

OXFAM IN ACTION

Building Capacity of Dalit and Muslim Women to Access Healthcare in Bihar



ऑक्सफैम इंडिया
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Oxfam India believes that the right to universal access to good quality healthcare, among other things, is a practical way of closing the gap between rich and poor. By 2020, Oxfam India will work towards 'financing for development and universal essential services', especially among the marginalised communities and women, in order to help reduce inequality¹. In India, it works in six states² and supports organisations to mobilise the marginalised communities to demand, access and improve the uptake of health and nutrition services provided by the government. In Bihar, one of its focus states, Oxfam India has been working with Centre for Health and Resource Management (CHARM), since 2012, to mobilise women especially in the *Dalit* and Muslim communities to gain access to healthcare and strengthen the demand for improved delivery of health and nutrition services.

The 2016 Economic Survey states that 'providing accessible, affordable and equitable quality health care, especially to the marginalised and vulnerable sections of the population' is one the key objectives of Government of India³. It also agrees that there is a positive correlation between social sector spending (including health and education), and growth and development⁴. Yet, health expenditure is dismal. It has remained less than 2 per cent of the Gross Domestic Product (GDP); it has hovered around 1.3 per cent since 2008⁵. This is much lower than the 2.5 per cent recommended in the draft National Health Policy 2015. The Centre's share of merely 0.28 per cent in 2017-18 continues to signal the low priority accorded to the health sector⁶.

Due to paucity of funds, lack of infrastructure and personnel, and huge demands, there remain several challenges to the delivery of efficient public health services. For instance, though number of health centres have increased between 2005 and 2015, the infrastructure continues to be inadequate (see table below). Those centres that do exist, lack basic facilities like water, electricity, medical equipment, and labour rooms affecting the accessibility of services.

It is here that the private health services providers, with unregulated costs and quality, step in. In Bihar, 86 per cent of its rural population opted for private healthcare facilities in 2014; this is among the highest in the country⁷. Bihar is also one of the poorest states in the country; high medical costs and lack of public health facilities and professionals has an impact on the

health of the state. According to the latest Sample Registration System (SRS) data (2015), Infant Mortality Rate (IMR) for Bihar is 42 and Maternal Mortality Ratio (MMR) is at 208⁸. The state's MMR is among the highest in India and it points towards underlying needs for improving maternal health that include Antenatal Care (ANC), immunization, institutional delivery and Postnatal Care (PNC)⁹.

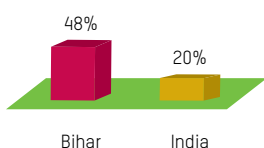
A study conducted by CHARM, a Patna-based organisation, and Oxfam India, in 2012-13, shows that the uptake of maternal health services is low among *Dalits* and Muslims¹⁵ in Bihar and it is reflected in their health parameters. According to National Family Health Survey (NFHS)-3, 68 per cent of Muslim women and 75 per cent of *Dalit* were anaemic; 9.6 per cent of Muslims and 11.2 per cent of *Dalit* opted for institutional delivery. Fewer *Dalit* and Muslim women went for recommended ANC visits¹⁶.

The study cited a host of reasons for the exclusion faced by *Dalits* and Muslims. These included lack of Health Sub-Centres (HSC) in Muslim areas and health workers in *Dalit* areas, and lack of awareness regarding services provided by government health facilities; user fee charged for transportation and investigation were a huge deterrent for these communities¹⁷.

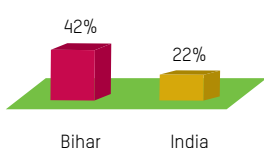
Oxfam India supported CHARM to mobilise women, from these two communities, to enhance uptake of health and nutrition entitlements and to strengthen demand for improved delivery of services. They work in 49 villages in two blocks—Maner and Phulwarisharif— in Patna district. Community-based monitoring groups like *Nari Sabhas* (in *Dalit* communities) and *Khatoon Majlis* (in Muslim communities) have helped empower women to demand and access health services.

Oxfam India and CHARM have been successful in influencing state stakeholders. CHARM is the secretariat for *Jan Swasthya Abhiyaan (JSA)*¹⁸ in Bihar. JSA carries out state-level advocacy to improve accessibility and availability of health services, and initiated Maternal Death Review and Infant Death Review. On the basis of the evidence generated, Bihar government initiated Community-Based Maternal Death Review (CBMDR) in 2014-15. After CHARM and JSA shared evidence that there was discrimination in health service provisions in Bihar, the state government announced that new Health Sub Centres would be opened in Muslim-dominated villages in Bihar.

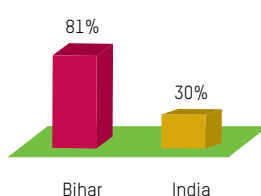
Shortfall of Sub Centres (March 2016)¹⁰



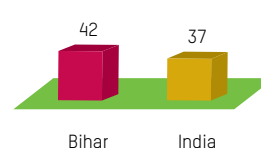
Shortfall of Primary Health Centres (PHCs)¹¹



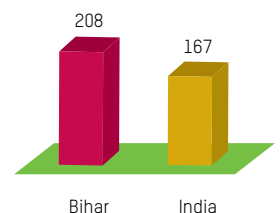
Shortfall of Community Health Centres (CHCs)¹²



Infant Mortality Rate (deaths per 1000 live births)¹³



Maternal Mortality Ratio (deaths per 100,000 live births)



NARI SABHA AND KHATOON MAJLIS

Oxfam India supported CHARM with the aim to improve health and nutritional status of women and children in the two marginalised communities, so they started collectivising women at *Anganwadi* Centre in villages. Women from these Centres were formed into *Nari Sabha* and *Khatoon Majlis*. Each Centre accommodates eight pregnant and eight lactating women, and up to 40 children; some of the mothers of these children too joined the group which meets once a month. The enrollment is not restricted to women at the Centres and includes others from the village; membership goes up to 20-25 members.

"The *Nari Sabhas* have provided a platform to discuss a host of issues, and spread information. Through these *Sabhas*, we get information on immunisation, institutional delivery and the cash benefits, ANC, breastfeeding, birth controls, birth spacing, family planning, nutrition, and vaccination. Earlier, women would just come to the *Anganwadi*, collect their Take-Home-Ration (THR) and go back. They had no exposure and were ignorant; this affected their health. That has changed," says Rupa. She is the president of the *Nari Sabha* of Chitnawa village in Maner block.

However, forming women into groups and bringing them to meetings was not easy. Initially, they were not interested in attending meetings. Then their husbands would not allow them to go unaccompanied for meetings to neighbouring towns or villages. But with women like Rupa, who insisted on joining the *Nari Sabhas* and fought resistance from within the family, the groups have grown. At present, there are 320 members of *Nari Sabhas* and *Khatoon Majlis*. These groups federate at the block level. The federation meetings take place every quarter.

Apart from officers at CHARM, the *Anganwadi* worker or '*Sevika*', trained by CHARM, serve as crucial resource persons. "We are given Infant and Young Child Feeding (IYCF) training. For lactating mothers, we train them to clean and feed colostrum. We counsel mothers to exclusively breastfeed their children upto six months, and six to eight times a day. Healthy Baby Shows encourage mothers to take care of their children's nutrition through the year," says Basanti Devi, who has been a *Sevika* for the last 30 years. The Healthy Baby Shows, organised by CHARM and supported by *Sevikas*, identify and felicitate healthy babies and their mothers.

25-year old Phoolwanti Devi, from Bayapur village, and a mother of three, has benefitted from these meetings. She used cotton balls dabbed in breastmilk to feed her first-born nearly five years ago. "That was a mistake. I was told how cotton could increase the chances of infection. I was careful when my second and third child were born," she says.

There are others, like Neelam Devi, also from Bayapur, who learnt of Nutrition Rehabilitation Centre (NRC) through the meetings. The NRC is the first line of primary care against malnutrition; there is one NRC for each district in the state. Bihar has 5 million malnourished children under-five years of age¹⁹. Health of children attending *Anganwadis*' is regularly monitored. This is measured using age, height, weight, and measure of mid-upper arm circumference²⁰.

Neelam was weak and her three daughters were malnourished; Supriya (6) and Julie (2) were severely malnourished while Khushi (3) was moderately malnourished. She and her three children went to the NRC. Though NRC is for children below five years, Supriya was taken in as she was severely malnourished and looked underage. At the NRC, the mother and child are kept for 20 days; they are given nutritious meals and their weight is regularly monitored. The children get *khichdi* and milk twice a day along with *halwa*; the mothers get a combination of rice/ roti, pulses and vegetables along with tea and biscuit. NRC gives Rs 50 per child per day, transportation cost as well as a diet schedule. Once back home, children are constantly monitored at the *Anganwadi*.

The improvement in Neelam and her daughters encouraged another mother, in the neighbourhood, to avail facilities at the NRC. "The husband would not allow the mother and the child to go. The members of *Nari Sabha*



Neelam and her three children were sent to the Nutrition Rehabilitation Centre in Masaurhi block

went and spoke to the couple. Even my husband met him. He was finally convinced and he sent them to the NRC," says Neelam.

The one problem is that the NRC is far from the two blocks. While earlier it was in Patna, it has now shifted to Masaurhi block. Shabnam Khatoon, mother of nine children, last went to the NRC in 2012, soon after CHARM started working in Phulwarisharif. "I had gone with two of my children. They showed improvement. My younger children also need to be taken to the NRC but it is too far," she says. Shabnam is a member of the *Khatoon Majlis* in Nosha village.

Like *Nari Sabhas*, *Khatoon Majlis* helped Muslim women to collectivise and demand their rights. Apart from lack of information or awareness, they avoided PHCs due to poor infrastructure, lack of facilities and jibes about 'having too many babies'. "There were no curtains where check-ups were conducted. There were no beds available in PHCs. After delivery, they would ask the woman to leave within a few hours. They did not do a good job of cleaning post-delivery unless of course we shelled out upto Rs 2000 for the nurse and the help," says Razia, a member of *Khatoon Majlis* from Nosha village in Isopur Nagar Panchayat.

The PHC Razia mentions, is over-burdened. While one PHC, which has six beds, should cater to 30,000 people, here it caters to 2.5 lakh people. "We had to go to the Bhusaula health centre which is far from our village. We wrote to Nosha *Mukhiya*¹⁹, Akila Khatoon, demanding a Health Sub Centre in 2014," adds Farhat, another member of the *Majlis*. However, it gained momentum after the election of the new *Mukhiya*, Kumari Gita Rani, who was elected in June 2016. She met with the *Majlis* members to understand their requirements. A piece of land has now been identified for setting up an Additional PHC, which will cover Nosha Gram Panchayat. The matter is now with the Circle Officer.

CHARM has been crucial in information dissemination. Due to lack of information, women paid out of their pockets for services that were free or were supposed to be paid by the government. "For instance, for each institutional delivery, mothers are given Rs 1400. But according to the latest NFHS (round 4) data, a woman visiting a government facility for delivery incurs Rs 1674. This is because they have to pay nurses and *dai*, and are asked to get medicines and tests from outside instead of being provided at the Centre. At times they also have to pay for transportation, if an ambulance (also called *102*) is unable to come. This dissuaded them from going for institutional delivery," explains Dr Shakeel Ur Rahman, executive committee member, CHARM.

Farhat and Razia acknowledge that these additional payments have stopped to a large extent. "We simply refuse to pay. In fact, for each immunisation they used to charge us up to Rs 50. This was discussed at the meetings and *Jan Sunwais* (organised by CHARM and Oxfam India). We came to know there is no fee. We also made sure that we got medicines from the Centres itself," says Razia.

Further, these groups have given them the confidence to take control of their bodies and reproductive rights. Matoran Khatoon, associated with CHARM for the last five years, encourages young mothers to get a



Razia, Shabnam and Farhat (left to right) are members of Khatoon Majlis of Nosha village

KISHORI MANDAL AND DOSHIZA MAJLIS

The confidence of the women has rubbed on the younger generation. Adolescent girl's groups have been formed — *Kishori Mandals* in Dalit communities and *Doshiza Majlis* in Muslim communities. These groups have 10 members and meet once a month. At present, there are 110 members in adolescent girl groups.

"Discussions are mostly around menstrual hygiene, use of sanitary pads and cleanliness. We help disseminate information on maternal health, NRCs, immunisation, and IYCF within our community. These meetings prepare us to take care of our health and take control of our reproductive rights," says 18 year-old Amrita Kumari. She is a member of Bayapur *Kishori Mandal*.

Girls and their parents are encouraged to continue and complete their education. Before Farhat became a member, she wanted to get her daughter married off as soon as she turned 16. After joining the *Majlis*, she was convinced that her daughter should complete her education. Her daughter, too, joined the *Doshiza Majlis*. Today, as part of *Majlis*, CHARM has sent her daughter to a professional training institute.

Apart from education, stress is laid on good nutrition, equality of girls and boys, hygiene within and outside the house, and legal marriageable age. At Murgichak village, Bushra Jahan, a class six student tells us of a fellow classmate about to get married. Her teacher asked her, and her group, to try and stop the marriage; this is evidence that adolescent groups are of consequence. When we met the girls, they were deciding on ways to tackle these issues.

These groups have given confidence and clarity to the girls. Shabnam of Murgichak village attends college and takes tuitions as well. She started working after her father suffered a paralysis attack. She is 20, and along with her brother, supports her family. She is clear that she will have only two children.

COMMUNITY-BASED MATERNAL DEATH REVIEW

It is mandated to register births and deaths under "The Registration of Births and Deaths Act, 1969", but there is no punitive action for not doing so. Moreover, maternal deaths in rural areas are reported less as compared to deaths in urban areas; most maternal deaths in rural areas occur at home due to either direct obstetric and non-obstetric causes like haemorrhage, anaemia, abortion, and sepsis²².

tubectomy done. "We monitor young mothers and their health, keep a tab on the schedule of their immunisation, ANCs and PNCs. We ensure that they attend meetings. If required we accompany them during their visits to health centres," she says. Two young mothers have opted for tubectomy in her *Majlis*.

Jaidu Khatoon, the ASHA (Accredited Social Health Activist) at Murgichak village in Phulwarisharif block has kept a tab on the changes in the community since CHARM started working. "Since 2012, maternal death has reduced. Earlier, there were hardly any visits to the health centres and no intake of iron and folic acid tablets. The reason was that the in-laws would stop them due to some misinformation. This has changed. Women and their families are better informed and avail the facilities at health centres now," she says.

Apart from healthcare, women have become more aware of their rights. Whether it is ration in Public Distribution Scheme (PDS) shops or the legal marriageable age, whether it is getting funds under the *Indira Awas Yojana* scheme or seeking help to end violence against women, these women have new found confidence and are standing up for their rights in the society.

Some of these young girls will join the women's groups once they are married. "Training young girls means that they will take this information and awareness to villages, towns, and cities they get married into. This knowledge and confidence will make for a better society," says Dr Shakeel.



Shabnam (in white) and Bushra (in orange) are members of the Doshiza Majlis in Murgichak village

Though mandated under National Health Mission (NHM), the Bihar government was not carrying out the Community-Based Maternal Death Review (CBMDR). CHARM and Oxfam India began state-level advocacy in 2013-14 and presented a roadmap, after which CBMDR was included in the state's programme implementation plan. In 2015-16, Rs 9 crore was allocated for CBMDR but no reporting was done, so the money remained unspent. Reporting finally began in 2016-17.

“CBMDR is important to identify causes of maternal death. This is not about penalising families but identifying reasons for delay that caused the death, identifying systemic gaps, and then improving them. Earlier, ‘due to pregnancy’ was given as the blanket cause of death,” explains Dr Shakeel. The CBMDR aims to find out whether the maternal death was caused due to (a) delay in decision-making by the family, or (b) delay in getting transportation, or (c) delay in getting treatment at PHCs.

As part of NHM, each block has a Block Community Mobiliser (BCM). He collects information on maternal death from the ASHA facilitators. ASHA workers are important because they are closest to the community and the BCM is overworked with the functioning of the PHC. The ASHA workers of each block are clubbed into groups of 20; they report to ASHA facilitators, who in turn report to the BCM. For instance, in Maner block, 190 ASHA workers are formed into nine groups.

Once informed, BCM visits the family of the deceased to collect information regarding the cause of death and prepares a report. This is submitted to the Medical Officer In-Charge (MOIC) who presents a final report to the Chief Medical Officer, and subsequently, to the

District Magistrate (DM). The DM will then review it and give orders for corrective action to take place.

In Maner block, reporting of maternal deaths began in May 2016. Until December 2016 around six cases were reported. “As per rules, the report to the MOIC should be submitted within 24 hours. But out of six only one was reported within the stipulated time. The ASHA workers get an incentive of Rs 200 to report each death, but reporting is only catching up now. There is a stigma attached to maternal death and ASHA workers feel that they will be held responsible for these deaths. This is where CHARM plays an important role,” says Rakesh Pandey, BCM, Maner Block.

CHARM bridges the gap between community and ASHA workers. “The importance of CBMDR is explained to the community through women group meetings. They were either reluctant to inform or ignorant about maternal death review,” says Rakesh. In addition, the *Jan Sunwai* organised in 2014 in Patna, highlighted problems at PHCs due to lack of human resources and infrastructure, and complete lack of reporting of maternal deaths. The public hearing attended by top politicians and bureaucrats, turned out to be an effective community-based advocacy tool. It helped them understand the community better.

NOTES

- 1 <https://www.oxfamindia.org/sites/default/files/01N-Strategy-Report-2016.pdf> [as viewed on Jan 24, 2017]
- 2 Bihar, Uttar Pradesh, Jharkhand, Chhattisgarh, Odisha and Assam
- 3 Economic Survey 2016; pp 193 <http://indiabudget.nic.in/es2015-16/echapvo2-09.pdf> [as viewed on Jan 24, 2017]
- 4 Economic Survey 2016; pp 193 <http://indiabudget.nic.in/es2015-16/echapvo2-09.pdf> [as viewed on Jan 24, 2017]
- 5 Economic Survey 2016; pp 193 <http://indiabudget.nic.in/es2015-16/echapvo2-09.pdf> [as viewed on Jan 24, 2017]
- 6 <https://www.oxfamindia.org/blog/1783/union-budget-2017-18%3A-look-health-sector>
- 7 This data refers to outpatient care. There isn't much demand for inpatient care or hospitalization especially in the rural areas. Even in urban centres this has decreased from 38% to 32% from 2004 to 2014. Budget Briefs | Vol 9, Issue 4 | National Health Mission (NHM) GOI, 2016-17 http://accountabilityindia.in/sites/default/files/pdf_files/BudgetBrief_NHM_2017.pdf [as viewed on Jan 24, 2017]
- 8 Maternal Mortality Ratio Bulletin 2011-13; http://www.censusindia.gov.in/vital_statistics/mmr_bulletin_2011-13.pdf [as viewed on Jan 24, 2017]
- 9 Maternal Mortality Ratio Bulletin 2011-13; http://www.censusindia.gov.in/vital_statistics/mmr_bulletin_2011-13.pdf [as viewed on Jan 24, 2017]

- 10 Budget Briefs | Vol 9, Issue 4 | National Health Mission (NHM) GOI, 2016-17 http://accountabilityindia.in/sites/default/files/pdf_files/BudgetBrief_NHM_2017.pdf [as viewed on Jan 24, 2017]
- 11 Budget Briefs | Vol 9, Issue 4 | National Health Mission (NHM) GOI, 2016-17 http://accountabilityindia.in/sites/default/files/pdf_files/BudgetBrief_NHM_2017.pdf [as viewed on Jan 24, 2017]
- 12 Budget Briefs | Vol 9, Issue 4 | National Health Mission (NHM) GOI, 2016-17 http://accountabilityindia.in/sites/default/files/pdf_files/BudgetBrief_NHM_2017.pdf [as viewed on Jan 24, 2017]
- 13 Sample Registration System (SRS) data [2015]
- 14 Maternal Mortality Ratio Bulletin 2011-13; http://www.censusindia.gov.in/vital_statistics/mmr_bulletin_2011-13.pdf [as viewed on Jan 24, 2017]
- 15 Dr. Shakeel ur Rahman, Assessment of Utilisation of Maternal and Child Health Services by Muslims and Dalits | Study conducted by CHARM and Oxfam India | 2012-13
- 16 Dr. Shakeel ur Rahman, Assessment of Utilisation of Maternal and Child Health Services by Muslims and Dalits | Study conducted by CHARM and Oxfam India | 2012-13
- 17 Dr. Shakeel ur Rahman, Assessment of Utilisation of Maternal and Child Health Services by Muslims and Dalits | Study conducted by CHARM and Oxfam India | 2012-13
- 18 Jan Swasthaya Abhiyan (JSA), India is part of international Movement on Public Health led by

Civil Society Organisations, and is nearly two and half decades old. JSA has state chapters in 28 states and union territories in India. CHARM has held the JSA secretariat in Bihar for last five years. A core committee elected by members of JSA meets regularly. 58 NGOs (national and international), Civil Society Organisations, Public Health activists, and social workers are members of JSA.

- 19 Shashank Srikant & Nishant Ojha Why Bihar Can Treat Only 0.3% Of Malnourished Children | IndiaSpend.com | September 28, 2016 <http://www.indiaspend.com/cover-story/why-bihar-can-treat-only-0-3-of-malnourished-children-63235> [as viewed on Jan 26, 2017]
- 20 Another metric to assessing malnutrition is the mid-upper arm circumference (MUAC). The circumference of the child's upper arm half way between their shoulder and elbow provides an indication of acute malnutrition independent of the child's age. If the child's arm is less than 11.5 cm in circumference, she is severely malnourished; if the child's arm is between 11.5 and 12.5 cm in circumference, she is moderately malnourished. These values are appropriate for children from 6 months to 60 months. <http://www.hungamaforchange.org/maasuringmalnutrition.html> [as viewed on Jan 26, 2017]
- 21 Village headman or headwoman
- 22 Dr. Shakeel ur Rahman, Community Based Maternal Death Review – Verbal Autopsy in two blocks of Patna district, Bihar | Study conducted by CHARM and Oxfam India | Dec 2013

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