgarh and Bihar***, people and NGOs do not have much of an idea about the scheme. Participants from Chhattisgarh informed that a similar type of scheme run by the state government, i.e. Chhatishgarh Mahila Kosh, is popular in the state and is very successful.

Orissa: The scheme of RMK was running effectively 16 years back in Orissa. But the number of default cases in Orissa has been so high that currently applications from the state are not approved. One of the reasons for this was a liberal screening of the applications.

to get the status or result of the application and three years to get the money.

- RMK does not take into account the beneficiaries' situation in terms of the utilisation of funds. Often, even before starting a business, the beneficiary is asked to pay back money.

v) Working Women's Hostel:

The scheme aims to provide accommodation for single working women, unmarried women, widows, divorced or separated women, and for married women whose husband is out of town. These hostels are to provide accommodation to women who are being trained for employment, provided the training period does not exceed one year. Voluntary agencies/public trusts working in the field of women's welfare/social welfare, women's education are eligible for assistance under the scheme. Women development corporations, universities, schools/colleges of social work shall also be eligible for financial assistance under the scheme.

People's Concerns:

- *Coverage area:* The hostels are mainly situated in the cities. This does not cater the need of the women in the smaller towns and semi-urban areas. Women in t hese areas are facing more difficulties in comparison to that of the women in the cities in getting a safe accommodation. These hostels are not in every district. More hostels are needed. A participant from Uttar Pradesh shared that in Gurgaon the hostel is situated in a strategic location. Food and other services are of good quality. There is security and safety for the inmates. Minorities have equal access but capacity of the hostel is limited.
- *Quality of services*: The basic facilities provided in the hostel are of inferior quality. The inmates in the hostel have to do a lot of work, which should actually

be done by the attendants. Due to low budget allocation and delay in release of funds, there are compromises made in the quality of services provided and appointment of staff for providing services.

- *Sanitation condition*: The sanitation and hygiene condition is very bad in most of the places. Health care for the inmates is not available adequately.

vi) Swadhar

Is a scheme designed to serve the primary needs of shelter, food, clothing and care of marginalised women/girls living in difficult circumstances and who are without any social and economic support. The scheme promises to provide emotional support and counselling to such women. It also aims at rehabilitating them socially and economically through education, awareness, skill upgradation and personality development through behavioral training, etc. Through this programme, there is provision to arrange for specific clinical, legal and other support for women/girls in need of those intervention, by linking and networking with other organizations in both government and non-government sectors, on a case-to-case basis.

People's Concerns:

- *Quality of services*: The Swadhar homes are not functioning well in almost the states where they exist. Even the basic needs of the inmates are not met adequately.
- *Lack of initiative for rehabilitation and linkages*: The aged and helpless women stay for a longer period, as they do not have any place to go to and often their stay becomes life long. This constraint not only overcrowds the existing homes but also limits the chances of a better rehabilitation of the inmates.
- *Insufficient budget allocation*: There is a provision of Rs 500/- per inmate, which is insufficient in the present context. As a result, both the quantity and quality of basic services suffer. There is no provision for clothing in the scheme. Old clothes are collected and distributed among the inmates. One bedsheet and bed is provided for six years that actually does not last for such a long time.

Two-thirds of this money, i.e. Rs 500/- provided to women will be towards meeting the food and medical expenses of the children accompanying such women. However, this amount is grossly insufficient to meet the needs of children, which costs much more than for adults.

The lack of communication among the government departments is also affecting the services on the ground. Though the Department of Women & Child Development claims to have directed the government hospitals to provide treatment to the inmates of Swadhar and short stay homes, the CDMO denies having any such information.

Helplines are there but no community member knows the purpose of helplines. The salaries of the staff at the helpline are very little (Rs 2000 to Rs 3000). Thus, commitment among employees is weak and they often disconnect the line on the pretext of wrong number.

People's Voice

In the eastern region, in ***Orissa***, a participant pointed out that *Basundhara, an organisation working for women development got a grant for 50 women for three years. But presently, they are housing 120 women. The reason for this high ratio is that the home has become a dumping centre for the police, NGOs, Court, family members, and victims themselves come to the home and request for shelter and later, an extension of the period of stay.*

❖ *Irregular release of fund*: Not only the funds are limited but their release is also irregular, causing problems in the running of Swadhar homes. The Department of Women & Child Development is not taking any initiative for the development of the inmates or their rehabilitation.

vii) Ujjawala Schemes:

The Ministry of Women & Child Development, Government of India, during the year 2007-2008, had introduced a comprehensive scheme for the prevention of trafficking and rescue, rehabilitation and re-integration of victims of trafficking for commercial sexual exploitation – UJJAWALA, with the objective to prevent trafficking of women and children and facilitating rescue of the victims and rehabilitating them. The scheme facilitates repatriation of cross-border victims. The scheme provides financial assistance for prevention, rescue, rehabilitation, re-integration and repatriation of the victims.

People's Concerns:

❖ *Lack of awareness*: There were very few participants in all the regional consultations held across the country, who knew about the programme. Implementation of the scheme has not yet started in most of the states.

viii) Swayamsidha:

This scheme aims at empowering women to demand their rights from the family, community and government; have increased access to, and control over, material, social and political resources; have enhanced awareness and improved skills, and be able to raise issues of common concern through mobilisation and networking. The long-term objective of the programme is the all-round empowerment of women, especially socially and economically, by ensuring their direct access to, and control over, resources, through a sustained process of mobilisation and convergence of all the ongoing sectoral programmes.

People's Concerns:

❖ *Less information about the programme*: People from the community and representatives from NGOs were not greatly informed about the programme. For most, it was a new scheme. None of the participants were involved in the implementation of the programme and were also not aware of any other organisation in their network who was implementing the programme.

ix) Gender Budgeting:

Gender budgeting is an integrated scheme which has emerged with the objective to initiate an integrated approach and guide the Gender Budgeting Cells (GBCs) set up by different Central ministries/departments, by disseminating the concept, tools and strategy of gender budgeting. This is to coordinate and monitor gender budgeting exercises of GBCs and facilitate gender budgeting analysis. Gender budgeting aims at organising workshops to facilitate capacity building and training for various stakeholders including officials of Central and state governments, PSUs, corporate sector, PRIs and NGOs, etc. It also aims to provide assistance to develop training modules/packages, training material, information booklets and manuals for gender budgeting for all stakeholders.

People's Concerns:

❖ *Less knowledge about the concept*: Most of the NGOs were not aware of the concept of 'Gender Budgeting'. However, some participants associated with the universities and education institutes were aware of the programme.

Participants from Tata Institute of Social Science in Maharashtra mentioned that there are some

independent studies and exercises on gender budgeting. Representative from NAWO, Orissa, Ms Lalita Biswas informed the group about the concept of gender budgeting. However, she admitted that enough work had not been done in this regard.

The people from the community and many organisations do not have any training or orientation regarding this programme. There is no inclusion of gender budgeting in the existing women- related programmes and strategies.

x) Prevention of Violence against Women:

The legal Act under this provision is framed to protect women from various forms of domestic violence. This law addresses the issue of domestic torture on the woman, dowry- related problems and other domestic issues.

People's Concerns:

- *Lack of awareness*: There is not much awareness in the community regarding this Act.
- *Operational difficulties at the ground*: The financial power is not transferred to the Protection Officer, despite his shouldering maximum responsibilities under the Act. There is less clarity on various provisions of the Act.

People's Voice

Assam: Ms Jutika Baruah from Assam said that, *"'Bell Bajao' campaign, which has been initiated to promote this Act, is not comprehensive. At the community level, people have different views about this campaign. There is no concept of 'calling bell' in the villages. So it is presumed that this initiative is meant only for the urban dwellers. Not just that, the service providers under the programme are not well aware of their roles, duties and responsibilities."*

- *Lack of capacity and willingness to implement the Act*: Protection Officers are not present in all the districts. In rural areas, cases are seldom filed and there are very few cases in urban areas. In most places the police do not accept the DIR and sends back the victim after minor counselling.
- *Filing of cases is time consuming*: As per the law any case must be solved within 60 days. However, with a lengthy filing process, this rarely happens.
- *Lack of convergence*: There is no convergence with other services, programmes and schemes related to the Act.

Section - 2

This section brings together the suggestions of the participants to meet the gaps and challenges in the current state of implementation of various programmes and schemes for the welfare and development of women.

- *Budget allocation and release of fund*: As clearly reflected in the section of concerns, participants have articulated strongly against the quality of services provided in the homes and centres meant to provide succor to women in distress. These women are in the most vulnerable condition and need both physical and mental comfort. Therefore, it is very important to have adequate funds to address the issue. The budget allocation should be revised and increased to adequately meet the basic needs, psychological and mental support services, medical, legal and other requirements. There should be special provision to address the needs of children who come with the woman to the centers.
- For all programmes there is irregularity in the release of funds, which needs to be regularised. In fact there should be an advance release of funds, so that the

critical needs are addressed in time. The fund release process should be simplified.

- *Awareness about the schemes and programmes*: Most of the schemes and programmes are not known to participants. This shows that the information has not gone down and reached the beneficiaries. There is a need of wider awareness generation through a better involvement of the NGOs who have a community presence. Well designed IEC activities can act as a tool to spread the information. The media campaigns should be well planned and comprehensive, so that people can understand the schemes clearly.
- *Restructuring the vocational training programme*: There should be market mapping of products and skills. The vocational training should then be imparted to train the inmates to produce those products which have a market demand. Such training can ensure economic rehabilitation of women in distress.
- For such market-driven vocational training programmes, the trainers should be well-skilled and provided with an increased honorarium. The duration of the vocational training should be increased to a period of minimum of six months to a year.
- *Monitoring of the schemes and performance*: As the schemes for women are not well known and their implementation at the ground level is surmounted by several overriding impediments like inadequate or irregular funds, outdated vocational training, lack of transparency in selection and an ineffective or even absent monitoring system in place.

  In Delhi, the state government has already taken up initiatives to revive the schemes. Such process should be adopted in every state, so that there can be a basic assessment of the current position and accordingly, strategies can be developed to improve the implementation of the scheme. There should be regular and unbiased monitoring of the government schemes and programmes.

  A joint committee, comprising of representatives from both the government as well as the NGO sector, should be formulated to monitor the implementation of these government schemes and programmes. There could be perhaps an involvement of the convener of the SSH forum, officer from SWB, local police, CDPO, member of NGOs, etc., in the monitoring committee. The monitoring committee should aim at improving the functioning of programmes through constructive suggestions. Yearly review of the scheme should be done to check whether the whole idea of the scheme is implemented or not.
- *Coverage of the programme*: The programmes and schemes should be implemented widely so that they can address the concerned issues with a better capacity. The number and availability of the short stay homes should be decided by the demand and supply doctrine. There should be more than one SSH in a district and even at the block level where required. Same is suggested for the family counselling Centres and other programmes.
- *Selection of NGOs*: The process of selection of NGOs to implement different programmes should be transparent. NGOs should have the infrastructure and capacity to run the programme. The status of application should be shared on the Scheme website along with the rationale for selection/rejection. In every five years, the schemes should be revised. Licenses of NGOs should be renewed every three years instead of one year, in order to reduce the trouble of paper work and meeting formalities.
- *Public private partnership*: Through PPP a stronger implementation plan can be put in place in most of the schemes. The private-for-profit sector can come

up to join the partnership under their corporate social responsibility and create a stronger finance base to improve the quality of services.

- *Inter-sectoral convergence*: The issues relating to women are cross-cutting. All the programmes developed to support the women need to be linked with each other. There should be a coordinated convergence of line departments and among different sectors to build linkages in order to make various services accessible to women when they are in a distressed condition. There should be convergence of health, women and child development, social justice, human rights, rural development, Panchayati Raj, law and other departments.
- *Effective implementation of RMK*: Awareness should be created at all levels regarding micro-credit and the role of RMK in strengthening and promoting it. Some mechanisms should be developed at the state level so that the agencies can sign MoUs in the state. A state oOffice should be there in each state for operation and administration. This office can closely monitor the development. Speedy processing of applications should be done and applicants should be informed about the status as soon as possible. The loan amount should be increased and the process should be made simple. More effective and strict monitoring should be done. Strict scrutiny of nodal agencies and NGOs should be done before sanctioning the funds. There should be a long-term planning and partnership with the agency while giving the first grant.
- *Popularising the Act 'Prevention of Violence Against Women'*: District- and block-level task forces should be prepared for a strict enforcement of the Act. There should be a proper communication at the community level regarding the Act and its provisions. The law should be translated into vernacular language so that awareness programme would be more effective and successful. The information should be disseminated through media and IEC activities. There should be a website with a regular update on the implementation of the Act. The '*Bell Bajao*' campaign should be broadcast in regional languages and should be redesigned so that the meaning and objective of the advertisement will reach the people successfully.

  The Protection Officer should be given training on the Act. S/he should be given more powers so that the duties can be discharged easily. The PO should be given financial power for rescue operation, etc.

  There should be regular interaction among the lawyers to motivate them to take up cases of domestic violence and use the Act for procuring necessary court orders. It should be strictly followed that the cases should be solved within 60 days and this can be monitored by the task force.
- Monitoring mechanism should be made strong. The police, instead of sending back the victim after counselling, should refer such cases to the Protection Officer. There should be better coordination between the Protection Officer and the service provider. The Protection Officer is from the District Collector's office and service provider from the family counselling centre.

  There should be more than one service provider and Protection Officer in a district. Better awareness should be generated among the public regarding the laws, roles and responsibilities of the service providers and Protection Officers. A display board mentioning the name and telephone number of the PO and the service provider, etc., should be there in most of the public buildings. The follow- up of monetary relief granted should be done, so that the victim can really get it and also in time.

Chapter – 3:

Children's Issues

Children constitute more than one- third of the country's population, i.e. around 440 million persons below the age of 18. The strength of the nation lies in a healthy, protected, educated and well-developed child population, which will grow up to be productive citizens of the country. The Constitution of India recognises the vulnerable position of children and their right to protection. Article 15 of the Constitution guarantees special attention to children through necessary and special laws and policies, which safeguard their rights. The right to equality, protection of life and personal liberty, and the right against exploitation is enshrined in Articles 14, 15, 16, 17, 21, 23 and 24. There have been several schemes and programmes geared towards a holistic development of the children, especially those in difficult circumstances and in need of special care. With the mid-term appraisal of the Eleventh Five-Year Plan, it was judicious to assess, through the eyes of people, the actual beneficiaries and the level of implementation of the various welfare and developmental schemes for the children.

The discussion during a series of state-level consultations with the community-level stakeholders, on the actual implementation of the various Child Welfare and Development Schemes, revolved around the three schemes, namely ICDS (Integrated Child Development Services), Rajiv Gandhi National Crèche Scheme, and the Integrated Child Protection Scheme. This chapter has been divided into three sections – the first section sharing a brief note on the various schemes and programmes divulged during the nation-wide deliberations, followed by the second and third sections sharing the outcome of these deliberations. The second section puts together the voice of the actual beneficiaries and other stakeholders on the gaps and challenges in the implementation of the schemes and programmes. The third section comes up with the participants' recommendations to meet the challenges in the implementation of schemes.

Mr. Alok Mukhopadhyay, Chief Executive, VHAI interacting with the participants in the Western Region Consultation

Section – 1

Brief Note on the Schemes relating to Children for Consultation with Civil Society, as part of MTA of Eleventh Plan

i) ICDS (Integrated Child Development Services):

Launched on 2 October 1975, in 33 community development blocks, ICDS today represents one of the world's largest programme for early childhood development. The scheme provides an integrated approach for converging basic services through community-based workers and helpers. The services are provided at a centre called the *anganwadi*, which is a childcare centre located within the village itself. A package of the following six services is provided under the ICDS scheme:

- Supplementary nutrition
- Non-formal pre-school education
- Immunisation
- Health check-ups
- Referral services
- Nutrition and health education

The three services, namely immunisation, health check-up and referral are delivered through the public health infrastructure, viz. health sub-centres, primary and community health centres under the Ministry of Health & Family Welfare.

ii) Rajiv Gandhi National Crèche Scheme:

Rajiv Gandhi National Crèche Scheme for the children of working mothers was launched with effect from 1 January 2006, by merging the National Crèche Fund with the scheme of assistance to voluntary organisations for crèches/day care centres for the children of working and ailing women. The scheme has an in-built component of monitoring of crèches. So far, about 31,737 crèches have been sanctioned to the implementing agencies.

As per the scheme, the crèche should have a minimum space of 6-8 sq. ft. per child, to ensure that they can play, rest and learn without any hindrance. The centre should be clean, well lighted, with adequate ventilation. Food and other essential items are to be made available in the centre. The crèche worker should be trained to provide quality services to the children.

iii) Integrated Child Protection Scheme:

The Constitution of India recognises the vulnerable position of children and their right to protection. Article 15 of the Constitution guarantees special attention to children through necessary and special laws and policies that safeguard their rights. The right to equality, protection of life and personal liberty, and the right against exploitation is enshrined in Articles 14, 15, 16, 17, 21, 23 and 24.

The existing institutions and programmes for child protection in India primarily stem from the provisions under the Juvenile Justice (Care and Protection of Children) Act, 2000 and National Plan of Action for Children, 2005. These comprise of several programmes and schemes implemented by the different ministries and departments among which are Programme for Juvenile Justice, Integrated Programme for Street Children, Childline Service, scheme for assistance to homes for children (*Shishu Greha*) to promote in-country adoption, scheme for children in need of care and protection,

Rajiv Gandhi National Crèche Scheme for the children of working mothers, pilot project to combat the trafficking of women and children for commercial sexual exploitation, Central Adoption Resource Agency (CARA) and National Child Labour Project (NCLP). All these programmes collectively formulate the Integrated Child Protection Scheme.

The Ministry has formulated a new centrally-sponsored scheme –'Integrated Child Protection Scheme (ICPS)', with a view to create an environment free from abuse, discrimination, neglect, violence and exploitation, thus ensuring comprehensive development of children in the country.

ICPS brings the following existing child protection programmes under one umbrella:

vi. Programme for Juvenile Justice

vii. Integrated Programme for Street Children

viii. Scheme for Assistance to Homes [Shishu Greha]

ix. Scheme for the welfare of working children in need of care

iv) Childline:

The Government of India launched Childline service during the year 1998-99. The Childline is a 24-hour free phone service, which can be accessed by a child in distress or an adult on his behalf, by dialing the number 1098 on telephone. Childline provides emergency assistance to a child and subsequently based upon the child's need, the child is referred to an appropriate organisation for long-term follow up and care.

The basic objectives of the Childline service are:

- To respond to children in emergency situations and refer them to relevant governmental and non-governmental organisations;
- To create a structure which ensures the protection of the rights of the child, as ratified in the UN Convention on the Rights of the Child and the Juvenile Justice (Care and Protection of Children) Act, 2000;
- To provide a platform for networking amongst organisations and to strengthen the support system, which facilitates the rehabilitation of children in especially difficult circumstances;
- To sensitise agencies such as hospitals, municipal corporations and the railways towards the problems faced by these children: and
- To provide an opportunity to public to respond to the needs of children in difficult circumstances.

v) Central Adoption Resource Agency (CARA):

CARA was set up in 1990 and has been designated as the central authority by the Ministry of Social Justice and Empowerment on July 17, 2003, for the implementation of the Hague Convention on Protection of Children & Cooperation in respect of Inter-country Adoption (1993). CARA grants recognition to Indian placement agencies on the recommendation of the state government for processing inter-country adoption. It also accords enlistment to foreign agencies that are engaged in sponsoring applications of prospective adoptive parents from abroad.

Section – 2

Concerns of the Participants -- Gaps and Challenges in the Implementation of the Schemes / Programmes for Child Welfare & Development

i) ICDS (Integrated Child Development Services)

Concerns:

- *Accessibility and physical facilities* - Geographical variations have not been taken into consideration in the plan of the scheme. In the hilly region, where population is sparsely spread, the geographic area is much wider so as to meet the guideline on 1 center per 1,000 population. It is impossible for the children to go to the ICDS centres and also for the ICDS worker to visit the houses regularly.
- *Absenteeism of the ICDS workers* - In most ICDS centres, particularly in the hilly and tribal areas, the ICDS workers do not visit the centre on a regular basis.
- *Building and infrastructure* - Most of ICDS centres do not have their own building and the centres are mostly run in a rented house or the Panchayat's building, as well as the household of the local ICDS workers.
- *Water supply and sanitation facilities* – There is hardly any ICDS centre with its own water supply facility. Water from nearby wells/tube-wells is generally used in the centre for cooking and drinking purposes. There is no toilet facility available in most of the centers.
- *Level of expertise of the ICDS workers* – There is no system in place for proper selection and on- job training of the ICDS functionaries. Furathermore, in the tribal and hilly regions, there is an absence of candidates with the required qualifications.
- *Hygiene practices* - Most of the ICDS workers and helpers themselves do not have proper knowledge and awareness on hygiene and sanitation during storage of water and food, and preparation of food. Personal hygiene practices, such as regular cutting of nails, proper hand washing, etc. are not followed.
- *Absence of basic infrastructural facilities* like height and weight measuring machines.
- *Infant and young child feeding* - The food supply is not regular and is often of inferior quality. Proper care and hygiene practices are not followed during the food preparation. There have been reports of insects found in the food served by the ICDS centre to the children. There is no proper storage facility for the foodstuff supplied.
- *Involvement of the community members and mothers* - There is a lack of community involvement and participation in the activities of ICDS. The community members are not well aware about the ICDS scheme and responsibilities of the ICDS workers.
- The *funds available for running the ICDS centres* are very minimal.
- *Multi-tasking by the ICDS workers* - They are involved in many different programmes of the government at the grass roots and are thus often not able to give sufficient time to the AWCs. There is a lack of coordination between the Panchayat and the ICDS centres.
- *Early childhood education* – In a situation of absence of the required basic educational and play material in most of the AWCs, the quality of ECCE does not meet the expectations. The ICDS workers are not imparted training on a regular basis and are thus less competent in delivering quality services.

People's Voice

Uttar Pradesh: The issue of the girl-child is a pressing social concern and ICDS centres look after these concerns in terms of provision of nutritional supplements to some extent. However, there is no follow up at the community level, through home visits by the workers.

West Bengal: One of the participants felt that the children from the red-light areas should also be covered under the ICDS programme.

Orissa: ICDS workers do not go to the centres regularly. They distribute raw food stuff once in every seven days. Further the parents are unaware of their entitlements in the Scheme.

Bihar: The caste factor has been found as having a significant role in the approach towards the ICDS centres. The centres located near to the hamlet of upper caste have an inferior feeling towards the children of low castes. And where the AWWs are from low caste, the upper caste people do not send their children to the centre (same in Chhattisgarh).

Jharkhand: The monitoring of the functioning of the centres and performance of the workers is judged on the basis of a one day survey or visit.

Chhattisgarh: There are no fixed norms followed in deciding the remuneration of the AWWs. It is greatly regulated by the Sarpanch's mercy and satisfaction.

Arunachal Pradesh: Difficulties faced due to the difficult geographical terrain bar the families from sending the child alone or sometimes even with the mother to the centre. The ICDS centres are located quite far from the inhabitants' houses.

ii) Rajeev Gandhi National Crèche Scheme

Concerns:

- The number of crèches in the different states of the country is far less than planned and needed.
- The functioning of these crèches, wherever they are in place, is also not satisfactory. Care and support for the children not just lacks the spirit but also often violates the rights of the children.
- The crèche workers are very irregular in visiting the centre in the absence of any proper monitoring system.

iii) Childline

Concerns:

- Childline services are not available in each district of the states.
- The Helpline is not available on a 24x7 basis.
- Follow-up support is missing in the actual implementation of the scheme.
- There is absence of a comprehensive policy on Childline. There is no protection mechanism.

People's Voice

Karnataka: '*Encouraging Experience*'

Mrs Ruth Manorama mentioned that in the state of Karnataka, there are three Childlines and all are functioning effectively. The calls are answered with an immediate response. Children who are rescued from difficult situations are referred to the Child Welfare Committee and appropriate care and protection is provided. She feels that there should be a greater number of such Childlines and people, especially children, should be aware about this service.

- The monitoring system is not strong and well organised. The departments/ institutions are supposed to provide lateral services and support systems such as police, labour, law, etc., are not integrated and the child does not get a holistic support.

Section – 3

Recommendations

- *Service coverage of ICDS centres and other programmes:* In India the population size and population density varies from one place to another. In plain areas the density is high, whereas in the hilly and tribal pockets it is very thinly spread. The standard population coverage is not suitable for all the areas. There are also disparities with regard to caste and ethnicity in many areas, which has a serious impact on the children at the ICDS centres.

Shagufta Khan, Secretary, Gareeb Nawaz Mahila awam Baal Vikas Sanstha in Ajmer shared some of the factors contributing to the flawed functioning of ICDS centers. She also thanked the Planning Commission for providing this opportunity.

- These geographical variations and caste factors must be kept in consideration while setting up common ICDS centres in the same village. There should not be any mismatch between the caste of the ICDS workers and the intended beneficiaries. The scheme must bring into its coverage the juvenile homes and red- light areas in the urban settings. Similarly, the Rajeev Gandhi Crèche Scheme must cover the children of the workers in the mining areas.
- *Infrastructure:* From the discussion it was clear that the ICDS centres have their own buildings in very few places. For a successful functioning of an ICDS centre and other programmes, a well equipped infrastructure is a pre- requisite. The ICDS centre should be an independent structure, having its own boundary. The lay out of the building should have the plan of adequate space and ventilation. There should be segregation for the play space, kitchen, store room and toilets. There should be a boundary to give the children protection from outside elements. A garden, overhead water tank ensuring regular water supply for cooking and drinking purpose, are a must in an ideal ICDS centre where the children are to be nurtured for both physical and mental growth.
- *Facilities in the ICDS centres* - The ICDS centre should be adequately supplied with all necessary requirements. There should be enough edu cational and play material in the centre to keep the children engaged. Provision of chairs and tables to sit, beds to take rest and almirahs to store valuables should be there in all centres. The height and weight measuring devices must be there with a system of regular inspection for ensuring accuracy. A mirror in the centre can help the children in understanding issues of cleanliness and personal hygiene. The cooking vessels, serving bowls and spoons should be adequate in number. The children should not be required to carry bowls to have food in the centre. Regular inspection of the building and the facilities available must be put in place.
- *Human resource development:* There should be an appropriate unbiased selection of ICDS workers, forming the backbone of the implementation process. There should be a system of capacity building and orientation of the ICDS workers and helpers through a system of periodic training and visits to other centres. The training programme for these workers must involve the technical and educational aspects which will take care of nutrition, growth measurement, a well-designed module of pre-school education. Secondly, there should be orientation on social issues and determinants influencing status of nutrition and health. The ICDS workers must be oriented on the principles of child psychology, helping them to handle the children with love and affection.
- With this kind of training and orientation of the ICDS workers resulting in a better and much envisaged functioning of the centres, there will be a sure increase in the number of beneficiaries resulting in a gradual change in the situation of malnutrition. This will surely raise the attendance of children to the centre due to their own interest and willingness of parents to send them to the place. The training of the ICDS centres may be organized at the block or district level. For a better convergence of programmes, there should also be joint orientation of the ICDS workers, ASHAs and ANMs.

- The ICDS centres should be given instructions to treat the children from backward classes with proper attention. The workers should play an important role in orienting the community members to have equality for children irrespective of their caste.
- *Monitoring of the programme*: The roles and responsibilities of the ICDS workers, helpers and care-takers in different programmes are to be assigned specifically. There should be a strong monitoring system to assess the performance of the centres. The monitoring committee should have representation from the government as well as the NGO sector. Regular system of monitoring of all child welfare and development related programmes, i.e. ICDS, Early Childhood Education, Rajeev Gandhi Crèche, Childline, must be in place to ensure their proper implementation and achievement of the expected outcomes.
- *Financial Resources: 'Creating a Flexi Pool'***:** Finance plays a major role in affecting the interest and involvement of the workers. There is no flexibility to address the critical needs at the community level in case of any urgent demand. A flexi- pool should be created at the district, block and community level. Where accountability is concerned, there may be a committee to take decisions on the spending of money. Innovations in the work are not possible without more flexible availability of funds. In different places. there can be diverse innovative ideas on generating mass awareness on nutrition, hygiene and other health issues. With some financial independence, such activities can be taken up.
- *Inter-sectoral convergence:* Nutrition is not a subject to be dealt in isolation. Nutritional imbalance is a result of lack of input from the field of health, social justice, social welfare, Panchayati Raj, women and child development, finance, rural development, education, water and sanitation, etc. Thus, there is a need of convergence of the efforts of all the departments dealing with the above subjects. ICDS activities should be included in their yearly planning and budget. There should be accountability and responsibilities of these departments towards meeting the overall goal of improving the nutritional status of the children and their overall development.
- *Life-cycle approach*: The ICDS workforce must be oriented to have a life-cycle approach ensuring an overall improvement in the growth and development of the children visiting the centres. Some of the centres where this practice is successfully followed should be visited by the workers from other centres as a learning exercise. This life cycle approach should cover education in an application mode, for e.g. instructing children about personal. The pregnant women and lactating mothers should be counselled for their own and children's nutrition. The elderly women of the community should be involved in the various activities of the centre, to share their experiences and ideas on child health.
- *Sustainability of the efforts of ICDS through community participation and ownership:* Sustainability of the efforts of the ICDS and other such schemes can be ensured through an enhanced participation of the community members. Another proposal was to orientate adolescent girls on nutrition, low-cost nutrition, complementary feeding, etc., who could then also help the workers in motivating the community and can be the agents of change.

- *Women self- help groups* are the most sustainable groups at the community level. The ICDS should take initiative of strengthening these SHGs, who will support the centres with respect to a proper supply of food materials and also the cooking can be directly done by the SHGs. This initiative will not only ensure a regular monitoring of the quality of the goods supplied but will also gainfully employ the SHG members. These SHGs can further be linked with banks for strengthening their financial status. Mothers of the children should also be involved directly or through the SHGs.
- *Panchayat should be involved in the process.* There should be regular meetings amongst the various stakeholders i.e., the Panchayat representatives, ICDS workers, pregnant and lactating women and mothers of the children. These meetings will provide an opportunity to the members to share the challenges faced in the centre and how the centre can be made better. The Panchayat members would be motivated to take self initiative towards meeting the gaps of the ICDS centres.
- *Convergence of the schemes and programmes* designed for the welfare and development of the children should be a priority and an in-built component in the formulation of any programme.
- *Awareness through mass media and IEC activities*: Most of the programmes for the welfare and development of the children are not well known at the community level. To meet this challenge, there is an urgent need of generating mass awareness through IEC activities at the community level with a mass media approach.
- *Addressing the critical socio-political issues:* There is strong socio-political bias at the community level; the marginalised section is deprived of their entitlements due to their affiliation to a specific political party. For this reason they are discriminated for being enlisted in the BPL list and thus excluded from various schemes meant to improve their socio-economic condition. The Women & Child Department must pay attention at the district and block level to address such issues.

Chapter – 4:

Minorities Issues

Minorities in India, as per the National Commission of Minorities Act, 1992, comprise of Muslims, Christians, Buddhists, Sikhs and Zoroastrians (Parsees). As per the 2001 Census, these communities constitute about 18.4 per cent of the total population of the country, numbering about 18.94 crores. The Ministry of Minority Affairs was created in January, 2006, to ensure a focused approach to the issues related to the minorities and to play a pivotal role in the overall policy, planning, coordination, evaluation and review of the regulatory and development programmes for the benefit of the minority communities. There are several government- run schemes for the development of the minority communities.

Section- 1

Brief Note on the schemes for the minorities, for consultation with civil society, as part of mid-term appraisal of the Eleventh Five-Year Plan

1. Educational schemes for the minorities

(i) Merit-cum-means scholarship for technical and professional courses at under-graduate and post-graduate levels, for students belonging to the minority communities.

Razia Khatoon from Maharashtra mentioning their ignorance about the schemes for the minority group

(ii) Post-matric scholarship from class XI up to PhD, including technical courses at XI and XII level, recognized by NCVT.

(iii) Pre-matric scholarship from Class I to Class X.

(iv) Coaching and allied schemes.

(v) Multi-sectoral development programme for minority concentration districts

These scholarships are awarded to students who fulfil certain requirements of the scheme, including an income criterion.

2, *National Minorities Development & Finance Corporation (NMDFC)* is one of the institutions under the purview of the ministry, focusing on the empowerment of the minorities. NMDFC provides term loan and micro-finance to persons from the minority communities below double the poverty line, for income generating activities. It does so through state-channelising agencies and NGOs. It also extends education loans and assists in the upgradation of technical and entrepreneurial skills for proper and efficient management of production units.

In keeping with the government's policy and approach to minorities, some commitments have been made in the Eleventh Five-Year Plan in Chapter 6 of Vol. I, Social Justice. The mid-term appraisal (MTA) exercise of the Eleventh Plan is in progress and to assess the awareness, access, quality and outreach of the schemes/services and also the inclusiveness/non-discrimination factors, a series of consultations, nation-wide, involving the stakeholders from the community, government, NGOs and the bilateral agencies, were organised.

The following section shares the concerns followed by the recommendations of these stakeholders, comprising the actual beneficiaries for a better implementation of the schemes and programmes.

Section – 2

Concerns of the Participants - Gaps and Challenges in the Implementation of the Schemes / Programmes for the Welfare and Development of Minorities

i) Educational Schemes for Minorities

The scholarships at pre-matric and post-matric level are given to the students to encourage them to continue their study and financially assist them to lessen the burden on parents. The schemes intend to form the foundation for the students of the minority section for their educational attainment. Empowerment through educational schemes has the potential to lead to the uplift of the socio-economic conditions of the minority communities.

Concerns:

- Pre-matric, post-matric and vocational scholarships are given, but the processing of applications for scholarship is cumbersome and time taking.
- It is mandatory to produce an income certificate from the *tehsildar* and one has to go through a lot of difficulty in obtaining it.
- In the scheme of things, only government schools provide scholarships and the private schools and *madarsa*s are not liable to follow this system and support the need- based students.
- The total number of scholarships available is very less and the application procedure involves a lot of paper work.
- The selection process is not unbiased and often the affluent and influential get the benefit. The practice

People's Voice

Manipur: "*I was studying in one of the mainstream schools in Manipur. Having secured good marks in my 10th exam, I could convince my parents, after a lot of struggle, to allow me to continue my education and could attend college. Our family comprised of 12 members with one earning member i.e. my father, working as a tailor. Thus the expenses were far more than the income. With all such constraints I was able to complete my graduation. As a principle, we were not aware about any scholarship scheme or financial benefits available for us. I wanted to sit for the competitive examinations but did not have any money to get coaching or buy the coaching material. I had to leave the idea of appearing for the competitive examination and for any further studies.*"

This is a narration by Sheikh Nazeera, a woman from the Muslim community of Manipur, who attended the north-eastern regional consultation. Currently she is working with the Manipur State Voluntary Health Association and till that day, as revealed by her, she was not aware about any of the schemes.

of corruption at the government level during the selection of candidates has been noted in most of the states.

- ❖ There is no efforts made to mainstream the minorities.
- ❖ There is an open discrimination by the schools for the minority students.
- ❖ The uniforms provided to the minority girl students are not sensitive to their culture. The students from the Muslim community are also supposed to wear tunic and other dresses, which are not accepted in their conservative families. This is becoming one of the major reasons for increased drop-out rates.

ii) Free Coaching for Minorities:

The scheme aims to empower the minority communities, which comprise of a relatively disadvantaged section of the society, by assisting them as well as those institutions working for them, towards enhancing their skills and capabilities to make them employable in industries, services and business sectors, in addition to the government sector. The scheme has the in-built resilience to adapt itself to the market dynamics on a continuous basis, so that the target groups are not deprived of the professional acumen demanded by the changing/emerging market needs and opportunities for employment at domestic as well as international levels.

Concerns:

- ❖ There are very few institutes which have these facilities.
- ❖ There are no efforts to increase awareness about such provisions amongst the intended beneficiaries.

iii) *National Minority Development and Finance Corporation:*

The National Minority Development and Finance Corporation (NMDFC) was set up with the aim to promote economic and developmental activities for the benefit of the economically backward sections amongst the minorities, preference being given to the occupational groups and women. The schemes and programmes under the corporation aim at assisting by way of loans and advances for economically and financially viable schemes and projects.

Concerns:

- The interest charged by NMDFC is very low and there are no difficult rules to apply. However the funds are very limited, i.e., Rs 5 to10 lakh per NGO. When RMK charges 8 per cent, NMDFC charges 1 per cent, which creates conflict among the community members. The loan repayment period of two years is also very less.
- It has been noted that the loan is paid randomly, without a proper assessment of the capacity of the applicant.
- The level of awareness amongst the intended beneficiaries and other people regarding the corporation and its schemes is very low, thereby limiting the scope of the scheme from making any significant impact on the ground.
- The official website of NMDFC doesn't provide any information regarding the program and its various components.
- It was a common concern that the corporation doesn't respond to the enquiries and there is no transparency in its dealings.
- The Christian community is being ignored and is not given this facility. Linguistic minorities are also not considered.

Section – 3

Recommendations

The deliberations had been fruitful in generating a voice amongst the community groups as well as other stakeholders about the existing gaps as well as suggestive measure to fill those gaps and achieve the desired outcomes.

- *Building awareness about the schemes/programmes:* Contrary to the general belief at the top levels, very few, including the intended beneficiaries from the minority section, were aware about the schemes and programme designed for the minority section. This was one of the major findings of the nation- wide consultations, to assess the level of implementation of various welfare and development-oriented schemes and programmes in the Eleventh Five-Year Plan.
  - Even if there was some awareness, there was no clear understanding about the entire programme and all its components. It was thereby strongly felt and recommended that an intensive media campaign for creating awareness about these various schemes and programmes be undertaken by the government, involving appropriate agencies.
  - In electronic media this information should be telecast in campaign mode with regular advertisements and articles about the schemes and their implementation in the national and local newspapers.

- ✦ The scheme guidelines should be printed in the local dialects and made available at different convenient points i.e., educational institutes, religious centers, *madarsa*s, Panchayat, etc.
- ✦ It is not only the minority section but also others should be aware about the schemes and programmes. The government website should be regularly updated with the complete information on these schemes.

❖ *Simplification of the application process and transparency in selection***:** Unlike the NMDFC, the educational schemes for the minority groups have a cumbersome application procedure with no transparency in selection. As shared by some of the beneficiaries, sometimes the expenses involved in efforts to avail the scheme benefits in terms of travel and loss of the daily wages exceeded the benefits.

- ✦ Keeping these various facts, it is important that some urgent initiative is taken to simplify the procedures with more transparency in processing and selection. The scheme website should perhaps share the selection criteria and the reasons of rejection of the applicants.

❖ *Increased fund allocation*: During the deliberations, it came out that most of the schemes and programmes meant for the minority sections have very limited funds. This often limits the scope of the scheme by limiting the probability of improving the socio-economic conditions of the marginalised people from the minority section.

The schemes should be revised with an increase in the financial provisions so that the critical issues affecting the marginalised groups can be addressed properly.

❖ *Integrating the educational schemes***:** Scholarship schemes should be integrated and distributed through Sarva Shiksha Abhiyan so that it will be a popular and well known scheme.

- ✦ The funds for scholarship should be increased for individuals so that it will be a financial support for continuing education. The current amount is very little and not at all sufficient to meet any complete expenditure for education.
- ✦ The overall fund for scholarship should also be increased so that more number of students can benefit. The school uniforms should be culture sensitive. Free coaching should be available in different coaching centres. There should be availability of information in the website showing a list of these centers. In the website there should be an option for suggestions and feedback from the students regarding functioning of the education schemes.

❖ *Streamlining the functioning of NMDFC* – The corporation was applauded for providing finance at an interest rate much lower than the market rates. However the amount of finance is very less, which must be re-looked at.

- ✦ The repayment period of two years should be enhanced to thee to five years, since the borrower needs some time to invest, initiate and grow the business to be able to pay back the money.

Chapter – 5:

Handicrafts and Handloom

The Indian handicrafts and handloom sector has an overwhelming presence in the economic life of the country through its contribution to industrial output, employment generation and the export earnings of the country. Currently, the handloom sector contributes about 14 per cent to industrial production, 4 percent to the GDP and 16.6 per cent to the country's export earnings. The handicrafts and handloom sector comes under the purview of the Ministry of Textile (MoT), Government of India (GoI).

In recognition of these facts, the Government of India set up an autonomous All India Handicrafts Board in 1952 and under the MoT, the Office of the Development Commissioner (Handlooms) and the Office of the Development Commissioner [Handicrafts] have been implementing various departmental schemes at the central level to supplement state's activities in the handlooms and handicrafts sectors, besides in the new thrust areas.

With the state governments pitching in through financial assistance and implementation of various developmental and welfare schemes, in the promotion and upgradation of the handlooms and handicrafts industry, the office of Development Commissioner (Handlooms and Handicrafts) has been implementing various developmental schemes at the Central level.

Community members thanking Dr. Syeda Hameed and other members for the initiative "Listening to the Voices from the Field"

Section – 1

Brief Note on the Government Schemes for the Uplift of the Handlooms Industry, as Part of Mid-Term Appraisal of the Eleventh Five-Year Plan

The Ministry of Textiles announced the following five schemes in the Eleventh Five- year Plan by merging the different schemes of Tenth Five-Year Plan.

Five Schemes of Eleventh Five-Year Plan

1. Integrated Handlooms Development Scheme (IHDS)
2. Mill Gate Price Scheme
3. Handloom Weavers Welfare Scheme
4. Marketing and Export promotion Scheme
5. Diversified Handloom Development Scheme

1. Integrated Handlooms Development Scheme (IHDS)

- ❖ To form handloom weavers' groups
- ❖ To assist weavers for becoming self-sustainable
- ❖ To cover weavers within and outside the co-operative fold
- ❖ To upgrade the skills of the handloom weavers
- ❖ To provide suitable workplace to the weavers
- ❖ To orient marketing, designing and managing the production
- ❖ To facilitate credit from banks
- ❖ To encourage co-operative actions of weavers
- ❖ To intervene each cluster with specific holistic and flexible manner

2. Mill Gate Price Scheme - The Mill Gate Scheme is designed to provide the handloom weavers easy access to yarns with a reasonable price. The yarn banks are set up and the scheme aims to create a free flow of supply of yarn to the weavers for uninterrupted production.

- ❖ National Handloom Development Corporation (NHDC) is the agency authorized to implement the scheme
- ❖ The scheme benefits all handloom organisations of national/state/regional/primary level and NGOs
- ❖ All types of yarn required for production of handloom items are covered under the scheme
- ❖ NHDC arranges the yarn from the mills at Mill Gate price, to the godown of the agencies
- ❖ Reimbursement to the user agencies

3. Handloom Weavers Welfare Scheme

- ❖ This scheme comprises two parts, namely:
  a. Health Insurance Scheme

Ms. Ithishree from VHAI raising concerns on the implementation of Govt. Schemes and Programmes for the social sector

b. Mahatma Gandhi Bunkar Bima Yojana Scheme (MGBBY)

4. Marketing and Export Promotion Scheme

- This scheme comprises of two parts :
  - A. Market Promotion Scheme
  - B. Export Promotion Scheme

5. Diversified Handloom Development Scheme

- This scheme provides technological upgradation through a variety of programmes, which cover skill upgradation of weavers, development of designs and product development.
- Strengthening of Weavers Service Centre, (WSC), Indian Institute of Handloom Technology (IIHTs) and National Centre for Textile Designs (NCTD).
- Research and development.
- Jammu & Kashmir wool project and Weavers Service Centre.
- Setting up of new IIHTs.
- Starting handloom census and issuing identity cards to handloom weavers.

With these progressive schemes for the promotion of the handicrafts and handloom sector, the mid-term appraisal of the Eleventh Five-Year Plan placed due importance to the implementation of these schemes at the grassroots level. There was an attempt to assess the awareness, access, quality and outreach of the schemes/services and also the inclusiveness/non-discrimination factors through a series of consultations nation wide involving the stakeholders from the community, government, NGOs and the bilateral agencies were organised.

Section – 2

The following section shares the concerns followed by the recommendations of these stakeholders comprising the actual benefi.ciaries, for a better implementation of the schemes and programmes.

Concerns:

- *Awareness about the schemes:* In most of the states awareness about the Integrated Handloom Development Scheme and almost all other schemes under handlooms and handicrafts domain was grossly missing. Thus there was not much discussion about the problems related to the implementation of these schemes. However, the participants, especially the intended beneficiaries and also the related agencies, i.e. the NGOs working in the field of handicraft and handloom were concerned that despite the existence of a bundle of promotional schemes, they were not getting benefits.
- The Mill Gate Scheme is also not well known among the weavers present during the deliberations, except a very few. The concerns raised by some of the beneficiaries include the absence of raw materials' bank at the state level.
- Ambedkar Hastashilpa Vikash Yojana (AHVY) is the only programme of handicraft and handloom sector which is well known, with a wide coverage and is implemented in most parts of the country.
  - Some of the *operational problems involved in AHVY implementation* are less numbers of market support programmes, resulting in the artisans losing interest from the programme. There is no regular monitoring system in place.

    With the provisions for the artisans to attend exhibitions outside their respective state, they are often not provided any TA/ DA.

Very few common facility centres are established under the scheme. The process of the artisans getting the ID card under the scheme is very cumbersome.

- The scope for an integrated development of the artisans gets limited by the fact that most of the programmes run independently.
- Besides AHVY, there is no other scheme envisaging partnership with the local NGOs. It was agreed that the NGO sector, having a better presence at the grassroots, can increase awareness about the various government schemes and programmes, identify potential beneficiaries and effectively implement the programme in collaboration with the government.
- Since there is no baseline data available to analyse change in the income pattern, social condition and cultural changes among the artisans after implementation of the programmes, it becomes difficult to assess the effectiveness of any programme.

Section – 3

Recommendations

- *Awareness and information dissemination:* The schemes and programmes of handloom and handicraft sector, like the other sectors, have not been able to reach the community and most of

People's Voice

Orissa: Nabaghana Behera, a male artisan from a potters' village in Orissa said that his life has been transformed with the intervention of AHVY scheme in their cluster. It was all possible because of a local NGO, Aparajita. Now his income has increased substantially. Nabaghana is currently into the production of goods which have better market prospects. He has developed an understanding of the market and has also learnt the skills to interact with the customers at different levels. His work involves interaction with many buyers, designers and exporters.

They have a common facility centre in the village, which is ISO certified. Nabaghana, a neo-literate, is able to speak the language of a mature entrepreneur.

Through a proper dissemination of information about the schemes with an appropriate implementation, the government schemes can be thus very fruitful at the ground.

them are not known to the weavers and artisans. This situation calls for an urgent response by way of developing an appropriate strategy for awareness generation. This may involve partners from the NGO sector, owing to their community presence. The various modes of media, i.e. electronic and print should be used effectively, with some system of checks and balances in place.

- *Partnership with NGOs:* Participation of the NGO sector in generating awareness and the implementation of the various schemes and programmes is one of the strategies to ensure a desired change in the current state of the implementation of government schemes at the grassroots.
- This has been proved with the success and popularity of AHVY scheme in comparison to the other schemes of the sector. The NGO sector should be involved at all levels, starting from designing the programme to implementation, monitoring and establishing linkages.
- *Monitoring of the schemes and programmes:* There should be a systematic monitoring mechanism to assess the progress of the schemes. Regular feedback should be taken from the artisans and the implementing agencies, in order to improve the implementation strategy. To ensure transparency and avoid any kind of bias, monitoring should be jointly undertaken by both the government and non- government agencies.
- *Export Promotion*: Handicrafts and handlooms of India, from its different states, are of high value in the export market. It is very important to streamline and organise the production process by way of adding designs and improving craft and marketing skills of the artisans. The private agencies are able to export handicraft products and earn high margins of profit. Adequate steps should be taken by the government to promote export activities and provide the artisans their due share of the profits.
- *Market orientation and promotion:* This is one of the pre-requisites towards the promotion of both the sector as well as the artisans. The marketing of the products made by the local artisans should be done in an organised way. As envisaged in some of the schemes, but is not happening, marketing events should be regularly organised and should ensure the participation of an increasing number of artisans. These events provide a venue for the sale of their products in an enterprising fashion.
- This outlines the need for the orientation of the artisans with the marketing skills and should be encouraged and assisted for building market linkages at different levels. They should be oriented to handle larger orders.
- *Integrated development through cluster development:* A systematic mapping of the artisans should be done at the state as well as the district level. The clusters need to be identified and organised depending on the crafts practiced in the specific area, followed by efforts towards an overall development of the craft and the cluster. The implementation of integrated craft development programme in these areas must form the next step.
- *Integration of programmes and schemes:* All the programmes and schemes for artisans and weavers should be clubbed and integrated for a wider coverage and intensive interventions. All these schemes should function under one umbrella so that the implementation, monitoring, follow-up and linkages turn out to be effective. These programmes should further be converged with different sectors.

Abbreviations used in the Report

AHVY	Ambedkar Hastshilp Vikas Yojana
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Center
AWW	Anganwadi Worker
CARA	Central Adoption Resource Agency
CHC	Community Health Center
DA	Dearness Allowance
DOTs	Directly Observed Treatment
FYP	Five Year Plan
GBC	Gender Budgeting Cell
GDP	Gross Domestic Product
GOI	Government of India
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
ICPS	Integrated Child Protection Scheme
ICTC	Integrated Counseling and Testing Centres
IEC	Information Education Communication
IFA	Iron Folic Acid
IHDS	Integrated Handlooms Development Scheme
IIHTs	Indian Institute of Handloom Technology
ISO	International Standard Organisation
IUD	Intra- Uterine Device
JSY	Janani Suraksha Yojana
MGBBY	Mahatma Gandhi Bunkar Bima Yojana Schemes
MH	Maternal Health
MoT	Ministry of Textiles
MTA	Mid Term Appraisal
MTP	Medical Termination of Pregnancy
NACP	National AIDS Control Programme
NAWO	National Alliance for Women
NCTD	National Centre for Textile Designs
NGO	Non Government Organisation
NHDC	National Handloom Development Corporation
NMDFC	National Minority Development Finance Corporation
NMDFC	National Minorities Development & Finance Corporation
NRHM	National Rural Health Mission
OBC	Other Backward Classes
ORS	Oral Rehydration Solution
PHC	Primary Health Center
PNC	Post Natal Care
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RMK	Rashtriya Mahila Kosh
RNTCP	Revised National TB Control Programme
SC	Schedule Caste
SHG	Self Help Group
SSH	Short Stay Home
ST	Schedule Tribe
STEP	Support to Training and Employment Programme for Women
TA	Travel Allowance
TB	Tuberculosis
TT	Tetanus Toxoid
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UPA	United Progressive Alliance
VHAI	Voluntary Health Association of India
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
WSC	Weavers Service Centre

Where the mind is without fear and the head is held high
Where knowledge is free
Where the world has not been broken up into fragments
By narrow domestic walls
Where words come out from the depth of truth
Where tireless striving stretches its arms towards perfection
Where the clear stream of reason has not lost its way
Into the dreary desert sand of dead habit
Where the mind is led forward by thee
Into ever-widening thought and action
Into that heaven of freedom, my Mentor, let my country awake.

Rabindranath Tagore