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

Concluding Remarks and Recommendations

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SINCE THE launch of the National Rural Health Mission (NRHM) on April 12, 2005 by Dr Manmohan Singh, Prime Minister of India, undoubtedly the Mission has achieved a great deal, especially in the areas of putting in place an ASHA for every 1,000 population; creating greater awareness about ante-natal care, institutional delivery, post-natal care, and child immunization; raising institutional deliveries; raising the number of outpatients being provided with healthcare services in the health facilities; providing untied funds at all levels of facilities; and providing the much needed flexibility for outreach of services, and so on. These are all very commendable achievements. However, the scale of the challenge that remains is immense, but so too, we believe is India's capacity.

It is for the first time in independent India that a rural public health program as ambitious as NRHM has been put in place to address real issues on the ground with real resources, both financial and human, though there is much more needed on both the fronts as our study argues. Obviously, a rural public health system that has been largely dysfunctional for the most part especially in the northern and eastern parts of the country all these decades cannot be expected to begin delivering results in a short span of 3–4 years with the infusion of some additional funds and some new strategies and interventions. Be that as it may, we do think from what we have seen across many states—Uttar Pradesh, Madhya Pradesh, Rajasthan, Assam, Andhra Pradesh, Karnataka, and Tamil Nadu—and our empirical analysis of the primary and secondary data in this report that NRHM has surely begun to make a difference.

Put briefly, we think what the NRHM has been able to accomplish in a relatively short period of time is to create a much higher level of demand for public health services from the ground up. This in turn, we believe, will force the systems and processes to function better in order to meet this surging demand. Our overall assessment is that should the central and more importantly state governments undertake the necessary corrective measures—which we have attempted to explain and highlight throughout this report—during the next four-five years, there is a real possibility of witnessing some far-reaching results, such as the reduction of infant, under-5 and maternal mortality rates; much higher immunization rates; and sizeable reductions in out-of- pocket expenses for healthcare services for India's hundreds of millions of poor rural residents.

We believe that the following seven broad issues are critical if the NRHM has to succeed on scale: (a) a much higher level of public health spending in general and much higher outlays for NRHM in particular; (b) proper recruitment, comprehensive training, effective control and oversight, and timely and adequate payments for the ASHAs; (c) an effective and efficient management structure for the health facilities at the village, block and district levels; (d) a well-defined and implementable role of the Panchayati Raj Institutions (PRIs) and a comprehensive and ongoing training program for the panchayat members; (e) commensurate physical infrastructure and human resources in the sub-centers and the Primary Health Centers (PHCs) with the growing needs of the regions; (*f*) scaling up necessary interventions to bring down the infant mortality rate (IMR) (focusing on neonatal mortality in particular) and maternal mortality rate (MMR); and (*g*) NRHM to work hand-in-hand with the anganwadi workers of the Integrated Child Development Scheme.

The health conditions, of course, cannot be studied in isolation. The shortfalls in health, education, and population control, among others, are all mutually interactive. Illiterate mothers are much more likely than literate mothers to suffer the deaths of young children due to disease, since literate mothers are more effective at care giving and at seeking out medical help in emergencies. High infant mortality rates promote high fertility rates, since households have many children to compensate for the risks of childhood deaths. High fertility rates, in turn, promote a social bias against educating young girls. Since parents lack the resources to provide a quality education for all of their children, they invest scarce resources on boys, for whom the perceived market returns to investment are higher.

1. Specific Recommendations

The following is a list of 24 specific recommendations that follow from our extensive site visits and consultations with stakeholders including the Ministry of Health and health officials at state and local levels.

1.1. For Immediate Action

1.1.1. Management and Co-Ordination Between the Center and States

1. NRHM should hold the states accountable for results. In this regard, Memorandums of Understanding (MoUs) between the state governments and the central government should be signed without any delay. This will bind the states and the NRHM progress could be better monitored particularly through the benchmarking of performance given in the MoUs. Also, while the funding of inputs is certainly needed, the Mission may be more effective if it were to pay for outputs.
2. We suggest a health sector strategy for India that is Millennium Development Goals (MDGs) based not only at the national level, but also more importantly at the state and district levels. States and districts should strive hard to attain the MDGs, such as reducing IMR, under-5 mortality, MMR, immunizations and access to safe drinking water and the like especially for the laggard states and districts, with particular focus on the 150 most backward districts of the country. Based on the MDGs, state governments should announce targets for health to be met at the state and district levels by the year 2015.
3. We suggest that the central government should plan to convene a meeting of Chief Ministers and Health Ministers of all Indian States in 2010 to discuss how the states will meet the health targets. This meeting will allow states to present their most successful initiatives, so that all states can adopt “best practices” in public health.
4. We recommend that the Prime Minister chair an inter-ministerial group on India's nutrition challenges—sub-populations with chronic under-nourishment as well as the rapid rise of disease from obesity, diabetes, and the “urban/industrial lifestyle”. This inter-ministerial group is crucial since clearly several different governmental ministries play a significant role in dealing with India's nutrition challenges. The group would include ministries involved in public health and family welfare (Ministry of Health and Family Welfare); urbanization (Ministry of Urban Development); nutrition (Ministry of Women and Child Development); rural development (Ministry of Rural Development); transport (Ministry of Roads, Transport and Highways) and the food sector (Ministry of Agriculture) to give a widely-based approach to the multiple challenges facing India in achieving healthy nutrition.

1.1.2. ASHAs Incentives

- 5. ASHAs should be paid a regular salary in the range of Rs 1,000 to 1,500 per month plus incentives. The incentive amounts being paid currently are too meager.
- 6. Untimely payment of incentives to ASHAs is serving as a huge disincentive for taking on the role that is expected of them. The presently followed system of paying the ASHAs is a lengthy process which is not only cumbersome, but very poorly implemented as well. The result, almost all the ASHAs

we spoke to received their payments after months. A much simpler and straightforward system needs to be put in place for paying the ASHAs so that they are paid *every* month. Likewise in the National Rural Employment Guarantee Scheme, ASHA payments should also be electronically wired into their bank accounts.

1.1.3. Utilization of Flexi Funds

7. During all our field visits, we found that untied funds were not being utilized, especially at the PHC and the CHC levels. ANMs at most SCs that we visited did utilize untied funds. We suggest that all SCs, PHCs and CHCs, be provided a list of essential items and equipment that each HF should necessarily have. This will automatically help utilize the untied funds.
8. Clear guidelines should be provided to PHC/CHC doctors and ANMs about the use of NRHM funds at their disposal.

1.1.4. Pre-Natal Checkups

- 9. With the exception of pre-natal checkups for expectant mothers, the delivery of healthcare in rural India remains almost entirely curative in nature. With hypertension on the rise in the country, it is suggested that blood pressure be examined on a regular basis for all patients visiting SCs and PHCs. ANMs at the SC level and nurses at the PHC level should in the normal course examine blood pressure as part of ante-natal care, as pregnancy-induced hypertension is a major contributor to maternal mortality in India.

1.1.5. PHC Infrastructure

- 10. With surging institutional deliveries, there is urgent need to provide larger space in the PHCs to accommodate expectant mothers such that they stay in the health facility where they deliver for at least 36–48 hours post-delivery.

1.1.6. Training for PRIs, VHSCs, and RKS Members

- 11. There is a need to impart training and conduct awareness camps for the members of PRIs, VHSCs, and RKS without losing time.

1.2. Actions to be Completed within the Next Two Years

1.2.1. Improving Infrastructure and Facilities

- 12. The increased public health spending should finance infrastructure improvements in the rural SCs, PHCs, CHCs and the district hospitals. Additionally, much higher level of spending is needed for higher salaries to be paid to doctors working in remote and inaccessible rural areas, essential drugs and supplies, vaccines, medical equipment, laboratories, and the like. In terms of human resources in the health centers, state governments need to appoint more ANMs, trained birth attendants, technicians, pharmacists, doctors, and specialists. In the lagging states, governments need to provide cell phones to doctors and ANMs in rural PHCs. These measures will help increase the utilization of the public health centers and consequently bring down the rather high out-of-pocket expenses of their rural residents.

1.2.2. Information System and Data

- 13. We suggest that the state governments utilize information technology—NRHM Health Management Information System (HMIS)—to improve the performance of their public health facilities. The primary objective of the HMIS will be to provide operational information for better service delivery and monitoring and policy formulation. It will also provide adequate feedback to the providers facilitating constant assessment of their performance and thereby providing opportunities for improving the same. clear directives are needed for high quality routine health information systems that rely on one time accurate data capture at source of transactions between beneficiary and health system.

1.2.3. Village Level Management and Supervision

14. In order to improve the delivery of health services, we suggest supporting community oversight of village-level health services, including panchayat responsibilities for oversight of SCs, and PHCs. While the 73rd and 74th Amendments to the Indian constitution allow for a democratic system of governance in health to the multi-layered local bodies, their implementation leaves much to be desired. Such devolution of authority has taken place only in Kerala, which invested time and resources in systematically building capacity for governance in local bodies. Most states need to strengthen their existing programs of capacity building in the PRIs.

1.2.4. ASHAs' Training

- 15. NRHM can play a significant role in bringing down diarrhea, pneumonia and neo-natal mortality. Together, these three diseases are responsible for more than two-thirds of the under-5 mortality. MDG 4 cannot be met without significant inputs into preventing these deaths. Neo-natal mortality reduction in particular is complex and will require specialized training for ASHAs. It is unrealistic for all

ASHAs to be trained in the complexities of managing neo-nates. All ASHAs should have basic training in new-born care but a selected cadre of ASHAs should have specialized training in neo-natal care.

- 16. Current training programs of the ASHAs are extremely inadequate, both in terms of the quality of training being imparted and the time being allocated for their training. Presently, training of ASHAs is only for 21 days as a one-time course and occasionally an additional five days of in-field training, the latter being implemented very irregularly. Not only is the training required to be far more comprehensive than what it is currently, it should be an ongoing process, at regular intervals, throughout the year, say at least for the first two years of an ASHA's recruitment.
- 17. Ideally, ASHAs should be trained using information and communications technology (ICT) at the district headquarters. The training can be imparted by a group of trainers centrally from the state capital to all the districts simultaneously on fixed dates which can be announced well in advance. Additionally, trainers available at the district headquarters should supplement classroom training with infield training of ASHAs. ANMs can play a critical part in the in-field training of the ASHAs.

1.3. Actions to be Completed within Five Years

1.3.1. Public Health Managers

- 18. In all our field visits, we found serious problems due to lacking management structures. An effective and efficient management structure needs to be put in place at the village, block, and dis-trict levels. Most importantly, there is need for a health coordinator to manage the proliferation of specific health programs (ASHAs, nutrition, immunization, malaria control, and countless other programs directed to specific disease conditions) and to look after the integration of logistics, physical facilities, staffing, and community outreach. Clear directives are needed for professional management by public health managers (not clinicians or generalists) at least up to the district level.

1.3.2. Emerging Disease Burden

- 19. Many parts of rural India are experiencing an epidemiological transition and this is reflected in a growing burden of non-communicable diseases. Non- communicable and chronic diseases are increasingly being seen as a leading cause of death in rural India. Hypertension, Type II diabetes and cardiovascular diseases are on the rise in rural India. It is critical to keep these emerging disease burdens in mind while scaling up health services. We suggest that under the NRHM umbrella, programs are put in place to deal with the growing burden of these diseases.

1.3.3. Large-Scale Training and Education

- 20. Increased supply of doctors, specialists, pharmacists, technicians, trained nurses and midwives, and so on has to be ensured for the success of the scaling up effort. This requires large-scale training and specialized education by encouraging private sector institutions to operate and expand the number of seats in such professional courses. Such institutions need to be formally recognized and properly monitored and supervised to ensure quality of training and education imparted. Although all this can take four to five years before qualified doctors and specialists can emerge in adequate numbers, it can increase the supply of paramedics very quickly. If the expansion of facilities is properly planned and phased out, the problem can be solved to a considerable extent.

1.4. Issues Requiring Immediate Review and Subsequent Action

- 21. Since one of the core strategies of the NRHM is to train and enhance capacity of the PRIs to own, control and manage public health services, the following questions need to be looked into by the state governments: Has the power and authority devolved to the PRIs on paper actually reached the people? Do they understand their duties and responsibilities on the one hand and their authority on the other? Do the PRIs have the capacity to manage health centers? Are there regular and comprehensive capacity building programs in place? And are any measures being undertaken to ensure that the caste and patriarchy do not prejudice effective management at the local level?
- 22. The monetary incentives provided to population under different programs need to be seriously reviewed and modified appropriately. For instance, the monetary incentives for accompanying the delivery cases or for sterilization operation motivated by ASHA are perverse—Rs 500 for a delivery case and Rs 150 for a sterilization operation. In general, there is a need to review and improve the incentives for voluntary uptake of family planning services as fertility rates remain very high among impoverished rural populations, and for improvement in the quality of family planning services.
- 23. The policy to have several specialist doctors at CHC level must be reviewed. Instead, general practitioners (GPs) with some experience in adequate number can address the current local needs much better. Specialists can be encouraged at higher level right now and later at the lower levels.
- 24. The system of insisting on co-signatories for operating NRHM funds needs serious review. With some indirect checks and balances, the relevant departmental official should be given the authority to operate the funds with only his/her signature.