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National Rural Health Mission:

Identifying critical gender concerns

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I. Executive Summary¹

The National Rural Health Mission (NRHM) is an umbrella programme launched by the Government of India in 2005 to provide accessible, affordable and quality health care to the rural population, especially women and children. NRHM, unlike earlier health programmes, laid greater emphasis on communitization and decentralization of health care; flexible financing; strengthening human and physical resources; effective public health delivery system and integration of health concerns with social determinants of health. Launched for a period of seven years, NRHM is now in its last leg of implementation. The government proposes to convert the National Rural Health Mission (NRHM) into a National Health Mission to provide health care to the urban poor also, during the course of the Twelfth Plan².

This policy brief is an effort to highlight critical gender concerns in Health, drawing particularly on experiences of the NRHM. By assessing the current approach of NRHM towards engendering health and the constraints thereof on its overall performance, this policy brief attempts to provide a set of recommendations to enhance the gender responsiveness of NRHM, which need to be considered in its new avatar.

II. Context

The linkages of health to poverty eradication and long-term economic growth are strong, and so is the intrinsic value of health for health's sake.

Health, however, is a product of the physical and social environment in which we live. Gender, like caste, class, and ethnicity is an important social determinant of health, given that in almost all societies women and men have differing roles and responsibilities within the family and the society; experience different social realities; and enjoy unequal access to and control over resources³.

Therefore, a gendered approach to health while not excluding biological factors, considers the critical role that social and cultural factors and power relations between men and women play in promoting or impeding health—such as, how men and women seek health care, how health concerns are communicated to medical practitioners, how diagnostic and treatment decisions are made etc. For instance, efforts to engender health would recognize spousal violence as a gender-related health problem to which women are more exposed to, because of social norms sanctioning male violence and their right to control women. In case of women specific health issues, an engendered health programme would go beyond merely providing a technical service. A 'safe motherhood' policy, for instance, would not assume either that women alone are responsible for childcare, or that they have access to resources to ensure their own as well as their child's well-being. Research, policy and services aiming to improve the health status of a population will have to examine, understand and address these differences which tend to discriminate against girls/women.

¹This policy brief draws on valuable inputs provided at a two day National Consultation held on 5-6 July 2012 on "Engendering Health: The Experience of the National Rural Health Mission". It was organised jointly by the Centre for Development Studies (CDS), Trivandrum and UN Women, New Delhi at the CDS. Those who attended included officials from the government, officers of health/population related organizations, academics interested in Health, specifically NRHM and its various components, NGOs working in the area of health. This Policy Brief is based on the views expressed in the Consultation. Secondary literature on NRHM like the latest Common Review Mission, Joint Review Mission, the High Level Expert Group on Universal Health Coverage (UHC), Report of the Steering Group on Health for the 12th Plan, Evaluation Reports/research studies, studies on Engendering Health and the Reprohealth E-Listserv maintained by the Centre for Health and Social Justice, New Delhi which keeps us up to date on news linked to health, nationally and internationally were also reviewed to prepare this policy brief.

²This was announced by the Prime Minister in his Independence Day address on August 15, 2012.

³Studies show that inequalities in health across population groups arise largely due to differences in social and economic status and differential access to power and resources. (Leena V Gangolli et al 2005, WHO 2008).

Box 1: Women's Health in India – A Factsheet

Maternal Mortality Rate is 212 per 100000 live births
Less than half of the women couldn't access all the three Ante Natal Care (ANC) visits
Overall only two out of five deliveries were institutional and less than half were safe.
Only 12 per cent of births to women in the lowest wealth quintile households were assisted by a doctor compared to 78 per cent of births in the highest wealth quintiles.
As much as 58 per cent pregnant women are anaemic which makes them and their children vulnerable to chronic malnutrition related diseases and death.

Source: for maternal mortality rate, Sample Registration Survey (2007-09); for other facts, National Family Health Survey 3 (2005-06)

2 Till the mid 1990s, India's health policies/ programmes looked upon women only for their reproductive role, the overarching objective being the need to control population because of which abortion was made legal as early as 1972. The major gender concern in official policy has been the declining female/male sex ratio highlighted since the 1970s⁴ and continues to be so. It was subsequent to the International Conference on Population and Development (ICPD) 1994 in Cairo that a number of changes were introduced into the national population and family welfare programmes in India. The National Population Policy 2000, created in 1998, based on the ICPD principles moved away from the method-specific family planning target approach to introduce a programme dedicated to improving the reproductive and sexual health

(and not just childbirth) of women. Named the Reproductive and Child Health Programme (RCH-1), it generated awareness about the need for women-centric services, quality of care, community participation, informed consent, decentralized supervision of female health workers and the need for services beyond maternal and child health and family planning. There were some attempts at changing mindsets in the health systems towards greater gender sensitivity, though nothing much happened on the ground⁵.

At the end of the RCH-I period, an intensive review of where the programme had failed in terms of engendering health was undertaken and the RCH-II was launched in 2005 with a very comprehensive section on gender in the Programme Implementation Plan (PIP) document, which incorporated several discussions of the past years' conferences, workshops and expert opinion on gender⁶.

It was reported that while India had made substantial gains in improving overall health of the people, its slow progress in reducing maternal and child deaths remained a significant burden of disease among women and children, particularly in rural areas. In India in 2005 the Infant Mortality Rate (IMR) was 58 per 1000 live births, Maternal Mortality Rate (MMR) was 254 per 100,000 live births much higher than the estimates for some other countries in the region. The IMR in China, Philippines and Sri Lanka among others was nearer 20 per 1000 live births in 2005. With respect to MMR it was 45 in China and 58 in Sri Lanka in 2006; however, in other countries like Bangladesh at 570, Nepal at 830 and Pakistan at 320, the MMR was much higher.

Several commentators have argued that these programmes failed because they lacked focus

and consistency and interventions were not always evidence based⁷. The need for a gendered approach to health, though recognized in the RCH's PIP did not gain much headway.

One of the root causes of the poor health indicators in India was the inadequate allocation of resources for public health, and this had an adverse impact on the creation of a preventive health care infrastructure. At a time when public expenditures on health should have been increasing in India, they in fact declined from 1.3 per cent of the GDP in 1990 to 0.9 per cent of the GDP in 1999; even by 2005-06, the total government spending was stagnant at 1 per cent of GDP.

Moreover, within the country the low income states had even poorer health indicators, and the gap between the actual spending and the required amount was even larger, which perpetuated inter-state inequality. With the imperative of meeting the Millennium Development Goals on maternal and child health (taken on board by RCH-II), the health sector challenge in India was quite formidable requiring a quantum increase in public spending on health and family welfare.

It was in this context that the National Rural Health Mission (NRHM)⁸ was launched by the Government of India on 12th April 2005. It aimed at undertaking an 'architectural' correction of the public health care delivery system in the country to enable it to provide affordable, accessible and accountable primary health care services to poor households in remote rural areas, focusing specifically on women and children. Under the Mission, to eliminate regional inequalities, areas with weak health indices were categorized as special focus states to be ensured greater attention. Accordingly, 18 states were grouped under special focus states⁹.

Box 2: Five Main Approaches of NRHM

- Improving public health delivery system by making it fully functional and accountable to the community.
- Making critical human resources available in rural areas.
- Capacity building of human resources at all levels.
- Delegation of financial and administrative powers to lower tiers of administration.
- Flexibility in financing.

A concomitant reduction in IMR/MMR/Total Fertility Rate (TFR) was its major objective for each of which targets were set to be achieved by the end of the Mission period (2012)¹⁰. Outlays for public health were expected to increase from 0.9 per cent of GDP to 2-3 per cent of GDP. With its emphasis on maternal and child health, the NRHM was primarily a programme focusing on women's health but did it really bring about a new health architecture, which was gender sensitive?

III. Critique of Policy Option(s)

A detailed framework of implementation was created by the Mission and approved in July 2006, to facilitate a range of interventions for strengthening primary and secondary health care systems, and the role of the state as a health provider. What distinguished it from the earlier health programmes, with largely the same objectives, was its approach - based on a communitization and decentralization of the health care system, the major features of which were:

- Provision of a flexible financial pool for innovative and need-based decentralized

⁴Source: Committee on the Status of Women (CSW), 1974

⁵Renu Khanna, 2012

⁶Chapter 2 addresses cross cutting issues in State PIPs and has a section on Mainstreaming Gender and Equity giving a very useful analysis of factors (at the economy, social and cultural levels) that influence women's access to health care, the systemic factors and mind-sets and attitudes, including the population control mindset, the primary focus on women of reproductive age group, attitudes of providers towards adolescents and women 'out of wedlock' that hinder women's access to health care etc. It addressed the discrimination girls/women face in society due to the cultural and social barriers that restrict their mobility and the way patriarchal norms deny women the right to make decisions regarding their sexuality and reproduction, which in turn expose them to avoidable risks of morbidity and mortality.

⁷Ved and Dua, 2004

⁸The Mission was conceived as an umbrella programme subsuming under it RCH-II, National Disease Control programme for Malaria, TB, Kala Azar, Filariasis, Blindness and Iodine Deficiency and Integrated Disease Control Programme. A separate Budget head was introduced for NRHM only during the fiscal year 2006-07.

⁹The 18 states are Arunachal Pradesh, Assam, Bihar, Chhatisgarh, Himachal Pradesh, Jharkhand, J&K, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal, and Uttar Pradesh.

¹⁰For IMR (less than 30 per 1000 live births), MMR (less than 100 per 100,000 live births) and TFR at 2.1.

utilization of funds to improve infrastructure, human resources and capacity at the state level; and provision for planning and management at district level.

- The creation of female health activists (ASHAs) chosen by and accountable to the *panchayats* to act as the interface between the community and the public health system to promote access to improved health care at the household level.
- Creating and upgrading sub-centres (SCs), primary health centres (PHCs), and community health centres (CHCs) using untied flexi-pool grant and maintenance funding.
- Promoting institutional childbirths and safe motherhood by improving facilities through improved hospital care and conditional cash incentives under *Janani Suraksha Yojana* (JSY); and promoting integrated management of neo-natal and child care (IMNIC).
- Setting up village health and sanitation (now also nutrition) committees (VHSC) and *Rogi Kalyan Samitis* (RKS) for encouraging the involvement of the community at decentralized levels.
- Generating health plans for each village through the village health committee of the *Panchayat* and an amalgamation of field responses through the Village Health Plans into a District Health Plan, which also integrates state and national priorities for water supply, sanitation and nutrition.

The NRHM was certainly conceived much better than earlier health programmes in terms of its high level of support, larger resources and relatively open review and monitoring. Budgetary allocations for NRHM more than tripled from Rs. 6,788 Crores in 2005-06 to Rs. 20,885 Crores in 2012-13. That in these seven years of its functioning NRHM has put rural public health care firmly on the agenda

cannot be denied. It's attempts at structurally reconfiguring the public health system to facilitate decentralization and communitization, in terms of new/upgraded sub-centres, PHCs, CHCs and human resources, is impressive. Many innovative initiatives have also been taken in providing health care to the most disadvantaged in society utilizing the provision of a flexi-pool of resources. However, as highlighted by various evaluation studies/reports, several concerns remain.

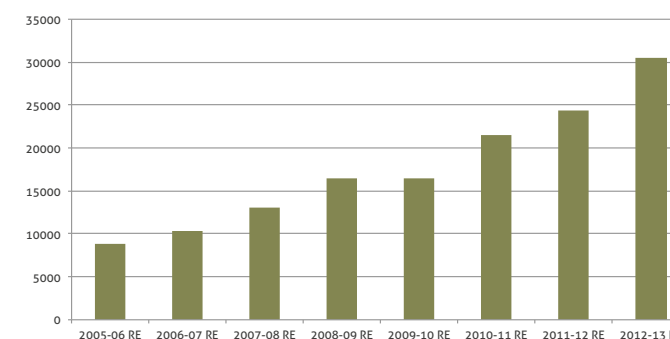
a. Overall trends in fund allocation and expenditure of Government of India and states

The NRHM was envisaged as the main vehicle to realise the promise of increasing the health expenditure to at least 2-3 per cent of GDP¹¹. However, even after eight years of the commitment made by UPA-I, the health expenditure remains 1.01 per cent of GDP, a marginal increase of 0.2 per cent since 2005.

Low public spending has forced the population, including the poorer sections, to seek private health care. With over 70 per cent of the spending on health being out-of-pocket (OOP) expenditure, the low levels of public spending indeed a matter of great concern¹³. Poverty increases with high out-of-pocket expenditures on health. Approximately 32.5 million persons figured below the poverty line in 1999-2000¹⁴ through OOP payments, implying that the overall poverty increase after accounting for OOP expenditure is 3.2 per cent as against a rise of 2.2 per cent published in earlier documents¹⁵. Later estimates using 61st NSSO Round (2004-05) also show that health expenditure, continues to be one of the main reasons owing to which, households slip into poverty¹⁶. According to WHO (2010), the ratio of public to private spending on health in India was 26.2:73.8 as compared to 47.5:52.5 in Sri Lanka, 70:30 in Canada and 73.2:26.8 in Thailand.

Share of NRHM in the total health budget of the Government of India has declined from over 60 per cent in the early years to less than 60 per cent in 2011-12.

Figure 1: Central Plan Outlay on Health and Family Welfare



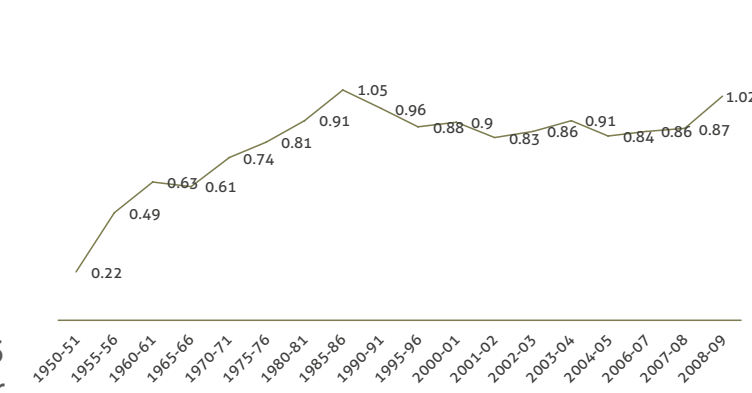
Source: Budget at a Glance, Union Budget, 200-06 to 20012-13.

Two major schemes were launched in 2005 – District Hospitals and Human Resources for Health. However, the budgetary allocations for both the schemes have been 20 per cent and 16 per cent of the recommended outlays respectively during the Eleventh Five Year Plan¹⁷.

Release of funds has been much below the sanctioned amount and lower than the expected annual increase as stated in the Mission document itself. The Mission had projected an additional 30 per cent over existing budgetary outlays for the first two years and thereafter 40 per cent, which did not happen at all. Furthermore, states which lagged in provisioning public health are still lagging behind. Health expenditure in these high focus states has not increased as expected, partly because the low income states could not avail the grants by making their own contributions. Also the data show significant substitution of central grants with states' spending from their own resources instead of supplementing the budgetary support. This calls for a re-examination of the mode of transfer of NRHM funds to state governments.

Expansion of public health spending is absolutely imperative from a gender and equity perspective, as it is essential for public financing to reach the poorest of the poor. Even as a proportion of total government expenditure, the share of health was about 2 per cent in 2010-11.

Figure 2: Public Expenditure on Health since Independence



Source: I Mukhopadhyay: Public Health Care Expenditure in India: A study of Kerala, Tamil Nadu and West Bengal. unpublished PhD thesis, Centre of Social Medicine and Community Health, JNU, New Delhi, 2011.

Note: Figures represented as percentages of GDP.

As far as utilization figures are concerned, the utilization of NRHM funds has picked up in most High Focus States. However, factors that continue to constrain fund utilization include deficiencies in the decentralized planning process, bottlenecks in budgetary processes and systemic weaknesses such as lack of human resources and weak monitoring and supervision¹⁸. There is a provision for untied grant in NRHM. However, a survey conducted by Population Research Centre found that in 2008-09, only 49 per cent of SCs, 36 per cent CHCs and 42 per cent PHCs received such funds. Moreover, these funds were spent on meeting telephone expenses, power expenses and purchasing drugs. Most of the officials were unaware of how to spend the untied fund¹⁹.

¹¹As stated in the National Common Minimum Programme of UPA -I

¹²Figures cited as per Centre for Budget and Governance Accountability (CBGA) 2012. Response to the Union Budget 2012-13. New Delhi.

¹³Rao and Choudhury, 2012

¹⁴55th round of the NSS.

¹⁵Garg and Karan, 2008

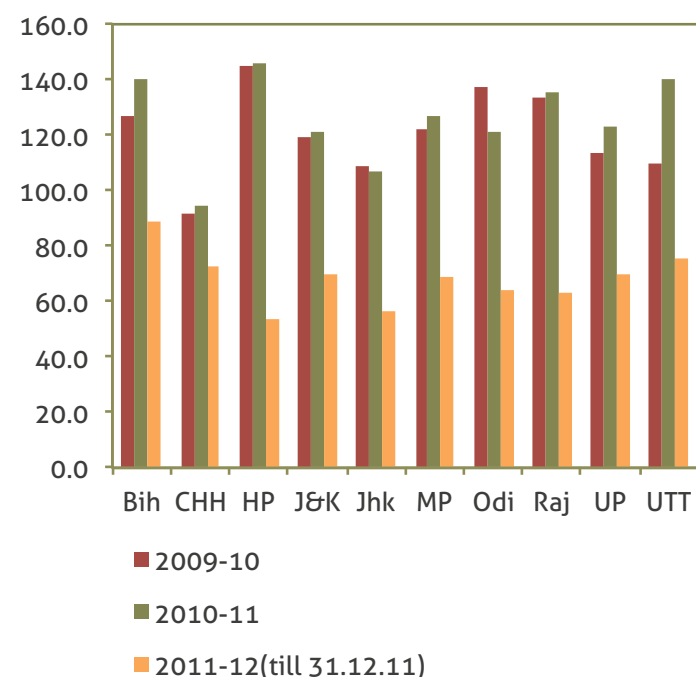
¹⁶Gupta, 2009

¹⁷Centre for Budget and Governance Accountability, 2012.

¹⁸Centre for Budget and Governance Accountability, 2012.

¹⁹Husain, 2011.

Figure 3: Utilization of NRHM funds across states



Source: CBGA 2012.
Note: Figures represented as percentages of GDP

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b. Poor infrastructure

Table 1: Status of Public Health Facilities

	2005	2011	Percentage increase
Number of Sub-Centres	14,6026	148124	1.4
Number of Primary Health Centres	23236	23887	2.8
Number of Community Health Centres	3346	4809	43

Source: Rural Health Statistics, 2011

Despite some improvement in infrastructure, significant shortfalls exist in many states. Recent

data point to the dismal state of infrastructure in rural areas²⁰. There has been an increase of about 43 per cent in the number of CHCs, 2.8 per cent in the number of PHCs and about 1.4 per cent in the number of sub-centres in 2011 as compared to 2005. However, the latest provisional figures show that many states such as Uttar Pradesh, Bihar and Assam have a significant shortfall in the quantum of CHCs. The situation is similar at the level of PHCs where states like Andhra Pradesh, Madhya Pradesh, Uttar Pradesh, Bihar and many others fare worse²¹.

- As on March 2011, 62.7 per cent of the sub-centres, 86.7 per cent of the PHCs and 95.3 per cent of the CHCs were located in Government buildings, while rest were either in rented building or panchayat/Voluntary society building.
- As per the evaluation conducted by Population Research Centre in select districts, it was found that only 36 per cent of the PHCs at the all-India level and 27 per cent of the PHCs in high focus states were functional 24 hours a day. The process of physical upgradation has also been rather slow.
- The availability of functional labour rooms also continues to be very low. Most of the PHCs were found to lack basic facilities such as toilets, medical waste disposal system etc. Also, many PHCs were found to be devoid of medical equipment and medicines. There was a huge gap in supply of essential drugs in PHCs as well.

c. Inadequate human resources

Various evaluation studies have also pointed to huge deficits in human resources. As per the Rural Health Statistics Survey (2011)²², 3.2 per cent of the subcentres were functioning without a Female Health Worker/Auxiliary Nurse Midwife (ANM). According to Husain (2011), the proportion of ANMs in sub-centres has gone down in several states because of non-availability of quarters

for them due to which they have to reside in poor conditions. There are also huge concerns concerning their safety.

4.6 per cent PHCs were without a doctor and 24.6 per cent PHCs were without a pharmacist. At the level of CHCs, which are supposed to provide specialized medical care, as compared to the requirement of specialists, there was a total shortfall of 75 per cent surgeons, 65.9 per cent obstetricians and gynaecologists, 80.1 per cent physicians and 74.4 per cent pediatricians. In fact, the shortfall in total specialists at the level of CHCs has actually gone up from 6110 in 2005 to 12301 in 2009. The shortfall in specialists is especially huge in states such as Madhya Pradesh, Gujarat, Uttar Pradesh, Rajasthan, West Bengal and Maharashtra.

Another issue with regard to recruitment has been hiring on contractual basis to meet the deficit in human resources. As Husain rightly notes, the issue is therefore one of sustainability of appointments made so far.

d. Communitization and Decentralization

NRHM marks a significant departure from other programmes because it envisages inter-sectoral

convergence through an Integrated Health Action Plan. However, in several instances, the process of drawing this Plan was hardly participatory. Also, the Village Health Sanitation Committees (VHSCs), which ideally should comprise the ANM, ASHA, panchayat representatives and women's groups were generally found to be devoid of such representation. In many states, VHSCs did not hold regular meetings and were found to play a very limited role (Husain 2011). However, as presentations at the National Consultation revealed, concerted efforts by the Health department, civil society organizations and *panchayats* did result in well-functioning VHSCs in these pockets

e. Failure to mainstream gender into key components of NRHM and institutional mechanisms for its implementation

NRHM has failed to mainstream gender despite a strong gender perspective built into the RCH-II. One of the major objectives of NRHM was a concomitant reduction in IMR/MMR/TFR by the end of the Mission period. As shown in the table below, improvements in IMR/MMR/TFR have been very slow.

7

Table 2: NRHM Performance Score-card

RCH II Goal Indicator	All India Status (Source of Data)				RCHII/NRHM (2012)
Maternal Mortality Ratio(MMR)	398 (SRS 1997-98)	301 (SRS 2001-03)	254 (SRS 2004-06)	212 (SRS 2007-09)	100
Infant Mortality Rate (IMR)	71 (SRS 1997)	60 (SRS 2003)	53 (SRS 2008)	47 (SRS 2010)	30
Total Fertility Rate (TFR)	3.3 (SRS 1997)	3.0 (SRS 2003)	2.6 (SRS 2008)	2.6 (SRS 2009)	2.1

Source: Ministry of Health and Family Welfare, Government of India, Sample Registration System 1997-98 to 2009-10.
Note: For Kerala the figures are: MMR 95; IMR 12; and TFR 1.7.

²⁰Gol. 2011. Rural Health Statistics in India. Ministry of Health and Family Welfare, New Delhi. Available at: <http://nrhm-mis.nic.in/UI/RHS/RHS%202011/RHS%202011%20Webpage.htm>. Accessed on 20.10.12

²¹Gol. 2011. Rural Health Statistics in India. Ministry of Health and Family Welfare, New Delhi. Available at: <http://nrhm-mis.nic.in/UI/RHS/RHS%202011/RHS%202011%20Webpage.htm>. Accessed on 20.10.12

²²Gol. 2011. Rural Health Statistics in India. Ministry of Health and Family Welfare, New Delhi. Available at: <http://nrhm-mis.nic.in/UI/RHS/RHS%202011/RHS%202011%20Webpage.htm>. Accessed on 20.10.12

Janani Suraksha Yojana (JSY) though perceived as a success, needs strengthening especially in the management of emergency obstetric care and neo-natal care (to some extent addressed by the new scheme launched in June 2011, *Janani-Shishu Suraksha Karyakram*) and much greater attention needs to be paid to integrated provision of safe abortion services and contraception services²³. While the NRHM document talks of universalizing health care for women and children; emphasizes safe motherhood via JSY, there are important ways in which existing gender inequities at the household, community and institutional level operate (such as hierarchies within the health system, low female autonomy and inadequate infrastructural support, underpaid female health workers etc.), which if neglected/ underestimated, impinge on health outcomes at the grassroots level. While RCH II spells out the task for mainstreaming gender and improving gender equity, it is not the centre of attention since NRHM has a narrowed focus on reduction of maternal mortality via JSY.

8 Let us consider JSY which is a critical component of NRHM. Recent studies²⁴ reveal that although there has been a steep rise in institutional delivery and decline in maternal mortality in general, the quality issues such as poor medical infrastructure and sanitation persist. Most of the public health institutions that women go to do not even have basic facilities like beds, clean bed-sheets etc. In most cases, women were assisted in delivery by ANM, ASHA or *dai*; very few saw a doctor. This would not be without risk unless the three categories of paramedics have been adequately trained in birth preparedness and complication readiness. In terms of state of readiness for Emergency Obstetric Care (EmOC), data from DLHS-3 three in five high focus states show that except in Odisha, less than 50 per cent of CHCs had an Obstetrician / Gynaecologist; CHCs offering caesarian section

were less than 15 per cent; those with blood storage facility were nil or less than 10 per cent (DLHS-3). In a number of states, women continue to incur out-of-pocket expenditure, mostly on travel, diagnostics and drugs- what is provided under JSY as cash incentive is too meagre. As a study²⁵ on the working of JSY in Ernakulam district showed, even in Kerala, there are long delays in JSY payments; sometimes because women normally deliver in natal homes and the accreditation process is delayed; or unnecessary documents are demanded. Payment to ASHAs is also delayed.

That social factors interplay with health outcomes in a complex way has to be understood and interventions may sometimes have to be based on local evidences; institutional delivery may not always be the answer. For instance maternal mortality may be due to geographical and social inaccessibility as for certain tribal communities in very hilly, inaccessible areas, their socio-cultural background, tribal women's distrust of health facilities and the health system's inflexibility and inability to accommodate tribal realities²⁶.

The inadequate public health facilities in the primary and secondary sectors mean that there is tremendous pressure on tertiary level facilities, which reduces the quality of services. Data collected by National Health Systems Resource Centre (NHSRC) in 2011 shows that over 50 per cent of deliveries in eight high focus states happen in 10 per cent of institutions. In most public facilities, there is continuing need to improve physical and human resource infrastructure to provide safe delivery services. Approaching JSY through a gender lens would mean service delivery in terms of interventions to address accessibility issues such as waiting rooms for pregnant women; availability of transport facilities; availability of separate, clean toilets; privacy and adequate facilities for safe abortion.

ASHA Workers

ASHA is a key player in the communitization of health under NRHM and acts as a (community) link worker between the pregnant woman and the health facility and is the first port of call for any health related activity. There are 8,61,548 ASHA workers as of December 2011²⁷. Most of them (based on a documentation of the working of the programme by National Health Systems Resource Centre in eleven states)²⁸ are in the age group 25-35 years (except Kerala); are married, have two children and secondary pass ranges from less than 25 percent to over 80 percent between states in 2011-12 (Ved 2012).

What about the gender based inequalities that ASHAs face? Although the inclusion of ASHAs has been hailed as one of the most significant interventions under NRHM, their work conditions and paltry remuneration remain critical areas of concern. As computed by the Ministry of Health and Family welfare, the maximum compensation for ASHA per annum is Rs.17,200 which means Rs.1,433 per month. It is important to remember that this remuneration is only available to an ASHA who is able to meet the highest targets. Given the nature of their job, this remains highly difficult to attain, a fact borne out by different studies. In fact, public health specialist Abhay Shukla, from *Jan Swasthya Abhiyaan*, asserts that a significant number of ASHAs actually earn less than two days of wages in a month²⁹.

ASHAs are considered volunteers, required to work only two to three hours a day. The guidelines clearly state that the work assigned to her shall be such that it does not affect her normal livelihood. It is assumed that the work required of them is not very time consuming and that they can carry out their responsibilities even if they are employed elsewhere. All evidence however points to the contrary.

In terms of their roles and responsibilities, ASHAs have performed most successfully in tasks like mobilizing women for institutional delivery and immunization day, which are incentivized as well as supervised and require relatively little knowledge and skills³⁰. In different aspects of community mobilization, the percentages of ASHAs involved vary widely across states and except in Kerala and AP, the percentages are low.

ASHAs not only have to counsel the expectant mother about JSY, importance of institutional delivery, cleanliness and sanitation and good nutrition but also need to have a birth preparedness³¹ plan and be aware of danger signs for complications and be ready with appropriate and timely referral to obstetric care.

In addition to their existing duties, the ASHAs are bestowed with another incentivized duty - family planning counseling. Though spacing and family planning are progressive ideas, putting the onus of this on ASHAs for a pittance is unfair. NHSRC data also reveal the different ways in which ASHA's role has evolved in different states- (i) as a link worker and not a service provider; (ii) providing essential services that save lives at the level of the community and also a link worker; and (iii) as mobilizing communities to work for their health entitlements.

Given the wide range of responsibilities spelt out in the NRHM guidelines, birth preparedness and complication readiness certainly need substantial training, support and guidance. An ongoing study in Koppal district of North Karnataka³² revealed that a very small proportion of ASHAs had identified institutions for referral delivery and blood donor required in case of complication during delivery. However, progress on training and capacity building is rather slow.

Another question that merits scrutiny is how gender sensitive are these ASHA workers

²³Gita Sen, 2012

²⁴Abhijit Das, 2012

²⁵K V Beena, 2012

²⁶Jithesh, 2012

²⁷Management and Information System. Available at www.mohfw.nic.in/nrhm/htm, accessed on 14.10.2012

²⁸The 11 states are Assam, Bihar, Jharkhand, Orissa, Rajasthan, Andhra Pradesh, Kerala, W.Bengal, Madhya Pradesh, UP and Uttarakhand.

²⁹Shukla, A. (2005). National Rural Health Mission – Hope or disappointment? Indian Journal of Public Health Vol.XXXXIX No.3 July-September.

³⁰Ved, 2012

³¹Birth preparedness and Complication Readiness means a strategy which promotes timely use of skilled maternal and neo natal care, especially during child birth, which means inre alia having knowledge of danger signs, choosing a birth location and provider, knowing the location of a skilled birth provider, identifying someone to accompany the woman and arranging for transport, money and a blood donor.

³²Kochukuttan et al, 2012

themselves? The Koppal study on ASHA workers³³ also assessed attitudes towards gender norms by using a 21 item Gender Equitable Scale for Women (GESW), among 67 ASHA women, which revealed the extant gender norms and practices have been imbibed by the women themselves. For instance in an item like “A woman who has female children is unfortunate” 30 per cent agreed; 25 per cent agreed that women should not earn more than their husband; 90 per cent agreed that a mother should take more time than father to look after children; 87 per cent agreed that a husband has the right to beat his wife if she cheats on him and 78 per cent agreed that a woman should tolerate violence to keep her family together. Hence, there is need to engender ASHAs themselves. Unfortunately, not much attention has been paid to this, except for one module, which is part of the ASHA training programme. Module 5 has an interesting section on “Knowing Myself” which has Activities on “Who Am I” and “My Socialization” which guides discussion around how the external environment influences development, especially of a woman’s personality; her value in society from the very beginning of her life being identified by her relationship with others, like that of a daughter, mother, sister, wife, etc. Being brought up in a patriarchal society, a woman internalizes the norms, which makes her devalue herself and neglect her needs. All this affects her self-esteem and overall personality and in the beginning she may lack confidence to effectively perform the role of an ASHA, but she should be aware that she was not born like this but it is her socialization that makes her feel subordinate, weak, immobile, dependent, etc. These qualities can be changed (Facilitator’s Module for ASHA, Book No.5 2008).

The discrimination they face at home and in the health system also needs to be noted: they may face difficulties at home when they escort pregnant women at night. Neither are they

provided any basic facility to stay overnight at the hospital facility, nor do they have any back-up support in case of emergency. No regular payment for transport is available to them. They also face disrespectful treatment by service providers in the health system³⁴.

Above all a gendered issue, which needs redressal is that they are underpaid ‘voluntary/ social workers’ receiving a meager incentive, piece-rated and not even an honorarium, payment of which is very often irregular. The Eleventh Report of the Parliamentary Committee on Empowerment of Women on the working conditions of ASHAs, presented to the Lok Sabha on September 2011, recognized that ASHAs are overworked. It made a strong case for better compensation and regularization of these workers.

IV. Policy Recommendations

One of the major critique leveled against NRHM is that it “did not adequately take into account the complexities of Indian rural societies, characterized by gender disparities, and divided on the lines of caste, micro-politics and economic class. In its focus on architectural modification of the health system and introducing modern managerial concepts, the NRHM did not pay sufficient attention to the sociocultural context in which the health system is situation and which ultimately determines the success of policies and measures, including decentralization”³⁵. The other is of course that although RCH II is under the NRHM umbrella and on paper is more gendered, it is not the centre of attention; the focus has been primarily on maternal mortality and JSY³⁶.

Keeping in mind the limitations of the current approach of NRHM towards engendering health and constraints on its overall performance, in

this section, recommendations to engender NRHM have been framed around the following

a. Enhancing Gender Sensitivity of the NRHM Programme: Key Components and Institutional Mechanisms for its Implementation

i. Changing the approach from a techno-centric to socially equitable approach

- More attention needs to be given to the importance of changing gender norms and practices within families, communities and the health system. There is a virtual neglect of certain gender issues, such as preventing early marriages, early and repeated pregnancies; under-nutrition of girls, care in pregnancy, post-partum care, domestic violence and sensitizing boys. Greater emphasis should be given to morbidity (STI/RTI), adolescent reproductive and sexual health, integrated provision of safe abortion services and contraception services.
- The gender agenda painstakingly prepared in the RCH-II PIP document needs to be brought back into the discourse and mainstreamed into the health system
- There is need to broaden the focus from MMR/ institutional deliveries to related sexual/ reproductive health concerns; to shift focus from a ‘technical’ fulfillment of the goal of institutional delivery via JSY to improving the quality of services to women in terms of improved infrastructure, physical and human resource, at the lower levels of public health facilities, and providing more women-centric services, like privacy, waiting rooms, toilets near the labour room, safe abortion services etc.
- Quality of care needs to be emphasized especially when so much training is meted out to health workers, not only in terms of utilization of funds but how it is being used to improve quality of services- for instance, it

is important to check whether the ANMs are using partograms.

- That social factors interplay with health outcomes in a complex way has to be understood and interventions may sometimes have to be based on local evidences; institutional delivery may not always be the answer. For instance maternal mortality may be due to geographical and social inaccessibility as for certain tribal communities in very hilly, inaccessible areas, their socio-cultural background, tribal women’s distrust of health facilities and the health system’s inflexibility and inability to accommodate tribal realities. Unless training programmes of ASHAs, Behavior Change Communication (BCC) and training of health providers incorporate such factors, meeting health needs of the poorest women may remain a distant dream.
 - One needs to emphasize that engendering NRHM requires building in a stronger gender focus in data collection and monitoring which should be consciously kept in mind.
- ###### ii. Revising the scope/operational guidelines of NRHM
- Very little progress has been made on addressing issues of gender based violence (GBV), which is a gender related health problem within the ambit of NRHM. Some hospital based Family Counseling Centres (FCC) have been piloted in Rajasthan and Maharashtra; FCCs in police stations in MP and police help desks in Odisha. However, this is inadequate given the magnitude of the problem. In Kerala, the Health department together with NRHM has started GBV clinics called *Bhoomika* in all district hospitals and in the coming years it intends to reach out to lower levels³⁷. In Chhatisgarh, it is the Community Health Workers called *mitanin*, who define health as including freedom from

³³ibid

³⁴Kochukuttan et al, 2012

³⁵Husain, 2011

³⁶Gita Sen, 2012

³⁷Jameela, 2012

violence, and have a well-planned training curriculum on gender, monitoring spousal violence and supporting women victims³⁸.

- NRHM was supposed to bring about a convergence of several national disease control programmes, which need to be gendered. While more men than women are affected by malaria, the consequences are very serious for pregnant women due to reduced immunity, anaemia, poor pregnancy outcomes like abortions, still births and low weight babies. Yet, adequate attention has not been given to this fact in the National Malaria Programme or the RCH-II, even while data shows that burden of malaria in pregnant women in India is very high. Similarly, gender issues are there in TB affliction, which is much more stigmatizing for women and needs to be addressed.
- The inclusion of mental, palliative care and geriatric care needs to be strengthened within the NRHM system. An attempt was made to examine the gender component of the two community interventions in terms of palliative and mental health care in Kerala³⁹. Kerala is the only state with an NRHM project in palliative care developed as a public health model and has established itself as a forerunner in the field of palliative care in India. Only about 50 per cent of patients have cancer, the others suffer from paralysis, HIV/AIDS and other life-threatening diseases. The public health, community-based model in both interventions certainly provides relief and support to the care giver, in most cases women. Care givers have major emotional, social and physical problems due to the stress of caring. In palliative care the fact that women dominate the aging population, care of elderly women is to some extent built into the programme.
- The health insurance scheme, *Rashtriya Swastha Beema Yojana* (RSBY) in Kerala

with support of NRHM has expanded health insurance coverage substantially and a gender disaggregated utilization of services reveal that almost 45 per cent of the health care services were availed by women⁴⁰.

- It is necessary to re-examine the prepared guidelines for some interventions, for instance, Adolescent Reproductive and Sexual Health (ARSH) whose implementation has remained sporadic and nothing much is happening on the ground, though it is an area which needs to be addressed urgently for both girls and boys. A model for ARSH named Adolescent Health District Plan Project, developed in Kerala⁴¹, has made considerable progress at the Trivandrum district level; adolescent clinics have been set up in CHCs with an initial build up of a widespread community-level training programme for medical/paramedical staff, ASHA workers and health professionals, and awareness classes for adolescents, mothers, *Anganvadi/Kudumbashree* workers⁴².
- The support that the Boat Clinics of Assam have given to lakhs of persons, in particular the most vulnerable, that is women and children living on the isolated and inaccessible islands of Brahmaputra, is unparalleled. The need was to take the health service to the people, not wait for them, with all their difficulties to come to the mainland and thus was born the "Ship of Hope in a Valley of Flood". These ships are equipped with laboratories on board as well as pharmacies through a Public Private Partnership (PPP) and operate in 13 districts of Assam⁴³.
- There is no doubt that one of the key vehicles for the expansion of PPP in health is NRHM, which has ushered in a greater inflow of funds from the Government of India and a push for involvement of non-state actors in service delivery. However, there is little experience or information in the public domain about

most PPPs beyond the technical detailing and their regulatory framework is still at an evolving stage. An issue which arises is - what are the mechanisms of public accountability within the varied forms of PPP projects under NRHM? These should be clearly laid out and available in the public domain.

iii. Training and Capacity Development of Service Providers

- Training is particularly important since without a change in mindsets, engendering the health system would become difficult. The trainings on gender sensitivity for the health staff are yet to be institutionalized. Unless training programmes of ASHAs, BCC and training of health providers incorporate social factors for instance in a tribal setting, meeting health needs of the poorest women may remain a distant dream.
- No gender training or capacity building for frontline women workers (except for Module 5 of ASHA training programme) is conducted. There is need for more trainings on this issue.
- While the declining sex ratio has been projected as the major gender issue in health policies of the government, and Preconception and Pre Natal Diagnostic Techniques Act (PCPNDT) Act as a redressal mechanism; much more effort needs to go into understanding the social compulsions, cultural beliefs and behavior which perpetuate such practices. ASHAs should be trained on the social aspects of health and their house visits can be utilized for sensitizing family members on gendered norms and behavior to demolish certain existing myths.
- Provide for trained dais in underserved areas; to explore possibility of ASHAs to be trained in post-partum care, as women greatly feel the need for this, especially in the context of nuclear families.

Emergency Obstetric Care (EmOC) and Basic Neo natal Care for the newborn have to be ensured at the secondary levels. 'How best and to who should' training in EmOC and general obstetric care be given to ensure availability of trained staff at the First Referral Units (FRU) level has to be decided by the Health department of respective state governments.

- However, in certain very specific micro situations, for instance sickle cell anaemia patients, genetic and pre-marital counseling which form an important part of the programme has to be handled differently creating a positive picture of the disease (since it need not be lethal) and confidentiality maintained regarding the girls and boys who have the trait or the disease, by not distributing differently coloured cards to the carriers or the diseased. For young girls in particular, this can be very stigmatizing. NRHM funds should be used to provide necessary treatment including additional immunization, which has now become available⁴⁴.
- With respect to promoting men's involvement in reproductive health, a pilot intervention has only recently been introduced⁴⁵, which certainly needs to be up-scaled.

iv. Improving working conditions and remuneration of ASHA

- As mentioned earlier, ASHAs have been ascribed different roles in different contexts. It is important to recognize that no matter whichever role they do it deprives them from any other source of livelihood. As ASHAs they are entitled to only low piece rate incentives. Treating women as supplementary earners is a highly gendered issue. Managing workers through piece rates is even managerially a very antiquated way of motivating workers. Hence, it is very essential to treat ASHAs as workers (role being decided by the region

³⁸Samir Garg, 2012

³⁹M R Rajagopal, 2012; Suresh Kumar, 2012; Harish, 2012

⁴⁰Sukumar, 2012

⁴¹The Adolescent Health District Plan Project has been designed in the Child Development Centre, Medical College, Thiruvananthapuram.

⁴²M. K. C. Nair, 2012

⁴³Dipankar Das, 2012

⁴⁴Aravindan, 2012

⁴⁵Srinivasan, 2012

they are in) to be paid on non-piece rate basis with supportive training (including on gender). They should also have a chance to explore better opportunities.

- Another debatable issue is that in practice, ASHAs in a number of states appear to be functioning under the ANM whereas they are supposed to report to the Village Health and Sanitation Committee, which is their key support structure. In the 11 states examined earlier it is interesting to note that in the selection of ASHAs, it was the *sarpanch* or ANM playing the lead role and not the community⁴⁶. It is important to ensure that the roles of the *Anganvadi* worker, ANM, and ASHA should not overlap and job descriptions clearly laid out.
- As recommended by the Committee on Empowerment of Women, data on number of ASHAs recruited from disadvantaged communities such as SC, STs must be collected.

v. Strengthening Community Participation and Decentralization

- While the numbers of VHSNCs and RKSs set up are impressive, as stated in the Common Review Mission (NRHM 2010), with wide inter-state differentials, there is no doubt that awareness about these committees and their functioning is still very poor, since village health planning is still at a rudimentary stage. Village health plans are still not institutionalized.
- In areas where these committees are functioning, with the help of NGO trainings as in two blocks of Dehradun, Uttarakhand (Project PEHEL of Emmanuel Hospital Association) or with the support of the pre existing group of community health workers (e.g., *Mitanin* in Chhatisgarh) supporting the VHSNC constituted under the *Panchayati Raj* Institutions (PRI) umbrella (with 75 per cent

women membership and a gender agenda built into the Health Plan) or initiative of a District Medical officer as in Kallikkad Panchayat in Trivandrum district, the outcomes are encouraging⁴⁷. While here too, different models exist, finally ownership has to rest with either a strong community structure or a strong local body. If it is the former a strong support structure should be there and if latter, autonomy of PRIs should be maintained without becoming 'bureaucratized'. These case studies offer different ways in which the committees have been formed but how they shape up would be specific to the area concerned.

b. Financial Outlays and Budgets

- The overall public expenditure on health should be at least 2-3 per cent of GDP. Prioritizing health expenditures will ensure better access and quality of services in health facilities at the primary and secondary level. Keeping in mind women's concerns; spending on ambulances would only increase the pressure at the tertiary levels.
- Given the fact that States which lagged in provisioning public health are still lagging behind and health expenditure in these high focus states has not increased as expected (the reasons for which were cited earlier), calls for a re-examination of the mode of transfer of the NRHM funds to state governments⁴⁸.
- While Kerala has used NRHM funding to visibly improve physical and human infrastructure in public health institutions, new challenges of health, sanitation and hygiene in urban areas; lifestyle diseases; and delivery of health care services in coastal and tribal areas remain.
- It is necessary that the untied funds given to the committees should really be untied; training for VHSNC/RKS leaders, members is

essential and also training of PRI members on understanding Health through a gender lens.

- Certain health issues such as GBV, mental health, palliative care and geriatric care are not being addressed adequately and have to be given more attention. There are several examples where innovative initiatives have been undertaken through untied funds such as starting the GBV clinics in Kerala.

c. Universal Health Coverage(UHC) and NRHM/ Gender and UHC

- With the move towards bringing the NRHM and NUHM under a proposed National Health Mission, which envisages extending coverage to the rural areas and other marginalized communities, it will be important that concerns of women in these communities/ areas are adequately addressed.
- If the proposal of Universal Health Coverage (UHC) comes through, the transition would be to a larger programme since it addresses a broader package of health services and not primarily maternal and child health, covering a nutrition package, reproductive health beyond child birth, screening for domestic violence and occupational health programmes, infectious diseases such as malaria and TB through a gender lens and mental health. However, it will be important to assess whether sustainable structures for providing universal health coverage are in place in most states.
- The UHC emphasizes that a gender perspective has to be at the centre in envisioning health reform in India and recognizes women's role in health care provision in both the formal health system and at home; need to build the capacity of the health system to recognize, measure monitor and assess gender concerns; support and empower girls and women.
- While the gender concerns are incorporated

very comprehensively in the UHC, it will be important to ensure that efforts to change mindsets are made at all levels. The culture of hierarchy, bureaucracy and patriarchy which are embedded in the health system should be replaced by a culture of pride in providing quality care amongst health care providers from their student days. There is also need for greater awareness among users of health services and collective action to demand sensitivity, responsiveness and quality care.

d. Reorienting Medical Education to Address Rural Health Issues, Engendering Medical Education

- It is necessary that efforts at engendering health system must necessarily include efforts to engender medical education. An initiative for gender mainstreaming in medical education was planned collaboratively with six medical colleges across the country⁴⁹ coordinated by the Sree Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum. It included a review of medical texts from a gender lens; training of trainers (ToTs) in medical colleges and advocacy efforts at creating an enabling environment for sensitizing senior medical officers to gender.
- While some headway has been made on each of the components listed above, much more needs to be done to bring about changes at the individual as well as institutional level. For a majority of medical professionals, gender is not a priority and for those who are concerned, support inside the institutions is not forthcoming.
- There are problems with trainings also. To strengthen and extend the initiative of ToTs, it is necessary to create a core group of trainers and provide facilities within an institution that are enabling for experiential training; advocacy initiatives with medical/health systems to reward those who take initiative towards engendering medical education; and

⁴⁶Ved, 2012

⁴⁷Peהל 2012, Samir Garg 2012, Sanjeev S 2012.

⁴⁸Parvati and Mitra, 2012

⁴⁹The initiative has been undertaken by the SCTIMST through a grant by the MacArthur Foundation and the WHO.

⁵⁰Mala Ramanathan, 2012

identifying a sufficient number of mentors within the system for those newly trained⁵⁰.

- One of the components of NRHM is reorienting medical/health education to support rural health issues; to serve the needs of the most vulnerable in rural and underserved areas. Gendering education is one way of making this socially more relevant. Doctors going to rural areas could play a significant role in challenging extant social and cultural norms and reducing rural urban disparities since the distribution of doctors is biased towards urban areas⁵¹.
- Some practical suggestions could be that half the house surgeoncy (post completion of MBBS) period of students to be spent with NRHM. Each college could adopt a village, with constant interaction with the community to facilitate repositioning of medical education in the societal context. Logistics would have to be worked out for linking this work with local governments and local health services.
- Gendering and reorienting medical/health education would impact the health architecture by increasing the share of public health expenditure and good governance, decentralization, integration and institutional capacity building.

V. Conclusion

The Health sector, as is well accepted, is characterized by tremendous information asymmetries and externalities and hence state intervention in actual provisioning becomes critical. Government spending on health from domestic sources, therefore, is an important indicator of a government's commitment to the health of its people, and is essential for the sustainability of health programmes and for redressing the inequities in health care access based on the inequalities in social and economic

status across population groups, including gender. That in these seven years of its functioning NRHM has put rural public health care firmly on the government's agenda cannot be denied.

But, the above review reveals that despite several achievements, several concerns remain; in particular the inadequate reductions in IMR and MMR. At times this may warrant a revisit to the drawing board and at times a greater effort to design appropriate mechanisms for implementation. There is no doubt that there is need for a much larger injection of funds into NRHM to extend the reach of a revamped public health system and a greater commitment to 'engender health' embedded in the social realities of our society spelt out fairly extensively in RCH II, if we are to realize a new health architecture that will be gender sensitive as well as sensitive to the needs of the poor.

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⁵¹Mohandas, 2012

