

Health of the National Rural Health Mission

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The National Rural Health Mission was introduced as a flagship scheme of the United Progressive Alliance government in 2005-06 to address the needs of the rural population through an architectural correction of the health system. With the completion period drawing to a close in 2012, this paper critically evaluates the success of the intervention strategies under this scheme. Based on rapid appraisal surveys in selected districts, three common review missions by the Ministry of Health and Family Welfare, and data reported on the NRHM website, this paper attempts a desk review of the progress of the mission with respect to its core strategies – provisioning of health services to households through accredited social health activists, strengthening rural public health facilities, enhancing capacity of panchayats to control and manage provisioning of health services and positioning of an effective health management information system.

1 Introduction

The Alma-Ata Declaration in 1978 called on all governments to “formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system”. In India, however, health has traditionally received low priority in the central and state budgets. Expenditure on the health sector comprised, for instance, less than 1% of the gross domestic product (GDP) in 1999 – one of the lowest in the world. Further, there was a considerable urban bias characterising health policies and investment strategies – about 75% of the resources and infrastructure were concentrated in urban India (Patil et al 2002). The resultant increase in the incidence of both communicable and non-communicable diseases, coupled with poor health facilities in rural areas resulted in high infant, child and maternal mortality rates.

While the United Progressive Alliance government integrated public health as a critical component into its common minimum programme, this objective could not be attained without providing efficient and affordable healthcare services to the rural population, which constitute three-fourths of India’s population. However, the sheer enormity involved in servicing a population of over 74 crore calls for integrated macroeconomic and grass-root level efforts to improve the rural health infrastructure, ensuring adequate presence of healthcare manpower and addressing local needs and concerns.

The need for a concerted targeting of rural India led the government to introduce the National Rural Health Mission (NRHM) as its health flagship scheme in 2005. The objective of this scheme was to “carry out necessary architectural correction in the basic health care delivery system ... to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children” (GOI 2005: 1). This objective is sought to be attained through strategies aimed at improving household health status through the introduction of female health activists, strengthening the three-tiered public health system, increasing community participation through the involvement of panchayati raj institutions (PRIs) and strengthening capacities for data collection to facilitate evidence-based planning, monitoring and supervision.

With the deadline of this scheme drawing to a close in 2012, it is an appropriate time to undertake an evaluation of the success of the NRHM. Three common review missions (CRMs) have been completed. The population research centres (PRCs) have undertaken a first round evaluation of the mission based on rapid appraisal methods in select districts on behalf of the Ministry of Health and Family Welfare.¹ These reports and the data available from the NRHM website provide a useful source of secondary

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information to undertake a desk review of the progress made so far.² This paper attempts such an evaluation, with a focus on some key components: provisioning of healthcare at the household level through the accredited social health activist (ASHA), strengthening the rural public health facilities, decentralising the health sector by enhancing the capacity of panchayats to control and manage the provisioning of health services, and positioning of a health management information system.

2 Strengthening Rural Public Health Facilities

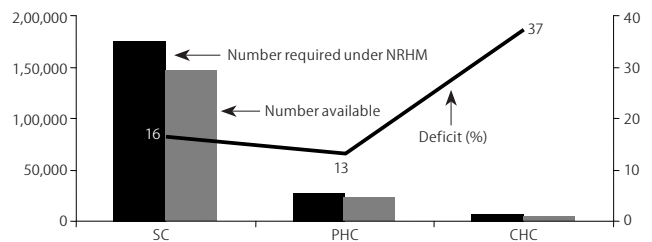
One of the core strategies for providing accessible healthcare to the population is to strengthen the sub-centres (SCs), primary health centres (PHCs) and community health centres (CHCs) – units where healthcare is actually delivered. Accordingly, the NRHM envisages sanctioning of new SCs as per 2001 population norms, upgrading existing SCs, provisioning 24-hour service in half of the PHCs, upgrading all the PHCs and 3,222 CHCs as 24-hour First Referral Units (FRUs), etc.

2.1 Deficiencies in Physical Infrastructure

Using data from the NRHM portal, we have estimated the number of units required, the number available and the deficit (as a proportion of available units) in Figure 1. It can be seen that a substantial deficit persists, particularly at the CHC level.

The extent to which attainments have fallen short of targets is also indicated through the estimates of PHCs that are functional for 24 hours. Despite an increase of 44% (between 2005 and 2010) in their numbers, such PHCs comprise only 36% at the

Figure 1: Infrastructural Deficiency under NRHM (2008)



Source: Estimated from http://www.mohfw.nic.in/NRHM/Documents/Executive_summary_January10.pdf

all-India level and 27% in high focus states. The corresponding figures for CHCs are 93% and 88%, respectively. The progress with respect to upgradation is also a matter of concern. About 71% of the CHCs have been selected for upgradation. While facility surveys have been undertaken in 95% of these CHCs, the process of physical upgradation has been started in only 65% of the CHCs and completed in only a third of the CHCs. Another disturbing feature is that about 46% of the SCs are not operating out of government buildings. This figure is slightly higher in high focus states (49%). The evaluation surveys undertaken by the PHCs also reveal that the availability of functional labour rooms is very low and that the Indian Public Health Standards (IPHS) facility survey remains to be undertaken in the majority of SCs (Table 1). Gill's study (2009) also notes the lack of regular electricity supply to SCs in some states like Uttar Pradesh (UP).

The situation in PHCs and CHCs is equally distressing. In majority of the states surveyed, PHCs did not have 4-6 beds, or care corner

for newborn babies. Few PHCs are performing on a 24-hour basis. Except for Assam, Jammu and Kashmir (J&K) and Rajasthan, provisioning of obstetric facilities is poor. Although the situation with respect to infrastructural facilities in CHCs is reported to be satisfactory, the non-availability of facilities like mobile medical units,³ blood storage, emergency care facilities for children and surgery needs to be addressed by the concerned states.

Gill (2009) found an absence of toilet facilities and medical waste disposal system in many SCs, PHCs and CHCs. The general cleanliness of PHCs and CHCs is also lamentably poor, despite the presence of a sufficient number of cleaning staff. Gill suggests that this laxity could be explained by the fact that awarding regular or contractual cleaning jobs was one of the few patronage tools used by small-time decentralised functionaries, such as the Hospital Development Society members, to get known people employed and on the pay roll (ibid: 23).

Table 1: Facilities and Personnel Available in Public Health Facilities in High Focus States (2009, in %)

Indicators	Uttar Pradesh	Madhya Pradesh	Assam	Jammu and Kashmir	Chhattisgarh	Himachal Pradesh	Rajasthan
Sub-centres surveyed (number)	60	36	24	24	12	12	24
Functioning in own government building	61.7	53.4	91.7	75.0	8.3	91.7	100
IPHS facility survey done	25.0	0	29.2	100	100	33.3	29.2
Sub-centres with ANM quarter	41.7	37.5	41.7	4.2	16.7	83.3	58.3
Labour room available	36.7	22.4	16.7	4.2	8.3	0	37.5
Labour room currently in use	25.0	0	0	4.2	8.3	0	37.5
Primary health centres surveyed (number)	20	12	8.0	8	4	4	8
With 4-6 beds	45.0	58.3	37.5	62.5	50	25.0	50
Labour room available	40	91.7	87.5	75.0	50	75.0	100
New born care corner	0	16.7	25.0	12.5	0	0	0
Names of JSY beneficiaries maintained in record	50	75.0	100	75.0	0	50	100
IPHS facility survey done	10	25.0	37.5	100	100	50	25.0
Functioning 24x7	20	33.3	62.5	25.0	0	25.0	37.5
Provide basic obstetric services	45.0	41.7	62.5	62.5	0	0	62.5
Labour room currently in use	25.0	83.3	87.5	62.5	0	25.0	100
Community health centres surveyed (number)	10	6	4	4	2	2	4
CHCs with 30 or more beds	40	16.7	50	25.0	100	50	75.0
Operation theatre available	100	100	75.0	75.0	100	100	50
Operation theatre used for gynaecological purposes	20	33.3	25.0	25.0	0	50	50
Labour room available	100	100	100	100	100	100	100
Functioning on 24x7 basis	90	100	100	100	100	50	100
IPHS facility survey done	30	66.7	50	100	100	50	0
Surgery facilities available	50	16.7	50	50	50	0	50
Blood storage facility available	0	0	25.0	0	0	0	0
Emergency care for sick children available	60	0	25.0	25.0	0	0	25.0
Mobile medical unit available	20	33.3	25.0	0	0	0	50

ANM – auxiliary nurse midwife, JSY – Janani Suraksha Yojana.

Source: Estimated from State Fact Sheets, NRHM site /www.mohfw.nic.in/NRHM/PRC_Reports.htm

2.2 Shortage of Equipment and Medicine

The shortage of medical equipment also needs to be addressed by the states. The rapid appraisal survey undertaken by the PRCs observed shortages in basic equipment. Some evidence in this regard: (i) None of the surveyed community centres in Kanpur-Dehat in UP had any electrocardiogram (ECG) machines, operation theatre (OT) care fumigation apparatus, and cardiac monitors for OTs.

(ii) Shortage of baby cradles, laryngoscope, wheelchairs were observed in surveyed PHCs in the Sidhi district of Madhya Pradesh.

(iii) None of the PHCs surveyed in Shrawasti (UP) had oxygen cylinders, infant warmers, baby cradles, laryngoscope or wheelchairs, while 75% of the PHCs did not have delivery tables.

(iv) Around 42% of the SCs surveyed in Anuppur (Madhya Pradesh) did not have thermometers and fetoscopes; 83% lacked sterilisers; and 92% did not have reagent strips for urine tests.

(v) Around 42% of the SCs surveyed in Siddharth Nagar (UP) were found to lack blood pressure apparatus and 75% did not have fetoscopes.

It is necessary to identify common shortages at each level and attempt to cover such deficits on a priority basis.

A similar shortage was also observed with respect to the medicine stock. Surveys undertaken by the PRCs found a significant gap in the supply of essential drugs to the PHCs. Gulati et al (2009a) found that iron folic acid tablets, oral pills, vitamin A, measles vaccine, oral rehydration salts and intrauterine device (IUDs) were not regularly available in every three out of four PHCs surveyed by them in UP. Even basic medicines like albendazole/mabendazole tablets, bandages, cotrimoxazole syrup, etc. were found to be out of stock or in irregular supply (ibid). The non-availability of medicine and material at the health facilities is forcing patients to purchase them from private sources, where the cost of medicine is substantially higher (because of the large profit margins maintained by intermediaries). This is leading to high out of pocket expenditures, defeating the objective of providing accessible healthcare services to vulnerable sections of the population, and pushing households below the poverty line.

Realising the need to provide autonomy and flexibility to meet local needs, the NRHM had stated that SCs, PHCs and CHCs would receive respectively Rs 10,000, Rs 25,000 and Rs 50,000 annually as untied grants. Based on figures relating to the disbursement of untied grants to SCs in 2008-09, an attempt was made to estimate the proportion of SCs covered under this component.⁴ It appears that only 49% of SCs received such funds; the figure is even lower in high focus states outside the north eastern region (40%).

The corresponding figures for CHCs and PHCs are 36% and 42%, respectively. Moreover, evaluation reports suggest that this money was generally spent on meeting telephone and power bills, maintenance, purchasing drugs and facilities for patients. During the evaluation surveys, most local officials were found to be unaware of the guidelines for utilising untied funds; the latter also reported that changes in the guidelines created confusion. This indicates the need to further simplify procedures for spending the untied funds. It is also necessary to monitor the proportion of expenditure of such funds under different heads.

3 Deficiencies in Manpower

The quality of the health workforce is crucial in delivering good health outcomes. Evaluation reports have highlighted a shortage of manpower – of doctors at the PHC level and specialists at the CHC level (Table 2). Data from the health ministry reveals that 11% of the PHCs do not have a doctor (this is 17% in high focus states). At the CHC level, only 49% of the required specialist posts have been sanctioned so far, and 25% positioned. Less than a third of the required number of staff nurses has been positioned.

The proportion of auxiliary nurse midwives (ANMs) staying at the SCs has reduced in several states, owing to the non-availability of quarters for them. ANMs also attribute reluctance to reside in staff quarters to the poor conditions of the quarters, lack of infrastructural facilities and safety concerns. This has resulted in a low proportion of SCs with arrangements for night delivery, and is responsible for the continued dependence of the rural population on district hospitals and private providers. In particular, the lack of availability of delivery arrangements has affected the JSY in many regions, thereby limiting the role of the ASHAs.

Manpower shortage in rural areas has emerged as a major problem in other developing countries also. An examination of

Table 2: Manpower Availability in Rural Public Health Facilities (as on 31 January 2010, in %)

Indicators	Uttar Pradesh	Madhya Pradesh	Assam	Jammu and Kashmir	Chhattisgarh	Himachal Pradesh	Rajasthan
Sub-centres surveyed (number)	60	36	24	24	12	12	24
ANM staying in sub-centre	18.3	15.1	20.9	0	8.3	8.3	54.2
Health worker male in position	20	44.1	0	58.4	33.3	91.7	0
Health worker female in position	91.7	61.8	70.8	70.9	83.3	50	62.5
Additional ANM contractual	60	42.9	83.4	29.2	0	0	37.5
No ANM	5.0	0	4.2	20.9	16.7	50	0
Arrangement for deliveries and referral between 8 PM and 8 AM	6.7	0	0	4.2	8.3	0	37.5
ANM been trained on the insertion/removal of IUD A380	68.3	46.0	50	8.4	25.0	25.0	95.9
IUCD insertions being carried out using IUD A380	48.3	42.2	25.0	0	25.0	25.0	83.3
Primary health centres surveyed (number)	20	12	8	8	4	4	8
At least one medical officer	65.0	100	100	100	75.0	50	100
MO AYSUH available	20	33.3	37.5	100	0	0	25.0
Community health centres surveyed (number)	10	6	4	4	2	2	4
General surgeon available	70	33.3	25.0	50	0	0	25.0
Physician available	50	33.3	0	50	0	0	25.0
Obstetrician and gynaecologists available	70	16.7	75.0	50	0	0	0
Paediatrician available	70	50	25.0	25.0	0	0	0
MO trained in sbstetrics available	50	0	0	50	50	0	0
MO trained in anaesthesia available	20	0	0	0	0	0	0
Anaesthetist available	30	33.3	75.0	0	0	0	0

MO – Medical officer.

Source: Estimated from State Fact Sheets, NRHM site www.mohfw.nic.in/NRHM/PRC_Reports.htm

the policies undertaken in other countries provides valuable insights into how this problem can be tackled in the long run. A cross-country study of the success of compulsory service shows that such a strategy can work only when supported by economic incentives (Frehywot et al 2010), though the type of incentives that are likely to be attractive varies among countries (Blaaw et al 2010). Some states like Rajasthan and Chhattisgarh have been successful in designing an attractive combination of financial and non-financial incentives (NRHM 2009a). Persons from rural backgrounds may also be relatively willing to accept rural postings (Serneels et al 2010); location-specific selection of ANMs in West Bengal, for instance, has been successful in this regard.

Apart from lack of manpower, another factor that affects the delivery of health services is absenteeism. Evaluation reports identified the absence of social facilities like educational infrastructure for children, irregular supply of electricity and potable water, and safety of women in some of the rural tracts in UP, and unhygienic and insanitation in villages and health facilities as reasons underlying absenteeism and reluctance to accept rural postings. This led to suggestions that such handicaps be compensated by enhanced financial incentives in the form of non-practising and transport allowances (Gulati et al 2009b).

This view has been criticised by Gill (2009), who points out that given the lower cost of living in rural areas, paramedical and medical staff in rural India fare quite well in real terms (particularly after implementation of the Sixth Pay Commission recommendations). Moreover, the disparity in the public/private pay packages applies to all spheres and in all countries irrespective of their levels of development. Rather, according to her, the main reason for absenteeism and other manpower-related issues is the complacency arising from the assured nature of regular lifetime employment in the government sector, along with a complete lack of monitoring by the state health hierarchy. This has eliminated fear of reprisals (in the form of firing or transfers) for under-performance. As a result, medical staff are scarcely accountable to the rural community they supposedly serve. This affects the ability to access health services, particularly by the poorer and often illiterate category of patients. The principal-agent problem characterising patient-provider relations inhibits any kind of protest – “key informants actually articulated that the doctor might give them the wrong medicines if they complained too much!” (Gill 2009: 34-35).

States have relied on contractual employment to solve the shortage of manpower. Under the NRHM, contractual appointments to the extent of 14% have somewhat reduced this deficit. This, however, may not be sustainable beyond the sanctioned NRHM period, especially where states have not planned for such expansion in their budgets (NRHM 2008).

Apart from the genuine shortage in manpower, health departments in many states fail to utilise even the available resources optimally, leading to misalignment of services demanded and supplied. The third CRM has observed irrational deployment of doctors in many areas. For instance, several specialists were not performing procedures in which they were trained.⁵ It is therefore necessary to improve the fit between posting of specialists and the patient load.

3.1 Accredited Social Health Activist

Global experience shows that women, even when briefly trained, can successfully increase the coverage of healthcare, particularly if they are locally recruited and made accountable to the local clients (Global Equity Initiative 2004). The introduction of the ASHA is thus an important and welcome step. The NRHM envisages that every village will have an ASHA, chosen by and accountable to the panchayat, who will “act as the interface between the community and the public health system”. ASHAs will be given induction training and provided with a drug kit containing generic AYUSH (Ayurvedic, Yogic, Unani, Siddhi and Homeopathic) and allopathic formulations for common ailments. While ASHAs will be volunteers, they will be given a performance-based incentive for promoting immunisation, referral and escort services for reproductive child health (RCH) and other health delivery programmes. In addition, they are also to be involved in the preparation of village health plans.

The ASHA website reveals that 7.49 lakh ASHAs have been selected from 2005-06 to 2009-10. While this is a large number, implying that about 90% of all villages have been covered (Table 1); the selection process has to be made more transparent. Although norms for recruiting ASHAs state that they should be selected on the basis of recommendations of ANMs, anganwadi workers and the panchayat head, in many cases they are recruited from influential families. In Madhya Pradesh, evaluation reports observed that the majority of ASHAs belonged to influential families of the villages and selection criteria such as education, willingness to serve community and her background were not considered (Basu 2009: 148). Further, in some cases, wives of community health workers were appointed, with most of their duties undertaken by their husbands.

Table 3: ASHAs Selected, Trained and Provided with Drug Kits

Indicators	Years	India	HFS non-NE	HFS NE	NHFS (Large)	NHFS (Small) and UTs
Number of ASHAs selected in	2005-06	1,30,315	1,19,642	10,673	0	0
	2006-07	3,00,699	2,52,454	29,639	18,606	0
	2007-08	1,71,931	58,270	5,718	1,07,702	241
	2008-09	1,22,048	19,383	4,238	95,838	2589
	2009-10	24,447	11401	2,733	10,313	0
	Total	7,49,440	461150	53,001	2,32,459	2830
No of ASHAs per village		0.9	0.9	0.8	0.9	0.3
% of ASHAs who have received training	First module	94.1	95.7	94.4	91.2	83.1
	Second module	80.8	81.2	91.3	77.6	83.1
	Third module	78.5	80.9	90.7	70.7	83.1
	Fourth module	75.5	78.5	89.4	66.2	83.1
	Fifth module	26.6	18.3	69.5	33.8	3.1
No of ASHAs with drug kits		69.4	75.8	90.8	51.6	84.9

HFS – High focus states; NE – North-eastern states; NHFS – Non-high focus states.

Source: Estimated from http://www.mohfw.nic.in/NRHM/Documents/Executive_summery_January10.pdf.

The position with regard to training and availability of kits is also not satisfactory (Table 3). Though 94% of ASHAs have received the first module training, only 26.6% have received the fifth level of training. While this can be explained partly in terms of the newness of the scheme – ASHAs inducted in the last two or three years can hardly be expected to have received fourth or fifth level training – it is also true that training is very discontinuous

and infrequent, and most states do not even reach a minimum of 12 days training per year (against the desirable period of 28 days). The quality of training has also been observed to vary between states due to a weak support structure. The experience of Andhra Pradesh shows that making such training residential improves quality. Fieldwork and visits should also be made an important part of the training to ensure on the job training of ASHAS.

The provisioning of drug kits also needs to be improved. In 2008-09, only 56% of ASHAS had received kits. While the situation did improve in 2009-10, the current figure (69%) is still low. It has also been claimed that the kit often contains just four medicines (iron tablets, chloroquine, paracetamol and oral hydration therapy packets); ayurvedic and homeopathic medicines have not been supplied to most of the ASHAS (Ashtekar 2008: 25). Evaluation reports also list complaints by ASHAS that their kits are not adequate and contain drugs close to the expiry date. Timely re-filling of drugs is not undertaken in many states.⁶ This has restricted the role of ASHAS to essentially providing directly observed treatment, short course (DOTs), immunisation, institutional deliveries, and antenatal checkups. Even with respect to increasing coverage of women under the JSY, as revealed by the evaluation reports, delays in the release of funds have eroded the faith of the community in ASHAS.⁷ In several states like J&K and Madhya Pradesh, delays in receiving incentives have resulted in dropouts of ASHAS (Bajpai et al 2009; Bhat et al 2009).⁸ Ashtekar (2008) also reports unhealthy competition between ASHAS and anganwadi, with the latter viewing ASHAS as encroaching upon their jurisdiction and reducing their income.

At the same time, it would be hasty to dismiss the ASHA scheme as a failure. A study by Bajpai et al (2009) found that the introduction of ASHAS has had a positive impact in increasing the proportion of women taking at least three antenatal checkups and immunisation institutional deliveries. It should also be kept in mind that the scheme requires the volunteers to play an activist role in communities which are often characterised by religion and caste politics, conservative attitudes and where women are still looked down upon. Expecting partially trained local volunteers to adapt to the complex dynamics of Indian rural communities and effect an immediate radical change in the situation is expecting too much. It is necessary to persist with the scheme and strengthen it by providing ASHAS with improved support structure, regular financial incentives and better quality of services through training. This will ensure that their activism is gradually accepted so that they can become "social workers", rather than merely "health workers".

3.2 Mainstreaming Indigenous Health Systems

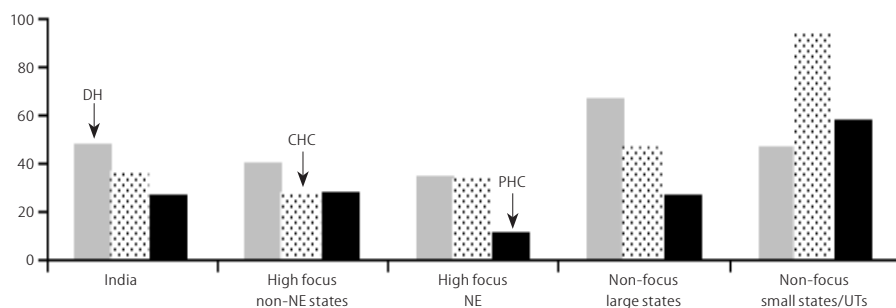
In order to meet the manpower and drug shortage in rural areas, the NRHM seeks to revitalise local health traditions and mainstream AYUSH infrastructure. This is sought to be attained through two means: (i) AYUSH medicine shall be included in the

drug kit provided to ASHAS, and additional supply of generic drugs for common ailments at SCS, PHCs and CHCs under the mission shall also include AYUSH formulations, and (ii) AYUSH practitioners will be mainstreamed at the PHC and CHC level – single doctor PHCs will be upgraded to two doctor PHCs by incorporating an AYUSH practitioner, and at the CHC level, two rooms will be provided for an AYUSH practitioner and a pharmacist.

AYUSH is an innovative strategy with important implications for the provisioning of healthcare services and increasing choice available to households (Sinha 2009). Duggal (2009) reports that expenditure under this head has increased fourfold between 2005-06 and 2009-10. There has also been a concerted attempt to incorporate AYUSH components in the state programme implementation plans (PIPs) and in different organisations like health societies, state health missions, rogi kalyan samitis (RKS) and ASHA training. The record has been mixed. While AYUSH has been incorporated in the PIPs of most states, its record in ASHA training is quite poor – it has been introduced in only 56% of the states.

In particular, the record with respect to integrating AYUSH components into the health delivery system at the grass-root level leaves much to be desired (Figure 2). The health management information system (HMIS) data reveals that AYUSH staff has been integrated in only 49% of the district hospitals, 37% of

Figure 2: Integration of AYUSH Staff in Healthcare Institutions (2010, in %)



Source: Estimated from http://www.mohfw.nic.in/NRHM/Documents/Executive_summery_January10.pdf

the CHCs and 29% of the PHCs. The record of such integration is also low in priority states outside the north-eastern region. The concurrent evaluation undertaken in 2009 by the PRCS on behalf of the health ministry also presents a disappointing picture. Except in J&K, less than a third of the PHCs surveyed in UP, Uttarakhand, Madhya Pradesh and Rajasthan have AYUSH practitioners. In J&K, where the record of mainstreaming is relatively better, AYUSH practitioners complain that the lack of AYUSH drugs and pharmacists trained to deal with such drugs, and preference of patients for allopathic drugs have limited their role in offering alternative healthcare services. In fact, a study of Rajouri, a district in J&K, observes that in such circumstances many AYUSH doctors are forced to offer allopathic drugs to their patients (Bhat et al 2009).

The availability of AYUSH practitioners has, in many cases, managed to sustain demand for public health facilities. A study by the Planning Commission, however, questions the limits to which alternative AYUSH practitioners can substitute for allopathic medical staff. Although the former can provide effective remedies in the case of minor and certain kinds of chronic

ailments, such as skin and digestion-related illnesses, their remedial skills are inadequate in the cases of surgery and extreme life-threatening conditions (Gill 2009). Thus, AYUSH practitioners should be conceived as a supplement to allopathic staff, and not their substitute. Further, their deployment should be keeping in mind the load of facilities and the observed preference of the public for AYUSH doctors only in the case of chronic ailments.

4 Decentralising Health Sector

Recognising the importance of involving grass-root level organisations in the healthcare delivery system, the NRHM has sought to encourage decentralisation as part of its core strategy.

4.1 Role of Gram Panchayats

As pointed out by Gulati et al (2009b), decentralisation facilitates the integrated delivery of health services through the convergence of services like drinking water, sanitation, nutrition, empowerment, etc, that are of crucial importance in ensuring a healthy population, while simultaneously ensuring that local healthcare needs are addressed.

The Integrated Health Action Plan is a major instrument in leading to the inter-sectoral convergence. At the initial stages, this plan would be prepared only at the district level – by the district health mission under the zila parishad. Given that this is a pioneering exercise in large-scale decentralisation, the initial experience has been quite encouraging though diverse (Sinha 2009). Some states have been able to involve panchayats in the planning process, resulting in the identification of important micro-level issues and problems. In other parts of the country, consultants with technical planning skills formed the core of the planning process. While this somewhat reduced the participative element in these plans, at least it has initiated the process in states where conditions were not conducive for decentralised planning (ibid). In 2006-07, about 48% of the districts had prepared district plans, and by 2008-09 this figure rose to 85%. However, 2009-10 witnessed a decline (74%) – which might indicate that the process of decentralisation is running out of steam. Some of the State CRMs also support the observation that these district plans have not been repeated after the initial year in some villages.

The PRIs from the village to the district level are expected to get the ownership of the public health system in their respective jurisdictions. While the CHC and PHC will involve the elected members of the panchayati raj in their management through the RKS, the SC will be accountable to the gram panchayat (GP) through the local committee under the village health and sanitation committee (VHSC). So far, VHSCs have been established in nearly 75% of the villages, and have received cumulative financial assistance of Rs 970 crore as untied funds. The objective of this committee is to help the ANM in preparing the SC action plan and help her in planning and implementing various programmes related to health, hygiene, nutrition, sanitation and drinking water. The NRHM guidelines state that the VHSC should comprise the ANM, ASHA, representatives of the village panchayat, women non-governmental organisations and self-help groups. Backward social classes should also be represented. Some evaluation

studies have noted that the constitution of the VHSC does not always follow these norms – for instance, in J&K, representatives of the village, socially backward classes or women representatives are not present in many of the VHSCs formed (Bhat et al 2009). The failure of the state health departments to provide training through orientation programmes to the VHSC members has limited their role to helping the ANMs utilise the untied funds. Meetings are not regularly held in many states, and the role of the VHSCs in preparing the district plans has remained limited.

Bajpai et al (2009) report that 95% of ANMs had joint bank accounts with the sarpanch of the panchayat. Further, analysis of expenditure patterns⁹ reveals that in general, funds were used for overcoming the infrastructural shortcomings wherever they were used. However, expenditure of the untied funds in some cases is planned by the ANM in consultation with the block medical officers, bypassing the panchayat members (Bhat et al 2009).

4.2 Increasing Accountability: Community Monitoring

It was expected that the establishment of the RKS would improve service quality and management by increasing accountability, but the actual progress has again fallen short of expectations. While almost all district hospitals and CHCs have registered RKS, the coverage of PHCs is much less. At the all-India level, only 71% of the PHCs have registered RKS; this figure is slightly better in the high focus states covered in the rapid appraisal survey (77%). Despite expectations from the RKS, their actual performance has been below par. The first CRM observes that the role of the RKS is limited by the tendency to view them as an alternative financing device and the consequent emphasis on user fees as cost recovery. Further, the composition of these bodies and processes of functioning are also not always conducive to community participation (NRHM 2007).

Evaluation surveys observed that display boards stating members and decisions about meetings are often not in order. There is no adequate system of grievance redressal. The RKS need to be strengthened as they can monitor the local health delivery system and also solve some of its deficiencies through its untied funds.¹⁰ The third CRM report for Bihar observes that though RKS have been formed up to the PHC level in most places, meetings are irregular and do not undertake the specific activities outlined in the NRHM documents (NRHM 2009b).

5 Health Management Information System

The mission statement acknowledges that a strong component of technical support is essential for the success of the NRHM. This requires, inter alia, the positioning of programme management units and an improved health information system.

The overall situation with respect to the positioning of district programme management units (DPMUs) is quite satisfactory. While the coverage of blocks is still inadequate, the situation is slightly better in the high focus states. The problem lies at the PHC level (Table 4, p 59).

In their survey, Bajpai et al (2009) found lack of coordination and cooperation between the health facilities and the DPMUs. Another important issue is that the role of the DPMUs has been so defined that they lack the required authority to take crucial

administrative decisions. For instance, in case of non-performance of paramedic staff (ASHA or ANM) at the village level, the DPMUS cannot take any corrective action directly; nor is the feedback given by these units to the paramedic staff always accepted by the latter.

Further, in order to complete unfinished tasks, it is necessary to identify weaknesses in the implementation procedures of the NRHM. A crucial component in this context is the health management information system (HMIS). The HMIS should be so designed that it can serve as a mechanism for effective monitoring and supervision of the Mission activities and evidence based planning.

Table 4: Snapshot of Programme Management Units (2010, in %)

Indicators		India	High Focus	High Focus
			Non-NE States	NE States
Number of districts where	District programme manager (managerial) is in position	90.5	92.6	87.5
	District accounts manager (accounts) is in position	90.2	84.2	98.9
	District data manager (MIS) is in position	82.7	86.8	98.9
	DPMU established	99.5	102.3	98.9
Number of blocks where	Block manager is in position	48.5	72.5	64.2
	Accountant is in position	59.2	79.4	54.9
Number of PHCs where accountant is in position		12.5	3.0	57.3

Source: Estimated from http://www.mohfw.nic.in/NRHM/Documents/Executive_summery_January10.pdf

Unfortunately, despite the elaborate structure created and data validation checks, the quality of the HMIS reportedly remains poor.

At the PHC and SC level, all registers are not maintained; those maintained are not updated regularly or in accordance with the RCH formats.¹¹ Part of this may be attributed to the unrealistic expectations of “health managers” regarding the information that the health facilities are able to furnish, and seeking too much information – even if it is not used subsequently. Often the same data has to be repeatedly supplied. Further, the second CRM found that multiple reporting existed, with earlier forms still being used (NRHM 2008). It also identified the existence of various constraints to data collection and flow. This creates pressure on the PHC and SC personnel, often making it difficult for them to both undertake their health-related duties and keep detailed records of their activities.¹² The CRMs have also noted that copies of reports sent to higher authorities (like office of the chief district MO) are not maintained by the facilities.

Overall, as CRMs have observed, the HMIS is not used adequately to inform planning and responsive corrective action. It is therefore necessary to revamp this system by identifying essential informational requirements, eliminating redundant formats, revising formats for primary data capture by taking into account operational constraints, increasing quality of data input at the grass-root level through proper training and capacity building, greater convergence between staff supplying data and providing a loop for feedback to the SC and PHC level. The PRCs may be

involved in the process of capacity building with respect to the HMIS.

6 Conclusions

To sum up, the actual delivery of the NRHM has fallen far short of its targets. Evaluation studies undertaken by the Planning Commission, the Ministry of Health and independent authorities indicate that the situation in terms of quantitative goals and quality of service in many states leaves much to be desired. With the mission nearing its deadline in 2012, it is unlikely that unfinished tasks can be completed within the remaining period.

However, within this limited period, the NRHM has succeeded in putting back the issue of public health at the top of the government agenda. This has put pressure on the state governments to divert resources to the health sector, thereby substantially strengthening the public health system, including its workforce (GOI 2010). Although these achievements have fallen short of what was originally conceptualised, the investment has had a positive impact on several health indicators like immunisation, institutional deliveries and antenatal care (Duggal 2009).¹³

A study of UP found that the service delivery capacity of the public health system had increased at each level (Kumar 2010). Outdoor patient visits had increased at all three levels (SC, PHC and CHC). The maximum improvement was found at the PHC level (129%) followed by an almost similar increase at the district and CHC level (86%). The main beneficiaries of indoor services at each level were invariably women followed by children and men, respectively.

Given the condition of the health infrastructure and manpower shortage in 2005, and the size of the country, the NRHM had an immense task before it. The fiscal crisis of the states, diversity in administrative ability and political will to administer the architectural modifications envisaged under the NRHM, and constraints in creating the workforce essential to provide the quality health services promised to a rural population of 74.4 crore perhaps made the targets and goals of the NRHM overambitious – particularly in a period of less than a decade.¹⁴ Above all, the NRHM did not adequately take into account the complexities of Indian rural societies, characterised 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 situated and which ultimately determines the success of policies and measures, including decentralisation. This is perhaps the most important factor limiting the success of the NRHM.

NOTES

- 1 Available at http://www.mohfw.nic.in/NRHM/PRC_Reports.htm.
- 2 Most of the data has been extracted on 22 April 2010 from the link available on the NRHM website: http://www.mohfw.nic.in/NRHM/Documents/Executive_summery_January10.pdf (which provides data up to 31 January 2010) and http://www.mohfw.nic.in/NRHM/PRC_Reports.htm.

In addition, http://mohfw.nic.in/dmu_report.htm also provides some useful data up to 28 February 2010.

- 3 The Health Ministry data shows that mobile medical units are available in only 56% of the districts. The evaluation studies report that most of these units do not have life support systems (so that they are basically for transporting patients); in some districts they are reportedly unavailable

in the evenings. The common review mission notes that in some cases, they are used for purposes other than transporting patients. Fees are also being charged in some places, leading to dependence on private sources of transportation.

- 4 No of SCs covered = Total amount disbursed/10,000 (i.e., the annual amount to be disbursed to each SC annually).
- 5 It was reported that an orthopaedic surgeon in

- the Tamnar PHC, Chhattisgarh, had not performed any surgery in the last 18 months. Similarly, an ophthalmic surgeon in Basthar, Chhattisgarh, was undertaking general surgeries on a regular basis, while another in the same region was a non-operating surgeon (NRHM 2009a).
- 6 Minutes of ASHA Mentoring Group Meeting, 11 February and 6 August 2009, accessed on 15 March 2010 at <http://www.mohfw.nic.in/NRHM/asha.htm#AMG>.
 - 7 As an ASHA worker complains, "Since no money is presently available under JSY, we are rebuked and abused by women whom we had registered for JSY. This has demoralised ASHAs to perform their duties. Now even our family members criticise us and discourage us to work as ASHAs" (cited in Bhat et al 2009: 140).
 - 8 In Rajouri district of J&K, though ASHAs were selected in almost every village, information from the selected VHSC members indicate that in 55% of the panchayats, ASHAs had stopped working (Bhat et al 2009: 150).
 - 9 Sixty per cent ANMs used the fund for repairs and renovations, 50% for purchasing equipment, 31% for buying medicines, 24% for electricity supply and 19% for running water supply (Bajpai et al 2009).
 - 10 For instance, RKSs are empowered to make purchases to meet shortages in drugs.
 - 11 "MOs expressed that printed registers as per RCH format have not been provided to them. The workers maintain information on blank registers and each PHC has devised its own format for recording information" (Bhat et al 2009: 90).
 - 12 The Third CRM comments that it takes about two working days every week for the ANM to fill in formats (NRHM 2009c).
 - 13 The incidence of institutional deliveries has increased by 23% between 2005 and 2010, while the number of JSY beneficiaries has increased 11 times in this period (NRHM website).
 - 14 In some states the spread of Maoist insurgency may have created obstacles as medical staff are reluctant to be posted to "red" areas (Gill 2009; also, personal communication from local political leaders in West Bengal).
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