

CHAPTER VII

CONCLUSION

7.1 Findings:

The government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system adopting a synergistic approach by relating health to determinants of good health in segments of nutrition, sanitation, hygiene, and safe drinking water.¹ Improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children are the primary goal of NRHM.

Women's health rights specifically indicate reproductive and maternal health rights of women that have become a serious issue of concern in all over the world. Keeping it in mind, NRHM has implemented some of the specific schemes related to maternal and reproductive health of women in India like – JSY, JSSK and RMNCH+A, as an all-inclusive programme launched in 2013. This study has done on the implementation of these schemes in Nalbari district of Assam. Here, some core issues have been pointed out in reference to responses from the field and analyze has been made from the perspective of health rights based on the four parameters identified in General Comment 14, applying these parameters regarding the implementation of JSY, JSSK and RMNCH+A under NRHM.

7.1.1 Reproductive and Maternal Health Services:

7.1.1.1 Availability of Women's Health Services under NRHM:

The first element to measure the guarantee of health rights to the individuals is availability as identified by the ESCR Committee. Availability suggests that public health and health care facilities must be sufficient in number to meet the needs of the population. It is explicitly stated that such facilities include not only hospitals, clinics, essential medicines, and adequately paid medical staff, but also safe drinking water and adequate sanitation.²On the basis of the availability indicator, the finding of this research can be discussed as follows:

According to NFHS-4 (2015-16), Nalbari, 99.2% rural households in Nalbari district have the access to improved drinking water source, 52.1% rural households have been using improved sanitation facility, and 82.9% rural households are with electricity facility. During this study, it was found that 91.1% have the facility of drinking water within their household campus and other 8.9% have to collect water either from neighbour or from the water facility provided by the Public Health Department in the villages sometimes which is not sufficient. Carrying water is the responsibility of the women only within the family and it becomes problematic during their pregnancy and post-delivery period.

It was found that 5.1% respondents use open space toilet which may leave them vulnerable to attack and sexual assault. Further, 27.8% respondents use kachcha latrine for toilet and it may lead women to the vulnerability of communicable diseases, like RTIs, STDs, etc.

77.9% respondents informed about using of electricity facility in their households and 65.8% of them use clean fuel for cooking including L.P.G., Biogas and electricity. This percentage was found higher than the percentage shown in NFHS-4 (2015-16) as 33.6%. Rest 34.2% respondents use woods for cooking which pollutes the cooking environment and has health impact especially for the women using attached kitchen without ventilators.

On the basis of collected data from Assam Rural Health Statistics, 2016 and DLHS-4 (2012-13), as per the size of population, the quantity of health services in the study area could be seen as it was one of the important parameters related to the availability to measure the level of enjoyment of health rights. Study reveals that in Nalbari district, though the CHCs, PHCs and Sub-Centers meet the norms of population institution ratio, in terms of numbers of manpower or health personnel according to the needs of the population, the situation is very pathetic. There is a huge shortage of doctors according to the recommendation about minimum doctor population ratio of 1:1000 made by 'High Level Expert Group (HLEG) for Universal Health Coverage' constituted by the Planning Commission.³ In the district, doctor-population ratio is 1:4019. It is more than twice than the national average. Further, 1086.8 population come under the coverage of one paramedical staff along with 1349.02 populations, per one bed. Only 10 O&G specialists are there to cover up 3, 75,633 female population to deal with the obstetric care services. Only 40% CHCs are having Anesthetist including DH. Among the 192 total doctors available in the public sector, 69 of them are contractual employees under NHM. During the discussion with the doctors, it was found that the performance based salary structure of the doctors under NHM is not adequate and the

insecurity regarding their job-structure sometimes demoralizes them to concentrate in their works.

29.7% respondents reported non-availability of doctors in PHCs and CHCs which hampers providing the 24X7 facilities in the Govt. health institutions. Again, 29.7% of women revealed the non-availability of lady doctors, 16.4% non-availability of essential drugs and 15.8% reported non-functioning of laboratory facilities in public health institutions. 68.4% and 67.7% mentioned about the limited availability of essential medicines and limited functioning of laboratory facilities respectively. 62% respondents said about unavailability of RMP in their locality appointed specifically for the purposes related to maternal and child health that contains only 23 nos. of RMP (now known as CHO) in the whole district under NHM.

Research found that there is a close inter-connection between non-availability of services and the infrastructure facility of the health institutions. DLHS-4 shows that 85.7% PHCs have Residential Quarter for MO, 57.1% have regular power supply (Table 5.7). The discussion of the researcher with the health personnel, like– Doctors, ANM, Lab. Technicians, NRHM employees along with ASHA reveals that though the services are in name, these are not functioning. A doctor, working under Ghograpar BPHC (Borigog-Bonbhag Block) reported that according to the necessity of women, there is no labour room and operation facility in the health institutions for which women have to rush to other health institution with better facilities especially for C-Section delivery. There are so many PHCs and MPHCs with a single doctor. 18 PHCs and MPHCs from different blocks are running only with one doctor according to the report of NHM 2012-13 to 2016-17. 7 PHCs/MPHCs are functioning with single doctors who are in practice only for one year. Apart from this, Sialmari MPHC under Tihu block is

functioning without any doctor. As the doctors have other allotted duties too, in performing those extra responsibilities, women have to be deprived from the health facilities especially in hospitals running with one doctor. Again, inadequate and irregular supply of medicines, inadequate power supply with poor construction quality of health institutions hampers in giving adequate health services. It was reported that despite the availability of adequate number of health institutions, due to lack of manpower, health services do not reach to the needy women.

An ANM, under Tihu Block, while mentioned about Nathkuchi Sub-centre, revealed that due to establishment of Army camp, the actual location of the sub-centre's area shifted to a different govt. quarter to run its functions. She reported that maintaining 5311 population by a single ANM is difficult. It can be understood that though the sub-centers fulfill the average coverage of population norms at the district level, there is a disparity in the actual field regarding the distribution of population as per the health facilities.

Another ANM, from Barkhetri Block under Narua MPHC, reported that they have problems regarding staff quarters, availability of equipments related to maternal health care and laboratory facilities. Because of unavailability of staff quarters, employees have to come from distant places and 24×7 services cannot be given to the women. As because the ANM have to perform lots of responsibilities under NRHM, they have to face problem in delivering services. They cannot reach to each and every woman because they feel overburdened which resulted to remain certain areas untouched in the real field. As for the ASHA, there is no salary; ASHAs are not ready to assist the ANM in delivering services which they feel as their added responsibility.

Jamunattary sub-centre, under Tihu block is another example of sub-centre without facility. Because of reorganization of districts, a part of Jamunattary was included in Baksa district under Tihu-Barama CD Block and a new sub-centre was established without considering the population norms. As because this particular sub-centre does not cover the average population norms, Govt. has not constructed any building for the sub-centre and it has to continue its services in a room of a school as decided by the villagers and the school committee. Because of its establishment within school premises, it cannot serve the women of the locality as per their needs. Out of two ANM of this sub-centre, one of them reported that sometimes they have to organize VHND at ASHA's house or some neighbour's house though it is illegal as per the guidelines. As the sub-centre does not receive any grant due to its temporary settlement, ANM have to spend the expenditure for VHND and other services from their own.

Assam Rural Health Statistics (RHS), 2016 revealed that in Nalbari district, 9 nos. of CHCs are having functional laboratory, functional labor room and functional operation theatre. 3 of them have functional X-Ray machine including 2 FRUs. But it was found that though these facilities are available and functional; these cannot meet the needs of women within that locality. Regarding laboratory facility, laboratory personnel from Tihu FRU reported that all the facilities are not available in the FRU. There are certain very basic tests facilities are available, like– Blood RE, RBS, Urine test etc. Certain facilities like– X-Ray and Ultrasound are available, but only for two days is a week. THR test cannot be done within hospital facility as the equipment for this test is costly. He added that “though from the side of the govt., it has been announcing that all the health institutions are equipped with necessary facilities, it is actually in the hospitals like MMC civil Hospital and GMCH.” The condition is similar almost in all

the Blocks. Scarcity of manpower to run the laboratories and lack of equipment along with some structural problems e.g. adjustment of manpower in some other areas or institutions resulted to unavailability of laboratory facilities for women during ANC.

Through only 15.2% respondents reported about availability of essential drugs in their nearby health institution, it was found that 51.3% respondents paid for medicines during ANC which is the highest category of expenditure. It reflects that the essential medicines to be provided freely to pregnant women under JSY were not fulfilled. They had to buy it from pharmacy. Only IFA tablets are available as reported. Even then, 28 pregnant women constituting 17.7% bought it themselves of their own expenditure. 84 women constituting 53.2% did not get free medicine during delivery and 40 women constituting 25.3% spent on medicines during their postnatal period. There can be seen disparities regarding availability of medicines too. The health institutions have to inform the availability of medicines in that particular health institution openly for all on a board outside. During the survey, while the researcher visited the health institutions, it was found that regarding the availability of drugs in District Hospital and in other PHCs and CHCs, there is a huge gap. It reveals that the gap regarding availability of medicines and hence other health services are visible in primary and secondary or tertiary level health institutions.

7.1.1.2 Accessibility of Women's Health Services:

After the availability indicator, the next element of measuring health rights comes as 'Accessibility' which is very much closer to its first element. Accessibility has again four dimensions: non-discrimination; physical accessibility in the sense of being in safe physical reach (including water and sanitation); economic accessibility, in the

sense of affordability, for all including the economically most disadvantaged; and information accessibility, concerning the provision of health-related information to the general public.⁴On the basis of these four dimensions, accessibility of reproductive and maternal health services can be summarized as follows:

The research has done on women's reproductive and maternal health related schemes under the programme of NRHM giving special recognition to JSY, JSSK and RMNCH+A. Maternal health was analyzed through three different phases– prenatal care (antenatal care), intra-natal care (Delivery Care) and postnatal care. JSY includes certain provisions regarding antenatal care and delivery care with a view to decrease the MMR through maximization of institutional delivery. On the other hand, JSSK deals with certain provisions related to delivery or intra-natal and postnatal care services. Further, a new programme was launched in 2013 as a comprehensive programme including maternal, mental, child adolescent health along with reproductive health. During the analysis of data, access to different provisions under these three schemes were analyzed which shows the accessibility of health services under NRHM based on women health.

In the 9 month pregnancy period, according to the provision of JSY, at least 4 times Antenatal checkups are necessary. It helps the pregnant women to monitor and detection of pregnancy complications which could arise during delivery and post delivery period. ANC works as the preventive measures for the expecting mothers with complications. As per the data calculated on the basis of Health Management Information Systems (HMIS) Report, Nalbari, since 2012-13 to 2016-19 (March); among the total women registered for pregnancy, 82.7% pregnant women registered for ANC in their first trimester. But NFHS-4 (2015-16) recorded it as 60.4% in rural areas

of the district. On the other hand, study showed 92.4% women registered their pregnancy in their first trimester which reflects the positive role playing by the grass-root level workers like– ASHA and ANM. ANM under NRHM has a performance based salary structure where registration of women within first trimester is one of the most important indicators. It was found that ANM insists the ASHAs to make sure the registration for ANC within the time period as mentioned under JSY.

During four antenatal checkups, JSY, under its provisions mentioned about BP check-up, urine examination, weight measurement, and abdominal check-up, HB test, T.T. vaccination and IFA consumption for the pregnant women. NFHS-4 (2015-16) recorded 47.9% women have availed full ANC for four times. But study result showed a different data which is only 55 women constituting 34.8% out of the total respondents who completed 4 ANC checkups.

While JSY has made certain provisions for diagnostic tests during ANC checkups, JSSK has made are these tests free and zero cost facility. Table 6.20 reveals the percentage of pregnant women availing these facilities related to medicines or drugs, diagnostic tests including ultrasound and vaccination. Research shows a satisfactory result showing maximum numbers of women availing these facilities which is more than 90% almost in all services except 83.5% in ultrasound, 5.1% in X-Ray. It is clear that execution of JSY is positive in study area.

But, there can be found a different picture in case of implementation of JSSK which should be zero cost expenses for the pregnant women during their pregnancy or ANC checkups. Based on the ‘economic accessibility’ or affordability indicator, this research found that despite the implementation of JSSK, 67.7% respondents have to pay

for different services during ANC. This expenditure varies which costs maximum of Rs. 5000/--6000/-. Maximum 51.3% respondents have to pay for medicines followed by 27.8% for diagnostic tests including ultrasound.

Research showed that 24.1% respondents took money on interest for ANC expenditure and others who had to spend for ANC checkups had incurred their expenditure from their savings. Only 7% respondents were found having health insurance including accidental benefits. But it was not applicable in case of their maternal health. Economic accessibility or affordability indicates that health services should be affordable for all, including the socially disadvantaged groups and it should be based on the principle of equity. Giving emphasis on this indicator, Govt. of India, has decided to provide free delivery services to women through the implementation of JSY and JSSK under NRHM. Special provisions are made for the women from BPL categories that are more disadvantaged in terms of their socio-economic conditions and unable to afford quality health services for them.

Again, giving special emphasis on maternal health, JSY includes provisions on proper diet and rest for women during pregnancy. To support women for nutritional diet, JSY has made a provision of giving assistance for Rs. 1000/- under the scheme of 'Mamoni' for those women who have registered their pregnancies in two installments. 82.9% respondents received the assistance under Mamoni in full, while 10.1% received no benefit against 7% received single installment for Rs. 500/-. Further, 77.2% women mentioned about maintenance of nutritious diet during their pregnancy. A gap can be seen regarding the receiving of full assistance under Mamoni and maintenance of nutrition diet. The researcher found that a few respondents did not utilize the entitlement for them for having proper diet and they utilized it for the cause of their family as most

of them belong to the lower economic background. So, for them, health comes later in comparison to other socio-economic problems.

It is recommended that rest for pregnant women should be ensured for at least 8 hours sleep at night and another 2 hours rest during day time as mentioned under the provisions of JSY. Data showed that 41.1% respondents had no change in their life-style regarding physical labour during their pregnancy and other 58.9% respondents reduced their physical labour. Table 6.26 showed that 48.1% respondents were found from nuclear family and 51.9% respondents were from joint family.. But the commonality was that respondents felt themselves doing household works as the responsibility of women. Reducing physical labour was not found to be connected with the nature of family. Because a few women from nuclear family reported that as no one was with them to assist, they had to do everything till the day of birth of their baby since morning to night. They had no other option to escape from household work as they are women. In joint families, report was found different. Women, who did not reduce physical labour from joint families, mentioned that all the women within the family had their own confined works and the in-law did not want to assist and to do added works for them. Research found that among the respondents, those who are from much lower socio-economic background and are daily labourer or agricultural labourer, they cannot take rest as earning is a compulsion for them to run their families.

Tracking of pregnancy through registration is essential to encourage and ensure institutional delivery for safe motherhood. JSY was introduced to decrease the MMR encouraging for institutional delivery with the attendance of medical experts or skilled personnel and JSSK has come as a support for it ensuring physical and economical accessibility making it affordable for all women with free and zero cost delivery and

caesarean section. ASHA was appointed as they work at grass root level as a link between the pregnant women and the health facilities. To motivate women for institutional delivery and for motivating the pregnant women, under JSY, an incentive of Rs. 1400/- for rural women and Rs. 600/- for the ASHAs in rural areas are provided. Research found that 99.4% respondents were registered for ANC and received MCP card and 96.2% have gone for institutional delivery which is higher than the report of HMIS, Nalbari against 90.94% whereas NFHS-4 shows 81.5% institutional birth regarding the rural women of Nalbari district. 3.8% respondents were found doing home delivery without any attendance of skilled health worker or ASHA. The record of home delivery was found in Barkhetri Block among the women from Muslim religious group who belong to the Char areas of Mukalmua. Their geographical location leads to their socio-economic backwardness and alienated them from their physical accessibility to other services including maternal health services for women. It was found that health institutions were established in Char areas, boat clinics were introduced. Despite these, because of their geographical differences from the other parts of the district, health personnel are not interested to be present there. And it becomes difficult for the pregnant women in the Char areas to avail better health facilities in the health centers in town due to their problem of communication and transportation.

It was reported that 86.1% respondents received the incentive of Rs. 1400/- under JSY for institutional delivery against 56.9% for pregnant women and 54% for the ASHAs for motivating to do institutional delivery as reported in HMIS Report, Nalbari (2012-13 to 2016-17). This gap between the report and the data found from field survey shows that a larger percentage of women prefer delivery in private health institutions for which they do not get the benefit under JSY for institutional delivery. ASHA said that

women who can afford are interested to go to private nursing home for delivery even if they go for ANC in public hospitals. Delivery through caesarean operation is problematic due to unavailability of anesthetists in Govt. institutions and women have to be referred from primary to secondary and secondary to tertiary health institutions for it. As the public hospitals are overcrowded with less manpower, and referral service is only till the DH due to institutional hierarchy, the family members prefer to admit the expecting mothers in the private hospitals in the town of the district than taking them to GMCH. Hence, sometimes ASHAs do not get their incentives under JSY. Further, the beneficiaries have also to cut their entitlements sometimes as they have to bribe ASHA or Nurses or health officials as reported by a few respondents.

Information accessibility is another important element to understand the enjoyment of health rights which is directly related to the affordability of health services. Regarding maternal health, JSSK was introduced to provide free delivery care services with both normal and caesarean delivery. JSSK includes the provision of free drugs and consumable which includes free IFA (even after delivery upto 6 weeks), free essential diagnostics e.g. blood tests, urine test, ultrasound (during ANC, delivery and PNC upto 6 weeks), free diet during stay in the health institution, free provision of blood, free transportation from home to health institution, referral service and transportation between institutions and home with '108' and '102' services. It was found that a very higher percentage of respondents are not aware of the services under JSSK and JSY. 80.4% respondents were found having no knowledge about the provisions under JSY, 89.9% were unaware about the free provisions under JSSK. So it can be assumed that lack of knowledge on the schemes under NRHM has resulted to the poor health condition of women.

NRHM has incorporated the provision of Health Information System (HIS) as a technical support to the mission. VHND is a part of this health information system that to be organized in every villages once in a month with ANM, ASHA, AWW, PRI members, health personnel and officials, village head, teacher, academician including the mothers and children as the main part. It is a part of IEC (Information, Education and Communication) to make the common people aware of different schemes, provisions and facilities under the health sector and to make them understand about the preventive and curative measures. Research found that very few respondents were aware about the day is called by service providers to participate in the proceedings. Only 16.5% respondents heard about VHND which is organized on third Wednesday of every month on the day of Vaccination. They mentioned that only vaccination was done and there was no counseling and meeting and attendance of other personnel except ANM, ASHA and very often the member of PRI and AWW they could see. Actually, from the side of NRHM, information should be given on the schemes and services to the villagers through announcement on loudspeakers as it is a popular method of information in rural areas. Again, reminder should give over phone calls or messages from the health institution on timely checkups for ANC, PNC and vaccination or immunization with the help of technical experts. But no such record was found in the study area. Few respondents including 1 (one) from Tihu Block mentioned about receiving sms as reminder which was not regular at all.

Lack of information accessibility may lead to inapproachability of health services. During the survey of this research, 69% respondents were found from BPL category. Due to their socio-economic condition, availing better health facility is like myth for them. With the introduction of JSY and JSSK, Govt. has given emphasis on all

inclusive maternal health care for this disadvantaged group with the notion of equity. But, loopholes in HIS deprived the respondents in availing the facilities under these two schemes along with the provision of RMNCH+A programme.

During the study, it was found that JSSK is unable to meet the expectation of the women regarding free and zero cost delivery due to the unavailability of infrastructure and equipment in the Govt. health institutions. 76% respondents paid for availing delivery services and other 24% have not done any expenditure in the name of delivery. There are evidences of paying to doctors, nurse and other staff including sweeper, diagnostic tests, medicines, transportation and ASHA even in Govt. hospitals. Respondents, gone for both normal and caesarean operation revealed about these expenditures. 16.5% respondents reported paying to the doctors for delivery which is highest in amount. Doctors took Rs. 5000/- to 8000/- for caesarean delivery in some of the public health institutions in the district. Diagnostic tests have to be done at private clinic outside the hospitals. Basically ASHA use to assist them to the private diagnostic centre and pharmacy for medicines. Most of the respondents gone for caesarean operation revealed that “There is a nexus between the private diagnostic centre and the doctors via the ASHAs. All of them calculate their own commission.”

Regarding the free transportation facility under JSSK, it was found that 42.4% respondents availed the ‘108 Mrityunjay’ service, 0.6% availed the referral service and 67.1% respondents have used ‘102 Adarani’ service under NRHM. But even among these respondents, who availed free transportation services, maximum of them reported that they had to pay the drivers of the vehicles in the name of tea or for fuel. It was found in all the blocks. The respondents who did not receive the transportation service; more of them were due to their ignorance about the free service under NRHM. While a

few respondents reported that waiting for '108' during emergency is risky as the vehicles are not available in most of the time. It was observed that respondents were aware of '108' services and '102' services to some extent, but unaware of the referral services under JSSK.

As recommended by WHO, regular checkups for lactating mothers are very important to know the availability of the danger signs for the new mothers. The study found that the scenario of postnatal care in the study area is not at all satisfactory. Respondents are not aware about the danger signs during their post-delivery period. Research showed that only 19.6% respondents have received the PNC for 3 times other than the PNC they received during their stay in the health institution. After discharge, only 18.4% respondents were checked by the doctors during PNC check-up. 63.9% lactating mothers did not go for PNC check-ups. They mentioned, they were not aware that PNC is also necessary like ANC. No one informed them. It was found that a few respondents had pregnancy and delivery related problems that continued till their post-delivery period. 32.3% respondents reported complications including weakness, anemia, stomach pain, swelling of legs, excessive bleeding etc.

Respondents revealed that they are unaware of the free PNC services up to 6 weeks as mentioned under JSSK. Those who went for PNC had to spend in the name of medicines, and transportation and other. 5.7% respondents paid to the nurses for PNC. As the respondents are unaware of PNC checkups, they are unaware of the role of ASHA and ANM too. It was found that regarding caesarean mother, ANM took money for cutting the stitch. ASHAs were not regular; even if they came they never checked the lactating mothers. 1.3% respondents reported their expenditure in paying to the

doctors, 25.3% incurred expenditure in medicines during PNC and 26% of them had incurred indirect expenditure, like transportation and losing of wages etc.

To make the health services approachable and affordable for the socially disadvantaged class, to make it cheaper is necessary. Among the respondents, 76.6% were housewives with no income. They were unpaid laborers of their house as they did not get anything for household works and had to depend upon others for every kind of needs. Their dependency on their husband and other members of their family sometimes restrict them to share their problem and avail the health facilities. Though the Govt. has made maternal health services free, still it is far behind in practice. Even they do not take rest after delivery which is visible everywhere due to their feeling of responsibility for household works.

It was observed that 8.2% of the respondents were engaged in their household work within 15 day of delivery. Even it was reported that women do not want to stay in the health facility as they feel their household and outside works (in case of laborers) can be hampered. A few women reported their starting of work just after their coming from the hospital. But majority respondents constituting 49.4% started working since 30-40 days. A major social reason is behind this 30 days rest for women 70.3% respondents are from Hindu religion. According to their religious norms, women are considered to be impure for one month after delivery. As they are considered as impure and stay separately they did not work for one month. It was revealed during the discussion with respondents while surveyed.

NRHM, under its newly launched RMNCH+A programme, includes the reproductive health as one of its core part. Under this programme, this study found that

80.4% respondent uses different methods of spacing for family planning. A larger section of respondents with 73 in number mentioned of using contraceptive pills as a method of spacing. According to the HMIS Report, Nalbari, since 2012-13 to 2016-17 (March), 2, 31,709 oral pills were distributed among eligible couples and 1715 weekly pills and 2335 emergency pills were distributed. But research reveals a very negative scenario regarding the free contraceptive pills distributed to the needful. It was found only 5% respondents received free contraceptive tablets from ASHA and sub-centers, while 94.4% revealed a negative result. 2.5% respondents are not aware about the distribution of oral pills by ASHA and ANM to the households. Regarding family planning method, 19 respondents out of 158 reported using of IUCD/PPIUCD and 35 respondents have done female sterilization. Only 13 respondents received the incentive for sterilization. 94.3% respondents did not get the pregnancy kit from ASHA. Respondents reported that even if they get it, they have to pay for the pregnancy kit.

Safe abortion is another aspect of protecting women's reproductive rights. 15.8% respondents mentioned about their abortion due to different reasons among which unwanted pregnancy was the major one, 5 respondents were found aborted due to medical complications 19 respondents were found aborted through surgical process. On the other hand, 2 respondents were found to be aborted using traditional method at home. 7 respondents reported that they had complications after abortion, like— pain, headache, excessive bleeding and menstrual problem.

It was revealed that for abortion too respondent had to pay the doctors in public hospital. 1(one) respondent from Tihu block mentioned that she had miscarriage and had to go for abortion due to unwanted pregnancy for 3 times. Every time she paid the doctors to operate the surgical procedure which cost minimum Rs. 500/- for each

abortion procedure. This expenditure and non-availability of services under JSY, JSSK and RMNCH+A is due to lack of information and thus it creates problem in the enjoyment of reproductive and maternal health rights.

7.1.1.3 Acceptability of Health Services

Acceptability is considered as the third element of health rights framework which requires that medical facilities and services meet standard of medical ethics, and are “culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, [and] sensitive to gender and life-cycle requirements”: a complex matter.⁵

As per the recognition of the eleventh five year plan, AYUSH was included in the health delivery system in India to meet the cultural needs of the society along with health services. NRHM also revitalized the local health traditions mainstreaming AYUSH within the health care services. NHM Progress Report, Nalbari, 2012-13 to 2016-17 showed that 38 Ayurvedic doctors were appointed in Nalbari along with 13 doctors from Homeopathy background. The relationship between different system of health services and peoples’ belief in different types of medicine is visible in the present research.

On the basis of their religion, customs, and personal experiences, peoples’ adoption regarding the system of medicine is different. A few respondents from Muslim religious groups specifically from Barkhetri development block were found who believe in the Unani system of medicine. Further, respondents were found believing in Homeopathy for child care, explicitly for neonatal care. Mothers took their children to some private Homeopathy clinic as they believe them to be the best for newborns and

scared to give allopathic medicines as the medicines are very strong. It was observed that with variation of illnesses and nature of illnesses, the acceptance of health care system also differs. In this study, 70.3% respondents were from Hindu religious group against 29.7% were from Muslim religion. Research found that there is a belief among the respondents curing certain illnesses by using traditional herbs and casting spells that was evident among the respondents of both the religious groups. It makes clear that a few respondents still believe in “white magic” for healing certain illnesses which seems to be unable to identify by the doctors or western or AYUSH system of medical care. 1 (one) respondent from Tihu block mentioned, “the child had a problem of becoming senseless since birth. The doctors including pediatricians were unable to cure the child. That is why husband went to a person who had a record of curing many people with his spells. He gave some herbs to eat and to wear a ‘taabiz’ and the baby became cure.” To believe or not to believe is a very sensitive issue. That is why to ensure people’s acceptability of the health delivery system; it needs to be structured according to people’s needs along with the maintenance of the quality.

Regarding reproductive rights, NRHM has given emphasis on family planning through the use of contraceptive pills, insertion of IUCD/PPIUCD and sterilization for both male and female under the scheme of RMNCH+A. Data revealed that 4.4% respondents had no knowledge on the method of spacing. 5.1% were against spacing between children and 19.6% respondents reported not using of any spacing method. During survey, it was revealed that women, who were either against spacing or did not use the family planning methods, most of them were from the Muslim religious group. They reported that using the method of spacing or going for sterilization is against their religion. Society excludes them from taking part in some religious rituals if they go for

sterilization. Further, an ANM from Narua MPHC, herself who is a Muslim, reported that motivating women for sterilization or to make them understand for adopting the methods of family planning is difficult due to their religious barriers. The same report came from the ASHA's from different blocks too. But, exceptions were there as a few women were found who have gone for tubal ligation procedure even though they were Muslims from different villages.

Safe abortion is another aspect of protecting women's reproductive rights. 15.8% have mentioned about their abortion due to different reasons among which unwanted pregnancy was the major one. 2 respondents were found to be aborted using traditional methods at home. Respondents from Mukalmua Char areas reported that sometimes they go to Unani doctor, who are very much available in those areas for medication regarding the problems arises with them and their children.

Though accessibility of information is necessary, confidentiality should be maintained regarding personal health data as a part of medical ethics. It was reported that 44.3% respondents did not found privacy during their ANC while consulted with the doctors. Though labour rooms were there in most of the delivery points, for ANC there were no separate room for the pregnant women. As there is a rush in the Govt. health institutions women have to consult everything in front of others and it becomes difficult for the doctors and other staffs to control the people from gathering surrounding the doctor's table. As a result of this, pregnant women get disturbed in consulting their problems with doctors and they cannot become satisfy with the services provided by the doctors. For doctors too, certain assessments, like- abdomen checkups during ANC become problematic which has an impact on detection of complication regarding maternal health of women. One ASHA from Tihu block reported that due to

scarcity of O & G specialists, the cabin of the specialized doctors become overcrowded and it cannot meet the necessity of pregnant women. Sometimes, because of the name and fame and behaviour of the doctors, people use to rush to such doctors for every kind of problems and hence it becomes difficult to maintain privacy for pregnant women.

It was observed during research that though maximum respondents were availed the services under Govt. facilities they were more interested and trustworthy regarding the service and facility provided by the private nursing homes. As reported, they cannot avail it due to their economic condition and lack of awareness regarding the inclusion of provisions as supplementary strategies under NRHM based on Public-Private Partnership for achieving public health goals. Thinking health care services in public facilities as their fortune due to their poor economic status, they feel to go to Govt. hospitals. But a few respondents exceptionally reported their satisfaction in public health facilities, especially regarding maternal health services as they feel the scenario of Govt. health institutions has changed after the implementation of NRHM since the decade.

7.1.1.4 Quality Health Care Services:

The fourth and final element of understanding health rights is Quality. As well as being culturally acceptable, health facilities, goods and services must also have to be scientifically and medically appropriate and of good quality. Good quality requires well-trained skilled medical personnel, scientifically approved and unexpired drugs, functional machinery and equipment, adequate sanitation etc.

Women's health is the area of special importance under NRHM including reproductive and maternal health. NRHM has taken various initiatives for safe

motherhood. Under JSY and JSSK, emphasis has been given on antenatal care, delivery care and postnatal care with a view to improve the quality of maternal health services. For early pregnancy complication detection, 48.1% respondents were checked by doctors and 34.8% were by ANM or CHO during their ANC checkups. Institutional delivery is one of the most important features of providing quality maternal care for women with the attendance of skilled and trained health personnel. 96.2% respondents were reported to give birth in public and private health institution. But 18.4% of total institutional delivery was only by nurse as reported. This was happened due to the scarcity of registered medical practitioner. Though there is a scarcity of manpower, there are problems regarding their qualifications too. WHO reported that in rural India, just 18.8% allopathic doctors have a medical qualification as published in the study titled “The Health Workforce in India”, 2016 (June). As a portion of respondents were found to be the believer of the Indian System of Medicine (AYUSH), they use to go to some private clinic, especially Homeopathy and Unani. But there is a doubt regarding their qualifications as most of them are not registered. Simultaneously, respondents were found who don’t have trust on this system and they prefer Allopathic showed hesitation in consulting with Ayurvedic doctors available in the health institutions.

For a quality delivery and postnatal services, JSSK was implemented under NRHM. Provisions were made with free services to keep the lactating mothers attached to the health personnel to maintain the quality of their health. Despite this, a very negative picture was found in case of postnatal care. 63.9% women did not receive PNC checkups. Respondents were reluctant to go for PNC checkups as they were not aware about PNC and PNC related free services under JSSK.

Under RMNCH+A, NRHM has been trying to provide a better reproductive health service for women. Reproductive health rights and maternal health rights are interrelated and overlapping. Safe abortion is a part of reproductive health rights having an impact on maternal health. RMNCH+A was implemented to popularize the method of abortion in a safest and medically approved way. During the research, out of 25 respondents going through abortion, 76% were found to be aborted through surgical procedure with the presence of skilled health personnel or doctors. Emphasis was given on quality sterilization using laparoscopic operation in hospitals with an incentive of Rs. 1400/- for female, Rs. 2000/- for male and Rs. 2200/- for post-partum sterilization to motivate them. 22.2% respondents were found who went through this procedure including 13.9% who did not receive the incentive and 8.2% who received the incentive for sterilization. 18 respondents were found who felt sterilization to be risky and unsafe because of its repercussion during post-sterilization period as they have seen in case of other women. Respondents reported that there are so many cases of its failure which also prevent them to undergo through this procedure. They are skeptical about the quality of operation and the operators specifically the operations held in health camps. Quality medicine is another criterion for quality health service. During the discussion of the researcher with health personnel, a variation was found in data regarding the quality of medicines provided by different health personnel. 1 (one) NRHM employee from Barbhag Block and an ANM from Tihu Block mentioned that though medicines are not strong, but it maintains the quality. Whereas, a doctor from Borigog-Banbhag block said that the quality of medicine is not good, hence it does not work sometimes and have to prescribe some other medicines that are not available in hospital pharmacy. People have to buy it outside. Most of them including doctors, nurses and respondents mentioned

about irregularity of supply of medicines to the health institution according to the need. Even the researcher can see this variation of opinion regarding the quality of medicines among the respondents too. Respondents reported that though medicines are not available for the beneficiaries, it become expired inside the storage of the hospital. Most of the respondents revealed about “the nexus between the pharmacy outside the hospital, Medicine Company and the doctors” on the basis of doctor’s prescription. They also reported that “there is also understanding of commission between ASHA and private pharmacy as ASHA sells out some medicines and equipment to them and takes the expecting mothers to the pharmacy they want for buying medicines.”

According to Assam Rural Health Statistics, 2016, 9 nos. of CHCs are having functional laboratory with 70 Lab. Technicians and 6 Radiographer (NHM Progress Report, Nalbari) in Nalbari district. It can seem that more than 90% respondents have done the necessary tests during ANC checkups. Though this data looks quite pleasant, the actual truth behind this data is very different. Survey revealed that maximum nos. of respondents who went for ANC in Govt. facilities had done their tests in private diagnostic centre either with the recommendation of the doctors or the suggestion from the ASHA. Most of the respondents reported that they did not get actual result from the tests done in public facility. Though the ultrasound facility is available, as one ASHA from Tihu block reported, the picture does not come clear which creates problems in detection of pregnancy complications and they have to take them to private diagnostic centre. Scarcity of manpower is another problem of non-functioning or limited functioning of laboratory facilities. Respondents revealed that during delivery, whether it is caesarean or normal, they had to buy the Celine, syringes, cotton, thread and other equipment from outside as it was not available in the hospital pharmacy. Respondents

were little aware about the expiry of drugs, but not at all aware about expiry of equipment.

For adequate sanitation, hospitals have their own employees for cleaning, mopping and washing. But in the Govt. facilities, hygiene and sanitation is not up to the mark. Maintenance of hygiene is essential to protect the lactating mothers and newborns from outside threats and infections. But study found that for maintenance of hygiene respondents had to pay to the sweeper. Otherwise, they refused to clean and wash. Scarcity of water, unhygienic lavatory, improper disposal due to lack of waste management and unavailability of and unorganized dustbin, public health institutions fail to maintain its quality.

The above analyze on the reproductive and maternal health services under NRHM on the basis of four elements including availability, accessibility, acceptability and quality has shown the scenario of women's health rights in Nalbari district. It is well understood that Child health occupies an important place in the health services which is related to reproductive and maternal health. The life of a child starts from mother's womb and its cycle proceeds through the process of pregnancy, delivery, neonatal, child and adolescent stage. NRHM, under its jurisdiction has covered up all these stages with the implementation of RMNCH+A programme in 2013 with special emphasis on maternal health implementing JSY and JSSK. JSSK is the scheme which covers the neonatal stage of children, meant 0-28 days of delivery, with free and zero expense treatment for newborn till 30 days. It contains free drugs and consumables, free diagnostics, free provision of blood, free transportation facility for the newborns. Again, RMNCH+A is a comprehensive programme of the mission extending the special health services to Child and Adolescent health along with reproductive, maternal and neonatal

health. As the children are the future of a Nation, adolescent girls are tomorrow's mother. Therefore, special care and counseling is necessary during adolescence. But as this research has done specifically on women's health rights with special reference to maternal and reproductive health of women; the researcher has confined the research work to Reproductive and Maternal health rights giving a touch on Neonatal child health.

7.1.2 Neonatal and Child Health:

Weight measurement during birth is important because it helps in tracking the newborns that are underweight or below 2.5k.g. It was reported that 96.2% newborns were weighed just after birth. 62.7% newborns were given colostrum within one hour of delivery necessary to strengthen their immune system.

First week is very significant for the newborns and the mothers and there are chances of diseases as they are prone to infections. To reduce neonatal death preventing these diseases, counseling for the lactating mothers is necessary. The responsibility for counseling is given to ASHA through 6 time home visit till 42 days of delivery. Study shows that only 1.9% respondents were found who reported 6 times home visit by ASHA. But 22.2% were found without a single home visit by ASHA. It means ASHA went for home visit, but did not complete the cycle and child and lactating mothers was not counseled when they actually needed.

Research found that 90.5% respondents were not aware about the free and zero cost treatment till 30 days, 94.3% were not aware about the free transportation service during neonatal period under JSSK for newborn. Respondents had no information of the tracking system by ASHA for Low Birth Weight (LBW) child. 57.6% respondents had

no knowledge of free NBSC and 62.7% were unaware of SNCU. Lack of information resulted to non-availability and inaccessibility of services which may contribute to rise of IMR with neonatal death.

Study found that regarding baby illness in first month, 36.7% reported about falling ill of their baby. They were not aware about free treatment for neonatal under JSSK and most of them had taken the newborns to the private clinics, especially for Homeopathy. Respondents were not aware about the existence of Homeopathy doctors in public hospitals. They did not avail the free services for treatment, diagnostic tests, medicines and transportation.

Immunization Programme is one of the preventive mechanisms for children. Out of 158 respondents, during survey the researcher found 154 living babies. 100% were provided Immunization card. Report was found of giving bribe to ASHA for immunization card. 1 child was found without a single vaccine given. There were so many cases of lapse of vaccines for the children due to unavailability, lack of awareness, lack of information and reluctance of the mother and family. Report was found on post-vaccine complications from few respondents.

Children within the age group of 0-6 years with pregnant mother and adolescent girls come under the domain ICDS which provides supplementary nutrition, health counseling and health check up with growth monitoring of the children and home visit. It is an initiative of NRHM to strengthen the institutional mechanism with integration of other departments. Bringing ICDS, the Health department has tied up with the Department of Social Welfare through the inclusion of AWW in various activities under NRHM. But research showed that respondents' perception towards ICDS services is very negative. They reported that AWC are surviving only with the distribution of

nutritional supplement which is too very limited in number of items, quantity and quality.

Behaviour of the service providers has a greater impact on availability, accessibility and acceptability of services. Regarding their behaviour, a mixed response was found in Nalbari district. A common view can be seen regarding the activities of AWW in all the development blocks of the district. They were unaware of the activities that to be performed by the AWCs. While the researcher had tried to make them understand about their activities, respondents had shown their dissatisfaction with them. It was reported that neither for health check-up nor for any other activity, AWW entered into the villages. Therefore, the submission of yearly family health report on women and child by the AWW is doubtful. Only 28.5% respondents were found to be satisfied with the activities of AWW. On the other hand, problems are there in the implementation of ICDS from the higher level too. It was reported by some AWW that AWC do not have proper infrastructure. One AWW from the village Nathkuchi No. 2 under Tihu block mentioned that they have temporary settlement with temporary infrastructure facility. Sometimes AWW have to build up their centre from their own salary. Centers do not have water facility to prepare food for children, to maintain hygiene. The same condition was revealed by another AWW in Barkhetri block too. Apart from these, the women of the locality are not interested in their counseling regarding health as they are not the persons from medical background as some of the AWW reported. People scare to take medicines supplied by the Govt. related to child health. So, providing service as per the norms become difficult for AWW.

Behaviour of Govt. hospital staff members is an important factor to increase the level of satisfaction of women and to motivate them for institutional delivery and other

key indicators in NRHM. It was found that 79% women were satisfied with the doctors including their services and service related behaviour. Again, 85.4% respondents showed their satisfaction with Govt. hospital staff; specifically with the staffs under NRHM, who are young, energetic despite their nature of service is contractual. Few respondents and ASHAs were dissatisfied with the services and behaviour of the doctors and NRHM employees. It was found in Tihu, Pachim-Nalbari and Madhupur block. Some of the ASHAs complained that they treat them as no one and do not want to give the basic respect as a human being. Both the respondents and ASHAs were more complaining on the service and behaviour of the staff nurses in all the seven blocks. Respondents reported that for each and every kind of services they have to request the nurses and they demand money for it. Behaviour of staff nurses is worse in District Hospital as revealed by respondents and ASHAs than the PHCs.

Knowing the behaviour of ANM is important as ANM is the key person who has technical knowledge and has presence in the village also. 75.9% respondents showed their satisfaction with the behaviour of ANM. While from the rest 24.1%, few respondents reported it unsatisfactory mentioning that ANM do not perform their duty specially related to village level survey and PNC checkups and demand money from the respondents. Some ASHAs also complained about ANM regarding their survey and home visit. It was found especially in Madhupur, Pachim-Nalbari, Tihu, Borigog-Banbhagand Pub-Nalbari block. They reported that the surveys which are under the domain of ANM, usually they do not do it and do not go for home visit for PNC checkups. ASHAs have to do it for them but do not get any incentive as these are not their responsibility and it is wastage of time for them. Sometimes, ASHAs have to share their entitlements with ANM and hospital staff especially from the amount they get

from special programmes. While ANM reported that they face problems from beneficiaries as some of them are reluctant to avail the facilities to be provided and hence it influences in the performance of ANM. It was found from the discussion with the ANM that ASHAs are having less educational qualification and their ignorance and reluctance in maintaining data on daily or monthly basis creates mismanagement in keeping records and becomes problematic for ANM.

ASHA workers are working like a bridge between community people and ANM. Though ASHAs are at lowest hierarchical position among the health personnel under NRHM, they are the most attached persons with the women and their situation having all information of all the people of the villages. Therefore, the behaviour of ASHA should be co-operative with the villagers to bring them towards the services to fulfill the goals of NRHM. 83.5% respondents were found to be satisfied with the overall behaviour of ASHAs. Rest 16.5% respondents complained regarding the services provided by ASHA saying that ASHAs were not regular in their service. They are reluctant to come when needed. Research showed that though ASHA are voluntary health workers, they get incentives for providing services for each and every kind of activities under NRHM. NRHM has given the moral responsibility to the ASHAs for a better health service in rural areas. But research revealed that ASHA takes bribes for different types of services especially for maternal and reproductive health service as respondents are unaware of prescribed services under NRHM. It was reported that ASHA sells out the facilities they get as ASHA Kit including pregnancy kit, contraceptive pills, condoms etc which should be free. Apart from these, for some other facilities too ASHA take extra money other than fixed from the side of NRHM. Respondents are not satisfied with the cooperation from ASHA in some villages as they

mentioned that the behaviour of ASHA is not equal for all. Some ASHAs are not active in their performance, but some respondents are highly satisfied with the behaviour of ASHA in the same locality. Respondents revealed that “in most cases, ASHA works for incentives, not for the sake of their profession. This is visible in their PNC checkups.” ASHAs do not inform the villagers for organizing VHND as reported.

But the discussion of the researcher with the ASHAs has revealed the problems facing by the ASHAs. It was reported that during the first implementation of NRHM in 2005, ASHAs were told just to assist the expecting mothers to the health institution for institutional delivery. Later, the responsibility of the ASHAs has increased. They have to take all the responsibilities of women and child health along with the programmes related to curative and preventive health care. They have to attend trainings of their own cost as they do not get the minimum allowance regularly on time, conduct meetings, counselling, home visit, assist pregnant women for ANC and deliveries, conduct survey and submit reports and so on and so forth. Along with these, they have added household services and responsibilities for their husband, in-laws and children as a woman. They are over-burdened with their responsibilities. Some of the ASHA s reported that the size of population under them is much more than the existing norms. All these are the factors which hampers them in giving regular and quality services to the women. In the context of organizing meeting and counselling, they reported that though there is a Fund for ASHA of Rs. 10, 000/- per annum, it has to keep with the member of concerned Gaon Panchayat in a joint account. This fund is performance based. Most of the ASHAs reported that they have to bribe the members of PRIs in withdrawing the amount as their signature is needed which restricts them in the utilization of the fund properly and annually. Reports found that from transportation to Xerox, everything they have to incur

the expenditure of their own. As the ASHAs do not get salary, it becomes difficult for them to pay from their own entitlements. Research showed that the concept of voluntary worker under NRHM is not clear among the ASHAs as well as for AWW and members of PRIs.

NRHM has brought PRIs under its domain to provide hygiene and sanitation which is one of the most essential and important aspects of understanding health rights. Hygiene and sanitation ensures prevention of communicable diseases and women's vulnerability in the society. NRHM envisage inclusion of PRIs in District Health Plan led by Zila Parishad, selection of ASHAs, involvement in RKS for good hospital management and VHSC led by Gaon Panchayat to prepare Village Health Plan with the implementation of Total Sanitation Campaign (TSC). Provisions were made to provide training to members of PRIs. But in the actual field, the research found that 94.9% respondents were not aware of the existence of VHSC in their village. When they were asked about safety latrine provided by Panchayats, 32.9% reported the construction of safety latrine by the Panchayats within their households. But some of them paid Rs. 500/- to 1000/- to the Panchayat members for construction of it. Again, it was reported that the whole for the latrine had to dig by them as they were asked to do so. Most of the respondents were found dissatisfied with the quality of construction of toilets. ANM and ASHA revealed that members of PRIs are not interested to be present on the VHND as they feel it as not their responsibility showing themselves to be busy on their own schedule. They have to collect the signatures from members showing the organization of VHND going to their house. Further added that to both the President of Gaon Panchayat as a joint account holder with the ANM and the member of GP with the ASHA, they have to pay a portion from the account, belong to sub-centre and villagers

through ASHA. Record was found even of taking Rs. 6000/- to 7000/- from ASHA. PRIs do not want to involve ASHAs in its TSC. While asked to a member of 43 No. Mathurapur Gaon Panchayat about it, he revealed that the data provided by the ASHA and ANM are true in case of almost all the GP within the district. Though they were given a class on NRHM during training, no execution of the services in practical field can be found due to lack of interest of the PRI members or their reluctance to provide service wholeheartedly. The particular member of PRIs, known to all as an active and dedicated member in that locality, reported that due to his straight-forward nature, sometimes he is alienated from his own GP or from other PRI members. A slightly better condition was found only in Barkhetri Block regarding the involvement of Panchayats in the activities of NRHM, especially in their attendance on VHND.

On the basis of the above discussions on findings of the research, it can be revealed that Government has started and implemented various maternal and reproductive health related schemes under NRHM. But due to lack of knowledge of the people about the schemes and proper implementation and monitoring mechanism, expected results have not been found. Findings showed that there are problems in every level from top to bottom in the structure of NRHM. These problems are visible in case of infrastructure and equipment, manpower, service provider, facilities and so on and so forth, which are responsible for non-enjoyment of reproductive and maternal health rights. Regarding child health too, findings has shown a similar result. Calculating all these, the problems of NRHM and its true realization can be summarized as follows:

7.2 Problems in Realizing the Provisions of NRHM in Nalbari District:

1. It was observed during research that though the health sector in Nalbari district shows a positive result in terms of establishment of health facilities in quantity, there are much more scope to improve the quality of its infrastructure. Poor construction of infrastructure without electricity, water facility, sanitation and maintenance of hygiene was found which hampers availability of services.
2. Govt. hospitals are not well-equipped. There is no provision of ICU, Ventilator facility in the primary and secondary level of health institutions according to the norms. It creates problem for people in remote areas as they have to refer to tertiary level health institutions. Ambulance service is not properly working according to the needs of the people due to scarcity of vehicles in number and due to the adequate facilities like- availability of oxygen etc.
3. It was found that there is a scarcity of doctors and other staffs in many parts of the district. As the public hospitals are over-crowded, doctors feel overburdened. There is no work environment for the doctors due to lack of facilities like- isolated cabin, no hygienic lavatory, no regular power supply, proper canteen to eat etc. Apart from these, doctors are attached with other health institution other than own settlement to provide extra services due to scarcity of manpower which compels them to feel overburdened. Again, there is no designated person as service bearer and incentives to manage MCP programme and carrying of record books to the health institution from the sub-centres.
4. Medicines are not available and there is no facility available to check the efficacy of supplied drugs. Hence the quality cannot be measured.

5. Irregular supply of medicines, non-functioning laboratory, poor quality of machines for diagnostic tests, less number of ambulances, scarcity of vehicles for referral services etc. has been hampering in the enjoyment of maternal and child health services under JSSK.
6. There is unavailability of usable staff quarters and that is why doctors and other staffs have to stay outside the hospital campus. It resulted to unavailability of manpower that makes health services inaccessible during emergency.
7. There are reports of misbehaviour with doctors and other staffs from community people. Due to improper facilities and equipment to deliver certain services are not possible in some of the health institutions for which doctor have to face misbehaviour from the guardians and relatives. So, doctors feel insecure to provide services staying in those areas.
8. It was found that the behaviour of the health service providers is not good at all sometimes. It creates problem in the acceptability of health services for the common people.
9. Role of the stakeholders are not satisfactory especially in case of members of PRIs and AWW. They are not active. Non-cooperation of the members of PRIs can be seen in their role on the day of VHND and VHSC. Again, NRHM has given emphasis on the role of NGOs through their involvement to make the health services accessible and available. But, research found that no respondents were aware of any role of NGOs. It was reported by the health providers that though sometimes NGOs involve in certain activities, their working and involvement is not static and regular.

10. It was seen that regarding preparation of survey reports from the villagers by the ASHA, ANM and AWW; it is not proper. Data showed that they do not go to the households for survey and prepare it of their own. It creates problem in rendering services according to the needs.
11. It was reported that there is no co-operation between NRHM and State Health Employees. NRHM employees are on contractual basis that do not get any service benefit, like- leaves, medical allowance, house rent, insurance etc. They do not have job security. They cannot control the laboratory personnel, who are permanent Govt. employees, for the diagnostic tests for the services to women under NRHM. They are demoralised sometimes by some other officials as they are contractual employees. Further, it was reported from a regular doctor that as the doctors under NRHM are contractual employees, they have a time-schedule and hence to maintain O.P.D. for regular doctors becomes difficult.
12. Again, there is a gap between the planning and execution of different provisions under NRHM. Planning in higher level and its implementation at ground level is mismatched which is one of the major defects of NRHM. For example, ASHAs were appointed just to assist the deliveries and initially there was no educational qualification for them. But ASHAs reported that the language of the forms to be filled up by them is very tough to understand. Certain forms are in English which creates problem for them in getting their incentives as without proper documents they do not get their entitlement. They have to take the help from others to fill it up. Doctors revealed that once they complete their internship during formal education, there is no training for the doctors. It hampers them to

avail the knowledge and information regarding newly developed techniques, medicines and services in the health sector.

13. Study found that there is no co-ordination among the health provider and the stakeholders. It is very much visible in organising VHND. No co-operation can be seen among ASHA, ANM, AWW and PRI members. ASHA and AWW feel their works as overlapping.
14. It was found that there are certain socio-cultural barriers which affect women's access to reproductive and maternal health services in a negative way. It was prevalent in the study area too. Such negative attitude and belief hampers in implementing the schemes and to make it a reality.
15. The Health Information System is not strong under NRHM. People do not get information on the schemes, provisions and facilities under NRHM. It can be seen regarding the implementation of JSY, JSSK and RMNCH+A related to reproductive, maternal and child health.
16. Above all, the major problem in implementing NRHM was found as huge corruption in each and every layer of the health system in the study area. During the study on maternal and child health, it was found that despite the provision of free and zero cost delivery for women and free treatment for children under NRHM, women had to spend and bribe during ANC, delivery and PNC check-ups along with the neonatal health services. This expenditure was due to paying to the doctors, nurses and other staffs, ANM, ASHA, for diagnostic tests, medicines and transportation which is against the existing provisions under JSY and JSSK. Corruption was found in the name providing reproductive health services too. AWW were found involving in corruption by selling the items for

Supplementary Nutrition that to be provided to the children and pregnant women. Further, evidence was found on the involvement of the members of PRIs in corruption in implementing the scheme of housing and sanitation under the Department of Panchayat & Rural Development along with the withdrawal of the fund allotted for ASHA and ANM under NRHM for health services. Huge corruption was reported in the name of advertisement, meeting and organising occasional programmes under NRHM by its employees.

From the above mentioned problems for implementing NRHM, it is clear that these problems and barriers can be removed with proper planning and execution of this Mission. For this, certain strategies have to be maintained with the collaboration of all people from different departments and backgrounds with the support of common people. Positive changes should have to be brought in the articulation of the provisions of various schemes on reproductive and maternal health under this Mission. Here, can be mentioned some of them:

7.3 Suggestions:

1. Age of marriage can be one of the reasons for pregnancy related complications including MMR and IMR. Pregnancy in immature age may result to poor maternal health condition. Therefore, it is essential to increase the awareness among the rural people about the implications of pregnancy in immature age through meeting and counselling.
2. Initiatives should be taken from the Govt. in contributing their development of socio-economic background. For this, PDS should provide the items regularly,

housing (IAY) and sanitation (Swaswa Bharat Abhiyan)) from the P & RD department should be implemented properly to the need based, schemes like Rajiv Gandhi Grameen Vidyutikaran Yojana (RGGVY) for electricity, Pradhanmantri Ujjwala Yojana for L.P.G. to BPL people should be expanded which will help them to concentrate on their health coming out from the basic necessities of life.

3. Rural people from lower socio-economic background should be motivated for health insurance and special health insurance scheme should be initiated regarding maternal and child health.
4. Opening of Bank Accounts should be made compulsory to receive the benefits of schemes like JSY and JSSK and the Mission should have to be strict and direct in disbursing the entitlements to the beneficiaries.
5. To bring women for PNC check-ups, ASHA and other health workers should have to be more active and efficient. There should be proper monitoring on the record of home visit. Women should have to be made aware about post-delivery danger syndrome during their delivery in the institutions.
6. Infrastructure should have to be developed, emphasis should have to be given on work environment for the health personnel to maintain comfort, and laboratory should have to be well-equipped and organised with new and developed technology to attract the women towards Govt. health services.
7. For availability of doctors and others staff, proper residential set up should have to be maintained. For this staff quarters should have to be constructed or renovated with total facilities of water, sanitation, electricity and hygiene. Area should have to be developed with availability of market complex, schools,

banks, refreshment parks etc. within a reachable distance with collaboration of Govt., PRIs, NGOs and people from the locality.

8. Number of specialised doctors should have to be increased with increase in delivery points including caesarean operation to get rid of the rush in public health facility and lessening the burden of the doctors for quality health care. Appointment of Lady Doctors in every health institutions should have to be made compulsory to remove some social and cultural barriers.
9. Special MCH Wings should have to be established including maternal, reproductive and child health other than the 100/50/30 bedded health centres. ANC, Delivery and PNC services should have to be disbursed to different health personnel even after integrating the services which will lessen the burden of a single ASHA or a single ANM in concentrating their own areas among these three. Different cell should have to be established within MCH Wings giving responsibilities to some other health personnel other than the maternal health service provider on Reproductive health and child health.
10. Monitoring system should have to be effective and transparent. To prove the accuracy of the survey reports, survey should have to be separate and confidential for ANM, ASHA and AWW each. Survey Reports should have to be separately evaluated with confidentiality. It will help in preventing the ASHA, ANM and AWW submitting report without survey.
11. There should have to be a provision of reward for the role models regarding maternal health services. Already there are provisions of rewarding institutions. But this provision should have to be there in case of ASHAs and beneficiaries to motivate women from backward region. ASHAs should have to be rewarded for

their services on the basis of best performance and there also should have to be the provision of rewarding the expecting mothers or becoming mothers for the best availing of ANC, Delivery and PNC services.

12. Irregular attendance is one of the major problems regarding availability of health services. Ensuring attendance of the employees, biometric attendance should have to be made compulsory for all. For village level workers like- MPW, GPRS can be applied.
13. To ensure the participation of Panchayats, incentive in terms of monetary benefit can be announced for their performance from the Department of Health and Family Welfare. As GP is a grass root level organisation, it is important to ensure their involvement in public health sector.
14. NGOs can play a very important and positive role in making women aware about their rights related to health care. NRHM has also given the responsibility to monitor and mentor the ASHA. NGOs prepare Annual District Report on People's Health collaborating with Govt. Involvement of NGOs should have to be ensured with their co-ordination and collaboration with mainstreaming health services.
15. Behaviour of health provider matters a lot to understand the problems of women. Reproductive and maternal health is a closed area which people do not want to share with others. To extract actual information from women, health providers need to behave them softly, clearly, with caring attitude and respectfully.
16. Necessary training should have to be given to the Doctors for new introduction, invention and implementation of health services in the different parts of the world.

17. A separate counselling cell should have to be established to motivate women towards availing maternal health services. Counselling is necessary for the male members and other family members of women too.
18. The social issues that hampers women's access to reproductive and maternal health services should have to be carefully and tactfully handled showing them the reality with a scientific approach so that it cannot hurt their sentiments and emotions.
19. During survey, it was found that media plays a very important role in making women aware about the provisions and facilities of health services. With popular advertisement and campaign through electronic and print media, awareness can be brought among the women so that they can become aware about the facilities initiated by the Govt. and hence their health rights will also be protected.
20. A Quality Assurance Cell need to be established in every health institution including representative from all backgrounds, like- doctors, nurse, other hospital staff including NRHM employees, ASHA, villagers including women, academicians, member of NGOs, students etc. to evaluate the working of their own on delivery of services.
21. Organising Conferences and seminars can have impact on the policy-making procedure. But rarely the voice reaches to the grass root level. That is why involvement of academicians through research project can take them to the women directly and it can help in making them aware about the provisions of the programmes under the mission through discussion and can influence in policy-making on the basis of the findings of those research.

22. Above all, lack of information is the main problem behind the implementation of the schemes under NRHM. Health Information System should have to be strengthened. Though, NRHM publishes some small publications on its schemes, these are not reachable to the women from every nook and corner. Again, using of medical terms makes it difficult to understand. Therefore, the language of these publications should have to be multi-lingual and easy to understand avoiding the medically recognised terms. For giving information to the women from remote backward areas, “door to door approach” can be done. And to monitor it GPRS system can be introduced as a concept of “Digital India”.

Experience from the study on NRHM showed that NRHM is an important inclusion in the Indian Health Sector. The Mission in its Preamble itself has declared about improving the availability, accessibility and quality of health services for the people in India with special focus on the poor, women and children from rural areas. Though demand for recognizing of Health as a human right has already been started in India, India has not included ‘Health Right’ as a fundamental human right under Part III of the Constitution. Health Rights, is a right which gives emphasis on availability, universal accessibility, acceptability and quality health care services to all without any discrimination. Hence, NRHM can be considered as one of the major steps taken by the Govt. of India to ensure Right to Healthcare for All.

Reproductive and Maternal Health is considered to be the key indicator to assess Women’s Health. Therefore, to understand women’s health rights, understanding of reproductive and maternal health rights is necessary. It is the responsibility of the state, government and other governmental organizations to ensure reproductive and maternal

health rights making it available, accessible and acceptable for all women without any discrimination of their belonging to any caste, social group, class, religion, geographical location, race etc. Though India has started emphasizing on maternal health since the time of Colonial Rule, it is the RCH programme that has given a new sight to the concept of maternal health in India. Further, NRHM has expanded the importance and essentiality of maternal health exemplifying the RCH Programme-II under the regime of NRHM. Under the Mission, NRHM has launched some of the schemes related to maternal health of women. JSY and JSSK were implemented to improve the quality of maternal health care with a view to its availability, accessibility and acceptability. Research found that with the implementation of these two specific schemes, the scenario of women's maternal health rights has changed and women started enjoying their important exciting stage of life with full responsibility. Again, as maternal and reproductive stage of women overlaps each other, special care has been taken under NRHM for ensuring reproductive rights to women introducing RMNCH+A, reproductive health as a part of it.

Despite this, there are various problems that women have been facing regarding the provisions of these schemes and its enjoyment due to the unavailability of infrastructure, manpower, unavailability of information and lack of co-ordination at different levels of the Mission. But these problems can be solved with an adequate strategy, active manpower, proper monitoring, technical support, involving different stakeholders and collaboration from every group of people living in the society with their strong mental and moral support. From the whole research, it has become very much clear that NRHM was implemented as an outside support to the health services. But at present, it has become the mainstream health service for the people of India.

Without NRHM, not only in Nalbari district, but also in all over India, maternal health service cannot be imagined. It has become the heart of all kinds of maternal, reproductive and child health services in rural areas. The expansion of NRHM to urban areas and its new look as National Health Mission (NHM) including both National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) has started a new phase of this Mission. Until and unless it will be replaced by some other programme, NRHM cannot be exempted from the health system of India. Otherwise, the whole system will be collapsed. In near future, it can be hoped that NRHM will help in recognizing 'Health' as a fundamental right in the Indian Constitution and will ensure women the enjoyment of maternal health rights along with reproductive rights as a part of it through its newly developed schemes with full co-operation from the people of all the backgrounds in the society.

Notes & References:

¹Govt. of India. (2005). *Preamble: National Rural Health Mission*.(2005-2012) - Mission Document.

²Wolff, Jonathan, (2012). *The Human Right to Health*.New York: W.W. Norton &Company.,p. 28.

³ Planning Commission of India.(November 2011). High Level Expert Group Report on Universal Health Coverage for India.New Delhi. [Accessed on October 10, 2012. Available from: <http://planningcommission.nic.in/reports/genrep/rep-uhc0812.pdf>].

⁴Wolff. Op.cit. p.28.

⁵Ibid. p.28.