Reviewing National Rural Health Mission

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Improving Access and Efficiency in Public Health Services:
Mid-term Evaluation of India's National Rural Health Mission

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Sage Publications, New Delhi;

That India's Rural Health Services leave much to be desired is a known fact despite 60 years of independence. India's Rural Health services do not even match many other Asian nations notwithstanding its superpower ambitions. UPA1 launched the NRHM in 2005 to kick-start reforms in the rural health sector, especially on the background of commitments to the MDGs. The NRHM relied on the introduction of village health activities (ASHA), improved management, decentralization through PRIs, enhanced central assistance etc to bring about an "architectural change in the rural health system". NRHM is expected to be complete its work in 2012.

The GOI does an annual assessment of NRHM progress in each state through common review mission combining administrative, academic and civil society participation. These reports are available on the GOI-NRHM website. The International Advisory Panel (IAP) setup with Norwegian assistance, and help by the Bill Gates Foundation and headed by the Columbia university Earth institute has done a mid term review in 2009 which is now published by SAGE. All the authors have close interaction with India's health and development and one of them belongs to IIM Ahmadabad.

This is a report of a study undertaken by the IAP team in three backward and high focused states namely MP, UP, and Rajasthan. The team selected five districts in each state and surveyed health facilities and functionaries. The focus of the study was on ASHA's, Role of Panchayat Raj institutions (PRI), existing infrastructure and human resources at subcentres, primary health centres and Community health centres. The study also reviewed NRHM efforts to reduce IMR and MMR. The field visits intended to find –"ground truths". The study project has systematically analyzed gains from the NRHM interventions in comparison to scenarios that would have otherwise developed without NRHM.

The report states that NRHM is 'undoubtedly the most ambitious rural health initiative to be launched in independent India by the UPA Govt as part of their common minimum programme' and is linked to MDGs, specifically Infant Mortality Rate (IMR) and maternal Mortality Rate (MMR). The authors note the fact of extremely poor primary health care

infrastructure in both quality and quantity and the need for a massive scaling of effort to provide improved health care. The NRHM set out an ambitious agenda to provide effective health care to rural population throughout the country and to raise health expenditure from 0 to 9 per cent to some 3 per cent of GDP, promote policies to improve public health management, promote AYUSH, and for all this define schedule. The goal was to improve access of rural people, especially poor women and children for equitable, accountable, affordable and effective primary health care.

This study has done a valuable comparative analysis in all the states using parameters such as ASHA training, percentage of women taking minimum 3 ANC checkups, immunization, institutional delivery, IMR, unmet need of health infrastructure based on DLHS 2 (2002-2004) as benchmark, and DLHS 3 (2007-2008) as achievement in the NRHM period. The group has analyzed the progress of health indicators employing statistical methods of Regression analysis.

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The important findings of the report are as follows.

- Creation of 24 hours PHCs and increasing Janani Suraksha Yojna (JSY) birth proportion have somewhat reduced IMR. But the rate of IMR reduction is unsatisfactory. However no other NRHM intervention has made an impact on IMR. The study suggests the NRHM is nt likely to achieve the desired reduction in IMR.
- Some of the interventions in NRHM may be counterproductive for increasing institutional births in states except the impact of ASHAs er thousand population. It further notes that JSY deliveries have actually negatively influenced IDR (Institutional Delivery Rate) in states.
- NRHM does not seem to have any impact on ANC check up rate.

The report presents some evaluation of NRHM based on sample surveys of CHC and PHCs.

- The NRHM strategy to Mainstream AYUSH has not worked.
- The CHC physical infrastructure has improved in 71% units.
- The physical infrastructure in PHCs was found unsatisfactory.
- The Rogi Kalyan Samiti (RKS) is not very effective for improving patient services except by way of infrastructure improvement.
- None of the PHCs were able to conduct C section delivery (*is this expected? No!*)
- Public participation to improve health care services seems to be quiet illusory.
- The rate of institutional delivery is not affected by availability of specialists in CHCs.

The observations regarding ANM, ASHA and VHSC

- Many ANMs complained about demand of money by Sarpanch for signing the cheque on the joint account.
- ANMs felt that their funds were adequate contrary to the observation that the infrastructure was in bad shape.
- DDKs were available only with 29% ANMs I am not surprised because DDKs not required for institutional delivery but home delivery and the NRHM discourages a later.)
- About 62% ANMs conducted deliveries, out of which 40% did it at home and half of these (21%) at the sub center. Some 19% ANMs *reported the home delivery as institutional delivery*
- The referral rate to Public Health facilities has improved as regards childbirth rather than to private facilities. (it looks like the childbirths were diverted from private to public facilities thanks to JSY incentives)
- About 71% ASHAs received some formal training for 12-19 days during the first year and they found it useful.
- Drug kits have reached most ASHAs.
- More than 90% ASHAs informed about their active involvement in creating awareness for health.
- ASHAs earned incentives varying from an average of Rs 317 (in a UP district) to Rs. 788 in a Rajasthan district.
- Village Health Sanitation committee (VHSC) members had very limited understanding of NRHM and about ASHA, Auxiliary Nurse Midwife (ANM) and Anganwadi worker (AWW).
- ANMs and contractual doctors did not receive timely salaries.

Other findings include -

- 50% vacancies of medical officer's positions in UP.
- The payment for MOs and specialists in UP is quite low -- approximately one fifth of what is paid in private sector and real expectations are about 30000-40000 Rs.
- Recruitment of medical and paramedical staff is unsatisfactory.
- Only 10 out of 49 sub centers in Varanasi district are credited for institutional delivery.

The report concludes that NRHM has created a much higher demand for health services in relatively short time span. But for NRHM to succeed, we need following seven factors: a) Much higher spending, b) a better ASHA program, c) better management of health facilities at village (?), SC, block level, d) Better role for PRI e) Better Human Resources in SC and PHC f) better efforts on IMR and g) integration with ICDS.

In summing up, the report also adds some specific needs like coordination between centre and states, accountability of states, health sector strategy for MDGs, nutrition initiative, ASHA training and incentives, ANC checkups, use of flexi funds, infrastructure improvement, use of IT and MIS, looking at emerging disease burden, more public health managers, HHR expansion thru training institutes etc.

This IAP study substantiates our fears that NRHM has not been able to achieve against its own expectations. The report dwells on infrastructure, field workers and the achievements in MDGs. However, this report misses problems and mismatches regarding the larger context of NRHM within health policy in India.

Will this NRHM design solve the chronic problems of rural health sector in India? The report does not engage with this issue. One feels after reading this report that the peripheral structures of NRHM have not done well at least in the three states covered. However, either due to design of the study or because of limitations imposed on itself by the study team the analysis is an incomplete story. It talks more of delivery failures rather than the causes of failure.

The failure of India's health policy, programmes and missions need to be seen as a continuum of failed efforts and faulty designs from early days of independence. The report also creates an impression about NRHM being the biggest effort of independent India for reform in health care. In reality, such efforts in the past have also abandoned due to failures or the shifting responsibilities of the bureaucrats. Like other health sector failures a proper review of intentions, designs, strategies and implementations of NRHM are necessary from internal as well as external agencies. The IAP study has hovered around "ground truths" and has missed the larger health policy issues in Delhi's skies.

It must be said now, especially because NRHM is sure to get an extension, that the intentions, policies, strategies and implementation of NRHM are substantially flawed. First of all NRHM promised comprehensive health care for all but actually ended in a whimper raising the rates of institutional delivery (IDR) with questionable quality of care. The birthing at sub centre is arguably no better than at home in the given circumstances of the sub centre. The ANM has been deprived of ANC and maternity work for decades and harnessed to family planning programme. She cannot be expected to switch to delivering the maternity services overnight. The male multipurpose health worker (MPW) has been a major help in public health programs regarding disease control. But NRHM has missed the MPW completely. That the NRHM could not have done without doctors and nurses in the system has been well known. However NRHM only relied on sending deliveries to half hearted institutions with the questionable incentive attached to JSY scheme. The shortcut of paying women for going to institutions for birthing has surely filled some records but this cannot be a long-term strategy of attracting people to health care institutions. Experience shows that a better health care institution attracts people who fill up the beds and even sleep on the floor if good services are ensured.

ASHA, an Elusive Activist

The policy of making contractual appointments with unfair terms (esp. in the context of hefty salaries for permanent staff thanks to the Sixth Pay Commission) is not going bring or retain Health HR. NRHM has hardly looked beyond institutional deliveries and immunization, thanks to its fixation with MDGs. It seems that there is little impact on immunization. Further, it appears that all the so-called progress of NRHM is due to ASHAs in big numbers. However, the condition of ASHA programme itself is lamentable as is evident of common review missions and the IAP recommends better inputs for this. Poor training, paltry payment, hardships for distant ASHAs as regards JSY programme, lack of timely refill of medicines and not enough medicines are all evident from various reports. The ASHAs still have a faint asha (hope) of good work conditions some day- a fixed monthly incentive and job-stability. Being women who have to go through hardships every day, they wear a smile as they only can. The ASHA programme itself is in jeopardy as there is not enough support for it at central and state level. The ASHA programme is seen as a liability and may be disposed of like the CHW programme of 1978 once the health system thinks it has the villagers hooked on to CHC-PHCs and subcentres.

ASHA has not become a health worker by design but remains an elusive activist, a euphemism for a fetcher of delivery cases and children for immunization clinics. The IAP report argues for a health care provider role for ASHA, especially for childcare. While IMR and MMR are major MDG goals, these cannot be the only important issues in India's health care, as NRHM believes. The reductionist approach of MDG for IMR and MMR coupled with narrow and confused strategies of developing referral institutions at the cost of fostering good health care units at villages has not paid off either. The idea of putting a second ANM at the sub centre is also questionable because first, there are not enough nurses and second she cannot be expected to deliver when the first ANM has not done well due to the systemic constraints. So it is that we see two ANMs in many NE states but the sub centre remains closed between 4 pm. to 8 am the next day, without any midwifery work to speak off. The VHSC has also failed to touch the real issues as it is still struggling with elementary and expected problems of corruption at the Panchayat level. NRHM did talk about integration with ICDS but that has now faded even from policy discussions except that there is a village health day at the venue of Anganwadi. The Anganwadis themselves are in poor shape because of neglect by states and complexity of the malnutrition challenge.

NRHM wanted to reclaim 80 per cent ground in rural health sector and thus wrest the initiative from the booming private sector of rural India known for its wily quacks and cut practices. The NRHM never threw up any worthwhile programme or strategy for this purpose. However there is some rise in outpatient registrations in PHCs. Similarly the Public Private partnership (PPP) have not materialized except in Gujarat.

The most important problem the NRHM has created in the health sector is centralization of health initiatives by way of funds and disbursement mechanisms. The states were already showing a decline on their health commitments by way of funds and initiatives. NRHM has

further complicated this problem. Many states now bank heavily on the Centre rather than generate the local political and financial support for health care, except few states. Making NRHM societies at state and district levels to handle the NRHM funds has split all the state health systems departments into cash rich NRHM and cashless non-NRHM/ much like the FP and non-FP departments.

May be it is not all so gloomy in some states that have used this opportunity. But that the high focused states have not done well is evident from this IAP report. Now, one can argue that NRHM can be just as good as the individual state's health system or the time is too short. It is necessary to take stock of the context, content, programmes and strategies of NRHM in the light of ground realities and the National Health Policy 2002 (NHP). May be it is necessary to think anew besides NRHM to build up a proper health care system from below for rural &urban India using and expanding the given template of public health care system. One may think of using 'quacks', dais, MPWs and ASHAs for creating a cogent and viable health unit in each village of India. Otherwise, the people have already voted for the neighborhood rural private 'doctor' rather than SC or PHC. Moreover, for this each state needs to take its own responsibility and generate resources. IAP report largely misses this point.