

DEPARTMENT OF HEALTH & FAMILY WELFARE
GOVERNMENT OF ORISSA



EQUITY CELL SET-UP SUPPORTED, PROGRESS ON
EQUITY REVIEWED AND GENDER AND EQUITY
ACTION PLAN 2011-12 (NRHM) DEVELOPED

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1. BACKGROUND

Health equity is integral to Orissa's vision for health and essential for achieving the Millennium Development Goals (MDGs) and the Five Year Plan goals. The OHSP aims to achieve equity in health outcomes and has a key focus on access and utilization of services by vulnerable and marginal groups including women, schedule caste (SC) and schedule tribe (ST) populations. Gender and social equity is also central to achieving the objectives of the NRHM.

Disparities in use of health services follow wealth, caste, tribal, geographical and education lines, impacting for example on Immunization uptake, ANC use, Institutional Deliveries, PNC as well as access to health information. Vulnerable groups also often lack the information needed to access health entitlements. Keeping this in view an Equity strategy was developed in consultation with Government and NGOs in 2009.

2. EQUITY STRATEGY DEVELOPMENT

In May 2009, the Orissa Health Equity Strategy and Action Plan (2009-2012) was approved by the Department of Health and Family Welfare. The overall objective of the strategy is to improve the health of the most disadvantaged people in the state and to reduce disparities in health that currently exist between them and the rest of the population. Strengthening leadership and oversight of equity in the State, and establishing institutional arrangements for implementing the strategy and monitoring results, are key objectives.

3. INSTITUTIONAL DEVELOPMENT

Over the past year commitment to establishing an Equity Cell within Department of Health and Family Welfare has taken root, and is an entry point for establishing a sustainable institutional structure through which the Department can oversee and drive forward gender and equity. Once operational, the Equity Cell will be an internal source of technical advice for the Department, well placed to guide and support gender and equity mainstreaming, strengthen coordination on gender and equity within the health sector, and improve linkages to nutrition and other key sectors. This organizational home will also provide an anchor for gender and equity capacity building efforts across the sector and for identifying and forging ways for capacity development to be put to best effect.

TMST has been advocating for the Department to create an institutional home for gender and equity since the development of the Strategy in 2009. Despite high level political commitment to equity in the State, mobilizing administrative support for a dedicated gender and equity focal point has been relatively slow compared to programmatic commitments to tackling inequities. The approval and designation of an Equity Nodal Officer from the Department of Family Welfare in July 2010 (Annex III) was a step forward. However, as a full-time officer the incumbent's capacity to push forward on gender and equity has been constrained. The Department advertised (December 2010) and interviewed (February 2011) candidates for an Equity Advocacy Manager post (Annex IV) reporting to NRHM Mission Director, but the response was poor and no candidate was selected. Plans are in place to re-advertise and proactively head hunt candidates. Originally it had been

intended to support the post through OHSP, but from April 2011 the post will be financed by NRHM.

By leveraging the focus on gender and equity in the NRHM planning process, TMST has been instrumental in including the Equity Cell within the NRHM PIP (2011/12). This has now been reconfigured as a Gender and Equity Cell with two divisions, one for gender and the other for equity and advocacy; the gender section draws into its remit work on sex selection which is supported by UNFPA. Commitment from the Department leads us to believe that the pace of establishing the Cell will fasten and that a fully fledged unit will be operational by March 2012.

NRHM planning for 2011/12 included a more systematic review of gender and equity than in previous years. A separate Gender and Equity Technical Committee was constituted and assigned the job of providing guidelines for developing the PIP for reference by all other technical groups. It was also decided to review each section of the PIP from a gender and equity perspective before finalization by the Gender and Equity Technical Committee of which TMST was a member. The Health Equity Strategy and its regular updates provided a useful resource for the NRHM PIP teams. The NRHM PIP developed for 2011/12 has a separate section on equity and gender and incorporates a number of the activities already proposed in the Health Equity Strategy. It also includes a separate Convergence PIP which has a strong gender and equity dimension. TMST's technical support on gender and equity had helped prepare the conceptual and institutional ground work for NRHM gender and equity planning, and fed into the identification of gender and activity activities for NRHM's PIP for 2011/12. See Annex II.

The establishments of the State Project Management Unit and 15 District Project Management Units under Nutrition Operation Plan in 2010 are institutional developments that will contribute to improved health equity. The project management units are strengthening the institutional capacity of DWCD to manage and deliver the Nutrition Operational Plan which has strong health equity objectives. With the support of SPMU and DPMUs, decentralized nutrition and health planning and improved convergence with health is being enabled, which will in turn contribute to more equitable health and nutrition outcomes.

4. PROGRESS REVIEWED

In the absence of an Equity Cell, TMST has provided technical support to the Department of Health and Family Welfare to keep abreast of gender and equity concerns and developments, and take key elements of the strategy forward. This has included inputs into key planning, programmatic and strategic areas of work of the Department of which key highlights are presented below. This up dates progress which was presented at the September 2010 Annual Review included as Annex I.

4.1. Building Gender and Equity Capacity

4.1.1 Strengthening Gender and Equity Capacity of Service Providers:

TMST coached and supported the State Institute of Health and Family Welfare to lead the contracting out of this piece of work. This has resulted in SIHFW's strong ownership of the process including regular field visits to monitor the quality of the training. The approach made sense from a systems strengthening perspective although it added unforeseen delays and raised a number of quality issues. Two agencies were hired through a competitive bidding process to conduct gender and equity training for service providers of 8 KBK districts and 80 blocks. Both agencies were assigned districts and budgets, and a standard training module developed. The training has been nearing completion in 4 districts. The major learning from this exercise is that it is not always a very smooth process to outsource training activities to external agencies, and more specifically the capacity related to gender and equity training is still weak among local service agencies.

4.1.2 International Training in Equity and Health

World Bank Institute (WBI) Asia Network on Capacity Building for Health Systems strengthening organized a Course on Equity and Health in Asia Tagaytay City, The Philippines, from November 29 to December 3, 2010 for the first time in Asia. Department of Health nominated Dr. U.K. Sahoo and Pranay Mohapatra Planning consultant for the said training and DWCD nominated Ms. Sujata Karthikeyan, Director Social Welfare (DSW). But only DSW along with Biraj Laxmi Sarangi TMST was selected for the course by the course director and attended the five days course. It was a very useful course focusing on health financing and both represented the India team at the international training. Participation in the course was financed by DFID through TMST.

4.1.3 Gender Stock Taking Exercise

Secretary Health has decided to undertake a gender stock taking exercise for which a ToR has been developed and submitted for approval. This will feed into the plan of action of the Gender expert to be recruited to the Gender and Equity Cell and help guide the Department in its gender mainstreaming action.

4.2. Increasing Access to Services

4.2.1 Transport Voucher for Pregnant Mothers and Neonates

A comprehensive review of Janani Express (JE) commissioned by DOH&FW and NRHM in 2009 found a number of design and management weaknesses and recommended the re-design of the transport system to make it more accessible to pregnant women and to increase its efficiency and effectiveness. It was also agreed that people need to be more aware about the availability of the service for taking women and their babies to facilities for care in case of illnesses arising during the immediate post-natal period.

To address the deficiencies of JE, including the bias against women living in remote and inaccessible areas, DOH&FW and NHRM with the support of TMST have agreed to pilot a transport voucher in two districts in the State, and NIPI has agreed to provide support in one of the districts.

The voucher will entitle pregnant women and their babies up to one month old to be transported free by either JE or a private vehicle to the appropriate named and approved CEmOC/BEmOC or post-natal/neo-natal care facilities (level 3 and level 2) or to accredited private facilities if accessible. Sometimes there is no “motorable” road near the residence or hamlet and ways will be explored to include “local Transport” (e.g. bullock carts/stretchers) to take women to the nearest road where they could be picked up by a vehicle. The scheme will also be able to test means to provide ways for emergency cases occurring in remote and poorly accessible villages to reach to a point where they can be picked up by the Orissa Ambulance System which is about to be implemented. The transport voucher will be designed so that women being picked up from remote or difficult to reach areas will be recorded and payments to the JE Operator will be higher for these journeys rather than staying with the standard rate as is done now. This will act as an incentive for JEs to expand their area of operations and JE will be encouraged to base themselves in more remote areas, especially those where few private transports exist. The voucher scheme will also provide return to home transportation free of cost which is often not available under the current scheme.

A detailed transport voucher proposal has been prepared by TMST and approved by DOH&FW to seek appointment of a Voucher Management Agency. The tender document and RFP have been completed and we expect the Agency to be contracted in April 2011.

4.3. Health Protection

4.3.1 Out-of-Pocket Spending (OOPS)

The OOPS data collected as part of the larger Public Expenditure Review in Orissa has added to the evidence base on the level of OOPS in the State. Although the PER study which draws data from patients in a facility cannot be compared to data from the NSSO 2004-5 which comes from household surveys, it nevertheless throws up a number of interesting findings on health spending:

- the high levels spent on medicines;
- the main reason for patients purchasing medicines from outside public facilities attributed to stock-outs;
- the high use of private facilities for medical tests due to reasons such as “trust deficit” and uncooperative behaviour of government staff;
- greater OOP spending by BPL than APL persons;

- the high expenses paid by institutional delivery JSY cases on medicines, transport, and unofficial fees.

As with the NSSO data, and the National Health Accounts report of the GOI, the qualitative study on equity undertaken to inform the Health Equity Strategy also reported illness and cost of treatment as the leading cause of impoverishment (though the sample was small).

Despite the evidence base, there is limited debate and focused attention on OOPS within Government. To address this gap, TMST plans to forge debate and bring together key evidences and experts that can contribute to policy level thinking on how to reduce OOPS and provide health protection in Orissa. This will involve (a) additional small scale qualitative research into the impact of OOPS on the poor, (b) roundtable discussion to consider where Orissa is at in terms of OOPS and health protection, drawing on existing evidence, progress with key reform agendas, national expert views, and (c) the development of a Position Paper to guide the Government in taking action to reduce OOPS. Draft TOR are attached in Annex VI.

4.3.2 Rastriya Swasthya Bima Jojana (RSBY)

RSBY has been implemented in the first phase in 6 districts (Nayagarh, Puri, Deogarh, Jharsuguda, Kalahandi, Nuapara). All public hospitals up to CHCs have been empanelled. RSBY counters along with the equipment and manpower has been provided from NRHM in these 6 districts. Technical Support has been provided by TMST to support the formation of the RSBY Cell under Directorate of Health Services; this will be the nodal body for coordination and implementation of RSBY from DOH&FW's side. IEC/BCC materials have been developed in consultations with labor department and Insurance Company and sensitization of hospital authorities and RKS members are completed. MoUs have been developed for the Hospital to manage RSBY Counters at Hospital level, and preparation of incentives formats for the service providers and guidelines for the utilisation of the RSBY fund has been supported by TMST. Reaching the targeted BPL population is constrained by the use of an old BPL list (1998), but this is under review. NRHM have committed to include all ASHA, irrespective of their status, under RSBY registration.

4.4. Convergence to Achieve Increased Health Equity

In addition to support to DHFW, TMST has worked to strengthen convergence of DHFW with the Department of Women and Child Welfare (DWCD) and to support delivery of the Nutrition Operational Plan that has strong gender and health equity objectives.

4.4.1 Convergence of Health and DWCD Program

Support is being provided to institutionalize state level convergence meetings between both the Departments. These meeting have tried to resolve a number of quality and coverage issues related to both Departments including VHNDs, Pustikar Divas, AWW medicine kit, Mother and Child Protection card. Assessment reports

specifically from the most difficult districts on VHNDs and Pustikar Diwas were presented at the convergence meetings to take corrective actions and ensure quality services.

4.4.2 Support and Review of the Adolescent Anaemia Control Programme

This programme in 9 KBK districts is one of the key convergent actions of both health and ICDS where IFA is procured by health but distributed to adolescent girls through DWCD channels. Constant follow up has been provided to the programme, and capacity building delivered to district and sector level staff. Follow up and training of all AWWs in 9 districts has been provided. Distribution and utilization of IFA has improved in this districts and there is now a plan to scale the programme to all 30 districts.

4.4.3 District level TA to 6 of the most Vulnerable Districts

In recognition of the challenges of translating policies into practice, external facilitation is being provided to support the implementation of the Health Equity Strategy and Nutrition Operational Plan at the district level. Kandhamal, Kalahandi, Bolangir, Gajapati, Raygada and Nuapada will receive 18 months of technical support to assist with the development and effective implementation of decentralized district nutrition plans which incorporate equity and convergence indicators. The TA will also demonstrate functional convergence among AWWs, ANMs, ASHAs and GKS (Gaon Kalyan Samiti) members in all villages of 5 identified blocks piloted in two districts through capacity building, data triangulation and development of Village Health Plans.

The technical and managerial support is expected to contribute to improvements in convergence at block and district level, raising of the quality of capacity building inputs, inclusion of nutrition and equity indicators in district PIPs, improvement in routine monitoring and supervision, and convergence among village level stakeholders in addressing health and equity issues in pilot blocks. Improved quality and management of services will enable improved priority health and nutrition outcomes.

OBJECTIVE OF DISTRICT LEVEL TECHNICAL ASSISTANCE**Broad Objectives**

- Diffusion of policy reforms/new initiatives in to implementation
- Capacity building of new DPMU in 6 districts (out of 15 DPMU districts)
- Pilot intensive capacity building of GKS through NGOs in 5 blocks of 2 districts (Nuapada and Kalahandi) and dissemination for capacity building of GKS in other districts
- Feedback for grassroots experience to inform policy development (eg. VHND, Pustikar Divas)

Specific Objectives

- Mainstream equity and gender in local level planning [increase attention on the 'left-outs' from services -greater focus on the denominator for planning and delivery]
- Promote nutrition, health and watsan convergence at local level
- Document and share health and nutrition activities by non-state actors
- Enhance the focus of activities for under 2 year olds
- Enhance the focus of activities for adolescents

4.4.4 Concurrent Monitoring

Concurrent monitoring as independent feedback for improved programme management is being initiated in the state for the first time. Both DHFW and DWCD are very keen to receive independent views about the various key performances and outcome related indicators. The first quarterly report will be shared in the month of April 2011 which is expected to facilitate management improvement in the programming areas. This will address a number of equity issues as all the blocks are going to be covered in a year.

4.4.5 Conditional Cash Transfer for Nutrition

As a response to bottlenecks in the performance and results of the ICDS programme, the DWCD plans to test whether a cash transfer scheme is more efficient and effective than ICDS in improving the nutritional status of children. With support from TMST an outline of the Odisha Child Support Programme has been designed. The scheme will entail a conditional cash transfer that gives benefits to all women attending the Supplementary Nutrition Programme at the Anganwadi Centre living in the pilot intervention districts. The scheme will give women cash payments from the first ANC visit and continue until the child is 36 months old. Payments will be conditional on ANC attendance, immunisation and growth monitoring/BCC attendance at the Anganwadi Centres. Once DWCD have provided feedback on the outline design this piece of work will be taken forward.

4.4.6 Social Protection Cell

DWCD currently manages a range of social protection programmes for vulnerable groups including women, youth, the elderly and disabled. Present capacity in DWCD to monitor, evaluate and promote synergy and coherence across the schemes is however limited. Consideration is therefore being given to setting up a Social Protection Cell to strengthen coherence and enhance effectiveness across the various programmes. Such an arrangement will strengthen institutional capacity within DWCD and provide the enabling framework for monitoring for pro-poor results, and the potential to streamline monitoring across all schemes.

5. CONCLUSION

Momentum to establish the Equity Cell in the Department of Health and Family Welfare is now in place and has support from NRHM, and wider buy in with the relocation of UNFPA's consultant for sex selection. The institutional strengthening and capacity building of DWCD through SPMU and DPMUs are also important developments for improving health and nutrition equity objectives and convergence of the two Departments. The development of the Gender and Equity PIP as part of NRHM 2011/12 reflects the increasing institutionalization of gender and equity objectives and activities in the sector, and will be complemented over the next year by several TMST supported streams of work on gender and equity in health and nutrition.

ANNEXURES

Annexure 1: Progress towards Health Equity in Odisha and Service Delivery in KBK+ Districts

Health Equity is Integral to Orissa's Vision for Health, Essential for Achieving the MDGs and the Five Year Plan Goals and Central to the Objectives of the National Rural Health Mission.

Introduction

This is a short paper documenting the progress made in implementing the Odisha Health Equity Strategy and achieving greater gender and social equity in the health sector in 2009/10. It is divided into two sections, the first presents key actions taken over the past year, and the second discusses prioritised areas of action for the future.

Progress made in 2009-10....

Strategic leadership

Equity continues to receive high level political commitment within the Government and within this enabling environment good progress has been made on several fronts.

The Health Equity Strategy and 3 Year Action Plan was approved in May 2009, and a Prioritized Action Plan for 2009-10 was approved and budgeted in September 2009.

A Nodal Officer for Gender and Equity has recently been nominated, and the appointment of an Equity Advocacy Manager to be based within the NRHM is in process.

At the policy level, NRHM has taken equity as a priority focus, and the NRHM PIP 2010-11 has absorbed many of the initiatives included in last year's Prioritised Action Plan. Tackling malnutrition in the state is a priority, and the Nutrition Operational Plan (NOP) which is now operational in 15 high burden districts provides a much strengthened vehicle for doing so.

Moving towards more equitable human resources for health

One of the priority areas for action is to create more equitable human resources for health (HRH). To this end several key actions have taken place over the year:

The State Human Resources Management Unit has been established and will be the driving force for achieving greater gender and social equity in the development, distribution and management of Orissa's HRH.

A policy decision has been taken to double the number of nurses in the State. 4 new GNM schools and new ANM Training Centres are to be established in KBK areas with preference for local candidates who will be bonded for 5 years to KBK districts.

Scholarships for SC/ST students of KBK districts has been approved by the Chief Minister.

The Nursing Management Support Unit has been established to lead the development of a new nursing policy and professional development of the profession.

To strengthen the functioning and performance of grassroots workers two studies have been completed, one looking at the role of ASHAs vis-à-vis Yashodas, and the second on ASHA's role and remuneration in KBK districts. Further work is now planned to study how ASHA/ANM/AWWs work together to inform future policy and HR decisions on how to increase their effectiveness.

To address the challenges of working in difficult areas, additional financial incentives for health staff working in difficult areas has been approved. Plans are underway to investigate how incentives for staff in difficult areas are impacting on provider motivation and retention.

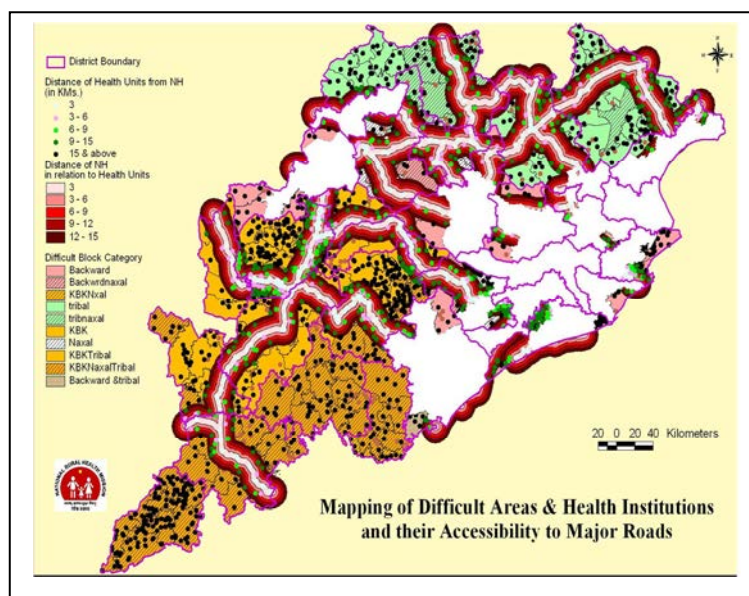
Equity sensitisation of health providers has been approved and agencies are in place and preparing to deliver this training in KBK in coordination with the State Institute of Health and Family Welfare.

Various special initiatives have been launched to improve the working environment of grassroots workers including the provision of mobile telephones to all ANMs and doctors under Mission Connect, the provision of cycles to ASHA, and setting up of ASHA Gruhas.

Prioritising KBK+

The KBK+ districts remain a high priority in the State. Some of the main actions to increase access to services include:

- Approval of around 2550 additional ASHAs which translates into 1:60 households.
- ASHAs to receive additional financial incentives under NRHM PIP 2010/11.
- Prioritisation of the construction of sub-centre buildings with ANM quarters in KBK+ up to 2012.
- Implementation of an anaemia control programme for adolescent girls in KBK and Mayurbhanj districts to tackle the high rate of anaemia among ST girls in the state. Later scale up across the state is planned.
- The proposal to enter into partnerships with NGOs in each vulnerable blocks to support the planning and management of special KBK+ initiatives has been planned in NRHM PIP.
- Disaggregated planning for vulnerable populations



Vulnerability mapping has been undertaken as part of NRHM State and District Plans for 2010-11 and additional funding has been allocated to reach vulnerable populations and areas. A thorough mapping of difficult and most difficult blocks has been done based on an integrated matrix. Each facility has also been graded for differential support.

Preparation of a state wide Vulnerability Atlas through GIS mapping is underway and will

provide further evidence to inform state budget allocations and programme decision-making.

Increasing access and demand for services

Multiple actions have been taken to increase access to services for women, the poor and vulnerable populations.

Long lasting insecticide treated nets have been freely distributed in select clusters of high malaria endemic areas of 21 districts with plans to distribute more based on supply. Alongside net distribution BCC campaigns have been launched, and LQAS introduced.

A clinic and research centre to research and treat patients with the neglected disease, sickle cell anaemia, has been set up at VSSMC, Burla with links to 6 DHHs in western Orissa.

Janani Express has been scaled up to 284 blocks and mini Janani Express introduced in Nawarangpur. Two studies into the performance and management of Janani Express have been completed, and a pilot voucher scheme for transportation of pregnant women and children has been approved.

194 mobile health units have become operational in rural and urban areas, including KBK+ to increase outreach. They include GPS tracking of the unit's movement, fixed day tours, and performance incentives and hardship allowances for staff.

Piloting of maternity waiting homes for women from the most difficult to reach areas in 4 districts.

Making facilities more women and client friendly through separate male and female toilets, the erection of partitions in labour rooms to improve privacy and dignity for women, and creation of waiting rooms for families.

Planned piloting of community mobilisation for maternal, newborn and child health and nutrition building on the success of the Ekjut model in Keonjhar. The approach will work through women's groups with the support of grassroots health and nutrition workers.

Study into male involvement in promoting safe motherhood initiated and BCC strategy and programme planned.

Health protection

Implementation of RBSY has been initiated in 6 districts with plans for gradual scale-up across the state.

JSY transparency and management arrangements have improved with back-log payments cleared, increase in on-the-spot payments to pregnant women, the introduction of e-payment to ASHAs, and increases in the free issuing of birth certificates.

Establishment of a PC&PNDT Cell to eliminate sex determination of fetuses.

Public private partnerships

Public Private Partnerships are an important vehicle for reaching poor and vulnerable populations in the state.

Strengthening the capacity of the PPP Cell and developing more efficient and systematic procedures and systems for contracting partners is ongoing.

The first ever mapping of municipality hospitals and dispensaries to assess the availability and quality of services provided to urban populations has been undertaken.

Evidence base

Improving the evidence base for health and gender equity is an ongoing area of concern. Highlights this year include:

Concurrent monitoring has been introduced in joint agreement of the departments of health and WCD to monitor the status of health and nutrition services to provide an independent source of disaggregated information and feedback on health, nutrition, and water and sanitation service delivery and utilisation.

Initiation of a Public Expenditure Review to inform government of where public funds are being directed and how this could be made more efficient and equitable.

Studies on the distribution of human resources and bed strength across districts.

Vulnerability mapping to guide the allocation of funding for new initiatives and additional resources.

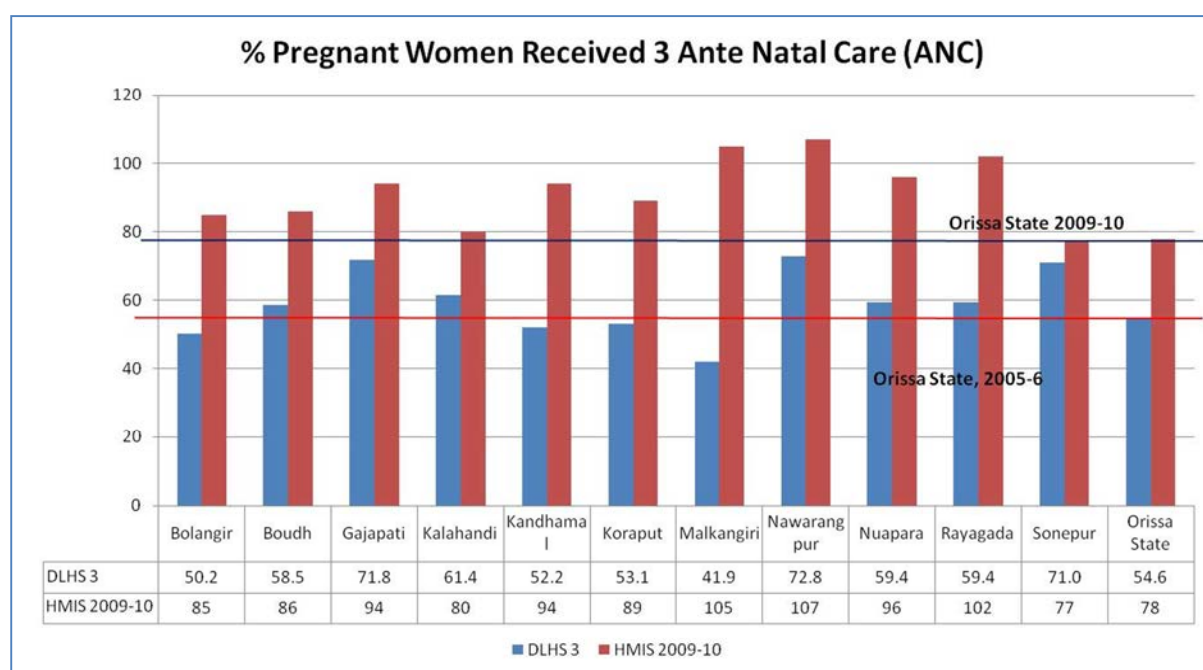
Continued strengthening of the HMIS.

Enhanced emphasis on counting and investigating maternal and infant deaths at district level. Expansion of MaPaDir.

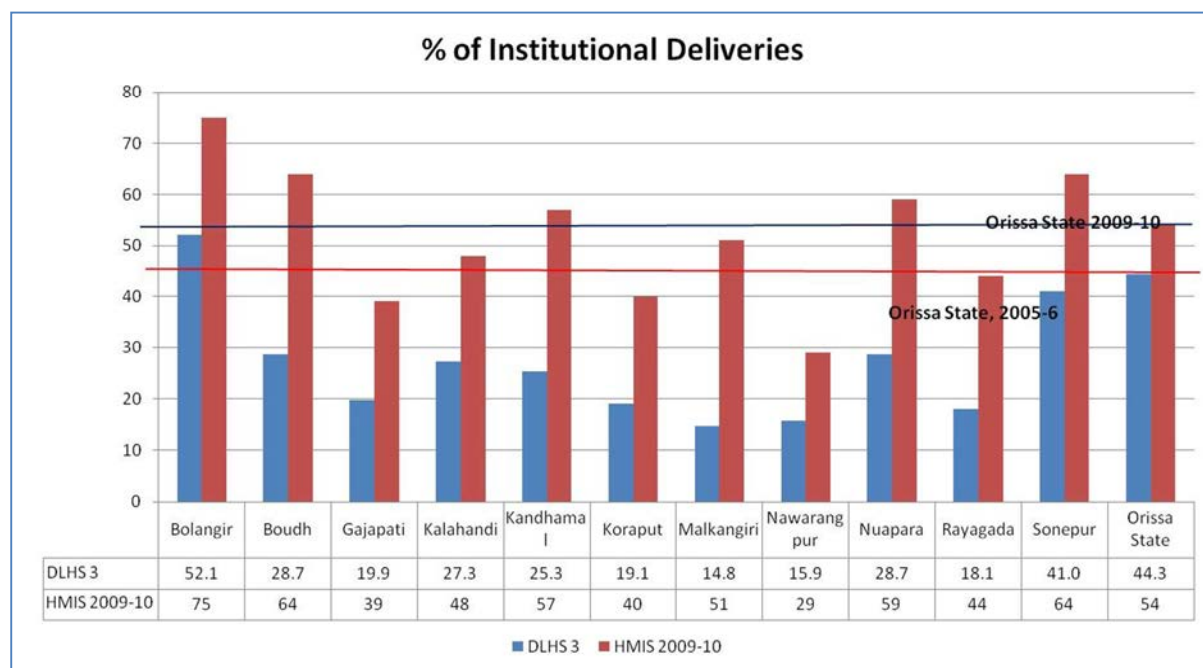
Service delivery in KBK+

Some positive steps forward but a lot more to do....

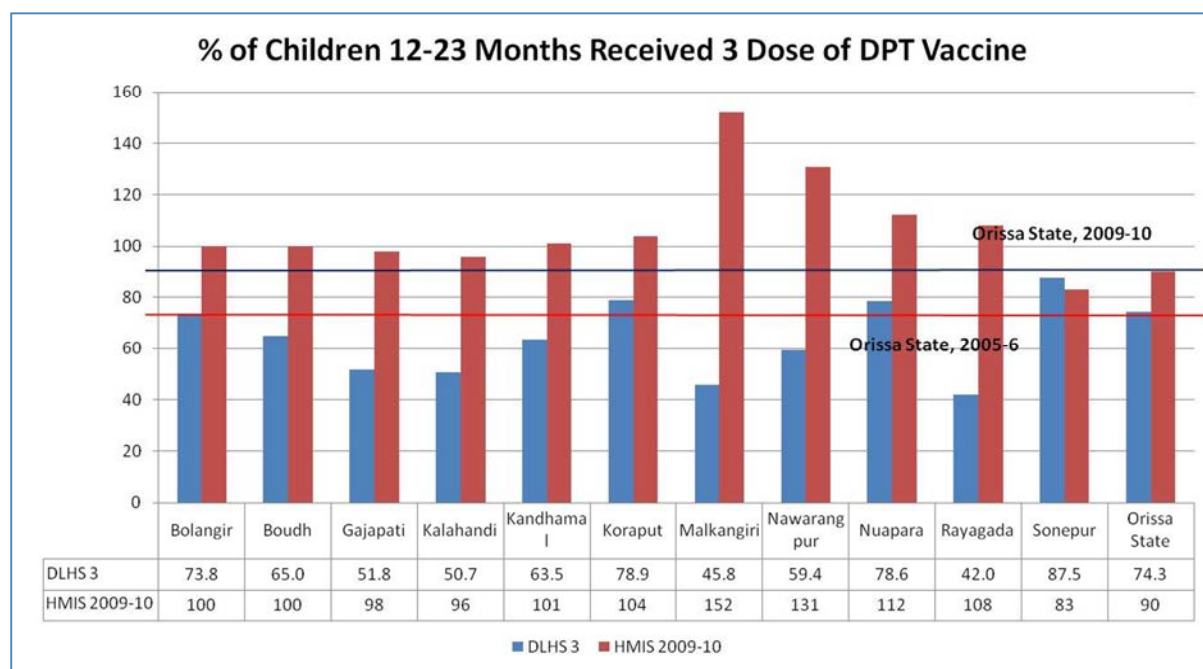
The availability of reliable service delivery trend data is weak. The strengthening of the HMIS in the past year has increased the reliability of the HMIS data, but weaknesses in previous years make it difficult to use earlier HMIS data for trend analysis. To provide an indication of trends in key service delivery indicators, a comparison of DLHS3 (2005-6) and HMIS (2009-10) data has been made. However, caution is needed in interpreting comparison of these two very different data sets, one a sample survey and the other routine data, especially given the tendency of routine data to report higher than surveys. While bearing that in mind, the data does suggest that there are signs of some positive trends in service utilisation in KBK+ districts, specifically with the take up of 3 ANC, and institutional delivery.



The percentage of pregnant women receiving 3 ANC visits in all of the KBK+ districts respectively in 2009-10 was above the State level, ranging from 80% to over 100% compared to the State level of 78.8%. This is in contrast to the situation in 2005-6 when coverage of 3 ANC in the KBK+ districts ranged from 41.9% to 72.9% compared to the State level of 54.6%, and Bolangir (50.2%), Kandhamal (52.2%), Koraput (53.1%) and Malkangiri (41.9%) all had lower rates than the State. However, the strong improvements shown in ANC do not translate across into institutional deliveries. This may reflect the fact that ANC is a relatively easier service to deliver and report on. JSY has also increased the value of reporting higher ANC for ASHAs. Caution is therefore needed in interpreting this data which may reflect actual increase in demand or be skewed by false reporting.

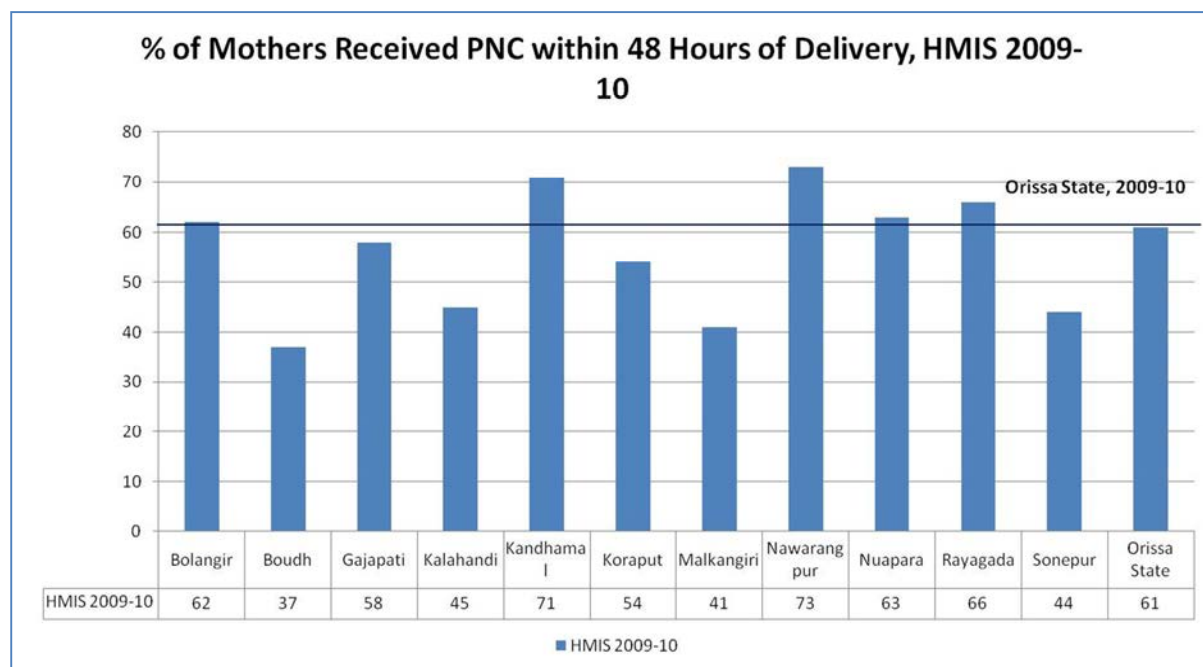


Analysis of the percentage of institutional deliveries in KBK+ since 2005-6 shows an almost doubling in many of the districts, including Boudh, Gajapati, Kandhamal, Koraput, Malkangiri, Nawarangpur and Rayagada, though most districts were starting from a low base. Despite these sharp increases, institutional delivery rates in these districts continue to lag behind the State average. In Bolangir (75%) and Sonepur (64%) where rates were higher to begin with the rise since DLHS3 has been less steep but the rates are now higher than the State level (54%). Comparing within the data sets, in DLHS only one district is above the state average, whilst in HMIS, five districts are above the state average.

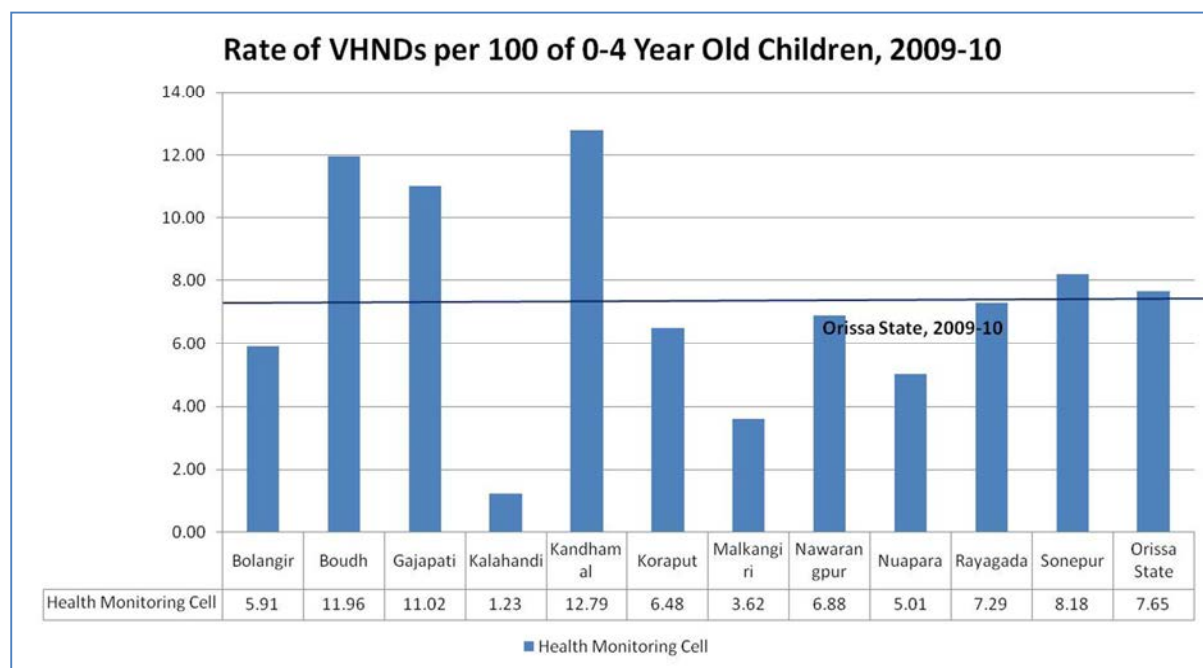


Reliable routine immunisation data is particularly difficult to collect and looking at the HMIS 2009-10 data there are obvious validity issues, with several states reporting well over 100%

coverage of DPT3. According to the HMIS 2009-10 data, most of the KBK+ districts are covering all children with DPT3 with only Sonepur lagging behind at a coverage rate of 83%. It would appear that most KBK+ districts are performing above the State level but given questionable validity of the data this needs interpreting with caution.



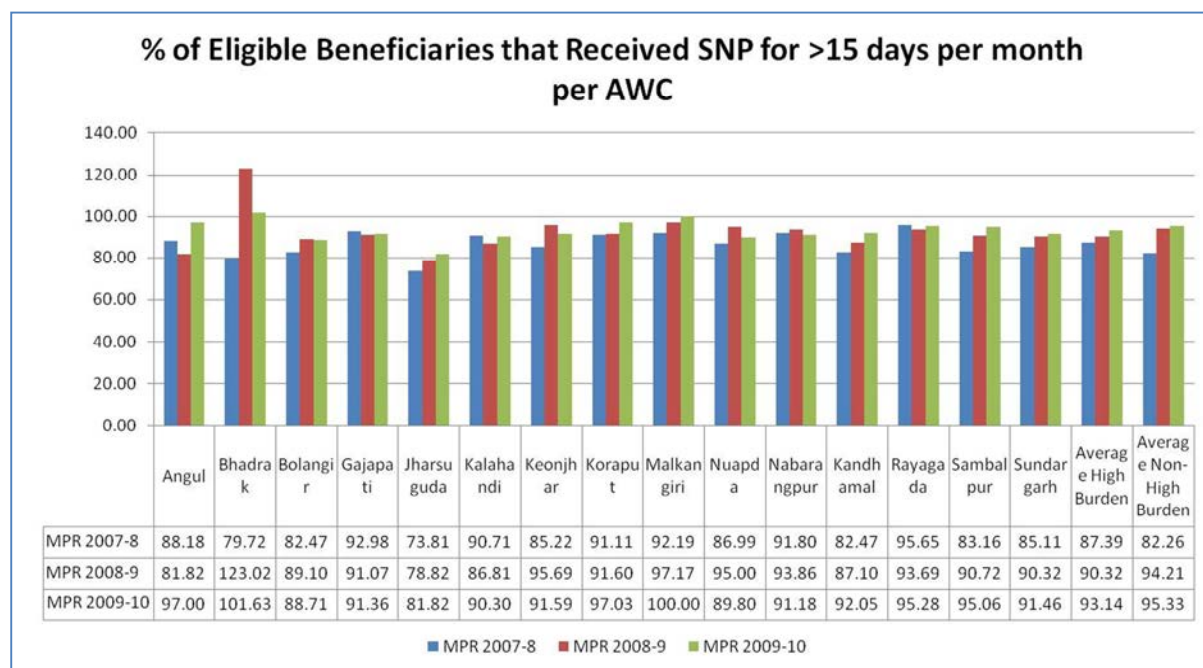
Indicator inconsistencies prevent comparison of post natal care within 48 hours between DLHS3 and HMIS (2009-10). However, as the graph above shows, PNC coverage in KBK+ is notably lower than the State average. Inconsistencies between coverage of PNC and institutional deliveries, such as in Nawarangpur where the former is a low 29% but PNC coverage is reported at 73% suggest some data may not be reliable. Likewise for Rayagada which has an institutional delivery coverage of 44% but 66% PNC. Generally, coverage of PNC in KBK+ is reported by the HMIS to be lower than the State level and this is consistent with the lower institutional delivery rates in KBK+, however caution needs to be exercised when interpreting this data due to its questionable reliability.



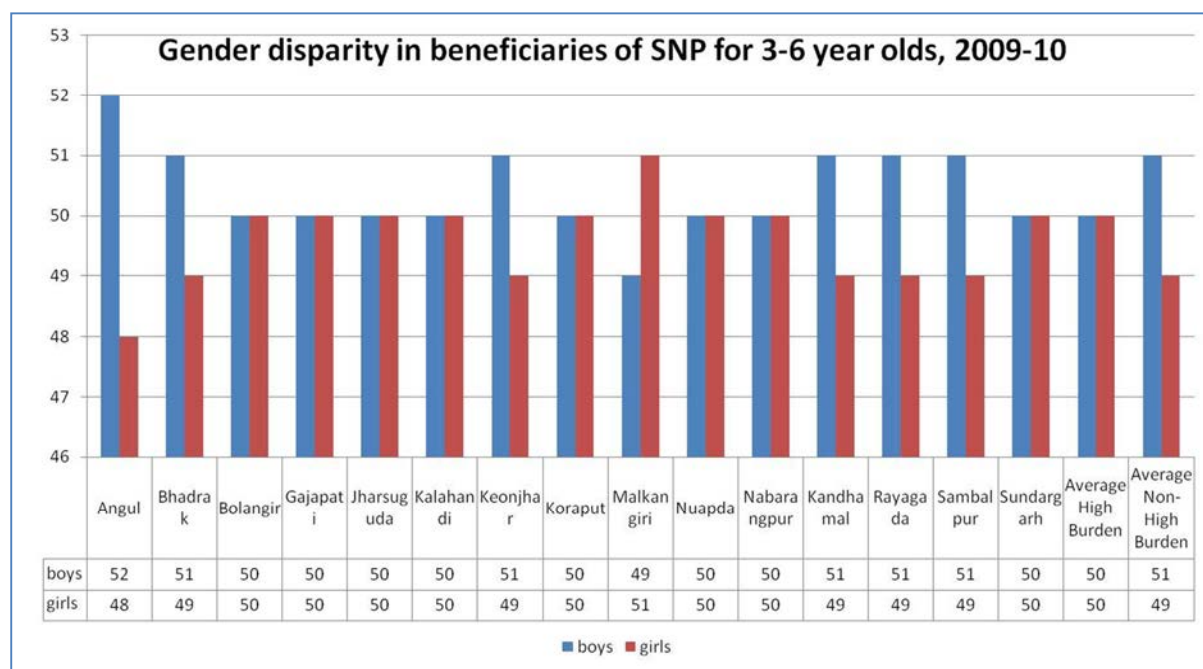
To measure relative progress of holding VHNDs across KBK+, a standardised indicator was developed which measures the rate of VHNDs based on the number of children in the 0-4 age range: the number of VHNDs per 100 of 0-4 year old children. The result shown above suggests that other than in Boudh, Gajapati and Kandhamal, the KBK+ areas have lower coverage than the State; Kalahandi's coverage is extremely low. This indicator reinforces the Government's decision to increase the number of ASHAs in KBK+.

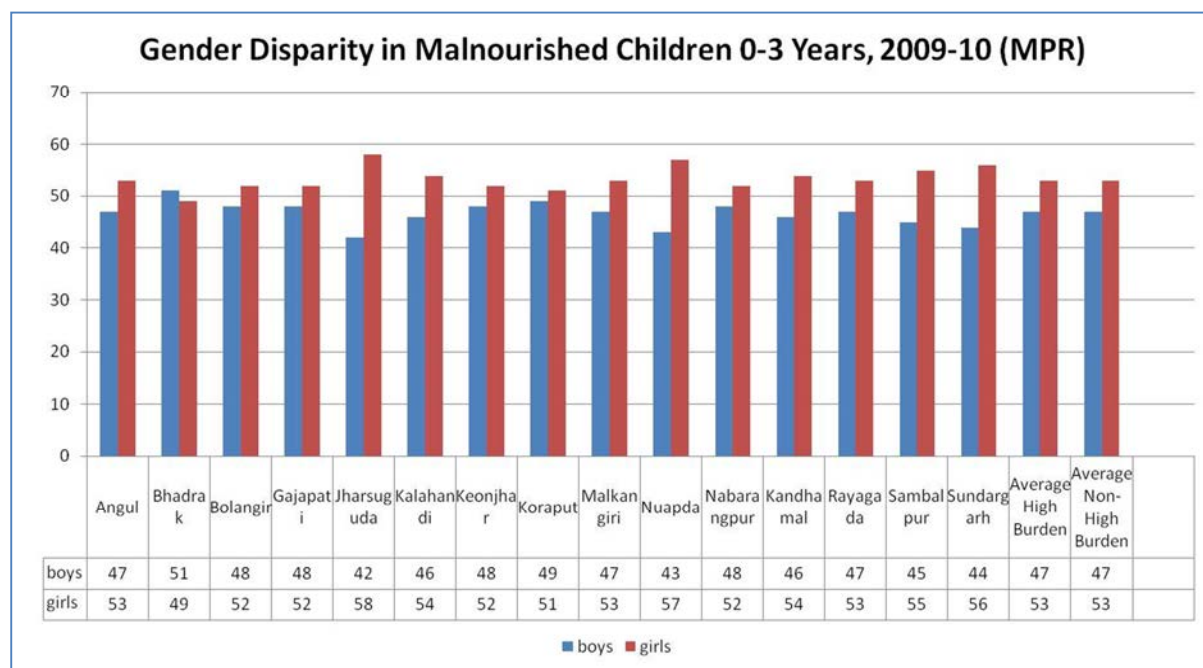
To gauge progress in the ICDS programme in KBK+, data from the Monthly Performance Reporting system has been reviewed. Reliability of this data is a concern and data needs to be interpreted with caution.

One indicator reviewed is the percentage of eligible beneficiaries that received supplementary nutrition for more than 15 days per month per AWC. The graph below shows that this figure has tended to slightly increase or remain steady in high burden districts over the past 3 years. The range spreads from 81% in Jharsuguda to 101% in Bhadrak with the average for high burden districts falling lower than that of non-high burden districts. However, the high and common levels of this indicator across districts suggest that reporting maybe skewed, and leave the findings difficult to interpret.



To gauge the relative extent to which ICDS is reaching boys and girls, sex disaggregated data on receipt of SNP and participation in pre-school education was reviewed. As the graph below shows boys are more likely to receive SNP in some districts, and this is the same for pre-school education (graph not shown). However, looking at the spread of malnutrition between boys and girls, girls are more likely to be malnourished. While caution needs to be taken in interpreting this data, it does suggest that more proactive action is needed to increase girl's access to the benefits of the ICDS programme as a step towards reducing their malnutrition.





Looking forward.....priority areas for action....

**Equity has taken off
Now is the time to institutionalize it into government
structures and build the evidence base to sustain momentum.**

The scope and content of the action underway reflects the Government's seriousness to reduce health inequity in the State. While recognizing the good progress made to date, this section of the paper draws attention to some of the challenges and priorities for the future.

Institutionalizing gender and social equity into government structures

Political commitment towards more equitable development remains visible at the highest levels of the State and sector. Over the past 3 years, the vocabulary of equity and gender has become commonplace among policy makers and senior staff, and the raising of gender and equity concerns in programme planning and review has become standard practice. This reflects the heightened awareness of gender and social equity in the departments as well as personal and political commitment among key actors to tackling inequity. The Equity Strategy and Action Plan have contributed to the raising of awareness among senior staff, and leveraged space for gender and equity advocacy.

The slow progress and dynamics involved in establishing a home for equity within the Government is a good example of the complexity of bringing about change in how government works. The agreement to a Nodal Officer nominated by Government supported by a contracted Equity Advocacy Manager to push forward actions on a day-to-day basis is a step forward; and once appointed may resolve some of the delays in moving files. With continued advocacy and measureable achievements in addressing gender and social

inequity, the current management arrangement may lead to a firmer institutional and more sustainable set-up for leading equity in the longer-term; establishment and functioning of the Equity State Taskforce will be key in achieving this.

NRHM's PIP for 2010-11 positively illustrates the extent to which equity is being mainstreamed including for example vulnerable area mapping, graded incentives for providers working in facilities in the most difficult areas, and the planned voucher scheme for the transportation of pregnant women in response to the deficiencies and poor reach of Janani Express. Analysis is on-going but it appears that the inclusion of vulnerable area mapping in the district PIP planning process has acted to increase budget allocations for RCH to districts with more vulnerable areas. A priority now will be to establish a monitoring and evaluation mechanism to capture the impact of the various equity promoting initiatives under NRHM.

Institutionalising gender and social equity is a long term process and significant progress has been made over the past 2 years. Looking to the future there is a need to build on the commitment and programmatic progress being made by establishing the State Taskforce as an oversight body and by generating regular and systematic evidence of progress and impact.

Focus on vulnerable areas

Political attention towards the underdevelopment of the KBK+ districts plus the pressures resulting from the Maoist movement has created a climate for equity. Political agendas have helped open up discussion around equity, highlighted attention on the multiply disadvantaged, and provided an uncontested legitimacy to the targeting and prioritising of KBK+. For the Nutrition Operational Plan the focus is the 15 high burden districts which include 9 of the KBK+ districts.

This readiness to prioritise vulnerable areas has been an important entry point for equity. It has led to the systematic mapping and classification of vulnerable areas under NRHM and targeted initiatives and funding for them, including for example allocation of second ANMs (700 in 2010/11), designation of a 24/7 PHC, additional allocation of Rs. 1000 untied funds to ASHAs, and untied funds for village contact drives. There has also been a strong drive to prioritise programmes and initiatives in KBK+, such as the adolescent anaemia control programme, the construction of sub-centres, and the appointment of additional ASHAs. Building on these important advances there is now the scope and need to support efforts to "get below" the geographical focus to understand the drivers of inequity and how services can work to better effect to reach vulnerable groups within priority districts including more localised and convergent solutions. Here the concurrent monitoring of NOP will provide valuable independent evidence for local managers to develop targeted approaches for different geographical areas and social groups.

Working to strengthen access and equity in conflict-affected areas raises additional challenges related to the security and mobility of users and providers. The NOP baseline study and concurrent monitoring will provide insight into the delivery and use of services and user knowledge and perceptions in conflict-affected areas and could contribute to the design of local approaches. At the state level, there is also the need to ensure that state led

programming and equity planning is conflict-sensitive and tailored to the realities of working in those areas that are conflict-affected.

The Nutrition Operational Plan and the challenge of convergence

The NOP presents a major breakthrough in raising the profile of malnutrition, and intensifying efforts to reach the most socially and nutritionally vulnerable groups. Gender and social equity are integral to the objectives of NOP, and its planned equity monitoring and evidence gathering through regular annual household and service surveys and concurrent monitoring will provide important evidence for the broader health sector, including nutrition and water and sanitation. This is particularly important given the loss of SC/ST disaggregated data from the HMIS.

The emphasis of NOP on interdepartmental convergence is strengthening the impetus towards convergence. Although the vertical structuring of the departments dissuades from convergence important strides are being made between ICDS and health and there is agreement at Secretary level of DWCD and DoHFW to meet bi-monthly for this. Examples of how the departments are working for greater convergence include:

- The technical workshop on Malaria and Malnutrition (May 2010) forged consensus among technical experts and the two departments to take forward a stream of work to investigate the causal nature of malaria and malnutrition in Orissa, and the policy and programme related implications.
- Plans to strengthen district and block level advisory committees to investigate mortality and malnutrition cases in a systematic and convergent manner bringing together key departments.
- Review of the quality of Mamta Divas and Fixed Immunisation Days and to assess the feasibility and efficiency of integration to make more efficient use of the ANM.
- Review of the quality of Pustikar Divas and how they can be improved.
- Joint work on disability to identify the extent and types of disability in the state and the development of guidelines for identifying disabled children by ANMs and AWWs and referral and treatment protocols.
- Plans to investigate how ASHA/AWW/ANMs can more effectively work together.
- Shared interest and commitment to pilot community mobilisation through women's self-help groups to reduce maternal, newborn and child mortality and malnutrition.

Forging convergence with water and sanitation is less straightforward given that the department is not formally a partner of OHSP and the institutional links are weaker in the field compared to those of ICDS and health. The common platform for all three departments rests with the GKS but as these bodies are still nascent in Orissa their capacity is currently weak. NRHM has recently appointed 3 nodal agencies (CARE, ActionAid, and UNFPA) to support GKS capacity strengthening across the state, but this will take time to translate into results.

Beyond DWCD, health and water and sanitation, the broader social determinants including poverty and food security carry significant weight in reducing malnutrition. In this vein, strengthening social protection and livelihoods programmes including NREGS, PDS, the mid-day meal scheme which are hampered by their own access, distribution and management weaknesses, will be critical to impacting on malnutrition particularly among the most vulnerable social groups.

Gender and human resources for health

The gender and social equity issues surrounding the state's human resources for health are extensive. Significant steps have been taken to increase the availability of nurses and paramedics in the state and specifically KBK and the new training schools and scholarships for SC/ST students will make an important difference. Within the current political environment and the high profile attention given to reducing social inequities there is a need to ensure that the focus on gender equity and the needs of the state's female workers is not lost. This is particularly pertinent given the voicelessness of female health and nutrition workers (AWWs). Female health workers operate in a male dominated culture, and doctors and nurses who serve men and women in remote areas are particularly vulnerable. A fuller understanding of the constraints they face and how they can be dealt with seems necessary. Financial incentives alone may be unable to counter the perceived and real threats women health workers face in remote areas and need complementing with initiatives targeting their physical security and well-being.

The efforts underway to strengthen the nursing profession aim to transform the profession and are likely to have knock-on benefits for women health workers more broadly. This has the potential to validate the cultural, political and institutional factors that affect the female workforce and raise attention and action to creating a more gender responsive working environment.

Health protection programmes

An important step forward has been taken to reduce out-of-pocket spending of the poor through the Government's approval of RSBY. Implementation has started in 6 districts including Kalahandi and Nuapada in KBK+, and gradual scale up is planned thereafter. Although still at an early stage of implementation, the lack of IEC/BCC being provided by the insurance company is a serious gap undermining public awareness and access to entitlements. Strong stakeholder coordination among the government departments overseeing this scheme will be necessary to resolve this problem. Monitoring implementation and impact of RSBY on access to treatment of BPL families and their out-of-pocket spending will be necessary for correcting programme gaps and enhancing the scheme's poverty reducing impact.

The recent impact evaluation of India's JSY programme offers a positive picture of Orissa's performance compared to the rest of the country with Orissa's 42% uptake of JSY only surpassed by Madhya Pradesh's 44%. Overall, the study has found that JSY is increasing ANC and institutional births, and reducing neonatal and perinatal mortality in India. Although the study was not powered to provide an indepth state level analysis of reach and performance, the national level findings of the study raise issues for consideration and further

investigation in Orissa. Chief amongst these from an equity perspective is that the poorest and least educated women are less likely to receive JSY than those in the middle income quintile and the better educated. Lack of information, physical access and cultural barriers are key factors likely to be reducing the downward reach of JSY. Given the performance and reasonably efficient functioning of JSY in Orissa attention now seems warranted to investigate progress and bottlenecks in reaching the most disadvantaged women and testing how this can be further improved.

Studies into the functioning of Janani Express have highlighted a number of weaknesses in its design and management. This includes the allocation of flat monthly rates to the operating agency without incentives for higher numbers of journeys or for transporting women from distant areas. The result has been that Janani Express has been underused, and does not typically transport women who are the most transport vulnerable because of their distance and remoteness from the facility. Based on the evidence gathered on Janani Express performance, the department has modified management terms and relocated vans which are consistently underperforming, it has also agreed to the piloting of a voucher scheme for transporting pregnant women to a facility for delivery and in case of emergency.

Out of pocket spending was found to be Rs 520 by the NSSO 60th Round in 2004; spending on drugs is a major contributor. While the state drug budget has risen more than 5 times between 2005/6 and 2009/10 this still only covers a small fraction of the estimated spending on drugs in Orissa. The Public Expenditure Review currently in process will provide some insight into drug spending but in addition there is a need to carry out the out of pocket spending survey which has been planned for some time. This will provide much needed evidence to measure the trend in OOPS which is a key indicator for how the state is performing in reducing poverty caused by health spending.

The demand side of quality of care

While important strides are being made on improving the provision of care through for example upgrading physical infrastructure, staff development and improved competencies, strengthening of referral systems and data management, there is also the need to attend to the factors that impact on client's experience of care including for example cleanliness of facilities, and the quality of interpersonal communication and provider behaviour. The demand side of quality, being treated with respect, dignity, sensitivity and equity influences the user's experience of services, their preparedness to return and the opinions they share with family and friends. Improving the interpersonal elements of quality and how users experience care needs not to be left behind.

Strengthening the evidence base

Several streams of work are strengthening the evidence base on equity including the NOP baseline, planned annual household surveys on service use and user knowledge, concurrent monitoring, GIS vulnerability mapping, HR and bed strength studies, public expenditure reviews, etc. Other evidence bases, such as LQAS, have the potential to analyse progress according to disaggregated data on gender and SC/ST. As the scope and volume of equity initiatives takes off, there is now a pressing need to develop a coherent and systematic approach to monitoring equity at the state and district levels especially given the removal of

SC/ST classifications from the HMIS. Building on planned and existing evidence bases, there is a need to identify and fill critical gaps in evidence for measuring progress in gender and social equity so as to inform policy and programmes.

Two important gaps are the lack of regular out of pocket spending surveys, and the lack of more regular disaggregated mortality data outside of NFHS rounds. The planned OOPS survey will provide a benchmark to compare spending to the findings of the NSSO 60th Round in 2004, and in future more regular surveys are needed. To collect disaggregated mortality data other than through large and expensive household surveys which may not be affordable, consideration could be given to community sentinel surveillance in a difficult geographical area, as set up for maternal mortality by Ekjut in Keonjhar. This could be a means of collecting regular evidence on changes in mortality for the more disadvantaged and inaccessible, and used as one of the markers of State progress in health equity. Furthermore, the weaknesses in routine data collection in health and ICDS reiterate the need for continued strengthening of these core evidence bases which even without SC/ST data are primary sources for evidence on service use by gender and district, which are important components of measuring equity. Further work on developing the evidence base on equity is a priority for the future.

Annexure II: NRHM PIP Gender and Social Equity

Background

In spite of significant decline in MMR and IMR, Orissa continues to contribute to high rates of infant and maternal mortality.¹ The earlier chapters clearly indicate that there are stark differences between high focus and other districts. Decline in infant and under-5 mortality follow a social gradient based on tribal, caste, wealth and education status. The poor, marginalised, fringe communities, women, Scheduled Tribe (ST), Scheduled Caste (SC) and disabled especially in the high focus districts are exposed to higher risks due to poor access to quality health services.

Declining Child Sex Ratio (0-6 years) in Orissa

Child Sex Ratio which was 967 in 1991 has reduced to 953 in 2001 as per census reports. The decline is by 280 points from 1035 in 1971 to 953 in 2001. Though the overall sex ratio appears good, there are wider inter and intra district variations with worst ratios in coastal and better developed districts of the state. Comparison across districts shows that the highest decline has been in Nayagarh from 953 in 1991 to 901 in 2001; by 49 points. In an attempt to respond to the declining sex ratio, the State Government made institutional arrangements at State and District levels for effective implementation and monitoring of PC & PNDT Act. Currently there are 17 cases filed in different districts under the Act.

Steps towards Social Inclusion and Gender Equity

The Orissa Health Equity Strategy and 3 Year Action Plan (May 2009) committed to gender and social equity in health, provides a roadmap for sector wide action for promoting equity that includes policy, institutional, financial, human resource and programmatic initiatives and developments.

¹ Please refer to chapters Maternal and Child Health for the status, issues and concerns and related chapters like Tribal Health, ASRH etc.

I.	Strengthened Institutional Mechanisms for Social and Gender Equity	
	Availability of designate government official, technical consultants or institutions to oversee inclusion of social and gender equity at the state level?	<p>Equity receives high focus both at political and programatic levels that has resulted in;</p> <p>Approval of Health Equity Strategy and 3 Year Action Plan in May 2009.</p> <p>Designation of a Nodal Officer for Gender and Equity and appointment of an Equity Advocacy Manager is proposed within NRHM</p> <p>Establishment of a PC & PNDT Cell to curb sex selection.</p> <p>State Supervisory Board, State and District Appropriate Authorities, implementing and advisory bodies have been rejuvenated. District Magistrates designated as District Appropriate Authorities</p>
	What are the identified key entry points to ensure social inclusion and gender - specific strategies, capacity building, BCC, MIS	<p>Orissa Equity Strategy identifies the following entry points: mainstreaming gender and social equity into core health sub-systems,</p> <p>strengthening gender and social equity focus in service provision,</p> <p>increased accountability and stakeholder participation towards improving access and delivery of services in high focus districts,</p> <p>Vulnerability mapping of block, district and facilities completed and additional funding allocated for incentivisation of service providers</p> <p>Special plan for expansion of transportation services – JE, Voucher Schemes etc.</p> <p>Outreach services through MHU to ensure services in the community in difficult areas</p> <p>A clinic and research centre to investigate and treat patients with genetic disorders like sickle cell anaemia, has been set up at VSSMC, Burla with links to 6 DHHs covering Western Orissa</p> <p>Maternity waiting homes for women from most difficult to reach areas established in 4 districts</p> <p>Mo – Masari scheme (bed nets to pregnant women at 1st ANC) introduced in malaria endemic areas</p> <p>Gender/Patient Friendly hospital environment emphasized and promoted – with display of citizens charter, rights and entitlements of service seekers, separate toilets, female sweepers, privacy at outpatient and inpatient facilities, female security for female wards and maternity wing, , gender sensitization training of service providers</p> <p>Special Funds for IEC/BCC for RCH focus blocks</p>
	What are the mechanisms to capture and monitor	Concurrent monitoring mechanism has been initiated to monitor service delivery to the marginalized and vulnerable groups. HMIS, at state level provides little

	programme reach to socially excluded groups ?	scope for generating appropriate socially disaggregated data. Concurrent monitoring systems within the department will be strengthened. However, DHFW has conducted different studies with an aim to inform future policy and HR decisions to ensure increased effectiveness to reach socially excluded groups. i) ASHAs vis-à-vis Yashodas, ii) ASHA's role and remuneration in KBK districts to assess the their role in service provision iii) Public Expenditure Review to assess the efficiency of public expenditure, iv) Distribution of human resources and bed strength across districts
II. Improved Health Financing		
	Are there guidelines and plans for the use of un-tied funds at the village level and sub-centre level and adequately disseminated across the different districts?	Guidelines for RKS, GKS, Sub Centre Untied Fund have been developed and distributed to all stakeholders at state, district and community level
III. Training		
	Is there a systematic training and capacity building strategy and plan developed on gender and social inclusion in relation to - ANM, ASHA, SBA, MIS, BCC person. Are they shared across the districts?	Equity and Gender sensitization Training of health service providers ongoing through engagement of specialized agencies
IV. Policies, Guidelines, Human Resource Policies		
	For effective out reach work by women service providers is there an anti sexual harassment policy and cell at the state level	Sexual Harassment Cell at district level to address issues and concerns of women and service providers
	For effective out reach to socially disadvantaged groups are policies for staffing of service delivery units representative of excluded groups e.g. SC, ST being	4 new GNM schools and new ANM Training Centres are to be established in KBK areas with preference for local candidates Financial incentives for health staff working in difficult areas have been introduced for retention

	implemented?	
	Are there sufficient women doctors, at least one in every PHC?	-No-
V.	Facilities for Women Health Care Providers under NRHM	
	Are there plans to improve safety of housing for all ANMs/ LHV's/ Front-line workers?	Prioritization of the construction of sub-centre buildings with ANM quarters in KBK+ by 2012.
	Are there plans to improve field level functioning of ANMs/ Frontline workers e.g. provision of mobile phones, provision of vehicles for easy transport	CUG (close user group) SIM cards to all front line health providers Cycles to ASHA, and ASHA Gruhas established
VI.	Implementation of PC and PNDT	A PC and PNDT Cell established to support the state appropriate authority. State and District level Advisory committees reconstituted, oriented and rejuvenated. Series of training and orientation programs organized for key stakeholders – Advisory Committees, District Appropriate Authorities, CDMOs, ADMOs, ultrasound clinic owners and doctors Partnerships established with Medical fraternity, judiciary and civil society organizations Institutional mechanisms strengthened, website, compliant mechanism and toll free number functional and extensive communication programs organized

Issues:

The following issues and concerns have been identified:

- Orissa has a huge proportion of population from the disadvantaged communities, the policy intentions could not transform into action in the want of dedicated unit or personnel to provide necessary program direction.
- With a view to address the implementation concerns of the 'Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994; Department of Health & Family Welfare, GoO established the PC & PNDT Cell with UNFPA's support to strengthen monitoring of implementation of PC & PNDT Act in 2009. The establishment of PC and PNDT Cell in the State has facilitated in strengthening institutional mechanisms and creating an enabling environment for Act implementation. Although institutional mechanisms are in place and key

stakeholders have been oriented, addressing sex selection requires collaborative efforts in harmony with different constituencies, which is process intensive and time taking. The PC and PNDT cell is a standalone unit and needs to be integrated into larger program initiatives for sustainability and coordinated efforts.








GENDER AND EQUITY ACTION PLAN 2011-12

(All the activities in red color are related to PC PNDT cell)

Activities		Output	Time frame			
			Q1	Q2	Q3	Q4
Strengthened Techno- Managerial Mechanisms for effective functioning of Gender & Equity Cell						
1.1	<p>Establishment of State Gender and Equity Cell to facilitate policy direction, oversee implementation and monitor progress of mainstreaming of gender and equity concerns</p> <p>Two divisions (1. Gender Division & 2. Equity & Advocacy Division) will be operational under the leadership of an Addl. Director at DFW.</p> <p>The PC & PNDT Cell will be part of Gender Division. Presently the cell consists of a State Facilitator and Legal Advisor supported by UNFPA. From this year onwards the positions will be taken over by NRHM</p> <p>Other Equity Issues</p>	<p>State Gender and Equity Cell with two sectors functional;</p> <p>Gender Division oversees implementation of PC & PNDT and gender activities like capacity building</p> <p>Equity and Advocacy Division operational; Equity and Advocacy Manager appointed; health related expenditure reduced</p>				


	Activities	Output	Time frame			
			Q1	Q2	Q3	Q4
	will be operationalised with the appointment of one Equity & Advocacy Manager. A Programme Assistant will be placed to support both divisions.					
1.2	Strengthen State and District Gender and Social Equity Task Force Capacity Building Reviews held Mobility and other expenses	State and District task Force functional with representation from related department like Health, ICDS, RD, Education headed by Chief Secretary at state and Collector at district Task Force equipped and oriented to oversee gender, PC& PNDT and other equity issues				
2 Strengthening Capacity Building initiatives						
Activities related to Gender division with focus on PC & PNDT tasks						
	Orientation of District level officials and reporting personnel for strengthening monitoring reporting mechanism.	150 members from 30 District trained in 3 batches				
	Zonal orientation of PPC staff (including O & G Specialist of Govt. Hospital)	Government O&G Specialist, PPC I/C, Staff Nurse, ANM oriented on PNDT Act – 3 persons from 79 PPC – 500 persons in 5 batches				
	State level orientation of Executive Magistrates on PC & PNDT Act and redressal of complaints	118 members (2 EM from each district and 1 EM from each sub division) trained in 2 batches				
	Seminar for District Bar Association on PC & PNDT Act. UNFPA will support	State and District level stakeholders trained and partnerships strengthened				

Activities	Output	Time frame			
		Q1	Q2	Q3	Q4
activities with Judiciary and Orissa State Legal Services Authority on PC and PNDT act)					
Interaction and partnerships with IMA, FOGSI and IRIA on PC & PNDT Act for promoting “Doctors for Daughters”	Activities organized to promote spirit of “Doctors for daughters” and to create peer pressure to abstain from sex selective practices. 100 persons from each branch, trained, IMA teams mobilized for action				
Overall Training and Capacity Building					
Sensitization of Service Providers at district and block on gender and equity issues in high focus districts <i>Agency finalized</i>	All service providers trained and have increased awareness on equity and equality issues with OHSP funding				
3	Implementation of Study Recommendation				
Implement Recommendations of ‘out-of-pocket spending study’ (Study Ongoing. Expense for implementing recommendation will be allocated from OHSP/state budget)	Critical recommendations implemented in select districts				
Implement recommendations of studies on gender and social equity i)ASHAs vis-à-vis Yashodas, ii) ASHA’s role and remuneration in KBK districts iii) Public Expenditure Review iv) Distribution of human resources	Critical recommendations implemented in select districts				


Activities	Output	Time frame			
		Q1	Q2	Q3	Q4
	and bed strength across districts (Study Ongoing. Expense for implementing recommendation will be allocated from OHSP/state budget)				
4	Overall Review and Monitoring of Gender and Equity Initiatives				
	Half Yearly State level Review Meeting	State review meetings of CDMOs and ADMOs organised			
	Inspection of Ultra – sound clinics by State & District Task Force	Ultra sound clinics and imaging centres monitored regularly and randomly for verification of records			
	Decoy customer operation for PC & PNDT monitoring	Violating Imaging Centres identified and tracked			
	Establishment of “Health Line” for reporting on gender and equity and health care services. (Toll free number existing under the PNDT cell will be converted to health line and popularized)	Toll free number functional for reporting on gender and equity issues with back up support for complaint redressal (The complaint redressal mechanism is being planned to be supported by OHSP).			
	Follow up of PNDT legal cases	Legal cases resolved			
5	IEC/BCC activities for increased awareness on Gender and Equity				
	Communication activities for addressing gender, sex selection and equity issues promoting PC & PNDT and Equity Issues Audio Visual	Increased awareness on social and legal implications of sex selection and gender and equity issues			

Activities	Output	Time frame			
		Q1	Q2	Q3	Q4
Print Material IPR					

Annexure III: Approval and Designation of Equity Nodal Officer



**DIRECTORATE OF FAMILY WELFARE
(STATE FAMILY WELFARE CELL)
DEPARTMENT OF HEALTH & FAMILY WELFARE,
GOVERNMENT OF ORISSA**



Letter No. 140/FW/FWC/035/10 Date: 21/7/10

To,
**Dr. Pramod Meherda, I A S
 Mission Director, NRHM-Orissa
 Bhubaneswar**

From,
**Dr. Nirmal Kumar Mishra,
 Director of Family Welfare, Orissa**

Sub: Designating Additional Director (Child Health) as the 'Nodal Officer for Gender & Equity' for Orissa in the Department of Health & Family Welfare.

Ref: Your Letter No. 7039/CHSP/631/2009, Dtd. 10.06.2010.

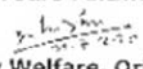
Dear Sir,

Greetings from 'State Family Welfare Cell, Orissa !

With reference to the subject cited above, I am pleased to inform you that, Additional Director (Child Health), Dr. Upendra Nath Sahu has been designated as the 'Nodal Officer for Gender & Equity' for Orissa in the Department of Health & Family Welfare, Government of Orissa.

He would be henceforth coordinating with Mission Directorate for all the matters relating to Gender & Equity.

Yours Faithfully,

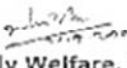


Director of Family Welfare, Orissa

Date: 21/7/10

Memo No. 141

Copy forwarded to, Additional Director (Child Health) of Directorate of Family Welfare & HRD Manager, NRHM for information and necessary action.



Director of Family Welfare, Orissa

3rd Floor, Heads of the Department Building, Bhubaneswar- 751 001, Orissa
 Phone: (0674) - 2390434, Fax: (0674) - 2390656

Annexure IV: ToR for Equity Advocacy Manager**Equity Advocacy Manager**

Post Title	:	Equity Advocacy Manager
Organization	:	Orissa Health Sector Plan (OHSP)
Job Location	:	Bhubaneswar, Odisha
Duration	:	One Year
Reporting to	:	Mission Director, National Rural Health Mission (NRHM)

Work Context / Background

Health equity is integral to Orissa's vision for health and essential for achieving the Millennium Development Goals (MDGs) and the Five Year Plan goals. The OHSP aims to achieve equity in health outcomes and has a key focus on access and utilization of services by vulnerable and marginal groups including women, schedule caste (SC) and schedule tribe (ST) populations. Gender and social equity is also central to achieving the objectives of the NRHM.

Disparities in use of health services follow wealth, caste, tribal, geographical and education lines, impacting for example on Immunization uptake, ANC use, Institutional Deliveries, PNC as well as access to health information. Vulnerable groups also often lack the information needed to access health entitlements.

In May 2009, the Orissa Health Equity Strategy and Action Plan (2009-2012) was approved. The overall objective of the strategy is to improve the health of the most disadvantaged people in the state and to reduce disparities in health that currently exist between them and the rest of the population.

Purpose of the position

The RCH and NRHM has focused on equity and gender as a cross cutting agenda for this year PIP (2010-2011) and emphasize on having a gender and equity point person. A Senior Officer is required to drive this cross-cutting agenda forward. S/he will provide strategic direction and oversight to Senior Management and facilitate inter-departmental coordination. From this strategic location the equity advocacy Manager will be well positioned at NRHM and coordinate with all directorates to forge consensus and coordination for improving health equity.

Role Dimension / Description

1. Review and understand the current situation of the state on Gender and Social Equity and the approved Orissa Health Equity Strategy and Action Plan for 2009 – 2012.

2. Support Senior Management for implementation of the Equity Strategy Action Plan as per the timeline.
3. Coordinate establishment of cross sector Equity Task Force at State and District level.
4. Support various Departments in development of gendered, socially differentiated, integrated BCC plan for the state.
5. Provide technical assistance in capacity building of State and District level Managers to shift focus to differential planning and monitoring.
6. Provide guidance to State and District level Managers in improving their skill in management of data collection, analysis and interpretation of disaggregated monitoring information and data for policy development and planning.
7. Support the Senior Management of various Departments in infusing gender and social equity into human resource management and development systems.
8. Provide technical inputs related to Gender and equity for the various capacity building workshops of the Department of Health & Family Welfare (DoH&FW) and Department of Women and Child Development (DWCD) of the Government of Orissa.
9. Support in developing a State of Health Report against equity objectives and achievement for public presentation and disseminations.
10. Provide technical guidance and inputs in conducting various studies on factors leading exclusions and deprivation from services for policy decisions.
11. Provide technical inputs to the gender related interventions planned in the RCH-II programme of NRHM at the State level.
12. Responsible for monitoring and documentation of the progress of gender and equity action plan.
13. Undertake field visit to Districts to monitor the activities of the task force and provide guidance for achievement of the equity objective.
14. Assist in developing appropriate strategy to review the progress made on a six monthly basis.

Knowledge, Skills, Abilities (The following knowledge, skills and abilities may be acquired through a combination of formal schooling, self-education, prior experience or on-the-job training)

Qualifications

Post Graduate degree in Social Sciences or related subject

Knowledge & Skills

- Knowledge on gender related issues and women empowerment programmes by Government and Non Government Sectors
- Communication, linguistics, presentation, Leadership, Organising, planning, Computer knowledge and Project Management Skills

Experience

- 5 years of experience in Managing Senior Leaders and 10 years experience in developmental field
- Experience in working on policy issues related to gender and equity

Abilities

Ability to perform a variety of specialized tasks related to results management, including support to design, planning and implementation of the programme, managing data, reporting etc. S/he demonstrates openness to change and ability to manage complexities. S/he displays cultural, gender, religion, race, nationality age sensitivity and adaptability.

Honorarium

A consolidated salary of ₹ 35,000/ per month.

Annexure V: Draft Terms of Reference to Lead and Facilitate the Development of a Policy Position Paper on Reducing Out of Pocket Spending in Orissa State

Background

The Government of Orissa (GoO) has developed a comprehensive Orissa Health Sector Plan (OHSP) 2005-2010. This provides a unique opportunity for the Government to align its own, the Government of India's and development partners' resources to meet the State's priorities and help address the major shortcomings in both public and private health provision. DFID provides Health Sector Budget Support to the GoO channelled through the Departments of Health and Family Welfare (DoH&FW) and Women and Child Development (DWCD).

The OHSP aims to achieve equity in health outcomes and has a key focus on access and utilisation of services by vulnerable and marginal groups including Women, Scheduled Caste (SC) and Scheduled Tribe (ST) population. It aims at delivering accountable and responsive health care to reduce maternal mortality; infant and child mortality; reduce the burden from infectious diseases; under-nutrition and nutrition-related diseases and disorders.

GoO has established an Orissa State Health Mission (OHSM) for OHSP oversight, consisting of a Steering Group chaired by the Chief Minister and an Empowered Committee headed by Commissioner-cum-Secretary, DH&FW. The Mission Directorate, headed by the Director National Rural Health Mission (NRHM) provides technical and implementation support for NRHM and OHSP. Responsibility for delivery of health services lies with the Directorates of Health Services and Family Welfare. Other Directorates are responsible for Medical Education and Training, State Institute and Indian System of Medicine and Homeopathy.

DFID has contracted a Technical and Management Support Team (TMST) to work with the OHSM, the Directorates and DWCD to help achieve OHSP objectives. The Options-IPE Joint Venture, in association with CARE, was awarded the contract on 1 April 2008 and became effective from 10 April. Technical Assistance is provided from within a Core Team, short-term Resource Pool, or through Options-IPE procuring additional sub-contracts on behalf of the DoHFW.

Purpose

The purpose of this assignment is to support the Government of Orissa to review the evidence on out-of-pocket spending on health (OOPS) in Orissa, review policies and plans in place to reduce OOPS, and to provide policy guidance on how OOPS can be reduced.

Of the families that fall into poverty in India each year, health expenditure is a contributing factor in more than half of cases². NSSO data from 1993-4 and 2004-5 shows that household spending on health in Orissa has increased, and as in other poor states in India, medicine is the major cost incurred³. A recent facility based OOPS study in 8 districts in Orissa undertaken as part of a larger public expenditure review study shows that medicines,

² Balarajan, Y., Selvaraj, S., Subramanian S.V. Health Care and Equity in India. Lancet 2011;.....

³ Ghosh, S. 2010.

transport, medical tests and diet make up the largest share of household spending on the illness/health condition that patients were experiencing at the time of interview⁴.

Health indicators in Orissa are improving and various programmes and schemes are in place to increase access to services of the poor and vulnerable. The Health Equity Strategy of the Department of Health and Family Welfare and the State Nutrition Operational Plan led by Department of Women and Child Welfare are driving an increased focus on underserved geographical areas and high burden districts, leading to increased investments in these areas. The National Rural Health Mission is also making an important contribution to improving services and generating demand. Alongside these developments, RSBY is now being piloted in the State, and policies to develop an Emergency Ambulance Service and to increase the State's financial allocation on diet for inpatients are expected to reduce OOPS. Health systems strengthening initiatives supported by TMST including work to improve human resource management, and drug procurement and logistics will address some of the underlying systems factors that result in patients of public sector health facilities incurring costs.

In this environment of political commitment to tackling health inequity and poverty, the Government seeks high level policy guidance to inform further action. This assignment will lead this response to the Government in consultation with TMST and by drawing on national expertise. Specifically it is expected that the consultant will:

- Consult with Government stakeholders.
- Review existing evidence on OOPS in Orissa.
- Review GOO policies and key programmes that aim to increase access to quality services.
- Review key features of the health system in Orissa and health care seeking.
- Develop a Policy Position Paper that:
 - reviews the evidence base on OOPS in Orissa,
 - analyses how Government policies and programmes are likely to impact on this,
 - presents national and relevant international evidence on how Governments in other parts of India and the world have improved health security and reduced OOPS,
 - puts forward policy options for the Government of Orissa to consider.
- Facilitate and Lead a Roundtable dialogue with stakeholders in Orissa and invited health financing experts in the country. The Roundtable will review the evidence,

⁴ TMST. 2011. Out of pocket spending study in Orissa. Findings from a field survey in 8 districts.

debate the policy options drafted by the consultant, and support the Government identify a way forward and key actions.

- Finalise the Policy Position Paper and Action Plan for submission to Government.

Specific tasks

1. Consultation visit to Orissa to meet policy makers, key stakeholders in Government and TMST.
2. Desk review of key literatures.
3. Outline of a draft Policy Position Paper to be shared with Government and TMST by early May.
4. Preparation of a draft Policy Position Paper to be shared with Government and TMST by early June 2011.
5. Revision as necessary of the Policy Position Paper in preparation for dissemination to Roundtable participants prior to the Roundtable meeting.
6. Identification of health finance experts to be invited to the Roundtable by June.
7. Facilitation and lead the Roundtable discussion which is planned to be held in end July.
8. Finalise the Policy Position Paper by middle August.

Timeframe

x days of consultant time spread over 5 months.

Expertise and experience

The consultant will be a senior, well-recognised health financing expert with considerable experience of working with Government in India, and international health financing experience.

Reporting

The consultant will report to the TMST Team Leader and work closely with IPE's health economist, Pinaki Jodhar.