Review of Health Equity

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Technical and Management Support Team
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Acronyms

AIDS: Acquired Immuno Deficiency Syndrome
ANC: Ante Natal Care
ANM: Auxiliary Nurse Midwife
APL: Above Poverty Line
ASHA: Accredited Social Health Activist
AWC: Anganwadi Center
AWW: Anganwadi Worker
BCC: Behavior Change Communication
BPL: Below Poverty Line
BPO: Block Program Organizer
BeMonc: Basic Emergency Obstetric and Neonatal Care
CBO: Community Based Organization
CGHS: Central Government Health Services
CHC: Community Health Center
CMC: Christian Medical College, Vellore
CeMonc: Comprehensive Emergency Obstetric and Neonatal Care
CRM: Common Review Mission, NRHM
DFID: Department For International Development (United Kingdom)
DFW: Directorate of Family Welfare
DHH: District Headquarters Hospital
DHS: Directorate of Health Services
DPMU: District Program Management Unit
ESI: Employees' State Insurance
ESP: Essential Services Package
FP: Family Planning
FRU: First Referral Unit
GIS: Geographic Information System
GKS: Gaon Kalyan Samiti
GoO: Government of Orissa
GoI: Government of India
HDR: Human Development Report
HIV: Human Immunodeficiency Virus
HMIS: Health Management Information System
HR: Human Resources
ICDS: Integrated Child Development Scheme
IDDCP: Iodine Deficiency Diseases Control Program
IMNCI: Integrated Management of Neonatal and Childhood Illnesses
IEC: Information, Education and Communication
IMR: Infant Mortality Rate
IPHS: Indian Public Health Standards
JSY: Janani Surakshya Yojana
KBK: Koraput, Bolangir and Kalahandi districts
LHV: Lady Health Visitor
LMIC: Low and Middle Income Countries (World Bank)
M&E: Monitoring and Evaluation

MIS: Management Information System
MKCG: Maharaja Krushna Chandra Gajapati Medical College, Berhampur
MMR: Maternal Mortality Ratio
MO: Medical Officer
MPHS (M): Multi-purpose health supervisor – Male
NCMH: National Commission on Macroeconomics and Health
NFHS: National Family Health Survey
NGO: Non Governmental Organizations
NIMHANS: National Institute of Mental Health and Neurosciences, Bangalore
NIRTAR: National Institute for Rehabilitation Training and Research
NLEP: National Leprosy Eradication Program
NRHM: National Rural Health Mission
NVBDCP: National Vector Borne Diseases Control Program
NSSO: National Sample Survey Organization
OHSP: Orissa Health Sector Plan
OOP: Out of Pocket (expenditure)
OPD: Out Patient Department
OSACS: Orissa State AIDS Control Society
OT: Operating Theatre
PG: Post Graduation
PIP: Program Implementation Plan
PHC: Primary Health Center
PHC (N): Primary Health Center (New)
PNC: Post Natal Care
PPP: Public-private partnership
PRI: Panchayati Raj Institution
RCH: Reproductive and Child Health
RD: Rural Development
RKS: Rogi Kalyan Samiti
RNTCP: Revised National Tuberculosis Control Program
RTI: Reproductive Tract Infection
RWSS: Rural Water Supply and Sanitation
SC/ST: Scheduled Caste/Scheduled Tribe
SCB: Sri Ram Chandra Bhanja Medical College, Cuttack
SDH: Sub-divisional Hospital
SDMU: State Drug Management Unit
SHG: Self Help Group
SIHFW: State Institute of Health and Family Welfare
SPMU: State Program Management Unit
SRS: Sample Registration System
STI: Sexually Transmitted Infection
TB: Tuberculosis
TBA: Traditional Birth Attendant
T&MST: Technical and Management Support Team
UNFPA: United Nations Population Fund
UNICEF: United Nations Children's Fund
GKS: Village Health and Sanitation Committee
W & CD: Women and Child Development Department
WHO: World Health Organization

Executive Summary

Executive Summary

Background

The health system of Orissa witnessed major changes in terms of policy outlook and implementation. A major landmark has been the design of the 'Vision 2010' document. The vision document tries to *ensure "improvement in the health status of the people of Orissa with their participation, by making healthcare available in a socially equitable, accessible and affordable manner within a reasonable timeframe, creating partnerships between the public, voluntary and private health sector and across other developmental sectors"*. The Orissa Health sector plan(OHSP) has also been formulated to ensure health equity in a sector wide approach.

A brainstorming workshop on health equity was held in the State Institute of Health and Family Welfare (SIHFW) Orissa on April 15, 2008 with the stakeholders from government departments, civil society organizations and public health institutions. The necessity to look into current health equity and review of different health policies and programs has emerged as a major highlight of that workshop. This report is the outcome of a three-month review of health equity vis-à-vis various policy strategies, programs and action plans. of the Orissa health sector. The review has tried to find out the strengths and weaknesses in the existing health care delivery system in terms of health outcomes, policy outlook, program action plans, their implementation, monitoring and evaluation.

The report has the following specific objectives:

1. To review various policy documents and action plans of health system of the state vis-a-vis health equity
2. To suggest further improvements in the existing system

A. Rationale and scope for Health Equity in Orissa:

The health system of Orissa exhibits inequities in terms of inadequate social, economic and geographical access to the needy. The existing data sources (NFHS 3, HDR 2004, NSSO 2004) reflect the adverse health outcomes for the vulnerable in terms of morbidity, mortality, risks to diseases and impoverishment.

B. Defining Health Equity and Equality:

Health inequality describes differences in health experience and health outcomes between different population groups – according to socioeconomic status, geographical area, age, disability, gender or ethnic group. In other words, health inequality is differences in health status. On the other hand, health inequity describes differences in opportunity for different population groups which result in unequal life chances, access to health services, nutritious

food, adequate housing and so on. Health equity and inequality are mutually intertwined. Health equity is a means and health equality is the result.

Methodology and Framework for Review of Health Equity

Given below are the various methods and frameworks of equity review.

Step 1: *Design of the general framework and the components for equity review by T&MST in due consultations with the various concerned stakeholders from the government.*

Step 2: *Design of the checklist for equity review under each component in due consultations with various stakeholders of the government and review of key policy documents and program action plans.*

Step3: *Consultations with stakeholders from sub-sections of DoHFW (Secretariat, DHS and DFW), SIHFW, State Drug Management Unit (SDMU), Dept of WCD, Dept of RWSS, NRHM, UNICEF, UNFPA, SCB Medical College, Cuttack, field based NGOs and public health experts.*

Step 4: *Review of various policy documents, action plans, and monitoring and evaluation reports of various programs vis-a-vis health equity*

Step 5: *Recommendations for policy formulation, design of action plans, implementation, and monitoring and evaluation for an effective, affordable, acceptable and quality health care delivery for the vulnerable groups.*

APPROACH TO HEALTH EQUITY ANALYSIS:

We approached the concept of health equity as follows:

Approach 1: Assessment of health outcomes (health equality)

The trend analysis of major health outcomes through NFHS 1, 2 and 3 shows that there are inequalities in the health status of the populations with different states of advantages (residence, economic status and social status). This difference also persists in terms of awareness about various health programs and diseases. The trend of improvement in the health status of different groups shows a mixed tendency i.e., the proportion of improvement is relatively higher among disadvantaged groups for some indicators and relatively less among disadvantaged groups for some indicators. For example, the proportion of reduction in IMR is high in rural areas compared to urban areas. When it comes to PNC, the coverage has increased in urban areas compared to rural areas.

Approach 2: Assessment of health processes(supply side health equity)

Component – I (Human Resources and Capacity Development)

Findings:

- Preference given to underserved/ remote areas for multi skilling
- Monetary incentives to HR in KBK districts and three backward districts (Boudh, Kandhamal and Gajapati).
- There is no gender and equity sensitiveness in both pre-service and in-service trainings

Recommendations:

- Preparation and Maintenance of database on the availability of HR and their skill sets in remote and underserved areas, and different specialization skills.
- Ensuring availability of HR in underserved/ remote areas through different non-monetary incentives
- Ensuring availability of specialists for vulnerable groups (disabled, elderly, mentally ill) through short term trainings
- Gender and equity sensitiveness in pre-service and in-service training
- Non-monetary incentives for HR in remote and underserved areas as follows:
  - Arranging fully furnished accommodation facilities at the place of work
  - Providing transportation to the children of service providers for education at the district/block level
  - Early promotion for those who work continuously for 5 years in such areas
  - Appointment at district and state head quarters for those who work continuously for 5-10 years and 10-15 years in such areas respectively
  - Sponsored admissions in PG courses and other career development courses

- District/block level township for the families of such providers

Component – II (Monitoring and Evaluation)

Findings:

- Disaggregated information is available for different age groups, SC/ST and male/female for NRHM and other National Health Programs.

Recommendations:

- It is essential to have disaggregated information on impact and outcome indicators with respect to male/female, different age groups (including elderly), SC/ST, rural/urban, BPL/APL, disabled and remote areas, under-served areas. For example, disaggregated information on morbidity and mortality (impact indicators) and disaggregated information on case detection rate (outcome indicator)
- It is essential to have disaggregated information on process indicators (e.g. Number of HR trained) with respect to male/female, BPL/APL and SC/ST, remote areas, under-served areas.
- Capacity development of program officers at the state, district and block level to collect, compile, analyze and interpret such information to enable appropriate policy formulations for various vulnerable groups.

Component – III (Supply side issues)

Findings:

- Preference is given to KBK districts, under -served areas and remote areas for strengthening of facilities.
- The drug allocations are based on the demand by each district. There is no mechanism to ensure that the demand for drugs by each district is based on local disease burden and population requirements.
- Public health care facilities do not ensure user friendly services to the disabled.(eg. Absence of ramps in facilities)

Recommendations:

- Maintenance of database on availability and level of functionality of facilities, quality of infrastructure, availability of drugs and utilization of services in each district
- Availability of drugs as per local specifications, disease burden and populations.
- User friendly health care services to the disabled and elderly

- Citizen charter in each facility mentioning the services provided facilities available, quality of services entitled to, responsibilities of the patients and grievance redresssal mechanism.

Component – IV (Program Implementation Plans, NRHM)

Findings:

- There is an equity focus in the state PIP, though not comprehensive. And some of the vulnerable groups such as the physically challenged economically deprived and elderly are excluded.

- Though there are district specific vulnerable groups and related issues in each district, there is no attempt to identify and quantify such vulnerable groups, their issues and remedial measures.

Recommendations:

1. Capacity development
   a. Sensitization – to the community and service providers to make them aware about different vulnerable groups and their needs
   b. Skill development – to ensure delivery of services to the vulnerable groups as per the need e.g. training on geriatrics, psychiatry, physiotherapy etc.
2. Identification of the vulnerable groups
   a. Expansion of the list - inclusion of gender, elderly, disabled, economic vulnerability, populations residing near industries and at risk for occupational health hazards, migrant population
   b. District wise mapping and quantification of the vulnerable groups

3. Health needs assessment of the vulnerable groups
   a. Health determinants - poverty, education, safe drinking water and sanitation, occupation, social and ethnic status, availability and quality of services etc.
   b. Health outcomes - morbidity, mortality, disability and impoverishment

4. Planning and resourcing as per the needs assessment
   a. Inclusion of gender and equity component in PIPs
   b. Inclusion of gender and equity component in each program (eg. National Health programs)
   c. District specific planning and budgeting to address the needs of various vulnerable groups

Component – V (Public Health Expenditure)

Findings:

- The allocation is not based on differential health status of populations and regional specifications
- There is no attempt to assess the per capita allocation and utilization of funds to various vulnerable groups

Recommendations:

- The criterion of allocation to each vulnerable group needs to be based on the number of respective populations, regional specifications and disease burden (differential health status).
- There needs to be specific allocation for elderly care.
- Appropriate tracking mechanism to understand the efficiency in spending for various vulnerable groups
- Benefit incidence analysis to assess the impact of spending on vulnerable groups
- Attempts (capacity development) to reduce structural bottlenecks in identifying the needs of the vulnerable groups and enhance efficiency in financial management and speedy channelization of funds from state head quarters to the village/block level.
- Allocations for primary health care need to be 55% of the total allocations (as envisaged by OHSP and vision 2010). This is to ensure essential services to the vulnerable groups.
- Provisions to avoid collection of user fee at the time of service delivery to reduce the catastrophe on vulnerable households. This can be ensured through
    - Setting up Community based health insurance (CBHI) with cash less mechanism for both out patient and hospitalized care. CBHI has proved as a viable mechanism to provide health care to the poor in Indian settings (eg. RAHA scheme in Chhattisgarh, Karuna Model for tribals in Karnataka, CBHI for tribals in Wayanad district of Kerala and health insurance run by PREM in Orissa)
    - Increase the state government's share on public health spending
    - Encourage, club and manage new sources of financing such as micro finance , health insurance and medical saving accounts (MSA) by the state government/ NRHM (Micro finance and MSA are proved to ensure health care to marginalized groups such as women in India (eg. MSA in Karnataka and Kudumbashree scheme in Kerala)

- Pool external finance direct or through partnerships.
- Emergency medical funds (EMF) at RKS level for emergency care

Component – VI (Interdepartmental schemes)

SANJOG:

Scope for strengthening of convergence:

- Sanjog scheme and health programs can help each other in common goals (E.g. ASHA and GKS can help in BCC for effective and proper use of water and sanitation facilities, personal hygiene and quality of water to prevent water borne and water related diseases)
- Use each other's resources (E.g. Toll- free grievance redressal mechanism can link the community to various depts.(sub-centre).
- Collaborations in outbreak investigations and preventions.
- Collaboration in improvements of the social determinants of vulnerable groups (eg.quality of water, sanitation facilities etc).
- Design and follow up of village health plan to include local specific health equity issues.

ICDS:

Scope for strengthening of convergence:

- Integrated BCC and social mobilization for improving the social determinants of health (nutrition, anemia, body mass index etc).
- Sensitization and capacity development of ASHA, AWW and ANM on equity.
- Collaboration in village health plan for identification and follow up of local specific health equity issues.

Component VII Behavior Change Communication

Findings:

- The BCC strategies cater to those vulnerable groups, addressed by the specific health program
- There are local specific themes and media in tribal areas (street plays, folk media etc)
- Community awareness programs cater to underserved areas.
- Use of local dialects to address linguistic differences

Recommendations:

- To achieve larger health equity, it is essential to identify the BCC needs of the various vulnerable groups (SC/ST, economically vulnerable groups, women, disabled, elderly and populations residing in inaccessible/underserved areas).Current health seeking behavior, life style, social, economic, cultural and ethnic background, and household dynamics need to be considered to decide a specific BCC plan for each region and population. If properly identified, these information can be an insight for the formation of the BCC activity as well as the broader objectives of the health program.
- To ensure health equity, the BCC strategies require the following elements;
  - Contents of the BCC strategy identifying and addressing the specific needs of each vulnerable section (E.g. malaria program on pregnant women and malnutrition, AIDS program on spouses of truck drivers etc)
  - The language and media of the BCC strategy easy to understand and acceptable to each vulnerable group (E.g. Use of local dialects, audio-visual methods for non-literates, verbal methods for blinds etc)
- Regular review of the BCC programs on health seeking behavior of the vulnerable groups (change in health seeking behavior, utilization surveys and level of health awareness)
- Integrate the identification of BCC needs, planning, implementation and review with GKS.
- Sensitization and capacity development of GKS on the above process.

Component – VIII (Civil society organizations – Best practices)

We reviewed a community based health care delivery program, a community based health care financing program and a facility based health care program run by NGOs to explore the scope for scalability and integration with government.

Scope for scale up:

- Identify NGOs working in chosen areas to sensitize and train the community to manage the program
- Integrate with GKS
- GKS to manage Community based programs(e.g CBDs)
- Specific focus on vulnerable groups
- Integration with NRHM and other health programs
- Tracking of utilization by various vulnerable groups

Conclusion

The review of different programs vis-à-vis health equity in the state reveals that the health system has initiated to address the needs of various vulnerable groups. The major attempts for various vulnerable groups are under the aegis of NRHM and National health programs. However, the approach towards health equity is not comprehensive to identify all the vulnerable groups and their needs in the state. The approach towards health equity is confined to rural/urban, SC/ST, gender (Male/female) and remote/underserved areas. Still, the needs of such groups are not completely identified and addressed. Moreover, the vulnerability due to economic status, physical disability, age, occupation and environmental hazards (industrialization) are not substantially addressed in the ongoing programs. This asymmetry in identification and planning for vulnerable groups by each program synchronizes with the subsequent steps such as monitoring and evaluation and further improvement measures for such groups. It is essential to have comprehensive approach towards health equity i.e. the proper identification of vulnerable groups and their needs in the state. There needs to be specific strategies for various vulnerable groups to address health equity in the state. It would be appropriate for each program (NRHM and National Health Program) to have a specific component on gender and equity to address the specific needs of different vulnerable groups in the state. To achieve vertical health equity, the less advantaged groups (vulnerable groups) need to get more attention, specific programs and more attention compared to more advantaged groups. Moreover, the proportion of improvement in the health status of vulnerable groups needs to be more than that of more advantaged groups. This more than proportionate improvement can only reduce the current gaps between vulnerable and more advantaged groups.

COMPREHENSIVE RECOMMENDATIONS:

Goal: Comprehensive approach to health equity			
Objective: To reduce barriers to demand and utilization of services by various vulnerable groups			
Expected outcome: Improvement in the health status of various vulnerable groups			
Step1: Proper identification of vulnerable groups and their needs			
Strategies	**Action Points**	**Responsible Stakeholders**	**Prioritization**
Capacity development on health equity	**1. Sensitization on various vulnerable groups, their current status and their health needs of** • Stakeholders (all the medical professionals, health administrators, nurses, lab technicians, auxiliaries, NRHM officials, PRIs and GKS)· Sensitization to be done at each district level to orient more on local needs. • Community through GKS,CBOs auxiliaries, ASHA and BCC activities of various health programs **2. Identification of vulnerable groups** on the basis of age (children and elderly), gender, caste (ST, SC), economic status (BPL), disability, location (underserved areas, industrial areas, forest villages, migration pockets, border areas etc.) and occupation (industries,	SPMU, DPMU, RKS, GKS, disease control programs, outreach workers, community volunteers and CBOs	Immediate

	mining etc.) **3. Skill development** to ensure delivery of services to the vulnerable groups as per the need e.g. training on geriatrics, psychiatry, physiotherapy etc. *DoHFW can identify training institutes and medical colleges in Orissa and other states for imparting the capacities.*		
Identification of vulnerable groups and needs	**Step 1: Each district to identify its vulnerable groups** **Step 2: Identify the needs of vulnerable populations** in terms of 1. Health determinants - poverty, education, safe drinking water and sanitation, occupation, social status and ethnicity, health seeking behavior, availability of services (facilities, equipments and HR) 2. Health outcomes – morbidity, mortality, disability, impoverishment 3. BCC to identify the information needs of various vulnerable groups through surveys, knowledge, and attitude and practice (KAP) studies, Focus Group Discussions, Participatory Rural Appraisal (PRA) methods etc.		1.Short term 2.Short term 3.Immediate

Step 2: Planning for the most vulnerable groups and their needs			
Each district to follow specific plan, in accordance with the needs of its vulnerable populations	1. Specific focus for disabled, elderly, economically vulnerable groups, tribals in non-tribal districts, scheduled castes, forest villages, migrant populations, mine areas, industrial areas' conflict areas (naxal, natural calamities) and populations at risk for occupational health hazards and at disease outbreaks.	SPMU, DPMU, RKS, GKS, disease control programs, outreach workers, community volunteers and CBOs	1. Immediate
	2. Citizen charter in all health care facilities mentioning the services provided, equipment and facilities available, quality of services entitled to, complaints and grievance redressal mechanisms and responsibility of the users		2. Immediate
	3. Promote partnership mechanisms in capacity development, BCC, health care delivery, financing and M&E. Identify local partners/NGOs to cater to remote areas. Give small catchment area to each NGO and/or community to make effective management.		3. Immediate
	4. Allocations to be based on local specifications, respective populations and local disease burden.		4. Immediate
	5. Drug distribution to be based on local disease burden (differential health status)		5. Immediate

	6. BCC strategies to be easy to understand, accessible and acceptable to each group. These need to be local specific in terms of addressing the issues, themes, language and media.		6. Immediate
	7. Health camps, mobile clinics, drug distribution centers and home based care for the most vulnerable regions.		7. Immediate
	8. Emergency Medical Funds (EMF) at RKS to address the emenergency health care requirements of vulnerable groups		8. Immediate
	9. RKS to identify and address the issues of vulnerable in each facility (e.g. provide ramps in hospitals for disabled populations).		9. Short term
	10. To address the economically vulnerable groups, ensure health insurance coverage. Appoint a manager for each district to ensure effective management of such schemes.		10. Short term
	11. Provision of funds to purchase drugs, if drugs are not available in the facilities		11. Short term
	12. Convergence to use the resources of other departments and integrated BCC strategies		12. Short term
	13. Ensure home based care for		13. Long term

	disabled and elderly 14. Appoint a new professional/assign the current HR to look after vulnerable groups in each district 15. School health cards to include the health profile of each student 16. Toll-free grievance redressal mechanism connecting the community to various health functionaries, and departments working on health and allied issues		14. Long term 15. Long term 16. Long term
Step3: Implementation of various programs after planning			
Implementation of the health equity component explained above has to go side by side with the ongoing programs			
Step 4: Monitoring and Evaluation of programs/activities			
Ensure disaggregated information for different vulnerable groups (SC/ST, BPL/APL, Male/Female, age groups and disabled)	Indicator based M&E (in terms of processes and outcomes) for each program Indicators need to address: ▪ Per capita allocation/utilization of funds for vulnerable groups ▪ Per capita allocation of drugs for vulnerable groups ▪ Programs planned/ implemented for vulnerable groups ▪ Vulnerable groups included/ existing	SPMU, DPMU, RKS, GKS, disease control programs, outreach workers, community volunteers and CBOs	Short term

	▪ Vulnerable groups targeted/included ▪ HR planned/deployed in hard to reach and underserved areas ▪ Trainings planned/conducted in hard to reach and underserved areas ▪ Facilities' strengthening planned/undertaken in hard to reach and underserved areas ▪ Reduction in disease burden of vulnerable groups ▪ Improvement in health status (morbidity and mortality) of the vulnerable groups ▪ Assessment of Improvement in health awareness, change in life style, health seeking behavior and utilization of services through utilization surveys, coverage surveys, KAP studies and FGDs ▪ Trend in health care expenditure by vulnerable groups ▪ Impact assessment of programs on various vulnerable groups e.g. social and beneficial assessment (SABA)		
Step 5: Compilation and interpretation of the data with a focus on the vulnerable groups			
Develop a comprehensive documentation to understand the status of vulnerable groups in terms of			

social determinants, household dynamics, health status, health seeking behavior, health awareness, health care expenditure, money mobilization pattern. This report needs to cater to each and every vulnerable individual and households. This report can be expanded as an "Orissa Health Report", to include the rest of the populations and to track the health system's progress district wise annually.

Background

Background

The health system of Orissa has witnessed prime changes in terms of policy outlook and implementation. A major landmark has been the design of the 'Vision 2010' document, which is considered as the manual of health sector strategies of the state. The vision document tries to *ensure "improvement in the health status of the people of Orissa with their participation, by making healthcare available in a socially equitable, accessible and affordable manner within a reasonable timeframe, creating partnerships between the public, voluntary and private health sector and across other developmental sectors".*

The Orissa Health Sector Plan (OHSP 2005-10) has been formulated as an action plan to achieve the goals of Vision 2010. The OHSP envisages for the enhancement of demand and utilization of services, by mainstreaming equity and gender.

To achieve health equity the plan caters to

- Equitable access to quality health care
- Specific focus on the access and utilization of services by women, dalits (SC), adivasis (ST) and other marginalized groups
- Specific focus on the health concerns of the most marginalized such as maternal mortality, infant mortality, the burden from infectious diseases, and nutrition related diseases and disorders

- Integrated approach to each and every component/issue of health equity in sector wide approach

The Technical and Management Support Team (T&MST) has been constituted with the support of DFID to review the strategies and implementation of OHSP in the present context and make further action plans to make the system more efficient and responsive to the needy. A brainstorming workshop on health equity was held in the State Institute of Health and Family Welfare (SIHFW) Orissa on April 15, 2008 with the stakeholders from government departments, civil society organizations and public health institutions. The necessity to look into current health equity and review of different health policies and programs has emerged as a major highlight of that workshop. This report is the outcome of a three-month review of health equity in terms of the various policy strategies, programs and action plans of the Orissa health sector. The review has tried to find out the strengths and weaknesses in the existing health care delivery system in terms of health outcomes, policy outlook, program action plans, their implementation, monitoring and evaluation.

The report has the following specific objectives:

1. To review various policy documents and action plans of health system of the state vis-a-vis health equity
2. To suggest improvements in the existing system

A. RATIONALE AND SCOPE FOR HEALTH EQUITY IN ORISSA:

The health system of Orissa exhibits health inequities in terms of inadequate social, economic and geographical access to the needy. For example, there is a situation of insufficient human resources and infrastructure in the system, which is preventing timely health care in remote areas and remote areas.

The health inequities and inequalities have been in-built in the health system of the state since its inception. The subsequent formation of health inequalities are in terms of adverse health outcomes for the populations by age, geography, socio-economic status, gender, disability etc. The existing data sources (NFHS 3, HDR 2004, NSSO 2004, DLHS 2006) reflect the adverse health outcomes for the vulnerable in terms of morbidity, mortality, risks to diseases and impoverishment (detailed in page 44).

A significant proportion of the population in the state is marginalized on various aspects of vulnerability. For example, the state has a dubious distinction of being first in the country for poverty (39%).[1] Similarly, the state has nearly 22% of the population indigenous (second in the country).[2] Geographical inaccessibility is also enhancing the vulnerability of the populations. Nearly 121 blocks have been identified as outreach/ underserved areas for health care delivery in the state.[2] The health status of scheduled castes, women, elderly, children, adolescents and disabled also call for special focus on health care.

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[1] *Economic Survey 2008, Planning commission, Government of India, New Delhi.*

[2] *PIP, 2008-09, NRHM, Government of Orissa.*

B. DEFINING HEALTH EQUITY AND EQUALITY: NEXUS

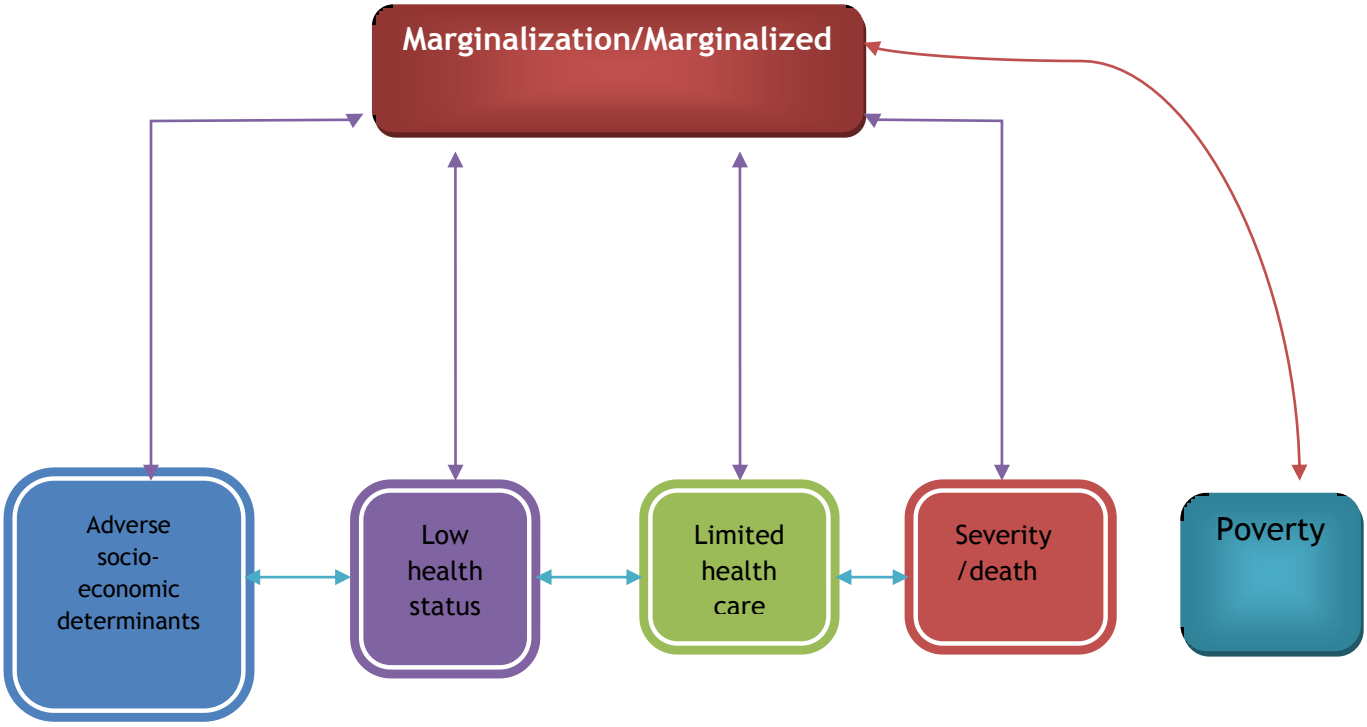
Though health inequity and inequality are used interchangeably, there is a gross difference between health equity and health inequality.

Health inequality is the presence of unfair and avoidable or remediable differences in health among social groups.[3] Health inequality describes differences in health experience and health outcomes between different population groups – according to socioeconomic status, geographical area, age, disability, gender or ethnic group. In other words, health inequality is differences in health status. Pursuing equity in health means trying to reduce avoidable gaps in health status and health services between groups with different levels of social privilege. Equity in health is operationally defined as minimizing avoidable disparities in health and its determinants—including but not limited to health care—between groups of people who have different levels of underlying social advantage.

On the other hand, health inequity describes differences in opportunity for different population groups which result in unequal life chances, access to health services, nutritious food, adequate housing and so on (WHO 2007).[3] In short, health inequity is differences in treatment, approach or exposure. Health equity addresses the way in which health equality is assured. Equity means that people's needs, rather than their social privileges, guide the distribution of opportunities for well-being.

[3] *Report 2007, Commission on the social determinants of health, World Health Organization, Geneva.*

EQUITY EQUALITY NEXUS



Health equity and inequality are mutually intertwined. Health equity is a means and health equality is the result. For example, health inequality is a result of unequal treatment/exposure (health inequity). At the same time, experiences around the world reveal that populations/regions are facing health inequity because they have already poor health status (health inequality). This situation of health inequality leading to again health inequity and vice versa is a vicious circle. Such a situation is highly detrimental with larger societal and developmental implications.

In such a context, any attempt to look into health inequity (in health processes) needs to address health inequality (health outcomes). This is to correlate how much health processes are addressing the health inequalities.

Methodology

Section 1 B

Methodology and Framework for Review of Health Equity

Given below are the various methods and frameworks of equity review.

Step 1: *Design of the general framework and the components for equity review by T&MST in due consultations with the various concerned stakeholders from the government.*

Step 2: *Design of the checklist for equity review under each component in due consultations with various stakeholders of the government and review of key policy documents and program action plans.*

Step3: *Consultations with stakeholders from sub-sections of DoHFW (Secretariat, DHS and DFW), SIHFW, State Drug Management Unit (SDMU), Dept of WCD, Dept of RWSS, NRHM, UNICEF, UNFPA, SCB Medical College, Cuttack, field based NGOs and public health experts.*

Step 4: *Review of various policy documents, action plans, and monitoring and evaluation reports of the various programs vis-a-vis health equity.*

Step 5: *Recommendations for policy formulation, design of action plans, implementation, and monitoring and evaluation for an effective, affordable, acceptable and quality health care delivery for the vulnerable groups.*

APPROACH TO HEALTH EQUITY ANALYSIS:

We approached the concept of health equity as follows;

- *Approach 1: Assessment of health outcomes (health equality)*
- *Approach 2: Assessment of health processes (supply side health equity)*

We used the checklist (designed in due consultations with concerned stakeholders from the government and public health experts) to review both approach 1 and 2 of health equity analysis. The indicators are given in the report in matrix format.

Approach 1:

We assessed the health outcomes by various sections of the society by socio-economic status, gender, geography, age, educational status and physical disabilities. This assessment of health outcomes was to look into the existing health equality among various sections of the society.

Approach 2:

To review the supply side health equity, we looked into the various components of the health system such as human resources, financial resources, physical resources (facilities and infrastructure), planning, implementation, monitoring and evaluation of health programs, health information system, and service delivery.

Thus, we reviewed the following components: health system, we divided the

1. HR and capacity building policy
2. M&E framework of health programs
3. State and districts PIPs of NRHM
4. Allocation and utilization of funds by the government for the vulnerable groups
5. BCC plans
6. Health supply issues in relation to outreach and underserved areas
7. Interdepartmental (departments integrating with health dept) schemes
8. Evidence based best practices by the Civil Society Organizations (CSOs)

Information Sources:

- Consultations with stakeholders from various sub-sections of Dept. of Health and FW (Secretariat, DHS and DFW), SIHFW, SDMU, DoWCD, RWSS, NRHM, UNICEF, UNFPA, SCB Medical College, Cuttack, field based NGOs and public health experts.

- Review of the following documents:

    1. Vision 2010 document, Government of Orissa
    2. NRHM - Mission Document, Government of India
    3. State and district PIPs of the NRHM, Government of Orissa
    4. BCC action plans of NVBDCP, NLEP, RNTCP, NACP, RCH, NPCB and NIDDCP
    5. M&E format of NRHM, NVBDCP, NLEP, RNTCP, NACP, IDSP, NPCB and IDDCP

6. SRS Report 2005, Reports of NFHS1, 2 and 3, DLHS 1st and 2nd round, HDR 2004, CRM report 2006
7. World Health Report 2008 on primary health care (WHO), Geneva
8. Report of the Commission on social determinants and health (WHO 2007), Geneva
9. NSSO 52nd round on household consumer expenditure, Government of India
10. NCMH Report 2005, Government of India
11. Activity reports and action plans of ICDS and RWSS
12. Evaluation Report on PHC Management, Sukinda, Jajpur district

Major NRHM initiatives addressing Health Equity

Major NRHM initiatives addressing health equity

NRHM[4] has a specific focus on the health care needs of the vulnerable, to improve their health status and to reduce their vulnerabilities towards adverse health conditions. As such the main focus of NRHM is operationalised through RCH II program. However, apart from RCH NRHM also tries to cater to other health issues under 'NRHM initiatives'. It is essential to explore the equity focus of such initiatives.

The following matrix gives a glance of some of the major programs of NRHM vis-à-vis health equity.

NRHM Initiatives vis-à-vis health equity

Janani Surakshya and Sahayata Yojana

Major objective:

To reduce maternal mortality by encouraging institutional delivery.

Strategy:

Financial incentives to pregnant women below poverty line for institutional delivery.

[4] NRHM Mission Document, 2005, MOHFW, GOI

Health equity focus:

There are three specific equity focus

1. Target on pregnant women who are vulnerable to death, due to unsafe delivery.
2. Protection for BPL families from catastrophic health care expenditure by giving financial incentive.
3. To ensure safe delivery in those areas where there is no sufficient government facilities by partnering with available private provider.

However, virtually, there may not be much financial relief for the BPL families. This is because there is no pre-payment mechanism to cover the delivery expenses. Women have to make payment at the point of getting care and financial incentives are paid as reimbursement after delivery. For a BPL household and especially women having money at disposal to pay for care may be difficult. The process of arranging money may lead to sale of assess, loan etc.

Janani Express

Major objective:

To reduce maternal and neonatal mortality by promoting institutional delivery.

Strategy:

To provide transportation to pregnant women and sick neonates in remote areas and remote areas for institutionalized care.

Health equity focus:

- The program caters to vulnerable groups (pregnant women and neonates) in remote areas. There are many areas in the state, where there are no public and private providers. To address this, Janani Express program targets pregnant women and sick neonates who are deprived of essential care by virtue of their residence.

However, at present the program does not reach the entire remote areas of the state.

Accredited Social Health Activist(ASHA)

Major Objective:

To help vulnerable groups, specifically women and children in prevention of diseases and timely access of care.

Health equity focus:

- ASHA is selected from within the community and works as a community health volunteer
- ASHA looks after the other local health issues such as providing drugs for

malaria, coordinating GKS etc.

- ASHA caters to one of the most vulnerable sections of the society such as women and children
- The program has an indirect equity implication as it gives weightage to SC/ST women for selection as ASHA. This is a very good attempt to promote participation of women especially SC/ST in community participation for better health.

Mobile medical units

Major Objective:

To provide health care in remote areas/ tribal areas/underserved/outreach areas.

Health equity focus:

- Mobile health units provide primary health care services (consultation, diagnosis and essential drugs) to geographically marginalized groups. Primary health care is considered as the minimum assurance for necessary health condition[5].
- This also acts as a venue for health awareness for the community in remote areas.

[5] Alma Ata Declaration 1978, World Health Organization

- There are mobile medical units in 30 districts. However, there is a high focus for KBK districts.

Gaon Kalyan Samiti

Major Objective:

To address local health issues through decentralized planning.

Health equity focus:

- The program forms a local body from within the community and integrates with other allied departments like water and sanitation and WCD. This envisages for local identification of the issues and local redressal through village health plans.
- The program ensures community participation in identification of the problems, planning, implementation and monitoring and evaluation.
- For the vulnerable groups, this gives scope to address their health issues. Since, the initiative envisages for inter-sectoral co-ordination, there is scope to address the social determinants of health (safe water, sanitation, housing, sanitation etc) too.
- There is scope to materialize a comprehensive village health plan, by catering to all the vulnerable groups.

- The indirect impact on equity is that, it gives preference to women, especially SC/ST women as members of GKS.
- But, there is a concern on the vulnerable groups' ability to identify their own problems and solve it. Without ensuring this particular aspect through capacity development and external support, decentralization may not result in health equity.

NGO involvement

Major Objective:

To cater to geographically remote areas and underserved areas.

Health equity focus:

- NRHM has identified locally established NGOs to address the health care issues of hard to reach and underserved areas.
- The program has the scope for health equity by targeting the geographically marginalized groups.

24X7 PHCs

Major Objectives:

- To ensure timely primary health care services to the needy

- To upgrade PHCs capable to provide services 24X7

Health equity focus:

- This initiative is useful for vulnerable and non- vulnerable groups to get timely emergency care services

However, there needs to be specific attempt to make the PHCs in remote and underserved areas to be eligible to upgrade as 24*7 PHCs.

Indian Public Health Standards(IPHS)

Major objectives:

- To ensure skilled HR and equipped facilities
- To strengthen the existing facilities with adequate number of skilled HR and adequate infrastructure and equipments

Health equity focus:

- It can address the HR and infrastructural needs in remote areas/ tribal areas/ urban slums.

Multi skilling

Major objectives:

To skill the available HR with additional skills.

Health equity focus:

Multi skilling has been taken place on CeMonc, BeMonc, anesthesia and SBA.

This initiative has the scope of assuring essential health care services to the vulnerable groups in inaccessible/tribal/urban slums and outreach areas, where the facilities do not have adequate skilled HR.

However, it is essential to give preference for multi skilling of HR from such areas.

The state faces a shortage of HR with specialization in geriatrics and psychiatry too. In such a context, multi skilling needs to be given in geriatrics and psychiatry.

Rogi Kalyan Samiti

Major objective:

Decentralization in hospital management to ensure patient welfare

RKS forms a committee at the hospital level, with the involvement of PRI, service providers, and the community

Health equity focus:

- The initiative has the scope for addressing the issues of the vulnerable groups. For example, it can address the concerns of a disabled person in getting care from a facility. It can construct ramps for disabled persons in the hospitals.

Health Melas and Camps

Major objectives:

- To provide health care and awareness to vulnerable groups
- Specific health melas and awareness camps in tribal areas and urban slums

Health equity focus:

- Health melas and awareness camps are useful for vulnerable groups who cannot afford health care

However, it is essential to have frequent health melas and camps to cater to different vulnerable groups, including elderly and economically deprived.

Dimensions of health: Comparing more and less advantaged groups

Approach 1: Dimensions of health comparing more and less advantaged groups

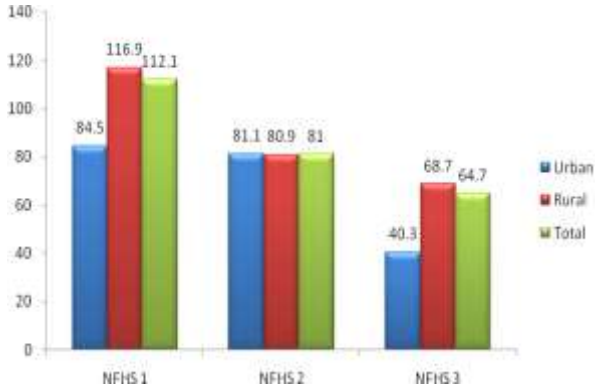
Trend analysis of health equality

Sources NFHS 1 (1992-93), NFHS 2 (1998-99) and NFHS 3 (2005-06)

Infant mortality rate (IMR)

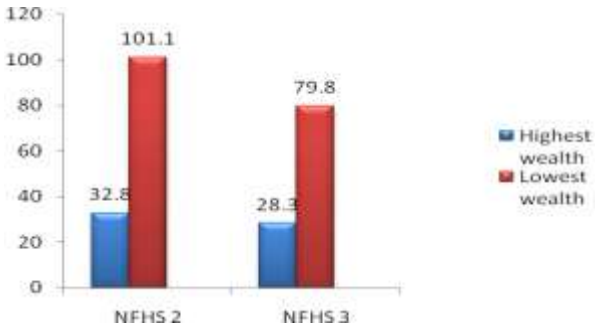
Residence:

IMR has reduced in both rural and urban areas from NFHS 1 to NFHS 3.The reduction in IMR is 44.2 in urban areas. The reduction is more in rural areas compared to urban areas and it is 48.2 in rural areas.



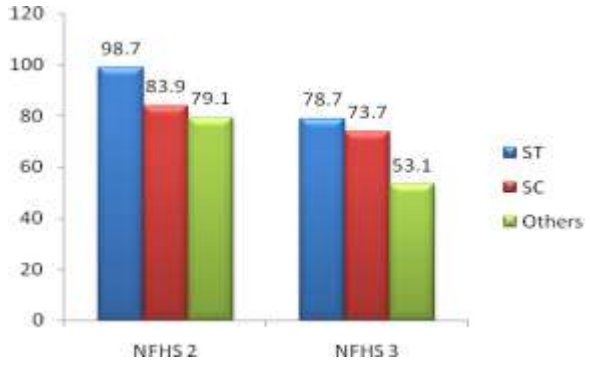
Economic status:

IMR has reduced among different economic groups from NFHS 2 to NFHS 3. The reduction is 4.5 in the highest wealth quintile. In the lowest wealth quintile the reduction is more compared to the highest wealth quintile and the reduction is by 21.3.



Caste:

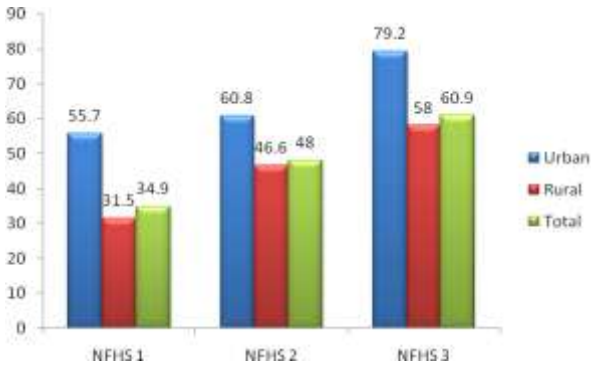
IMR has reduced among different social groups from NFHS 2 to NFHS3.The reduction in IMR is by 20.0 and 10.2 for SC and ST populations respectively. It is 26.0 for 'other' social groups.The reduction is more for 'other' social groups compared to ST and SC populations.



Antenatal care (3 or more)

Residence:

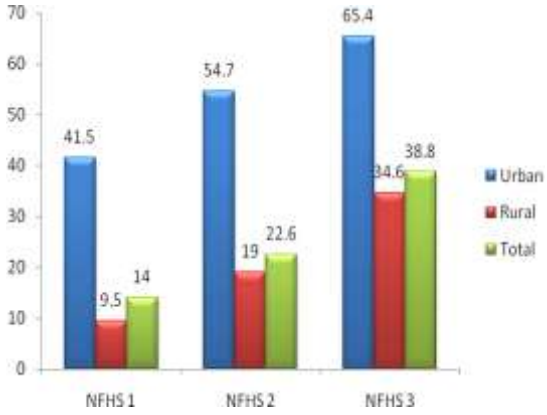
Antenatal care coverage has increased in both rural and urban areas from NFHS 1 to NFHS3. The increase in urban areas is 13.5. In rural areas it is 16.5. The rise is more in rural areas compared to urban areas.



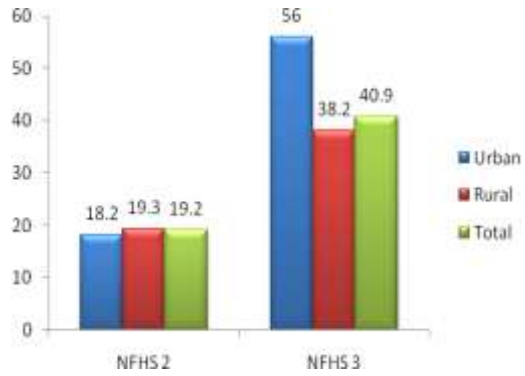
Institutional delivery:

Residence:

Institutional delivery has increased in both rural and urban areas from NFHS 1 to NFHS3. In urban areas the increase is by 13.9. In rural areas the increase is by 25.1. The augmentation in institutional delivery is



more in rural areas compared to urban areas.



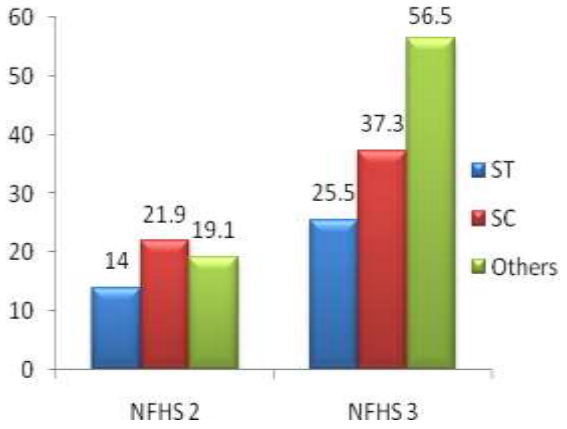
Post natal care (PNC)

Residence:

PNC coverage has increased in both rural and urban areas from NFHS 2 to NFHS3 .The increase is 47.2 and 18.9 in urban and rural areas respectively.The rise in PNC coverage is more in urban areas compred to rural areas.

Caste:

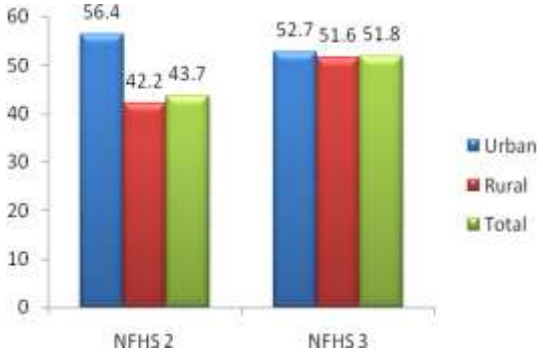
The PNC coverage has increased for different social groups from NFHS 1 to NFHS3. The rise in PNC coverage is 11.5 and 15.4 for ST and SC populations repectively. For 'other' social groups the rise in PNC coverage is relatively more at 37.4.



Immunization

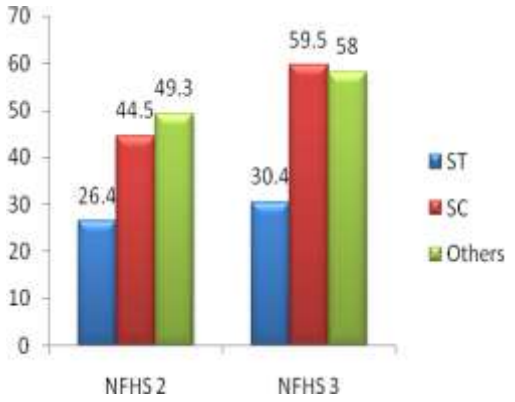
Residence:

Immunization coverage has reduced in urbal areas from NFHS 2 to NFHS 3 by 3.7. In rural areas it has increased by 9.4.



Caste:

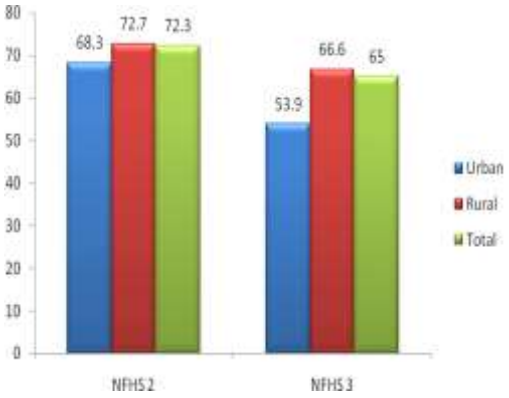
Immunization coverage has increased for different social groups from NFHS 2 to NFHS 3. The increase is 4.0 and 8.7 for ST and 'other' social groups respectively. The rise is more for SC populations and it is 8.7.



Anemia among children

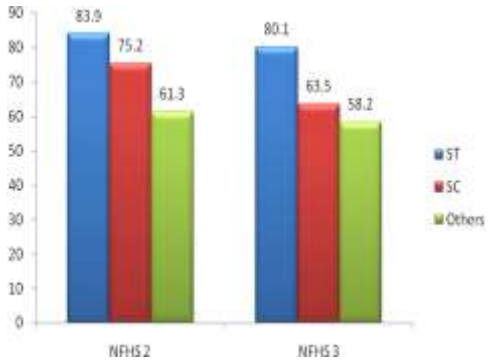
Residence:

Anemia among children has reduced in both rural and rban areas from NFHS 2 to NFHS 3. The reduction is 14.4 and 6.6 for urban and rural areas respectively. The reduction is more in urbal areas compred to rural areas.

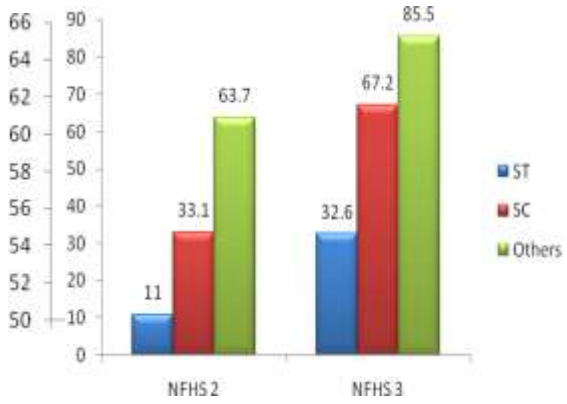


Caste:

Anemia among children has reduced for different social groups. The reduction is 3.8 and 11.7 for ST and SC populations. The reduction is 3.1 for 'other' social groups. The reduction is relatively more among SC populations.



Anemia among women

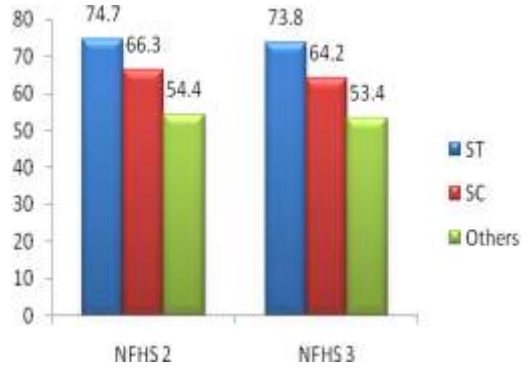


Residence:

Anemia among women has reduced in rural and increased in urban areas from NFHS 2 to NFHS3. The increase in urban areas is 1.1 and the reduction in rural areas is1.8.

Caste:

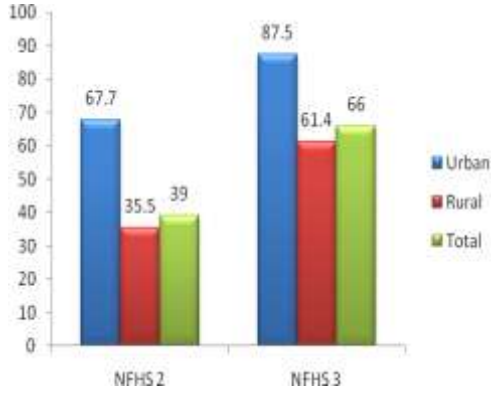
Anemia among women has reduced for different social groups from NFHS 2 to NFHS 3. The reduction is 0.9 and 2.1 for ST and SC populations. For 'other' social groups the reduction is 1.0. The reduction is relatively more among SC populations.



Knowledge about AIDS (Women)

Residence:

Knowledge about HIV has increased among women from NFHS 2 to NFHS 3 in both rural and urban areas. The rise in knowledge is 19.8 and 27.0 in urban and rural areas respectively. The rise in knowledge is relatively more in rural areas.



Caste:

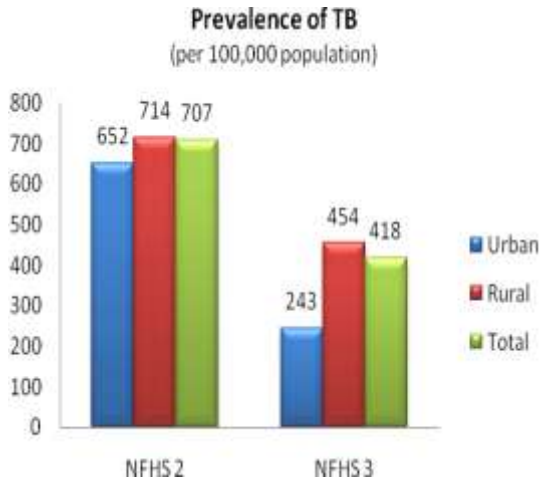
Knowledge about HIV among women has increased for different social groups from NFHs 2 to NFHS 3. The rise in knowledge is

21.6 and 34.1 for ST and SC populations respectively. For 'other' social groups , the rise is 21.8. The augmentation is relatively more among SC populations.

Prevalence of Tuberculosis

Residence:

The prevalence of TB has reduced in both rural and urban areas from NFHS 2 to NFHS3. The reduction is 409 and 260 in urban and rural areas respectively. The reduction is relatively more in urban areas.



The trend analysis shows that there are inequalities in the health status of the populations with different states of advantages (residence, economic status and social status). This difference also persists in terms of awareness about various health programs and diseases. The trend of improvement in the health status of different groups shows a mixed tendency i.e, the proportion of improvement is relatively higher among disadvantaged groups for some indicators and relatively less among disadvantaged groups for some indicators. For example, the proportion of reduction in IMR is high in rural areas compared to urban areas. When it comes to PNC, the coverage has increased in urban areas compared to rural areas. Therefore, it is essential to look into health policy outlook and programs (supply side health equity) to address this nexus of equality-equity.

Equity Analysis Framework

Approach 2: Assessment of Health Equity (Supply side)

COMPONENT – I (HUMAN RESOURCES AND CAPACITY DEVELOPMENT)

Methodology

Skilled human resources are inevitable to ensure effective and timely care to the vulnerable groups. To address health equity as well as the minimum essential health care requirements of vulnerable groups, primary health care is considered as the minimum assurance. Therefore, while reviewing the current HR vis-à-vis health equity, we gave preference to primary health care services. To understand the latest availability of HR in various primary health care services, we reviewed NFHS 3 (2005-06), PIP of NRHM 2008-09, and consulted the training departments of SIHFW, NRHM, and Community Medicine Department, SCB Medical College, Cuttack.

Equity Analysis Framework

Elements of analysis	Current Status	Remarks
Sub-centers without ANM	28%	In the state on an average, about half of the sub-centers are either without ANM/male health worker/additional ANM. By considering the primary health care requirements of populations, a single health worker cannot manage a sub center. Inadequate availability of Health workers affect the out-reach work, which is most essential for remote areas and vulnerable groups who don't have an appropriate health seeking behavior. Moreover, people who stay in rural areas and remote areas depend on sub- centers/ auxiliaries for
Sub-centers without male health worker	41%	
Sub-center without additional ANM	49%	

		primary health care services. In this context, health equity is not ensured without addressing the health care needs of such sections.
CHCs not having Obstetrician/Gynaecologist services	13.7%	Obstetricians, gynecologists and staff nurses are essential to address maternal care. JSY aims at reducing maternal mortality by improving maternal health care and enhancing institutionalized delivery. In this context, JSY may not be able to achieve its targets.
Proportion of staff nurse positions filled up in CHCs (against sanctioned)	21.7%	
No. of health facilities with at least one provider trained in Facility Based Newborn Care	1 district	The state stands second in the country for IMR. IMR is high in tribal districts, with low socio-economic status and remote areas. In such a context, the current situation of having 29 districts without at least one provider trained in newborn care may not help in reducing IMR in the state.
Proportion of specialist positions filled at FRUs to sanctioned posts	60%	Specialist skills are essential for specific services such as surgery, reproductive and sexual health, child health, mental health, eye care, dental care, ENT care, disabled care and care of the elderly. Out of these, reproductive and sexual health, mental health, child health, disabled care and elderly care very much cater to vulnerable groups.
Proportion of PHCs without lady doctor to total number of PHCs	49%	There are many health conditions specific for women, which might be better uncovered to a lady doctor. After all, the gender power structure and cultural norms of the society in some settings may not allow women to seek health care from a male doctor. In this context, women belong to such settings would be more affected by the absence of a lady doctor in a PHC.
Proportion of Gynecologists to women among reproductive age groups	Sufficient information not available	At present, sufficient information is not available to conclude the sufficiency of Gynecologists to cater to women among reproductive age groups.
Number of districts with geriatric	Sufficient information	

specialists/ total no. of districts	not available	To ensure health equity and to meet the health care requirements of the needy, the number of doctors/ specialists/pharmacists, nurses, lab technicians/auxiliaries needs to be in accordance with the IPHS norms.
Proportion of mental health specialists to total population	Sufficient information not available	
Is there any monetary incentive to work in tribal blocks/outreach/ underserved areas for medical doctors?	Yes	There are monetary incentives to work in KBK districts and three backward districts (Boudh, Kandhamal and Gajapati). The incentives are fixed as follows: • DHH and SDH- Rs 4000/month • PHC/CHC/Area hospital/PHCN - Rs 8000/month • Specialist allowances - Rs 3000/month
Is there any non-monetary incentive to work in tribal blocks/ outreach/underserved areas? 1. Early promotion 2. Higher studies and training 3. Pre-service training	No	At present there are limited non-monetary incentives to work in remote areas and the incentives are limited to pre-service training. For example, to address the needs of nurses in tribal areas, sponsored nursing education is given to females from such areas. They are required to work in such areas after the education. However, non-monetary measures are essential for in-service work force to incentivize them to work in such areas.
Is there any gender and equity component in in-service training programs?	No	At present, there is no gender and equity component in various training programs. Sensitization on gender and equity issues is required to ensure appropriate, timely, acceptable and affordable care to the various vulnerable groups.
How much gender sensitive are the training programs with respect to • Venue	Sufficient information not available	It is not possible to conclude from the information available at the state level about each district's gender and equity sensitiveness in their trainings. However, for the state level trainings at SIHFW, there are separate toilets available for females and sufficient conveyance is available. The trainers are selected as per the

• Logistics • Trainers • Residential training		subject specialty and there is no specific attempt to include/exclude females. There are sufficient facilities available for residential trainings at the state level.
How many male/female got trained in each training? What are the criteria for selecting candidates?	Sufficient information not available	There is no preference for inclusion or exclusion of female candidates for training.
Proportion of HR trained to current HR in under-served/ remote / tribal blocks	Sufficient information not available	It is essential to have a database of the number of HR getting trained from such areas. This is to look at whether HR from such areas are getting trained equally/more, compared to other areas. If there is a discrepancy in the proportion of HR trained in remote areas etc, it is essential to look into the reasons for it. It could be due to many reasons such as the workload may not give them time to get trained or there can be more preference to HR from other areas for training.
Proportion of HR multi skilled from tribal, underserved/outreach and urban slums to normal areas	Sufficient information not available	Since multi-skilling is considered as the best alternative strategy to meet the requirements for additionally skilled HR, it is required to keep track of HR multiskilled in underserved/remote areas.
No. of multi-skilling trainings addressing Geriatrics, Disability care, Psychiatry, disabled, BeMonc, CeMonc and anesthesia	Sufficient information not available	There are no attempts to impart multi-skilling on elderly care, disabled care and psychiatric care.
Is there any sensitization on gender and equity in the pre- service trainings (Nursing,	No	At present, there is no such attempt. Sensitization on gender and equity issues would be helpful to ensure an acceptable and appropriate care to the vulnerable groups.

ANM training and MBBS curriculum)?		
Is there any specific focus for the availability of HR in outreach/underserved /tribal/remote areas?	Yes	The measures taken to address the issue of HR in such areas are as follows: • Attempt to appoint contractual staffs • Monetary incentives • Local training and appointment of nurses from tribal areas • Increasing the number of graduate and post-graduate seats in medical colleges • Multiskilling
RECOMMENDATIONS		**ACTION POINTS**
Preparation and maintenance of database on the availability of HR and their skillsets		1. Facility wise HR available for medical officers, specialists, pharmacists, nurses, technicians and auxiliaries 2. Availability of the above HR vs. sanctioned posts 3. Sanctioned posts of the above HR vs. requirements as per IPHS norms 4. Ratio of filled up and retained HR in remote areas/ underserved areas/rural areas, urban slums and tribal areas 5. Multiskilling done for HR in different cadres in underserved areas/urban slums/tribal areas/remote areas
Ensuring availability of HR in remote/underserved areas		1. Enhancement of the non-monetary incentives as follows: • Arranging fully furnished accommodation facilities at the place of work • Providing transportation to the children of service providers for education at the district/block level

	• Early promotion for those who work continuously for 5 years in such areas • Appointment at district and state head quarters for those who work continuously for 5-10 years and 10-15 years in such areas respectively • Sponsored admissions in PG courses and other career development courses • District/block level township for the families of such providers • Exposure visits to other states and countries • Recreation arrangements and family tour for such providers • Vehicles to families of providers (one vehicle for a club of families) 2. Enhancement of seats in pre-service training institutes 3. Establishment of more number of pre-service institutes, especially in tribal/remote and under served areas
Ensuring availability of specialists for vulnerable groups (disabled, elderly, mentally ill)	• Multiskilling on geriatrics, psychiatrics and disabled care • Multiskilling can be done by sending selected HR for short trainings to national level institutes in India
Equity sensitiveness in in-service trainings	• Include a gender and equity component in each training curriculum • Provide facilities (crèche) to accommodate the children of female/male trainees and trainers at the district/block level.
Equity sensitiveness in pre-service trainings	Include a gender and equity component in the curriculum of ANM, nursing, MBBS, pharmacy and technicians' training.

COMPONENT – II (MONITORING AND EVALUATION)

Methodology

The method of M& E has been different for different programs. We consulted the major stakeholders and reviewed the M& E formats of NRHM and the following health programs for the year 2008-09.

a. *National vector borne disease control program*
b. *National leprosy eradication program*
c. *Revised national tuberculosis control program*
d. *National AIDS control program*
e. *Integrated disease surveillance project*
f. *National blindness control program*
g. *National Iodine deficiency disease control program*

Equity Analysis Framework

a. National Vector Borne Diseases control Program (NVBDCP)	
Elements of health equity	**Remarks**
Goal of the program	NVBDCP has a specific focus on those regions which are endemic and those populations which are vulnerable to VBDs. The program gives focus on both medical and social determinants of health. For example, the program specifically caters to pregnant women and children based on medical determinants. Similarly, there is specific focus on socially vulnerable groups such as tribals.
Mortality indicators	Disaggregated information are collected for

(impact)	• Different age groups , Sex (Male and female) and Different blocks This block wise information can be compiled to understand the status of tribal areas, underserved areas, urban slums and remote areas, whereas there is no disaggregated information available for SC/ST, economically vulnerable and disabled. Since the age wise classification divides the age groups into 0-6 tears, 6-15 years and 15 years and above, the elderly (< 64) is excluded.
Morbidity indicators (impact)	Disaggregated information are collected for • Different age groups , Sex (Male and female) and Different blocks
Process indicators	Disaggregated information are available for • Different blocks Distribution of bed nets and training of HR are considered as process indicators. However, there is no disaggregated information available for male/female and BPl/APL households.
Community based M & E and participation of specific groups	There is no established community monitoring system.

a. National Leprosy Eradication Program (NLEP)	
Elements of health equity	**Remarks**
Mortality indicators	Disaggregated information are collected for • Different age groups, Sex (Male and female), SC/ST and Different blocks
Morbidity indicators	Disaggregated information are collected for • Different age groups, Sex (Male and female), SC/ST and Different blocks
Process Indicators	Disaggregated information are collected for • Different age groups, Sex (Male and female), SC/ST and Different

	blocks

b. Revised National Tuberculosis Control Program (RNTCP)	
Elements of health equity	**Remarks**
Mortality indicators	Disaggregated information are collected for • Different age groups , Sex (Male and female) and Different blocks
Morbidity indicators	Disaggregated information are collected for • Different age groups , Sex (Male and female) and Different blocks
Process Indicators	Disaggregated information are collected for • Different age groups , Sex (Male and female) and Different blocks

c. National AIDS Control Program (NACP)	
Elements of health equity	***Remarks***
Morbidity indicators	Disaggregated information are collected for • Different age groups, Sex, SC/ST, and BPL/APL
Mortality indicators	Disaggregated information are collected for • Different age groups, Sex, SC/ST, and BPL/APL
Process indicators	Disaggregated information are collected for • Different age groups, Sex, SC/ST, and BPL/APL
Outcome indicators	Disaggregated information collected for • Different age groups, Sex, SC/ST, and BPL/APL
Community based M & E and	There is no established community based monitoring system. However, there is an attempt to include different communities to participate in M&E.

participation of specific groups	

e. Integrated Disease Surveillance Project (IDSP)	
Elements of health equity present	**Remarks**
Morbidity indicators	Morbidity disaggregated information are collected for • SC/ST, BPL/APL, Different age groups and Urban slums
Mortality indicators	Mortality disaggregated information are collected for • Sex, Different age groups and Outreach areas and urban slums
Outcome indicators	M& E has just started for outbreaks. But formats have not been finalized to understand which are the groups included.
Impact indicators	M& E has just started for outbreaks. But formats have not been finalized to understand which are the groups included.
Outbreaks surveillance	Information available for • Floods, No. of villages and Affected population (but no disaggregated information for populations)
Syndromic surveillance	Information available for • Different age groups and Sex
Presumptive surveillance	Information available for • Different age groups and Sex
Lab surveillance	Information available for • Different age groups and Sex
Community based M & E and participation of specific groups	There is established community based M&E.

f. National Program for Control of Blindness (NPCB)	
Elements of health equity	**Remarks**
Goal of the program	NPCB has a specific focus on those populations which are affected by eye diseases and which are vulnerable to eye diseases. The program does not have any region specific focus. Therefore, there is no specific focus on underserved areas, urban slums and tribal areas.
Mortality indicators	There are disaggregated information collected for • Different age groups, Sex and SC/ST
Morbidity indicators	There are disaggregated information collected for • Different age groups, Sex and SC/ST
Process Indicators	There are disaggregated information collected for • Different age groups, Sex and SC/ST

g. National Iodine Deficiency Disease Control Program (NIDDCP)	
Elements of health equity	**Remarks**
Mortality indicators	Disaggregated information collected for • Different age groups, Sex and Different blocks
Morbidity indicators	Disaggregated information collected for • Different age groups, Sex and Different blocks
Process Indicators	Disaggregated information are available for • Different age groups, Sex and Different blocks

RECOMMENDATIONS

Recommendations	➢ It is essential to have disaggregated information on impact and outcome indicators with respect to male/female, different age groups (including elderly), SC/ST, rural/urban, BPL/APL, disabled and remote areas, under-served areas. For example, disaggregated information on morbidity and mortality (impact indicators) and disaggregated information on case detection rate (outcome indicator) ➢ It is essential to have disaggregated information on process indicators (e.g. Number of HR trained) with respect to male/female, BPL/APL and SC/ST, remote areas, under-served areas. ➢ Capacity development of program officers at the state, district and block level to collect, compile, analyze and interpret such information to enable appropriate policy formulations for various vulnerable groups.

COMPONENT – III (SUPPLY SIDE ISSUES)

Methodology

It is essential to address the supply side issues to ensure effective, timely and affordable health care to the vulnerable groups. To understand the supply side issues, we consulted the officials of NRHM, DHS, and DFW and reviewed the documents such as NFHS 3 (2005-06), State PIP, Report of DFW on health infrastructure in Orissa (2007) and Report of capacity building initiatives by DFID (2007).

Equity Analysis Framework

Elements of equity	Current status	Remarks
Sub center located in government building	60%	There is no database on these sub-centers working on government owned buildings are from which geographical areas.
Proportion of PHCs without minimum 4 beds to total number of PHCs	51%	Adequate beds, infrastructure, specialization services at PHCs, CHCs and FRUs are minimum necessity to ensure primary health care to vulnerable groups residing in remote and tribal areas.
Proportion of PHCs not having newborn care services to total number of PHCs	50%	
Proportion of PHCs not conducting minimum of 10 deliveries/month total number of PHCs	94%	
Proportion of CHCs not having 24X7 normal delivery services to total number of CHCs	21%	

Proportion of CHCs not having functional Operation Theatre to total number of CHCs	41.6%	
Proportion of FRUs not having newborn care services on 24 hour basis to total number of FRUs	43.8%	
Proportion of FRUs not having blood storage facility to total number of FRUs	87.2%	
Proportion of PHCs not having referral services for pregnancies/delivery to total number of PHCs	45%	Without ensuring referral services for delivery, it may not be possible to achieve the objectives of JSY in remote and underserved areas.
Proportion of PHCs not functioning for 24X7 to total number of PHCs	69%	If PHCs are not able to provide 24 hr services, it may not be possible to ensure timely emergency care to vulnerable groups.
Proportion of drugs to the tribal blocks/non-tribal blocks	Sufficient information is not available	The distribution of drugs to districts is based on the demand by each district. At present, there is no mechanism to assure that the quantum and the list of drugs demanded by each district is sufficient/optimum to ensure the needs of the populations. The per capita allocation for drugs in the state is Rs.3.26 (368 lakhs population). The state of Kerala with 318 lakhs population allots Rs.5.26 per person for drugs.
Is there any specific preference to tribal blocks with respect to up gradation of facilities?	Yes	For up-gradation of facilities and ranking of FRUs, preference is given to KBK districts.
Is there any specific approach to health care delivery in tribal	Yes	There are health melas, RCH camps and mobile health units in tribal areas/remote areas.

blocks, outreach/underserved areas and urban slums? (e.g. Mobile clinics in remote areas, health camps etc)		
Is there any specific health program for SC population?	No	There is no specific program for SC population. But, SC populations are identified as vulnerable groups in some districts and get specific focus for health care.
User friendly health care services for the disabled(e.g. ramp in hospitals)	No	At present, there is no attempt to ensure user friendly health care services for disabled population in public health care facilities.
Recommendations	**Action Points**	
Maintenance of database on availability and level of functionality of facilities, quality of infrastructure, availability of drugs and utilization of services in each district	To enable policy formulation vis-a-vis health equity, it is essential to collect, compile and update the information available on facilities, infrastructure and utilization of services with respect to; • Tribal and non- tribal areas • Underserved/ remote areas • Border areas • Forest villages • Urban slums • Migration areas • Mine areas • Industrial areas • Conflict areas	
Availability of drugs as per the need of vulnerable groups	It is essential to make the following provisions with respect to drugs' supply • Availability of drugs as per the local disease burden • Timely disbursement of drugs to each facility • Proper use of drugs in each facility	
User friendly health care services to the disabled and elderly	• Introduction of ramps in hospitals • Enlistment of the quality issues and specific issues of the disabled groups in each facility • RKS to look after the issues of disabled in each facility • Ensure regular supply of drugs for diabetes, screening for blood pressure and diabetes through home based care for the disabled and elderly.	

COMPONENT – IV (PROGRAM IMPLEMENTATION PLANS, NRHM)

Methodology

We reviewed the state and district PIPs of NRHM (2008-2009).

We selected the districts of Angul, Jharsuguda, Sundergarh, Kandhamal, Gajapati and Koraput and reviewed their respective PIPs. During selection of the districts, we tried to give representation to districts falling under both the extremes of HDI ranking. For example, Angul, Jharsuguda and Sundergarh fall under top five districts, whereas Kandhamal, Gajapati and Koraput belong to bottom five districts.

We reviewed the PIPs on the basis following health equity elements:

- Identification of the vulnerable groups
- Identification of the needs of the vulnerable groups
- Allocation of funds vis-a-vis health equity

Equity Analysis Framework

Element 1: Identification of the vulnerable groups	
Districts	**State**
• Though there is no separate component on equity, but it has been addressed under various programs targeted for vulnerable groups. For example, under RCH program, there are sub-	The State PIP identified the vulnerable groups on the basis of the following determinants: 1. Geographical accessibility 2. Social distance

heads for tribal and urban RCH.

- In each of the PIPs, the districts have addressed vulnerable groups and envisaged plans for them. The list of vulnerable groups is not comprehensive enough to address health equity. For example, the district of Angul has significant industrial hubs. But, the district PIP does not address the industrial and occupational health hazards of the populations.
- There is no focus on physically challenged in any of the districts.
- Similarly, there is no attempt to cater to elderly populations.
- The size and distribution of vulnerable groups are not mentioned in the respective PIPs.
- All the six district PIPs follow a uniform format where there is a goal in each component. However, there is no logical framework approach with specified objectives, input, process, output and outcome indicators for the various activities for

3. Deep rooted cultural tradition and practices
4. Discrimination
5. Gender and equity
6. Endemic status

In the above classification vulnerability is decided by access to health care and the status of endemic diseases. This classification poses a larger focus on health equity, as it addresses both social and medical determinants of health.

However, this classification has some limitations as follows:

- *In the category of medical determinants (endemic status), it is not clear whether the attempt is to look into people who have the risk for endemic diseases (prevention) or who are already affected by endemic diseases (cure). Ideally, it is essential to have an attempt to address both synchronously.*
- *There is no attempt to address direct biological attributes determining vulnerability. For example, women are more prone to STIs. Therefore, there needs to be a classification of diseases which are more risky for certain groups, on the basis of biological determinants too.*
- *Similarly, there is no address on disability as a determinant of vulnerability, hence no specific plans for them.*
- *Access to health care consists of social, economic and geographical access. In the above classification social access (Classifications 2-5) and geographical access (classification 1) are addressed. But, economic vulnerability is not addressed. If we look into NRHM initiatives also, they are in tandem with this particular classification. There is an absence of very essential element of health equity, i.e. financial protection among the NRHM initiatives.*
- *There is no attempt to look at the health care for the elderly among the NRHM initiatives.*

vulnerable groups.	• *The vulnerable groups indentified in the PIP for specific focus are - tribals, fisher folks, scheduled castes, under-served areas, refugee community, border areas, urban slums and remote areas. However, the size and distribution of such vulnerable groups are not mentioned in the PIP.* • *There are many areas in the state, which are industrial hubs. But, there is no attempt to cater to the populations who are prone to industrial and occupational health hazards in the PIP.* • *The state PIP, though not in a specified log frame manner, there are specified goal, objectives, and outcome targets. But, it is not mentioned clearly how these specific processes would achieve the targets with a timeline for vulnerable groups.*
Element 2: Identification of the needs of the vulnerable groups	
Districts	**State**
• There is no mention of the operational issues as well as the specific vulnerable issues in all the six PIPs. • Since each district has its own specified vulnerable groups, ideally, the identification of the specific issues of vulnerable groups needs to be done by the district.	• The issues of the vulnerable groups are identified in terms of operational issues (supply side issues) of the health system. For example, there is specific mention of operational challenges of urban areas, outreach and under-served areas. This identification of such operational issues (inadequate HR and infrastructure) is very much required and appreciable. • Also, there is more focus on region wise vulnerabilities than social, economical and physical attributes i.e. disability. For example, in the affluent villages of the coastal areas the scheduled caste hamlets may have adverse health outcomes. However, the actual health determinants and outcomes of the vulnerable groups are not identified, e.g. burden of diseases in the groups.

Element 3: Funds allocation vis-à-vis health equity	
Districts	**State**
• All the six districts follow a uniform pattern of allocation. • For all the six districts, the allocation for vulnerable groups falls within a range of 3.5 to 4 lakh rupees. • The allocation under tribal RCH is exclusively for tribal districts. Therefore, there is an exclusion of tribal groups in non- tribal districts. However, some such tribal groups are included under the category of vulnerable groups in non-tribal districts. For example, the district of Angul has 132,994 (11%) tribal population; there is no specific allocation for tribal RCH in Angul. However, the Bhuyan and Juang tribal communities are addressed in the vulnerable groups. • Similarly, there are no specific allocations for SC groups in the six districts who may have adverse health outcomes. For example, the district of Angul has 196,109 (17.20%) scheduled caste populations, but there is no specific allocation for them under RCH. They are not also covered under vulnerable groups in the district.	• If we consider the allocation of NRHM vis-à-vis health equity, there is an intention to allocate funds for health equity. For example, RCH itself is addressing the health care needs of the vulnerable groups such as reproductive age women, children and adolescents. • There is also another sub-category of allocation under RCH such as vulnerable groups, tribal RCH and Urban RCH. • However, there are some issues in identifying the real vulnerable groups and their equity issues (as we have seen element No. 1 and 2). • Since the pattern and trend of allocation match with each specified NRHM objective, some vulnerable groups are excluded. For example, physically challenged and elderly populations are not included. • With respect to economically vulnerable groups, BPL families are included in JSY. Otherwise, there is no specific allocation for economically vulnerable groups. The state allocation to vulnerable groups is nearly 68 lakhs rupees. But, without correlating it with the size of beneficiaries, it is not possible to calculate the per capita allocation and to conclude about the adequacy of the allocation.
Conclusion	
1. There is an equity focus in the state PIP, though not comprehensive. And some of the vulnerable groups such as the physically challenged, economically deprived, elderly and scheduled castes are not included.	

2. Though there are district specific vulnerable groups and related issues in each district, there is no attempt to identify and quantify such vulnerable groups, their issues and remedial measures.

3. All the six district PIPs follow the same format, same objectives and more or less same allocations for vulnerable groups. Only difference is that tribal districts have more allocation for tribal RCH.

4. There is no specific log frame format for both district and state PIPs. The state PIP has envisaged for specific goals and some activities. But, there is no clear mention of respective processes and expected outcomes with timeline for different vulnerable groups.

Recommendations

- **Sensitization of the stakeholders on health equity**
- **Capacity development for identification of vulnerable groups, needs assessment, planning, implementation and monitoring and evaluation**
  1. **Sensitization – to make community and providers aware about different vulnerable groups and their needs**
  2. **Skill development – to ensure delivery of services to the vulnerable groups as per the need e.g. training on geriatrics, psychiatry, physiotherapy etc.**
     DoHFW can identify training institutes and medical colleges in Orissa and other states for imparting the capacities.

Expansion of the list of vulnerable groups

1. Population wise - Elderly, BPL, disabled, migrants, populations vulnerable to occupational health hazards, tribals in non-tribal districts, scheduled castes and women.
2. Region wise - Populations residing in mine/industrial areas, forest villages and conflict areas (naxal affected, natural disasters etc.).

- **Health needs assessment of the vulnerable groups**
  - Health determinants - poverty, education, safe drinking water and sanitation, occupation, social and ethnic status, availability and quality of services etc.
  - Health outcomes - morbidity, mortality, disability and impoverishment

- **Planning and resourcing as per the needs assessment**
  - Inclusion of gender and equity component in PIPs
  - Inclusion of gender and equity component in each program (Eg. National Health Programs)
  - District specific planning and budgeting to address the needs of various vulnerable groups

COMPONENT – V (PUBLIC HEALTH EXPENDITURE)

Methodology

We consulted major stakeholders of the government and reviewed the allocations and utilization of funds by the DoHFW and NRHM.

Equity Analysis Framework

Elements of health equity	Remarks
Health equity focus and inclusion of vulnerable groups	• There are specific allocations for some of the vulnerable groups and regions as explained below. • The allocation directly by the department of H& FW caters to vulnerable populations more than regions. But, there is a separate head for rural areas, urban areas and KBK districts. There are specific allocations for scheduled castes, scheduled tribes and disabled. However, elderly care could not get priority in the state government allocation. • The allocations under NRHM cater to both vulnerable populations and regions. For example, there are specific allocations for scheduled castes, women and children. Similarly, there are specific allocations for urban slums, tribal areas, under-served areas and remote areas. The total allocation by the NRHM for vulnerable groups is Rs. 68 lakhs for the year 2008-09.
Per capita allocation and utilization for tribals, scheduled castes, underserved areas, remote areas, disabled, elderly care, mental health, maternal health, child health and reproductive health	• Sufficient Information is not available. It is essential to look into the per capita allocations to conclude whether the funds provided are sufficient or not for the specific vulnerable groups (allocative efficiency).
Ratio of allocation and utilization for research on vulnerable out of total R & D head	There are no specific allocations for vulnerable groups under the R& D head.
Per capita allocation and utilization on financial protection	At present the state government's financial protection is limited to CGHS and ESI. These schemes cater to central

to the vulnerable (in terms of user fee exemption, universal health insurance, subsidies etc.)	government and state government employees respectively.
Per capita allocation and utilization of public spending on private sector for the marginalized	At present, there is no mechanism to track the allocation and utilization of public spending on private sector for the vulnerable groups. Under NRHM, there is a specific head for NGO involvement in health care delivery. Rs. 730.59 lakhs have been allotted for PHC management in under-served/remote areas under PPP model.
Recommendations	➢ The criterion of allocation to each vulnerable group needs to be based on the number of respective populations, regional specifications and disease burden (differential health status). ➢ There needs to be specific allocation for elderly care. ➢ Appropriate tracking mechanism to understand the efficiency in spending for various vulnerable groups ➢ Benefit incidence analysis to assess the impact of spending on vulnerable groups ➢ Attempts (capacity development) to reduce structural bottlenecks in identifying the needs of the vulnerable groups and enhance efficiency in financial management and speedy channelization of funds from state head quarters to the village/block level. ➢ Allocations for primary health care need to be 55% of the total allocations (as envisaged by OHSP and vision 2010). This is to ensure essential services to the vulnerable groups. ➢ Provisions to avoid collection of user fee at the time of service delivery to reduce the catastrophe on vulnerable households. This can be ensured through • Setting up Community based health insurance (CBHI) with cash less mechanism for both out patient and hospitalized care. CBHI has proved as a viable mechanism to provide health care to the poor in Indian settings (eg.

RAHA scheme in Chhattisgarh, Karuna Model for tribals in Karnataka, CBHI for tribals in Wayanad district of Kerala and health insurance run by PREM in Orissa)

- Increase the state government's share on public health spending
- Encourage, club and manage new sources of financing such as micro finance , health insurance and medical saving accounts (MSA) by the state government/ NRHM (Micro finance and MSA are proved to ensure health care to marginalized groups such as women in India (eg. MSA in Karnataka and Kudumbashree scheme in Kerala)
- Pool external finance direct or through partnerships.
- Emergency medical funds (EMF) at RKS level for emergency care

COMPONENT – VI (INTERDEPARTMENTAL SCHEMES)

Methodology

We selected the SANJOG scheme of Dept. of RWSS and ICDS of Dept. of WCD. We reviewed the activity reports of such programs and consulted the major stakeholders.

Equity Analysis Framework

A. SANJOG	
Characteristics of the program vis-à-vis health equity	**Remarks**
Description of the program	The Sanjog Scheme was started by the Ministry of Rural Development in 2007. **Management:** The nodal agency for the program is the dept of rural water and sanitation services (RWSS). The program has convergence with the departments of health and family welfare (H&FW), women and child development (WCD), Panchayati Raj (PRI), SC/ST development corporation, School and Mass education. It is a flagship program (like NRHM) with the support of central government, state government and different development agencies. **Objective:** To provide water supply and sanitation facilities to rural families, schools and anganwadi centers in rural areas. **Functioning :** ➢ Toilets • Households: it is a contributory mechanism from the beneficiary as well as the central and state governments. At present, the total cost of constructing a toilet is fixed up as Rs 2500. Out of this, central govt. share is Rs 1500, state govt contributes Rs 700 and Rs 300 is charged from the beneficiaries. • Anganwadi centers and Schools (govt and aided): The total cost is fixed up as Rs 5000. Out of this, Rs 3500 and Rs 1500 are contributed by the central and state governments. At present, there is no charge

	of price to the beneficiaries. ➢ Water supply • Schools and anganwadi centers: If there is a building, water supply is provided free of cost. • For populations: Public water supply is provided to respective hamlets. ➢ To provide free repair of water supply and sanitation through toll-free grievance redressal mechanism
Focus on vulnerable sections	• The program aims at providing sanitation facilities and safe water to rural BPL households and rural schools and anganwadi centers. • Since the direct focus is on rural BPL populations, the program ultimately caters to other economically backward sections such as SC, ST, disabled and women and populations residing in remote areas. • The slogan of the program is to cater to those who do not have the affordability.
Focus on health equity	The program addresses one of the main determinants of health i.e sanitation and safe drinking water. The indirect impact of the program on health of the populations is as follows: 1. Sanitation facilities can prevent open defecation, contamination of water and thereby water borne diseases 2. Safe drinking water also ensures health by preventing water borne diseases 3. Sanitation and availability of water can ensure better personal hygiene and thereby prevent spread of diseases 4. Water supply and sanitation help women specific hygiene and health. Thus, the program addresses the health issues of those who are vulnerable to outbreaks of water borne diseases.
Collaboration with health government	There is collaboration with the health department starting from the state level to the village level. At the village level, self employed mechanic of the dept. of RWSS is a member of GKS
Scope for	➢ Functionaries of Sanjog and health programs can help each other in

strengthening convergence	common goals ▪ E.g. ASHA and GKS can help in BCC for effective and proper use of water and sanitation facilities, personal hygiene and quality of water to prevent water borne and water related diseases Use each other's resources ➢ Toll-free grievance redressal mechanism can link the community to various health depts. (sub-center). ➢ Collaborations in outbreak investigations and preventions. ➢ Collaboration in identification and improvement of the social determinants of vulnerable groups (quality of water, safe drinking water, sanitation facilities etc) ➢ Design and follow up of village health plan to include local specific health equity issues.

B. ICDS	
Characteristics of the program vis-à-vis health equity	**Remarks**
Description of the program	• Six key services are provided, including supplementary feeding, immunization, health checkups and referrals, health and nutrition education to adult women, micronutrient supplementation and preschool education for 3 to 6 year old children.
Specific focus	Rights of children under six including the rights of nutrition, health and joyful life, mother and adolescent girl with supplementary nutrition and education
Health equity focus (region wise and populations wise)	• Special focus on vulnerable population • Prioritize services for women, children, poor families and underserved areas, urban slums, remote areas, BPL families, SC and ST children
Community representation	Community involvement in program planning, implementation, monitoring and evaluation and IEC activities by including SHGs, Panchayat Raj members, health functionaries.
Focus on social determinants of health	The program caters to social determinants of health such as nutrition.

Integration with health department	The program integrates with health department for health checkups and referrals, immunization, health and nutrition education to women and children and micronutrient supplementation.
Scope for strengthening convergence	➢ Integrated BCC and social mobilization for improving the social determinants of health (nutrition, anemia, body mass index etc). ➢ Sensitization and capacity development of ASHA, AWW and ANM on equity. ➢ Collaboration in village health plan for identification and follow up of local specific health equity issues.

COMPONENT – VII (BEHAVIOR CHANGE COMMUNICATION STRATEGIES)

Methodology

The health sector BCC strategy has been separate for different programs and schemes, dealt by separate consultants or a department. We have consulted the major stakeholders and reviewed the BCC plans (2008-09) for the following programs;

- **National Health Program**
  - *Reproductive and child health (RCH 2)*
  - *National blindness control program (NPCB)*
  - *National Iodine deficiency disease control program (NIDDCP)*
- **National Disease Control Programs**
  - *National Vector Borne Disease Control Program (NVBDCP)*
  - *National Leprosy Eradication Program (NLEP)*
  - *Revised National Tuberculosis Control Program (RNTCP)*
  - *National AIDS Control Program (NACP)*

Approach: Assessment of the current BCC plans has been undertaken by considering the following elements of health equity:

- *BCC strategies designed after identification of the current health seeking behavior, social, economic, cultural, geographic, ethnic and household dynamics of the different vulnerable groups*

- *Specific contents in the program addressing the issues of each vulnerable group*
- *The delivery mechanism of the BCC activity (language, theme and media) easy to understand, accessible and acceptable to each vulnerable group*
- *The involvement of each vulnerable group in the identification of the needs, planning and delivery of BCC activities*
- *Review of the impact of BCC activity on each vulnerable group*

Equity Analysis Framework

1. National Health Programs	
A. Reproductive and Child Health Program (RCH II)	
Elements of health equity	***Remarks***
Inclusion of the vulnerable groups (region wise and populations wise)	RCH activities address the health concerns of the three specific vulnerable sections of the society such as women in the reproductive age group, adolescents and children. BCC activities are also designed to ensure these equity concerns. 1: Region wise equity sensitiveness: The BCC program specifically addresses the vulnerable groups residing in the following areas; • Tribal areas • Urban slums • Coastal areas • Underserved and remote areas Approach: For tribal areas, there is locally acceptable folk media. There is also an attempt to identify the health care issues of the community. This is to fine -tune the health seeking behavior of the community with the locally acceptable care. As a part of it, there is sensitization to informal providers on better service delivery. Visual/audio/print media are widely used in urban slums. In coastal areas, there is use of coastal

	dialect to make the program more acceptable and easy to understand. In under-served and remote areas, there is more involvement of community in BCC programs. Kalyani clubs members (youth volunteers) are trained to cater to such areas. 2: Disabled groups and non-literates: There is no specific use of media/materials and language for physically disabled and illiterates. However, it is assumed that, messages may reach out to such groups, since there are many ways and means (folk media, visual and print media, community sensitization) of message conveyance.
Identification of the evidence based BCC needs vis-à-vis health equity	There is a proposal in the strategy framework to understand the evidence based health needs and the BCC needs of the targeted groups. *For example: There is a plan to understand the existing Knowledge, attitude and practice (KAP) of RCH target groups for ANCs and PNCs, their mothers, mothers-in-law and husbands in coastal, tribal, non-coastal and non-tribal zones to examine the extent of behavior change needed in the target group*. If it gets materialized it would be a real means to understand the actual needs of the community on RCH. However, this step would have been implemented in the first year of the implementation of BCC plan for RCH 2 in 2005 or 2006. Such an attempt would have made the further formulation and implementation of BCC plans with proper focus to address the real health equity issues.
Family planning	There are specific BCC strategies to sensitize males on vasectomy at the district level. This attempt can change the present unbalanced gender power structure of the society. This is because, in the present context sterilization is more appreciated for females than males. For example, as per NFHS 3, male sterilization rate is 1% in the state. However, there has been no attempt to specifically identify and address the stigmas of tribal community on the use of family planning methods.
Adolescent health	There is specific focus on adolescent sexual and reproductive health, life skill education and health services. There is also a proposal to introduce school health program. But the specific objectives and strategies of the program has not been finalized yet.
Sexual and reproductive health	BCC strategies on sexual health are limited to adolescents. Similarly, there has been no attempt to strengthen men's support in pregnancy care and delivery of women.
Child health	BCC plan for child health are confined to immunization, newborn care and reducing infant mortality. This attempt may overlook the other

	health care concerns of children such as injuries and accidents.
Community participation in planning, implementation monitoring and evaluation	There is a very specific BCC approach to ensure community participation in implementation and monitoring of BCC programs through Kalyani clubs. Kalyani clubs consist of locally informed youth volunteers. This specific attempt has a specific focus on under-served/remote areas.
Conclusion	There is focus on health equity, though not comprehensive in the BCC strategy framework for RCH2. Overall, BCC strategies address the RCH program in general than a specified target group approach.
Specific Recommendations	➢ The BCC strategies need to be sensitive to the RCH needs of disabled in terms of identification of the needs, language, theme and media of delivery. ➢ Sensitization on reproductive health as a right of men and women. ➢ Sensitization on preventive measures to reduce child injuries due to accidents or other causes. ➢ Sensitization to community and providers on effective and special care to children suffering from mental illness and other physical disabilities.

B. National Program for Control of Blindness (NPCB)	
Elements of health equity present	**Remarks**
Health equity focus	The NPCB has a specific focus on those populations which are affected by eye diseases and which are vulnerable to eye diseases. NPCB does not have any region specific focus. Therefore, there is no specific focus on outreach/underserved areas, urban slums and tribal areas. But, there is a specific focus on school children and diabetic populations (prone to retinopathy). However, BCC strategy of NPCB tries to ensure equity by catering to local dialect needs.

Inclusion of the marginalized (Populations and Regions):	The BCC activities addresses the following vulnerable groups: ***1: Rural areas*** Approach: Community group meetings for sensitization, by involving health workers. ***2:Tribal areas*** Approach: Local specific methods such as folk media, street play and use of local dialects. ***4:Urban Populations*** Approach: Visual and print media are used more in urban areas. ***5: Other vulnerable groups*** *A: Non-literates:* Though the BCC program has not specifically envisaged for illiterates, the use of audio-visual media and fold media may cater to such groups. *B: Elderly:* There are workshops on sensitization of blindness in later life. *C: Other linguistic minorities:* Though most of the districts have specific local dialect, the program does not cater to such local linguistic needs. *D: School children:* Awareness seminars in schools on control of blindness and rally of school students
Identification of the BCC needs of the vulnerable	There was no specified attempt to understand the BCC needs of each vulnerable section and region.
Community participation and ownership of BCC program	There is an attempt to include the community in BCC activities. The scale to which it has been implemented varies from district to district.
Review of BCC activities on vulnerable groups	There is no specific attempt to review the BCC activities and their impact on vulnerable groups' behavior change.
Conclusion	There is an equity focus on BCC activities to some extent. It is not comprehensive enough to reach out to all the vulnerable sections of the

	society.

C. National Iodine Deficiency Disease Control Program (NIDDCP)	
Elements of health equity present	**Remarks**
Health equity focus	The program specifically caters to prevention of diseases due to iodine deficiency and better management of such diseases and promotion of the use of iodized salt. Thus, there is a health equity focus in the BCC program approach too. This is because the program caters to those vulnerable groups who are at risk of such diseases.
Inclusion of the marginalized (Populations and Regions):	The BCC activities addresses the following vulnerable groups: ***1: Women and children*** There are specific themes, materials and sensitization for women and children. ***2:Tribal areas*** Community awareness talks by local community members ***3: Remote and underserved areas*** Community awareness talks by local community members ***4:Urban Populations*** Approach: Visual and print media are more used in urban areas. ***5: Other vulnerable groups*** *A: Physically challenged:* There is no specific approach for physically challenged. Visual media and community awareness camps may cater to such groups. *B: Non-literates*: Though the BCC program has not specifically envisaged for illiterates, the use of visual media and community sensitization programs may cater to such groups. *C: Elderly:* The program does not specifically targeting elderly. Since the

	program caters to community sensitization, it is assumed that it may or may not reach elderly. This is because the mobility and interaction of the elderly is bit limited compared to the rest of age groups. *D: Other linguistic minorities*: Though most of the districts have specific local dialect, the program does not cater to such local linguistic needs. *E: School children:* There are school based screening and sensitization programs. *F: Rural areas: There are special sensitization programs at each village level to promote the use of Iodized salt.*
Identification of the BCC needs of the vulnerable	There was no specified attempt to identify the BCC needs of each vulnerable section and region.
Community participation and ownership of BCC program	There is an attempt to include the community in BCC activities. The scale to which it has been implemented varies from district to district.
Review of BCC activities on vulnerable groups	There is no specific attempt to review the BCC activities and their impact on vulnerable group's behavior change.
Conclusion	There is an equity focus on BCC activities to some extent. But it is not comprehensive enough to reach out to all the vulnerable sections of the society.

2. National Disease control Programs

a. National Vector Borne Disease Control Program (NVBDCP)

Elements of health equity present	Remarks
Health equity focus	The NVBDCP program specifically caters to those regions which are endemic to malaria and those populations which are vulnerable to the complications of malaria. The BCC activities are designed as catalysts to meet such objectives. Therefore, there is a health equity focus in the

	BCC program approach.
Inclusion of the marginalized (Populations and Regions):	The BCC activities addresses the following vulnerable groups: ***1:Pregnant women and children*** Approach: Specific themes, materials and sensitization for women and children. ***2:Tribal areas*** Approach: Local specific methods such as folk media and use of local dialects. ***3: Remote and underserved areas*** Approach: Community awareness programs and community involvement. ***4:Urban Populations*** Approach: Specific use of audio-visual and print media in urban areas. ***5: Other vulnerable groups*** *A: Physically challenged:* There is no specific approach for physically challenged. However, they may be benefitted from folk/ audio-visual /print media and community sensitization programs. *B: Non-literates:* Though the BCC program has not specifically envisaged for non-literates, the use of audio-visual media and fold media may cater to such groups. *C: Elderly:* The program does not specifically target elderly. Since the program adopts community sensitization, it may reach elderly. *D: Other linguistic minorities:* Since most of the districts have specific local dialect, the program caters to such local linguistic needs. *E: School children:* There is a plan to introduce school health awareness program for malaria.
Identification of the BCC needs of the vulnerable	The BCC activities try to change the behavior of the community for the prevention and better management of VBDs. But, there was no specified attempt to understand the BCC needs of each vulnerable section and region.
Community participation and	There is an attempt to include the community in BCC activities. But, the

ownership of BCC program	scale to which it has been implemented varies from district to district.
Review of BCC activities on vulnerable groups	There is no specific attempt to review the BCC activities and their impact on vulnerable groups' behavior change.
Expected outcomes of current activities vis-à-vis health equity	Use of locally acceptable and easy to understand methods (language, theme, materials and delivery mechanism) ensures better scope for behavior change. Such behavior change can lead to higher level of achievements of the program and thereby better health status for the vulnerable sections.
Conclusion	There is an equity focus on BCC activities to some extent. But it is not comprehensive enough to reach out to all the vulnerable sections of the society.
Specific Recommendations:	➢ *Since the program deals with VBDs, the overall objective is very much direct and limited to prevention and control of VBDs. But, to achieve the larger goal of health equity, the indirect and direct impact of such diseases also need to be highlighted through BCC activities. For example: The link of malaria with malnutrition for women and children need to be highlighted and sensitized.* ➢ *Since gender power structure of the households does not allow women to take independent decisions, there need to be sensitization to all the households and community. If sensitization is routed out through ASHAs it may get limited to members of the SHGs (who are supposed to be women) only.* ➢ *Sensitize health functionaries, households and community on special care for the disabled affected by VBDs..*

b. National Leprosy Eradication Program (NLEP)

Elements of health equity present	**Remarks**
Health equity focus	The NLEP program specifically caters to those populations which are vulnerable to leprosy and which are affected by the severities of leprosy. The BCC activities try to enhance the speed of achieving such objectives.

	Therefore, there is a health equity focus in the BCC program approach.
Inclusion of the marginalized (Populations and Regions):	The BCC activities addresses the following vulnerable groups: ***1:Endemic pockets*** Approach: There are specific themes, materials and sensitization for those populations residing in endemic pockets ***2:Tribal areas*** Approach: There are local specific methods such as street play, use of local dialects and delivery of message by local community. ***3: Remote and underserved areas*** Approach: This specific approach is prevalent in Jeypore, Koraput district. Since almost all the households have 'transistor' the messages are conveyed through AIR. This method is not used in other underserved areas. ***4: Urban slums:*** Approach: Visual and print media are more used in urban areas. ***5: Other vulnerable groups*** *A: Physically challenged*: There is a specific approach for disability borne out of leprosy. Service providers are sensitized on stigmatization of the disease. Sensitizations are also conducted to utilize the medical rehabilitation for the disabled. *B: Other physically challenged:* There is no specific method for sensitizing other physically challenged such as deaf, blind, deaf, dumb and orthopedically challenged (other than leprosy persons). *C: Non-literates:* Though the BCC program has not specifically envisaged for illiterates, the use of audio-visual media and fold media may cater to such groups. *D: Elderly:* The program does not specifically target elderly. However, community sensitizations might be powerful to reach elderly. *E: Adolescents:* There is no specific sensitization for adolescents and

	school children *F: Other linguistic minorities:* Since most of the districts have specific local dialect, the program caters to such local linguistic needs.
Identification of the BCC needs of the vulnerable	There is no specified attempt to understand the BCC needs of each vulnerable section and region.
Community participation and ownership of BCC program	There is an attempt to include the community in BCC activities. The scale to which it has been implemented varies from district to district.
Review of BCC activities on vulnerable groups	There is no specific attempt to review the working and impact of BCC activities on vulnerable groups and areas.
Conclusion	There is an equity focus on BCC activities to some extent. But it is not comprehensive enough to reach out to all the vulnerable sections of the society.

C. Revised National Tuberculosis Control Program (RNTCP)	
Elements of health equity present	**Remarks**
Health equity focus	The RNTCP program specifically caters to those populations who are vulnerable to TB and its complications. The BCC activities are designed as catalysts to meet such objectives. Therefore, there is a health equity focus in the BCC program approach.
Inclusion of the marginalized (Populations and Regions):	The BCC activities addresses the following vulnerable groups: ***1:Tribal areas*** Approach: Broadcast of messages through local radio program in Jeypore of Koraput District. But, for the rest of tribal areas, no such specific plans are envisaged.

	3: Remote and underserved areas Approach: Community awareness ***4:Urban Populations*** Approach: Visual and print media are used in urban areas. ***5: Other vulnerable groups*** *A: Physically challenged:* There is no specific approach for physically challenged. *B: Non-literates:* Though the BCC program has not specifically envisaged for illiterates, the use of audio-visual media may cater to such groups. C: Elderly: The program does not specifically target elderly. However, use of audio-visual media may reach some of the elderly. D: Other linguistic minorities: Though most of the districts have specific local dialect, the program does not cater to such local linguistic needs. E: School children: There are specific awareness programs in schools. F: Stigmatization: Specific sensitizations are provided on stigmatization of TB to providers and community
Identification of the BCC needs of the vulnerable	There was no specified attempt to understand the BCC needs of each vulnerable section and region.
Community participation and ownership of BCC program	Community mobilization in planning and delivery of messages are envisaged by the BCC action plan. However, community involvement in planning of the activities is not full fledged.
Review of BCC activities on vulnerable groups	Monthly review is being done for BCC activities with respect to outcome of the program. One district is selected per month for review.
Conclusion	There is an equity focus on BCC activities to some extent. But it is not comprehensive enough to reach out to all the vulnerable sections of the society.

d. National AIDS Control Program (NACP)	
Elements of health equity present	**Remarks**
Health equity focus	The program specifically caters to those regions which are high focused for HIV/AIDS and those populations which are vulnerable to the complications of HIV. The BCC activities are designed as catalysts to meet such objectives. Therefore, there is a health equity focus in the BCC program approach.
Inclusion of the marginalized (Populations and Regions):	The BCC activities addresses the following vulnerable groups: ***1:Pregnant women and children*** Approach: Specific themes, materials and sensitization for parent to child transmission. ***2:Tribal areas*** Approach: Specific themes, folk media and use of local dialects. ***3: Border and Migrant Areas*** Approach: There are specific themes in such areas ***4:Urban Populations*** Approach: Visual and print media are more used in urban areas. ***5: Other vulnerable groups*** *A: Physically challenged*: There is no specific approach for physically challenged. *B: Non-literates:* Though the BCC program has not specifically envisaged for illiterates, the use of audio-visual media and folk media may cater to such groups. *C: Other linguistic minorities:* Since most of the districts have specific local dialect, the program caters to such local linguistic needs. *D: Sexual workers:* There is sensitization for sexual health workers on

	prevention of HIV. *E: Migrant workers:* There are specific focuses on migrant population, who are at risk of HIV. *F: TB patients:* There are sensitization to prevent TB/HIV co-infection H: Truck drivers: There is specific sensitization for truck drivers in specific areas I: Women: There are specific themes for women to prevent STIs and RTIs J: Adolescents: Awareness programs are conducted for adolescents.
Identification of the BCC needs of the vulnerable	There were two rounds of surveys to identify the BCC needs of the various populations. In the first round (2002), the whole state was covered. In the second round, the survey was confined to districts of Koraput and Ganjam.
Community participation and ownership of BCC program	There is an attempt to include the community in BCC activities. But, the scale to which it has been implemented varies from district to district.
Review of BCC activities on vulnerable groups	There is no specified attempt to review the BCC activities and their impact on vulnerable groups' behavior change.
Conclusion	There is an equity focus on BCC activities to a great extent, since it focuses on the most risky groups of the disease.

RECOMMENDATIONS

Recommendations:	➢ To ensure health equity, the BCC strategies require the following elements; • *Contents of the BCC strategy identifying and addressing the specific needs of each vulnerable section* • *The language and the delivery mechanism of BCC strategy easy to understand and acceptable to each vulnerable section* ➢ Regular tracking of the BCC activities to assess the change in life style/ health seeking behavior/ level of health awareness through utilization surveys, coverage surveys, KAP studies and FGDs. ➢ Community participation in identification of the BCC needs, planning, implementation and review of BCC activities. ➢ Sensitize health functionaries, households and community on special care for the disabled affected by diseases ➢ Integrate the identification of BCC needs, planning, implementation and review with GKS. ➢ Sensitization and capacity development of GKS on the above process.

COMPONENT – VIII (EVIDENCE BASED BEST PRACTICES OF CSO)

Methodology

We selected one community based health care program, one facility based health care program and one community based financing scheme. The review of above programs was with respect to highlight the elements of health equity and scope for integration with government programs.

We indentified the following programs;

1: *Community based drug distribution centers (CBDs) in the district of Sambalpur by BISWA*

2: Management of PHC in Sukinda Block, Jajpur district by NYSASDRI

3: Community based health insurance Scheme by BISWA

We consulted the major stakeholders of programs (1 and 3) and reviewed the evaluation report of program 2.

Equity Analysis Framework

1.Community based health care program of BISWA	
Characteristics of the program vis-à-vis health equity	**Remarks**
Name of the program	Community based drug distribution centers (CBDs) in the district of Sambalpur.
Description of the	Trained community members manage the drug distribution centers in different locations of the district for the last two years. About 1 lakh

program	population is covered from different remote areas of the district. There is the provision of providing the medicines for routine and regular health care from the CBDs. If necessary, there is an OPD centre managed by the same NGO with a physician and staff nurse to for consultation. The procurement and maintenance of the drugs depends upon the regular needs assessment of the community. The drugs are distributed at subsidized rate. However, there is a no flat rate of subsidy. For the members of self help groups, if they don't have money in hands at the time of buying drugs, SHG loans are available to get medicine. However, there is a limitation that one SHG member can avail one loan at a time.
Conditions/diseases for which health care is sought at the maximum	The drugs are maintained in accordance with the demand of the community. All the necessary drugs to address the minimum primary health care are maintained by the CBD. The maximum demand and usage has been for reproductive health care, child care, hyper tension, diabetes, snake bite, malaria and other communicable diseases.
Health equity focus (region wise and populations wise)	The program is open for everybody. However, the maximum users are women in the reproductive age group, children, elderly, physically challenged economically vulnerable (BPL), SC, ST, and populations residing in urban slums and underserved areas. There is a specific focus on elderly and disabled, since they are members of the particular SHGs run by the NGO. Moreover, the program mainly focus on providing medicines at subsidized rate, the probability of ensuring access to medicines to the disabled and elderly is higher. This is because the limited paying capacity due to inability to earn is the major hindrance of the elderly and the disabled to get care. Apart from this, NGO has mobilized a community organizer for each village to encourage and support the community members to access healthcare. This support and encouragement can be very much appropriate and timely to the elderly and disabled as an escort to get medicines.
IEC and advocacy	This drug centre is used as an IEC centre to promote healthy life and prevent major communicable diseases. There is a community mobilization to realize health as a right and utilize the available resources (physical and financial) optimally. There is also an attempt to sensitize community on appropriate care for the disabled and elderly.

M&E	There is a practice of maintain the database of each person who is part of this initiative and who is using this initiative in terms of community, sex, economic status, residence and physical status.
Community representation	It is a purely community owned program with full involvement of the community in planning, monitoring and implementation. There is a regular needs assessment of the community to ensure the appropriate availability of drugs.
Focus on social determinants of health	Though this particular initiative does not focus on social determinants like safe drinking water, sanitation etc, the NGO has been taking the initiative to ensure such facilities in its areas of intervention. Apart from this, IEC materials have been used regularly for the effective and proper use of such facilities.
Collaboration with government	CBDs are established in the district of Sampalpur under the RCH 2 program with government support. But, the list of drugs has extended from reproductive health care needs to other primary health care requirements.
Efficiency	Routine evaluations have been done to know the utilization and availability of drugs. Though many SHG members use SHG loans to avail drugs at subsidized rate, there is a very commendable track record of paying back the SHG loans. Periodical assessment says that there is a substantial use of this drug centers by various marginalized sections of the society.
Limitations	There has been no attempt to assess the quality of drugs. Similarly, the system of not fixing the flat rate for subsidy can sometimes affect the capacity to pay for drugs by the vulnerable groups.
Sustainability	The initiative has strong potential for sustainability based on the following grounds 1: The program has government support. 2: The program has community ownership. The program is run by trained and sensitized community members. 3: The program caters to very essential requirements of primary health care. Therefore the compulsions to maintain it from the community side are high.

	4: There is a financial viability, since it ensures a sharing mechanism for buying drugs. 5: The program runs on the principle of the solidarity of self help groups.
Scope for scalability	It is essential to scale up the program to the rest of the state, specifically to inaccessible areas, underserved areas, tribal hamlets, forest villages and scheduled caste hamlets. Study the best community based health care models in the rest of the country. Make a comparison of the experience of Orissa and other Indian states. Adopt the best elements from each example and make it suitable for the local context. **Action points:** • Identify NGOs working in those areas to sensitize and train the community to manage the program. Give a small catchment area to each NGO, so that there would be proper attention and efficiency • Financial support to share the price of drugs to be provided by the government. • There can be a cross subsidy such as charging either free or 1/4th price to economically vulnerable groups and half price to economically well off groups (if there). But, fix the subsidy rate in such a manner that, it is affordable to the vulnerable groups. • Routine monitoring to ensure timely needs assessment, procurement and maintenance of drugs. • Routine tracking of the utilization by various vulnerable groups. If some groups are excluded, special redressal mechanism for them. • Ensure the quality of drugs provided • The program would be more efficient, if there is an availability of mobile consultations to such populations from respective block/ district head quarters hospitals. • Integrate with GKS and ASHA. • In some settings, if GKS are capable enough they can manage

	the CBDs.

2.Facility based health care program	
Characteristics of the program vis-à-vis health equity	**Remarks**
Description of the program	Management of primary health centers (PHCs) by NYSASDRI in Sukinda block of Jajpur district.
Health equity focus (region wise and populations wise)	The Block PHC management of NGO helped in providing care to the remote areas. Similarly, the absence of user fee helped the economically deprived in getting care. Since the area is socio-economically backward, most of the inhabitants were benefitted from the absence of user fee. The area was tribal dominated.
Conditions/diseases for which health care is sought at the maximum	Maximum utilization of services was for RCH, community awareness program and disabled care.
Evidence on the improvement of services	Increase in patient- turn over (40%), RCH services utilization (45%), and community awareness generation, renovation of infrastructure like bath room, waiting room, OT chamber and delivery room.
Use fee	There was no user fee for the services provided by the PHC
IEC and advocacy	There were regular IEC activities on various services such as RCH and communicable diseases.
M&E	There was a routine M&E system to track the utilization of services. However, there was no attempt to collect disaggregated information for various vulnerable groups.
Community representation	The community involvement was limited to IEC activities.
Focus on social determinants of health	The focus on social determinants was specifically on awareness generation though IEC activities.
Collaboration with	Though government provided support to the NGO in PHC management,

government	there was no financial contribution from govt.
Efficiency	Involvement of community volunteers by the Ngo helped the auxiliaries in outreach activities and helped in demand generation and increased utilization of services.
Limitations	IEC activities were limited. More focus was on clinical aspects and there was less focus on public health activities. There was no attempt on biomedical waste management. There was no sensitization to auxiliaries on NRHM initiatives There was absence of staff nurse, staff quarters, mobility and ambulatory support.
Sustainability	Sustainability is a concern without government financial support for effective management of primary health centers. It is not financially viable to manage the PHC for long term with funds from external agencies other than government. If the external agency support and pooling is through government, there is less financial and sustainability risk.
Scope for Scalability	It is essential to contract out the management of PHCs and Sub centers in the state to credible and efficient NGOs, specifically in remote areas, inaccessible, urban slums and forest villages, mine areas, industrial areas and tribal areas. Study the best NGO management of PHCs in the rest of the country. Make a comparison of the experience of Orissa and other Indian states. Adopt the best elements from each example and make it suitable for the local context. **Action Points:** • It is essential to keep the supervisory roles with the Govt. But, at the same time, it is essential to provide scope for NGOs for good innovations. • It is useful to bring in extra financial resource by the NGO, but, government needs to make financial contribution. • Effective orientation of staff on health equity, health programs and public health. • Mechanism to ensure integration with government run programs

	(e.g. NRHM and public health activities) • Integration with GKS to identify the local specific health equity issues and help in solving them. • Clear focus and specified work plan for vulnerable groups in the locality.

3. Community based financing program, BISWA	
Characteristics of the program vis-à-vis health equity	**Remarks**
Name of the program	Community based health insurance, started in 2006.
Description of the program	The scheme runs in 30 districts of the state, covering about 1 lakh population. Members of SHGs are eligible for group/family health insurance coverage for hospitalization. The coverage is limited to only 4 members of the family. But the selection of the members is at beneficiaries' choice. The premium is Rs 325 /year. The amount is payable as installments collected through micro finance mechanism. The sum assured is Rs 15,000 per person. The services covered include all care related to hospitalization including surgery and maternal care. There is a strict norm of all other insurance norms such as exclusion of pre- existing illness. Oriental Insurance company is the insurer. There is no fixed provider. The beneficiary can get care from any provider. The community development officer has to certify the process and cost of care to enable the reimbursement to the provider. The payment is through cashless system.
Specific focus	Members of men and women self help groups
Health equity focus (region wise and populations wise)	Though the larger focus is on the members of self-help groups, there is a substantial coverage of children, disabled, BPL and elderly. Among the SHG members, there is a substantial membership of disabled and elderly. However, if disabled and elderly are not members of SHGs, their inclusion in the scheme depends on the realization of their health care requirements by the household members.

IEC and advocacy	The community development organizer allotted to three self help groups has been giving sensitization on the need and use of health insurance through written materials and oral sensitization.
Community representation	It is a purely community owned program with full involvement of the community in monitoring and implementation.
Collaboration with government	There is no specific collaboration with government. However, availing care from government providers is also acceptable in the scheme.
Efficiency	• The scheme is helpful to prevent catastrophic health care expenditure. It ensures cashless payment for care. • There is no default in the payment of premium, since it is rooted out through SHGs. The premium is collected in installments and it gives enough flexibility to the beneficiaries. • It covers maternal care also, unlike other insurance schemes. • The schemes try to make use of providers of Indian systems of medicine. • The scheme has been implemented for the last three years there has not been any issue of financial non-payment by the beneficiaries. • The evaluations reveal the improvement of health seeking behavior of the community. Also, there is a provision of balancing the household portfolio and prioritize for health care needs.
Limitations	• There is no coverage of OP care. However, in the specified areas, where this scheme exists, there are OPD centers and community drug centers run by the same NGO to cater to OP care. • There is no sufficient check on quality of care and cost of care. • There is no ceiling on the cost of consultation and drugs. If the beneficiaries use private facilities, there can be excessive cost of consultation and drugs. • However, if there is a ceiling on the cost of drugs and hospitalization, the beneficiaries may not be able to get care in some cases.

	• Transportation costs are not covered
Scope for scalability	It is essential to scale up this scheme to the rest of the state, specifically for economically vulnerable groups, women, elderly and physically challenged. The scheme proves the potential for scalability on different grounds such as financial viability, efficient management, low administrative costs and sustainability.Study the best financing schemes in the rest of the country. Make a comparison of the experience of Orissa and other Indian states. Adopt the best elements from each example and make it suitable for the local context. **Action Points:** • Mechanism for quality assurance • Tie up with a panel of providers considering their infrastructure, public confidence and acceptance, quality of care and cost of care • Coverage of transportation costs • Cashless payment system instead of reimbursement. This is to avoid on the spot payment and consequent catastrophe on the vulnerable households. • There are many insurance schemes run by different entities such as NGOs, Missionary hospitals and insurance companies. In order to make it reachable to all vulnerable groups, the government can club all those schemes. Each such agency/NGO incurs substantial administrative costs. Clubbing all such schemes together reduces the administrative costs. Government can be the channel for pooling and management of such different schemes. But, implementation can be done by different agencies and NGOs at each district/block level. The subscription costs of the economically vulnerable groups can be borne by the Government. • A financial protection cell (say insurance) cell can be brought in at NRHM level. Each district/ block requires a trained HR for co-ordination and management to ensure services to the most needy, transparency and effective administration.

Conclusion

Conclusion

The assessment of health outcomes through NFHS 1, 2 and 3 shows that there is a trend towards vertical equity in the state. Vertical equity is a situation of treating each group as per their requirements i.e. more for the more needy. The trend analysis shows that the percentage improvement among less advantaged groups is high compared to more advantaged groups. However, this trend is not the same for all indicators. In such a context, the system may take some more time to achieve vertical equity in full swing.

With respect to the approach of different programs vis-à-vis health equity, the health system of the state has already initiated to address the needs of various vulnerable groups. The major attempts for various vulnerable groups are under the aegis of NRHM and National health programs. However, the approach towards health equity is not comprehensive to identify all the vulnerable groups and their needs in the state. The approach towards health equity is confined to rural/urban, SC/ST, gender (Male/female) and remote/underserved areas. Still, the needs of such groups are not sufficiently identified and addressed. Moreover, the vulnerability due to economic status, physical disability, age, occupation and environmental hazards (industrialization) are not substantially addressed in the ongoing programs. This asymmetry in identification and planning for vulnerable groups by each program synchronizes with the subsequent steps such as monitoring and evaluation and further improvement measures for such groups. It is essential to have comprehensive

approach towards health equity i.e. the proper identification of vulnerable groups and their needs in the state. There needs to be specific strategies for various vulnerable groups to address health equity in the state. It would be appropriate for each program (NRHM and National Health Program) to have a specific component on gender and equity to address the specific needs of different vulnerable groups in the state. To achieve vertical health equity, the less advantaged groups (vulnerable groups) need to get more attention, specific programs and more attention compared to more advantaged groups. Moreover, the proportion of improvement in the health status of vulnerable groups needs to be more than that of more advantaged groups. This more than proportionate improvement can only reduce the current gaps between vulnerable and more advantaged groups.

Recommendations

A: COMPREHENSIVE RECOMMENDATIONS:

On the basis of the review of above policies, programs and action plans, we made a comprehensive action plan with specific plans for each of the above components. Such an action plan would focus more on unmet needs under each component. However, such measures for unmet needs would be implemented side by side with the ongoing plans.

Goal: Comprehensive approach to health equity			
Objective: To reduce barriers to demand and utilization of services by various vulnerable groups			
Expected outcome: Improvement in the health status of various vulnerable groups			
Step1: Proper identification of vulnerable groups and their needs			
Strategies	**Action Points**	**Responsible Stakeholders**	**Prioritization**
Capacity development on health equity	**1. Sensitization on various vulnerable groups, their current status and their health needs of** • Stakeholders (all the medical professionals, health administrators, nurses, lab technicians, auxiliaries, NRHM officials, PRIs and GKS) Sensitization to be done at each	SPMU, DPMU, RKS, GKS, disease control programs, outreach	Immediate

	district level to orient more on local needs. • Community through GKS,CBOs auxiliaries, ASHA and BCC activities of various health programs **2. Identification of vulnerable groups** on the basis of age (children and elderly), gender, caste (ST, SC), economic status (BPL), disability, location (underserved areas, industrial areas, forest villages, migration pockets, border areas etc.) and occupation (industries, mining etc.) **3. Skill development** to ensure delivery of services to the vulnerable groups as per the need e.g. training on geriatrics, psychiatry, physiotherapy etc. *DoHFW can identify training institutes and medical colleges in Orissa and other states for imparting the capacities.*	workers, community volunteers and CBOs	
Identification of vulnerable groups and needs	1. **Step 1: Each district to identify its vulnerable groups** 2. **Step 2: Identify the needs of vulnerable populations** in terms of 1. Health determinants - poverty, education, safe drinking water and sanitation, occupation, social status and ethnicity, health seeking behavior, availability of services (facilities, equipments and HR) 2. Health outcomes – morbidity, mortality, disability, impoverishment 3. BCC to identify the information needs of various vulnerable groups through surveys, knowledge, and attitude and practice		1.Short term 2.Short term 3.Immediate

	(KAP) studies, Focus Group Discussions, Participatory Rural Appraisal (PRA) methods etc.		
3. Step 2: Planning for the most vulnerable groups and their needs			
Each district to follow specific plan, in accordance with the needs of its vulnerable populations	1. Specific focus for disabled, elderly, economically vulnerable groups, tribals in non-tribal districts, scheduled castes, forest villages, migrant populations, mine areas, industrial areas, conflict areas (naxal, natural calamities) and populations at risk for occupational health hazards and at disease outbreaks. 2. Citizen charter in all health care facilities mentioning the services provided, equipment and facilities available, quality of services entitled to, complaints and grievance redressal mechanisms and responsibility of the users 3. Promote partnership mechanisms in capacity development, BCC, health care delivery, financing and M&E. Identify local partners/NGOs to cater to remote areas. Give small catchment area to each NGO and/or community to make effective management. 4. Allocations to be based on local specifications, respective populations and local disease burden. 5. Drug distribution to be based on local disease burden (differential health status) 6. BCC strategies to be easy to understand, accessible and acceptable to each group. These need to be local specific in	SPMU, DPMU, RKS, GKS, disease control programs, outreach workers, community volunteers and CBOs	1. Immediate 2. Immediate 3. Immediate 4. Immediate 5. Immediate 6. Immediate

	terms of addressing the issues, themes, language and media. 7. Health camps, mobile clinics, drug distribution centers and home based care for the most vulnerable regions. 8. Emergency Medical Funds (EMF) at RKS to address the emenergency health care requirements of vulnerable groups 9. RKS to identify and address the issues of vulnerable in each facility (e.g. provide ramps in hospitals for disabled populations). 10. To address the economically vulnerable groups, ensure health insurance coverage. Appoint a manager for each district to ensure effective management of such schemes. 11. Provision of funds to purchase drugs, if drugs are not available in the facilities 12. Convergence to use the resources of other departments and integrated BCC strategies 13. Ensure home based care for disabled and elderly 14. Appoint a new professional/assign the current HR to look after vulnerable groups in each district 15. School health cards to include the health profile of each student 16. Toll-free grievance redressal mechanism connecting the		7. Immediate 8. Immediate 9. Short term 10. Short term 11. Short term 12. Short term 13. Long term 14. Long term 15. Long term 16. Long term

	community to various health functionaries, and departments working on health and allied issues		
Step3: Implementation of various programs after planning			
Implementation of the health equity component explained above has to go side by side with the ongoing programs			
Step 4: Monitoring and Evaluation of programs/activities			
Ensure disaggregated information for different vulnerable groups (SC/ST, BPL/APL, Male/Female, age groups and disabled)	Indicator based M&E (in terms of processes and outcomes) for each program Indicators need to address: ▪ Per capita allocation/utilization of funds for vulnerable groups ▪ Per capita allocation of drugs for vulnerable groups ▪ Programs planned/ implemented for vulnerable groups ▪ Vulnerable groups included/ existing ▪ Vulnerable groups targeted/included ▪ HR planned/deployed in hard to reach and underserved areas ▪ Trainings planned/conducted in hard to reach and underserved areas ▪ Facilities' strengthening planned/undertaken in hard to reach and underserved areas ▪ Reduction in disease burden of vulnerable groups	SPMU, DPMU, RKS, GKS, disease control programs, outreach workers, community volunteers and CBOs	Short term

	▪ Improvement in health status (morbidity and mortality) of the vulnerable groups ▪ Assessment of Improvement in health awareness, change in life style, health seeking behavior and utilization of services through utilization surveys, coverage surveys, KAP studies and FGDs ▪ Trend in health care expenditure by vulnerable groups ▪ Impact assessment of programs on various vulnerable groups, e.g. social and beneficial assessment (SABA)		

Step 5: Compilation and interpretation of the data with a focus on the vulnerable groups

Develop a comprehensive documentation to understand the status of vulnerable groups in terms of social determinants, household dynamics, health status, health seeking behavior, health awareness, health care expenditure, money mobilization pattern. This report needs to cater to each and every vulnerable individual and households. This report can be stretched as an "Orissa Health Report", to include the rest of the populations and to track the health system's progress district wise annually.

B: SPECIFIC STRATEGIES FOR VULNERABLE GROUPS:

	Strategies
1	**Vulnerable group: Elderly** **Strategies and prioritization:** ➢ **Immediate Strategies:** • **Quarterly health camps for elderly at block level/ panchayat level in each district** • **Sensitization to health functionaries on elderly care** • **Encourage NGOs, Multinational companies, other corporate bodies to initiate for such camps** • **Sensitization to community on elderly care** • **ASHA/ community volunteer by CBOs/ family member to help elderly in reaching the health camps** • 'Emergency care funds' at RKS for emergency care of economically vulnerable groups ➢ **Short term strategies** • **Mapping of HR trained in geriatrics in both public and private sector in each district. If the current strength is not sufficient, identification of potential HR to be trained on geriatrics from both private and public facilities in each district** • **Training on the above** ➢ **Long term strategy:** • **Ensure home based care to distribute essential drugs (diabetes, blood pressure etc) and screening (blood tests, check up for blood pressure etc).** ➢ ***Indicators:***

	• No of HR trained/planned in geriatrics • No. of blocks/panchayats covered/ total no. of blocks/panchayats • No of health camps conducted/planned break for public/private and public-private) • No. of health functionaries sensitized/ total no. of health functionaries in each region • No. of community members sensitized/ total adult population in the locality • No. of elderly availed care from each camp/ total no. of elderly in each locality • Per capita allocation of drugs for elderly • Per capita allocation/utilization for elderly in each district • Disaggregated information on male/female and SC/ST
2	**Vulnerable groups: Disabled** **Strategies and prioritization:** ➢ **Immediate Strategies:** • Quarterly health camps for disabled at block level/ panchayat level in each district • Sensitization to health functionaries on disabled care • Encourage NGOs, Multinational companies, other corporate bodies to initiate for such camps • Sensitization to community on disabled care • ASHA/ community volunteer by CBOs/ family member to help disabled in reaching the health camps • 'Emergency care funds' at RKS for emergency care of economically vulnerable groups ➢ **Short term Strategies:**

	• Mapping of HR trained in speech therapy, physiotherapy, psychiatry etc in both public and private sector • Identification of potential HR to be trained on psychiatry, physiotherapy, speech therapy etc from both private and public facilities from each district • Training on the above • Transportation facilities to ensure emergency care for disabled ➢ **Indicators:** • No of HR trained/planned in psychiatry, physiotherapy, speech therapy etc. • No. of blocks/panchayats covered/ total no. of blocks/panchayats • No of health camps conducted/planned break for public/private and public-private) • No. of health functionaries sensitized/ total no. of health functionaries in each region • No. of community members sensitized/ total adult population in the locality • No. of disabled availed care from each camp/ total no. of disabled in each locality • Per capita allocation of drugs for disabled in each camp • Per capita allocation/utilization for disabled in each district • Disaggregated information on male/female and SC/ST
3	**Vulnerable groups: Economically deprived groups** **Strategies and prioritization:** ➢ **Immediate Strategies:** • Quarterly health camps at block level/ panchayat level in each district • Encourage NGOs, Multinational companies, other corporate bodies to initiate for such camps

- Emergency care funds at RKS for emergency care of economically vulnerable groups

➢ **Short term strategies:**

- Partnering with above private sector to ensure the sustainability of such camps
- Introduction of community based health insurance schemes/medical savings accounts

➢ **Long term strategies:**

- Enlist a number of free essential services package (apart from various national disease control programs) for accidents, disease out breaks and other emergency care.

➢ **Indicators:**

- No of health camps conducted/planned (break for public/private and public-private).
- No. of blocks/panchayats covered/ total no. of blocks/panchayats.
- No. of BPL availed care from each camp/ total no. of BPL in each locality.
- Disaggregated information on male/female and SC/ST
- No. of health functionaries sensitized/ total no. of health functionaries in each region.
- No. of community members sensitized/ total adult population in the locality.
- Coverage of BPL households in insurance schemes/ total no. of BPL households
- Per capita allocation of drugs for BPL households in each camp
- Per capita allocation/utilization for BPL households in each district

4

Populations residing in industrial areas

Strategies and prioritization:

- **Immediate strategies:**
  - Identify those industrial areas in each district
  - Legislation to make mandatory for industries located in the areas to organize health camps and free drug distribution for essential health care
  - Legislation to make mandatory for industries located in the areas to provide health insurance coverage to the populations residing in the locality
  - Quarterly health camps in those areas
- **Indicators:**
  - No. of industrial areas covered/ total no. of industrial areas in each district
  - No. of health camps conducted/planned
  - Disaggregated information on male/female and SC/ST
  - Proportion of populations covered in the health insurance schemes/ total populations
  - Per capita allocation of drugs for such areas
  - Per capita allocation/utilization for such areas

5	**Populations at occupational health hazards (unorganized sector)** **Strategies and prioritization:** ➢ **Immediate strategies:** • Identify groups at risky through a disease burden study in each district • Awareness camps through GKS • If such populations are inhabited in a specified locality, regular health check ups ➢ **Indicators:** • Proportion of populations found at risk/ total populations in each district • No. of health awareness camps conducted/planned • Disaggregated information on male/female and SC/ST
6	**Forest Villages and conflict areas** **Strategies and prioritization:** ➢ **Immediate strategy**: • Quarterly health camps and awareness programs ➢ **Short term strategies:** • Identification of potential partners (NGOs, Missionary hospitals etc) to provide regular health care in such areas • Partnerships with such functionaries to ensure regular health care services • Transportation to get care from other nearby facilities ➢ **Indicators:** • No. of health camps conducted/planned (break for public/private and public-private)

	• Proportion of populations covered/ total populations in each forest village • Disaggregated information on male/female and SC/ST • No. of health functionaries sensitized/ total no. of health functionaries in each region • Per capita allocation of drugs for such areas • Per capita allocation/utilization of funds for such areas

C: RESPONSIBILITIES ENVISAGED FOR GKS AND RKS:

	Responsibilies
1	GKS - Community level • To identify the local needs • Maintain household and village profile (combining health determinants and health outcomes as explained under component IV NRHM PIPs) • Community level sensitization on health equity through convergence with Dept of WCD, R&D and Mass Education RKS- Facility level • To identify and address the issues of vulnerable groups in facilities • Establishment of ramps in facilities • Emergency medical funds(EMF) at RKS for emergency care • Maintenance of citizen charter in facilities

Annex I

List of stakeholders consulted

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ANNEX II Checklist

Equity Analysis Framework

Component – I (Human Resources and Capacity Development)

Human Resources				
No.	**Elements of analysis**	**Current status**	**National average/ Standard**	**Remarks**
	Availability			
1	Doctor Population Ratio in the state			
2	Nurse Population Ratio in the state			
3	Male female doctor ratio in the state			
4	Doctor population ratio in outreach/ underserved areas			
5	Nurse population ratio in outreach/underserved areas			
6	Doctor population ratio in tribal blocks vs non-tribal blocks			
7	Nurse population ratio in tribal blocks vs non-tribal blocks			
8	Doctor population ratio in urban slums vs non-urban slums			
9	Nurse population ratio in urban slums vs non-urban slums			
10	Number of Gynecologists/women among reproductive age group			
11	Number of districts with geriatric specialists/ total no. of districts			
12	Ratio of ophthalmologists to total population in each district			
13	Ratio of mental health specialists to total population in each district			
14	Number of sanctioned posts vs. Current HR in tribal blocks (for medicals, para professionals and auxiliaries)			
15	Number of sanctioned posts vs. Current HR in outreach/underserved areas (for medicals, para professionals and			

	auxiliaries)			
16	Number of sanctioned posts vs. Current HR in urban areas (for medicals, para professionals and auxiliaries)			
	Incentives			
17	Is there any monetary incentive to work in tribal blocks/outreach/under-served areas?			
18	Is there any non-monetary incentive to work in tribal blocks/outreach/underserved areas? 4. Early promotion 5. Higher studies and training			
	Capacity Development			
19	Do the training programs address gender and equity issues in programs (Enlist all those with and without such components)?			
20	How much gender sensitive are the training programs with respect to a. Venue b. Logistics c. Trainers d. Residential training			
20	How many male/female got trained in each training? What are the criteria for selecting candidates?			
21	Number of HR existing vs. number of HR trained (under-served, outreach and tribal blocks)			
22	No. of HR multi skilled from tribal, underserved/outreach and urban slums			
23	No. of multiskilling trainings addressing the health care of mentally sick, elderly, disabled, BeMonc and CeMonc /total no. of trainings			
24	Is there any sensitization on gender and equity issues in the curriculum of pre-service training (medical, ANM and Para			

	medical)?			
25	Is there any gender and equity sensitization of service providers (medical, para professionals and auxiliaries)?			

Equity Analysis Framework

Component – II (Monitoring and Evaluation)

No.	Elements of analysis	Current status	Remarks
1	Morbidity disaggregated data for 1. SC/ST/Others 2. BPL/APL 3. Female/Male 4. Age groups 5. Outreach/underserved areas 6. Urban slums		
2	Mortality disaggregated data for 1. SC/ST/Others 2. BPL/APL 3. Female/Male 4. Age groups 5. Outreach/underserved areas 6. Urban slums		
3	Information on participation of the above categories on community based programs? (E.g. community participation in malaria control)		
4	Disaggregated process indicators for the above group (E.g. no. of bed nets supplied)		
5	Disaggregated outcome indicators for the above group (E.g. reduction in SPR)		

6	Disaggregated impact indicators for the above group (E.g. reduction in mortality and morbidity)		
7	Community based M & E and participation of specific groups		

Equity Analysis Framework

Component – III (Supply side issues)

No.	Indicator	Current status	Remarks
1	Ratio of sub centers operating without building in the state to total no. of sub centers		
2	Ratio of sub centers in tribal blocks/non-tribal blocks		
3	Ratio of sub centers existing vs required as per population norms in tribal blocks		
4	Ratio of sub centers operating without own building to total in tribal blocks		
5	Ratio of sub centers operating without own building/non-tribal blocks		
6	Ratio of sub centers without own building in tribal blocks/non-tribal blocks		
7	Ratio of sub centers in outreach/underserved areas/		

	total no. of sub centers		
8	Ratio of sub centers existing vs requirement as per population norms in outreach/underserved areas		
9	Ratio of sub centers operating without building/total no. of sub centers in outreach/underserved areas		
10	Ratio of current urban health centers vs requirement as per population norms		
11	Ratio of urban health centers operating without own building/ total no. of urban health centers		
12	Ratio of FRUs in tribal blocks/non-tribal blocks		
13	No. of FRUs in outreach/under-served areas		
14	Ratio of 24X7 PHCs in tribal blocks/non-tribal blocks		
15	No. of 24X7 PHCs in outreach/under-served areas		
16	Ratio of current PHCs in tribal blocks vs requirement as per population norms		
17	Ratio of CHCs in tribal blocks vs requirement as per population norms		

18	Proportion of drugs to the tribal blocks/non-tribal blocks		
19	Proportion of drugs to the outreach/under-served areas		
20	Is there any specific preference to tribal blocks regarding upgradation of facilities?		
21	Is there any specific preference to outreach/underserved areas regarding up gradation of facilities?		
22	Bed population ratio in tribal blocks/non-tribal blocks		
23	Is there any specific approach to health care delivery to the vulnerable? (e.g. Subsidized rate)		
24	Is there any specific approach to health care delivery in tribal blocks, outreach/underserved areas and urban slums? (e.g. Mobile clinics in remote areas, health camps etc)		
25	Is there any specific health program for SC population?		
26	Is there any specific focus on health care delivery for ST population?		
27	User friendly health care services for the disabled (e.g.		

	ramp in hospitals)		

Equity Analysis Framework

Component – IV (District Program Implementation Plans)

No.	Indicator	Current status	Remarks
	Health care delivery		
1	Is there any special focus for vulnerable sections and regions on the following • Mental health • Disabled care • Immunization • Pregnancy care • Institutional delivery • User fees • Elderly care		
2	Is there any special focus on service delivery in tribal blocks (e.g. Mobile clinics in remote areas)?		
3	Is there any special focus on service delivery in outreach/underserved areas? (E.g. Mobile clinics in remote areas)?		

4	Is there any strategy for participation of different vulnerable sections in different programs/schemes?		
5	Is there any integration with program for malnutrition?		
6	Ratio of 24X7 PHCs in tribal blocks to those of non-tribal blocks		
7	No. of 24X7 PHCs in outreach/underserved areas		
M&E framework			
8	Disaggregation of data on process indicators for the vulnerable groups		
9	Disaggregation of data on outcome indicators for the vulnerable groups		
10	Is there any community based monitoring and evaluation?		
Capacity Development			
12	Do the training programs address gender and equity issues in programs (we will enlist all those with and		

	without such components)?		
13	How much gender sensitive are the training programs with respect to a. Venue b. Logistics c. Trainers d. Residential training		
14	How many male/female got trained in each training? What are the criteria for selecting candidates?		
15	Number of HR existing vs. number of HR trained (under-served, outreach and tribal blocks)		
16	No. of HR multi skilled from tribal, underserved/outreach and urban slums		
17	No. of multiskilling trainings addressing the health care of mentally sick, elderly, disabled, BeMONC and CeMONC / total no. of trainings		
18	Is there any gender and equity sensitization of service providers (medical, para medicals and auxiliaries)?		
Public Health Expenditure			
19	Per capita allocation to		

	the vulnerable		
20	Per capita utilization of funds for vulnerable		
21	Per capita allocation utilization ratio in tribal blocks		
22	Per capita allocation-utilization ratio in outreach/underserved areas		
23	Per capita allocation-utilization ratio in urban slums		
24	Ratio of utilization of funds generated through additional sources for vulnerable/total spending		
25	Proportion of utilization of untied funds for the marginalized		

Equity Analysis Framework
Component – V (Public Health Expenditure)

No.	**Indicator**	**Status**		**Remarks**
		Current status	**Allocation utilization ratio**	
1	Ratio of per capita allocation			

	for tribal blocks/ non-tribal blocks			
2	Per capita allocation for underserved and outreach areas			
3	Per capita allocation for disabled care			
4	Per capita allocation for elderly care			
5	Per capita allocation for the mental health programs			
6	Per capita allocation for child health			
7	Ratio of allocation for maternal health to population in reproductive age group			
8	Per capita allocation for reproductive health			
9	Per capita allocation for research on vulnerable out of total R & D head			
10	Per capita allocation to scheduled castes			
11	Per capita allocation to tribal population			
12	Per capita			

	allocation on financial protection to the vulnerable (in terms of user fee exemption, universal health insurance, subsidies etc.)			
13	Per capita allocation of public spending on private sector for the marginalized			

Equity Analysis Framework

Component – VI (Inter-departmental programs)

No.	Indicator	Current status	Implementing agency	Quantum	Remarks
1	Which are the vulnerable sections addressed by the initiative?				
2	Which issues of the vulnerable addressed by the initiative?				
3	Relevance of such issues				
4	How are the issues of the vulnerable addressed by the				

	initiative?				
6	Population covered by the initiative				
7	Total number of blocks/districts covered				
8	Is there any practice of disaggregated process and out come indicators for the targeted beneficiaries				
9	Is there any practice of maintaining disaggregated health profile of the vulnerable?				
10	Is there any practice of giving representation to vulnerable in the planning, implementation and monitoring?				
11	How the program is addressing health equity? (E.g. in terms of health status, health delivery etc.)				

8	Impact of the program (with respect to goal)				
9	Scope for further collaboration with health dept. to address equity				

Equity Analysis Framework

Component – VII (Behavior Change Communication)

No.	Elements of analysis	Current status	Remarks
1	How much equity sensitive the contents of the BCC plan? (Specific sections in the plan addressing equity) E.g. whether BCC plan for malaria addressing pregnant women, children, SC/ST etc.		
2	Is there a comprehensive BCC plan for outreach/under-served areas?		
3	Is there a comprehensive BCC plan for tribal areas?		
4	Is there a comprehensive BCC plan for urban slums?		
5	Is there any use of local dialects/colloquial languages for specific groups?		
6	Is there any use of culture and context specific media? Eg more use of radio in some areas, local folk in some areas etc.		
7	Is there any specific BCC approach for the disabled?		
8	Is there any specific BCC strategy for non-literates? (E.g. more use of pictures than text)		
9	Is there any specific BCC strategy for child health?		
10	Is there any specific BCC strategy for maternal health?		

11	Is there any specific BCC strategy for adolescent health?		
12	Is there any specific BCC strategy for sexual and reproductive health (SRH)? (Issues addressing men's participation in SRH)		
13	Is there any specific BCC strategy for elderly?		
14	Is there any specific BCC strategy for school health program?		
15	Is there any specific BCC strategy for non-communicable diseases affecting women? (E.g. cervical cancer, breast cancer etc.)		
16	Is there any specific BCC strategy for mental health?		
17	Is there any BCC strategy for communicable diseases?		
18	Is there any BCC strategy for sensitization for financial risk protection in terms of health insurance/community mobilization/community financing etc.?		
19	Is there any BCC strategy against stigmatization for specific diseases or health conditions? (e.g. HIV, TB, leprosy etc)		
20	Is there any specific BCC strategy for malnutrition in certain groups?		
21	Is there any specific BCC strategy against female feticide?		
22	Is there any specific BCC strategy to address health situation after disasters? (E.g. floods, cyclones, earthquakes, riots etc.)		
23	Is there any BCC plan for behavioral risks like tobacco, alcohol etc		
23	Is there any BCC strategy for the health care providers on equity? (E.g. dealing with various group of clients with compassion and respect)		
24	Is there any specific BCC strategy for participation of the community in various programs and schemes? (Participation in		

	planning, implementation and monitoring and evaluation)		

Equity Analysis Framework
Component – VIII (Civil society organizations – Best practices)

Community based health care program	
Characteristics of the program vis-à-vis health equity	**Remarks**
Name of the program	
Description of the program	
Conditions/diseases for which health care is sought at the maximum	
Health equity focus (region wise and populations wise)	
IEC and advocacy	
M&E	
Community representation	
Focus on social determinants of health	
Collaboration with government	
Efficiency	
Limitations	
Sustainability	

Scope for scalability	
Community based financing program	
Characteristics of the program vis-à-vis health equity	Remarks
Name of the program	
Description of the program	
Specific focus	
Health equity focus (region wise and populations wise)	
IEC and advocacy	
Community representation	
Collaboration with government	
Efficiency	
Limitations	
Scope for scalability	

Facility based health care program	
Characteristics of the program vis-à-vis health equity	**Remarks**
Description of the	

program	
Health equity focus (region wise and populations wise)	
Conditions/diseases for which health care is sought at the maximum	
Evidence on the improvement of services	
Use fee	
IEC and advocacy	
M&E	
Community representation	
Focus on social determinants of health	
Collaboration with government	
Efficiency	
Limitations	
Sustainability	
Scope for Scalability	
Recommendations	